The Acute Intervention Team:

Supporting both palliative and critical care

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'Q is for Quality' Conference June 12th 2019

Richard Hixson, Consultant Critical Care
Lucy Nicholson, Consultant Palliative Care
Lisa Ward, Early Detection and Resuscitation Lead Nurse

Tipping points

- 58 year old man 9-1-2004:
  - 98% burns, discussion with patient in ED (with capacity).
  - Decision to palliate and give him time with wife and 2 daughters.
  - **Agreed (eventually) this was a success for communication.**

Intervening 15 years…..?

- 62 year old man 3-2-2019:
  - Severe MS, chest sepsis, **ACP and DNACPR** in situ prior to admission.
  - IP cardiac arrest 5-2-2019, CPR, ventilated, bilateral chest drains.
  - **Withdrawal on ICU, safeguard, meeting, inappropriate escalation.**

Do not make life easy for ourselves

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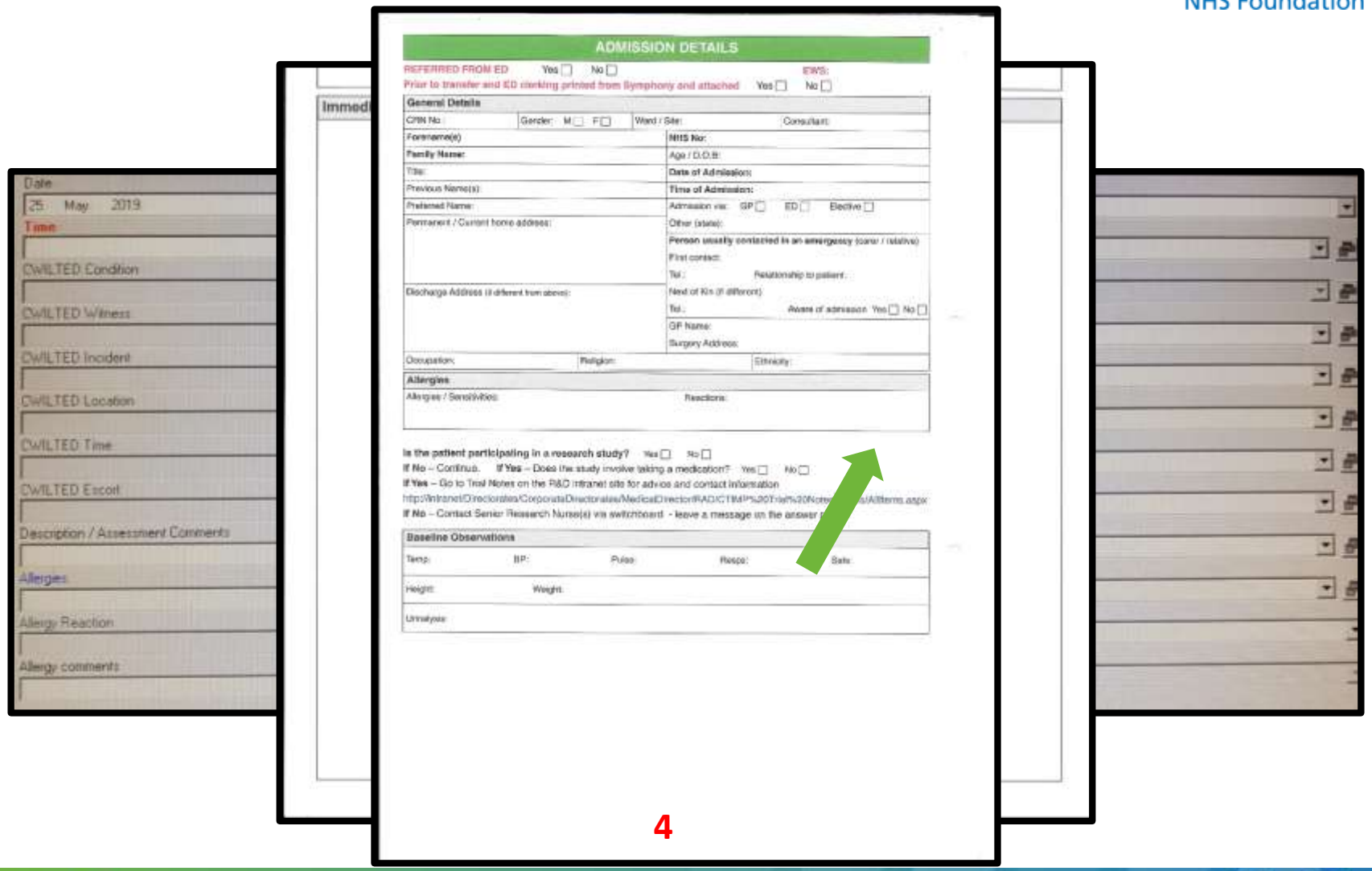

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- 71 year old man 1-12-2015:
  - Elective hemicolectomy, CPET, ward post-op.
  - Hypotensive, all medical staff busy with other patients.
  - Delay to 'simple' treatment (fluid), **died, failure to rescue.**

