Supporting patients to meet their preferred place of care at the end of life

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BACKGROUND

Given the choice 63% of people in England would elect to die in their own homes however only 23% do meet this preference, with 53% dying in hospital when only 3% would choose to do so (National End of Life Intelligence Network, 2012). In the last year of life the average number of admissions is 21 and estimates suggest that savings of approximately £659 could be made per person per episode of hospitalisation providing end of life care at home compared to hospital (National End of Life Intelligence Network, 2012).

Organisation of services is crucial in determining peoples’ wishes and with co-ordinated care more people could meet their wishes to die at home (World Health Organisation, 2004). One way this can be done is through the development of Specialist Discharge Facilitator roles to ensure safe, timely and co-ordinated discharges for this group of patients who have often complex, rapidly changing needs (National End of Life Care Programme 2010, 2012). To enable the timely discharge of this group of patients from the acute setting adequate support in the community is also required often additional to what the family/carers can provide themselves. Care should be flexible and staff should be trained to support the delivery of high quality end of life care to patients (National End of Life Care Programme 2012).

To enhance the delivery of high quality end of life care in Liverpool, The Royal Liverpool and Broadgreen University Hospital NHS Trust (RLBUHT) and Marie Curie Cancer Care (MCCC) have worked in partnership to develop both these discrete aspects of care. Case Managers - End of Life Care (CM-EOLC) meet patients in the acute hospital who are thought to be in the last short weeks of life and use their specialist knowledge to ensure a safe and supported discharge to their preferred place of care. To ensure this is done in a timely manner and with adequately trained staff supporting them in the community, the Supported Discharge Service (SDS) provides rapid access to carers specifically trained to deliver care to patients thought to be in the last short weeks of their life in their own home.

CASE MANAGERS - END OF LIFE CARE

The CM-EOLC combine critical decision making with their knowledge of specialist palliative care to focus on the discharge of patients rapidly nearing the end of their lives, whether through actively leading on the discharge of complex patients or advising and enabling other health and social care professionals in the hospital with less complex issues. Their responsibilities include:

• Assessing and meeting the discharge needs of highly complex patients and families
• Liaising with health and social care professionals across healthcare settings
• Supporting the Admission Review Conference (ARC)
• Applying for funding and arranging packages of care
• Arranging for delivery of equipment to patients’ homes
• Advising complex symptom control
• Providing specialist information, advice, education and training
• Participating in audit and research

Patients are referred to the Hospital Specialist Palliative Care Team (HSPECT) and as part of the team CM-EOLC will advise, assist or facilitate discharges for patients with complex discharge needs, primarily those whose conditions are rapidly deteriorating and have identified an alternative preferred place of care/death. The referrals are graded into 3 distinct categories.

SUPPORTED DISCHARGE SERVICE (SDS)

The service is jointly funded by Marie Curie Cancer Care and the Royal Liverpool and Broadgreen University Hospitals NHS Trust to facilitate rapid discharge of patients. The service is designed to support those patients who are thought to be in the last days of life and there is an urgency to get them home while there is a small window of opportunity. The SDS is a compliment of Senior Health Care Assistants (SHCAS) who have received enabling training for patients who are thought to be in the last days of their lives in their own homes. They cover the first 72 hours of care at home and provide a maximum of 4 calls during day and 3 night sits during that period. If the patient requires care after a 72 hour period they will liaise with on-going care providers to pick up the care. They will continue to support the patient and family at home until this is arranged.

METHOD OF DATA COLLECTION

Data presented here will display the activity of the CM-EOLC at RLBUHT and their use of the SDS to facilitate discharges between December 2012 and November 2013. In order to collect this information a data collection sheet was completed at the outcome of each patient seen by the CM-EOLC recording details including patient demographic, complexity and category of discharge, source of care package required and where applicable, the reason why the discharge may not have happened.

RESULTS

Data illustrates that the role of CM-EOLC within the acute setting has had a positive impact. The figures demonstrate a consistent number of patients being appropriately referred. Patients with a poor prognosis and rapidly deteriorating conditions benefit when their discharges are co-ordinated and lead by CM-EOLC. A significant number of patients are being discharged to their own homes or alternative preferred place of care when there are dedicated staff to co-ordinate and lead the discharge and to provide support once they are there.

DISCUSSION

The data collected and shown here clearly supports the introduction of the CM-EOLC role in the acute hospital, however this is only one aspect. An area for further analysis would be to explore the experiences of patients (where possible) and their relatives/carers when the Case Managers have facilitated these urgent and rapid discharges out of hospital.

RECOMMENDATIONS FOR FURTHER RESEARCH

The data collected and shown here clearly supports the introduction of the CM-EOLC role in the acute hospital, however this is only one aspect. An area for further analysis would be to explore the experiences of patients (where possible) and their relatives/carers when the Case Managers have facilitated these urgent and rapid discharges out of hospital.

REFERENCES

1. National End of Life Intelligence Network (2012) What do we know now that we didn’t know a year ago? New Intelligence on End of Life Care in England.