

Malnutrition Matters, Joint BAPEN and Nutrition Society Meeting, 2nd and 3rd November 2010, Harrogate

Completed audit loop for a multidisciplinary care pathway for the gastrostomy feeding of people with motor neurone disease

M. Sakel, W. Sansom, J. Lamming, C. Batts and S. Tupper

East Kent Motor Neurone Disease Service, Kent and Canterbury Hospital, Canterbury, Kent CT1 3NG, UK

Appropriate timing of gastrostomy feeding can optimise nutritional management and quality of life of patients with motor neurone disease (MND)⁽¹⁾ The aim of the initial integrated care pathway (ICP) and checklist was to coordinate the care process and improve communication between different professionals and to sequence the activities of the multidisciplinary team in a timely way, with the aim of improving quality of life and outcome for the patient. The original pathway was completed in 2006 and a retrospective case note review provided a snapshot of adherence to the ICP from January 2006 to September 2007. The initial audit highlighted evidence for changes to the care pathway and checklist, provided rationale to modify and simplify the process, suggested ways to improve documentation and identify the gaps. The audited pathway was presented at the International Dietetic Conference, in Kyoto, Japan in September 2008.

An action plan was drawn up after critical appraisal from NHS managers and clinicians and the checklist was amended in 2008/2009. Following the initial audit communication between different teams/services was addressed by having meetings with speech and language therapy, dietetics, endoscopy, radiology, gastroenterology, the home enteral nutrition team and the MND team. This completed the first audit loop.

The updated pathway was then re-audited between April 2009 and March 2010. The criteria used to place patients on the updated care pathway were whether they were at the risk of malnutrition or had symptoms of dysphagia and were referred to dietetics or speech therapy. The total number of patients with MND was 50, of which 30 were identified as being appropriate for the pathway, 47% were identified as having respiratory weakness. 40% were male and 60% female with an average age of 69 years.

Timely respiratory assessments were highlighted from the initial audit. The impact of the initial audit was to drive a change in practice whereby the percentage of patients referred for an initial respiratory assessment increased from 42% to 63% although fewer of these referred patients were assessed, 75% to 63%. Out of the 30 patients placed on the updated pathway 53% opted for alternative feeding, a decrease from the 63% recorded for the initial pathway. The median survival time post PEG in this audit was 7.5 months. This compares to Rio *et al.*⁽²⁾ 7.1 months.

The previous audit highlighted the need for improving the provision of written information to patients. This improved significantly from 47% to 81% for PEG feeding: making the decision and eating and drinking from 58% to 71%. Both leaflets were from the MND Association. More patients received home visits to discuss home enteral nutrition (increased from 50% to 80%). A parallel multi-centre research project is currently looking on into patient/carer and clinician's decision making process of referring and accepting PEG in MND in East Kent.

The MND team believes that a multidisciplinary care pathway is an important factor in improving patient care and impacting on quality of life. However, the pathway is complex and compliance with documentation is poor and cannot be enforced. Consideration needs to be given to developing a simpler pathway and an improved method of documentation, as the present care pathway is too complex. Such practice-based evidence may also have the potential to develop research ideas.

1. Shaw SS, Ampong M-A, Rio A *et al.* (2006) *Amyotrophic Lateral Scler* 7, 16–21.
2. Rio A, Ellis C, Shaw C *et al.* (2010) *J Hum Nutr Diet* 23, 408–415.