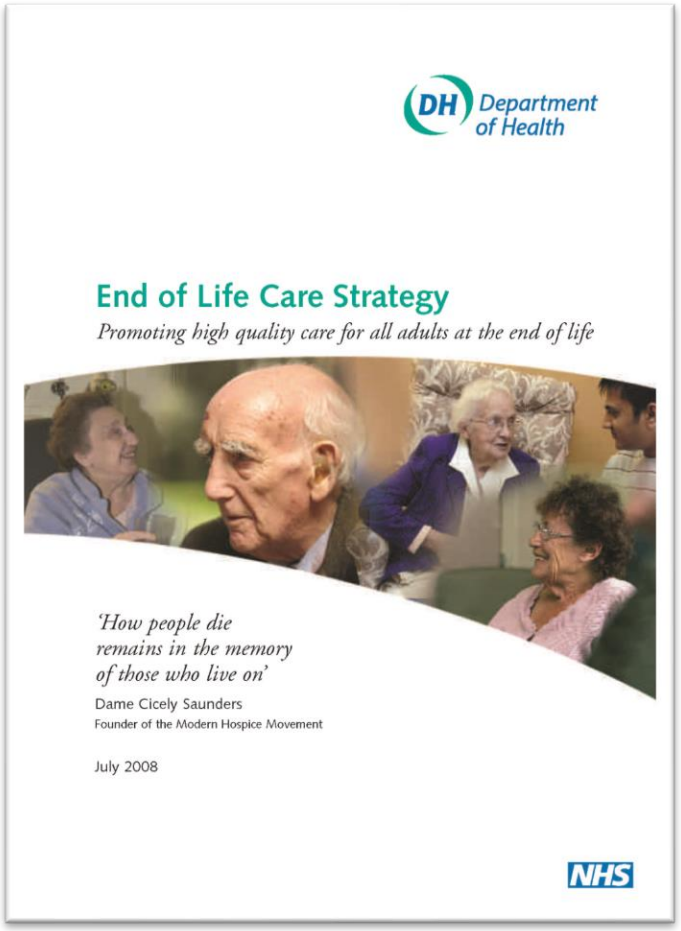
NUH End of Life Care Collaborative Project
Improving the sharing of the patients' end of life plan of care between secondary and primary care settings.

Category: Continuity of care

Project Team –

Sim Lan Koon, Consultant in Palliative Medicine,
Nicola Jones, Macmillan CNS Palliative Care,
Daljit Athwal, Deputy Chief Nurse,
Katie Moore, HOS for PPI,
Roz Bexon, Macmillan CNS Palliative Care,
Jeremy Lewis, Consultant Acute Medicine and Trust Caldicott Guardian,
Sandra Minich, Better for You Programme Manager

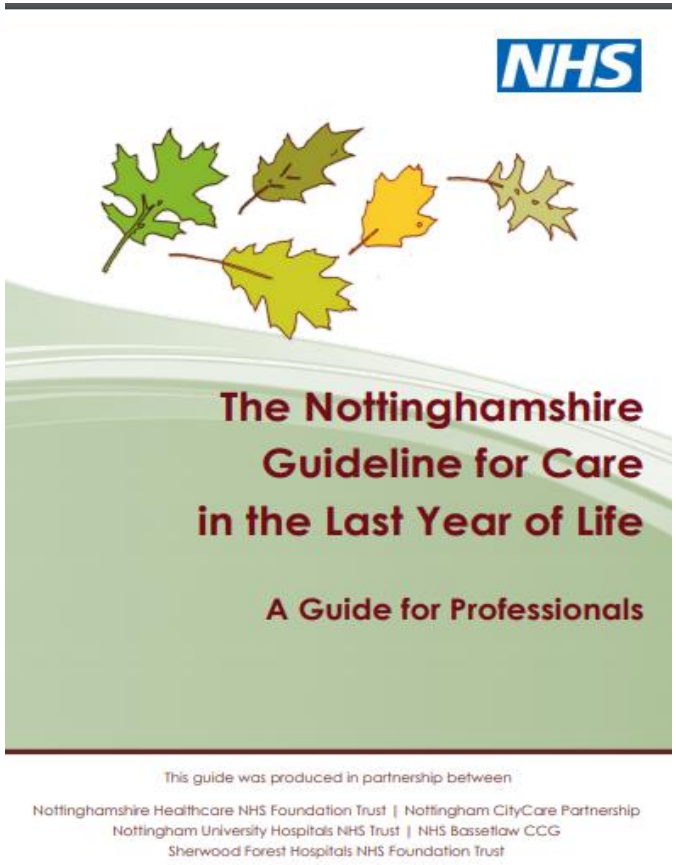
National Strategy - End of Life Care (EoLC)



The Six Ambitions

The National Strategy recognises the importance of coordinated care within teams and between services in primary and secondary care.

