An Alternative Place for Palliative Care

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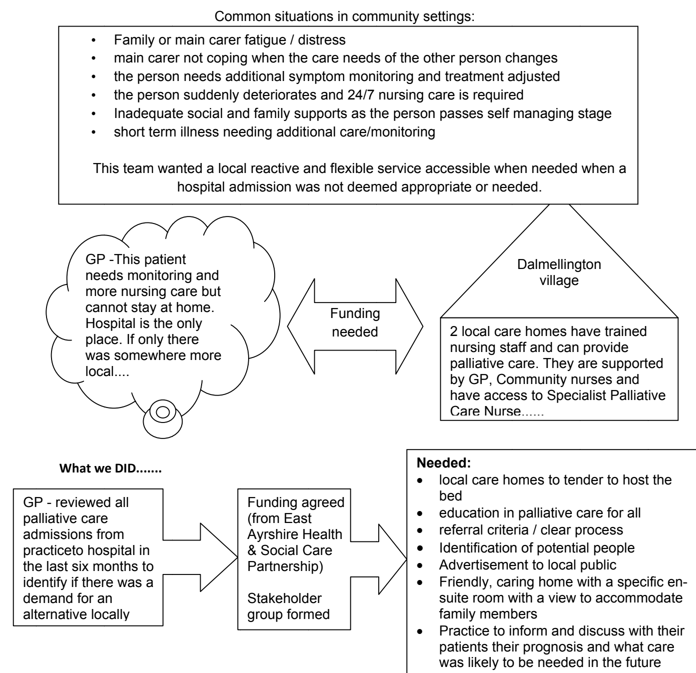
Ayrshire Hospice – Making today matter
East Ayrshire Health & Social Care Partnership
Glebe House Care Home
ihub – living well in communities

Introduction

The Scottish Government's (2015) commitment for improvement in palliative care included early identification of those who would benefit, irrespective of their diagnosis, to receive individualised and co-ordinated care from services that respond innovatively to emerging need.



The care home chosen has 44 beds and provides care for people with dementia, old age, mental health conditions, physical disabilities and those misusing substances. The Palliative care room was redecorated and in a quieter area of the home with a view of the garden. The room is en-suite and can accommodate relatives who wish to stay overnight.

Predicted risks

1. Person's acceptance of their prognosis & the need for palliative care support
2. Person's willingness to receive their care in a 'Care Home' instead of hospital
3. Funded for 6 months initially as a test – if evidence of reduced demand, funding will be stopped.

Outcomes

Referral Process included:

-Identification of people
-ECOG score & discussion at multi professional practice meeting
-anticipatory care planning / CPR discussions
-person consenting to share information / Electronic Care Summary
-transport from home to care home
-development of documents to support the 'Step up' & 'Step down' process and sharing of information with the care home.

Education Aim

To increase the knowledge, skills and confidence of staff providing palliative and end of life care in a care home setting. The programme was delivered by the Ayrshire Hospice education team and community palliative care nurse specialists 2 weekly, 3 hour session, time & location agreed with care home.

Education Programme Topics	
Session 1	**Pre-course evaluation** **Every session is evaluated** **Weekly reflective task** **Post course evaluation**
Introduction to Palliative Care	
Symptom management of advance disease	
Session 2	
Pain assessment and basic pain management principles	
Communication skills	
Session 3	
End of life care planning / symptom management	
Loss, grief and bereavement	
Session 4	
DNACPR and Advance/Anticipatory care planning	
Looking after yourself…..do you?	

Throughout the programme there were opportunities for staff attending to reflect on, and consider the benefits and challenges of this approach within the care home / home environment.

Cohort 1 Topic	Pre course	Post course	Change	Topic	Pre course	Post course	Change
Knowledge of palliative care	3.2	4.9	+ 1.7	Skills working with people	3.1	4.4	+ 1.3
Discussing PC with families	3.1	4.0	+ 0.9	Discussing PC with teams	3.7	4.5	+ 0 .8
How would you rate the programme?				Average score: 5.1 out of 6			

Improvement in knowledge and skills noted

Cohort 2 Topic	Pre course	Post course	Change	Topic	Pre course	Post course	Change
Knowledge of palliative care	4.0	4.7	+ 0.7	Skills working with people	4.1	4.8	+ 0.7
Discussing PC with families	4.4	4.9	+ 0.5	Discussing PC with teams	4.4	4.9	+ 0.5
How would you rate the programme?				Average score: 5.1 out of 6			

Additional support

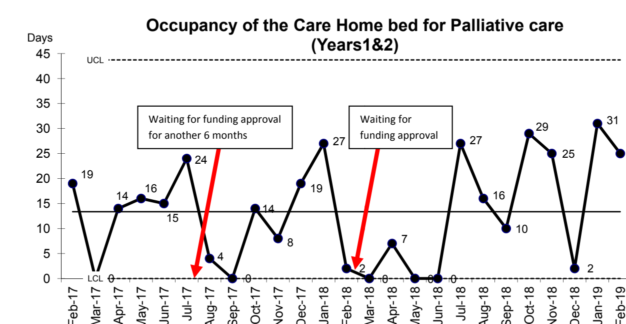
During the first year, staffing in the care home remained the same during day and night duty. Other support provided included visits and phone calls. It was noted that the support required, reduced in the second phase of the first year:

	Number of support visits/contact	
	Feb-Aug 2017	Aug 2017-Feb 2018
District Nurse	12	1
GP	47	28
Community Specialist Palliative Care Nurse	12	9
Additional support given	71	38

