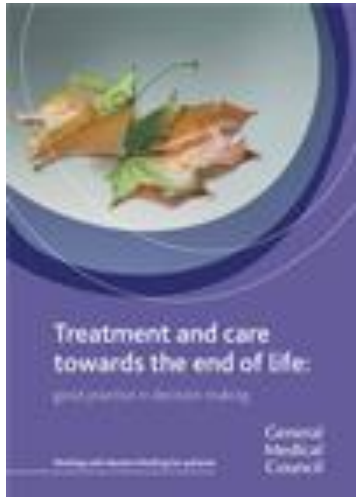
DOCTOR'S INDUCTION
Palliative and End of Life Care

2020

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Palliative and End of Life Care

- GMC define ‘End of Life’- All patients likely to be within the last 12 months of life. Within the hospital this equates to:
  - 1/3 acute hospital admissions
  - 80% acute admissions from a care home



Supporting Palliative Patients

Palliative Care Team

- Advisory service across both sites
- 7 day service with face to face availability
- OOH hospice advice line 24/7- 01772629171
- Referring Criteria for specialist palliative care (one or more of):
  - Symptom management
  - Care in the last hours to days of life
  - Complex social and psychological support needed
  - Complex discharge planning
  - Support with advance care planning
- Referrals to palliative care are made via QMED
- Ring if urgent and need reviewing the same day

Hospice

- Patients can be considered for a hospice IP admission for:
  - Complex Symptom Management
  - Care in the last days of life (prognosis less than 2 weeks)
  - Referrals for complex psychological or social needs may be considered depending on circumstances
- Local Hospice for patients in Preston, Chorley and South Ribble- St Catherine's Hospice
- Referrals are made through the hospital palliative care team

Sharing Key Information…

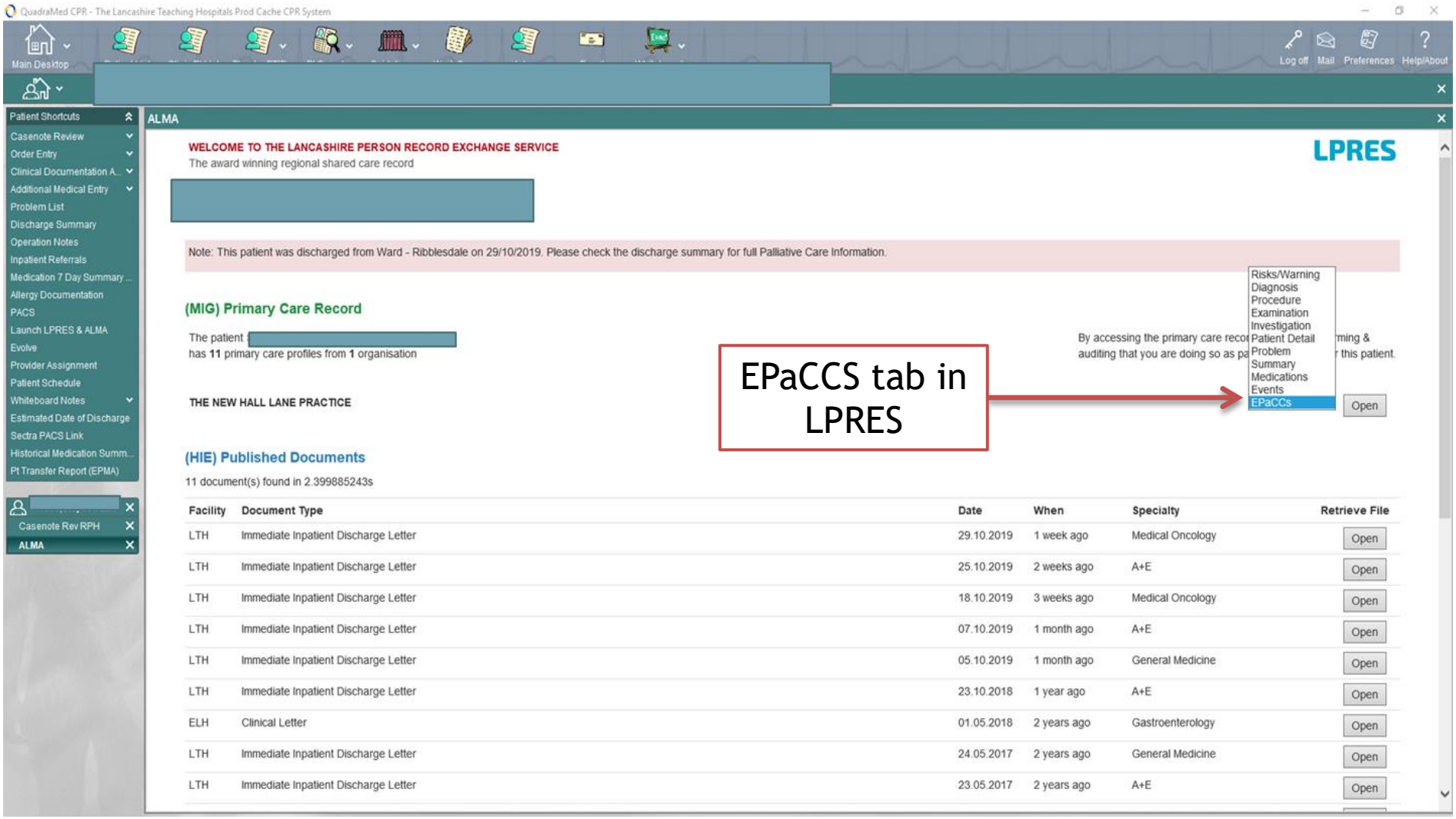
Ensuring good communication of key information is vital for good care, especially at the end of someone's life.

