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Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Sharing how we care

Learning from End of Life Care

Where good care for dying people has been and continues to be given, it is typified by looking at what that care is like from the perspective of the dying person, the people who are important to them and developing and delivering an individualised plan of care.

The Liverpool Care Plan was withdrawn in 2014 as it was associated with standardised treatment and care, carried out irrespective of whether that was right for the particular person in the particular circumstance. In many cases the Liverpool care pathway was associated with poor experience of care and a tick box exercise.

The new approach to End of Life Care focuses on achieving five priorities set out in **One Chance to Get it Right.**

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours:

1. This possibility 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.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
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.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
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.

Dying Matters

Throughout 2018/19 there were 1916 inpatient deaths at DBTH. A recurrent theme identified was the lack of recognition of a dying patient and so in some cases a few days of unnecessary investigations and treatments before placing the patient on an end of life care plan.

For the new inpatient Quality Accreditation Tool (iQAT), inpatient areas will be working towards end of life accreditation to support improvements in this care. This will include areas having a nominated End of Life Champions, who will attend regular updates to feedback to their area, training for all staff in relevant End of life and Palliative care to ensure they are aware and fully educated at delivering outstanding individualised care for all our patients.

Dying Matters is a coalition of individual and organisational members across England and Wales, which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.

The way we view dying and death can impact on the experience of people who are dying and bereaved. A lack of openness can also affect the quality and range of support and care services available to patients and families.

The Dying Matters Coalition is working to address this by encouraging people to talk about their wishes towards the end of their lives, including where they want to die and their funeral plans with friends, family and loved ones.

A series of DBTH graphics have been developed to help communicate some things staff, patients and families might not know about death.
Access DBTH's End of Life Care web page here to find out more information, how to contact the team and to print off resources for your area.

For more information, please contact Karen Lanaghan, End of Life Care Coordinator karen.lanaghan@nhs.net

Learning from **Deaths**

The learning from deaths national guidance is for NHS trusts on working with bereaved families and carers. It advises trusts on how they should support, communicate and engage with families following a death of someone in their care.

The new bereavement information booklet was launched this year and is available on all wards and should be given out to every family following a bereavement. Further supplies can be obtained from the bereavement office at DRI and the general office at BDGH.

A further issue identified has been the inaccurate completion of DNACPR forms with regards the reason for NOT resuscitating a patient. This finding has been identified nationally within the third annual Learning Disability mortality review (LeDeR) report. It has found that the rationale for a number of DNACPR decisions were documented as “learning disability” and “Downs Syndrome”. Neither of these terms should be a reason for a DNACPR order or used to describe the underlying, or only, cause of death on part 1 of a MCCD.

Timeliness of completing a medical certificate of cause of death (MCCD) and referring a death to the Coroner remains the biggest challenge as it is often very difficult to identify a Doctor who cared for the patient in life, due to shift patterns etc.

It is envisaged that once the new medical examiner (ME) system is in place, the processes to facilitate these two activities will be refined and result in improvements. As the result of a successful business case it is likely that we will have an ME team in place by the end of the year. By April 2020 this is to be statutory.

In addition to ensuring MCCD’s are completed and /or deaths referred to the Coroner, the lead nurses for learning from deaths screen a large proportion of the case notes in an attempt to identify any issues with care management and delivery.

Finally, the newly appointed National Medical Examiner (ME), Alan Fletcher is coming to the Trust on Friday 13th September to give a talk on the ME system. This will be held in the Education Centre lecture theatre at 1pm. All are welcome.

Five things I've learnt from nursing the dying

By Kimberley St John, Palliative care nurse, Guys and St Thomas NHS FT

1. We take our health for granted. I am so grateful to be able to run up the stairs.
2. Music, touch, scents and tastes are often the most effective way of communicating with people who are very close to death. The little things matter.
3. Most people don’t have fancy bucket lists. For many it’s being at home or having fish and chips.
4. It’s important to think about what you would or wouldn’t want at the end of your life. I know that I wouldn’t want intensive treatment if it wouldn’t help me. I have written it down and told my family in case they have to make decisions for me.
5. Don’t delay anything that is important to you. I have known people to put off marriage, a special trip, making up with a relative. None of us know how much time we have. Use it wisely.

ReSPECT

On 1 April 2019, DBTH removed the old DNA CPR policy and introduced the Recommended Summary Plan for Emergency Care and Treatment. A quick guide for clinicians on how to complete the ReSPECT form can be found here.

Butterfly Volunteers

Introduced in 2017, the Butterfly volunteers are a group of specially trained people who support dying patients, their families and friends at the end of their life. They offer one to one support, compassionate listening, comfort and companionship, particularly for those patients with few or no visitors.

Each visit is unique. The volunteer will work with the patient and visitors present to determine any needs at that particular time. The volunteers can help by reading aloud, offering mouth care, or by making a cup of tea and sitting down for a chat. Sometimes, silent company or just holding their hand is all that is needed. The volunteer can liaise with the ward staff if they feel that the patient has any additional needs.

Butterfly volunteers will sit and talk, run errands and also help the patient's loved ones, giving them valuable time to be able to go home for a few hours, safe in the knowledge that their friend, parent, child or significant other is not alone.

