

# Palliate

SPPC

May 2022

INSTITUTE OF  
GLOBAL HEALTH  
INNOVATION

## Who we are: an innovation team working in the clinical environment



## Lead for End-of-Life Care: Looking at the problem from a different point of view



## Who we are: our earlier work

**RoSPECT** Recommended Summary Plan for Emergency Care and Treatment for: Preferred name \_\_\_\_\_

**1. Personal details**

Full name \_\_\_\_\_ Date of birth \_\_\_\_\_ Date completed \_\_\_\_\_

NHS/CHI/Health and care number \_\_\_\_\_ Address \_\_\_\_\_

**2. Summary of relevant information for this plan (see also section 6)**

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

**3. Personal preferences to guide this plan (when the person has capacity)**

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort \_\_\_\_\_ Prioritise comfort, even at the expense of sustaining life \_\_\_\_\_

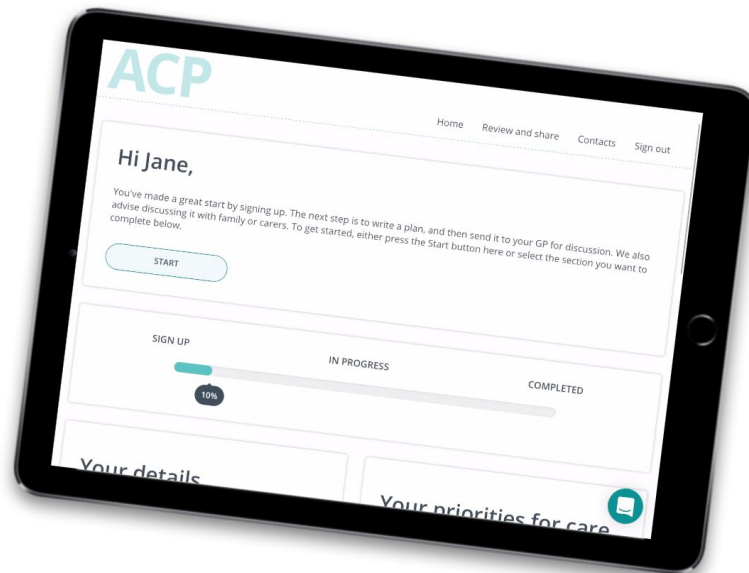
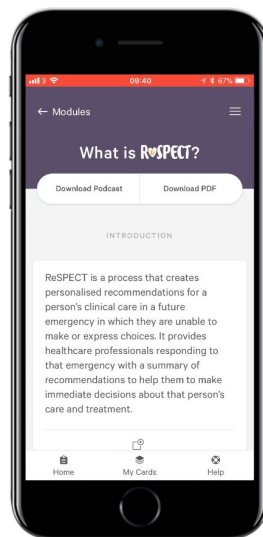
Considering the above priorities, what is most important to you is (optional): \_\_\_\_\_

**4. Clinical recommendations for emergency care and treatment**

Focus on life-sustaining treatment as per guidance below (clinician signature) \_\_\_\_\_ Focus on symptom control as per guidance below (clinician signature) \_\_\_\_\_

