Making a Difference:
The Provision of Palliative and End of Life Care in a Community Hospital

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1. Biggart Hospital
2. University Hospital Ayr
3. Ayrshire Hospice

Introduction

This poster describes the development of person centred individualised palliative care within a community Hospital in South Ayrshire.

Numbers are relatively small in comparison to urban centres however this model which is evolving can be replicated. Community Hospitals are at the core of integrated care between primary and secondary care and in the context of patients with palliative care needs, where in-patient care is needed and locality based care is a priority, they have a pivotal role.

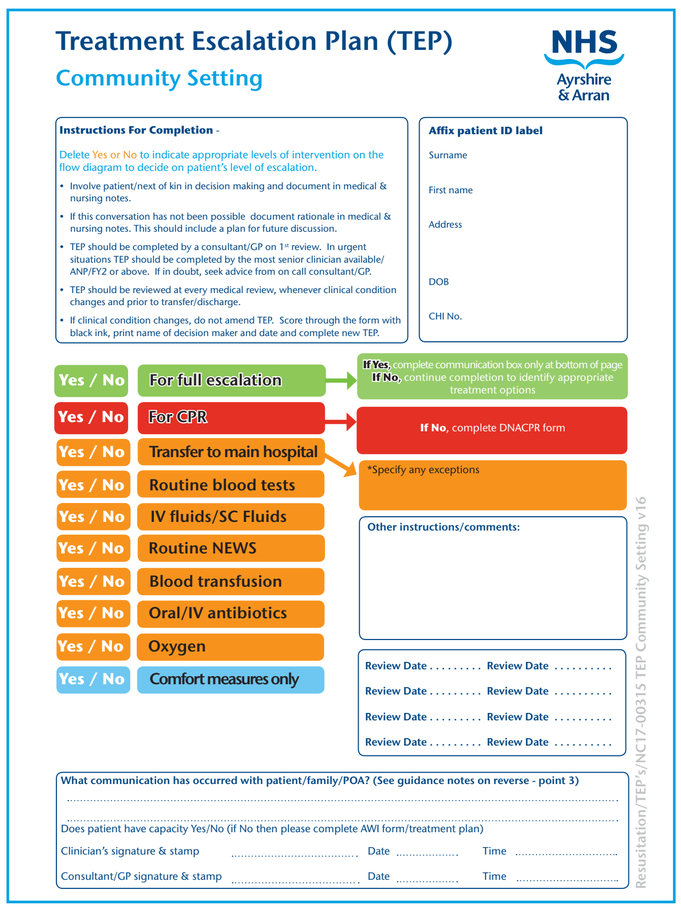
Background

The ward manager of a 30 bed continuing care ward took the opportunity to specifically emphasise to the Nurse Director that a significant number of patients in this ward had life limiting illness and palliative care needs which were not being met.

A clinical trigger was the gap in advance care planning and treatment escalation plans which consistently resulted in uncertainty when patients were being assessed and managed out of hours by the on call Teams. There was clear recognition of education and training needs for the team to enable them to offer optimal care and support for this group of patients, their families and carers.

Subsequently this resulted in collaboration with The Ayrshire Hospice to develop a Project Plan with measureable objectives to enhance the, care and support of patients with palliative care needs and their families in Biggart Hospital. The aim was to embed the core knowledge skills and competencies needed to support the provision of generalist palliative care in this setting. Alongside the formal, structured education programme: the following objectives were identified:

- Establish a working relationship with the Ayrshire Hospice Palliative Care Advanced Nurse Practitioner (ANP) to facilitate shared learning between the ANP, medical and nursing staff. This involved weekly sessions joining the Consultant Ward Round, facilitating shared learning to enhance recognition of the truly holistic approach of the whole team and meet the physical, practical, functional, social, emotional and spiritual needs of patients and carers.
- Develop an inclusive process- with patients, families and staff - in relation to the introduction and implementation of a Treatment Escalation Plan (TEP) with the aim of supporting continuity of care, robust communication and shared decision making.



Treatment Escalation Plan (TEP)
Community Setting

NHS Ayrshire & Arran

Instructions For Completion -

Delete Yes or No to indicate appropriate levels of intervention on the flow diagram to decide on patient's level of escalation.

- Involve patient/next of kin in decision making and document in medical & nursing notes.
- If this conversation has not been possible document rationale in medical & nursing notes. This should include a plan for future discussion.
- TEP should be completed by a consultant/GP on 1st review. In urgent situations TEP should be completed by the most senior clinician available/ ANP/FY2 or above. If in doubt, seek advice from on call consultant/GP.
- TEP should be reviewed at every medical review, whenever clinical condition changes and prior to transfer/discharge.
- If clinical condition changes, do not amend TEP. Score through the form with black ink, print name of decision maker and date and complete new TEP.

