PALLIATIVE CARE SERVICES PROVIDED BY THE BOARD OF HEALTH

What is Palliative Care?

In 1990 the World Health Organisation defined palliative care as:

"The active total care of patients whose disease is not responsive to curative treatment. Control of pain and other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and families. Many aspects of palliative care are also applicable earlier in the course of illness in conjunction with anticancer treatment."

How are Palliative Care Services delivered by the Board of Health?

This report will highlight two areas of service provided by the Board of Health, that of the Clinical Nurse Specialists Palliative Care and the service provided by the District Nursing Service.

It is acknowledged that there are other nurses who come into contact with the terminally ill in the hospital setting, here support is often provided by the Clinical Nurse Specialists Palliative Care.

CLINICAL NURSE SPECIALISTS PALLIATIVE CARE SERVICE

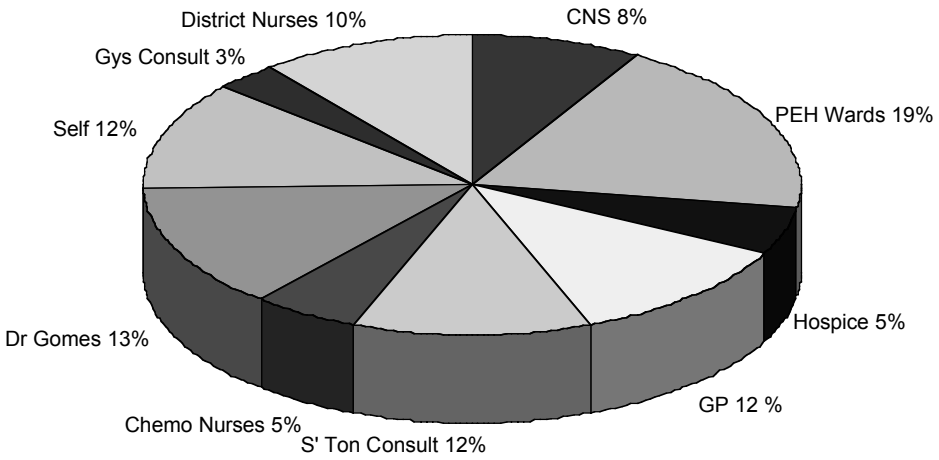
There are three clinical nurse specialist posts in Palliative Care. They are based in the Oncology Unit at Bulstrode House. The nurses have undergone specialist palliative care training and they promote the palliative care approach by:-

- Visiting patients in all settings, community, hospital and nursing homes.
- Working closely with other professionals, such as doctors both in Guernsey and the visiting consultants from Southampton, nurses in all settings and other clinical nurse specialists, Physiotherapists, Occupational Therapists, social workers and dieticians.
- Liasing with Les Bourgs Hospice.
- Utilising the resources of the many voluntary organisations, such as the Guernsey Society for Cancer Relief and the Red Cross.
- Acting as a consultant to other health professionals in the Bailiwick both in the public and private sectors.
- Developing policies about matters relating to Palliative Care.
- Running a rolling education programme for nurses
- Operating a "link nurse scheme" whereby a representative is invited from every ward, which cares for adult patients with palliative care needs to attend a monthly meeting, when there is a talk and discussion about palliative care issues.
- Patients now receive lymphoedema treatment in the community after negotiations took place between the Primary Care staff that provide this service and the Guernsey Society for Cancer Relief who fund the treatment of patients who do not have health insurance.

- The palliative care team is in the process of creating electronic notes, which would improve the communication with all health professionals within the board of health and in other settings, such as Primary Care.
- It is planned that work will begin on an Integrated Care Pathway for the Dying and Clinical Guidelines in the near future.

Which patients receive care from the Clinical Nurse Specialists?

An analysis of the service was undertaken, based on data collected between the 1st July 2001 and October 18th 2001. The figures are still relevant today.



