The first 6 months of an Acute Palliative Care Unit
Symptom improvement, outcomes measures and integrated working

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Introduction

Palliative care in the UK has traditionally been community focussed, and based in independent or NHS funded hospice institutions, which are physically separate from acute hospitals. More and more treatments are possible and patients attend hospital for consultations, investigations and treatment to a much later in their illness. Palliative care services have struggled to keep pace with increasing need. Most acute hospitals have an advisory service – some have hospice wards. But there is an increasing need to meet the palliative care needs of those patients having "active" treatment. (1) Palliative care therefore must be integrated into the core hospital activity and work alongside other hospital specialities. (2) Ninewells Hospital in Tayside has provided an advisory service since 1998.1 Tayside Health Board approved the development of an acute palliative care unit in 2007. We agreed to a one year pilot 2009 – 2010 to demonstrate the benefits for the hospital.

The Acute Palliative Care programme

Three beds [single rooms] were identified in an acute surgical ward. Round the clock staffing was delivered by 7.6 seconded nurses - some of whom had specialist palliative care experience. Medical staffing included 1 full time consultant who was also medical consultant to the hospital palliative care advisory service. An additional 0.6 WTE consultant with extensive experience in teaching was appointed to develop the hospital education programme.

Patients seen by the advisory service, and who had the most complex symptoms or needs were admitted to the APCU. Symptoms were assessed using the Edmonton Symptom Assessment Score (ESAS) (3). Data was prospectively collected – see PCU6.

Intensive control symptom & distress measure: Percentage reduction in 48hours		
☐Admission ESAS	☐Admission distress level and cause	
☐48 hrs ESAS	☐48 hr distress level and cause	
Intensive assessment measure: Percentage seeing with appropriate disciplines within 2 working days or less		
☐Palliative care nurse	☐Palliative Consultant	☐Occupational Therapist
☐Physiotherapist	☐Lymphoedema nurse	☐Social services
☐General Practioner	☐Pharmacist	☐Chaplain/Counsellor
☐Pain team	☐Neurosurgeon	☐Psychologist/Psychiatrist
Family meeting		
☐Achieved within 2 working days		
Intensive future planning		
☐Plan for discharge made	☐Discharge plan achieved	
☐Discharge plan achieved within 7 days		
☐Discharged home	☐Died in APCU	
Satisfaction		
☐Patient	☐Family	☐Staff
Patient story		
☐Patient story collected		

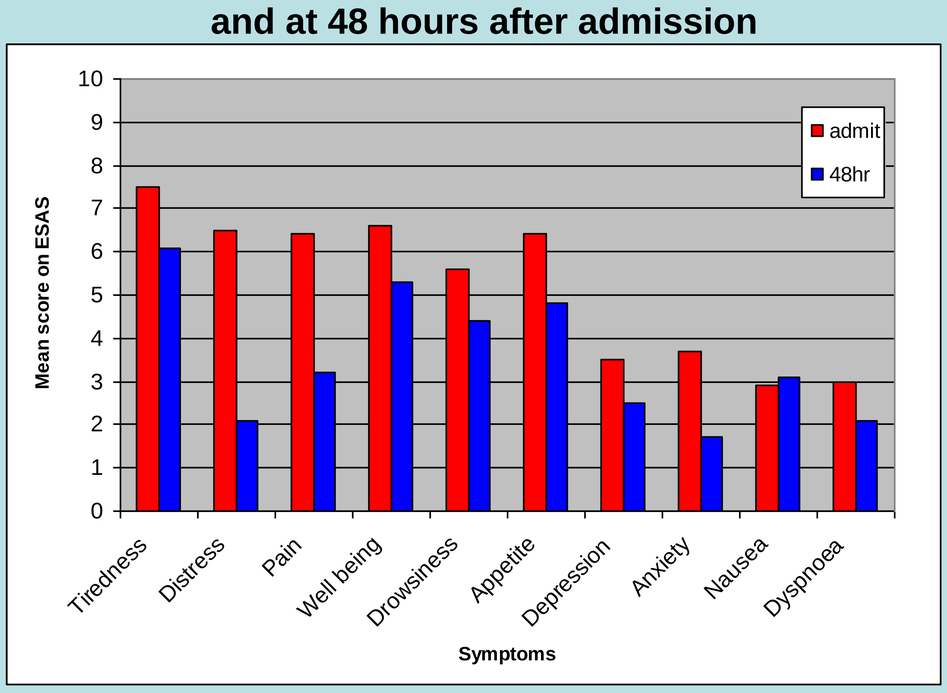
PCU6

Results

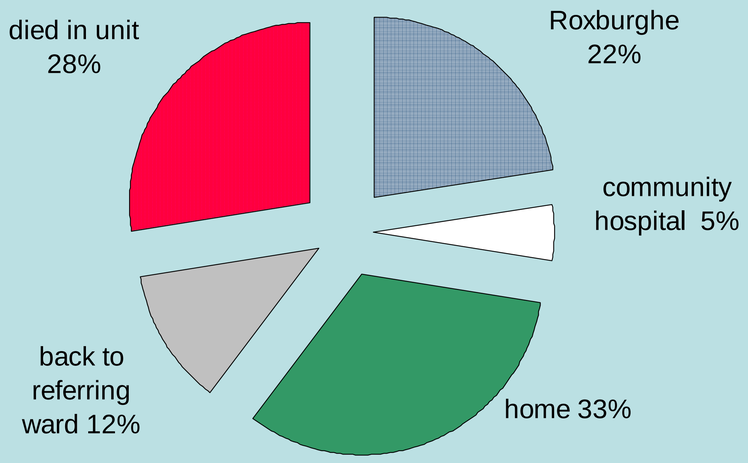
Within the 6 month period, 294 patients were referred to the hospital palliative care team. Of the 197 patients referred from oncology and surgery, 51 (25.8%) patients were admitted to the APCU. Median length of stay for patients in the APCU was 4.5 days.

At 48 hours post admission, significant reduction in intensity of symptoms were observed. Pain was reduced from a median of 7 to 3.5 ($p<0.001$) and distress was reduced from a median of 7.5 to 3($p<0.001$) within 48 hours. There were also significant reductions in: anxiety ($p=0.01$), nausea ($p=0.47$), poor appetite ($p=0.02$), loss of wellbeing ($p=0.046$ and overall ESAS ($p=0.001$). There was no significant increase in any symptom. [Mann-Whitney U test]

Average ESAS symptom scores on admission to APCU and at 48 hours after admission



Patient outcome:



Discussion

51 patients were admitted within the first 6 months of a pilot Acute Palliative Care Unit. The median length of stay was 4.5 days and the mortality was low for a palliative setting. 60% of patients were discharged directly from the APCU, with 33% being discharged home. Significant reductions in symptoms were observed, in particular pain and distress were reduced within 48 hrs. Initial feedback from patients, families and other teams within the hospital has been good and the integrated working model has helped produce signs of culture change in the acute setting: 'I never knew someone so ill could go home' – Consultant Surgeon.

Conclusions

1. We had hoped for a dedicated unit to start with but we got a small pilot in an acute surgical ward
2. It was possible to rapidly raise the profile of hospital palliative care. By working alongside the surgeons they knew where to find us & we learnt how to help each other
3. Symptoms and distress can be tackled rapidly and effectively within the hospital setting utilising an embedded acute unit

References
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