The practicalities of coordinating End of Life Care between Nursing Homes and Primary Care Services

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Group Rules

• Confidentiality
• Honest and open
• Allowing challenge
• Respect of others
• Finish on time!
Happy Gilmore get me outta here - YouTube
• Aims

• Objectives
• EC 91 yr old woman in EMI NH

• PMHx Dementia, Essential Hypertension, recurrent chest infections – previously leading to admissions during which she would become very agitated
• Recent diagnosis of hypercalcaemia-d/c endocrinologist not suitable for investigations and surgery (thought likely hyperparathyroidism)
• EC started having seizures- admitted X1 started on sodium valproate and discharged back to her nursing home
What would you do?

• EC lacks capacity

• Best interest meeting was held
  • Included the family (2x daughters), the care home manager, the lead carer for EC, GP
  • Forms put in place – DNACPR, Advance Statement
  • (not for admission to hospital and to be treated with oral antibiotics or other medication that could be administered at home only) EHCP
• Who is involved with the care of EC?
• What are the barriers or challenges present?
• How do they fit into the wider palliative care strategy?
5 priorities of care

• **Priority 1**
• this possibility [that a person may die within the next few days or hours] is
• recognised and communicated clearly, decisions made and actions taken in
• accordance with the person’s needs and wishes, and these are regularly
• reviewed and decisions revised accordingly.
• **Priority 2**
• Sensitive communication takes place between staff and the dying person, and those
• identified as important to them.
• **Priority 3**
  - the dying person, and those identified as important to them, are involved
  - in decisions about treatment and care to the extent that the dying person wants.
• **Priority 4**
  
  • the needs of families and others identified as important to the dying person
  
  • are actively explored, respected and met as far as possible.
• **Priority 5**
• an individual plan of care, which includes food and drink, symptom control and
• psychological, social and spiritual support, is agreed, co-ordinated and delivered
• with compassion.
Background
One chance to get it right
5 priorities of care

Deciding Right
GP Register
Toolkit
Education
Local/Regional/National experience
Enhanced SCR

Local End of Life Care Strategy

End of Life in Nursing Homes Development

Increase the number of patients dying in their PPC
Reduce inappropriate hospital admissions

North Tyneside Clinical Commissioning Group
Deciding right

Deciding Right
Your Life
Your Choice

A integrated approach to shared decision making in children, young people and adults
Primary care palliative registers

• Core to end of life care

• Deciding right documents support it

• Using the register increases quality of care and increases chances of dying in preferred place of death

• Vital information for other care providers
End of life Care in Nursing Homes

• Team
  • Band 7 part time Macmillan Nurse
  • Band 6 full time District Nurse
  • Admin support

• Facilitate education and care in nursing homes to enable staff to start to have end of life conversations with patients linking in with the primary care team
• Support nursing home staff to reduce inappropriate admissions to hospital
• Review any inappropriate admissions and learn from them
• £120 000 invested
End of Life Care in Nursing Homes and Residential Homes

Primary Care
District Nurses
POAS
EHCP
Social Work
NEAS
OOH
Secondary Care
Voluntary Groups
Nursing Home Palliative Care Register / MDT

Family Consultation/ Deciding Right Documentation

Ambulance/ Red Flag Notification/ OOH

Use of knowledge and skills/ on-going Assessment and Communication

Timely, Appropriate Quality Care

Patient deterioration Reassessment/ Family Communication/ Red Flag

Patient Centred Individual End of Life Care Plan

How it fits together......
Case 1

EC 91 yr old woman in EMI NH

- PMHx Dementia, Essential Hypertension, recurrent chest infections – previously leading to admissions during which she would become very agitated
- Recent diagnosis of hypercalcaemia d/c endocrinologist not suitable for investigations and surgery (thought likely hyperparathyroidism)
- March 2011 started having seizures- admitted X1 started on sodium valproate and discharged back to her nursing home
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  • Forms added to GP records shared with NDOC/NEAS (enhanced SCR)
• EC went on to have 5x chest infections from March to July
• 4 seen by other doctors in the surgery, 1 seen by NDOC
• all referred to advance statement, treated EC with antibiotics, kept EC at Nursing Home
• EC died July
• Family so pleased with her care asked the home if they could scatter her ashes in the garden
Links

• http://www.nescn.nhs.uk/deciding-right/

• http://www.dyingmatters.org/