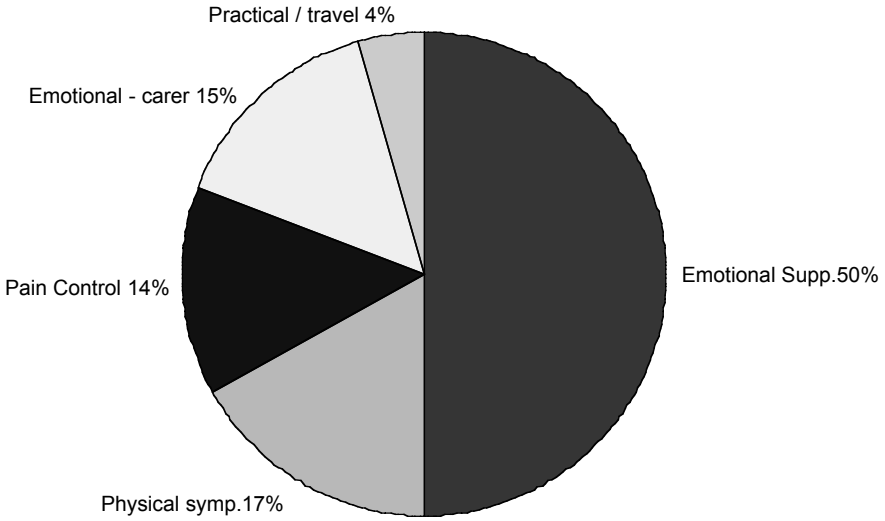
(n= 95)

Figure 1. Source of referral of patients on Palliative Care Caseload 1st July 2001 to 18th October 2001.

47% of patients on the Palliative Nurses caseload are referred by nursing staff working in the Princess Elizabeth Hospital, the Community and other clinical nurse specialists.

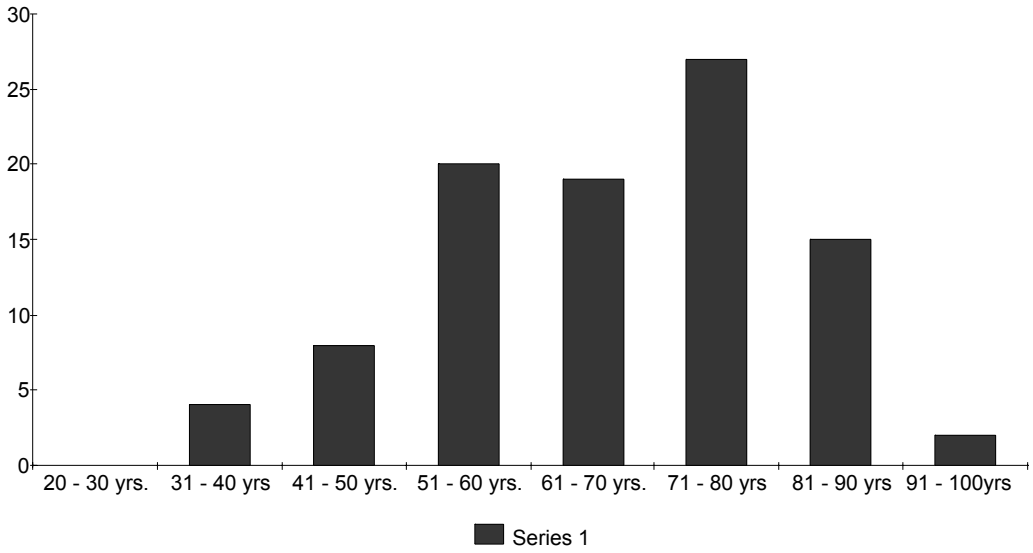
22% of the referrals to the palliative care service came from multidisciplinary services, General Practitioners and Community Nurses working in the Community.

Interestingly 12% of patients referred themselves. In an unpublished research paper into the role of Macmillan nurses in the United Kingdom (Skilbeck et al 2001 p. 11) found that 3% of referrals were self referrals or referrals from a relative.



