

“Seven days a week - Providing a Community Clinical Nurse Specialist Service : The Experiences of a Six Month Pilot at the Prince and Princess of Wales Hospice in Glasgow.”

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The Prince & Princess
of Wales Hospice

Introduction

The care of patients in the out-of-hours period is recognized as being particularly complex and potentially challenging. In-hours care from the regular team accounts for only 30% of the week. While anticipatory, proactive care goes some way to smooth the patient experience, support at weekends and out of hours is often left to clinicians who do not know the patient, and who are inadequately informed of their situation (Fergus 2010).

Worth (2006) highlights the challenges that patients out of hours face, and while District Nursing and GP out of hours services are available to them, the challenge to provide reassurance, information, advice, and comfort is considerable if the patient is not known to the service provider. This lack of clarity and personal knowledge is recognized as a barrier to accessing out of hours support.

It was therefore proposed to increase access to the Community Clinical Nurse Specialist (CNS) service by extending the provision to seven days per week, for a six month pilot, from April 2009. The aims of the pilot are outlined in Box 1.

Box 1 - The aims of the pilot:

1. To determine the need for, and use of, a seven day CNS service
2. To ensure that patients, families and healthcare professionals receive consistent and continuing access to and support from the community CNS team.
3. To address the barriers to accessing quality out of hours specialist palliative care, by providing care taking a joined-up approach
4. To make recommendations for the on-going viability of a seven day CNS service.

Method

The staff member on duty carried out planned urgent care (telephone or visit) for those patients with anticipated need, and was also available to provide unplanned telephone support and, where necessary, a home visit, to those patients whose condition changed and who contacted the team. Community staff were also encouraged to contact the service for support and advice.

It was agreed that the nurse on duty would respond to requests for support and advice, and furthermore could plan some “routine” work from her existing case load including first visits if appropriate and acceptable to patient and family. In addition, it was agreed that an assessment visit could be undertaken to any new patient whose referral was identified as being urgent.

All contacts, (telephone or visit) were recorded using a pro forma and analysed after the pilot was completed.

A focus group to gather subjective feedback from the Laurieston nurses was undertaken, with five members of the team (Box 3) and feedback from patients and carers is planned for later this year.

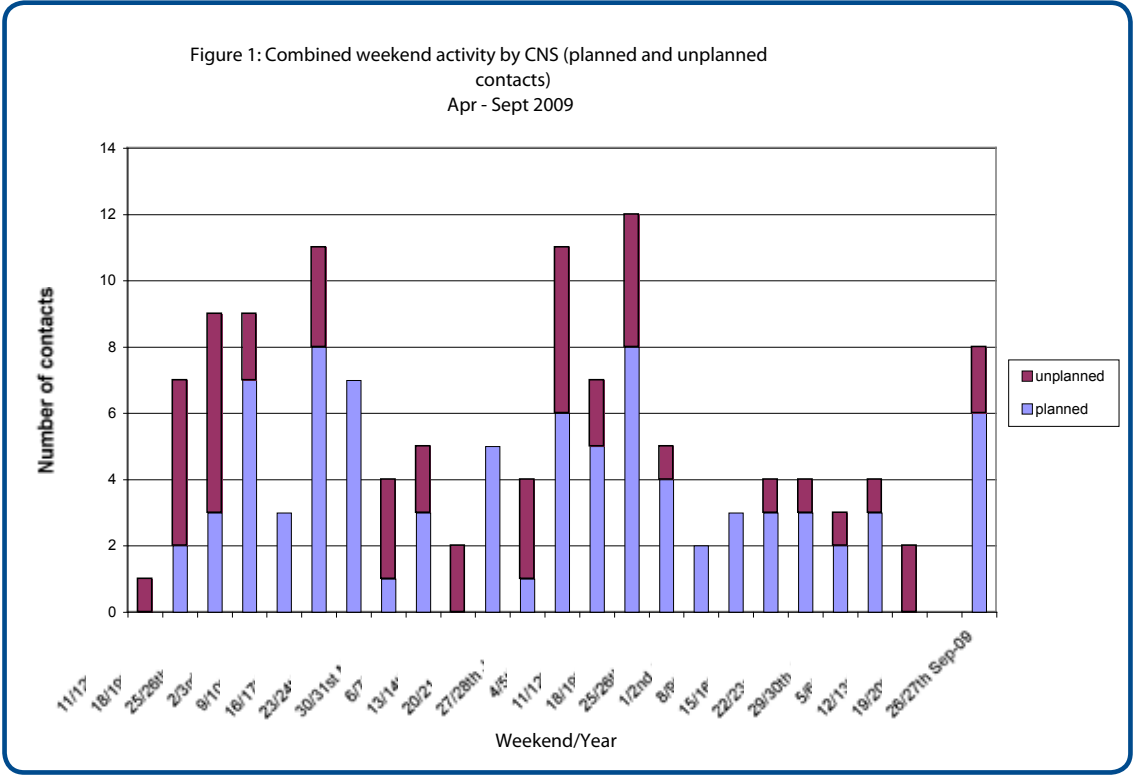
Results

Activity

Figure 1 illustrates data collected on both:

