Nottinghamshire Hospice
adding life to days

Standard Operating Procedure (SOP005) for: Hospice Outreach and Discharge Support team (short-term visiting service) during the COVID 19 pandemic.	
Staff groups SOP applies to:	All Care Services staff in the Hospice
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1 AIM

The aim of this Standard Operating Procedure (SOP) is to describe the model of care for the Hospice Outreach and Discharge Support (HODS) visiting service which is part of Hospice in your Home Services during the COVID 19 pandemic.

2 CONTEXT

There are five main service areas that make up the total service offer from the Hospice. These are traditional day therapy, wellbeing service, hospice in your home and carer and bereavement support.

3 PRINCIPLES

- The needs of the patient, carer and the family[1] will be core to the service offer
- Self-care, building resilience and maintaining privacy and dignity for the patient and carer will be promoted at all times.
- Where possible choices will be offered to meet the individual needs of patients and carers.
- The service will dovetail with existing Hospice, Community District Nursing and Domiciliary Care services to offer additional palliative care for those patients and carers requiring it in the day on a short-term basis either for very end of life to the death of a patient or until a domiciliary care package is in place following discharge from hospital/prevention of admission to hospital.
- The service provision will be on a **maximum of 30 days** before a review and decision made regarding the appropriateness of continuing the service for a further 30 days.

[1] Family and carers will be referred to as carers throughout this SOP

4 PURPOSE

The purpose of the HODS is to:

- Provide responsive supportive palliative nursing[2] care to meet the needs of the patient and the carer to enable them to remain in their preferred place of care; home.
- Provide an additional palliative care resource to offer practical support and care during the day to enhance the community services on offer when it is required to support a patient to remain in the community until their death, support a discharge home from hospital until their death or commencement of a community domiciliary care package.
- To provide a day resource to compliment the night services on offer from the hospice to the patient and their family facilitating wrap around care where required over the 24-hour period.
- Provide services to maintain patients Personal Activities of Daily Living (PADLs).
- To achieve their goal of choice of being cared for and dying at home with dignity and support.
- Build carer competence, confidence, resilience and reduce fatigue to remain in the long-term role of caring.
- Support the care system in the reduction of end of life transfers from home to hospital and hospital admissions.
- Facilitate discharge from hospital for end of life care.

5 LOCATION AND HOURS:

- The Hospice Outreach and Discharge Support (HODS) is located at the Nottinghamshire Hospice, 384 Woodborough Road, Mapperley, Nottingham.
- It operates flexibly in the daytime, seven days a week for 52 weeks a year during the COVID19 pandemic and forms part of the other hospice in your home services that operate across the 24-hour period.

6 MODEL OF CARE

6.1 Referral criteria and Assessment

- Patients and carers are self-referred or are referred by a health or social care professional via the coordination number 0115 9621222. It is expected that the majority of referrals will come through the end of life (formally fast track) route.
- Care co-ordinators will take either a telephone referral or an eReferral onto the service and pass this through to the HODS to action.
- Liaison between the Care Co-ordination team and HODS is key to ensuring care flows and capacity is monitored.

2 Nursing includes qualified and unqualified staff

- Patients should be identified with a palliative diagnosis and likely to be within the last year of life, identified by the Gold Standard Framework and have an up to date EPaCCS record on SystmOne. Where the patient is being discharged from hospital, the referral will be accepted if the criteria is met and an EPaCCS record created as soon as is practical.
- Patients that have been confirmed or suspected to have to have COVID-19 19 symptoms but choose to die at home will be assessed through the coordination service for suitability of the hospice's care.
- Patients should be known to the District Nursing Service and the hospice palliative care services. Where this is not the situation an assessment will be made by the HODS team to ensure patient and carer safety and facilitate a referral to the appropriate services within the next working day.
- Referrals maybe from staff within the Hospice at Home nursing service where they require assistance from another staff member to provide personal care.
- Following referral the HODS team will triage the urgency and carer requirements of the patient and carer, they will assess the appropriateness of the care requested and how this can be met by the skills of the HODS service.
- The patient may receive a one-off visit or may remain on the service with planned care as long as they remain within the service criteria up to 30 days before review.
- A referral maybe for up to four calls a day however the HODS service will actively work with other Hospice Services (predominantly HNS) to plan the package of care provided. The Hospice will work with the patient and carers to ensure an optimum level of care is provided within service availability.
- Care will be delivered in-conjunction with the District Nursing care plan. SystmOne will hold documented care records for the patient and care delivered by the HDS service.
- The service can be planned as a visit or requested as an urgent response or call for help to support with nursing tasks for example personal care, moving and repositioning, emotional and physical support.