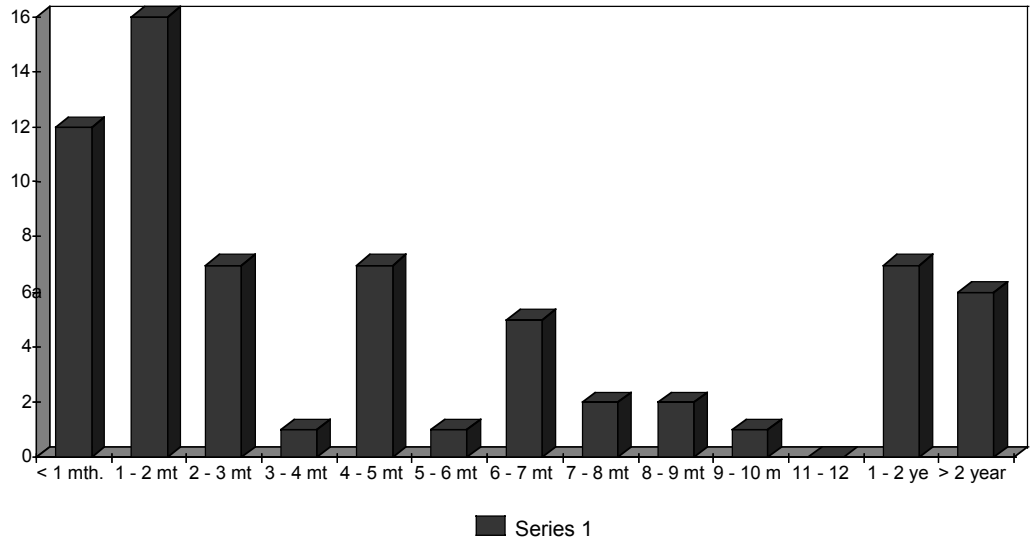
(n = 95)
Figure 2 Reason for referral to palliative care services 1st July 2001 to 18th October 2001.

The reasons for referral can be seen in Figure 2, 65% of referrals were for the emotional support of the patient and/or carer. This reflects the pattern of referrals in the United Kingdom, which has been found by the unpublished research paper mentioned in the previous paragraph (Skilbeck et al 2001).



(n = 95)
Figure 3 Age of patients seen by Palliative Care Nurses 1st July 2001 to 18th October 2001.

Authors such as Addington-Hall et al (2000) point out that people over 74 years of age are much less likely to receive palliative care in the community than younger people, they consider this to be unfair. Figure 3 shows that this is not the case with the Guernsey Palliative Care Service, admission is based on need rather than age criteria.



(n = 67).

Figure 4 Shows the length of time that patients have been on the Palliative Service caseload on 18th October 2001.

Once on the caseload patients tend to remain on it for an average of 3 months (Figure 4). This pattern is the same as the West Midlands Region (National Council for Hospice and Specialist Palliative Care Services 1999).

Most of the patients on the Palliative Care caseload have a malignancy, only 2% had a non-malignant disease in the period being considered in this report (1st July 2001 to 18th October 2001), although this figure does fluctuate. The level of non-malignant patients is slightly lower than the findings of the unpublished research conducted by Skilbeck et al (2001), where 4% of the caseload had a non-malignant disease.

(n = 95)

The Palliative Care services supports patients and their informal and professional carers during the terminal phase of their illnesses, in the community, in the hospital and in nursing homes. Figure 5 shows that during the period studied (1st July 2001 to 18th October 2001) 35% of people died at home, this figure fluctuates but is usually about 35-45%.

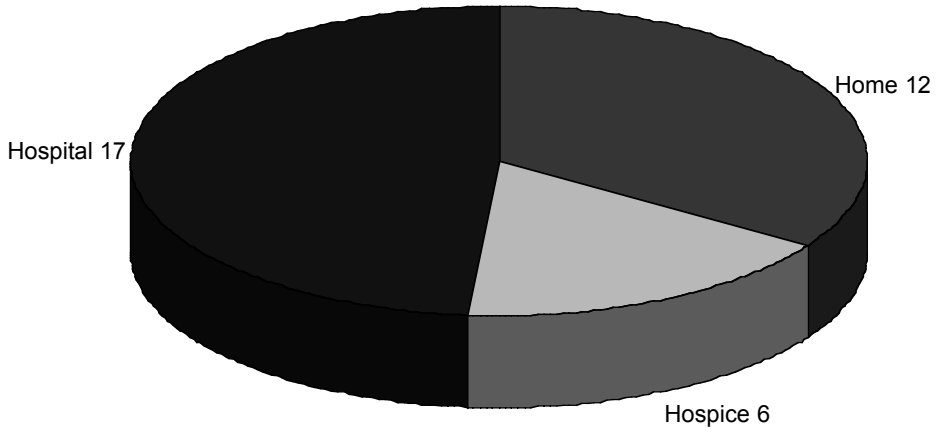


Figure 5 Place of death 1st July 2001 to 18th October 2001

The palliative care team will continue to promote specialist palliative care services and the palliative care approach for all those with a life threatening illness. It is anticipated that models of care that meet the needs of patients with a non-malignant disease will be further developed.

