

Dying in hospital – is there an alternative for older people?

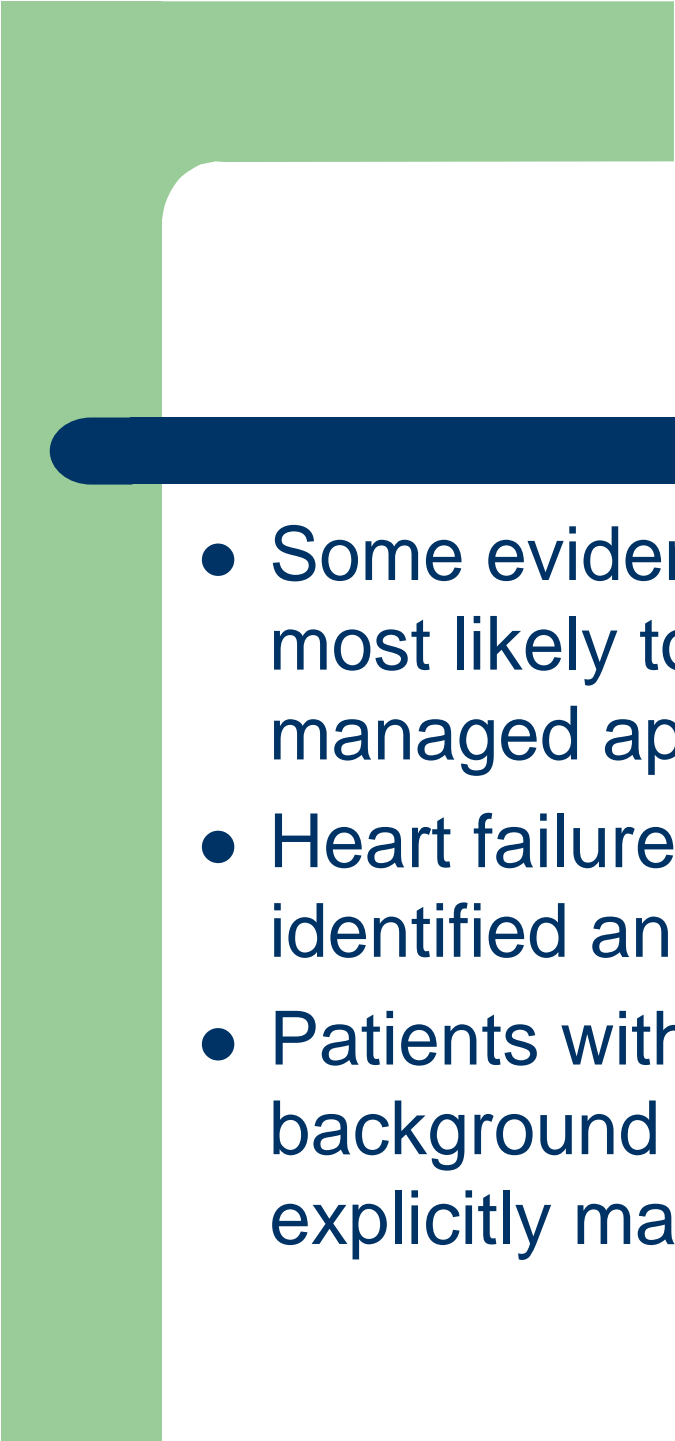



Dying in hospitals

- Some evidence of good practice:
- Use of the Liverpool care pathway (pathway to prompt appropriate care of the) dying
- Utilised in 80+% of hospitals (at least in some wards)

