URGENT HOME VISITING TEAM

Stacey Taylor – Lead Advanced Nurse Practitioner, Dundee Urgent Home Visiting Team
Lisa Stallerbrass – Advanced Nurse Practitioner, Dundee Urgent Home Visiting Team
Lynn Ritchie – Personal Secretary/Administrator, Dundee Urgent Home Visiting Team

Background

Our Urgent Home Visiting Team of Advanced Nurse Practitioners provides a same day response to Care Home residents who are deteriorating or acutely unwell, on behalf of the GP.

The Team supports care home staff to identify people approaching end of life, supporting symptom management and end of life care.

We work closely with multi-disciplinary colleagues to support residents, their relatives and care staff to prepare for, and deal effectively with, approaching end of life.

Situation

Challenges:

Frailty is a leading cause of death in older people. Late recognition can impact on place of care and decision making for people who are progressing towards end of life (EOL). This can lead to inappropriate interventions, unnecessary admissions to acute hospital and under-treatment of palliative symptoms.

The trajectory towards end of life for frail older people can be lengthy and often includes episodes of acute illness, resulting in frequent visits by the UHVT ANP.

Due to the nature of the service the ANP can encounter an EOL situation on a first contact which can make decision-making challenging as the baseline is not known and we are relying on carers/nurses/relatives giving history.

There was recognition of the variety of experience and backgrounds available within the UHVT and the ANP's identified a need for further training with regards to identifying frailty, symptom management and end of life care.

There was an identified need of auditing the ANP entries into patients electronic records to identify where development is required to meet records-keeping standards.

What We Did

Reviewed appointments from Jan 2022 and Dec 2023 and identified at least 18 different descriptors identified as potential palliative/EOL situations (see pie chart).

Use of evidence-based assessment tools such as Supportive and Palliative Care Indicators Tool (SPICT) and the Gold Standards Framework Proactive Identification Guidance to identify care home residents who would benefit from a palliative approach based on their individual need.

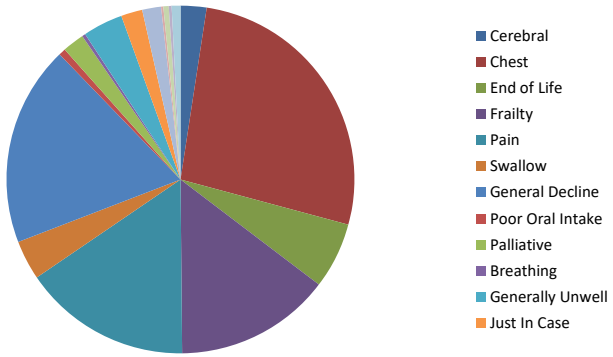
Developed effective working relationships with GPs/care home staff to ensure optimal communication and recognition of care home staff experience and skills.

Arranged training with palliative care team to develop skills and also link in with other services.

Commenced weekly case based discussions within the team to support each other and enhance decision making skills.

Developed record keeping audit tool, the team also identified the need to capture qualitative palliative outcomes.

Presenting Complaints which may indicate the resident is approaching end of life



Care Audit – Week of 9 January 2023

Total of 119 Calls – 100 patients seen (84%) / 19 telephone consultations (12%)

Of the 100 Episodes where Patients were Seen:
37% resulted in care advice being given to staff
51% resulted in an acute prescription being issued
12% were referred onwards

Of the 51% where Acute Prescriptions were Issued:
Only 1 was from Nurse Formulary
7 prescriptions were for Just in Case medicines

Of the 7 Episodes where JIC Meds were Issued:
3 people already had an appropriate ACP and KIS opened
2 people had their KIS opened
2 people did not have either ACP or KIS visible in Clinical Portal

Of the 9% Referred Onwards
9 referred onwards for bloods / to GP / Paramedics / CNS / Frailty Bleep Holder/1 acute hospital admission

Other
1 passed away during the visit / 1 notes not available

Feedback

From a GP – *"I was struck this year by how many patients identified as having cancer or long-term health conditions had been cared for at the end of their lives by your colleagues. Thank you."*

From a Care Home Manager – *"ANPs work extremely hard... this is an excellent service... enhanced my home through support and care... GPs pass a lot to them"*

From a Senior Carer – *"This team is now an integral part to the MDT for staff in care homes to feel supported and valued. Really good therapeutic relationships have been established."*

From Care Home Staff – *"We appreciate the single point of contact and the consistency of having support from one team rather than a large number of GPs"*

Future Plans

Undertake a retrospective review of patients with the above presenting complaints and utilise data from records audit and assess if these were in fact symptoms of people approaching EOL and if patient journeys can be enhanced.

Contact email: Lisa.Stallerbrass@nhs.scot