- Planned urgent activity (generated by one of the CNS team or other hospice staff member)
- Unplanned activity (generated by patient, family or community staff)

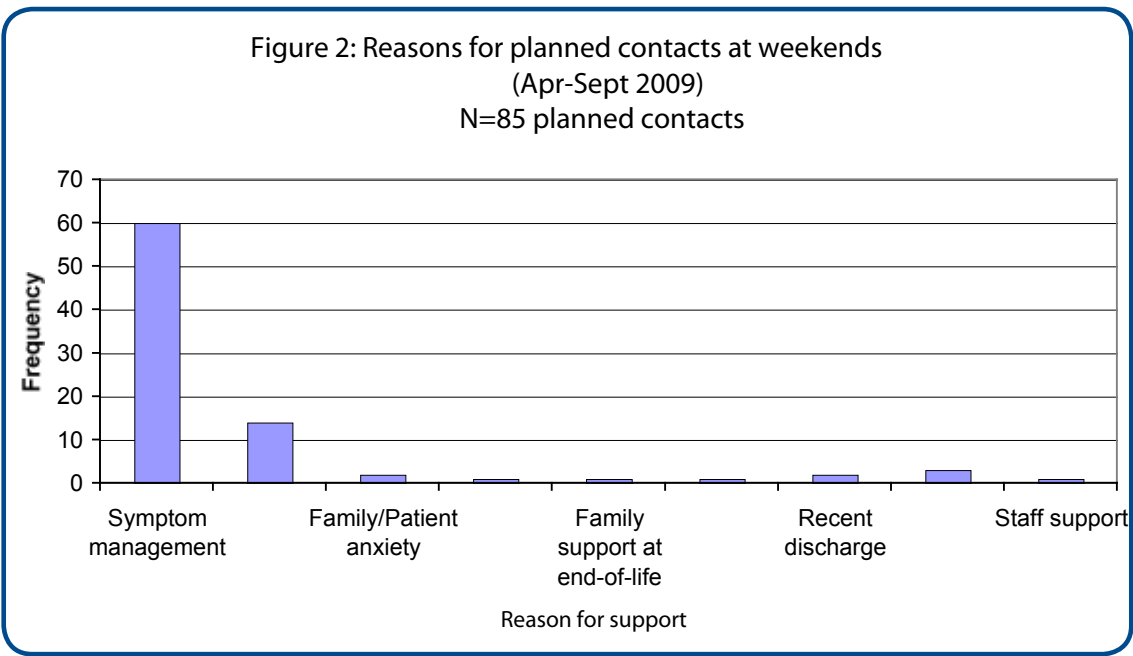
This activity does not include “routine” work undertaken by the CNS.



Reasons for Contact

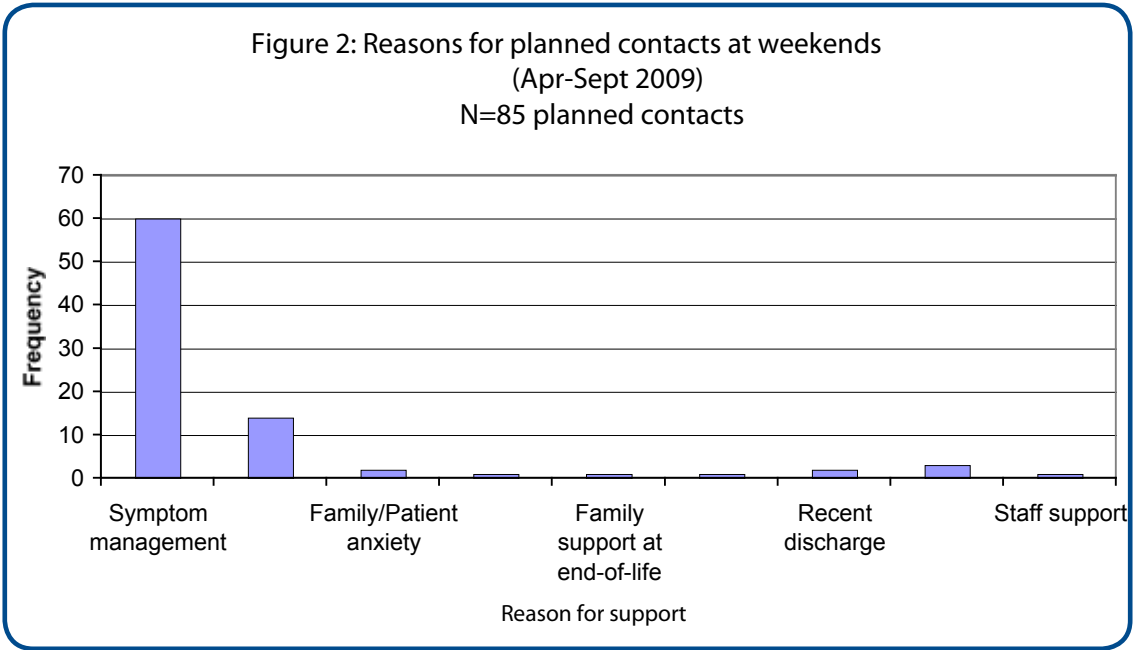
Planned :

