Staying in touch

Working in partnership with our clinical colleagues

st michael’s hospice
INTRODUCTION
FROM THE
MEDICAL DIRECTOR

Dr Mursheda Chowdhury

Welcome to our 1st Clinical Bulletin of 2016. I can say that we are well and truly settled in our temporary home at Hastings Court Care Home, albeit with much fewer beds than we are used to at Upper Maze Hill. Thankfully, we hope to be back in September in our old home where we’ll be much better equipped after refurbishment for the needs of our patients. We will let you know of upcoming Open Days nearer the time, so that you can have a look for yourselves.

There have been many changes not just in our service but within teams at ESHT, including Community Macmillan Nurses, GP Practices and SECAMB. The good thing to come out of all this change is the opportunity for even closer links with all services which are so interlinked in caring for people with terminal illnesses. We have advertised for a Consultant in Palliative Medicine with a community focus to further strengthen these links. I will keep you informed regarding any developments.

As part of the implementation of the Vulnerable Patients LCS currently being rolled out in General Practice, both St Michael’s Hospice and St Wilfrid’s Hospice have been invited to participate in Educational Events for GPs in both CCG areas (Eastbourne, Hailsham, Seaford and Hastings and Rother). Please keep a lookout for these events.

Hastings and Rother GPs are welcome to attend events at both Hospices.

In this Bulletin we have articles from;

• Beckie Akroyd, Doctor
• Alicia Hattersley, Senior Physiotherapist
• Felicity Barnett, Community Services Manager
• Geoffrey Cook, Spiritual Care Lead
• Paul McQuillan, Voluntary Services Administrator
• Jenny Wratten, Matron
• Sophie Stuchbury, Practice Educator
• Jay Godding, Day Services Manager
• Aideen O’Hagan, Bereavement Services Manager

Appended to this Bulletin is a copy of our referral criteria for IPU admissions (also available on our website), which may be useful for those of you who are new to this area.

We are hoping to offer our clinical colleagues the chance to visit and take a guided tour of our newly refurbished Hospice during August 2016.

If you are interested in the Open Days, please email us (marketing@stmichaelshospice.com) and we will contact you nearer the time with details.

Guided visits of the newly refurbished Hospice will take place before we move in-patients back into the building and during the period when the Hospice is being fitted out. We expect to move our services into the Hospice in early autumn.

This is a chance for us to thank our supporters and to showcase some of the new patient rooms and clinical areas, the chapel and our stunning gardens.
Management of Massive Haemorrhage in the Community

Case: 80 y.o. gentleman with a squamous cell carcinoma of the roof of his mouth.

Presented to Hospice with large bleed from his mouth (having had a smaller ‘sentinel’ bleed a month previously) initially treated with gauze soaked with 1:1000 adrenaline directly applied to the bleeding site. Once the bleed had stopped treated with tranexamic acid orally – 1g TDS. When swallowing tablets became more difficult, 1g tranexamic acid injection 100mg/ml, 5ml ampoules) stirred into 30ml warm water was used as a mouthwash (could be safely swallowed). No further bleeding occurred.

Bleeding occurs in about 20% of patients with advanced cancer. It contributes significantly to the patient’s death in about 5% of cases. Massive haemorrhage, and/or terminal haemorrhages, whilst uncommon, can be extremely distressing, particularly for witnesses, and especially if they are unprepared for the event. This article aims to cover the community management of massive haemorrhage, both in seeking to prevent its occurrence and actions that can be taken if it occurs.

Preventing massive haemorrhage: In more minor bleeds it may be appropriate to further investigate the cause, as these may be “sentinel” bleeds, and there may be scope for interventions to reduce the risk of further bleeds. Of course, bleeds can be unrelated to the patient’s cancer – for example, gastric erosions or ulcers, and whilst the underlying diagnoses need to be taken into account, it may be that hospitalisation for investigation and possible treatment of these bleeds may be appropriate.

