Guy's and St Thomas' NHS Trust

Irene Carey, Rachel Hill, Maggie Kennedy, Kimberley StJohn

About the project

1. Lack of smooth transition in and out of hospital for palliative care patients.
2. Variable advance care planning (ACP).
3. Variation in symptom control, care planning and experience for patients being supported by the priorities for care of the dying person.
4. Variation in knowledge and confidence with respect to end of life care (EoLC) and uptake of education.

Guy's and St Thomas' Hospital sees 2.4 million patient contacts per year, including more than 800,000 in community services, 103,000 daycase patients, 88,000 inpatients and 1.2 million outpatients (2016/17 statistics)

What was done?

- Questionnaires to GPs and patients
  Ethical approval obtained for research study interviewing patients re their experience of palliative care hospital discharge.
  GP telephone handover supported by SBAR (Situation, Background, Assessment and Recommendation) template and subject to quality improvement project.
  Testing of discharge checklist for palliative care patients – this project evolved into testing of a transfer of care navigator role within palliative care.
  Working group set up to develop rapid access pathway via Emergency Department (ED) for palliative care patients.

- Training in EPaCCS (Coordinate my Care, CMC) for ED and ITU nurses as well as disease specific clinical teams.

- Adapted Brighton symptom observation chart and tested its use in acute admissions ward alongside bespoke nursing care planning guide for patients supported by the priorities for care of the dying person.
  Tested more widely in three wards of Older Persons Unit as part of medical student QI project; the students have volunteered to run a further PDSA cycle following formal completion of their project.
  Discussions ongoing with Chief Technology Officer (CTO) and Chief Clinical Information Officer (CCIO) re embedding the above into electronic patient record.
  Worked with spiritual care team to ensure support given when wanted – championed by EoLC CNS and chaplains and automatic notification system.

- Worked with EoLC education subgroup to finalise prospectus / training matrix for essential EoLC training for all Trust staff and embedded EoLC education into Trust induction / mandatory training (as non-mandatory update).
  Successful bids for and recruitment to EoLC Darzi fellow and pan-London research fellow in EoLC.
  Developed novel educational initiatives including Second Conversation (in collaboration with the Royal College of Physicians) and one-day advanced communication skills training, supported by Darzi fellow. Darzi fellow led project with a focus on improving conversations around DNACPR and treatment escalation decision making, linked with all-Wales TalkCPR.

Outcomes

- Shared vision within palliative and end of life care team across hospital and community – remains work in progress but developing despite diverse teams and pressures.
- Culture of shared ownership – 'EoLC is everybody's business' campaign.
- Momentum maintained with champions' network and student nurse champions' network.
- Baseline data to inform ongoing improvement efforts e.g. GP telephone handover on basis of GP questionnaires; patient questionnaires prompted patient interview study re discharge.
- Rapid access pathway via ED for palliative care patients agreed, yet to be piloted.
- Symptom observation chart /nursing care planning guide – preliminary data suggests increased confidence in assessing and managing symptoms and knowledge of priorities for care of the dying person.
- Increased awareness of spiritual care needs at the end of life.
- Prospectus / training matrix for essential EoLC training for all Trust staff available to staff – implementation work in progress.
- Embedding of EoLC education into Trust induction / mandatory training (as non-mandatory update).
- Encouraging early evidence that Second Conversation improves junior doctor confidence in EoLC conversations.
- Multi-specialty and multiprofessional working group set up to improve conversations around DNACPR and treatment escalation decision making. This is the subject of a new Trust Quality Priority.

Sustainability

- Motivating and engaging others (at frontline to Board) is crucial but you still need key people to coordinate / follow through.
- Continue with champions' network and campaign approach, build quality improvement capacity within workforce, highlight good practice, tell stories.
- Combine with data collection e.g. run charting key aspects of care in line with the priorities for care of the dying person.
- Spot opportunities to work with others eg paediatric palliative care also wants to explore Coordinate my Care within the acute Trust so we will make a joint case.
- Need to continue to foster a 'pull' ('please come and do this in our area; we want to do this, will you help') rather than just a 'push' ('we want to do this in your area'). The profile associated with Botb has unquestionably assisted this.
- Maximise on national interest in innovations e.g. Second Conversation.
- Build on existing publications / conference presentations (e.g. re Second Conversation, symptom observation chart) subject to delivery of improvements (e.g. GP work, patient interviews).
- Review upcoming conferences / opportunities to present work e.g. RCP Innovation in Medicine 2018; King's Health Partners Safety Connections Conference 2018.

For full case study, visit www.hospiceuk.org/Botb