Day and night

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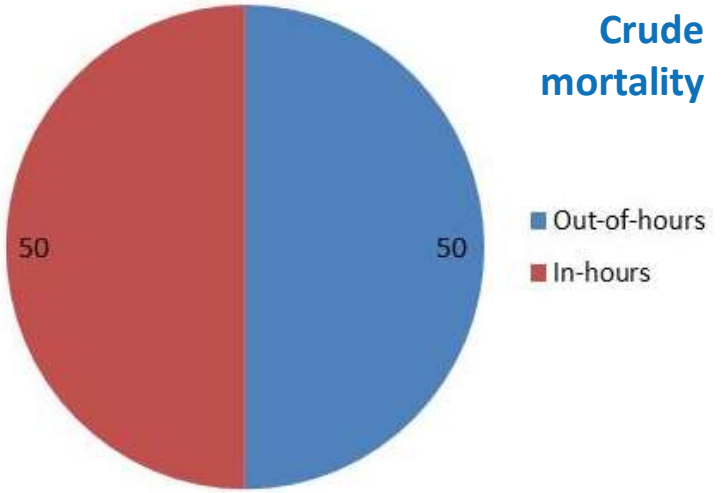
Working Day

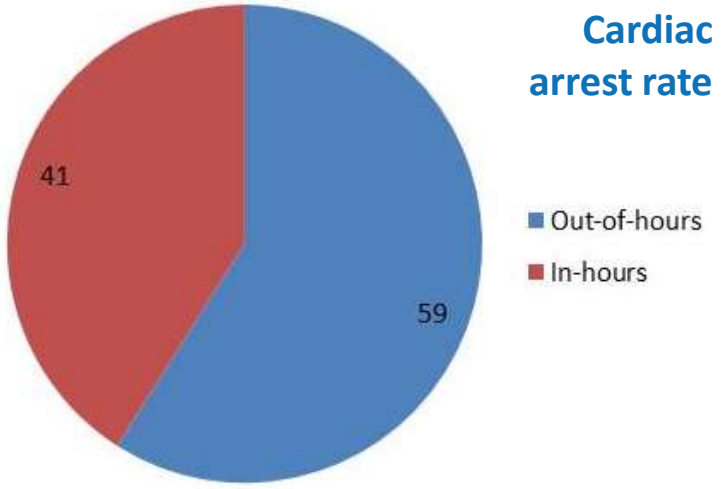
Patients.



Immediately accessible critical care and other specialist skills.

Weekends/BHs/Nights

Same patients.



Inconsistent level of specialist skills immediately accessible.

The reality of ROSC

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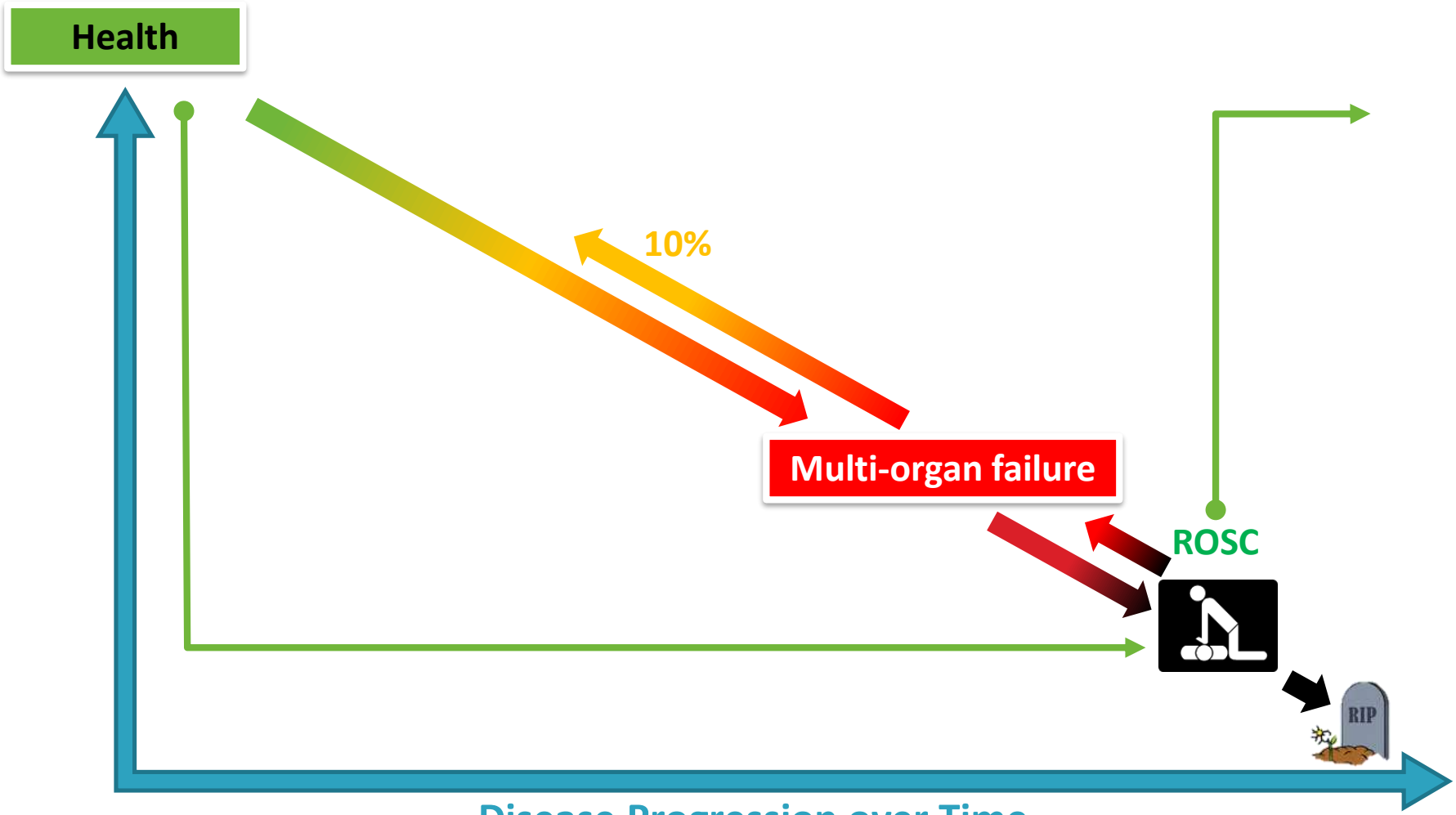