There are a number of mechanisms to support good information sharing including:

- **EPaCCS** (Electronic Palliative Care Coordination Systems)- This is available through the LPRES tab and shares info that GPs/ primary care providers have
- **LPRES**- A way to view parts of the patient record from multiple providers inc discharge and clinic letters
- **Palliative care information section** on:
  - IHDI- when asked select 'Palliative=YES' This should be considered for ALL patients likely to be in the last 12 months of life. (See section below for further details)
  - Clinic letters (oncology and palliative care)
- **Palliative Care tab on QMED-** this shares key information documented by the hospital palliative care team

- Using the same language- it is helpful to use the same terminology and descriptors across all healthcare settings:
  - GSF status for defining prognosis. This is the terminology used by GPs and DNs too.

EPaCCS

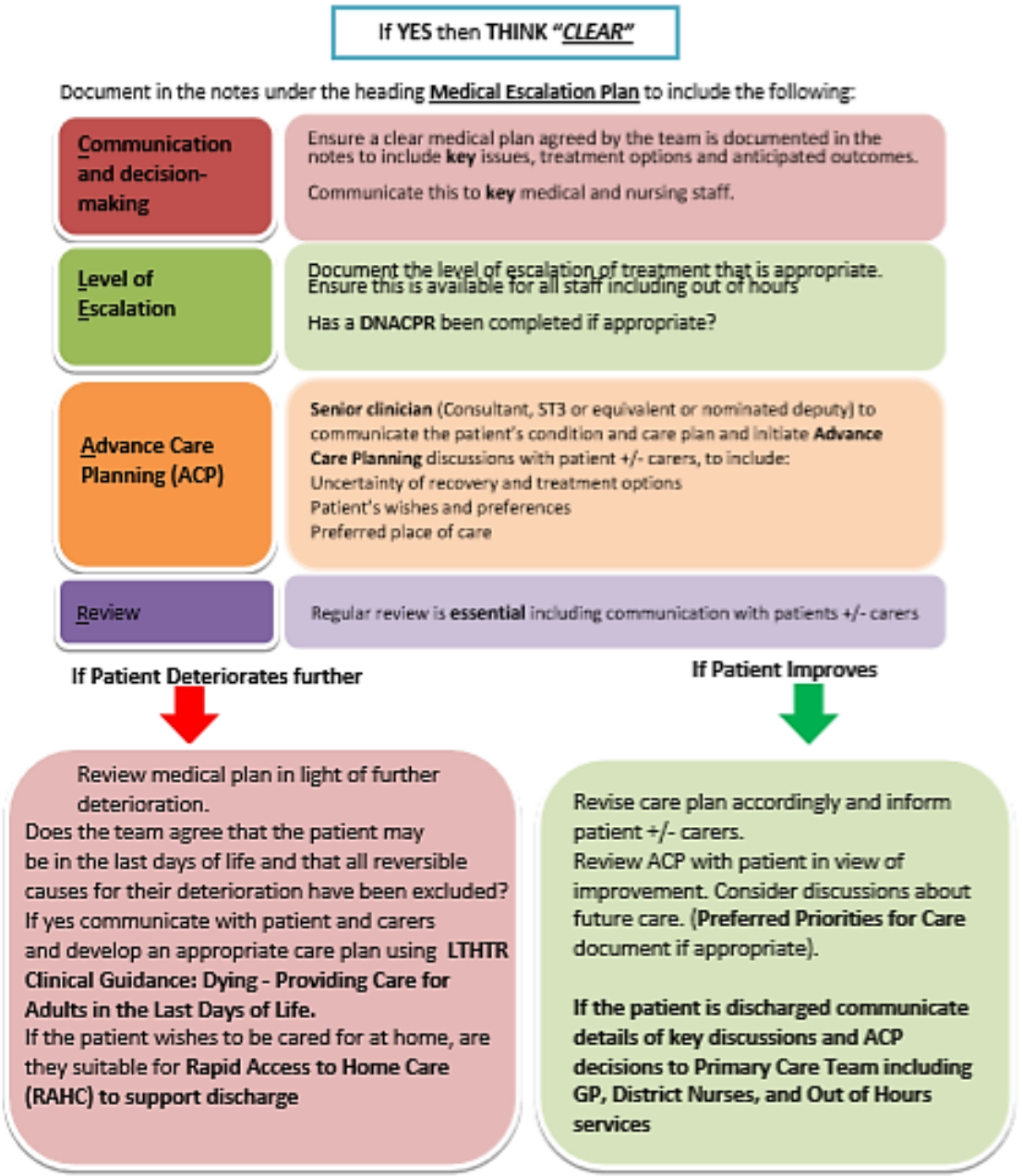

QuadraMed CPR - The Lancashire Teaching Hospitals Prod Cache CPR System
Main Desktop
Log off
Mail
Preferences
Help/About
Patient Shortcuts
Casenote Review
Order Entry
Clinical Documentation A...
Additional Medical Entry
Problem List
Discharge Summary
Operation Notes
Inpatient Referrals
Medication 7 Day Summary ...
Allergy Documentation
PACS
Launch LPRES & ALMA
Evolve
Provider Assignment
Patient Schedule
Whiteboard Notes
Estimated Date of Discharge
Sectra PACS Link
Historical Medication Summ...
Pt Transfer Report (EPMA)
Casenote Rev RPH
ALMA
ALMA
