Initiatives to Improve End of Life Care in the Acute Setting

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National Context
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Local Context

Salford Royal NHS
NHS Foundation Trust
Palliative Care Team at Salford Royal

- 1.2 WTE consultants
- Specialist trainee
- 1 nurse consultant
- 3 band 7 CNSs
- 3 band 6 CNSs
- 1.8 WTE OT
- 0.6 WTE SW
- Education team
- 7 day face to face contact 8.30 am-4.30pm
- 24 hour advice line
- MDT & close links with community and hospice
Background – Preferred place of care

• About 2/3 of people want to die at home
• In 2009/10, there were 2,200 deaths in Salford
  – 58% of deaths occurred in hospital
  – 20% of deaths occurred at home
Background – Unscheduled Care

- In 2009/10, 1,785 individuals in the last year of their life, attended A&E on 4,499 occasions
- 75% were admitted
- Mean length of stay in the final year of life was 27.8 days (per patient)
- Reducing time spent in hospital by people in the last year of life by 20% would save SRFT £177k per annum
Background - Use of the LCP in Hospital

• Currently, the LCP is started in only about 60% of expected deaths in Salford Royal
Aims for the Palliative Care Team

• Increase the percentage of people dying in their place of choice
• Decrease time spent in hospital by people in the last year of life
• Increase the use of the LCP for expected hospital deaths
• Cost saving
Experience so far - EAU in reach

- Attended post take ward rounds
- Attended ward, and discussed admissions with senior nursing and medical staff
- Review case notes of admissions from office

- Average monthly EAU referrals to Palliative Care
  - 2009/10 = 7 per month
  - 2011/12 = 22 per month (268/1123 or 24% of total referrals)
What else can we do?
End of Life Care Pathway for Acute Hospitals

**Step 1: Discussions as the end of life approaches**
- Open, honest communication
- Identifying triggers for discussion
- Advance care planning.

**Step 2: Assessment, care planning and review**
- Conduct a holistic assessment
- Agreed care plan and regular review of needs and preferences
- Assessing needs of carers
- Advance care planning.

**Step 3: Co-ordination of care**
- Strategic co-ordination working with primary and community health services, ambulance/transport services and social care
- Co-ordination of individual patient care
- Discharge planning
- Rapid discharge home to die
- Fast track continuing health care.

**Step 4: Delivery of high quality care in an acute hospital**
- Dignified environment
- Access to specialist palliative care advice around the clock
- Specialist hospital palliative care team
- Access to spiritual care
- Access to tailored information.

**Step 5: Care in the last days of life**
- Identification of the dying phase
- Review of needs and preferences for place of death
- Support for both patient and carer
- Recognition of wishes regarding resuscitation and organ donation.

**Step 6: Care after death**
- Recognition that end of life care does not stop at the point of death
- Timely verification and certification of death or referral to coroner
- Care and support of carer and family, including emotional and practical bereavement support.
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AMBER Care Bundle

• Developed at Guy’s and St Thomas’
• AMBER = Action Assessment Management Best practice Engagement Recovery uncertain
• Hospital patients
• Being used in medical assessment units and across hospital wards
Patients whose recovery is uncertain

- Critical care, full medical intervention, responding to treatment expected recovery
- Recognition of uncertain recovery
  - Full intervention with added symptom control
- Recognition of the dying phase.

Timeline:

- Well
- Uncertain recovery
- Last days

Steps:

- Early planning
- AMBER care bundle
- LCP
Is the patient suitable for the AMBER care bundle?
1. Is the patient deteriorating, clinically unstable, and with limited reversibility; and,
2. Is the patient at risk of dying within the next 1-2 months?

Remember to apply the principles of the Mental Capacity Act 2005

If the answer is “Yes” to both questions then the multi-disciplinary team is expected to proceed to the four interventions in the care bundle. As the AMBER care bundle is a multi-disciplinary tool, it involves doctors, nurses and the whole team working together.
# Day 1 Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Action</th>
<th>Comments</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess patient capacity for each decision and involve in line with the Mental Capacity Act 2005</strong></td>
<td></td>
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<tr>
<td>Medical plan documented in patient record</td>
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<td></td>
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<tr>
<td>Including:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- current key issues</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td>- anticipated outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- resuscitation status</td>
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<td></td>
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<tr>
<td>Escalation decision documented</td>
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<tr>
<td>Including:</td>
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<tr>
<td>☐ Ward only ☐ HDU only ☐ ITU</td>
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<tr>
<td>Medical plan discussed and agreed with nursing staff</td>
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<tr>
<td>Patient ± carer discussion or meeting held and clearly documented</td>
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<td></td>
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<tr>
<td>Which may include:</td>
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<td></td>
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<tr>
<td>- uncertain recovery and treatment options</td>
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<tr>
<td>- preferred place of care</td>
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<td></td>
<td></td>
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<tr>
<td>- any concerns or wishes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- who was present</td>
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</tbody>
</table>