Convergence

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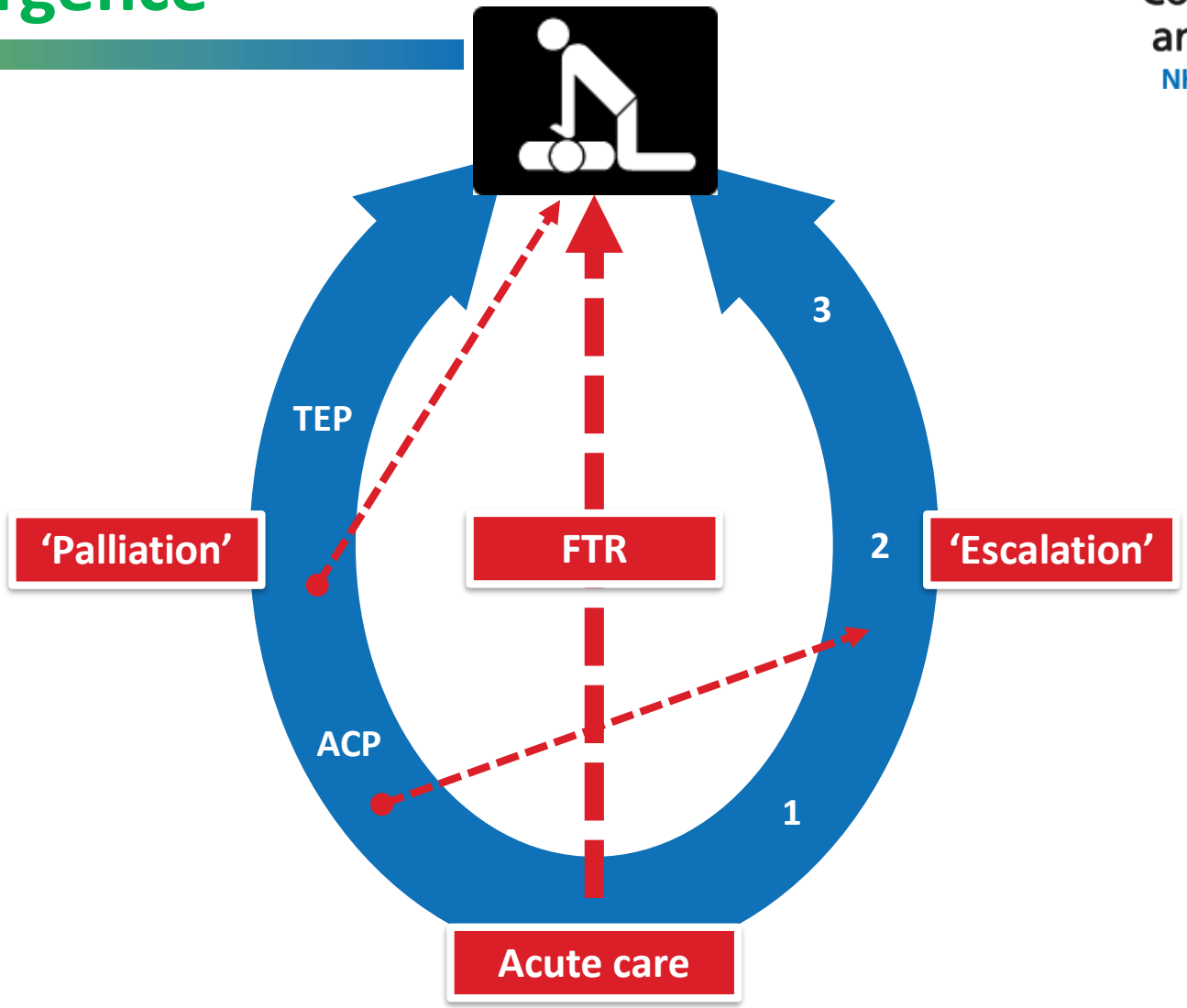

