Review of CMC plans within PCN2

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Introduction

Barnet has significantly increased its use of CMC over the past year, from ~250 completed records from 2013-2018 to 950 unique records created in April – December 2019 (115 unique CMC care plans were published in December alone)

Achievement of Preferred Place of Death (PPD) is one of the main outcomes of having a CMC care plan in place. Across the NCL STP 90.4% of residents achieved their PPD but in Barnet, 73.1% of patients achieve their PPD. Effective communication and quality of the record is important to help ensure PPD. A clinical quality audit was undertaken in order for CMC to be effective in reducing admissions and deaths in hospital.

With training available to care homes to access NHS mail with a view to ultimately accessing CMC, there are plans that care home staff will also be trained to write CMC plans with clinician support. As the use of CMC as a tool is set to increase in Barnet a deeper understanding of how to write effective high-quality plans is essential.

Method:

Since the Frailty MDT had been based within PCN 2 they were used as the test site. CMC completed a completeness audit looking at what percentage of records from each GP surgery within PCN2 were complete. A sample of 22 records were taken at random from each surgery and these were assessed in detail to see how clear the plans were and whether any key information was omitted. 20% of the records were completed by nurses either from the Frailty MDT or North London Hospice and 80% were completed by GPs.

A focus group with 7 paramedics was then held at Friern Barnet Ambulance Station to gather feedback from LAS clinicians into their experience of using CMC. A CMC record studied during the audit was shown to LAS and they were asked to feedback as to what information was or was not helpful.

Findings

1/3 of CMC reports reviewed did not list NOK details. Similarly, 8 out of the 22 records did not document whether family were aware of the contents of the CMC plan. LAS reported that this information is very useful to them when attending a call out. They will often contact the NOK, knowing what they understand already and how to contact them saves time and aids communication. One record did not state if there had been any discussion with NOK. While not every patient will have NOK for completeness this should be documented.

LAS reported that if an LPA for health is in place then it is important to state who holds this and ideally upload a copy of the LPA to CMC. LAS reported incidents where next of kin falsely stated they held LPA.

Of the records we looked at 16 out of the 22 records (72%) had clear documentation of the discussion surround DNAR decision making. One record had a decision documented from 2014, while this may still be valid it can be helpful to document that the decision this is so and the patient's situation is unchanged.

While ceilings of treatment were often stated further clarity around how to practically manage a patient at home could be added. Just over a third of records stated 'not for admission' yet there were no details given to help support OOH services in managing these residents at home. From the focus group with LAS information they would find helpful included details of whether there were rescue packs or emergency medications within the home environment and where these would be found. If medication for breakthrough

pain has been issued a clear plan of how this is to be given is useful. If a catastrophic event is a possibility due to the nature of the illness (e.g. terminal haemorrhage secondary to head and neck cancer), advising LAS of this in the plan and giving details as to how this would be treated can be helpful and allow them to focus on treating the symptoms and supporting the patient and their family rather than trying to correct the underlying cause.

Contact details for other teams involved in patient's care is important to document. Documenting which team and any contact numbers can help with making decisions. If the patient is known to the hospice the emergency treatment plan could outline that they should be contacted in event of emergency out of hours.

Additionally, LAS advised details regarding the patient's usual baseline can be very helpful. If they have dementia what is their usual baseline? If they have COPD what are their baseline oxygen saturations and respiratory rate. What are their target saturations?

Any social support already in place can be helpful information for LAS/OOH providers. If the resident has a documented package of care this may help as it can help with assessing if a patient is safe to remain at home and whether there is anyone else who could support them at home.