The vast majority of planned contacts with patients and their families over weekends were for symptom management (60, 70.6%, n=85) or end of life support (14, 16.5%, n=85) as shown in Figure 2.



Unplanned :

The main reason patients and families contacted the service was also for specific symptom management issues (30, 45%, n=66). Other reasons reported included the patient’s condition deteriorating, patient or family anxiety. Full details can be seen in Figure 3. As expected, there were often several reasons associated with same patient.



Box 2 - Analysis of calls:

- 68% from the families/carers of patients
- 17% from patients
- 15% from healthcare professionals

Discussion

The activity was sufficient to be viewed as worthwhile; however a mean of 5.3 urgent contacts in a weekend, some of which were short phone calls, indicates that for a part of the weekend the CNS was not carrying out acute or urgent care. It was therefore agreed by the team that routine care could be planned for the weekend, but the team quickly learnt not to over plan, leaving them unable to respond to urgent requests. This gave an unexpected bonus; the nurses became aware that for some families, having a visit at the weekend allowed contact with those who would usually be at work mid week.

A focus group of the CNS team made it clear their view was that weekend working was viable, and did not have an overall negative impact on their workload outwith the weekend (Box 3).

Family support was a crucial component of the role of the CNS in the pilot (Box 2), enabling carers to continue to maintain the patient at home in difficult and stressful circumstances towards end of life.

Resources : The service was established using existing staff resources, with 6.0 WTE staff participating in the weekend rota. This included two part time staff who participated in the rota on a pro rata basis. A reduction in staff numbers would be difficult to sustain and needs to be recognised in workforce planning. Staff new to the team were not expected to participate in weekend working immediately, and had a lead in time of several months.

In addition, enhanced payments for weekend working were introduced.

Box 3 - Focus Group of CNS Team:

Benefits of Service

- “It’s a brilliant service for patients - it gives them continuity of care and needs good communication prior to the weekend to make sure the nurse knows all about the patient when they phone – it’s not like a cold call, and is informed support.”
- “If one of the patients is unwell on a Friday, it means we can hand them over to a colleague and this reduces our anxiety”.
- “The service allows face to face assessment which is much better than phone contact.”
- “It might prevent unnecessary hospital admission, or make sure that admission is the best thing; perhaps generate appropriate admission to hospice.”
- “It has improved team working as we know we can rely on our colleagues.”

Challenges

- “It took a bit of time to establish with the community services; people needed to be reminded of the weekend working, but this is better now.”
- “It is hard to get the balance between a normal working day and the unplanned nature of the weekend work. This can make it very busy and you can be all over the city!”
- “We needed to learn to use the community services that are already in place; it was a steep learning curve to identify the networks and contacts for out of hours support.”
- “At times there was increased pressure after our days off as our caseload still had to be covered; we have got better at making use of our Laurieston nurse colleagues to pass on work to them.”

Conclusions

The seven day service was utilised by patients, families and professionals. Activity was established quickly and has been sustained throughout the pilot at a level sufficient to be viable. Workload has been a mix of both planned and unplanned urgent care to patients known to the team, with staff able to undertake routine care from their own caseload where appropriate and possible.

Feedback from the community CNS team on the completion of the pilot indicated that the augmented service was viewed by them as a success.

Challenges to setting up the service, which were mainly organisational, were easily overcome.

As a result of this successful pilot, seven day working has now been established as part of the community CNS service.



References

1. Fergus CJY, Chinn DJ and Murray SA (2010). Assessing and improving out-of-hours palliative care in a deprived community : a rapid appraisal study. Palliative Medicine 24(5); 493-500
2. Worth et al (2006) Out-of-hours palliative care : a qualitative study of cancer patients, carers and professionals. The British Journal of General Practice 56(522); 6-13

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