Poor decision making

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Data from 2222 MET Calls

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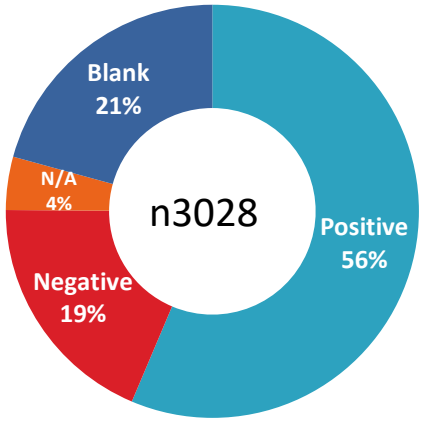
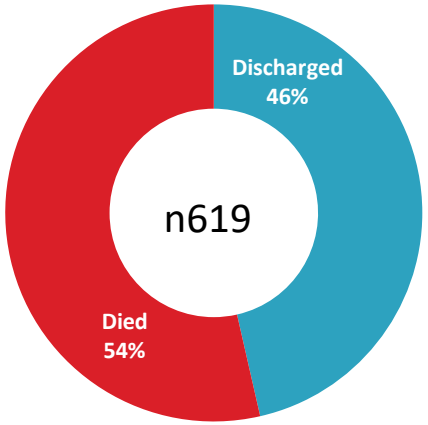
2018-19:

- 56% (n1707) of patients had unmet palliative care needs*



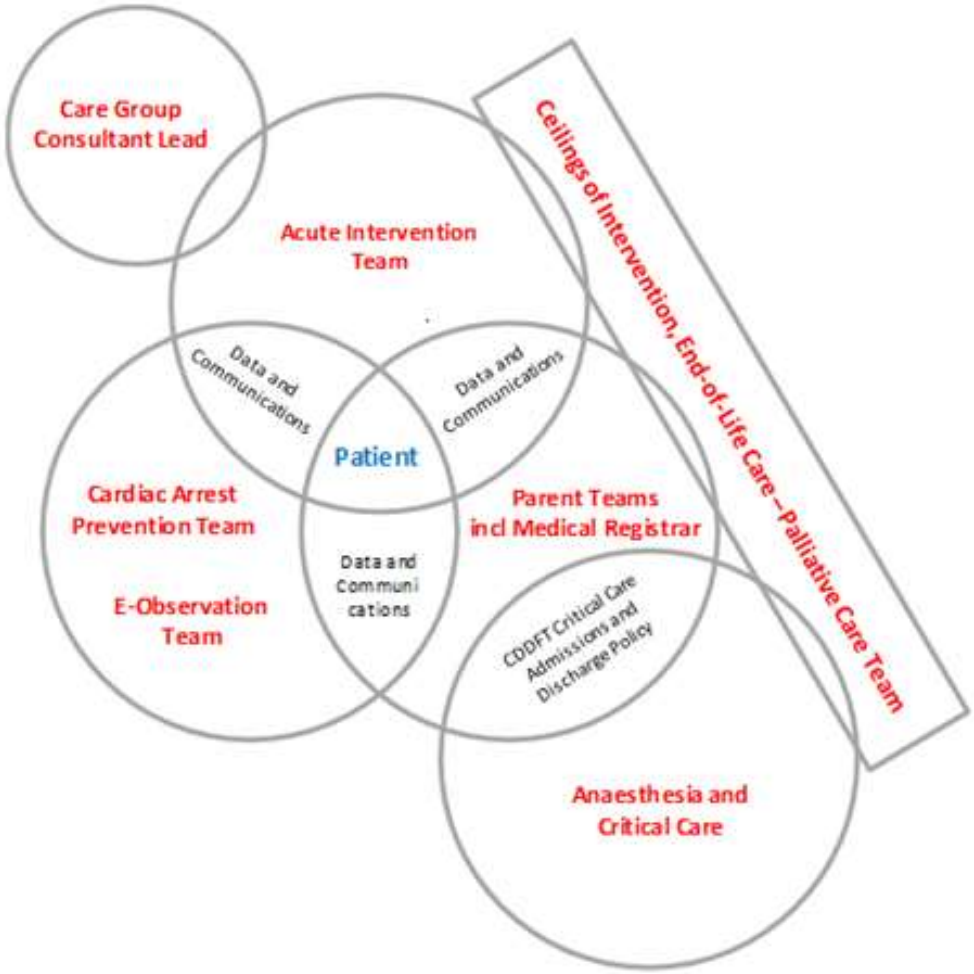
Four Months Analysis:

- 619 patients 'positive' on the tool*
- 54% (n330) died on that admission



*Supportive and Palliative Care Indicator Tool (2017) www.spict.org.uk

Our Model.....


Care Group Consultant Lead
Acute Intervention Team
Ceilings of Intervention, End-of-Life Care – Palliative Care Team
Data and Communications
Data and Communications
Patient
Cardiac Arrest Prevention Team
Parent Teams incl Medical Registrar
Data and Communi cations
E-Observation Team
CDDFT Critical Care Admissions and Discharge Policy
Anaesthesia and Critical Care

Referrals via ….

