StChristopher's

CARE

THE CENTRE FOR AWARENESS & RESPONSE TO END OF LIFE

Better Lives, Better Endings

Supporting people to live and die as they want in later life

Neil McCarthy – Octavia

Liz Bryan – St Christopher's

OCTAVIA

Who are we?

Octavia

“To make individual life noble, homes happy and family life good” Octavia Hill

St. Christopher’s Hospice

“You matter because you are you and you matter until the last moment of your life” Dame Cicely Saunders

Extra Care Housing

St Christopher's CARE THE CENTRE FOR AWARENESS & RESPONSE TO END OF LIFE

Changing needs – adaptable services

- Teams continually adapt to support people with increasingly complex physical, mental and emotional needs right up to the end of their life

    - Care staff play a key role as they are best placed to know the person as they are now and advocate on behalf of the individual

- Extra care teams seek to work very closely with GP’s, district nurses, pharmacy, community mental health and hospital teams

    - An integrated approach to managing complex health needs is proven to have the greatest impact.

- Health professionals often treat extra care as if it were nursing or residential care which can impact on expectations – frailty team or in-house nursing skills

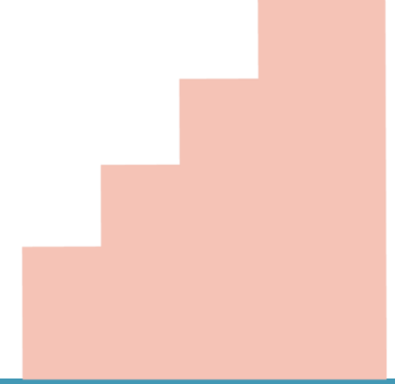
CARE
THE CENTRE FOR AWARENESS & RESPONSE TO END OF LIFE

Tackling loneliness, improving health and wellbeing

Balancing the risks in life to meet needs

Right care, right place, right time

Relationships, understanding and anticipation for Better Lives, Better Endings

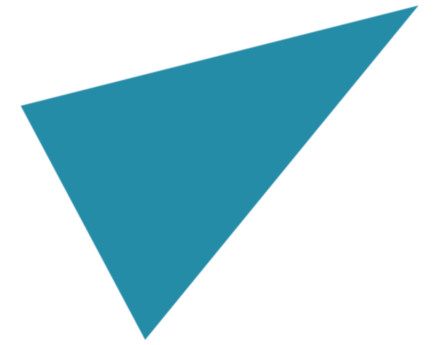


Life and death in Covid times

St Christopher's CARE

THE CENTRE FOR AWARENESS & RESPONSE TO END OF LIFE

Case Study



D was in her 80s and had final stage dementia. She had been an extra care resident for several years and attended a day centre run by Octavia. She was well known to many Octavia staff. She had family in Ireland, but was very reliant on Octavia care and support services for her advocacy and wellbeing. At the beginning of 2020 her dementia was deteriorating. She was having problems with chest infections and before lockdown had been admitted to hospital to be treated for pneumonia. She was discharged from hospital as the NHS pressure caused by the pandemic was emerging. Staff were shocked when she returned from hospital, carried on a stretcher. The scheme was not equipped to provide her with continuous nursing care (the stretcher didn't even fit in the lift to get her back into her home). There was an urgent review to increase her to 'double up care' to meet her needs. Though comfortable in her own surroundings D remained unwell and it was thought that she was 'slipping away'. Her GP was involved in making decisions for her end of life care and reported to staff that a "'Do Not Attempt CPR' (DNAR) decision was appropriate and, if possible, to avoid any further hospital admission. Within days D deteriorated, she had become restless and staff felt she may be reaching the end of her life. Because she was very religious, staff took the decision to call a priest to give her the last rights. Shortly afterwards, her breathing became worse and staff called 111. An ambulance was called and because paramedics could find no information on their system about the end of life plan for D, and despite the concerns of our care staff, they took her to A&E. Staff were not able to accompany her and D arrived at the hospital at 10pm and died 45 minutes later, on her own on a hospital trolley.

The undignified end to D's life had a profound impact on the care staff who had looked after her for the last years of her life. They were very upset that she had to die this way and felt disempowered in how the end of her life was managed. Counselling support was made available. All the agencies, the NHS hospital team and her GP, agreed that D was going to die, and how this should best be managed, but because database systems (in London this would be CMC) were not utilised effectively, the system failed D.