Superficial or wound bleeds (for example, from fungating tumours): gauze soaked in adrenaline 1:1000, sucralfate liquid (as of January 2016, there is a supply shortage of this, but latest press releases are hopeful that this will be resolved in 2016), gauze soaked in 100mg/ml tranexamic acid injection solution or application of kaltostat can be used over bleeding points in wounds to help stem minor bleeds, and dressings should be those that can be left for a few days to avoid frequent disturbances of the wound bed. Care and gentleness should be taken for dressing changes – irrigating dressings to help remove them may also preserve the wound bed. Referral to an oncologist for palliative radiotherapy can also be considered as sometimes this can help ‘dry’ the wound and reduce bleeding risk.

Non-superficial bleeding - the role of tranexamic acid: Tranexamic acid reduces bleeding by inhibiting fibrinolysis and can be an extremely valuable tool (often used “off-licence”) in preventing minor bleeds becoming massive haemorrhages. The tablets can be taken orally for systemic effect, the injection can be mixed with water to make a liquid formulation (each dose of one to two 5ml vials of 100mg/ml injection is mixed with 15-30mls of water and has to be prepared individually and used immediately as it is not stable for long periods of time, so is demanding for patients or their carers); the tablets can be used as pessaries or crushed in aqueous jelly for local action on vaginal bleeds; the injection can be mixed with 50ml warm water and given as an enema for rectal bleeds; gauze can be soaked in the injection and applied topically to bleeding wounds, and, as mentioned above, the solution can be mixed with warm water to create a mouthwash. The biggest concern raised about tranexamic acid is its potential thrombosis risk, particularly in the oncology population, with their already increased thrombosis risk. There is limited evidence that the effect on thrombosis risk is minimal – this evidence is drawn from trials such as CRASH-2 (looking at the effect of tranexamic acid in trauma patients and showed no thrombotic risk in that population, and a reduced rate of arterial thrombi), trials in hip and knee surgery also showed no increase in thromboembolic risk. However there are no currently available trials looking only at oncology patients. Physiologically and pharmacologically, theoretically a reduction in fibrinolysis could allow a clot to extend,
and this risk will need to be balanced and communicated to the patient and their carers, particularly as the medication is generally being used off-licence. Tranexamic acid should not, generally, be used for urinary tract bleeding as it may cause clots to form in the bladder, leading to retention. For relatively minor bleeds (such as small bouts of haemoptysis), with normal renal function, a dose of 500mg TDS is often sufficient to control this, but the dose can be increased up to 1g TDS (doses of greater than 4g daily are associated with seizures, and the manufacturer indicates that tranexamic acid is contraindicated where there is a history of seizures) if the patient remains symptomatic. Doses should be reduced in renal impairment.

Massive (potentially terminal) haemorrhage: Some haemorrhages, such as those from erosion of a cancer into a major vessel, may be rapidly terminal – in these cases, anticipation of such an event is paramount to ensure carers are prepared for what can be a very frightening event. A balance will need to be struck between preparing the patient and their carers for a potential massive haemorrhage, and the fear this may cause. Most haemorrhages are frightening, but not generally painful. In rapidly terminal haemorrhages, a dark towel or blanket placed over the bleeding site with light pressure applied can reduce the visual impact of the bleed – preparing carers ensures such items are obtained and stored safely, but there is unlikely to be time for any other action that holding the patient’s hand and providing the comfort of a human presence. Witnesses of such a bleed are likely to need a great deal of support after such an event (St Michael’s Hospice can offer bereavement support in these cases and refer on to other services if required). In cases of massive haemorrhage where the bleed is major but not immediately fatal (such as rectal bleeds, haematemesis, large wound or vaginal bleeds) the aim will be a combination of local control if possible, and sedation of the patient who is likely to be shocked and frightened. The aim of sedation is to provide symptom control, but not to hasten the end. The haemorrhage may prove fatal, but not as quickly as an arterial bleed and medications may be required to ensure the patient’s comfort. It is worth in these cases, having in the JIC box, a dose of 10mg midazolam, with an appropriate prescription or order to give, for single IM injection (the IM route is faster and more reliable in situations of extreme blood loss) so that if a healthcare professional is present or has been called, rapid sedation can be achieved. An alternative may be buccal midazolam (also 10mg as a stat dose) or rectal diazepam (4mg/ml, 2.5ml (10mg) tubes) – these have the advantage that a carer may be able to give these, although they are likely to need training first. Simple measures, such as adrenaline (1:1000) soaked gauze and dark blankets or towels, will also be appropriate here.

