Palliative Care Rapid Response Hub Community Palliative Care Centre, Ards Hospital

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CPCC

- Consultant lead rapid access unit providing short term intervention for palliative care patients with complex needs requiring specialist multidisciplinary input, within the North Down and Ards community area

Referral Source

- Acute Hospital Specialist Palliative Care team on discharge
- Hospital colleagues / other rapid access hubs
- Hospice nurse specialists in community
- Specialist community AHP's
- GP's

Staff resource

- Palliative Medicine consultant and specialist nurse 3 sessions per week, Specialist pharmacist 2 sessions per week
- Weekly MDT meeting which includes community palliative AHP's and NIH nurses
- Referral criteria for MDT discussion
- Advanced and progressive life limiting illness - malignant or non malignant

  Complex symptoms and/or

  Complex AHP needs and/or

  Complex psychosocial issues

Specialist Medical / Nursing / Pharmacy input

- Complex patients seen by consultant or specialist nurse and pharmacist in CPCC or at home or reviewed by phone
- Advisory service for GP's (telephone or CCG) and hospice nurse specialists (patients discussed at MDT and other patients known to community teams)

Aim

- Symptom management at home and close liaison with hospice. Aim to minimise acute hospital admissions
- Early review after discharge from hospital with hope of shortening length of admission. Continuity of staff and patient care across acute and community settings

Short Intervention

- Patient discharged from CPCC caseload when a stable plan of care established
- AHP and NIH team have a wider community caseload beyond the CPCC patients so when d/c from CPCC caseload are often followed up by individual team members
- Can be easily rereferred back for discussion
- If no follow up planned patient or GP can recontact if further review needed

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'Palliative care Rapid Response'

Community Palliative Care Centre Ards Hospital

A consultant led rapid access unit providing short term intervention for palliative patients with complex needs within the North Down and Ards community area, requiring specialist multidisciplinary palliative care input.

The aim is to provide improved continuity between acute and community, facilitating earlier discharge from hospital and enabling patients in community to be managed at home or in an outpatient setting as an alternative to acute hospital admission.

Referral criteria

Patient with advanced and progressive life limiting illness – malignant or non malignant

AND Experiencing unresolved physical symptoms **OR** Patient would benefit from a period of palliative rehabilitation or non-pharmacological management or psychological / financial support from the AHP team

Exclusion criteria

- Acute problem needing hospital admission
- Patient in stable phase of illness who can be managed by the primary care team
- Short intervention would not be beneficial and longer term follow up by NIH nurses, specialist AHP's, Marie Curie Day Therapy or Palliative Medicine OPC more appropriate

Services

- Palliative consultant and specialist nurse clinics 2 sessions per week
- Multidisciplinary discussion of patients weekly
- Palliative physio and OT clinics

Referrals

- Referral form from hospital or community specialist palliative care team emailed to CPCC
- Referrals also received by letter / email from consultant colleagues / other hubs
- Referrals from GP through CCG or vocera advice

Challenges

- Gathering data
- Limited referrals from GP's
- Overlap between rapid access staff and community staff
- Challenges with generic referral form for all MDT staff

Next steps

- Establish role of CPCC physio and OT
- Develop nurse led clinics

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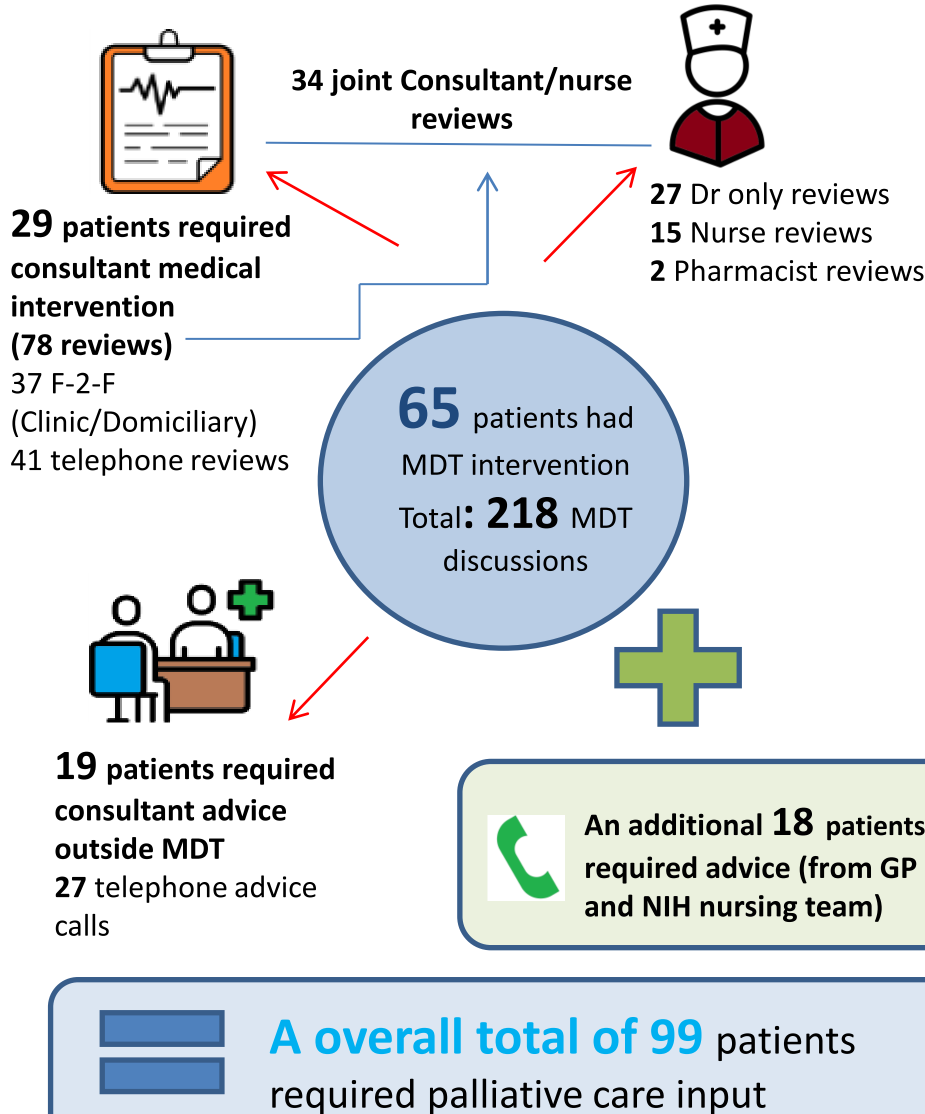
‘Palliative care Rapid Response’

