Renfrewshire Health & Social Care Partnership

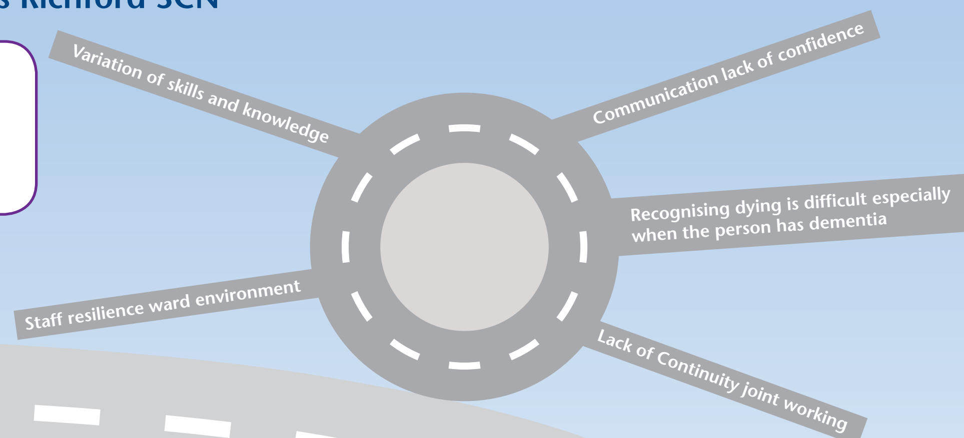
ACCORD Hospice

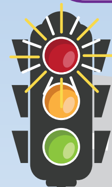
NHS Greater Glasgow and Clyde

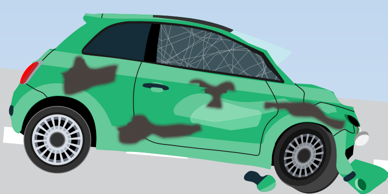
A Road Less travelled

Maria Banks SCN, Jill Graham Staff nurse, Billy McGuigan Charge nurse, Ruth McGillivrary Staff Nurse, Heather Robertson Staff Nurse, Andy McClafferty SCN, Chris Richford SCN

This poster is a visual representation of a 2 year improvement project on recognising dying and delivering end of life care in NHS mental health complex care wards in Renfrewshire. Driven by staff's desire to continuously improve this area of practice, in line with the Dementia Strategy, standards and the Strategic Framework for Action.







Baseline survey was undertaken with the MDT highlighted several themes. There is a complexity that is unique to people with dementia.

- Challenges
  - Recognising dying is complex and can be difficult, even more so when the person has dementia
  - Staff resilience
  - Assessment within complexity of advanced dementia and managing transitions
  - Staffing levels, concern about providing best care and patients not dying alone
  - Ward environment
- Suggested reasons why
  - Recognising dying is complex and can be difficult, even more so when the person has dementia
  - Staff resilience
  - Lack of experience, confidence and knowledge
  - Mix of communication issues including managing expectations of relatives and expectations within the MDT, common language
  - Staff Levels and ward environment

These are difficult times and the patient, family and staff need to be supported.

More training on end of life care and recognising dying.

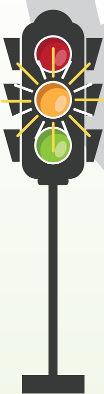
It can be difficult when you have patients who have been extremely frail and unwell for a long period of time and deciding when to accept end of life care is appropriate.

Saying "Dying" is a bit like saying "Suicide" a few years ago people where scared of the impact of using the word, so were used to having those kind of delicate conversations.

Palliative Resource Nurses

In partnership with Accord hospice the following education was delivered,

- The PRN's attended a training programme
  - Introduction to palliative care for registered nurses (4days)
  - Advanced communication skills (2 days)
  - 4 Shadowing days with Hospice MDT members
- Ward staff grade doctor attended 5 days bespoke shadowing and training with the Hospice MDT
- NHS GG&C Palliative care training calendar share with all mental health staff



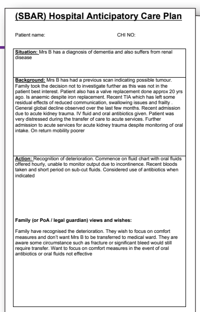
Introduction of SBAR Anticipatory prescribing

"Family members sometimes do not understand decisions we make and due to distress find it difficult to understand explanation"

"staff team may differ and getting consensus can be challenging"

"sometimes we know it was discussed at the ward round but when we call the duty doctor we cant always find it in the notes"

"the term "dying" is probably part of the problem as there will be different definitions held by different people"


(SBAR) Hospital Anticipatory Care Plan

The SBAR (hospital anticipatory care plan) was developed in response to the concerns raised in the baseline survey of the difficulties in accessing decision making outcomes from the MDT. The introduction of the SBAR format provided a clear identifiable communication tool. Once completed, in collaboration with the Power of Attorney, Guardian or family member, it supports medical staff by providing information to support decision making, especially in the out of hours period when the patient may not be well known to the medic.