References:
4. Bereavement support is available to anyone in the Hastings and Rother area, and people do not need to have had any previous contact with the Hospice. The referral form for Bereavement Services can be found here: www.stmichaelshospice.org/documents/9/Bereavement-Referral-Form or for more information please email bereavement@stmichaelshospice.com or call 01424 456361.

Dr Beckie Akroyd
Doctor
Making St Michael’s Hospice fit for the future

Last July, we awoke to news of a dreadful fire at St Michael’s Hospice – an unthinkable thing to happen in such a place of sanctuary and care. Following the devastating fire, we are now rebuilding and refurbishing our In-Patient Unit to make it fit for the future.

Construction started in January this year and work is due to be completed in July 2016. As Elaine McDonough, Head of Clinical Services states:

"Now we are several months down the line, we can start to look positively to the future. We have taken the opportunity not only to repair the areas damaged by fire but also to carry out some much longed for alterations to our beloved Hospice building. These works include the relocation of all in-patient rooms onto the ground and first floors and, creating dedicated and private areas for patients and their families. The installation of a large fire-safe lift will make it far easier for patients to spend time in our beautiful gardens, our improved coffee shop and the newly created therapy rooms. Whilst we have always provided a warm and welcoming environment, we cannot help but feel these improvements will greatly enhance the facilities that we provide.

Whilst the Hospice’s insurance will cover the cost of repairing the fire damage (approx £1 million), we need to provide the funds to pay for the additional works being carried out. We have been very fortunate in recent years and have built up our level of reserves, which every charity is required to maintain, allowing us to contribute £2 million towards this project. To raise the remaining £1 million we launched the Phoenix Appeal.

We will be converting the two communal wards on the ground floor that were destroyed by the fire into eight single bedrooms with ensuite facilities and direct garden access, enabling all our patients to benefit from the advantages of having their own personal space and facilities. All of our other patient bedrooms and ensuites will be refurbished, supporting our commitment that all patients are as comfortable as possible during their time at the Hospice. We have chosen a soothing colour palette for the

A computer generated image of a planned in-patient room"
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A number of fire safety precautions will also be installed in the building. These include the installation of a sprinkler system (this was previously due to be installed in September 2015) to provide immediate and isolated fire suppression. Additionally a new fire-safe lift (the first of its kind in Hastings and Rother) will be installed at the front of the building to support the swift and safe evacuation of the Hospice. The lift will also provide day-to-day assistance with patient transportation and accessibility by offering improved movement throughout the building, including direct access to the gardens as well as providing greater out-of-hours security for our patients, staff and volunteers.”

Visit our website for further details on the rebuild [www.stmichaelshospice.com](http://www.stmichaelshospice.com)

*All computer generated images are subject to change*
Physiotherapy at St Michael’s Hospice

I have been a qualified physiotherapist for 6 years now; I worked for East Sussex Healthcare Trust for three years completing my basic physiotherapy rotations, before moving to St Wilfrid’s Hospice in Eastbourne for the three years prior to moving to St Michael’s Hospice.

I am currently providing physiotherapy services both on the In-Patient Unit and to Day Services. This involves working with people to achieve the goals that are most important to them. I passionately believe that hospices and palliative care benefit from having allied health professionals as part of the multi-disciplinary team. Current research is telling us that people prioritise quality of life and independence at end of life and physiotherapists are trained to help people achieve this. It can be as simple as someone wanting to be able to get out of bed onto a commode rather than using a bedpan, or something more complex, for example helping a gentleman to become mobile enough to dance with his daughter at her wedding. Managing breathlessness and fatigue is also a large part of my clinical work.

At the present time being the only Allied Health professional at the Hospice; I am splitting my time between the In-Patient Unit at Hastings Court where I am spending my mornings (Monday – Friday) and Day Services where I am in the afternoons. I have established a simple chair based exercise class for the Tuesday Day Services group but am looking forward to being able to run this more effectively when the gym opens. I have a dedicated one hour slot each day where I can see the people we support in Day Services and have provided advice, exercise programs and completed appropriate onward referrals.

Alicia Hattersley, Senior Physiotherapist

Rapid Discharge

Last year a business case was submitted to the Hastings and Rother CCG to develop our Hospice at Home service to include a rapid response element. In July 2015 the Hastings and Rother CCG announced that additional funding had been secured to develop a rapid response element.