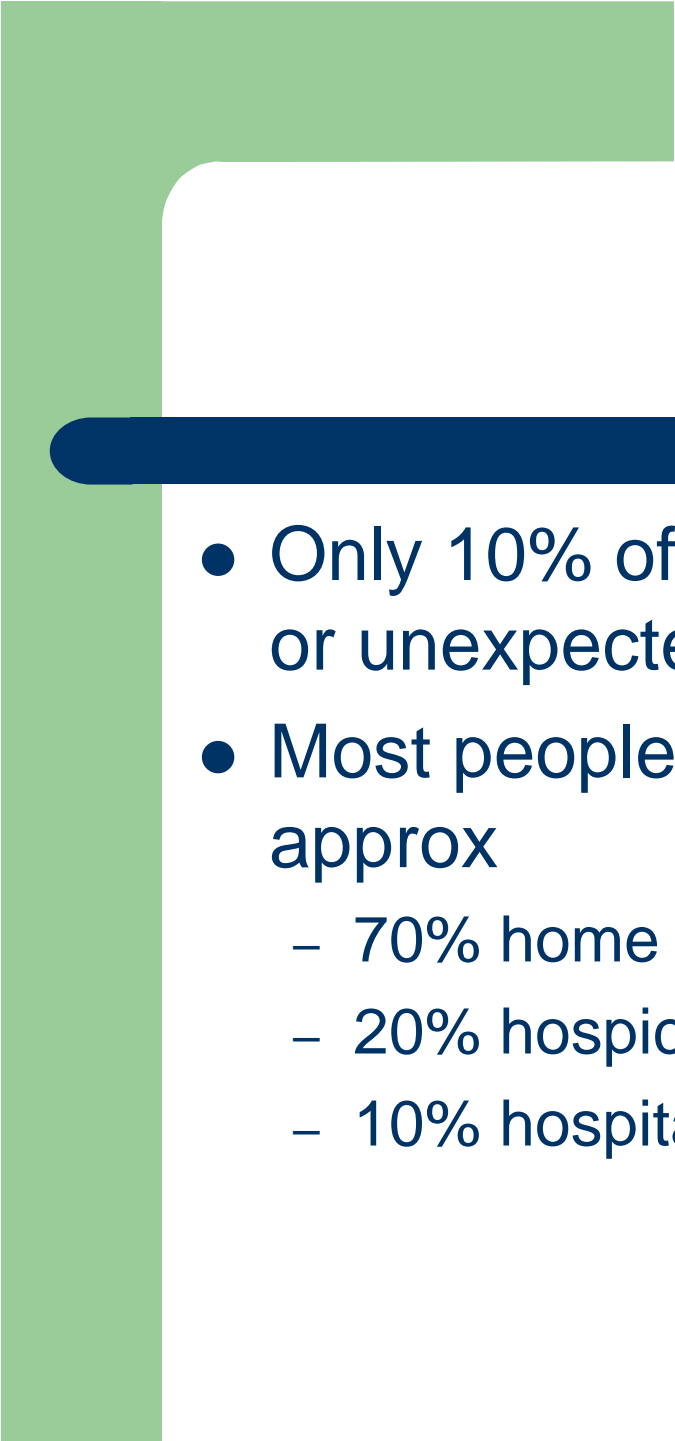

However...

- Older people in the last year of life tend to be admitted to hospital frequently
- In the UK on average 2-3 times
- Information about quality of care anecdotal
- Good and bad experiences of care reported
- NSF for older people launched partly in response to concerns about ageism and the quality of care older people might receive in hospital

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- Some evidence that patients with cancer most likely to be identified as dying and managed appropriately
 - Heart failure and COPD less likely to be identified and managed as such in hospital
 - Patients with multiple problems on a background of frailty may be less likely to be explicitly managed as dying

Why is this?

- Difficulties in prognostication
- Conflicting emphasis of purpose of care
- Conversations about end of life are difficult
- Professional reluctance to acknowledge patient is dying
- Availability of services for those at end of life – hospice, primary care, social care
- Access to additional equipment
- Difficulties in facilitating discharge
- Good supportive bereavement care

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- Only 10% of people (all ages) die suddenly or unexpectedly
 - Most people would like to die at home – approx
 - 70% home
 - 20% hospice
 - 10% hospital

Yorkshire data

- 60% people die in hospital
 - 18% in care home
 - 18% at home
 - 4% in hospices
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- A little variation around the country but over all picture very similar

What can we do to change this situation?

- Advance/anticipatory care planning
- Advance directives
- Improved community resources so that patients and their families/carers have resources they can draw on to provide support so that hospital is the only default in crisis

Who can provide this support?

- Patients and families themselves
- Primary care teams: GP's, district nurses
- Palliative care nurses/physicians
- Community matrons
- Community geriatricians
- Intermediate care teams
- Old age psychiatrists/community mental health teams

Patients' solutions

- Treat people with understanding and respect
- More nursing staff in community and secondary care
- Better out of hours GP services
- Improved supply of essential items
- Better communication
- Better co-ordination of services

What's the evidence for effectiveness?