Regional guidance



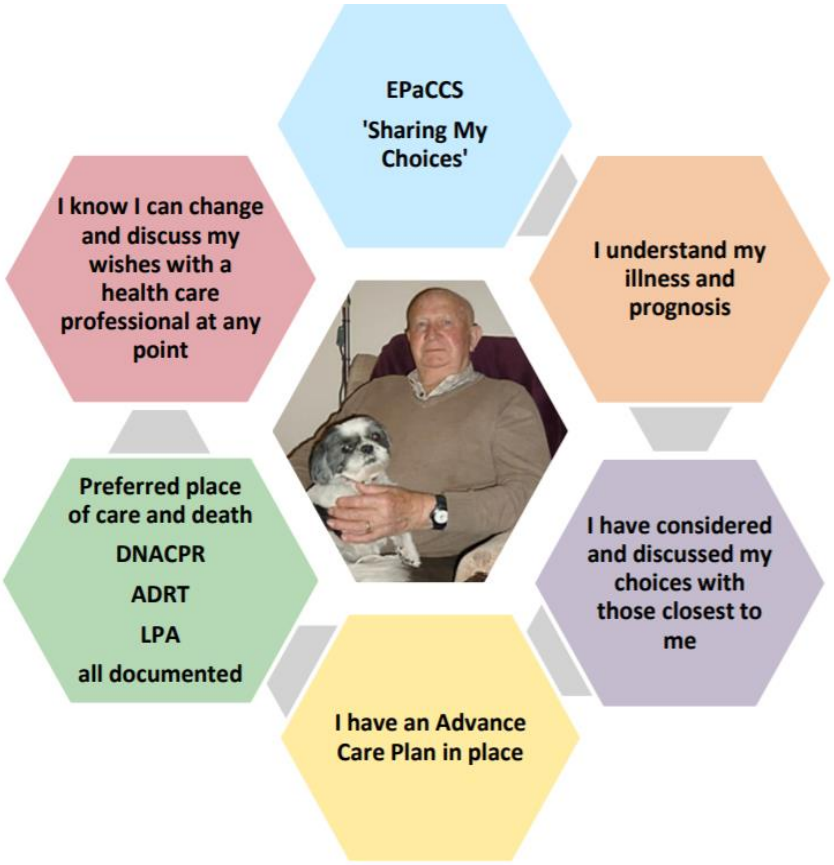
- Focused around the 5 priorities for care of a dying person:
- It emphasized on the importance of coordination of care, and sharing and recording of patient's individual care plan
- Recommended Electronic palliative care coordination system (EPaCCS) as a tool for effective communication between primary and secondary care

NUH Strategy - End of Life Care (EoLC)

NUH EoLC Strategy

To provide care of the highest quality	To provide the best experience for patients and their loved ones	To have confident and supportive staff
Roll out of improved EOL care plan documentation across NUH	Participation in the National Audit of the care of the dying	Electronic palliative care coordination system (EPaCCS) to be implemented in key clinical areas within acute care at NUH

