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A Community Specialist Palliative Care Service Evaluation: What Input Do Care Homes Need from Specialist Palliative Care?

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Abstract

Objectives: City Hospice is a community specialist palliative care (SPC) team caring for the population of Cardif. A service evaluation was undertaken to review the scope of SPC input required for residents referred from care homes (residential and nursing homes).

Methods: A mixed method evaluation was undertaken for all patients from care homes referred between 1st January 2019 and 31st December 2020. Key themes of the required input from the SPC team were captured, and statistical analysis performed on the dataset.

Results: 272 referrals (12% of total referrals) were from care homes during the specifed time period, the majority with a non-malignant diagnosis. 81% of residents were deemed to have SPC needs on frst assessment. The main SPC needs fell into the following categories: recognition of a deterioration, symptom control, future care planning (FCP), symptom control, and facilitation of communication and supporting care home staf.

Conclusions: Community SPC teams have an important role in supporting residents, care home and primary care in delivering high quality palliative care. This role has been amplifed in the current constraints placed on health and social care due to the COVID-19 pandemic.

K , . : Nursing home care; Residential home care; Care homes; End of life care; Terminal care; COVID-19; Specialist palliative care; Supportive care

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A service evaluation was undertaken to evaluate what input the City Hospice (CH) community SPC team has with care home residents. e aim of the service evaluation was rstly to answer the important question of whether care home residents have true SPC needs and hence require SPC input, or whether their care including end of life care could be managed exclusively by primary care. Secondly, the results of the service evaluation would help target resources depending on the speci c (if any) SPC needs. e time period for the evaluation (2019-2020) spanned both pre and post COVID-19 pandemic periods. Ethical approval was not required.

Cardi is the capital city of Wales, with a population of 372 000 with population demographics atypical of the rest of Wales. 14.2% of the population in Cardi is over age of 65, which is a smaller proportion of the overall population in comparison with all other local authorities in Wales [1]. 20% of the population of Cardi consider their ethnicity from a Black Asian or Minority Ethnic group which compares with only 5.6% of people in Wales [2]. Within Cardi there are 55 registered residential homes, 10 nursing homes, and 13 with dual registration of both residential and nursing facilities. roughout the article, 'care homes' encompasses both residential and nursing facilities.

CH provides community specialist palliative care (SPC) to the city of Cardi . City Hospice does not directly have any SPC inpatient beds, but has access to beds provided by another charity. Members of the SPC multidisciplinary team undertake domiciliary visits to care homes, patients' own homes, supported living accommodation and Her Majesty's Prison Cardi . Sta s work with heath care professionals in the wider primary care team, including local District Nursing (DN) services and General Practitioners (GPs) to provide palliative care support to any person with a life limiting illness aged 16 or over. SPC advice is available to all healthcare professionals (HCP) 24 hours a day across Cardi . Clinical Nurse Specialists (CNS) work a 7/7 rota, providing specialist advice and face to face review 7 days per week, with 2 CNS working within the Out of Hours service at weekends. City Hospice has continued face to face assessment throughout the COVID-19 pandemic following up to date infection prevention and control measures, including for care home residents.

Referrals for care home residents are received either from the residents GP or the care home directly (permission from the GP with whom the resident is registered is sought before review). A rst assessment by a SPC doctor and CNS, the resident, care home sta and any persons who are important to the resident is undertaken. Ongoing clinical review of the resident and support for the care home is provided by a named CNS, either until the resident dies or is discharged from the care of the SPC team.

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is was a mixed methods evaluation. All referrals for residents in care homes received by CH between 1st January 2019 - 31st December 2020 were included in the evaluation. e case notes of all residents were reviewed: key themes were generated through the review of all

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case notes by 2 Palliative Medicine Consultants. A proforma was designed to capture the key themes outlined in the initial referral or identi ed during rst assessment of all residents of care homes referred to CH during the speci ed time period. e actions undertaken by the SPC team resulting from the rst assessment were also categorised using a separate proforma, including any documentation of future care planning (FCP), including preferred place of care (PPC) and preferred place of death (PPD).

e data was entered into a spreadsheet, including demographic data of residents, and statistical analysis performed.

12% of all referrals during 2019-2020 came from care homes (n=272); of these 87% (n=236) were from nursing homes and 13% (n=36) from residential homes. 67% of residents had a non-malignant diagnosis, predominantly dementia and/or frailty (Figure 1).

Care home residents represented 18% of all patient deaths known to CH during 2019-2020; 288 nursing home and 30 residential home residents died during this time period (these gures included those care home residents referred to the SPC team prior to 2019 but who died in 2019/2020).

e overall number of referrals to City Hospice increased during the start of the COVID-19 pandemic [3], however referrals from care homes decreased from March 2020 onwards [Figure 1], presumably re ecting care home interpretation of the national guidance to 'limit footfall' and shield the residents of care homes [4], coupled with a reduction in face to face GP reviews of care home residents which would usually instigate a referral. is raises the concern of potentially unmet needs of residents who may have bene ted from SPC intervention but were not referred during this period. Evaluation of this impact is outside of the scope of this paper, but is likely to form part of national inquiries into the COVID-19 pandemic.

e average length of time that nursing home residents had SPC involvement was 146 days (median 57 days), with the average length of time for residential home residents being shorter at 49 days (median 23 days). During the timeframe analysed, 36 patients already under SPC were admitted to a care home environment from their own home, and were included in the data analysis.