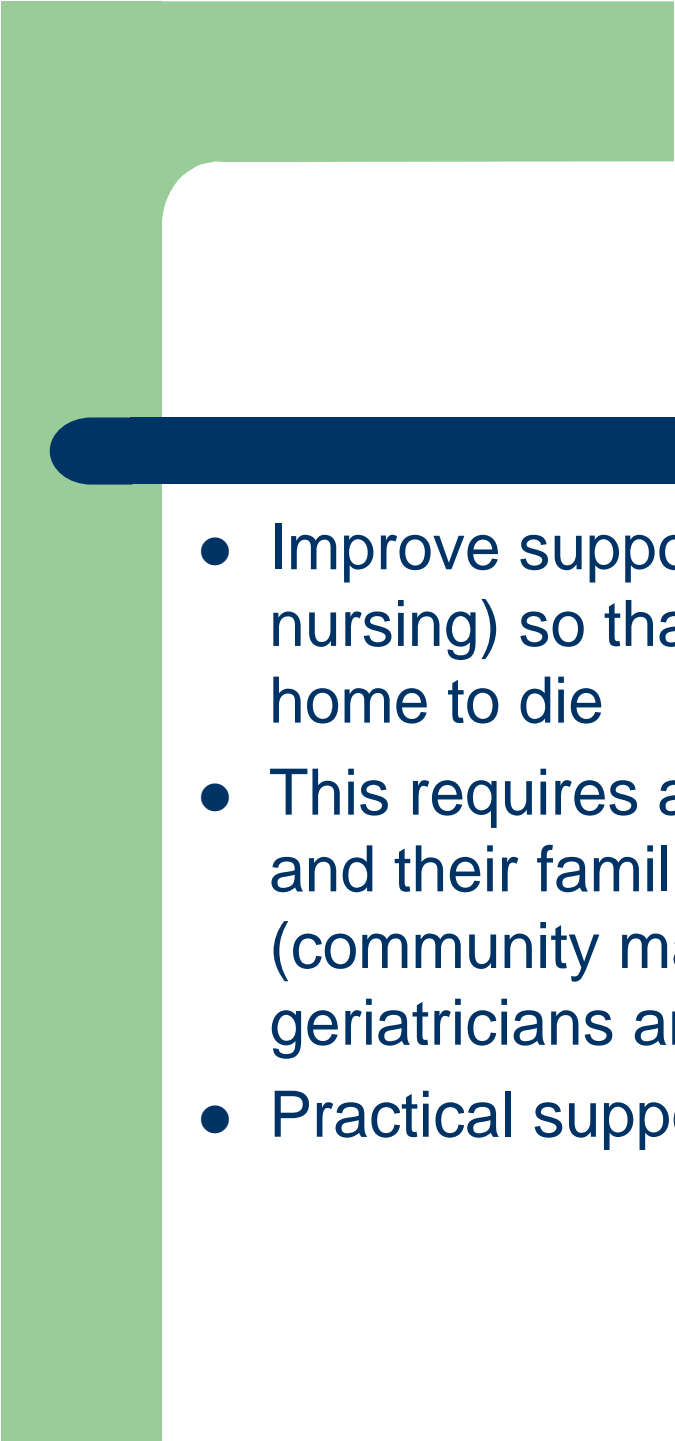

- Comprehensive geriatric assessment: multidisciplinary assessment (nurses, doctors, physios, OTs, social workers and other members of the team as needed) improves outcomes for frail older people
- Palliative care teams
- Evidence for heart failure nurses or respiratory nurses or teams indicates their role in maintaining health and avoiding hospital admission. As yet no data in relation to end of life care

Solutions

- People will continue to die in hospital
 - Thus we need to improve end of life care in hospital
 - Listen to patients and their carers where advance planning has been made
 - Talk with patients and their carers when events supervene
 - Implement good practice
- Darzi pathway for end of life care may drive some of this

Help people to die where they want to

- Improve and broaden the scope of community teams to see their role as part of the wider patient experience
- Link services to ensure communication and care planning are appropriate to the “bigger picture” for each patient

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- Improve support to care homes (residential and nursing) so that their residents may remain in their home to die
 - This requires anticipatory care planning by patients and their families, support from skilled nurses (community matrons or palliative care nurses), GPs, geriatricians and palliative care physicians
 - Practical support to homes- equipment, advice