Reporting period : Apr22 – Jun22

How much did we do?



An additional **18** patients required advice (from GP and NIH nursing team)

A overall total of 99 patients required palliative care input

How well did we do it?

- **26** patients remain on palliative care case load
- **32** patients discharged

41% of patients remained at their preferred place of care (PPC),(13/32)

34% did not have PCC reported (11/32)

25% did not remain in PPC (8/32)

62.5% reported symptoms had improved (20/32)

37.5% had on-going symptoms (12/32)

62.5% had a stable plan of care

37.5% unstable plan of care symptom control / need for equipment/ support

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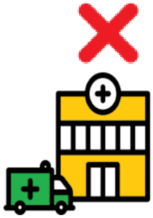
'Palliative care Rapid Response'

Reporting period :Apr22 – Jun 22

Is Anyone Better Off?



71% (n=46) patients **avoided** admission

How?

Symptoms managed at home (n=41)

Direct hospice admission (n=5)

Hospital admissions

29% patients **admitted** (n=19)
Average : **14.5 day stay**

11 referred to hospital palliative care team (PCT): **5** within **2** days, **3** within **3-5** days admission , **2** **>5** days, **1* transfer to other hospital**

Why?

- Sepsis requiring antibiotics (n=4),
- Uncontrolled nausea and vomiting (n=1)
- Falls (n=3)
- Poor swallow and constipation (n=2)
- Jaundice (n=1)
- Bowel perforation or obstruction (n=1)
- Pain (n=5)
- Seizure (n=1)
- Dehydration (n=1)

5% admissions avoidable

Who organised admission?

Oncology team (n=2)
GI team- post OGD (n=1)
Patient/Family(n=2)
ED attendance (n=11)
Unclear (n=3)

16 admitted in hours, 2 admitted OOH

Outcomes

12 discharged :
10 discharged home;
2 to Hospice;
6 died in hospital
1 remain in hospital

Follow up post-discharge
CPCC (n=8)
Tel review after discharge (n=1)
Readmitted (n=1)

Bed days saved from early discharge 43 (n=6)
Bed days saved from patient review in community 171 (n=20)
Bed days saved from direct admittance to hospice 101 (n=5)

Case Example

- 73 year old man
- Referral from GI CNS
- Intrahepatic cholangiocarcinoma
- Liver capsule pain
- Seen in CPCC 6 days later – Analgesics altered and trial of steroids, bloods checked
- Tel r/v 5 days later – pain improved
- CNS 5 tel reviews over follwing 3 weeks – reducing steroids and managing s/e

- Further phone review – nausea and constipation – meds changed and face to face review planned
- MST increased. Antiemetics altered
- Bloods and CXR
- CTPA requested
- AB commenced
- Follow up telephone review
- Laison with GP
- Hospital admission avoided

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Patient Feedback

My experience today was…
Excellent and caring. Professional in all manner
Excellent face to face consultation with Dr Anderson and her colleague
Very informative and helped me understand the medication more
No issues. Professional. Friendly. Helpful. Kind. Thoughtful. Understanding and considerate to my needs
Much appreciated. I had been in a lot of severe pain
As always, all of the above boxes ticked over the page. Some extra specific information and starting new extra pain relief meds

What went really well today was…
Dr Anderson and her staff allow plenty of time to discuss issues and check my well being whilst attending their check ups. I never feel rushed and plenty of time to discuss my concerns
Review of pain relief medicationincluding dose focus as necessary. Explanation of probable cause of pain / swelling in left leg and foot
The friendly staff and the information provided. They spoke to us in terms that we could understand
Listened to my pain issue
Very beneficial as the pain relief was excellent. I felt very supported

Anything else about today you would like to tell us…
Dr Anderson, Attracta and all staff treat me with great respect and dignity and make me feel important and this gives me a great boost to my well being
A good and very helpful appointment at the Community Palliative Care Centre
Just to mention the friendly nature by which we were welcomed by the receptionist and all staff
Staff are very helpful. Nothing is too much trouble. Very understanding. Still aiming to get pain under control
This review meeting takes time to help and explain matters to me. I value this repeat review and totally rely on its supporting me

Recent Developments

- Rapid Access Physio and OT
- Allows joint review and clinics in CPCC
- CNS sessions with NMS money – greater focus on early discharge from hospital and follow up post discharge
- Bed days saved
- Ongoing CNS input if funding allows