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

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Introduction

This paper 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 usually based care is optimal, they have a pivotal role.

Background

The ward manager of a 30 bed continuing care ward took the opportunity to specifically explain this process to the Nursing Director due to a significant number of patients in this ward had complex continuing care. 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 and on weekends. There was clear recognition of education and training being lacking in the need 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 measurable 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 of the information contained in the palliative care in this setting. Along 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.
- Involved weekly sessions involving the Consultant Ward Round facilitating shared learning to enhance recognition of the early holistic approach for patients with complex needs.
- Develop an inclusive pathway with patients, families and staff.

Referral and before admission

Patients 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 generated 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 enables care of our team to occur.

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 – visiting as Family and Friends Time, pan therapy, music therapy, access to the garden and the library. Involving patients and their families in the planning of their care is important as it has been shown that patients who are included in their care planning have better outcomes. The Ayrshire and Arran Medical Education and Training Board (AAMETB) and NHS Ayrshire and Arran have supported the development of the Palliative Care Specific Care Plan which has been developed and plans to update this plan in place for all patients who are prescribed controlled drugs on in acute trust and has now for our ward. This daily huddle is attended by the whole team which supports continuity and communication with patients, carers and families.

Multi-disciplinary team access to RIS, 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 to 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 enable robust documentation to enable the implementation of individualised care. The trigger was the need to provide a partnership with patients and their families, carers and the team, providing decision making in partnership with patients, relatives, nursing and medical teams. The Final Treatment Escalation Plan Version 1.0 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 TEP and this is discussed with families during the initial Consultant Review. The Treatment Escalation Plan is reviewed at least 1 monthly or in the patients clinical condition indicates.

Summary

With significant support from the Ayrshire Hospice and the ongoing ingenuity approach to patient care, change in practice and outcomes for patients are improving. The ability to transfer patients from the acute hospital to the Community Hospital to better meet their needs has been facilitated through clinical care pathways, and an improved clinical knowledge and the implementation of an assessment and symptom control, enhanced advanced communication skills and an inclusive team approach which is disseminated to all health care professionals who contact with the ward, and to every patient, care, 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

TREATMENT ESCALATION PLAN (TEP)

- Core components
- Upper GI Cancer
- Colorectal Cancer
- Breast Cancer
- Haematological cancer
- Urological Cancer
- Lung cancer
- Colorectal Cancer
- Liver failure
- Nausea
- Vomiting
- Fatigue
- Shortness
- Routine News
- Routine Blood tests
- Comfort measures only
- IV fluids/SC Fluids
- For full escalation
- As needed
- Suction
- Oxygen
- Pain
- Vomiting
- Fatigue
- Shortness
- Nausea
- Anxacity
- Help
- Dignity
- Bancercare
- Information sharing is a priority: Patients, relatives, friends and carers are given:
- Information about the patient’s illness
- Information about the care they will receive
- Information about their rights
- Information about how they can get help
- Information about any treatment that has been done
- Information about any other treatment that could be offered

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 needed to component to effectively prepare the team for these new changes, support for patients and families with the development of strong relationships with them and the importance of maintaining trust and confidence supported by robust anticipatory care.

The education programme is continually developing building 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 is continually developing and has been ongoing for over five years.

Low Pain
- Low Vomiting
- Low Fatigue
- Shortness
- Nausea
- Anxacity
- Help
- Dignity
- Bancercare
- Information sharing is a priority: Patients, relatives, friends and carers are given:
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Valued comments on Care Opinion

https://www.careopinion.org/alloptions/5f17e8/9f/50/1530/30

My Mum’s care

My Mum passed away on an aggressive stage A cancer at age 79.

Ayrshire hospital stood by her if I would be like to go to the hospice, but she chose the biggest one in Scotland and had our end of life care.

She was moved to the Macmillan ward 3 weeks ago.

From the moment we weren’t, the care, dignity and empathy she was shown by every single one of the staff was sugar and the kindness they had shown to myself and my family.

I can’t put it into words just how brilliant they are.

We sadly lost my mum this week but it has been the kindest experiences of my life seeing her

I will be forever thankful to every one of them from the nurses, to the ancillaries, to the porters. What a treat.

A million thank yous!

About: Biggar Hospital Biggar Hospital Premises 59 (1Q) Posted by Angela a service user; 3 months ago

Access to the Community Hospital was facilitated through clinical care pathways, and an improved clinical knowledge and the implementation of an assessment and symptom control, enhanced advanced communication skills and an inclusive team approach which is disseminated to all health care professionals who contact with the ward, and to every patient, care, friend and family member. Evaluation is ongoing.