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- 2222 Medical Emergency - NEWS ≥9 or significant clinical concern
- NEWS ≥6 or single parameter score 3
- ‘Sepsis Suspected’
- Clinical Concern
- Specialist Palliative Care Team Referrals
- ITU Discharges
- Post-op Referrals
- AI Follow up list
- H@N ‘Tasks’

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Benefits of the Model

with you all the way

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Improved Decision Making

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Palliative care flow chart

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WE ARE MACMILLAN. CANCER SUPPORT

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How to access support for a patient with palliative care needs

Is there a plan for rapid discharge or a complex discharge?

Has the person got uncontrolled symptoms either physical, psychological or emotional?

Monday-Friday 9.00am-5.00pm

CONTACT IF NEEDED
Meg Blenkinsop
Macmillan Discharge Facilitator
(based at DMH)
DMH Ext. 43336
Mobile: 07342087384

OOH / Bank Holidays / Macmillan Discharge Facilitator absence

Discharge flow charts are available in the palliative care folder and via Palliative Care Intranet site scroll down to
Policies and Guidelines

Monday-Friday 9.00am-5.00pm

Palliative Care Team
Macmillan Palliative Care Nurses
DMH Ext. 43336
or
bleep 43128/43129

Contact Consultants via switchboard

OOH / Bank Holidays

For prescribing advice

Please ensure a prescriber calls Marie Curie Advice Line for support in prescribing
- They should have reviewed the patient and their current medications
- 0151 219 1000

For palliative advice and support

Call the Acute Intervention Team
- They are trained to give general palliative care advice and support to all members of staff
- They may identify that calling the Marie Curie line for advice is appropriate

Palliative and End of Life Care Guidelines
Symptom control for cancer and non-cancer patients can be accessed via Palliative care Intranet site
Please scroll down to End of Life Information

Cardiac Arrests where DNACPR would be appropriate

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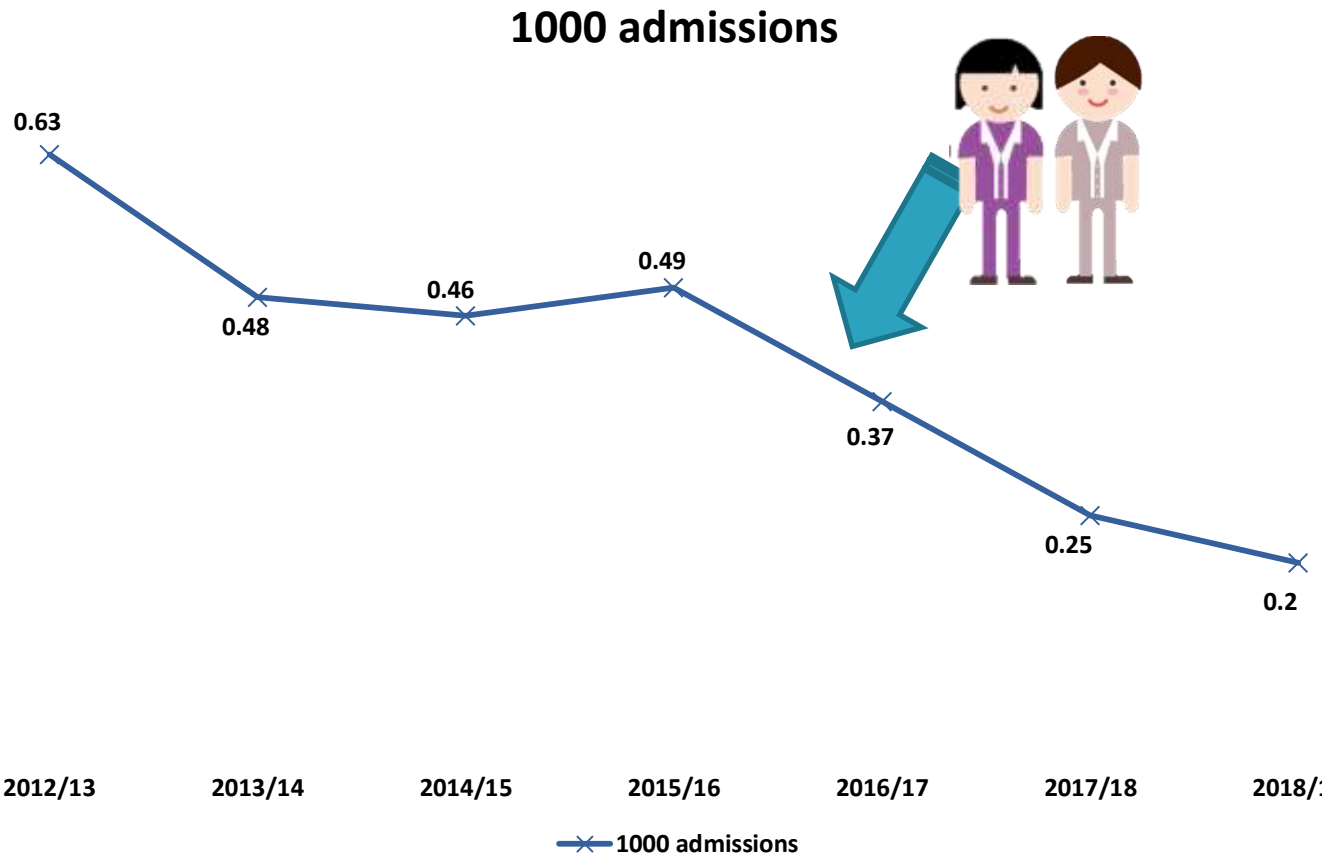