"According to data from the National Audit Office, up to 74% of people say they would prefer to die at home, but currently 58% die in hospital. By launching the Rapid Response service, we hope more people across Hastings and Rother can die in their preferred place of care." Felicity Barnett, Community Services Manager.
We have now launched a Rapid Discharge element to the Hospice at Home service.

**Aims of the Rapid Discharge element of Hospice at Home**
- Increase the number of patients who die in their preferred place of care/death
- Increase the Hospice at Home team’s ability to respond more effectively
- Operate seven days a week from 8am - 6pm from A&E, MAU, AAU and SAU.

**What is provided**
- Rapid assessment and regular review by a Registered Nurse
- Assessment by Community Specialist Palliative Care Doctor if required
- Skilled Health Care Assistants to provide hand on nursing care until other care providers can be sourced - CHC fast track package of care
- Health Care Assistant to provide night sits (dependant on availability).

**Who can refer**
Referrals can be made by any Health Care Professional involved in the patient’s care.

**How to refer**
Referrals can be made by calling the Rapid Discharge mobile phone number (07909 441162) which is held by either the Hospice at Home Team Leader, Community Services Manager during office hours or the Registered Nurse on duty until 8pm. If the patient is accepted (in to Rapid Discharge), a completed Specialist Palliative Care Referral Form will need to be emailed to the Rapid Discharge team. However delay in the receipt of this referral form should not be a barrier to the patient receiving the service.

**Response Times**

**Initial response** - Initial response will be within 30 minutes of receipt of referral.

**First contact with patient** - First contact with the patient will be made within 60 minutes of receipt of referral.

Assessment of urgency will be carried out and agreed between the referrer and the service assessor.

**Referral criteria**
- The patient is over 18 years old
- The patient has a progressive, life-limiting illness
- The patient is deemed to be in the last few days or short weeks of life (recorded in the patient’s notes)
- The patient is requiring JIC stat medication or has a syringe driver in place
- The patient’s preferred place of death/care is at home
- The patient consents to rapid discharge and agrees to service input
- The patient’s family agrees and supports rapid discharge plans
- The patient is registered with a GP within Hastings and Rother.

The service has started gradually, initially focusing on rapid discharge for end of life patients from the Conquest Hospital from the gateway areas; A&E, MAU, AAU and SAU, once the referral has been accepted the Hospice at Home Team will:

- Meet the patient in the acute setting prior to discharge, check that JIC medication, Community Prescription chart, DNAR and Syringe Driver is all insitu and correct.
- Potentially if required the HCA can accompany the patient home or meet at the house
- Potential for a night sit to be provided
- Provide support for patients being discharged to rest homes and/or nursing homes.

**Discharge criteria:**
- Rapid Discharge have delivered care for 72 hours
- Transfer to normal Hospice at Home service and community services
- Patient dies
- Patient no longer requires the service, their condition stabilises and care will be provided by CHC package of care.

**Contact us on 07909 441162 for more details**
There are many benefits a hospice can offer people when specialised palliative care is required.

St Michael’s Hospice aims to create ease and comfort for the patient and the family whilst working with them to provide personalised care, support in a place where patients feel respected and are treated with dignity and respect by competent professionals.

Spiritual care is an integral aspect of that holistic approach. It is more than just religious care; it is caring for the broad spectrum of needs of every person whether they profess a formally recognised faith or not. Everyone, whatever their race, gender, culture or belief can expect to receive compassion, friendship, professional healthcare and a listening, sympathetic ear especially at times when most needed by all staff at St Michael’s Hospice.

We are fortunate in that we have a choice of areas where people can express their spirituality. There is the beautiful St Augustine’s Chapel, founded in 1913 by the Augustinian Sisters of the Holy Heart of Mary, a Parisian French order. Many people find the chapel the perfect place in which to seek solace in the midst of the challenges of life and where they can attend services which help them connect (sometimes to ‘reconnect’) with their faith.

As well as the chapel there is the Multi-Faith/Quiet Room designed specifically to provide an alternative area for people who may not profess any particular faith but nevertheless need an existential space for quietness, tranquillity without distraction. Religious texts and non-religious literature are provided, along with a sound system (an iPod can be used for listening to music) for personal worship, meditation, private reflection, set in a pleasant and comfortable environment.

