Discharge case study
King’s College Hospital NHS Foundation Trust

Improving the quality of transfer between Hospital and Care home by Advance Care Planning using the PEACE documentation

Overview

King’s College Hospital has been committed to improving the quality of communication on discharge from hospital to nursing and residential homes for many years.

This work has involved standardising the transfer process using evidenced based practice, introducing guidance and documentation to ensure safe transfer of care for the patient, in particular elderly patients in the last stages of life.

The hospital has demonstrated that by collaborating with multi professional groups, both in the hospital and the community they have introduced a reliable, patient and family centred approach to preparing patients for discharge and transfer of care.

At a glance

- A Focus on Advance Care Planning using PEACE documentation.
- Improving transmission of clinical information and decision making.
- Improving communication between patient, family and professionals.
- Enhancing relationships and support between hospital and care homes.
- A focus on action planning for older adults and palliative treatment.
- Reducing adverse events or readmission to hospital at the end of life.

Background

Following a series of audits of hospital attendances and admissions from local care homes, clinicians in the department of clinical gerontology at King’s College Hospital, St Thomas’s and the Care Homes Support Team in SE London became increasingly aware of problems occurring in relation to the transfers of care from hospital to care homes for elderly patients with complex needs, dementia, and frailty or at end of life. The number and level of acuity of patients being admitted to hospital was increasing, with care home residents aged 75+ accounting for 13% of admissions.
The variation in the quality or accuracy and poor exchange of information on discharge affected the ability to adhere to clinical decisions, resulting in high hospital readmission rates (30 day) and poor quality experience of patients admitted from care homes. In a bid to improve transfers of care, collaboration by clinicians across the three organisations, working with care home providers locally, embarked on a programme of improvement.

Further audit was used in order to gain a better understanding of the problem. They also carefully considered the evidence base for changes to be made that would enhance the decision making and discharge process.

Solutions

Introduction of PEACE developed at King’s and Guys and St Thomas’s. A process of discussion between an individual, their care providers, and often those close to them, about their ongoing and future care needs.

- An individualised document captures the clinical action plan on progression of illness.
- Wishes of patient and family taken into account, documented and upheld.
- Advance care planning – decisions documented and agreed in the event of clinical incident or change in condition.
- Greater collaboration between health and care professionals.
- Greater experienced and optimal outcome for all concerned.

Impact and outcomes

There is good evidence from early pilot and testing, audits and qualitative review that engaging patients and families in early decision making, investing in co-ordinated MDT planning and implementing PEACE documents in the discharge and transfer process has a positive impact on the quality of transfer, ongoing care and experience for patients.

Patients

- Safe, well-planned, coordinated transfer from hospital to care setting.
- Patient returns to the right care setting with support package in place.
- Multi professionals fully informed of clinical decisions.
- A coordinated approach to managing end of life care in the event of a change in clinical condition.
- Patients and family wishes upheld, improving experience and satisfaction

**Whole system**

- Better working relationships between health and care setting, with greater integrated transfer processes.
- A reduction in unwarranted hospital readmissions and associated costs.
- Adherence to national guidance on Advance Care Planning, and treatment and care at end of life.

**Test results**

- When PEACE is used for patients judged to be on a palliative trajectory, readmissions are significantly reduced and patients are more likely to die at their place of preference than those discharged without PEACE.
- Further development of community ACP is indicated in order to promote end of life care in the right place.

**Further quality improvements and spread**

Due to the success of the standardised discharge process and the introduction of PEACE Community, PEACE documentation has been rolled out. This is to enable care home staff and GPs to develop Advance Care Plans and to avoid unwarranted transfer to hospital, should that be the wish or preference.

*Exploring professional roles in facilitating ACP and PEACE.*

The PEACE document is developed in consultation with patients/residents or where appropriate their family or representative. A range of health professionals including nurses, doctors and therapists can be involved in development of the document, both in hospital and community settings.

**Top tips**

- Ensure you obtain dedicated leadership for the project.
- Obtain organisational support by engaging your senior team.
- Be realistic about timescales, how much you can get done and by when.
- Do the ground work – systems are large and complex.
- Engage all stakeholders.
- Keep the patient at the centre of all decision making and involve them in the process.
• Look for support from other teams when it comes to transformation and integration.

**For more information about this project contact:**

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**Themes**

• Policies and systems that link health and Social Care

• Systems that involve patients in their care