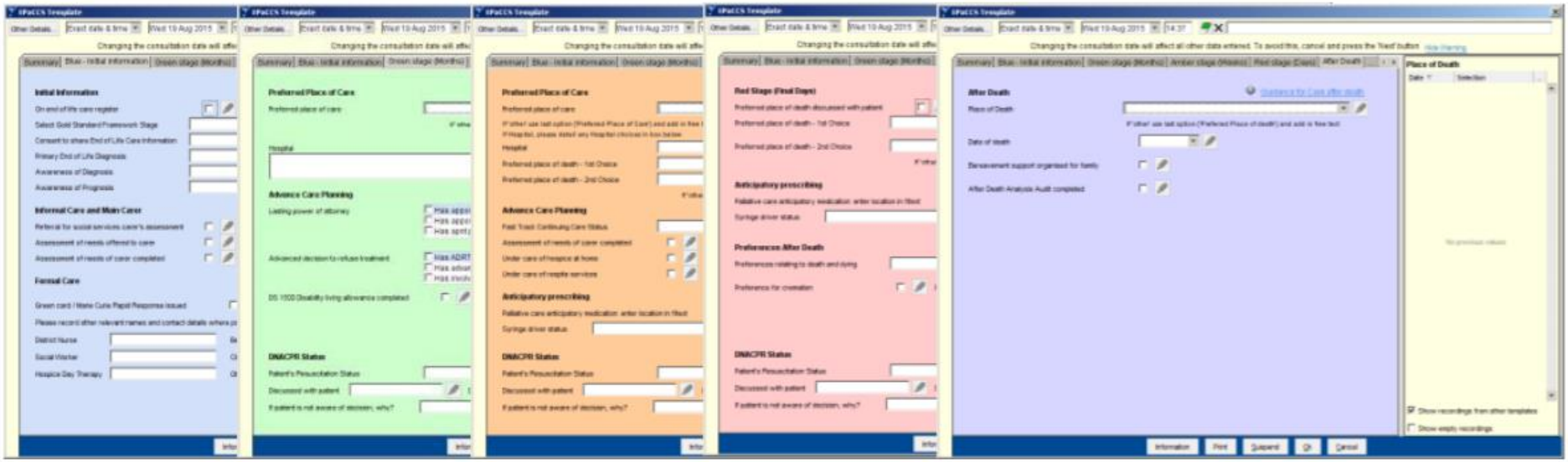
What is EPaCCS ?



- A system that enables the recording and sharing of information about patient's end of life care wishes and preferences with those delivering care.
- It supports coordination of care
- Increases the proportion of people dying in their preferred place of death
- Reduces hospital deaths and increases deaths in the home and in hospices

(Public Health England, 2013)