Recommendations:

While not all of these recommendations will apply to every patient or every care plan the following information is useful for LAS paramedics attending out of hours:

- Include as much detail as possible in the emergency treatment plan section especially if the plan is for residents to be kept at home.
- List and give contact details for any teams that could be contacted for additional support.
- It can be very difficult to anticipate potential adverse events particularly in the context of a frail elderly patient and this level of uncertainty can make discussions with relatives challenging. Documenting what potential scenarios have been discussed with NOK can aid OOH decision making.
- Document clearly if a patient lacks capacity and give full details about what discussions have been had with the family in this situation. If family members are appointed as LPA for health state this clearly and upload the paperwork if possible. If conversations have not taken place or there is no NOK document this.
- Document clearly where important paperwork (e.g. paper DNAR if not uploaded onto CMC) or emergency medications are kept. This is most important if the patient is in their own home.
- Try and clearly document what the patient's functional baseline is so LAS can determine if changes are new.
- Document contact details for next of kin as LAS will attempt to call these in an emergency.
- Document clearly whether the NOK are aware of the presence and content of the CMC plan. This is both of practical and medicolegal importance.
- Upload DNAR forms, hospital discharge summery or any other important documentation as a PDF. It is preferred if the details of the DNAR is added directly into CMC in case there are issues viewing attachments.
- LAS will aim to document in the 'urgent care update' section if they visit a patient with a brief note as to the presenting issue and plan. It may be helpful if OOH visiting doctors also add into this section.
- If completing a community drug chart with anticipatory medication detail the indication for each medication.
- In a residential or nursing home it can be helpful to have a system to highlight whether residents have a CMC plan as the LAS call system will simply highlight that there are 'multiple CMC records at

the address'. Some boroughs use stickers on the outside of patient's notes as a way of highlighting that there is a CMC plan

- We have attached a document showing the minimum data set required for a high quality CMC plan see page 4-5.

Future work**:**

- This report has been shared with Barnet CCG, CMC, PCNs, Barnet Training Hub, Barndoc and LAS. We recommend this audit is repeat in 6-12 months time to monitor ongoing quality.

CMC – Data Needed for a Good Care Plan

- Mandatory field

Patient consent screen

- *Type of patient consent, incl justification if care plan created due to a clinical decision taken in patient best interest.
- *Date of patient consent
- LPoA – if there is one in place, please document this and where possible upload a copy of the original document. LAS need to see this document before relying on it.

Patient Details Screen

Will automatically be pulled from records

- Name
- Gender
- Date of birth
- Main address
- GP practice
- Alerts e.g. key safe number and location if possible

Significant medical background screen

- *Main diagnosis
- Aware of diagnoses
- *Prognosis – patient aware? Family aware? Surprise question?
- *WHO performance status
- *WHO performance date
- ADRT
- Patient disabilities – really helpful to have as much detail as possible

Preferences Screen

- *PPC
- *PPD
- Patient wishes and discussions

CPR discussion screen

- *Has discussion taken place with patient? incl summary of discussion
- *Has discussion taken place with family? Incl summary of discussion
- *Should CPR commence?
- *Date of CPR decision?
- *Endorser
- Note especially if patient does not have capacity need to document whether discussed with family/NOK and if not why not.

Emergency Treatment Plan Screen

- *Clinical recommendation for ceiling of treatment

- Where possible include details of treatment especially if recommending patient not be conveyed to hospital
- Include details of anticipatory drugs if appropriate and where they are kept
- May not all be relevant to your patient but this will guide OOH medical providers as to how best support your patient.eg COPD – sats to aim for, upper limit of oxygen to be given, nebulisers etc. Pain – details what pt can be given for increased or breakthrough pain. Crisis management - if patient likely to have catastrophic event ie with head and neck tumour, please document as means LAS can concentrate on keeping patient comfortable and family supported rather than focussing on stopping it.
- If patient is under care of hospice, the plan could simply be call hospice and number listed.

Medications

- *Minimum record allergies or record NKDA
- Only include medications relevant in urgent care setting
- Can upload medication list if appropriate/state present in home

Contacts

- GP contact details automatically included
- The more detail the better, if under hospice or known well to hospital eg renal/respiratory team please provide details.
- Where possible put contact details for NOK/family. LAS will aim to call them if they are not present.

Social Situation

- Include detail that will give OOH team a good picture of what support is available. This will help in decision about whether patient can be supported at home or will need conveying.

Approval screen

- Review date – automatically sets to 90 days. You can extend this review date.
- Organisation

Remember to record death where appropriate.

If any clinical changes or further conversations/decisions with patient or family please remember to update CMC plan.

Any documents to be attached should be in pdf/JPEG form so LAS can access easily.

On drug charts in homes, please write indication for each drug as LAS not always aware which drug for which symptom.