Many religious communities i.e. Hindu, Sikh, Muslim, Jewish do not necessarily expect to be cared for in a hospice as it is either not within their tradition and/or because they are cared for by family members. There is therefore no expectation to be visited by a resident chaplain. However, with a patient’s permission we can arrange a visit by a local faith community leader (eg priest, rabbi, imam) who can offer appropriate spiritual support.

Liaising with local faith communities and with Hastings and District Interfaith Forum is also an integral part of providing of hospice palliative care as we aim to foster assurances that, with their help, a range of spiritual needs within the wider community can be met in a hospice setting.

Despite the traumatic fire we suffered in 2015, spiritual care (whether religious or otherwise) continues to be offered individually to all our patients, carers and the people we support in Day Services. This may simply be listening to people’s thoughts about their illness, friendship or to offer religious support when requested. We are very much looking forward to returning to the main hospice building and resuming the use of the St Augustine’s Chapel and the Multi-Faith/Quiet Room in September 2016.
Hospice Neighbours

St Michael’s Hospice’s aim is to provide excellent holistic care for people with life-limiting illnesses and Hospice Neighbours are there to provide practical support to those living at home (whether in their own home or a nursing home) to help people to get the most out of life.

In the words of Jane Cave, Head of Voluntary Services: “Some people may find themselves alone for long periods and in need of company, perhaps some help with household chores or shopping. Others may be cared for by their family but need a helping hand for everyday tasks they are no longer able to do, or are relying on their friends and family to help rather than spending precious time with them. Often, their carers are grateful for support too”.

Hospice Neighbours are volunteers from a wide variety of backgrounds, who have time to give and want to help. Referrals to the service can come from a wide range of clinical areas. Once they receive a referral, we will arrange an assessment to identify what the person would like in way of support, and then match them with an appropriate volunteer. That support can continue for as long as the person needs it – unlike many other support services, we don’t put a time limit on it.

Paul McQuillan, now a member of the Voluntary Services team, started his involvement with the Hospice as a Hospice Neighbour volunteer. “In one case,” he says, “I planted up a garden under the client’s supervision. In another, the client had no visitors and was unable to leave her apartment without assistance, so I would take her out for coffee and a chat.” Although it has only been in operation for three years, the Hospice Neighbour scheme has been an immense success, and now includes more than 80 volunteers all of whom are specially selected, trained and supported by the Hospice.

“Hospice Neighbours often become very attached to the clients they help,” Jane Cave says, “and know their services are appreciated. But part of our task in Voluntary Services is also to keep in touch with both the client and the volunteer to ensure that everything progresses smoothly”.

Referrals to the service can be made by completing the referral form which can be downloaded from the DXS system, or from the Hospice website at www.stmichaelshospice.com or email neighbours@stmichaelshospice.com
A week in the life of Matron

St Michael's Hospice has a superb reputation and I am very proud to be part of this. As the Hospice Matron, I provide a visible, accessible and authoritative presence, to whom patient and families can turn to for assistance, advice and support. I am passionate about care, compassion and high standards and therefore work closely with clinical/nursing staff.

A typical week begins each morning at 7.15am when I say hello to the night staff and welcome the day shift in. I listen to the nursing handover/report from the night staff to the day staff about their patients. This enables me to know and understand the patients’ needs and concerns. After the report I check staffing levels and find out what patient dependency levels are.

With the above knowledge each morning at 8.45am I attend the admission meeting. At this meeting we (Doctors, Nurse Practitioners, Hospice at Home and Community Macmillan Nurses) discuss the referrals we have had and prioritise who should be admitted depending on the patients’ needs for pain/symptom control, emotional/psychological support or End of Life Care. As Matron I decide which floor the patient should be admitted to taking into account the complexity of the patient, the other patients and the staffing levels. We are lucky to be a 26 bedded Hospice.

Once a week for a morning shift (from 7.30am–1.30pm)
I work hands on and give care to patients, which I really love.

This shift allows me to keep up my clinical skills and work alongside the nursing team supporting them and ensuring that we give the highest standard of care. Caring for patients involves treating people with compassion, kindness, dignity and respect. Team work is the common component for effective patient care. The development of a happy well motivated caring atmosphere with high standards of patient care depends on my ability to encourage and maintain a free flow of communication between patients, relatives, nurses, volunteers and the multi-disciplinary team.