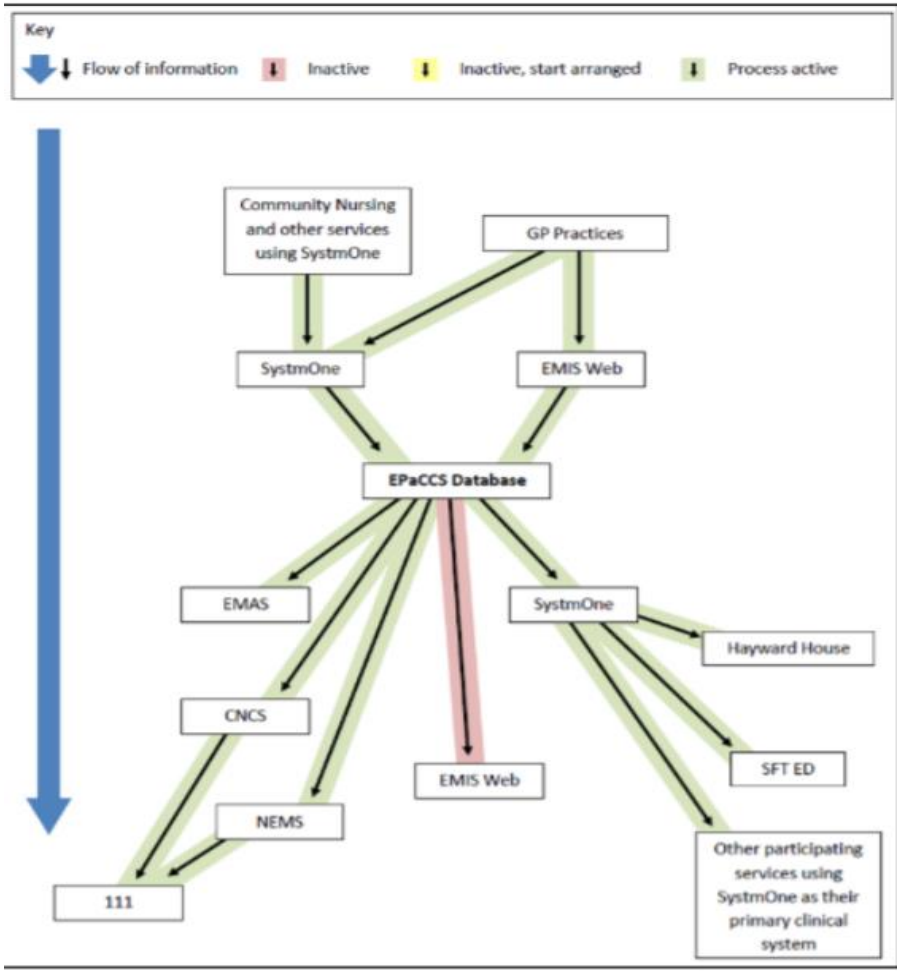
EPaCCS template



End of Life Planning: Details of Care Provision

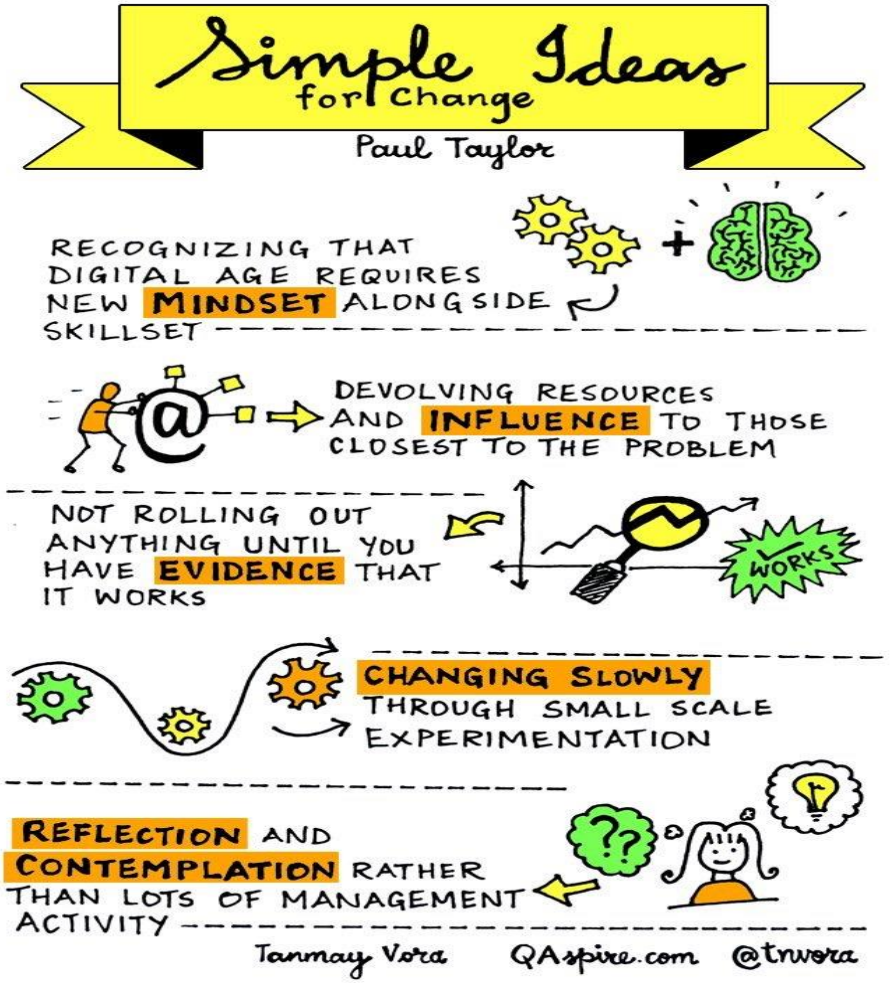
Prognosis: Over a year to months		Prognosis: Weeks	Prognosis: Days	After Death
GSF initiated	EPaCCS consent, complete, Special Patient Note (SPN) where required	ACP inc. ADRT, PPC re-viewed	Priorities of Care of the Dying Person – Create an individual plan of care	Verification of death
Carer needs assessment fast-tracked	Advance care planning (ACP) inc. ADRT, PPC initiated	DNACPR status reviewed and communicated	Bereavement support needs assessed	Care after death
Holistic needs assessed	DNACPR status reviewed and communicated	Continuing Care fast track completed if additional service funding required	EPaCCS / Special Patient Note updated	Bereavement support needs assessed and agreed. Referral made for further support if appropriate.
Understanding and infor-mation needs assessed	Respite care arranged if appropriate	Anticipatory medications supplied		Review case in MDT
Consider NHS Continuing Health Care	Blue Badge application fast -tracked if applicable	Carer needs reviewed		Consider after death audit
Appoint lead GP / nurse	Medication reviewed	Support arranged for provision of terminal care in setting of patient's choice e.g. Hospice at Home		EPaCCs/Special Patient Note updated
DS1500 completed (if < 6 months)		EPaCCS/Special Patient Note updated		