Palliative Care Service – Statistics

Year	**1999**	**2000**	**2001**	**2002**
Total new patients	141	326	172	193
Total visits	2660	2329	2591	2168
Total telephone conversations	4307	4154	4342	1577 (Consultations only)

- The number of patient's on the caseload each month varies between 120 and 60.
- The higher number of patients visited in 2000 may be explained by this transition.
- The lower number of visits in 2002 is due to a reduction in staff to two. So that weekend cover was not possible.

- On average 96% of the caseload have a malignancy. This is similar to other teams working in the UK; the figures for 1999-2000 suggest that 95% of palliative care services are delivered to cancer patients (Hospice Information Service 2002).
- Other activities undertaken by the Palliative Care Team can be seen in Appendix One, which is the report undertaken in 2001 that is highlighted above.

THE DISTRICT NURSING SERVICE

The District Nursing Service delivers individualised nursing care to patients and support to carers in the home environment. There are six District Nursing Teams (see figure 7), who are surgery attached and carry a mixed dependency caseload of patients Island-wide. The structure and skill mix of each team has a qualified District Nurse Manager, as caseload holder, who is supported by an "F" Grade Staff Nurse, D/E Grade Staff Nurses, Enrolled Nurses and Nursing Auxiliaries/Healthcare Assistants. An evening and night service continue this care through evening and nighttime hours.

During 2003 the District Nursing Service as a whole cared for the following numbers of chronically ill and palliative care patients in the terminal stages of their illness (see figure 6). Their aim was to facilitate patients' wishes to remain at home to die.

The types of symptoms patients had were:-

Pain, nausea, vomiting, agitation, confusion, anxiety, depression, reduced mobility and independence, falls, deficit in skin integrity due to traumatic injury, pressure sores, post surgical wounds, leg ulcers, Ascites, changes in bladder and bowel habit, retention of urine, incontinence of bladder and bowel, breathing difficulties reduced conscious level, difficulties with swallowing, care of the comatose patient.

The treatments patients received were:-

Holistic assessment of nursing and social care needs of patient and carers, administration of drug therapy, particularly analgesia, antiemetic therapy, anxiolytic therapy, oxygen therapy, bowel intervention; aperients, suppositories, enemas colostomy care, personal hygiene care, pressure area care including pressure relieving devices, risk assessment of moving and handling needs and use of appropriate equipment.

