MAGICE Model – getting palliative care right every time

EAST AYRSHIRE Health & Social Care Partnership

NHS Ayrshire & Arran

M Mindful that good quality palliative care needs

A Assessment and

G Great conversations that are

I Important to identify people early so that they have a

C Care plan and know how to communicate with their care co-ordinator to

E Enable excellence in end of life care & support in bereavement

Holistic Assessment & early identification

- Use SPICT to identify people with palliative care needs
- Assess assets already in place and what matters now
- Initiate ACP conversation
- Assess main carer needs
- Consider Realistic Medicine
- Prepare and plan for future changes
- Communicate all findings with all involved
- Early warning sent to services of changing needs

Communication & Information sharing with person and services involved

- Phone call to community team(s) involved – have knowledge of person's home situation- follow up with written information
- All teams involved need to know diagnosis/prognosis, current situation, person's preferences for care & their closest family understanding
- Clear, concise and honest communication- acknowledge uncertainty
- Explain in full, care needed during admission/significant conversations
- Care services – need informed in full of current situation/prognosis
- Timely recognition – Consider person's preferred place of care
- Prompt assessment of environment / order of equipment
- Assess needs in the present and future
- Medicines- order in advance and send 5 day supply home

Recognise symptoms

- Engage in conversation with the person and those closest to them always
- Assess and review need & outcomes with the person /with their carer
- Use Scottish palliative care guidelines (booklet, app & web site)
- Provide person with access details for help 24/7
- Access specialist support for complex issues
- Plan for pain – analgesia available always
- Symptom management – Communicate handover to teams what's current & been tried and alternative suggestions for the future

Medicines

- Assess compliance and ability to take medicines orally
- Good medicine management – prioritise most important medicines.
- Proactively anticipate Just in case medicines needed – include pain relief.
- Involve community pharmacist
- Provide/ signpost to training for social carers to give 'as required' medicines
- Assess literacy – what do people understand about their medicines?
- Improve access to anticipatory medicines

Assess/ review of Finances

- DS I500
- Make sure income is maximised
- Share updates with those who have knowledge of person's situation ie Care Co-ordinator

Care Coordinator

- Who is key person and has most input
- Known to family
- Knowledge of referrals
- Put on Key Information Summary who Care Coordinator is
- Family/Services must know who Care Coordinator is

Role

- Keep all services up to date including ACP's
- Needs to be right person at right time
- Care Coordinator needs role to be clear
- Identify key Care Coordinator at MDT
- Document centrally

Getting it right for people with palliative care needs in East Ayrshire

Fundamental Principles

- Easy access to information and services
- Respect/caring/safe/compassion/trust at all times
- Recognise and respond to education and training needs
- Proactive planning
- Agree right person/right place/right time
- Ownership /governance/accountability
- Assess risks

Support for Carer/ Family

- Carers Assessment completed/reviewed/shared
- Provide details for a Key person contact directly 24/7
- Understanding & clear information what NHS and Social Care can/can't do.
- Involve the main carer in all planning – listen to their views
- Provide /signpost to education ie moving and handling, medicines management
- Offer information/plan respite breaks with person and their carer
- Provide time for emotional support/discussion with Carer
- Help carer build resilience/coping strategy
- Assess need for overnight care/break for carer
- Provide/signpost to social/therapeutic groups for additional support/care ie Community Connector

Utilise Community Groups

Involve support in the local area:

- Neighbours
- Volunteers i.e. foodbank, Community Connectors, compassionate communities to support people at home
- Sacred Care
- Support groups
- Spiritual care

Equipment

- Assess need and liaise with key care co-ordinator
- Risk assess area
- Order equipment promptly
- Keep family informed and consider appropriateness
- Prompt removal of equipment and aids no longer required

Transport must be

- Accessible
- Reliable
- Consistent
- booked promptly for transfer of person to another setting

Education in Palliative care

- Provide/signpost to education for all staff
- Provide/signpost to education for family, public, volunteers i.e. Moving & Handling, Medicines, Reporting symptoms, Knowing what to do and who to contact when needed

Recognising Dying

- Provide/signpost to education and communication skills for all staff
- Ensure the main carer and the person is aware of the reasons for deterioration – open and honest conversations
- Ensure additional medication/JIC meds are readily available on site
- If wanted, prepare the person/main carer for the person dying and how this is likely to be/look like
- Provide verbal and written information so that the main carer knows what to do and who to contact when death occurs

Bereavement & Loss Support

- Respect cultural differences
- Provide/signpost to appropriate support if requested/needed
- Provide written information
- Communicate to ALL services when death occurs
- Arrange a bereavement visit from most appropriate person and inform other services

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