"I had a good starting point, knowing what the relatives wanted"

"it helped my decision making as to transfer or not"

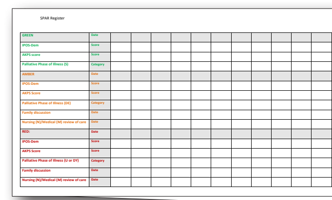
"I felt more confident talking to the relatives as they had already had this very difficult conversation"

Introduction of SPAR

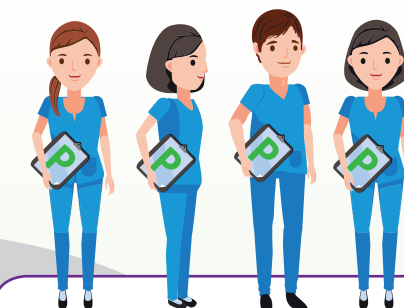
Use of the Supportive and Palliative Action Register (SPAR) process is intended to support early, system wide identification of the changing needs of adults living and dying in hospitals and care homes. It is also intended to improve recognition of key opportunities to think and plan ahead.

Using the SPAR process, all patients/residents are assessed using the following tools:

(a) **Ipos-dem**
(b) **Australia–Modified Karnofsky Performance Scale**
(c) **Palliative Phase of Illness Tool**



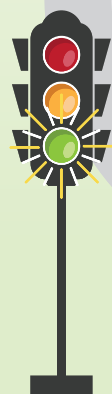
Use of these tools will help staff decide if patients should be coded GREEN (for monthly review, or sooner if change occurs), AMBER (for weekly review, or sooner if change occurs), or RED (for daily review, either because their palliative phase of illness is unstable, or the person is thought to be dying). Coding is recorded in the SPAR document. There are suggested actions for each coding.

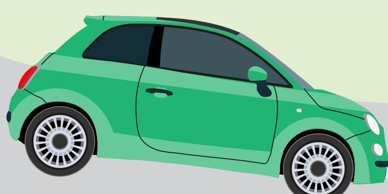


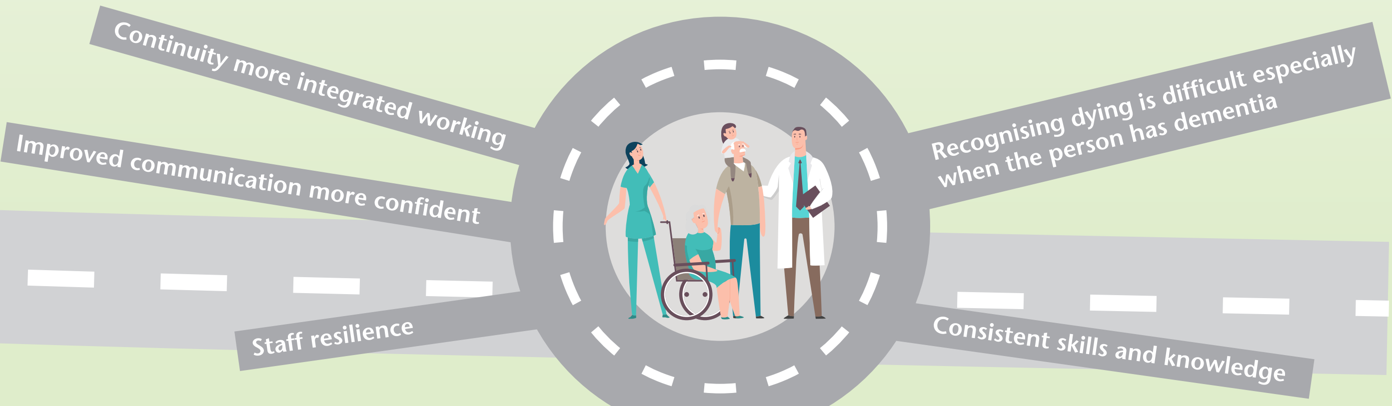
Implementation of training sessions

The PRN developed and delivered awareness sessions

- Last Offices
- Palliative care poster – "What does Palliative care mean"
- Communication with others - registered nurses
- Communication with others - un-registered
- Oral care
- Consulted on review of the GAEL Mental health End of life care bundle
- SPAR
- Use of Subcutaneous fluid when there is a reduced need for diet and fluids
- SBAR Anticipatory care plan







Contact details: Maria.banks@ggc.scot.nhs.uk