42 care home residents (15% of those referred: 40 nursing, 2 residential) referred during the time period were not assessed by CH, either dying due to an acute deterioration in the care home before initial assessment or the resident having been admitted to secondary care and dying in hospital. ese residents were included in the analysis as telephone advice was provided to the care home or GP to support the care of the resident in 47% of these referrals.

60% of the total referrals were marked 'urgent' by the referrer, necessitating contact by the SPC team with the care home within 48 hours as determined by CH clinical standards. e standard for routine referrals is contact within 5 days.

13% of patients referred from care homes died prior to the initial assessment. CH continued adherence to its clinical standards determined by the local University Health Board for review of urgent (contact within 2 days) and routine referrals (contact within 5 days), including throughout the COVID-19 pandemic.

Analysis of the data found that 81% of residents had SPC needs on rst assessment. Figure 2 outlines the key themes determined from referral and rst assessment (Figure 2).

e actions undertaken by the SPC team following rst assessment were also categorised (Figure 3).

FCP

89% of residents had a decision regarding CPR in place prior to rst assessment (recorded in the form of a completed All Wales DNACPR form [5]). Further FCP discussions was undertaken with the resident and/or family, resulting in:

- Preferred place of death (PPD) was established in 94% of residents. For the vast majority of nursing home residents this was the nursing home. For residential home residents, PPD was either the residential home or inpatient hospice.
- Completion of a formal ACP document occurred in 58% of patients, of which 46% were in the form of a treatment escalation guide for those patients who lacked mental capacity for such decisions.

O : In 69% of residents, medication was arranged via the GP to aid current symptom control, or to support an expected further deterioration in the

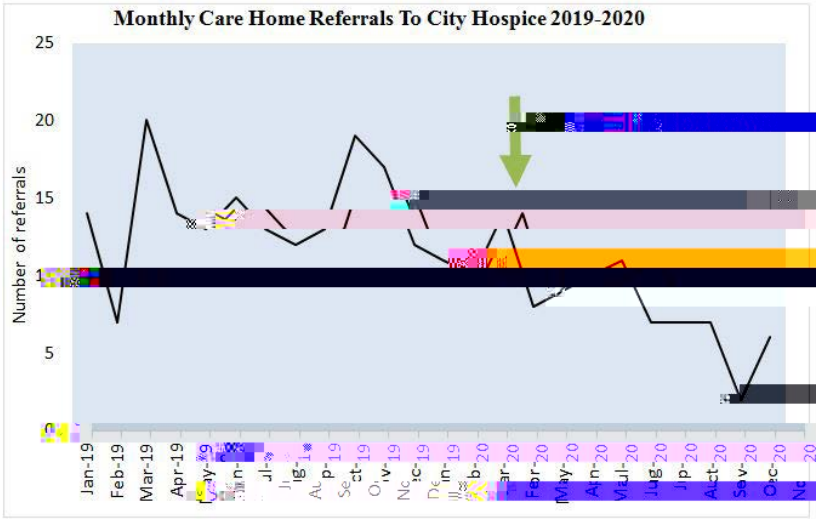

Figure 1: Monthly care home referrals to city hospice 2019-2020.

individual's health. is included subcutaneous injectable 'anticipatory medications' for managing potential pain, distress, nausea and vomiting and secretions at the end of life.

E . , . . . : In a small proportion (16%) of residents, referrals were made to other HCP e.g. DN's, Speech and Language therapists, dieticians. ese referrals were in addition to ongoing SPC support. e most common referral was to the DN service.

D , . . PC. , : 5% of residents were discharged from SPC follow up following the initial assessment, as no SPC needs were identi ed. A further 5% of residents were discharged at subsequent follow up visits as all actions from the initial assessment had been completed, symptoms were well controlled and the residents' health was considered stable at time of discharge.

What happened to residents' a er the rst assessment?

96% of residents of nursing homes achieved their PPD; this was the care home for the vast majority of residents. 98% of residents had anticipatory medication in place to support their EOLC at the time of death; 42% of residents received medication using a syringe driver. For those residents who did not achieve their PPD, the residents were admitted to secondary care due to acute precipitants including infection (including suspected COVID-19), haemorrhage and exacerbation of heart failure, where they subsequently died.

88% of residents of residential homes achieved their PPD. All of these individuals had anticipatory medication prescribed; 78% of residents received medications via a syringe driver, with DN support setting up and maintain the syringe driver. For those not achieving PPD, all were admitted to secondary care for management of acute infections, where they subsequently died.

o en take more than 1 visit or phone call in order to adequately allow patients and family member's time to consider the relevant issues before formalising FCP, which can be resource intensive. However,