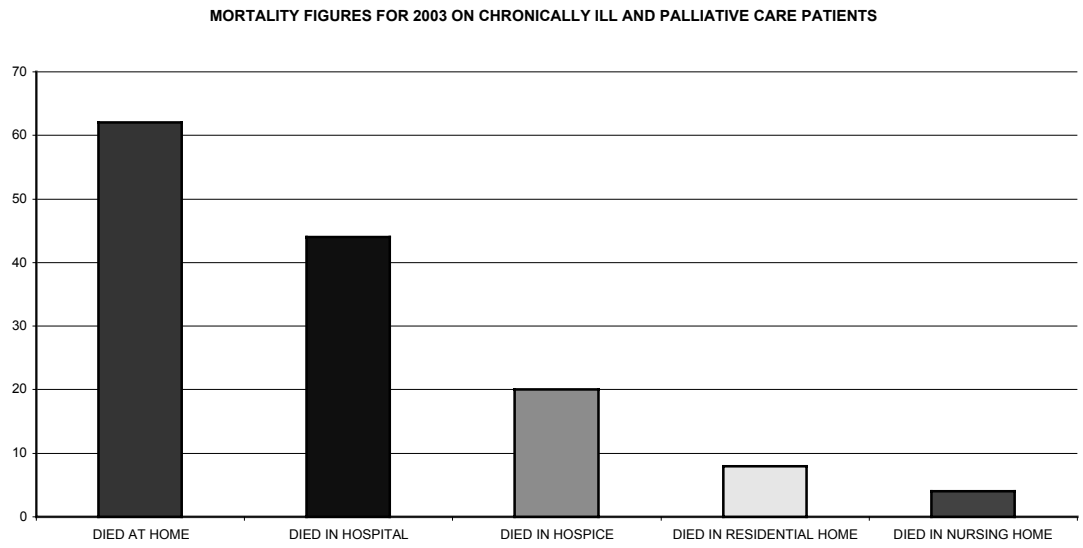


Figure 6

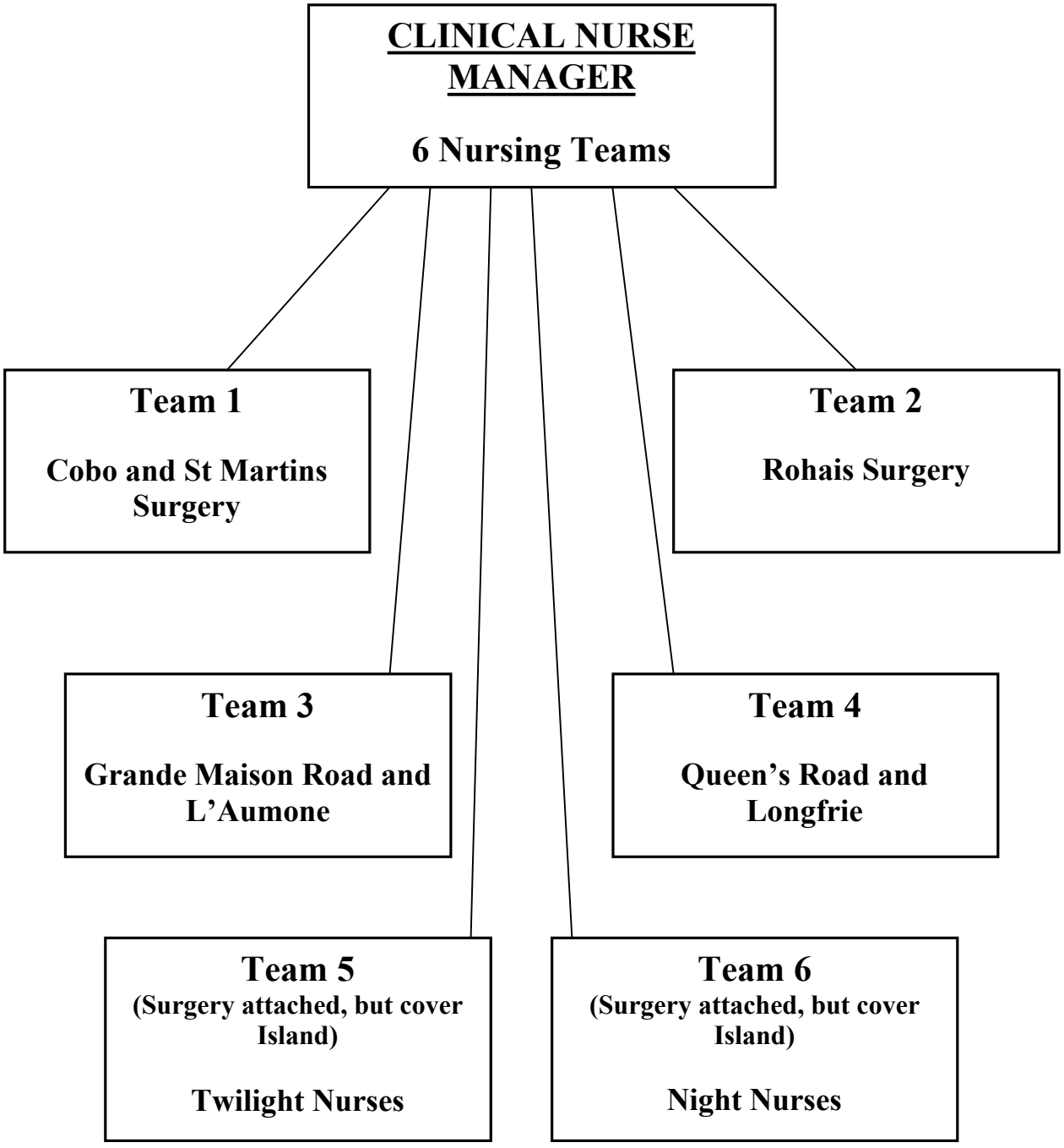
Mortality figures for 2003 on chronically ill and palliative care patients:-

Total 138

Died at home	62
Died in hospital	44
Died in the Hospice	20
Died in Residential Home	8
Died in Nursing Home	4

(Figure 7)

STRUCTURE OF DISTRICT NURSING SERVICE



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