

An audit of end of life care for renal patients at a tertiary care centre in England

Dr Alexander Burrell¹, Amy Verinder¹, Dr Alexandra Hodsman¹, Dr George Kimpton^{1,2}, Dr Barnaby Hole^{1,2}
¹North Bristol NHS Trust, Bristol, United Kingdom, ²The University of Bristol, Bristol, United Kingdom

INTRODUCTION

People dying with ESRD experience higher mortality, symptom burden, hospitalisation rates and procedure use than those with other life-limiting illnesses (1,2). Access to supportive care may also be lacking (3,4). However, patients with advance care plans are more likely to meet their end-of-life (EoL) goals (5). The Renal Association guidelines on EoL care (6) suggest the following audit measures:

1. Proportion of patients who died who were on a supportive care register (SCR)
2. Proportion of patients on the SCR with a workable advance care plan, including patient preferences and choices with respect to priorities of care
3. Number of patients withdrawing from dialysis as a proportion of all deaths on dialysis
4. Proportion of patients who achieve their preferred place of dying

These measures were used to audit care for people with ESRD in a UK tertiary renal centre.

METHODS

A retrospective audit was conducted of records for adults who died with ESRD between October 2018 – March 2019. All were receiving haemodialysis, peritoneal dialysis, transplant, or had a most recent eGFR < 10ml/min. Records were reviewed using the hospital electronic system and the supportive care team care records. A “workable advance care plan” (audit measure 2) was coded as present when an individual had both a documented preferred place of death and resuscitation status.

This audit was approved by the local Patient Safety, Assurance & Audit Service (number CA54321).

RESULTS

Of 87 records, 57 (65.5%) individuals were on haemodialysis, 15 (17.2%) were managed conservatively, 10 (11.50%) had a functioning transplant, 4 (4.6%) on peritoneal dialysis, and 1 (1.1%) had an eGFR <10 and was preparing for dialysis. Of the deaths on dialysis, 29 (48.3%) records included an entry indicating dialysis had been stopped before death.

Of the 32 people (36.8%) on the SCR, 8 (25%) had a documented preferred place of death, which was achieved for 5 (62.5%). Of those without, 11 (45.8%) died in hospital. Preferred place of death was documented for 1 person not on the SCR (1.8%). People on the SCR were more likely to have a documented DNACPR (46.9% vs 20.0%).

Individuals receiving conservative care were more likely than those receiving kidney replacement therapy to be on the SCR (40.0% vs 36.1%) or to have preferred place of death documented (26.7% vs 6.9%). However, they were less likely to have a documented DNACPR (26.7% vs 30.6%).

DISCUSSION

In a tertiary renal centre, 87 adults with ESRD died over six months. One third were on the SCR. Most deaths were amongst people receiving dialysis, and almost half stopped dialysis before dying. Preferred place of death and resuscitation status were poorly documented for all groups.

This audit suggests that either advance care planning and/or documentation of it is incomplete for individuals who die with ESRD. Whilst many deaths will have been unanticipated, it is likely that access to advance care planning needs to be improved. Further investigation is required to better-understand the factors that inhibit wider adoption and higher-quality documentation of advance care plans.