Flow of information with EPaCCS



Source: http://www.e-paccs.co.uk/sharing-through-epaccs/

Our Collaborative and Quality Improvement (QI)



Quality:

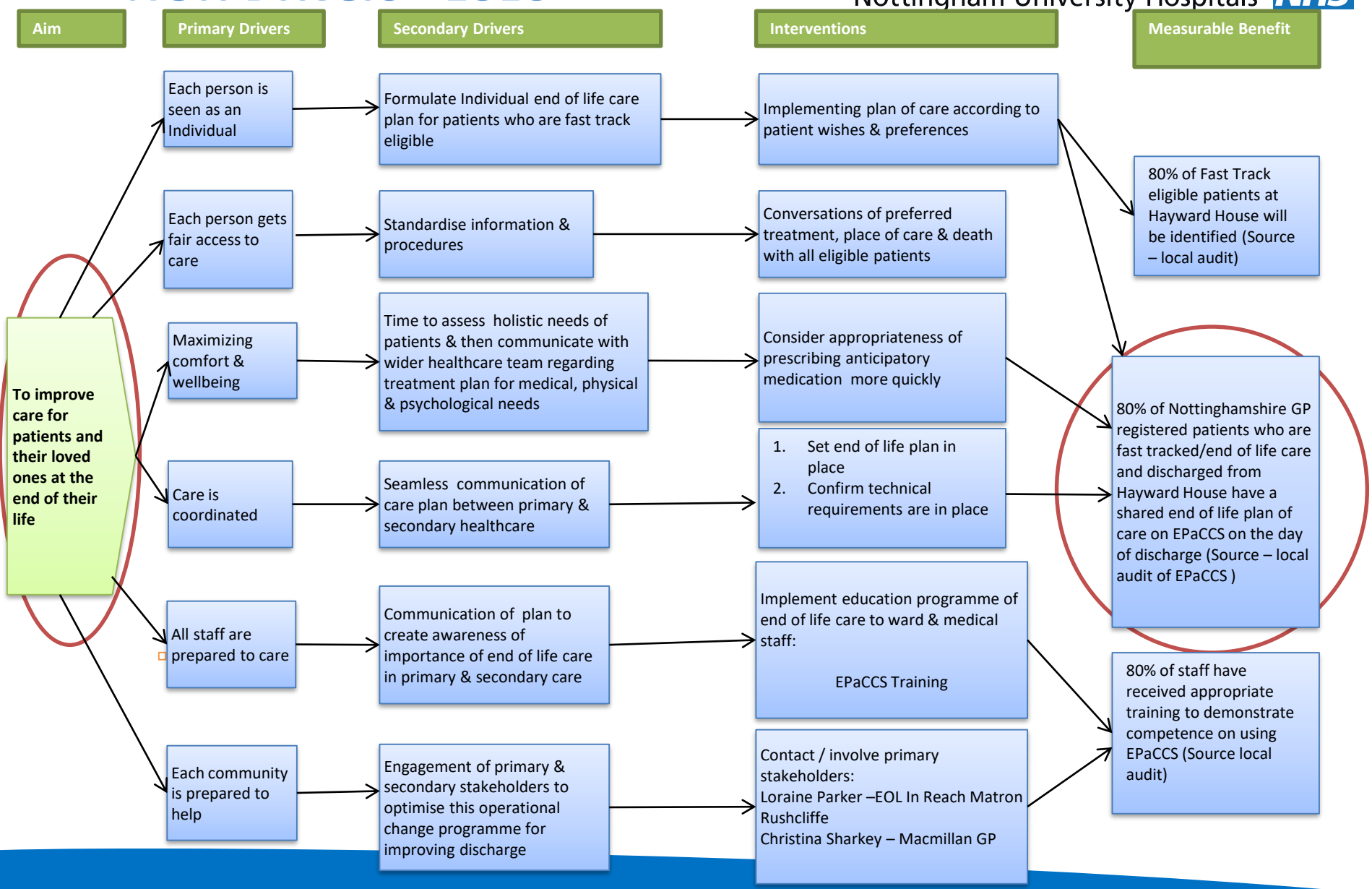
- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

Quality Improvement:

'A better patient experience and outcomes achieved through changing individual and organisation behaviour by using systematic change method and strategies.'