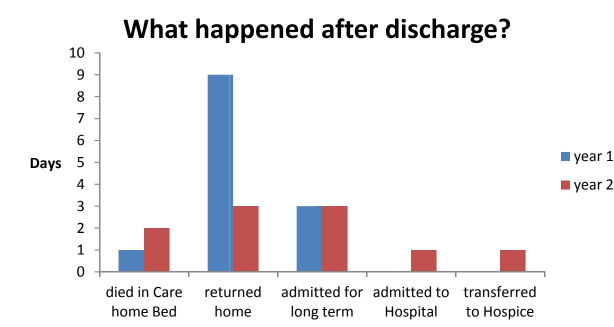
Occupancy

The reasons for being admitted to the care home bed were mainly for additional support and management to control symptoms caused by advanced disease. A neighbouring GP Practice within a few miles of the care home asked to access the bed for their patients.

Between 6 February 2017 and 6th February 2018 the palliative care bed in Glebe House was used for 162 days (45%). The bed was occupied by 12 known palliative patients (13 admissions) from Dalmellington and Patna GP practices. Their ages ranged from 61 to 99 years old with varying diagnoses. The average length of stay was 12.5 days. The approximate cost for admission to acute hospital bed for 162 days (£430 /day) was estimated at £69,660. Funding was agreed during February 2018 to continue providing this service. From 1st March 2018 to 28 February March 2019 the bed has been used by 10 people for 172 days (47%).



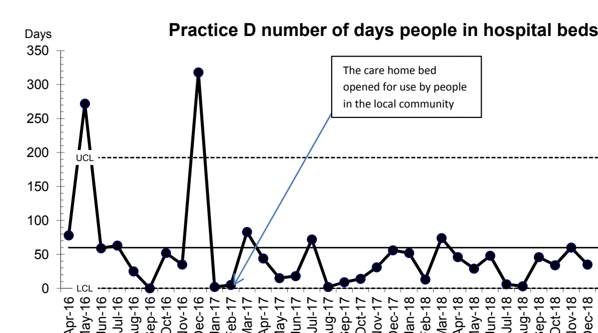
A typical perspective was that the palliative care home bed was a place people went to die. However what happened after discharge shows that of the 22 people using the bed (23 admissions), 3 died while using the bed, 12 returned home and 6 people decided they wanted to live in a care home, 1 person was transferred to hospital for emergency care and 1 other was transferred to the Ayrshire Hospice.



Impact

The GP practices using this facility already monitor people who they deem are palliative, irrespective of diagnosis. Their community nurses, community specialist palliative care nurses and social workers are involved in practice meetings and believe that good communication between services is essential. They plan together and discuss the patients who are a priority, using a traffic light system – red, orange, green. Their discussions with patients on the practice palliative register include anticipatory care planning, cardio pulmonary resuscitation and preferred place of care in the event of deterioration of their condition.

The practice (D) has reduced the number of people being admitted to hospital and the length of time that their patients are in hospital. However the care home bed is not wholly responsible for this reduction as there are a number of other initiatives supporting people to be cared for in their community.



D Practice	Financial year total for hospital stays	Financial year total for hospital bed days	Financial year total for average length of stay in hospital
2016/2017	61	992	16.3
2017/2018	56	400	7.1
2018/2019(incomplete)	55	307	5.6
Practice R			
2016/2017	92	936	10.2
2017/2018	70	743	10.6
2018/2019(incomplete)	39	524	13.4

The care home has provided palliative care for 22 people for 334 days over 2 years (46%). These are people who did not need hospital treatment but could not remain at home. They received the care, support and treatment they needed. Those closest to them were kept informed of any progress/deterioration. The majority of people admitted returned home to be cared for by family /social care teams with support from social workers, their GP, community nurses and specialist palliative care.

What has been learned?

- Everyone's understanding of what palliative care is, when it begins and who to turn to for help is not always clear
- Practitioner's need to get better at identifying people earlier and not at a time of crisis
- People's reaction to being cared for in a care home instead of being admitted to hospital
- Needs engagement from all stakeholders and the general practice
- People want to be cared for and receive good quality care at home /homely setting and only be admitted to hospital when needed/asked for

What action was taken?

- Educated our stakeholder group, colleagues, those involved in caring and related services on their understanding of palliative care and who can provide palliative care
- Practitioner's used their established monthly meeting to discuss potential people who could need the palliative care bed as well as discussing the people already on and to be added to their practice palliative register
- Practitioner's conversation with people about anticipatory care planning and place of care provided an opportunity to introduce the care home initiative as an alternative place of care
- A film was produced to share the learning and to raise awareness that palliative care can be delivered at home as well as in an alternative place to hospital. Film https://vimeo.com/272221484

Conclusion

The opportunity to provide palliative care in a setting which is not a hospital was tested out for 6 months. This has made a difference to the people living in this community and their families.

The care home staff have increased their knowledge, skills and confidence in palliative care and have added to the engagement and partnership relationship they had with their local GP's, District Nurses and Community Specialist Palliative Care Nurse.

It was recommended that this model of care was to continue. In March 2018 East Ayrshire Health & Social Care Partnership granted permanent funding pending annual review. The care home already hosting the bed will continue to do so with permanent funding tendered for and awarded. People in need of palliative care in their local community will continue to benefit from this facility with the support from the care home staff, social work, local district nurses, GP and the community specialist nurse. It is anticipated that this initiative will be mirrored in another rural locality in East Ayrshire.