Crisis Control

As the end of life approaches, the last thing patients need is uncoordinated care that has them repeatedly answering the same basic questions about their condition and plans for their care. Coordinate My Care explains how it can help care professionals provide a coordinated, integrated service that puts the patient's wishes first.

Nursing home support for patients requiring palliative care has been steadily improving over the past 10 years. There is, however, considerable variation in the range of support available locally and in local funding arrangements. One of the challenges for all patients with life-limiting illnesses and long-term conditions is coordinating the many health and social care professionals who provide their care, while ensuring their wishes remain at the centre of their care.

The 2008 End of Life Care Strategy published by the Department of Health determined that 'within each local health economy mechanisms need to be established to ensure that each person approaching the end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night'.

In 2010, Coordinate My Care (CMC) was set up to address this growing need to provide integrated care for patients.

What Does CMC Do?

CMC is an NHS service fully integrated across healthcare providers for patients with complex and life-limiting illnesses. The service has been developed to help people express their wishes for how and where they are treated and cared for as they near the end of their life. Most importantly, it ensures that any healthcare professional involved in an individual's care has access to this information, especially in an emergency situation.

CMC's aim is to offer patients choice and an improved quality of life. The CMC service is introduced to a patient by a clinician who has a clear understanding of their medical, nursing and social history. Based on this knowledge, the clinician creates a record of the patient's personalised care plan. The patient is then asked to consent to having the details of this care plan entered into the CMC online system and, subsequently, shared with their care providers who have legitimate reasons to view this information.

Looking After The Vulnerable

People over the age of 75 account for around 30% of emergency hospital admissions. Since they can be the most vulnerable people, this can be very distressing – not only for patients, but also for their families. Access to an up-to-date patient care plan is highly important for this group, as 60% of the week is 'out of hours' (OOH) when care of patients with life-limiting illness is provided by urgent and emergency care services e.g. Ambulance Services, OOH GPs and NHS 111.

Often the default reaction is to send these patients to hospital, which heightens patient, nursing home staff and carer anxiety, involves a usually unnecessary admission to A&E, and once admitted these patients sometimes stay longer than necessary and develop new problems. All of this puts significant pressure on the urgent and emergency care systems and NHS hospitals.

Patients in nursing homes who are nearing the end of life present particular challenges to care providers, both in and out of normal working hours. Many of their medical conditions have an uncertain trajectory, (e.g. heart failure, renal failure, Parkinson's disease(and they can deteriorate quickly or plateau at a poor level of health. Due to this, it can be hard to identify a potentially reversible problem from an irreversible deterioration. In addition, residents can often have a significant degree of cognitive impairment, with no family living nearby or no relatives still involved in their care.

Support For Staff

Across London, nursing home staff have been introduced to CMC so they can offer patients a personalised care plan. Having a plan in place removes uncertainty, encourages early decision-making and promotes forward planning. For dementia patients, it is particularly important to record their wishes before they lose mental capacity. Junior staff have reported that it empowers, directs and supports them when they would otherwise be uncertain.

For example, a treatment plan defined by a patient's GP can be accessed by a junior or agency nurse at 3am to help inform an urgent decision. Patient plans are produced by the right people, at the right time, to support those staff who may not know the patient's condition or care preferences out of hours or in an emergency.

Education is a key component of the support provided by CMC to nursing and care home staff. CMC clinical facilitators, all with palliative care experience, run training sessions on the following areas:

- Identifying patients in their last 12-18 months of life
- How to introduce CMC and gain patient consent
- Advanced communication skills to assist with difficult conversations
- DNACPR discussions and understanding patient wishes at the end of life
- Preparing advance care plans, outlining ceilings of medical treatment (escalation plans) and how this information is vital to OOH services to provide planned and coordinated care
- Documenting patient wishes and preferences

A patient leaflet is also provided to ensure the patient and their carers are fully informed and understand CMC. This is available in English and nine other languages.

Benefits For Patients

The benefits for patients who consent to have a CMC record is that they no longer have to repeat sensitive and sometimes difficult information over and over again. The existence of a clear care plan means that their wishes known, so their care can be easily coordinated.

At the moment, patients can have a print out of their care plan and request updates as and when they are made. In the future, patients, families and carers will be able to access their CMC personalised care plan online.

CMC has been commissioned in London by the Office of Clinical Commissioning Groups and Local Education and Training Boards. To date, 16,543 patients across London and Surrey Downs have a CMC personalised care plan. Around half of these patients have cancer; others have conditions such as dementia, renal failure, and motor neurone disease.

Out of the total number of patients who had a CMC record in place, 17% died in hospital and 83% died outside of hospital. Overall, 80% of people who had a CMC care plan and then died did so in their preferred place.

Supporting Urgent Care

One of the key functions of the CMC care plan is to support the delivery of urgent care by providing treatment escalation and advance care information. The CMC care plan can be viewed by out of hours GPs, NHS 111 and the Ambulance Services, as well as community nurses, community palliative care teams, social workers and staff in care homes, nursing homes, hospices and hospitals.

The urgent care provider can view specific information on the CMC care plan to assist them in dealing with the patient. For example, a terminal cancer patient's personalised care plan may have a treatment escalation plan and details of 'as required' medication for symptom control. Without a personalised CMC plan this particular patient may have been taken to hospital as the urgent care providers may not have had sufficient information to provide clinical support to the nursing home staff.

Planned care avoids crises and avoidance of crises decreases the number of unnecessary hospital admissions and improves quality of care for patients and their carers. CMC plans harness the expertise of those professionals who know patients and their conditions well to inform the care given by people who may be meeting patients for the first time. Ultimately, though, Coordinate My Care exists to encourage patient choice and preserve the dignity and autonomy of everyone as the end of life approaches.

CMC is working to support nursing and care homes across London that would like to create personalised care plans for their patients. If you would like to provide this service within your area, please contact the Coordinate My Care team at coordinatemycare@nhs.net or on 020 7811 8513.

www.coordinatemycare.co.uk

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