Affix patient ID label
Surname
First name
Address
DOB
CHI No.

Yes / No	For full escalation	**If Yes,** complete communication box only at bottom of page **If No,** continue completion to identify appropriate treatment options
Yes / No	For CPR	**If No,** complete DNACPR form
Yes / No	Transfer to main hospital	*Specify any exceptions
Yes / No	Routine blood tests	
Yes / No	IV fluids/SC Fluids	
Yes / No	Routine NEWS	
Yes / No	Blood transfusion	
Yes / No	Oral/IV antibiotics	
Yes / No	Oxygen	
Yes / No	Comfort measures only	

Other instructions/comments:

Review Date ..... Review Date .....
Review Date ..... Review Date .....
Review Date ..... Review Date .....
Review Date ..... Review Date .....

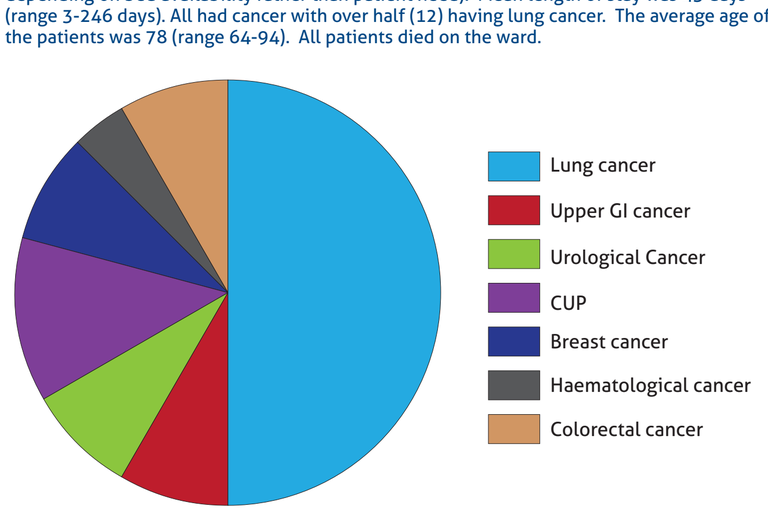
What communication has occurred with patient/family/POA? (See guidance notes on reverse - point 3)
.....
.....
Does patient have capacity Yes/No (if No then please complete AWI form/treatment plan)
Clinician's signature & stamp ..... Date ..... Time .....
Consultant/GP signature & stamp ..... Date ..... Time .....

Resuscitation/TEP's/NC17-00315 TEP Community Setting v16

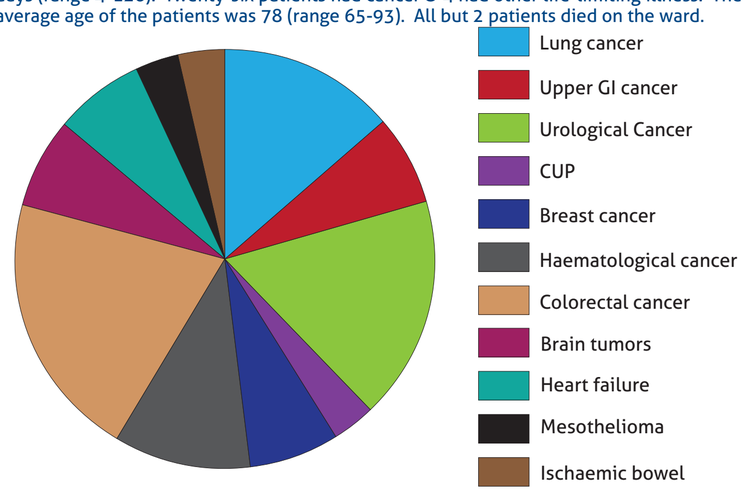
- Strengthen relationships with Specialist Palliative Care: The Ayrshire Hospice, Community Specialist Palliative Care Team and the Acute Hospital Specialist Palliative Care Team.
- Evaluate the effectiveness of this collaborative approach to care through rigorous analysis of questionnaires involving patients, their families and staff members.

Palliative and End of Life Care in MacMillan Ward

Of the 339 new patients referred to the HPCT between April 2015 and March 2016 (pre-project), 23 patients were transferred to Biggart hospital. (This could be to any of the 5 wards depending on bed availability rather than patient need). Mean length of stay was 43 days (range 3-246 days). All had cancer with over half (12) having lung cancer. The average age of the patients was 78 (range 64-94). All patients died on the ward.