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Increased palliative care capacity at no extra cost

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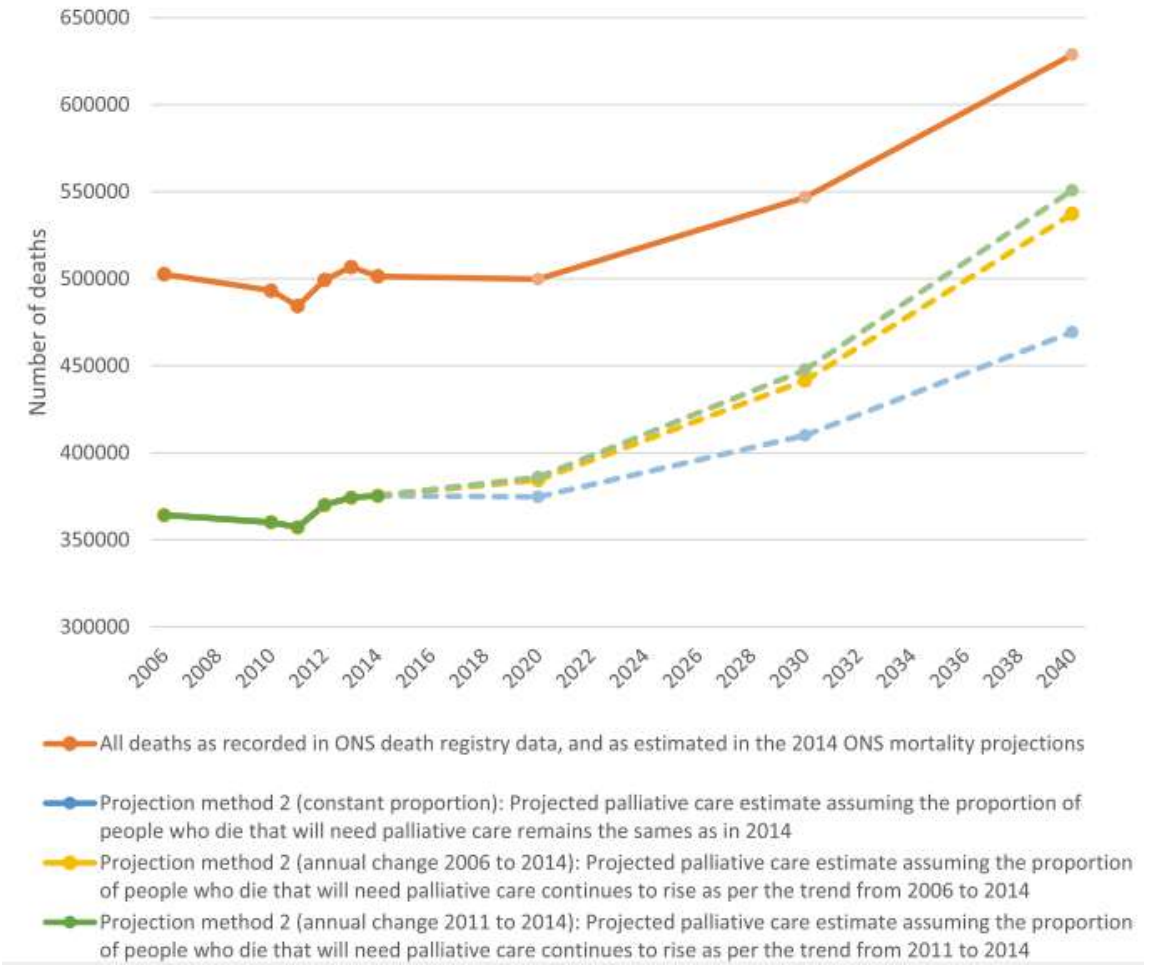
Predicted rise in palliative care needs



Etkind *et al*. BMC Medicine DOI 10.1186/s12916-017-0860-2

Increased palliative care capacity

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Before the AIT:

9-5 service

2 WTE band 7 specialist palliative care nurses

1 WTE band 6 discharge facilitator

0.6 WTE palliative care consultant

Out of hours – telephone advice only

With the AIT:

Specialist service 9-5 with telephone advice OOH

1WTE band 6 face to face, 24/7

1 WTE band 3 face to face, 24/7

Increased capacity for education for ward teams

Palliative care training

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Palliative care induction for band 6 practitioners:

- Recognising dying and potential reversibility
- Palliative care emergencies
- MCA/Best interests process
- Management of common end of life symptoms
- Opioid conversions and CSCI
- End of life care priorities and anticipatory medications

All team members shadow the palliative care team for a week

SPC consultants attend the AI team education events to provide Q&A sessions for ongoing support.

