End of Life Newsletter

Winter 2015/16

Partnership working between The Dudley Group NHS Foundation Trust, Dudley Clinical Commissioning Group, Dudley Council and Mary Stevens Hospice

Welcome!

In partnership with our healthcare colleagues across Dudley, we are working hard to transform the way we care for dying patients and their families or carers to ensure people nearing the end of their lives are treated with dignity and respect, receive compassionate care in accordance to their wishes, and in the place they choose.

We are also committed to involving and supporting families and carers at every stage of this journey.

5 Priorities for Care

Five new Priorities for Care have been launched across hospital, hospice, community and primary care to give health professionals a clear focus on providing the highest quality, personalised and compassionate care to patients nearing end of life.

The new national guidance forms part of the 'One Chance to Get it Right' report.

Audits have commenced within the hospital and are mandatory in the audit plan for 15/16. The first round of audits was completed in September 2015.

The hospital audit tool is currently being reviewed by hospice and community services for suitability for use in those areas. Audit in primary care for 15/16 will be part of the End of Life and Primary Care Local Improvement Service.

EPaCCS

Electronic Palliative Care Coordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their treatment choices with those delivering their care. Organisations across the economy are currently scoping requirements for a solution for Dudley.

Advance Care Planning

Advance Care Planning is the process of planning ahead and making decisions about the future. Patients may want to express their preferences about how or where they are cared for, who is to be involved in significant conversations about them, decisions about resuscitation or any specific rites or rituals which are important to them as they are reaching the end of their life, or even after they have died.

It is a broad term which encompasses any preferences or decision about their future care. This is then used to guide healthcare professionals and families at a point where the patient can no longer speak for themselves through weakness, semi-consciousness or confusion.

The new 'Advance Statement' document is a Dudley specific tool launched in 2015 to capture the preferences of patients. They are encouraged to fill this in with their families and they can be supported in doing so by healthcare professionals.

The palliative care team has been providing education across the region to the hospital teams, GPs, district nurses, community specialist nurses and others on how to support patients with Advance Care Planning, as well as the legal aspects around the documents that are used, and how to respond to the completed documents when they are seen.

We are currently looking at how to embed the work done to date, and how to start evaluating the impact and value of advance care planning

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Want to get involved or find out more? Visit www.dudleygroup.nhs.uk/end-of-life/ and go to the Professionals area using the case sensitive password '**palliative**'

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Macmillan Specialist Care at Home

The Macmillan Specialist Care at Home (MSCaH) is a two-year pilot, supporting local services to work more effectively together and enhance the quality of care and treatment they provide for people at the end of their lives.

The Specialist Palliative Care Hub, open Monday to Friday 9am – 5pm and available on 01384 321800, makes it quicker and easier for health professionals to refer patients to the specialist palliative care team.

This means there is now one simple way to access the multiple specialist teams involved in end of life care in Dudley, resulting in care that is better coordinated and puts the needs of the patient first.

Once a patient is known to the service, additional referrals are not required, just a telephone call to request support.

We support multidisciplinary teams to identify patients and the care they need earlier. Early referral enables better planning, which will give patients more choice and control over the end of their lives, reduces avoidable and stressful hospital admissions. This also means that more patients will be able to die where they choose.

Each member of the team is linked to primary care localities and ward areas, and will provide specialist palliative care support through attending palliative care MDTs and through education. The service has successfully recruited a team of volunteers to support patients and carers.

Referrals are made through the MSCaH service.

Rapid Discharge Home to Die

Most people would prefer to die at home and not in hospital. Rapid Discharge supports patients whose need to return home becomes urgent where discharge has not already been planned, or because circumstances have changed and there is a need for the patient to return home as soon as possible.

Our aim is to get patients home within 24 hours from an inpatient setting (on a ward in a hospital) and within four hours from an emergency care setting (A&E). Once at home, patients will receive appropriate medication, equipment and support to allow a safe and dignified death in their own home.

The pathway document, checklist and patient information leaflet can all be printed from the website (see below).

Support is available from the Specialist Palliative Care Team for those as yet unfamiliar with the process. Over the coming months, there will be further revision of the pathway, and additional work developed around rapid discharge home to die for nursing homes and areas outside the Dudley Borough.

Bereavement Group

Our aim is to enable people who have experienced bereavement and significant loss to receive the highest quality of care and support to understand their grief and cope with their loss. The Bereavement Group is mapping out the services available across the borough to find out what support is available and how it can be accessed.

We are working to agree a protocol for care considering potential areas of need across the bereavement pathway including health promotion, direct care and support, community outreach and integration, and addressing the needs of those with complex difficulties.

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AMBER Care Bundle

The **AMBER** care bundle provides a systematic approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.

It is an intervention that can fit with any care pathway or diagnostic group. It helps you to realise when you should talk with the patient about what treatment and care they would prefer, should the worst happen. It is a simple tool which combines identification questions, four clinical interventions and systematic monitoring for adult ward areas.

We are working to implement the **AMBER** care bundle across all wards over the next few months. Phase 1 is planned through February on wards C5 and C7, with concurrent education and awareness sessions for remainder of medical wards. Any member of the clinical multi-disciplinary team can identify suitable patients for the **AMBER** care bundle

The term **AMBER** is used to reflect the need for close attention to be given to a person who you are particularly worried about. It stands for:

- **A**ssessment
- **M**anagement
- **B**est practice
- **E**ngagement
- **R**ecovery uncertain

Evidence suggests that the **AMBER** care bundle results in:

- Patients being treated with greater dignity and respect
- Greater clarity around patients' preferences and plans about how these can be met
- Improved decision making
- A positive impact on multi-professional team communication and working
- Increased nurses' confidence about when to approach medical colleagues to discuss treatment plans
- Lower emergency readmission rates

Palliative Care Champions

To increase your confidence in addressing end of life issues across the economy, the 'Palliative Care Champion' role has been developed in Dudley. Each ward area and community nursing team nominated a champion who has received appropriate education to develop their skills in EOL care. This education programme for champions was initially funded by a successful bid to Health Education England and now forms the rolling programme delivered economy wide.

As a result of the recommendations from the End of Life Care Strategy (2008), competencies in end of life care have also been developed and have been launched across the economy. All champions have received competencies and, if not already, are working towards sign off.

The champions will have the responsibility of attending monthly meetings with a member of the palliative care team along with other champions in order to reflect on specific case studies and education, along with palliative care updates. They then cascade all information back to their teams. Future plans see them participating in data collection for end of life care audits and mentoring other colleagues through their competencies with support from the specialist team.

Evaluation is positive from champions acknowledging they are now getting support within palliative and end of life care situations. Reflection is utilised frequently, which is a good basis for learning. The specialist teams across the economy also have had competencies launched to work through in line with their appraisal.

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