WELCOME TO THE LANCASHIRE PERSON RECORD EXCHANGE SERVICE
The award winning regional shared care record
LPRES
Note: This patient was discharged from Ward - Ribblesdale on 29/10/2019. Please check the discharge summary for full Palliative Care Information.
(MIG) Primary Care Record
The patient
has 11 primary care profiles from 1 organisation
THE NEW HALL LANE PRACTICE
By accessing the primary care reco
auditing that you are doing so as pa
ming &
this patient.
Risks/Warning
Diagnosis
Procedure
Examination
Investigation
Patient Detail
Problem
Summary
Medications
Events
EPaCCs
Open
EPaCCS tab in LPRES
(HIE) Published Documents
11 document(s) found in 2.399885243s
Facility
Document Type
Date
When
Specialty
Retrieve File
LTH Immediate Inpatient Discharge Letter 29.10.2019 1 week ago Medical Oncology Open
LTH Immediate Inpatient Discharge Letter 25.10.2019 2 weeks ago A+E Open
LTH Immediate Inpatient Discharge Letter 18.10.2019 3 weeks ago Medical Oncology Open
LTH Immediate Inpatient Discharge Letter 07.10.2019 1 month ago A+E Open
LTH Immediate Inpatient Discharge Letter 05.10.2019 1 month ago General Medicine Open
LTH Immediate Inpatient Discharge Letter 23.10.2018 1 year ago A+E Open
ELH Clinical Letter 01.05.2018 2 years ago Gastroenterology Open
LTH Immediate Inpatient Discharge Letter 24.05.2017 2 years ago General Medicine Open
LTH Immediate Inpatient Discharge Letter 23.05.2017 2 years ago A+E Open

Managing Uncertainty of Recovery

Does this patient have a significant underlying co-morbidity which could put them at risk of dying in the next few months?

