Pilgrims Hospices

Action planning – day 1 - 2019

Principles & Practice in End of Life Care Registered Practitioners

Skills that can improve practice in end of life care

What can we do differently?

If you change Nothing, nothing will change.

Life of an Educator. J. Tarte 2013

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hello

my name is…

Always remember!

hello my name is ….
https://www.england.nhs.uk/tag/hellomynameis/
http://hellomynameis.org.uk/

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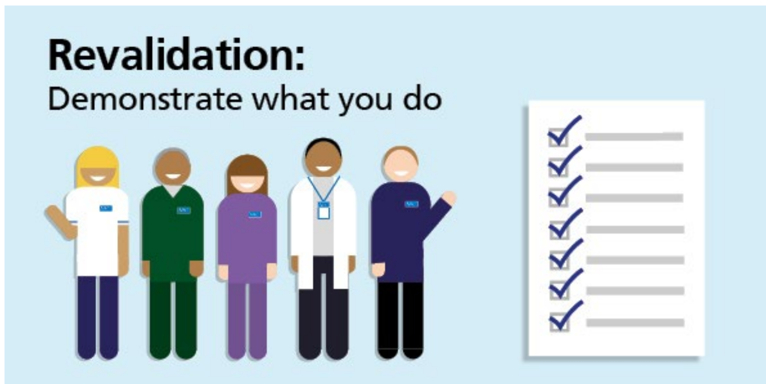
Practice Development Workbook

- Work through PDR following each session.
- Complete action plans
- All useful evidence to support continuing professional development portfolios!

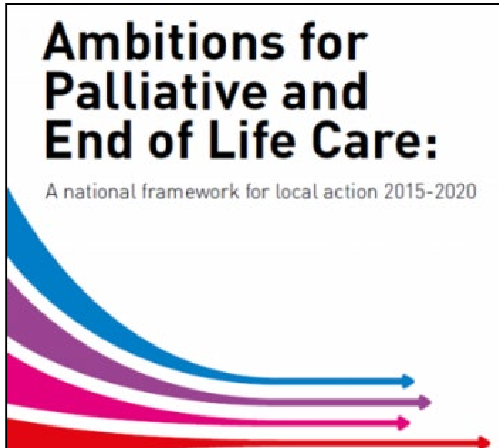


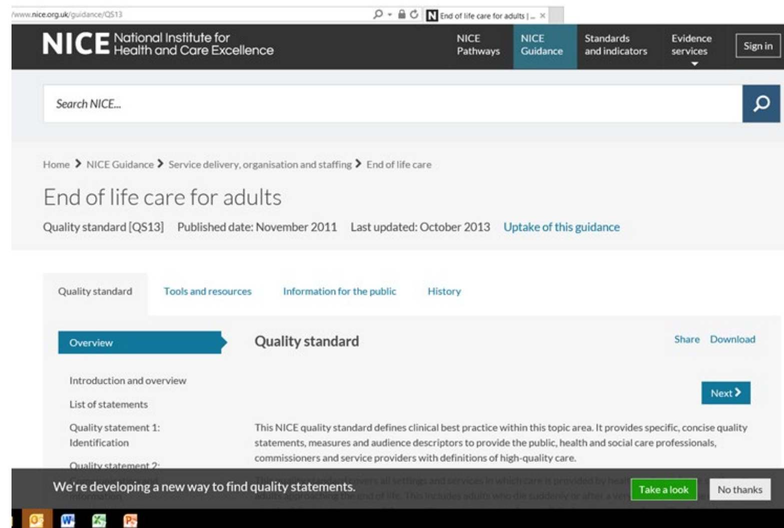
What can **we** do differently?

- Check you have read, understood & are implementing up to date guidance

https://www.nice.org.uk/guidance/QS13

http://endoflifecareambitions.org.uk/





https://www.nice.org.uk/guidance/ng31?unlid=3733136482016228163854

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Check out SPICT™ resources

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

**The SPICT™ is used to help identify people whose health is deteriorating.
Assess them for unmet supportive and palliative care needs. Plan care.**

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:
- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Other conditions

Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

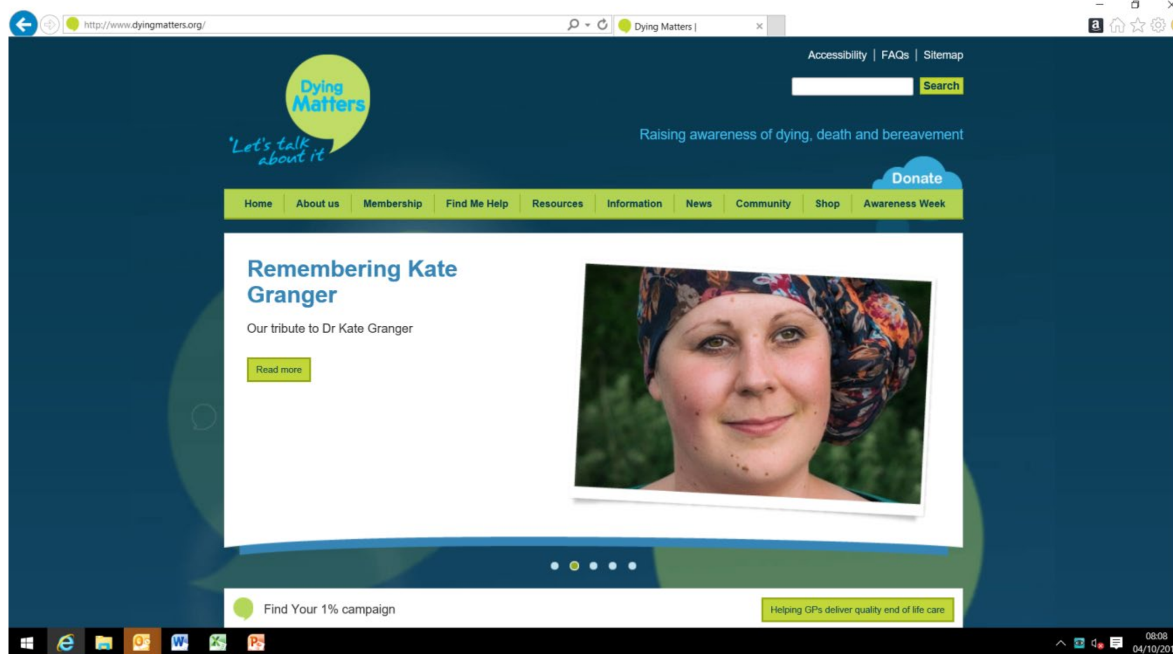
- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2017

www.pilgrimshospices.org

Check out Dying Matters website



http://www.dyingmatters.org/

www.pilgrimshospices.org

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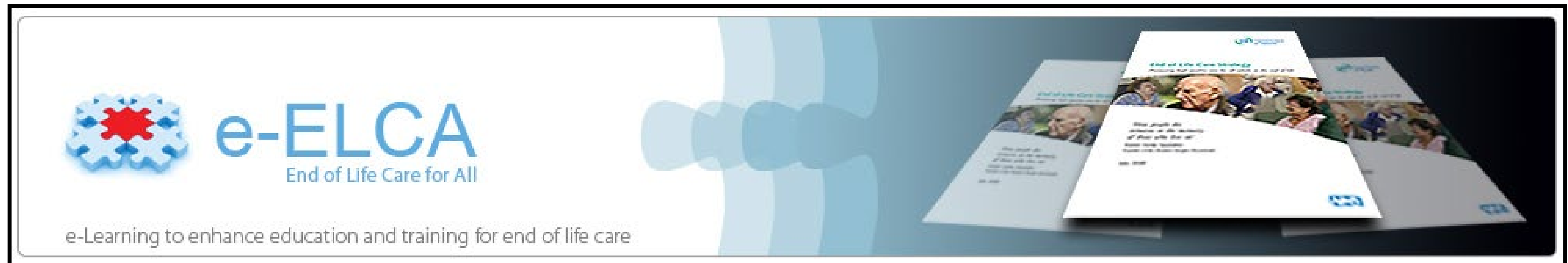
Do not forget to visit /register to the following e-learning resource!



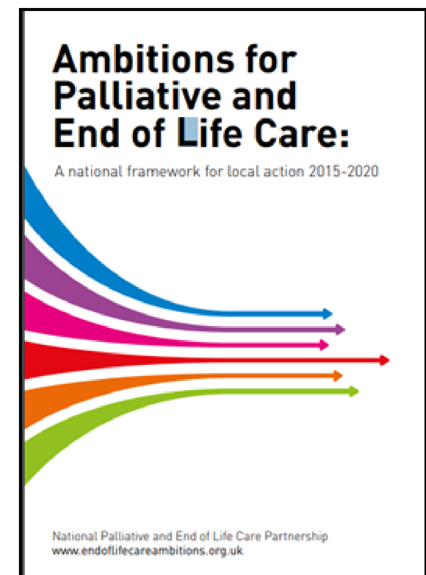
- e-ELCA (End of Life Care for All e-learning website)
  - http://www.e-lfh.org.uk/programmes/end-of-life-care/
- A number of sessions are available for all healthcare workers to access.
- Check out the sessions that support Priorities for Care of the Dying Person
- Add certificates & reflections to your portfolio!

Week 6 presentation

- 5 minute presentation
  - Very informal
  - Can be fun!
  - Any format accepted
  - Can either deliver individually or as a pair.
  - Relate one of the -

  Ambitions for Palliative & End of Life Care

  to your own role & area of work



Remember this will be very useful evidence for portfolios!

Develop an action plan

‘It’s often the small things that make a difference to patients & families..’

(Hansford 2015)