AI Review in notes

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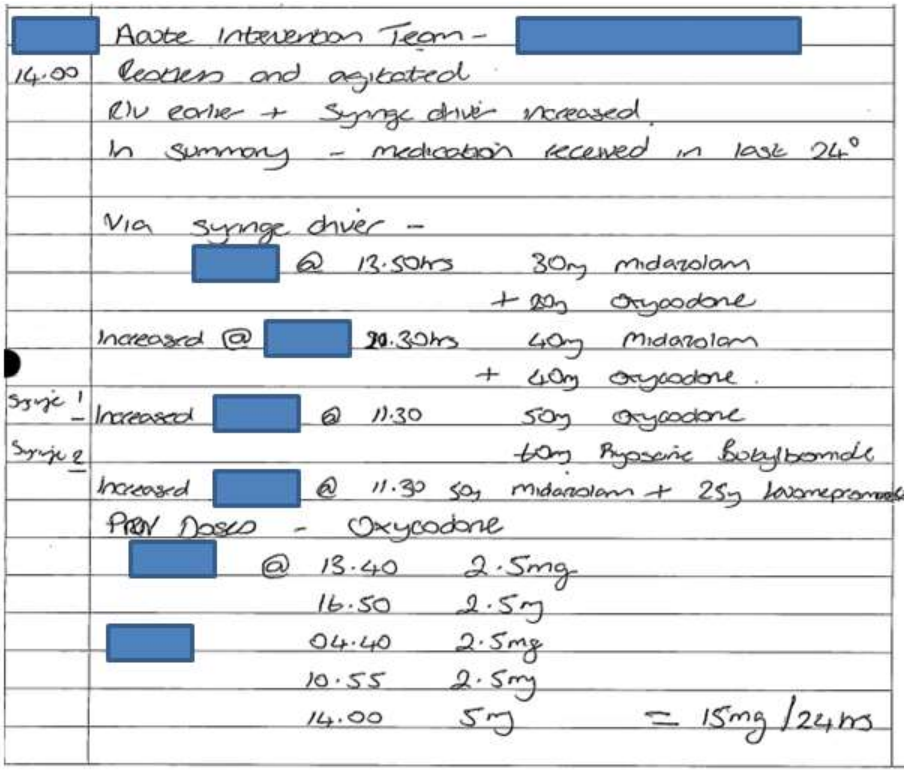


[redacted] Acute Intervention Team - [redacted]

14.00 Restless and agitated

PIV earlier + Syringe driver increased.

In summary - medication received in last 24°

Via syringe driver -

[redacted] @ 13.50hrs 30mg midazolam + 20mg Oxycodone

Increased @ [redacted] 20.30hrs 40mg Midazolam + 40mg oxycodone.

Syringe 1 - Increased [redacted] @ 11.30 50mg oxycodone + 60mg Hyoscine Butylbromide

Syringe 2

Increased [redacted] @ 11.30 50mg midazolam + 25mg levomepromazine

PRN Doses - Oxycodone

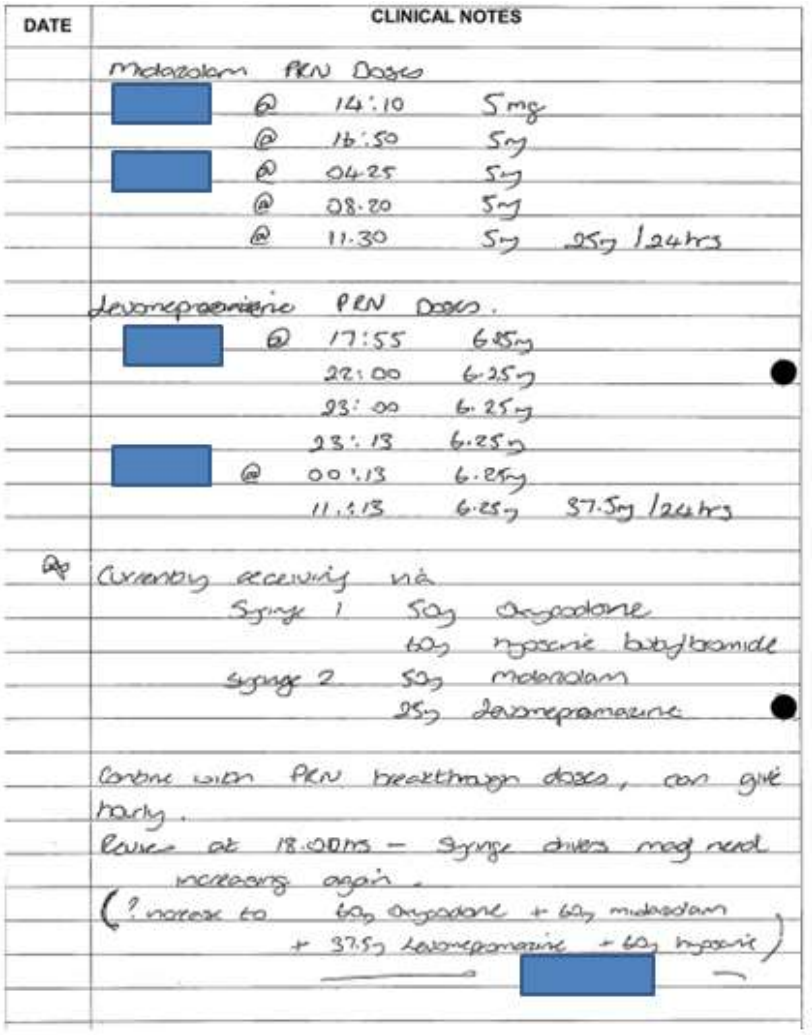
[redacted] @ 13.40 2.5mg

16.50 2.5mg

[redacted] 04.40 2.5mg

10.55 2.5mg

14.00 5mg = 15mg /24hrs



DATE | CLINICAL NOTES

Midazolam PRN Doses

[redacted] @ 14:10 5mg

@ 16:50 5mg

[redacted] @ 04:25 5mg

@ 08:20 5mg

@ 11:30 5mg 25mg /24hrs

Levomepromazine PRN Doses.