Is this patient acutely unwell, deteriorating clinically and is their likelihood of recovery uncertain?

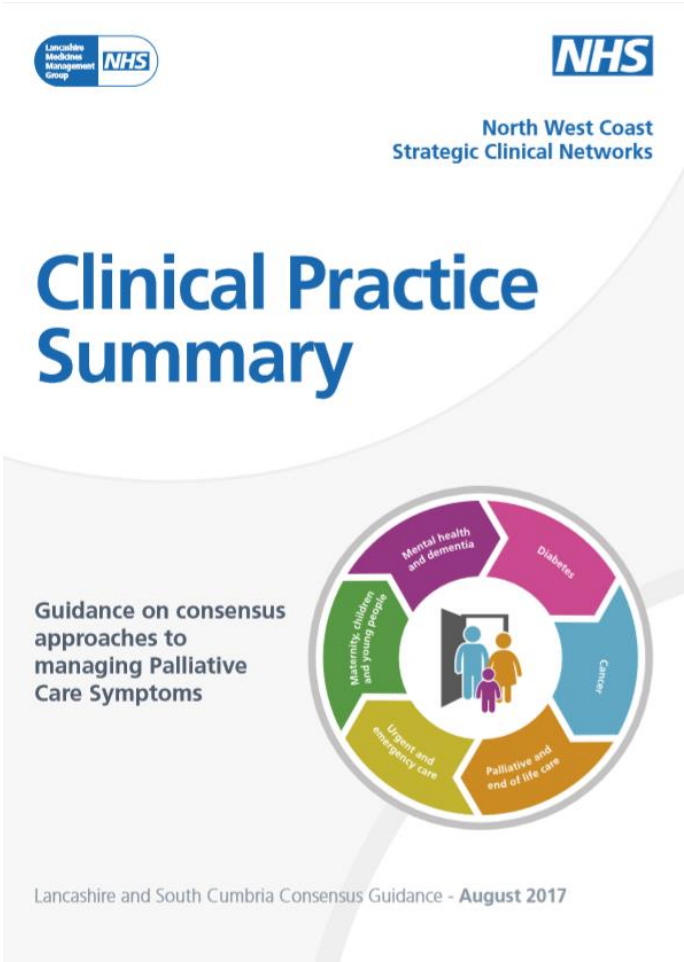
CPR status and ceiling of treatment should be documented in the CPR tab on QMED for **ALL** admissions- even if for full escalation



Clinical Practice Summary

- Guidance for symptom management (regional) is available on the trust's intranet – just search for palliative care

- Covers common symptoms inc:
  - Pain
  - N&V
  - Breathlessness
  - Bowel obstruction
  - Constipation
- Management of palliative emergencies



Managing Symptoms in COVID-19

- The most common symptoms in COVID-19 are:
  - Breathlessness
  - Cough
  - Delirium
  - Pyrexia
- Guidance is available on the Palliative Care page of the intranet to support with these
- An EPMA Order Set has been created to help with prescribing to manage these symptoms in patients who are NOT in the last days of life
- Patients in the last days of life should have medication prescribed based on the last days of life order sets