NUH Drivers - EoLC

Nottingham University Hospitals NHS



Initial challenges

- Leadership and collaborative working
- IT engagement
- Clinical engagement
- Interoperability of different systems
- Funding
- Implementation of project within 150 days
- Securing sustainability

EoLC Collaborative Project PDSA Cycles

Rapid improvement cycle

The aim of this programme is to:

- Improve the experience and quality of care received by patients at end of life
- Learn about quality improvement tools and techniques and put into practice
- Share best practice
- Improve our CQC rating for EoLC

What have we done PDSA's:

- Secured one year funding for the licences to use EPaCCS
- Identified key IT support personnel in the community
- Engagement of clinical staff at different levels with the inpatient SpR and ward sister part of the project team
- Improved efficiency of the discharge process for junior doctors by introducing the E-Discharge information guide
- Formulated a communication plan with all primary and secondary care stakeholders and obtained feedback
- Processes in place for ongoing monitoring and measuring outcomes

E Discharge information guide

H	**History of diagnosis/admission**
E	**End of life register, EPaCCS**
A	**Advance care planning, anticipatory medications**
R	**Resuscitation status**
T	**Treatment plan, escalation of treatments**

Quality of information in discharge summaries from Hayward House since implementation

BEFORE USE OF DISCHARGE GUIDE

Information regarding discharge

" She was assessed by physiotherapy and OT teams and the impression is that she will need to be nursed in bed at home. Both she and her husband seem to understand"

AFTER USE OF DISCHARGE GUIDE

Information regarding discharge

"We have completed the EPaCCS template on the following-

P has been a fast track discharge.

She has been prescribed anticipatory medications.

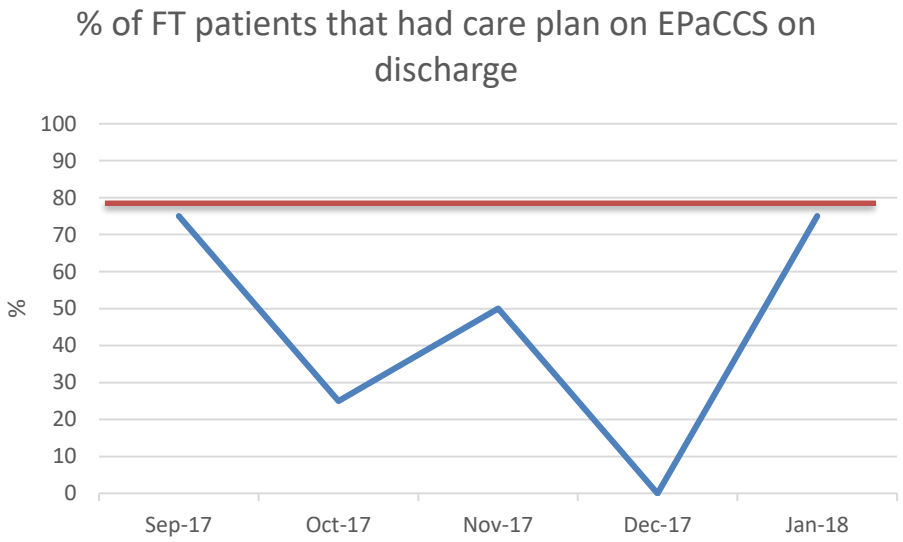
She has a DNACPR in place.

Her preferred place of care has been home & she has been keen to attend her grandson's marriage in November.

I would be grateful if you could put her on the end of life register.

It would be appropriate to treat her reversible causes, for example infections with oral antibiotics"

Audit on EPaCCS entry



PDSA's

- Standardised the Hayward House discharge process – Amending the existing discharge guidance in Hayward House junior doctors Guidance
- Continuous clinical staff engagement by presenting project and its potential benefits to the Hayward House Quality, Risk & Safety meeting and educational meeting.
- Made the identification of patients for EPaCCS straight forward. From Jan 2018 onwards, EPaCCS entry for all discharges from Hayward House
- Ensured that patients for discharge planning are identified early to enable entry onto EPaCCS . Daily reminder at morning Board Round
- Process in place to provide in house training for new doctors as part of their induction

Qualitative feedback from the community & NUH team

'Information entered onto EPaCCS was useful and helped coordinate patient's care'.