Of the 353 new patients referred to HPCT between April 2016 and March 2017 (post education), 30 patients were transferred to Biggart hospital. Twenty-four (80%) went to Macmillan ward based on need rather than bed availability. Mean length of stay was 46 days (range 4-126). Twenty-six patients had cancer & 4 had other life-limiting illness. The average age of the patients was 78 (range 65-93). All but 2 patients died on the ward.



Referral and before admission

Patents are referred from the acute hospital for palliative and end of life Care.

Post Project, 8.5% of all referrals to the Hospital Palliative Care Team were transferred to our ward. These patients had generalist palliative care needs. Importantly when patients are referred by the Hospital Palliative Care Team, multidimensional assessment is ongoing and significant conversations with the patient and their families about goals of care and their wishes have taken place. Sharing this information supports continuity of care in the transition from the acute hospital and transfer of care to our team.

We welcome families and carers who wish to visit and see the ward – this can be helpful to support decision making about the transfer and importantly begins to develop relationships before admission.

The Patient's experience

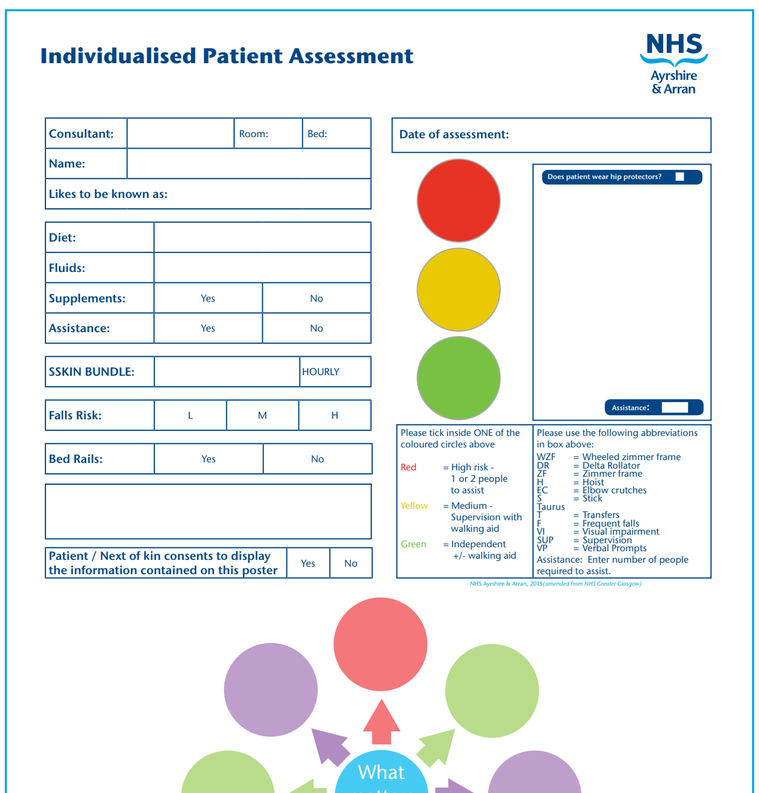
There is often a need to be flexible and identify creative ways of working within the context of an NHS Complex Care ward. The aim is to provide a "homely" environment: Open visiting – known as Family and Friends Time, pet therapy, music therapy, access to the garden and the invaluable support of volunteers contributes to this. Flexible use of space is ' skilled'. The Conservatory has been used for family gatherings and social events and also for patients to be cared for in the last days of life.

Information sharing is a priority: Patients, relatives, friends and carers are given:

- A detailed welcome letter
- A letter explaining hospital based complex continuing care
- The getting to know me booklet
- A leaflet explaining the Treatment Escalation Plan (which complements the discussion that takes place with the senior nursing and Medical teams) and ncludes a focus on shared decision making

What Matters to me: Integral to our practice ,from admission these conversations and shared information support the development of our relationships with each patient and most importantly of what is important for them .