My afternoons are taken up with different meetings or Clinical Audits. I work closely with Human Resources (recruitment and selection process), and the Education Department (on-going training is essential to improve skills and expertise).

I am responsible for the smooth day to day running of the In-Patient Unit and at mid-afternoon I go to the different areas and hopefully I’m offered a coffee somewhere so I can have a catch up chat. The buck stops with me so any problems/concerns do come my way. As Matron I try to be a good role model and lead by example, it is essential I am available and approachable to all.
Summer 2016 already, and as I look out my window at St Michael’s Hospice across our beautiful gardens, the hammering, the dust and the banging only means we are ever closer to being back on site together. For the Education Department, activity has not halted; in fact we have kept calm and carried on.

As some may be aware we are now a Joint Gold Standard Framework Regional Centre working with St Wilfrid’s Hospice (Eastbourne). This status enables us to facilitate the ‘Local delivery of a national programme with fully trained, supported and accredited GSF Trainers, enhancing local status as a centre of excellence in End of Life Care’ GFS 2016. We are already progressing with our first cohort, which is a mix of care homes from Hastings, Eastbourne and the surrounding areas.

Alongside this, our Community Educator leads a long established ‘Care Home Manager’s End of Life Care Discussion Forum’ which meets quarterly. This forum provide a platform for Care Home Managers to network, share ideas and best practice in end of life care in a supportive setting. Please contact the Education Department for further details.

Sophie Stuchbury RN Practice Educator

We continue to provide End of life Care training for East Sussex County Council in the form of four sessions which look at the experience of working in end of life care, communication, symptom control and bereavement. Further information on these opportunities are available via the East Sussex Learning Portal www.eastsussexlearning.org.uk/cpd/portal

An exciting development is the launch of our Syringe Driver awareness sessions which will be a hands-on workshop for Registered Nurses who are practising within organisations using the CME T34 ambulatory syringe driver. These two and a half hour sessions are available to book until mid-July but places are very limited at the cost of £30 per attendee. Please contact us if you feel this could be useful for your development on sstuchbury@stmichaelshospice.com or 01424 457961.

Finally we have been busy building links with the Community Learning Disabilities Team. This has led to the launch of a Learning Disabilities and End of Life Care Forum bringing staff from the Hospice together with professionals in the community with extensive Learning Disabilities experience to improve the access to our services and the care we give. As a result of this work we are grateful that the Community Learning Disabilities Team have been able to deliver several development sessions to our nursing staff over the past year.

We are delighted to welcome back student nurses from the University of Brighton, following the fire at the Hospice last year, this is someting we had to put on hold until now. This is always an exciting time and an opportunity for our staff to demonstrate the excellent end of life care they provide whilst inspiring the next generation of nurses.
Re-enablement and Fitness Service (RAFS)

From April 2016 we are delivering a new community based Re-enablement and Fitness Service (RAFS) for the benefit of adults with life-limiting conditions across Hastings and Rother. This service will complement our soon-to-open RAFS based at the Hospice (further details to follow in September 2016).

We provide specialist palliative care and support to those communities and strongly believe that RAFS will help to further benefit those communities.

Through the benefits of light exercise, and with professional advice and support from our physiotherapy team, this new service will tackle symptoms such as breathlessness and increase mobility, survivorship, general wellbeing and independence amongst those we support. The service will also extend our current in-patient and day service facilities.

Activities will include:
- Breathlessness support
- Lightweight circuit classes
- Walking football
- Seated tennis
- Seated badminton
- Dry water polo
- Tag walk rugby.

Users will be referred to us via local healthcare professionals and will benefit from support related to conditions that include breathlessness, heart conditions, disability and poor diet. In particular, we believe RAFS will be of great support to those experiencing difficulties related to cancer, heart conditions and life-limiting injuries.

The service will provide a range of activities and services to encourage people to make healthier lifestyle choices and introduce ways of looking after their own health that may not have been accessible to them before now. Activities will promote the benefits of light weight training, muscle toning, cardiovascular exercise, support with learning to walk, advice for general well-being, nutrition, fitness instruction, physiotherapy, and support for men’s and women’s health. We will also offer group classes and team activities that will provide an opportunity for people with similar support needs to meet others with common interests and experiences.

