Service Priorities and Programmes

Electronic Presentations

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Clinical Effectives: Hospital-Based Advance Directive Review

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Introduction

Hospital-based audit on Advance Directives (AD) was conducted in six Kowloon Central Cluster (KCC) hospitals as suggested by Group Internal Report (GIA) in May 2016. AD coordinators of KCC hospitals were invited to coordinate this activity and report to KCC Palliative Care (PC) Coordinating Committee Meeting. An audit on AD was conducted in Queen Elizabeth Hospital (QEH) in Nov 2017.

Objectives

To review the validity of AD and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Form for Non-Hospitalized Patients
To check documentation and record management
To identify area for improvement

Methodology

Name lists were drawn from 01/07/2017-30/9/2017 by Hospital Authority Head Office (HAHO). The samples had Clinical Management System (CMS) flagging for AD. There were totally 53 cases. To work in line with other cluster hospitals, it was agreed that audit period was from 1/11/2017-30/11/2017. Based on 'Guidance for HA Clinicians on Advance Directives in Adults (2016)' and 'Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (2016)', a structure audit form was revised to evaluate the records and documentations from KCC (PC) committee team members

Result

There were total 53 samples covering clinical oncology unit, medical (CGAT), medical (renal) and Paedi. Only 52 samples were used for auditing as one CMS wrong flagging was noted in the Paedi sample. The overall compliance rate was 95.3%. Comparable weak items include 'Copy of AD Form and its Alert in CMS is checked every 6 months by the issuing unit if the patient remains alive' and 'Copy of DNACPR Form for Non-Hospitalized Patients and its Alert in CMS is checked every 6 months by the issuing unit if the patient remains alive' reached 71.4%. However, relatively small numbers of samples were noted regarding to these two weak items. Some weak practices were also identified including delay to review DNACPR forms, CMS flagging, documentation & signature issues. All audit samples had short-AD signed except one,

had full AD done after review.
There was increasing trend of ACP discussion noted. Clinical oncology took active roles in selecting appropriate cases for AD and DNACPR discussion at outpatient setting. Other units like medical and outreach team (CGAT) were engaged too. There would be room for improvement about overall compliance especially related to record monitoring. To extend the scope of the audit, we can consider including the practice of DNACPR Form for Non-Hospitalized Patients in the future audit. A central registry to monitor the record is also noted under construction.