St Christopher's C A R E THE CENTRE FOR AWARENESS & RESPONSE TO END OF LIFE

Some thoughts for discussion

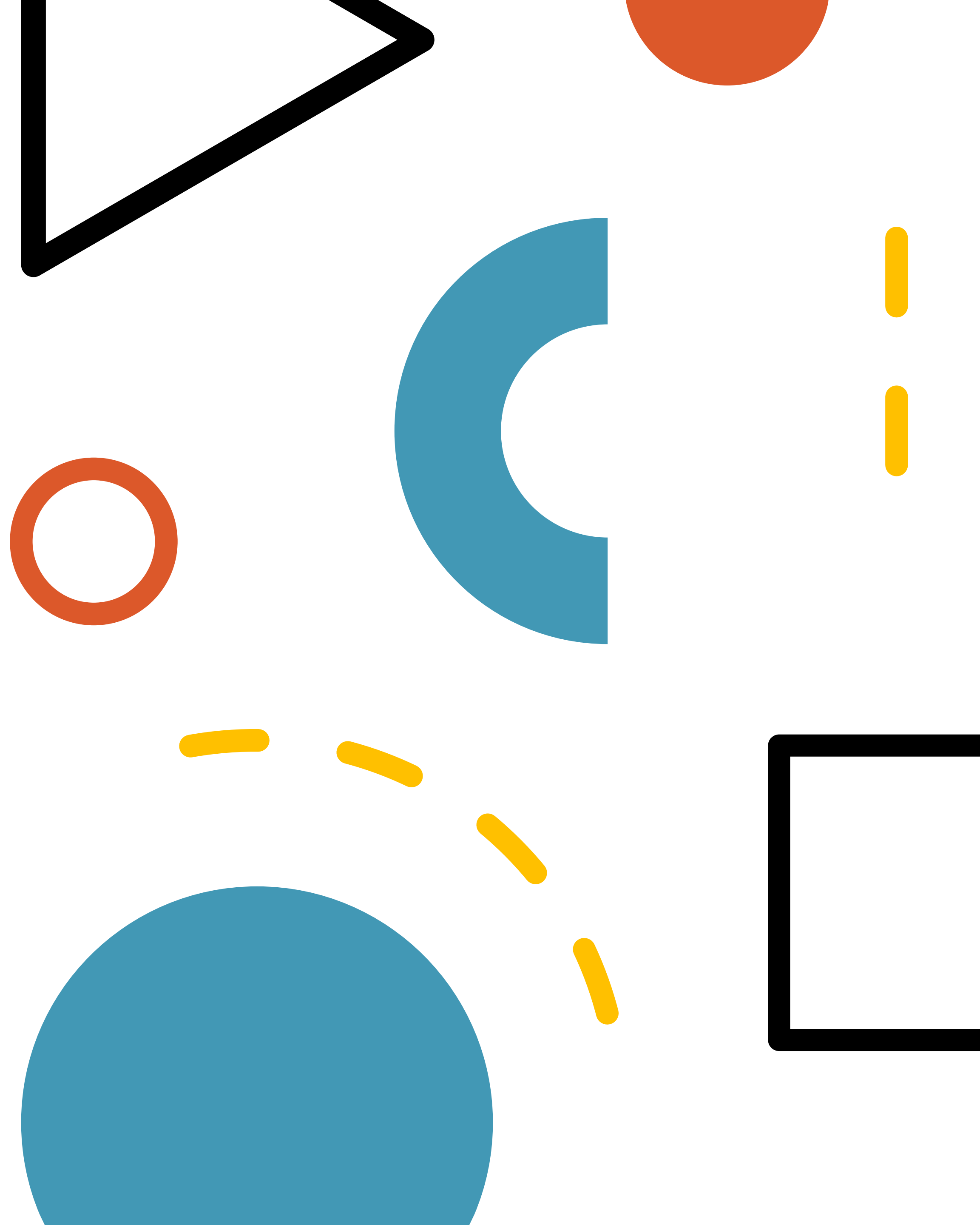
- We are all part of one system (or should be), seeking to provide the best experience for those we care for – how can the care sector integrate better with NHS funded health care?

- We are seeking better local partnerships – strengthening GP, district nursing community mental health relationships and developing better connections with LAS and hospital discharge teams – Community Matrons coordination really helps. What else might?

- How can we educate/create a better understanding of extra care across health care settings?

- How can care workers be better heard as advocates for the people they care for?

- Could we access prevention funding to deliver these projects to assist us to meet the objectives of local CCG's?



StChristopher's

CARE

THE CENTRE FOR AWARENESS & RESPONSE TO END OF LIFE

Neil McCarthy – neil.mccarthy@octavia.org.uk
Liz Bryan – l.bryan@stchristophers.org.uk

OCTAVIA