Record details in the patient’s record
Daily Monitoring and Review

Don’t forget to “ACT” daily:

Assess patient capacity for each decision and involve in line with the Mental Capacity Act 2005

• A  Is your patient still AMBER?
• C  Are there and medical Changes?
• T  Have you Touched base with the patient +/- carer?

Review the patient’s preferred place of care. Has it changed?
Results from Guy’s January 2010 – June 2011

- Total AMBER patients: 361
  - Recovered: 12 (3%)
  - Died on AMBER: 164 (45%)
  - Died on LCP: 74 (20%)
  - Discharged to community: 111 (31%)

87% of patients died within 100 days

Median number of days on AMBER: 6.0

87% of patients died within 100 days
Impact – from Guy’s and St Thomas’

- Improved decision making
- Improved MDT communication and working
- Increased nurses’ confidence to discuss treatment plans with doctors
- Patients being treated with greater dignity and respect
- Greater clarity around preferences and plans about how these can be met
  - >70% die in preferred place of care
- Lower emergency readmission rates
  - 30d – 14% v 35%
Salford Experience

- So far, piloted on gastro and cardiology
- Small numbers
- Positive experience
Next steps

• Rolling out onto other wards – respiratory, care of the elderly
• Facilitator
• Pilot of 10 patients on the EAU
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Electronic End of Life Register – Coordinate My Care

Potential unscheduled care needs (<24 hrs)
Direct iSoft input
Other routine communication
iSoft → Vision / EMIS loop

A&E

Evening DNs

Hospice

Community

Care Homes

SRFT

GPs

iSoft EPR

Co-ordinate My Care flowsheets

Social Care

Docman

SIR

Performance dashboard (quarterly)
Data quality audit
Other output?

NHS Mail

Care Homes

A & E

Adstra

OOH service

N W A S

UAG

Proforma
### Electronic End of Life Register – Coordinate My Care

<table>
<thead>
<tr>
<th>Observation</th>
<th>11 Oct 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPAND COLUMNS FULLY</td>
<td></td>
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<tr>
<td>EXPAND COLUMNS FULLY</td>
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<td>EXPAND COLUMNS FULLY</td>
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<td>EXPAND COLUMNS FULLY</td>
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<tr>
<td>EXPAND COLUMNS FULLY</td>
<td></td>
</tr>
<tr>
<td>Patient added to Co-ordinate My Care (ECS)</td>
<td></td>
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<tr>
<td>Consent given for upload to local shared electronic record</td>
<td></td>
</tr>
<tr>
<td>Refer to Health issue</td>
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<tr>
<td>Refer to Health issue</td>
<td></td>
</tr>
<tr>
<td>Refer to Health issues / Allergies</td>
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<tr>
<td>Refer to EPMRAR</td>
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</tbody>
</table>

- **End of Life Care Register**
- **Coordinate My Care**
Coordinate My Care –
Data from April - August 2012

• 81 deaths recorded on CMC
  – 20 (25%) died in hospital
  – 33 (41%) died at home
  – 11 (13.5%) died in a Care Home (2 Residential)
• 64/81 (79%) had a preferred place of death recorded
• 57/64 (89%) achieved their PPD
• 75% did not die in hospital
• >50% died in their usual place of residence
• 70% overall were cared for using the LCP
  (excluding Hospice data so likely to have been higher)
Next steps

• Promote use of Co-ordinate My Care
• Alerts – to A&E, EAU and palliative care team when a patient with a CMC entry is attending
Summary

The North West End of Life Care Model

Co-ordinate My Care

Advance Care Planning
‘Preferred Priorities for Care’

‘Rapid Discharge Pathway

‘Liverpool Care Pathway for the Dying’ (LCP)

AMBER care bundle

Advancing disease

1 year

Increasing decline

6 months

Last Days of Life

First Days after Death

Bereavement

1 year

Death