Karen Lanaghan, End of Life Care coordinator, said: "We will all be affected by death at some point and as a hospital it is our duty to ensure that we get this aspect of care right, treating the patient with dignity and respect."

Hospital worker gives home to orphaned pet

A member of Emergency Department staff at Doncaster Royal Infirmary has been awarded 'Star of the Month' after she went above and beyond to give one of her patients a last goodbye.

On 10 December, a lady arrived at Doncaster's Emergency Department who was nearing the end of her life. Her son, and main carer, was known to hospital staff from previous visits and was distressed about having left his mother's beloved dog in the car outside.

Emma, a Trainee Assistant Practitioner, jumped into action, clearing the family pet for access to the ward so that the family could spend their final moments together. Realising the German Shephard now had nowhere to go home to; Emma cared for him at her home for a few days to give the family time to make other arrangements.

Melanie Lane, who nominated Emma for the award said: "Emma went above and beyond to make sure that this lady got the chance to see her loving pooch one last time. The patient passed away just minutes after her beloved pet left the ward. It was almost like she waited to say her goodbyes – something which might not have happened if Emma wasn't on shift that day."

Cindy Storer, Head of Nursing, Midwifery and Allied Health Professionals at the Trust presented Emma with her award and said: "This is the part of the Emergency Department that people don't see. We are so lucky that our department is staffed by such caring individuals that will go the extra mile to make sure that our patients and their family members have the best possible experience.

"Whilst I imagine this seemed like a small act of kindness to Emma, it would have made all the difference to the family, who were processing their grief, to not have to worry about their family pet. On behalf of the Trust I would like to share how proud of Emma we are."

DBTH Stars is the Trust's awards and recognition scheme which recognises the exceptional work of its staff. Anyone can nominate a member of staff for Star of the Month, whether they are a doctor, nurse, service assistant or admin staff. If you've come across someone special whilst visiting our hospitals you can nominate them for the award by emailing dbth.comms@nhs.net.

Learning from Prevention

Smoking

Smoking is the single largest cause of ill health and preventable death in England and kills about half of all lifetime users. Tackling smoking provides the biggest opportunity for making services across the entire health and care system more sustainable.

A large number of smokers can be reached through health services and in particular in hospitals. It is estimated that 1 in 4 patients in acute hospital beds in England are smokers and this presents a unique opportunity to offer smoking cessation advice.

The British Thoracic Society audit of smoking cessation for secondary care in 2016 found that this opportunity to reach smokers through health services is not being exploited.

The smoking cessation audit found that:

- Over 1 in 4 (27%) hospital patients were not even asked if they smoke.
- Nearly 3 in 4 (72%) hospital patients who smoked were not asked if they would like to stop.
- Only 1 in 13 (7.7%) hospital patients who smoked were referred for hospital-based or community treatment for their tobacco addiction.
- Half of frontline healthcare staff in hospitals were not offered training in smoking cessation.

- Only 1 in 10 hospitals completely enforce their fully smoke-free premises: rates of enforcement were even lower for hospitals which provided areas where smoking was allowed.
- Provision of nicotine replacement therapies and other smoking cessation treatments were 'poor' in hospital pharmacy formularies.
- Only 1.5% of smokers in acute hospital settings go onto make a quit attempt with stop smoking services.

Alcohol

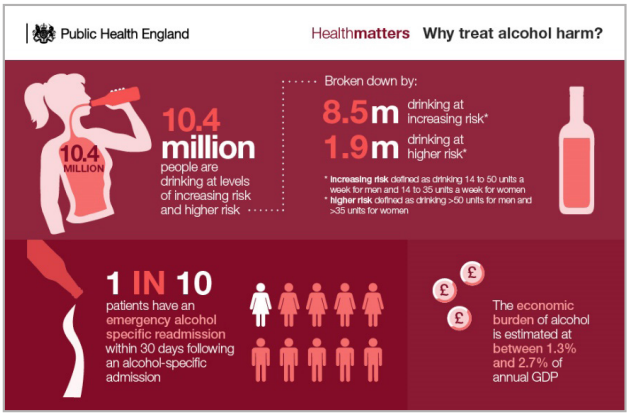
Higher risk drinkers

In England, 10.4 million people consume alcohol at levels above the UK chief medical officers' (CMOs') low-risk guideline and increase their risk of alcohol-related ill health.

Alcohol misuse contributes (wholly or partially) to 200 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include:

- Cancers
- Cardiovascular conditions
- Depression
- Liver disease

There were over 24,000 alcohol-attributable deaths in 2017. In 2017 to 2018, there were nearly 1.2 million admissions related to alcohol, of which alcohol was the main reason for admission for about 338,000 cases.



Alcohol identification and brief advice (IBA) can identify and influence patients who are drinking above low risk, but the level of implementation is varied across the country and nowhere near the optimal large scale delivery required to significantly impact on population health.

Learning from Prevention

Tobacco and alcohol CQUIN

This national CQUIN scheme offers the chance to identify and support:

- inpatients who smoke
- inpatients who are drinking above low risk.

