

APPENDIX 3B: GOOD PRACTICE EXAMPLES CONTINUED

ST CHRISTOPHER'S HOSPICE CARE HOME OUTREACH

We have a large community service covering 5 PCTs and so for our care home outreach we are experimenting with different models. The aim is to change our culture from being reactive into proactive and to use the framework of the current DoH End of Life Care tools as a basis for training.

Model 1

In three PCTs, Lambeth, Southwark and Lewisham (LSL) we have three Clinical Nurse Specialists (CNSs) each spending half a day a week to roll out the GSF in four care homes. We are well linked in with the LSL care home support team and work hand in glove with them. We have run three study days for care home Registered Nurses, and on each occasion had an increase in numbers attending - at the last one there were 80 participants. In addition each of our 10 CNSs that serve these PCTs are linked with particular care homes.

Model 2

In Croydon PCT we have a dedicated CNS whose whole case load is in care homes. This CNS also runs nurse clinics in a couple of these care homes. Also in Croydon we have a 12 hours per week post funded for three years by the strategic health authority end of life money. This post holder has implemented the the LCP in eight care homes. We also have a dementia project funded by the King's Fund. This is a project trying to identify the palliative and specialist palliative care needs for people with end stage dementia. It has a large care home component.

Model 3

During a planned ward refurbishment this summer, we are going to second some of our ward based nurses to work in local care homes. The care homes have been selected by the PCT care home support teams. Learning objectives will be identified with managers beforehand and the St. Christopher's staff will work intensively for a three week period in each home. We expect one to one teaching to occur during a shift and in the afternoons there will be planned workshops overseen by the ward manager and community CNS. During the three week period, two key 'movers and shakers' from the care home will be identified and invited back for a free clinical placement at the hospice. Ongoing support will be given by the community CNS. We aim to deliver this intensive input to 24 care homes.

Illustrative Model: Camden Palliative Care Centre

An example of a different approach to the provision of end of life care is the Camden Palliative Care Centre. In the late 80's and 1990's a number of practices came together that gave opportunity to develop very innovative models of practice between hospital and the community.

The philosophical priorities of the service were to deliver equality, and where possible choice. The service was structured around seamlessness and continuity as distinct from organisation or professional management lines. The result was that nurse specialists from the community, the hospital and from departments such as respiratory medicine and HIV were housed in the same open plan environment alongside doctors, AHPs and most importantly the co-ordinator who provided emergency home carers. The structure was supported by administrators and health service researchers involved with the centre, were also based there.

The result was a single place of contact for all palliative care related problems and for two of the disease groups where palliative care represented a large proportion of the workload, although the nurses were also involved in disease specific work.

At a managerial level integration extended beyond the centre itself to include home carers – some of whom came from the voluntary sector and importantly the night district nursing service and the Marie Curie budgets. This manager, who was also a practicing clinician, was in turn supported at director level with a commitment in the community trust to continuity and development of the overlap between continuing care and palliative care. The specialist palliative care service offered 24 hour on call and visiting in support of the night district nurses, as well as the hospital.

From an organisational point of view, there was agreement at director level that palliative care was to be provided to local residents and the teaching hospital to ensure that there was equal opportunity for all patients to have access to palliative and supportive care regardless of diagnosis, prognosis or social setting.

When the service was at its most functional, it provided a service to the population of 120,000 and looked after in the region of 700-800 patients a year up to half of whom had non-cancer diagnoses or co-morbidities and, whilst home death rate lay between 35 and 58%, 90% of patients were able to die in their place of choice.

One of the prominent advantages of this model was its flexibility and rapid response when patients who were in hospital wished to return home to die.

The following cameo illustrates this:

A lady in her seventies with cardio-respiratory disease had been admitted to hospital repeatedly over recent months and the staff felt that referral to Palliative Care would not only offer symptomatic help, but the means for her to avoid crisis admissions. Her enduring wish had been to die in her own bed.

Overnight on the day of her referral, she had deteriorated unexpectedly. When she was assessed in the morning, it was clear that she was unlikely to survive more than a few days. She and the extended family were adamant that she should go home. This was achieved in four hours with the patient indeed dying at home in the early hours of the following morning. Following the single call to the Centre, the following happened:

- Carelink, the home care support arranged for evening and overnight cover with a trained sitter that would run for 48hours whilst Social Service support was arranged;
- Occupational therapy visited the ward and established the immediate practical needs. She then arranged delivery, from the direct access, emergency equipment store, delivered a pressure mattress, and 24 hour supply of pads etc for personal care;
- Basic support was confirmed to be available and so the ambulance was arranged for discharge by direct discussion with Ambulance Control as an urgent discharge to die at home. They were able to offer help within the next four hours;
- Drugs and emergency supplies were ordered from Pharmacy;
- The community CNS from the Centre and the doctor, both of whom were on call that evening, met the family and arranged contact for when the patient got home;
- Day and Night Community Nurse Teams were notified of the discharge and arranged joint assessment with the CNS from the team;
- The General Practitioner was not on call that evening so was happy for things to proceed without his direct involvement that day;
- The patient arrived home at teatime, there was a joint early evening visit from Community Nursing and Palliative Care to ensure that medication and prescriptions were in place. The Carelink carer arrived.
- The family managed with a repeat visit at about 11pm from Community Nursing. The patient was settled and comfortable, but clearly dying. She dies in the early hours of the morning.