Coordinate My Care in practice

A case study by London Ambulance Service

October 2019

Overview

My crew mate and I were dispatched to an end of life care call. The description was ‘District nurse on scene, Sepsis. Temp 37.8. Patient Drowsy’.

We received the routine message alerting us that a CMC plan was available for this patient. We accessed CMC en route and found the plan was very detailed. It clearly stated that the patient had multiple cancers, chemotherapy had stopped over a year ago, a DNACPR decision was in place, and the patient was now palliative. The plan, written by the GP and dated recently, stated that the patient did not want to attend hospital under any circumstances and that they fully understood the consequences of this decision. The plan specifically mentioned that if sepsis was a possibility, the patient wished to be treated at home with oral antibiotics.

As we arrived we were greeted outside by the district nurse. She handed over, explaining that she had told the patient an ambulance had been called to take him to hospital due to suspected urosepsis. I mentioned the CMC plan, relating the patient’s advance care plan. The district nurse was unaware of the plan and said they were happy for us to decide what to do next and left for another visit.

Overview continued

The patient was sitting in an armchair and looked unwell. Their long term carer of fourteen years was also present. The patient was unable to engage in conversation due to confusion. Their observations were: RR 24, HR 102, BP 124/80, Temp 37.8. BM 8.6 GCS 13 - (usually the patient was stable and could hold a conversation). The patient had dark, strong smelling urine and based on their NEWS2 score met the criteria for red flag sepsis.

The carer was clearly concerned. They had known the patient for some time and were extremely attached to them. We explained that there was an advance care plan in place and discussed the patient's preferences as previously expressed. The carer was anxious about the suggested idea of not conveying the patient and tried to get them to say they wanted to go to hospital, however it was clear the patient lacked mental capacity. The carer then highlighted that the patient's mobility had declined because of the infection and they were now a significant falls risk if left at home.

Our plan

We planned to refer the patient to the 111 Out of Hours (OOH) doctor for an urgent home visit, medical assessment and consideration for oral antibiotics. We then assisted the patient to bed with a carry chair and placed a second mattress next to the bed in case of a fall – the best option in this difficult situation. We were aware this treatment plan was not typical and so we called our Clinical Hub to ensure we had not missed any key elements of assessment or safety netting. They were happy with our plan.

Management

111 took the referral immediately and said they would dispatch a GP for a home visit as soon as possible and we reassured the carer everything was being done for the patient. While we were completing our documentation the OOHGP arrived, performed a urine dip, prescribed and administered oral antibiotics, leaving the medications in the house with a care plan to be followed by the carer. It took 30 minutes from referral, to the GP prescribing / administering the antibiotics.

Personal reflections

The patient's CMC plan was detailed and clear, specifically regarding a sepsis plan, meaning we went into the situation well informed. The carer was obviously anxious and applied some pressure on us to take the patient to hospital - a potential short term solution. We found ourselves actively advocating for the patient and their wishes as previously expressed while seeking to respond actively to their medical crisis .

The falls risk that was raised meant we had to develop an unconventional, imperfect solution but this was the best we could do for the patient at the time.

I was happy we had carried out the patient's wishes and I was particularly encouraged that the CMC records were helpful and the 111 referral was fast and efficient, resulting in the patient remaining at home and improving.