'the discharge letter was clear and concise'

GPs

'avoided repeated difficult discussion'

'reduce the need for patients to tell their story again'

DNs

'helps coordinate patient's care in the community and provides continuity'

Community Palliative Care nurse

https://www.youtube.com/watch?v=U2C4mqG9LGA&feature=youtu.be

Hayward House Junior doctor

' We get one chance to get this right for both the patient and their family ' 'EPaCCS gives us the opportunity to holistically care for a patient by communicating with colleagues in other settings and therefore provides continuity that hasn't been possible in this setting before.'

Hayward House Ward sister

Qualitative PPI feedback

Trish Cargill – Chair of Patient Partnership Group

Katie Moore – Head of Patient and Public Involvement

Terence's story

72 yr old man with metastatic pancreatic cancer.
Fast track discharged from Hayward House to home for EOLC and has preferences of care recorded on EPaCCS.
Lives in Nottingham but has Derbyshire GP and DN team
Passed away peacefully at home 18 days later.

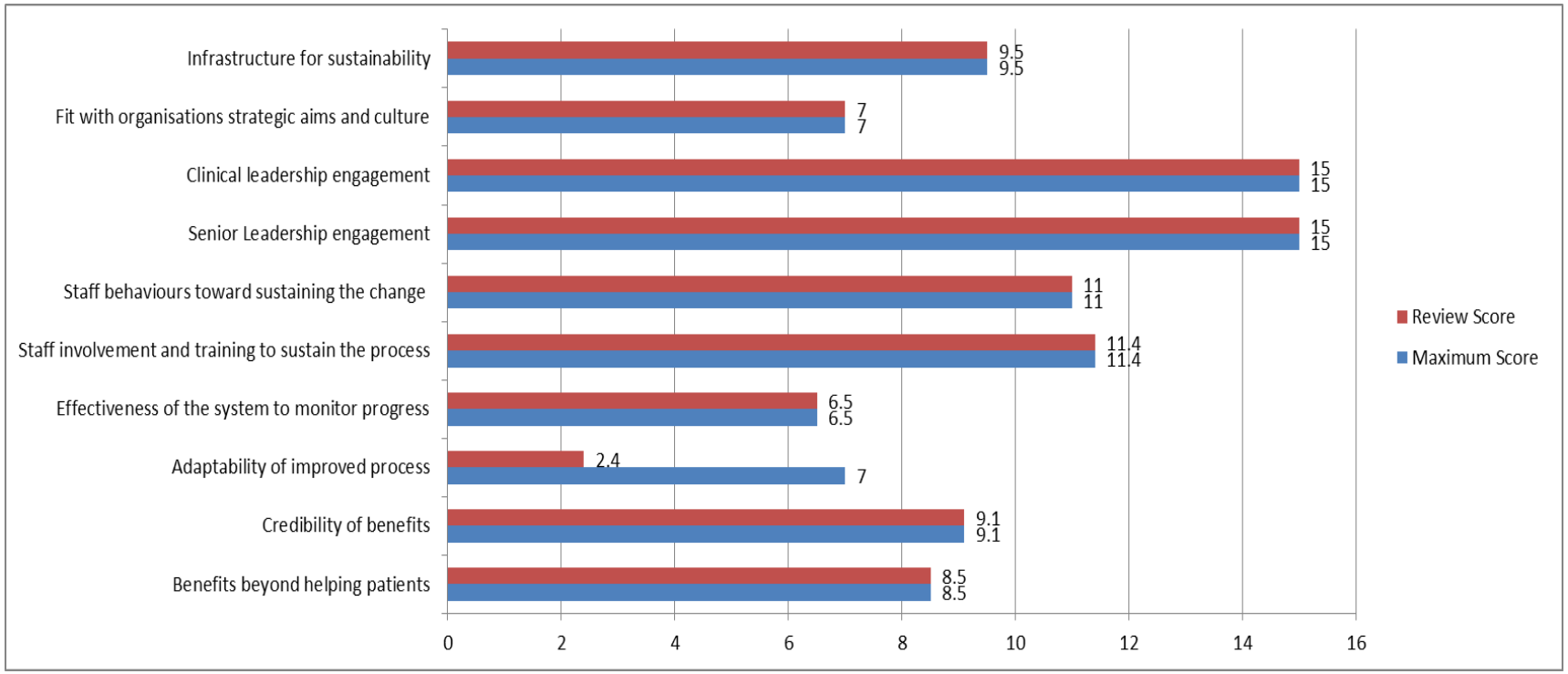
'Information on the EPaCCS template was useful and avoided the repeated discussion on DNACPR'
Derbyshire District Nurse