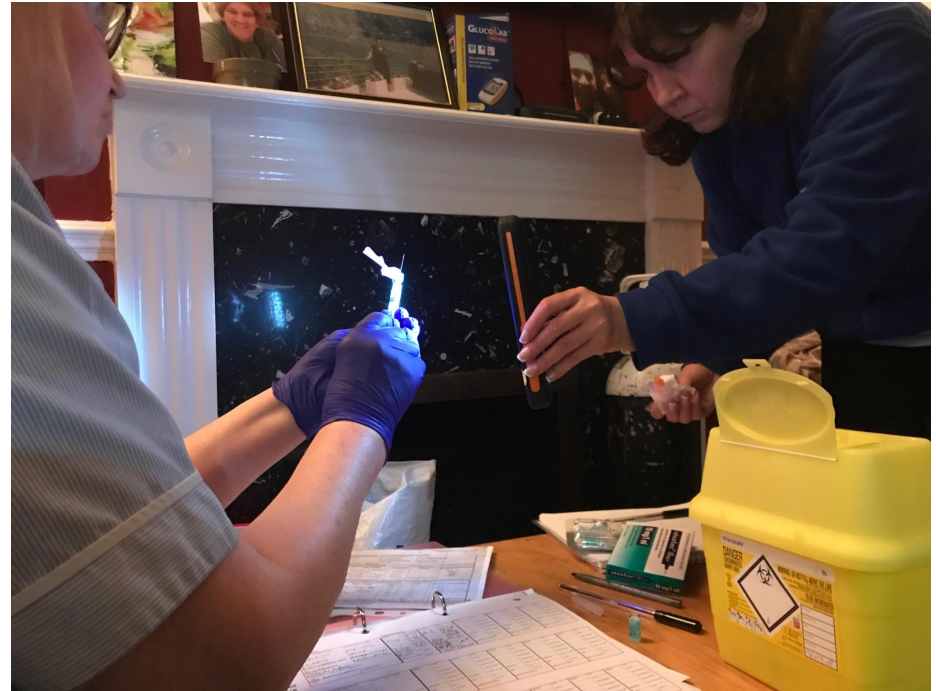
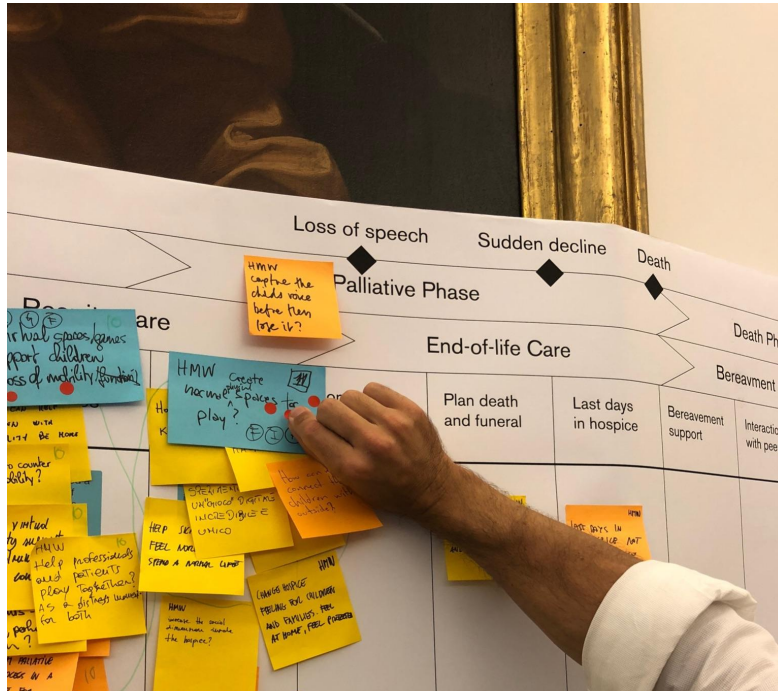
Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support: \_\_\_\_\_

CPR attempts recommended Adult or child (clinician signature) \_\_\_\_\_ For modified CPR Child only, as detailed above (clinician signature) \_\_\_\_\_ CPR attempts NOT recommended Adult or child (clinician signature) \_\_\_\_\_





## Who we are: discovering and exploring problems



## The problem

- The majority (92%) of the 500,000 people who die every year, would prefer to die at home, yet only a minority (23.5%) do die in their own home.
- Dying at home requires huge amounts of coordination, organisation and good communication to make things run smoothly.
- There is a hidden workforce of 500,000 laycarers - one for each person with a terminal illness - who make up the informal care system.
- But carers have a lack of knowledge around end-of-life care, which is a key barrier to decision making.
- Family members often 'panic' with changes to a person's symptoms in the dying phase.
- Unmanaged symptoms at the end of life at home cause late admissions to hospital, denying families a home death

*"It was the worst night of my life. I lay in bed holding my mother, stroking her as she was agitated and restless and trying to get up, delirious and restless, her eyes rolling back, all of us around the bed crying.... waiting for a nurse to come. We kept calling but no-one came. There was nothing I could do. By the time they came, she had died"*

— Family carer



## The opportunity

The 2021 IPPR report – developed with IGHI – outlined the case for community-led end of life care as the best, most sustainable alternative to a current reliance on hospitals, intensive treatment and low quality of life at the end of life.