We will aim to:
- Reduce the number of people accessing local health services
- Ensure at least 70% of service users attend for a minimum of 12 weeks
- Reach 90% of the carers of the people attending the service to offer them additional support around the person they care for
- Ensure 100% of service users are consulted at regular stages throughout the programme to ensure it is appropriate and meeting the individual needs and welfare of that person.

For further information and to make a referral please contact Jay Godding on 01424 456607 or email jgodding@stmichaels hospice.com

Jay Godding, Day Services Manager
Walk and Talk Group - an exciting new development in the Bereavement Service

Not everyone who is bereaved needs one to one support from our service. Most people in fact, with the support of friends and family, manage to cope with their loss without our input. Some people who are bereaved value talking to others who are bereaved. With this in mind, we have in partnership with The Conservation Volunteers/Healthy Walks Project, created a Walk and Talk group.

This group meets on a monthly basis with the first being held in June. The Group walk for an hour in Alexander Park, Hastings, followed by a visit to the café in the park (if they want). The walk is led by volunteers who have been trained by the Healthy Walks Project as well as our Bereavement Service. This exciting new initiative will provide an opportunity to meet with others who are bereaved, be outdoors and have some exercise at the same time. If people would like to access this service or other services we offer please contact us on 01424 456361 or email bereavement@stmichaelshospice.com.

Aideen O’Hagan, Psychotherapist
Bereavement Services Manager

GETTING IN TOUCH

About the newsletter:
ebailey@stmichaelshospice.com

General and patient enquiries:
01424 445177 or www.stmichaelshospice.com

Fundraising:
fundraising@stmichaelshospice.com
Criteria and Guidance for Referral to Specialist Palliative Care Services

Introduction
This guidance is for health professionals caring for patients who may need referral to specialist palliative care services within Hastings and Rother. It does not represent new policy on service provision but rather describes arrangements for the existing and ongoing services. It is supplemented by local guidance and by our local referral form.

Palliative care is provided for patients whose disease is no longer amenable to curative treatment. Not all patients who fall into this category, however, need specialist palliative care. Palliative care is quite rightly provided to them by the health professionals who are caring for them whether in primary or in secondary care. All teams should make use of local and national guidelines for advice on the use of first line drugs in symptom control. Specialist palliative care is needed when there are problems needing more intensive or more expert input such as complex symptom control, emotional and psychological support. The guidance here is intended to help the professional to identify which patients might benefit from referral. It is hard to define precise distinctions, however, between those who do and those who do not need specialist palliative care. For this reason, informal contact by phone, or face to face, or through site-specific cancer MDT meetings for advice on the appropriateness of a referral is encouraged.

Ongoing active treatment should not delay referral of patients who may benefit from specialist advice. Increasing numbers of patients with cancer are benefiting from active oncological treatment with palliative intent. Many of them also have palliative care needs and prompt referral should be considered.

Although specialist palliative care is usually concerned with advancing disease there may be patients with curable disease who can benefit from this expertise, for instance in the management of more complex cancer pain. Historically most specialist palliative care teams have dealt predominantly with patients with cancer. However, the use of a specialist palliative care approach by teams caring for patients with life-limiting disease from any diagnosis is also encouraged. Early discussion in all cases is encouraged for advice or with a view to a referral.
Referrals to the Service

Refer if the patient

**has progressive disease with an appropriate diagnosis; for non-cancer diagnoses discuss with team.**

**AND**

**lives within the Hastings and Rother area or is registered with a GP within the area or is a hospital in-patient.**

**AND**

**is willing to see the palliative care team (if able to discuss), OR the patient is not able to discuss but relevant carer is aware of the referral to the team.**