[redacted] @ 17:55 6.25mg

22:00 6.25mg

23:00 6.25mg

23:13 6.25mg

[redacted] @ 00:13 6.25mg

11:13 6.25mg 37.5mg /24hrs

Currently receiving via

Syringe 1 50mg Oxycodone

60mg Hyoscine Butylbromide

Syringe 2 50mg Midazolam

25mg Levomepromazine

Continue with PRN breakthrough doses, can give hourly.

Review at 18.00hrs - Syringe drivers may need increasing again.

(? increase to 60mg Oxycodone + 60mg midazolam + 37.5mg Levomepromazine + 60mg Hyoscine)

[redacted]

Palliative care input reduces costs

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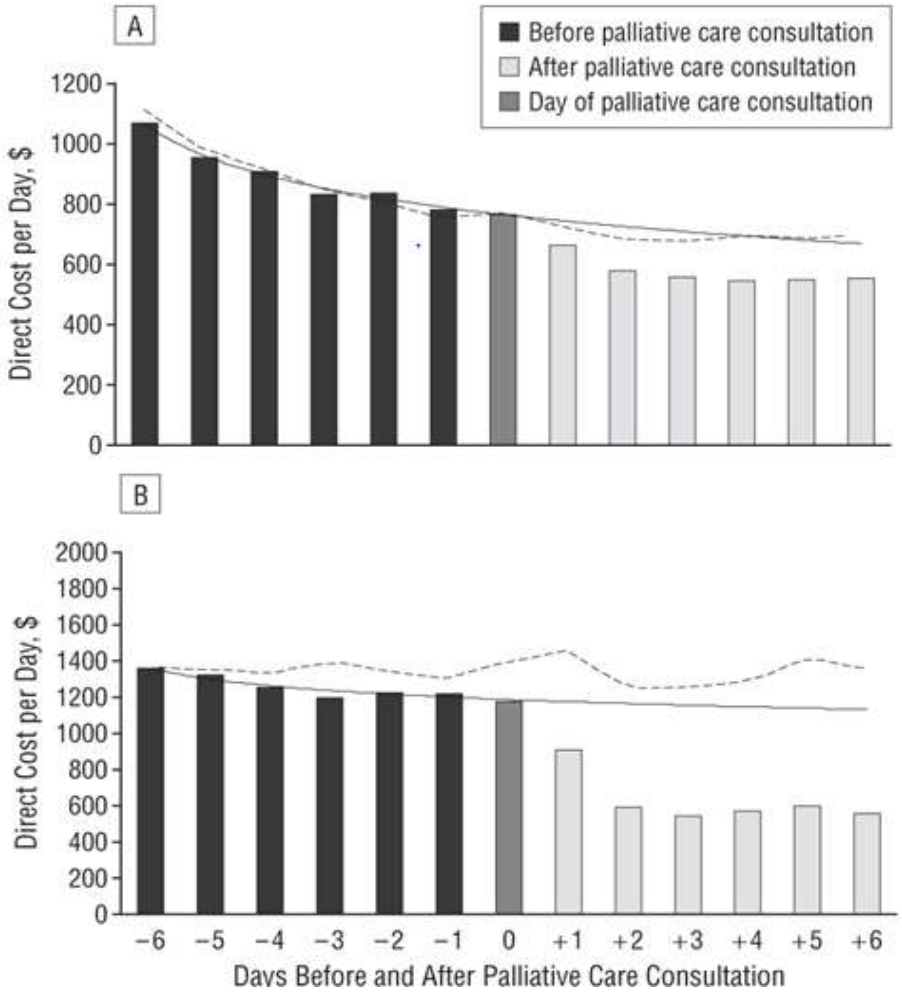
Discharges

Deaths



Morrison *et al, Arch Intern Med.* 2008;168(16):1783-1790. doi:10.1001/archinte.168.16.1783

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Our model improves the quality of patient care

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Thank You for Listening

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From: Grateful Relative
Sent:
To: Patient Experience
Subject: Compliments and gratitude for some extraordinary members of your team

Hello
I'm writing this email sitting by the bedside of my relative, the difficult decision has been taken to help them be comfortable as they reach the end of her life but not to prolong their treatment.....

.....In this last visit, however, my relative and all of us received a level of care and support from two individuals in particular that I wanted to write to you about. AI Nurse Practitioner and a Ward Nurse.....

'..... I can't thank you enough, without the team I think my mam would have been one of those people who has a cardiac arrest but shouldn't as they were dying.....'

'..... I just wanted to say thank you for everything you did last week to get my Gran home, you gave us some very precious time with her that we are all so grateful for.....'