**It recommends providing everyone the right care, from the right person, at the right time.**

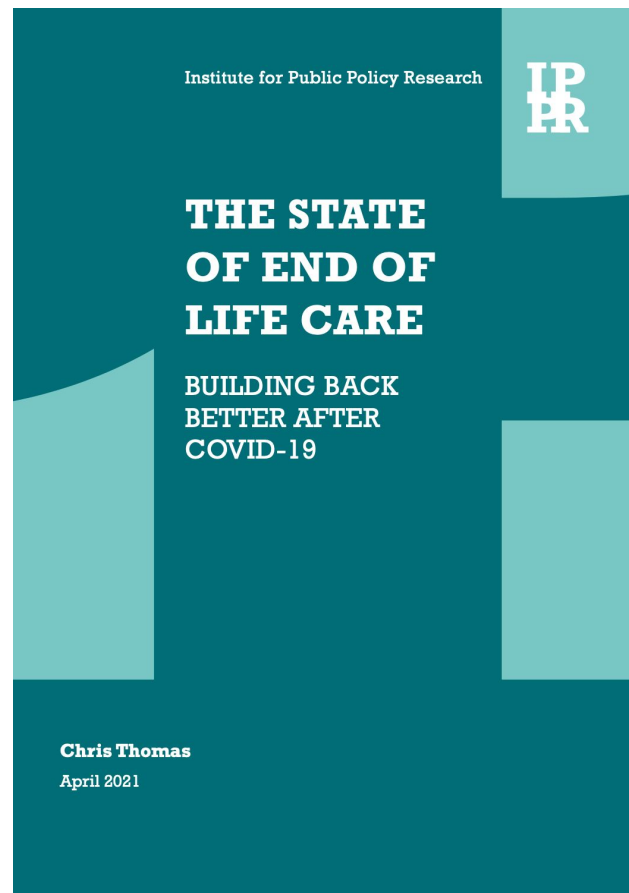
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IPPR



## The opportunity

- **For patients**
  - Avoid unnecessary suffering with better managed pain relief and symptom control
  - Maintain preferences and priorities to stay and die at home
  - Maintain dignity by families sharing care with HCP's
- **For carers**
  - Improve understanding of symptom management and end-of-life experience
  - Improved confidence, autonomy and decision making
  - Lower chance of complicated grief after death
- **For professionals and health services**
  - Faster, more informed feedback about patient condition
  - Better utilisation of limited resources
  - Lower risk of hospital admissions, resulting in lower costs

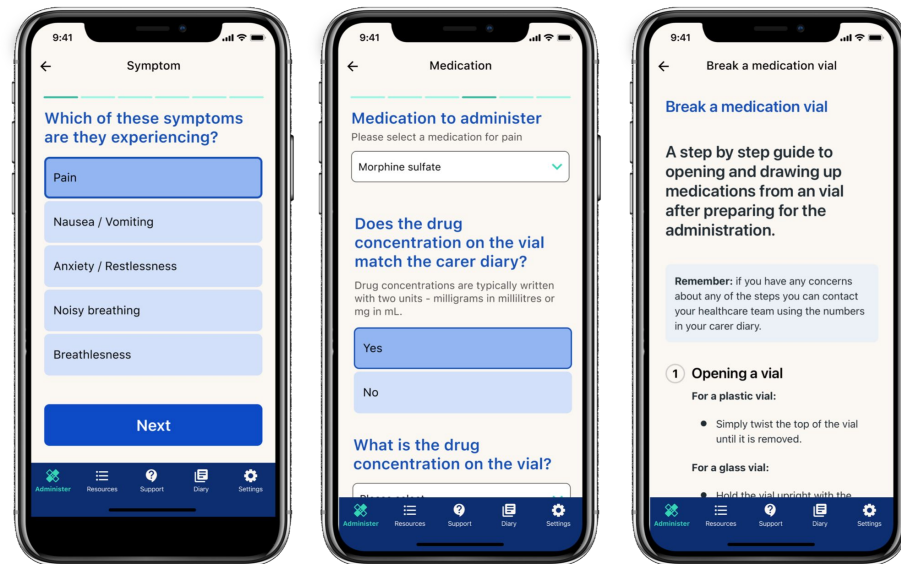




## The solution

Palliate is a digital platform to support people in the community as they look after loved ones in the last phase of their life.