**AND**

Has one or more of the following:-

- pain related to progressive disease uncontrolled by simple analgesia and/or first line strong opioid and/or 1st line adjuvant
- other physical symptom(s) uncontrolled by 1st line of drug treatment
- any severe related symptom uncontrolled within 48 hours of starting treatment of it
- symptoms uncontrolled after 48 hours in rapidly progressive disease
- psychosocial distress in patient or family concerning progressive illness, dying or related issues
- need for support and additional opinion on decisions such as whether treatments including artificial nutrition and hydration should be withheld or withdrawn
- need for further assessment of complex symptoms or other problems, or ongoing specialist support at home, following hospital discharge
- dying complicated by physical symptoms, psychological, social or spiritual distress in patient or family, complex care needs or other aspects of care for which specialist palliative care support or advice would be helpful.
What to refer for?
Referrals can be made for: support from the Community Macmillan Nurse (according to the patient’s location); day therapy; hospice at home; or in-patient admission. Referrals should indicate which service is being requested, although of course different parts of the palliative care team will refer to each other as appropriate – for instance referral to hospital or community palliative care teams will lead to consideration of whether inpatient admission is needed.

How to refer?
Referrals should be made on the referral form for the services. Contact details are provided on the form. Urgent referrals are accepted by some services without a standard form if using a form would delay the referral – contact the service in question for advice on this.

Urgency of referrals
Referrers should indicate the urgency of the referral as they see it. Description of the urgency is helpful so that the team can prioritise among referrals from different sources. Specialist palliative care teams are not responsible for providing emergency response (although within their working hours they may sometimes be able to respond rapidly) and emergencies are the responsibility of the primary health care team or hospital team as appropriate. Urgent referrals should be discussed by phone if possible. Patients referred urgently will be seen within two working days where possible, in line with national standards.

Outcome of referrals
Intervention by the team will be at one of the four levels:

Level 1 – advice only
The teams will offer advice and information to other professionals regarding a specific patient but will not have direct contact with the patient or carers

Level 2 – low dependency
The teams will do a one-off/consultative visit (often jointly with a member of the patient’s primary care or hospital team) in order to offer specialist advice and assist in a plan of care.

Level 3 – medium dependency
The teams will offer short-term contact and support to a patient and their carers where there are complex physical or psychological issues requiring input from a specialist team.

Level 4 – high dependency
The teams will undertake more intensive or longer-term interventions for patients with ongoing complex physical or psychological issues requiring specialist multi-disciplinary support. This could either be as an in-patient or in the patient’s own home.

Ongoing communication
Referrers will be informed of the outcome of a referral and may be given information on progress at other times. If it is not appropriate for the patient to be accepted into a service, advice may be available about alternative strategies.

In return, it is the responsibility of the referrer to continue to communicate necessary information to the specialist palliative care team, for instance on significant investigations, changes in treatment, information given to patient and family. The easiest way to communicate this is for all correspondence to be copied to the appropriate member of the palliative care team.

Referrals for admission to Hospice
Requests for admission should be discussed with the team before admission is offered to the patient or family.
Referral Guidance for Hospice In-Patient Unit Admission
Patients who live within the Hastings and Rother area with progressive, advanced, life-limiting illness and any of the following:

- Physical symptoms not responding to first line management
  - Eg pain related to progressive disease not relieved by simple analgesia +/- strong opiate +/- 1st line adjuvant
  - Eg any other symptom (ie nausea, breathlessness) related to progressive disease and not relieved within 48 hours of starting treatment for it (earlier if dying/rapid progression)
- Psychological, social and spiritual distress in patient or family concerning progressive illness, dying or related issues
- Need for discussion/second opinion to support decisions to be made by caring team/GP about ethical issues related to End of Life Care
  - Eg discussions about risk/benefits of continuing a particular treatment
- Likelihood of death in the next few days (or short) weeks where physical or psychological needs are complex.

Referral Criteria for Hospice at Home Services
Patients who live within the Hastings and Rother area with progressive, advanced life-limiting illness who need:

- A 24 hour palliative care advice and support line for patients and carers/professionals looking after them
- A 24 hour visiting service to support primary care provision of palliative care including syringe driver care and care of those who are dying at home
- A night sitting service (subject to availability)
- Hospice Neighbours (subject to availability).

Referral Criteria for Day Hospice Services
Patients who live within the Hastings and Rother area with progressive, advanced, life-limiting illness who may benefit from:

- Social interaction and support due to social isolation or psychological and spiritual distress brought on by their illness
- Rehabilitation to maximise their potential physical capabilities
- Spiritual input to help adjustment to the meaning of diagnosis and disease progression
- Support with financial issues related to their progressive disease.