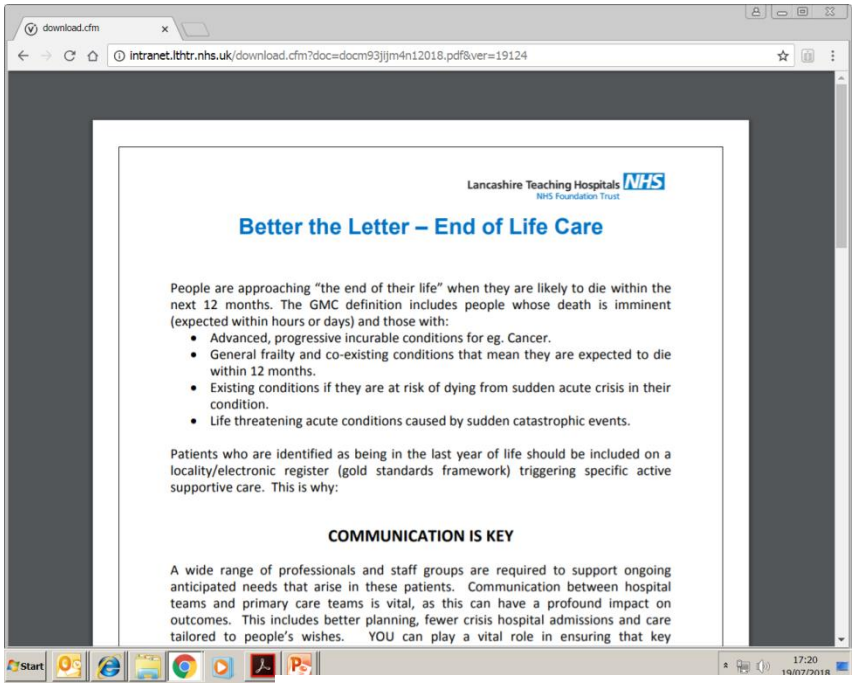
“Fast track” discharge

- Healthcare funded (CHC) care can be allocated on a ‘fast track’ basis for patients who are:
  - Rapidly deteriorating
  - Entering a terminal phase
- Typically patients whose prognosis is weeks to short months
- Funding reviewed after 3 months
- Funds NH or care at home (QDS)

- Refer eligible patients to the discharge team

Remember….Better the Letter

- The quality of information recorded in the discharge letter has been shown to improve outcomes in end of life care for patients.



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Immediate Hospital Discharge Letter – Palliative Care Section

- **Select Palliative Care= YES for all patients in the last 12 months of life**

- Patient's GSF status
- Escalation of treatment discussions and decisions.
- uDNACPR when appropriate and after discussion with patient and family.
- Patient's wishes eg. to avoid readmissions to hospital and preferred place of care
- The existence of any LPA

- The GP actions section should also be used to:
  - Suggest to the GP to include patient on GSF Framework.
  - Suggest to the GP to create EPaACS record for information sharing OOH.

- Please also include clear documentation of any:
  - Anticipatory Prescribing.
  - Palliative care follow up including referrals to the community palliative care team

Last Days of Life Care

Recognising 'dying'

- Focus on changes in the condition of someone who is likely to be dying rather than on "diagnosing dying".

- Dying patients often identified due to:
  - Ongoing deterioration AND
  - Lack of reversibility OR Patient wishes not to have further active treatment

End of Life Care decision making

The decision that a patient is in the last days of life should be made by an experienced registrar or consultant and supported by the MDT.

NICE Quality Standard 144: Care of dying adults in the last days of life (2017)

- Statement 1 Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering.

- Statement 2 Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan.

- Statement 3 Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.

- Statement 4 Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options

Exploring wishes and expectations

- Ask patients and families where they wish to be involved in decisions and discussions
- If patients wish to leave hospital- contact palliative care ASAP
- Rapid Access to Homecare- this is the route for getting someone home with equipment and support in the last days of life
- If staying explore other wishes e.g. side room/ music/ visitors etc

Individualised Plan of Care

- To support the care of patients in the last hours to days of life, an individualised plan of care should be completed.
- Patients have a right to be involved in the plan for their care. So, if possible, they and their families (if appropriate) should be given the opportunity to contribute to any decisions made.
- There is an initial medical assessment and nursing care plan which can be found under the clinical documentation assessments on QMED. Once the nursing care plan is completed this will prompt a daily nursing care plan review.
- Completion of this care plan will help to ensure that all key aspects of care are reviewed for dying patients.