It is comprised of medication administration recording and training, education and facilitation with on-demand professional support.



## Our approach

### Design

- Palliate is designed and built around the needs of patients and families, in close collaboration with carers and healthcare professionals.
- It is created using the lean startup cycle of *build-measure-learn*. Each component is built into a testable solution, which can be measured using data which informs the learning around development of further iterations.
- Our team of designers, developers, researchers and carer engagement leads means we can provide a holistic set of skills required to deliver for patients, families and healthcare teams.

### Research

- Palliate is translated from existing studies in providing education and training for carers to administer medications.

- Our aim is to evidence both the need for better community palliative care and barriers to it (e.g HCP anxiety) and research the acceptability and effectiveness of Palliate as a digital intervention through feasibility studies.

### Policy

- Working with CNWL NHS Trust on their new anticipatory medications policy
- Our team provides comprehensive training for HCP's on how to train and support the carer along with risk assessment tools and competency assessments
- Working across all levels of NHS management, we have developed a process that enables any community team to embed Palliate and deliver it to their patients.

## Problems with existing medication administration practice

- There is no single national policy for carer administration of medications, different regions have different policies
- Those that do utilise complicated paper-based policies that are hard for carers to use, and offer little monitoring opportunities for professionals
- The NHS has a tendency to duplicate and needlessly amend existing policies makes efficient scaling impossible
- There is professional anxiety around perceived risk/types of drugs in the home, yet the anticipatory drugs are already in the home for nurses to administer

*"I wanted clearer documents for recording, more carer-friendly, simpler. When you're tired it can be difficult to be clear about getting it ready and what you're giving."*

— Family carer

# What does it do?

## For carers

- Supports learning and understanding through educational resources, for both medication administration and beyond (last days/hours, after death, bereavement, self care)
- Assists with medication safety by providing the right information at the right time in the right format

## For professionals (in the future)

- Provides visibility of live data with multiple carers
- Monitoring and accounting of used/unused controlled substances
- Identify patients at risk of crisis and intervene to prevent problems
- Creating a direct link to CMC and LAS in London
- Integration with EHRs in Scotland and England

The screenshot displays the Palliate HCPView interface. At the top, there's a dark blue header with the 'Palliate' logo and navigation tabs for 'Patients', 'Policy', and 'Resources'. A user greeting 'Hello, HCPname Lastname' is on the right. Below the header, the patient's name 'Suoma Fredenand' is prominently displayed, along with an 'Edit profile' button. Patient details include NHS number, DOB, and address. Carer information shows the primary carer as 'Lovro Arevik' with an average confidence score of 7/10 and training status for top-ups.

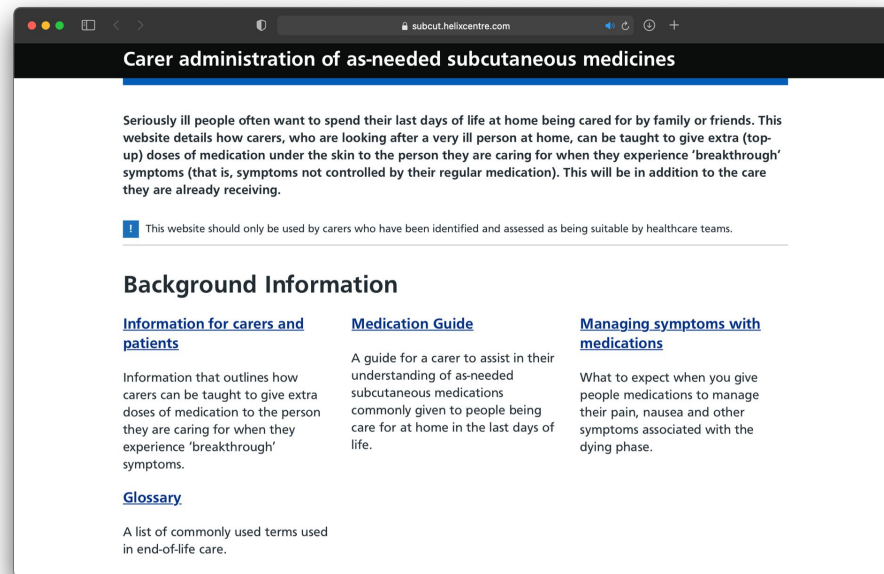
The main section is titled 'Administration overview' with a timestamp 'Last updated: 02/00/2020, 14:03'. It features a sidebar with 'Sort by' (set to 'Date and time') and 'Filter selection' (including Date, Medication, Symptom, and Indication resolved). The main content is a table with columns for Date and time, Medication, and Symptom. Each row includes a 'See more' link.