Beside everypatient's bed – the Individualised Assessment



Individualised Patient Assessment

NHS Ayrshire & Arran

Consultant:		Room:	Bed:
Name:			
Likes to be known as:			
Diet:			
Fluids:			
Supplements:	Yes	No	
Assistance:	Yes	No	
SSKIN BUNDLE:		HOURLY	
Falls Risk:	L	M	H
Bed Rails:	Yes	No	
Patient / Next of kin consents to display the information contained on this poster	Yes	No	

Date of assessment:

Does patient wear hip protectors? ☐

Assistance: ☐

Please tick inside ONE of the coloured circles above
Red = High risk - 1 or 2 people to assist
Yellow = Medium - Supervision with walking aid
Green = Independent +/- walking aid

Please use the following abbreviations in box above:
WZF = Wheeled zimmer frame
DR = Delta Rollator
ZF = Zimmer frame
H = Hoist
EC = Elbow crutches
S = Stick
Taurus
T = Transfers
F = Frequent falls
VI = Visual impairment
SUP = Supervision
VP = Verbal Prompts
Assistance: Enter number of people required to assist.

NHS Ayrshire & Arran, 2015 (amended from NHS Greater Glasgow)

What matters to me

Our purpose
Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

Please can you bring a pair of sensible outdoor shoes

Valued comments on Care Opinion

https://www.careopinion.org.uk/opinions/517506?t=f37t3ck3xd

"My Mum's care"

My Mum got diagnosed with an aggressive stage 4 cancer a month ago. She was 79.

Ayr hospital asked her if she would like to go to the hospice, but she chose the Biggart as she saw how well they looked after my Dad when he was in years earlier.

She was moved to the McMillan ward 3 weeks ago.

From the moment she went in, the care, dignity and empathy she was shown by every single one of the staff there was just amazing. As was the kindness they had shown to myself and my family.

I can't put in to words just how brilliant they are.

We sadly lost my mum this week but this brilliant lot made the hardest experience of my life easier.

I will be forever thankful to every one of them from the nurses, to the auxiliaries, to the porters. What a team!

A million thank yous!

About: Biggart Hospital Biggart Hospital Prestwick KA9 2HQ

Posted by Angela a service user, 2 months ago

Clinical Assessment, Symptom control and Communication

Measurably different from pre-project practice is the recognition that the team proactively build up relationships with patients and families quickly recognising that things can change and the importance of maintaining trust and confidence supported by robust anticipatory care. The education programme has specifically enabled staff to competently and confidently support patients and families, engaging in frank, open, honest ,and sometimes challenging conversations that they would not have felt confident in doing before . Establishing goals of care and expectations supports robust anticipatory care and importantly prioritises patient and family/ carer wishes and ensures that they are known.

Day to day the ward is Nurse led with a weekly Consultant ward round followed by a team meeting and review of patients by the middle grade medical team when needed. The Advanced Nurse Practitioner team cover Out of Hours.

Systematic symptom assessment is documented in the Palliative Care specific Care plan which has been developed and a Pain Care Plan is in place for all patients who are prescribed controlled drugs or have Palliative and End of Life Care needs . The daily huddle is attended by the whole team which supports continuity and communication with patients, carers and families.

Multi-disciplinary team access to AHP's, particularly physiotherapy, chaplaincy, dietetics and Speech and Language Therapy can be arranged if required.

Treatment Escalation Plan (TEP): MacMillan Ward

A trigger for the clinical improvement process and change in practice was identification that treatment escalation plans for patients were not in place resulting in uncertainty in clinical management and inappropriate interventions. Alongside this, the necessary communication skills in supporting patients and families had to be developed.

Although some patients had an Anticipatory Care Plan (ACP) prior to admission it was recognised that a similar but shorter tool was required to establish robust documentation to enable the implementation of individualised decision making in partnership whenever possible with the patient, relative nursing and medical teams. The final Treatment Escalation Plan (version 15) was implemented in July 2016 into daily practice. The recorded decisions are not binding and may be changed during an admission. All new admissions to MacMillan Ward are provided with written information on the T.E.P. and this is discussed with families during the initial Consultant review. The Treatment Escalation plan is reviewed at least 3 monthly or as the patients clinical condition indicates.

Summary

With significant support from The Ayrshire Hospice and the ongoing integrated approach to patient care, change in practice and outcomes for patients are measureable. The ability to target transfer of patients from the acute Hospital to the Community Hospital to best meet their needs has been facilitated. We have improved clinical knowledge and skills in symptom assessment and symptom control, enhanced advanced communication skills and an inclusive team approach which is disseminated to any health care professional who has contact with the ward, and to every patient, carer, friend and family member. Evaluation is ongoing

Future Plan

- Streamline a referral process from the Acute / General Hospital
- Ongoing training for new and current junior medical staff
- Explore a model to allow direct admission from the community

Some of the team; from McMillan Ward , The Ayrshire Hospice and The Hospital Palliative Care Team

NC18-00525 Making a difference