6.2 Hospice Outreach and Discharge Support Service care

- The patient and carer will receive information regarding the care aims of the service.
- The service may be utilised as a planned visit with a pre-arranged care need following previous assessment or an urgent visit if required by a known hospice patient or carer. Visits are not expected to last more than 90 minutes.
- Assessment of whether the care requires one or two working as a pair experienced healthcare assistant to meet their needs will be made by a Registered Nurse.
- Examples of types of care offered (but not exhaustive):
    - Personal care including mouth care, continence care and pressure area care.
    - Assistance with moving and handling.
    - Prompting and assistance with medication.
    - Provision of fluids and/or a light meal.
    - Emotional support for both the carer and the patient where this is required during the day.
    - Pre-arranged visit to support the DN service.

- Short-term visit where the patient and carer needs are unable to be met by core services due to capacity. For example at the time of death to support the family and carer through the imminent emotional stress.

- Care provided will be sensitive to the spiritual and cultural needs of the patient and carer.
- Advice may include initial bereavement support tailored to meet the needs of the carer.
- Utilisation of Holistic worker knowledge to enable referral on to appropriate services, for example equipment or aids.
- Caseload co-ordination and assessment will be undertaken/overseen through a Registered Nurse within the coordination team.
- Patients requiring equipment will be referred back to the Community Nursing Services.

6.3 Caring for Carers

- At the initial assessment visit the HODS team member will advise the carer of ongoing hospice support that maybe available.

- Carers will be able to pre-book to telephone counselling if appropriate.

6.4 Discharge

- On completion of the initial period of care up to 30 days the patient will be considered to be discharged from the HODS service but may remain within the Hospice palliative care services. Should a further period of care be required this should be agreed through the MDT, with clear goals or outcomes which are time limited to 30-day periods and review.

- Review will be part of liaison with the End of Life fast track administration team.

- Patients and carers will be made aware of the process to re-refer for support should they require it in the future.

- Where appropriate the patient and carer will be offered referral to alternative services within the Hospice palliative services or sign-posted on to other areas for support.

6.5 General Inclusion and Exclusion criteria

INCLUDED

- Patients will be registered with a Nottinghamshire GP and be over the age of 18 years. Initially this is limited to Greater Nottinghamshire.

EXCLUDED

- Patients who require care that can only be delivered by a Registered Nurse or complex care outside of the remit of the service. For example Symptom control by injection, blocked catheter, verification of death
- Patients referred who live in a Nursing Home.
- People under the age of 18 years old.
- Those people registered with a GP outside of Nottinghamshire.
- Whilst patients that smoke are not excluded from referral criteria, the Hospice has a No Smoking policy and therefore any patients that smoke will be asked not to smoke whilst the Hospice team are attending their home. The team have the right to refuse to attend the house where all reasonable measures to offer a smoke free environment have not

been achieved. Advice and support to the patient and their family will be given as appropriate.

7 STAFFING

- Operational team management and leadership is provided by Day Therapy and Wellbeing manager with support from the Director of Care Services.
- Assessment and delivery of the service is provided through experienced Registered Nurses.
- Experienced Healthcare Assistant's (HCA) working alone or as a team of 2 together will provide the supportive elements of the service.
- Minimum experience - HCA with NVQ3 or equivalent working independently, where this is not the case they will only work within a pair where one will have the more senior role.
- Where possible each experienced HCA should have undertaken the Holistic Worker training.
- In the event of staff sickness or shortages a member of the hospice at home service will provide support.

8 RECORD KEEPING

The HODS service will keep up to date records on the patient's progress in SystmOne through mobile working.
Liaison with the care co-ordinators to update hospice records will also be imperative in terms of organising visits and logistics.

9 EVALUATION & OUTCOME MEASURES

The Director of Care will collate information every month on the effectiveness of the HDS service assessed against the following criteria:

- Improve patient and carer experience and satisfaction. (S1 and feedback)
- Increasing the number of patients dying at home as per their choice.
- Reduction in ambulance conveyance for end of life patients. (measure with S1)
- Avoidance of hospital admission for patients at the end of their life. (measure with S1)
- Facilitate discharge from hospital with Hospice support.
- Reduction in short-term care package provision through fast track services.
- Reducing District Nurse call outs for PADLs. (measure with S1)
- For our hospice at home staff to feel well supported in the day. (measure with feedback/review)
- To provide palliative care to a greater number of people in Nottinghamshire every day. (measure with S1)
- Reduce carer fatigue. (S1 and feedback)

- Increase in hospice referrals. (measure with S1)

The Director of Care will present the information and evaluation to the Quality and Safety Committee bi-monthly and to others as required.