Date and time	Medication	Symptom	
00/00/2021, 00:00	Glycopyrronium ## mg	Pain ● Not resolved	<a href="#">See more</a>
00/00/2021, 00:00	Levomopromazine ## mg	Pain ● Resolved	<a href="#">See more</a>
00/00/2021, 00:00	Oxycodone Hydrochloride ## mg	Nausea ● Not resolved	<a href="#">See more</a>
00/00/2021, 00:00	Levomopromazine ## mg	Agitation ● Resolved	<a href="#">See more</a>
00/00/2021, 00:00	Oxycodone Hydrochloride ## mg	Anxiety ● Resolved	<a href="#">See more</a>
00/00/2021, 00:00	Glycopyrronium ## mg	Noisy breathing ● Resolved	<a href="#">See more</a>
00/00/2021, 00:00	Morphine ## mg	Breathlessness ● Resolved	<a href="#">See more</a>
00/00/2021, 00:00	Morphine ## mg	Pain ● Not resolved	<a href="#">See more</a>
00/00/2021, 00:00	Morphine ## mg	Pain ● Resolved	<a href="#">See more</a>

Palliate HCPView – currently in development

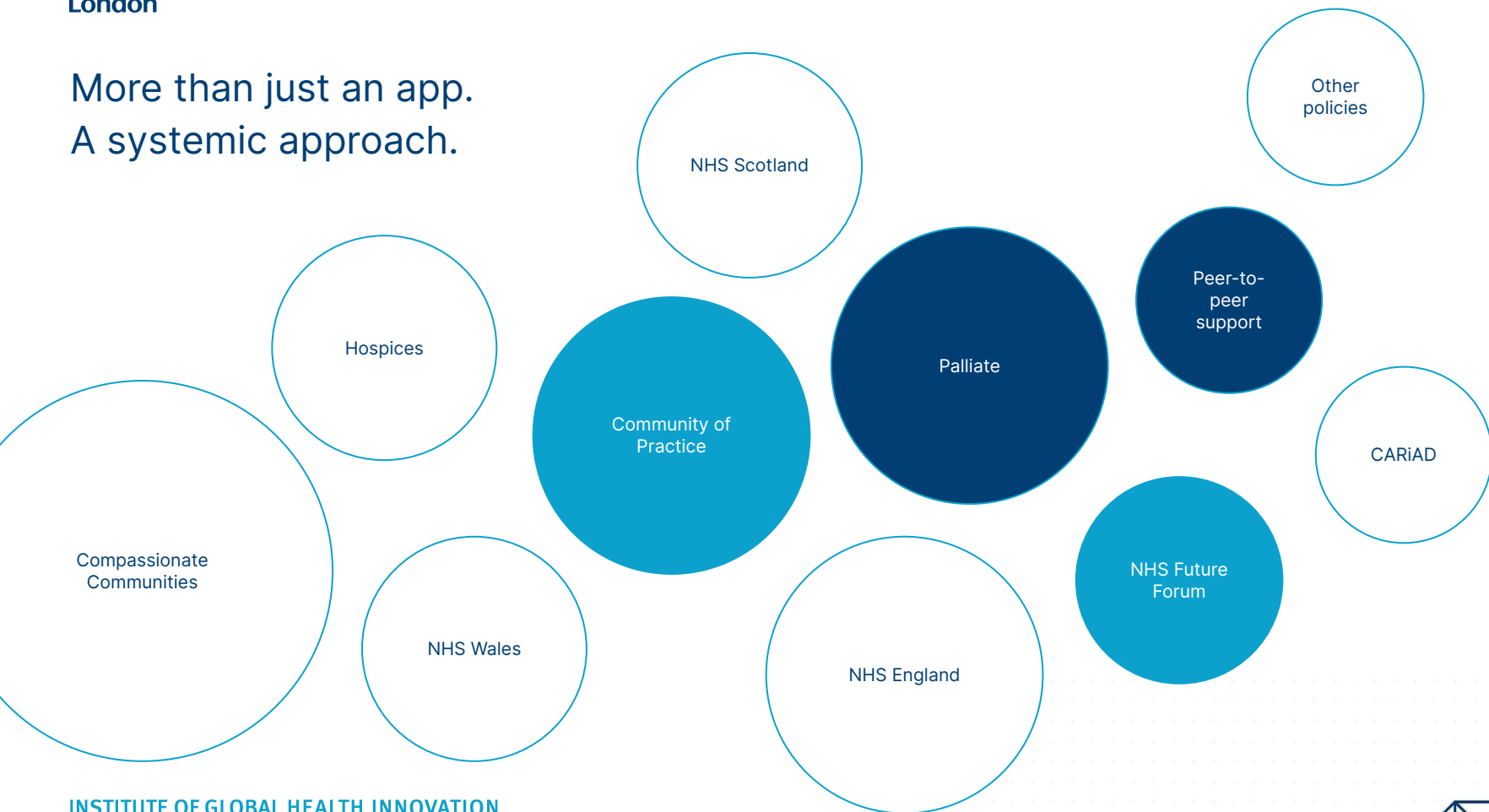
## Why now?