The initial assessment will include plans for:

- Symptom control
- Diet & hydration
- Psychological and Spiritual support
- Co-ordinated care- who is involved?

Symptom Control

- Anticipating 5 key symptoms:
- Individualised prescribing
  - Pain
  - Breathlessness
  - Respiratory secretions
  - Distress / agitation
  - Nausea / vomiting
- Adjust prescribing for renal failure
- Prescribing guidance on the intranet and EPMA order sets available for both normal and impaired renal function (eGFR <30)

- GOSPORT – Indication for prescription and rationale for dose must be considered and documented

Maintaining hydration

- Support the dying person to drink if they wish to and are able to.
- Consider whether it is appropriate to do this at risk of aspiration for those in the last hours to days of life
- Artificial hydration can be considered for symptom control (Sub-cut or IV)- indication is generally symptomatic thirst or dehydration
- Important to discuss and assess for risks and benefits.
- Hydration **must** be reviewed daily on the ward round for all patients in the last days of life

HOSPITAL GUIDANCE

"Dying - Providing care in the last days of life"

- Available on the Intranet under "Guidelines and Policies"
- Incorporates links to relevant supporting documents e.g. GMC Guidance , Clinical Practice Summary
- Attached guidance on prescribing and use of syringe drivers.
- Additional information available on Palliative Care intranet pages

Supporting Difficult Communication

Talking to patients and those close to them about prognosis, ceilings of treatment and possible end of life care is often challenging. In the current COVID-19 outbreak, such conversations with the population described may become even more difficult, as health professionals may have to triage patients, often in emergency or urgent situations, and prioritise certain interventions and ceilings of treatment.

Key points to consider when discussing ceilings of treatment:

- Don't make things more complicated than they need to be; use a framework such as SPIKES:
  - **S**etting /situation: read clinical records, ensure privacy, no interruptions
  - **P**erception: what do they know already? Don't make assumptions
  - **I**nvitation: how much do they want to know?
  - **K**nowledge: explain the situation; avoid jargon; take it slow
  - **E**mpathy: even if busy, show that you care
  - **S**ummary /strategy: summarise what you've said; explain next steps

- It is possible that patients and/or relatives may have concerns/ questions about limitations to treatment. If they request a second opinion this should be facilitated where possible.

- Be honest and clear:
  - don't use jargon; use words patients and those close to them will understand
  - sit down (where possible); take time; measured pace and tone; use silences to allow people to process information
  - avoid using phrases such as "very poorly" on their own – is the patient "**sick enough that they may die**"? If they are – say it

Further resources to support difficult conversations will be made available on the palliative care section of the intranet. A useful resource for having conversations is: https://www.vitaltalk.org/guides/covid-19-communication-skills

The ‘Three Talk’ model to support conversations

‘Three talk’ model for shared decision making can be used to guide the decision-making process:

1. Team talk

- Clarify the diagnosis, establish that a decision needs to be made regarding the next steps and reinforce partnership
- *For example, ‘You have coronavirus infection that has severely affected your breathing. **We** need to decide on the next steps’*

2. Option talk

- Check prior knowledge, then outline options along with what is known of the pros and cons of the options, then check understanding

3. Decision talk

- Further establish that a decision needs to be made, reinforce empathy and partnership, check for information gaps

The decision

- If possible, defer closure and give time for discussion with relatives, carers, advocates.
- If not possible, ‘*What thoughts do you have about the best way forward?’*
- If low confidence/high anxiety, empathy
- *‘This is so difficult, but I am here…’ What else can I do/tell you to help us come to the right decision?’*

Further Training

Once you have been given your log-in details for the Trust IT systems please complete the e-learning for care in the last days of life

If you need support…

For urgent telephone support please contact:

- Mondays to Fridays 8:30 – 4:30pm – Ext 2055 or 3225, Preston Bleep 7070, Chorley Bleep 5356
- Saturday, Sundays and Bank Holidays – 8:30am to 4:30pm – Bleep 7070
- Outside of these hours there is a 24/7 advice line via St Catherine's Hospice: 01772629171

Palliative care section of the intranet- https://intranet.lthtr.nhs.uk/palliative-care