'His preferences of care were clear on SystmOne'
'has made the referral process more efficient'
Derbyshire Community Macmillan Nurse

Next steps

- Change the measurable outcome to include all discharge from Hayward House from Jan 2018 onwards
- Continue to review effectiveness of the E-discharge guidance
- Continue to audit the measurable outcome from Jan 2018 onwards
- Identify another key IT support in the community and set up a more efficient way of transferring licences and gaining log in.
- Expanding project to other wards in the Trust

Aiming High – Sustainability Scores



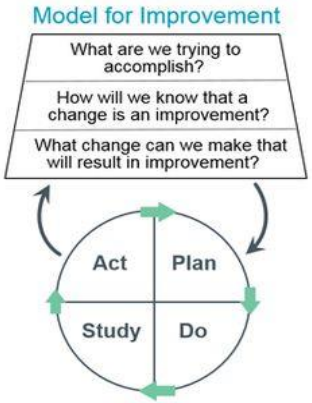
Raising Awareness:

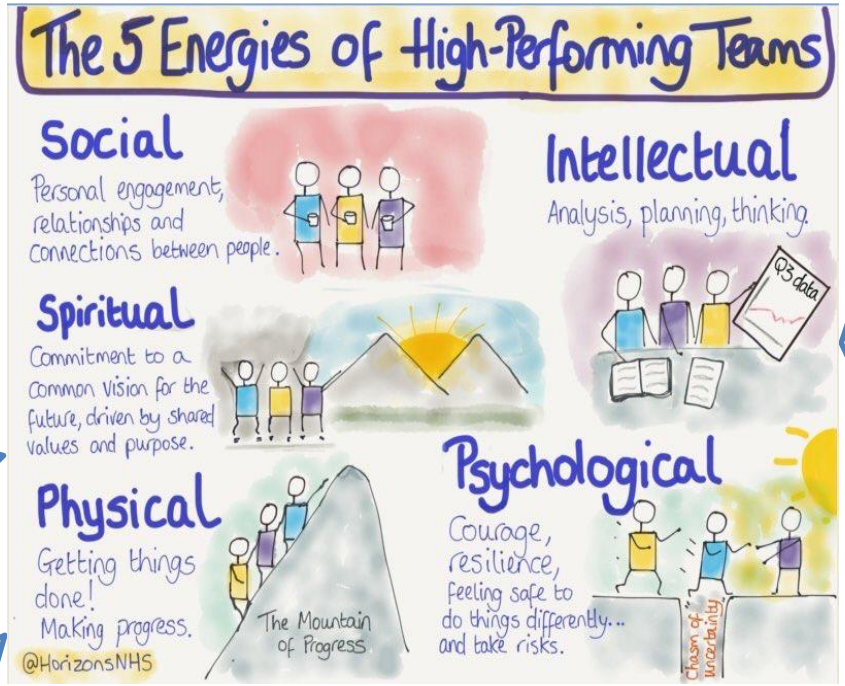
We are very proud of what has been achieved. We have shared and presented our outcomes at the National EoLC Collaborative Event, with Moorfields Eye Hospital as part of their visit to NUH, with our Nursing and Midwifery Board, through our internal Communications and via our Chief Nurse Blog. We also aim to share with our Patient and Partnership Group, NUH members and NUH Volunteers via their newsletters.

Closing Comments

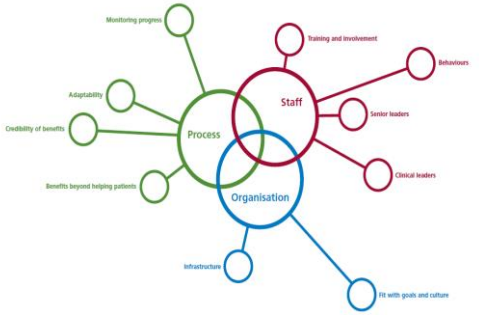
Collaborative working has brought an energy of engagement, relationship connections.
"us and us"
rather than
"us and them"

The collaborative energy of commitment to a shared vision has driven the confidence to move towards a different future, more compelling than the status quo





High energy from gaining insight from sustainability plans



Collaborative approach reinforced teams feeling supported to make changes. We used the 'ginger model' to gain feedback and insight