It is intended to complement and reinforce existing activity to deliver interventions to smokers and those who use alcohol at increasing risk and higher risk levels.

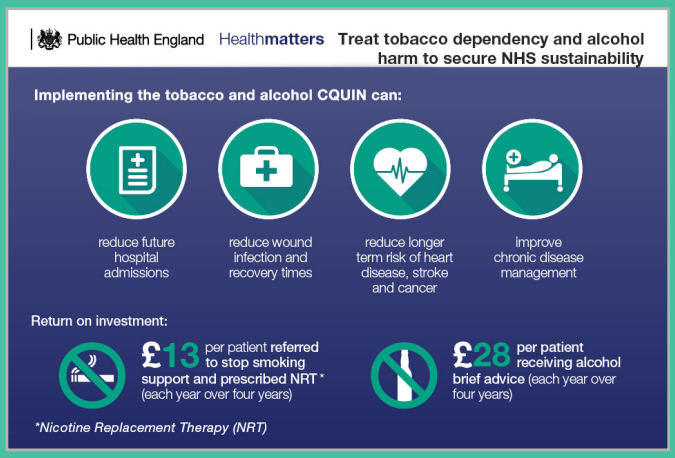
The CQUIN applies to community, mental health and acute providers. It covers adult inpatients only (patients aged 18 years and over who are admitted for at least one night) and excludes maternity admissions.

CQUIN indicators are:

1. The percentage of eligible adult patients who are admitted and screened for smoking and alcohol risk status and results recorded in patient's record.
2. The percentage of eligible patients who have been identified and recorded as smokers that are given brief advice, including an offer of Nicotine Replacement Therapy (whether or not this offer had been taken up).
3. The percentage of eligible patients who have been identified and recorded as drinking above low risk levels are given brief advice (or offered a specialist referral if the patient is potentially alcohol dependent).

All of these activities are directly linked to CQUIN payments.

This CQUIN will help providers to implement the guidance produced by the National Institute for Health and Care Excellence (NICE), on reducing smoking in acute and mental health settings and preventing alcohol use disorders.



In South Yorkshire and Bassetlaw (SYB), the average rates of smoking-attributable deaths in England are much higher than the England average (319.5 per 100,000 compared to an England average of 272.0 per 100,000).

At DBTH, we are taking part in the South Yorkshire and Bassetlaw QUIT programme which is based on four steps:

Q **ask the question:** all hospital patients should be asked if they are a current smoker.

U **understand their addiction:** all hospital patients should be asked to exhale into a CO monitor and their result noted in patient records. This provides not only evidence of the conversation taking place, but provides a strong indicator of level of addiction which will support and indicate further treatment, but also contributes to triggering quit attempts.

I **inform patients about smokefree sites:** all patients should be informed that the hospital site is smokefree and that patients and visitors are not permitted to smoke anywhere on site, but that they can access support for nicotine replacement.

T **initiate treatment:** refer patients to smoking cessation support including advice and treatment as soon as possible, enabling them to quit during their inpatient stay where possible and ensuring appropriate ongoing support after discharge. Patients should be offered nicotine replacement support within 6 hours of arrival on the ward.

Download your resource pack for your clinical area here

Learning from Prevention

Alcohol identification and brief advice

Alcohol identification and brief advice (IBA) aims to identify and influence patients who are drinking above low risk.

IBA is most impactful when it helps identify and advise patients who are not dependent on alcohol, but whose drinking is increasing their risk of a wide range of ill health linked to drinking alcohol. In addition, the intervention will identify dependent drinkers who may need further specialist support.

Healthcare professionals do not require a comprehensive knowledge about alcohol harm to deliver IBA well.

IBA can be approached efficiently through the use of this CQUIN by broaching the subject of drinking above low risk at the same time as addressing smoking with hospital patients.

For more information on the QUIT programme or smoking cessation CQUIN, please contact Tammy Brown, Matron for Women's Health services tammy.brown1@nhs.net

For more information on the Alcohol CQUIN please contact Kate Carville, Associate Director of Nursing for Medicine kate.carville@nhs.net

How are we doing?

In the first 3 months of this year (in a sample size of 1142 patients):

Smoking screening

- **91%** were screened for their smoking status while they were in hospital.
- Of these **13.6%** patients smoked. **86%** were given brief advice and guidance.
- **80%** were offered a referral to smoking cessation services and **10%** of patients accepted.
- **90%** of patients didn't want a referral, although **21%** patients wanted nicotine replacement therapy (NRT) prescribing (this is now stocked in all inpatient areas).
- **79%** of patients didn't want any NRT.

Alcohol screening

- **88%** of patients were screened for alcohol intake and advice.
- **17%** of patients did not drink alcohol.
- **74%** of patients were recorded as low risk, **5%** were at increasing risk and **4%** were high risk.
- Of the patients at increasing risk or high risk, **44%** were offered advice in an information leaflet.
- **53%** of patients at high risk were offered a referral to an alcohol specialist
- **23%** of patients at high risk declined the offer of referral.

Thanks this month go to: Cindy Storer, Karen Lanaghan, Mandy Dalton, Tammy Brown, Kate Carville, Bonny Stevenson.