623 Completed Cycle Audit on Treatment Escalation Planning Documentation in ENT In-Patients

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**Aim:** Treatment Escalation Planning (TEP) helps ensure treatment goals of patients are developed, understood, and respected. Treatment Escalation documentation is a communication tool that provides staff immediate and accessible guidance in times of crises. A standardised form was created to improve and standardise TEP documentation in ENT in-patients. This audit aimed to review form completion rates. A further cycle was done to assess whether interventions improved practice.

**Method:** A retrospective audit of TEP form completion rates and quality of documentation. Paediatric patients and patients from elective surgery discharged on the same day were excluded. Data tabulated included age, co-morbidities, reason for admission, type of admission (emergency/elective), DNACPR documentation (community and in-hospital), TEP form completion.

**Results:** The median age for patients included in the study was 73.5 years old. 83% were emergency admissions. Patients were multi-morbid (Malignancy, cardio and cerebro vascular disease, COPD etc.) In the first cycle 23% had in hospital DNACPR forms, 0% had community DNACPR and 0% had TEP forms completed. Intervention included staff education and physical reminders on handover documentation. Second cycle showed improvement, 40% of TEP forms were completed however 1 patient had community DNACPR in place but no in-hospital DNACPR.

**Conclusions:** Our intervention showed improvement in treatment escalation plan documentation. This audit also picked up a problem i.e., community DNACPR not converted to inpatient DNACPR whilst patient is an inpatient. Next steps include further intervention to improve completion rates and further audit to ensure long-lasting improvement.