- There is little realistic prospect of meeting increased demand for home deaths using existing professional services<sup>1</sup>
- COVID-19 continues to re-write the way in which end-of-life care is done in the community: people have had to do more without professionals in the home
- In March 2020, our [sub-cut medications website tool](#) validated the role of design and technology to support better community palliative care and was used through UK during the first pandemic wave.



1. Abel J, Kellehear A. Palliative care reimagined: a needed shift. BMJ Support Palliat Care. 2016 Mar;6(1):21-6. doi: 10.1136/bmjspcare-2015-001009. Epub 2016 Jan 31. PMID: 26832803.

More than just an app.  
A systemic approach.

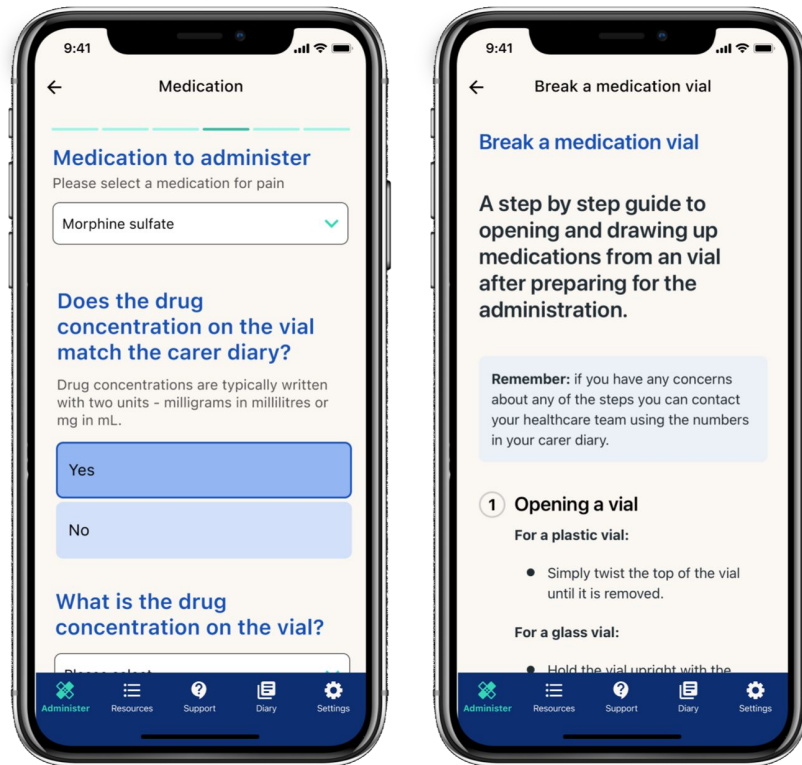




## Our vision

To enable home deaths to be  
safely and effectively supported,  
with dignity and care for everyone.





If you think Palliate could work where you are, please get in touch with me to learn more

**Thank you**

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