Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

END OF LIFE CARE IN A SECURE HOSPITAL

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Aim

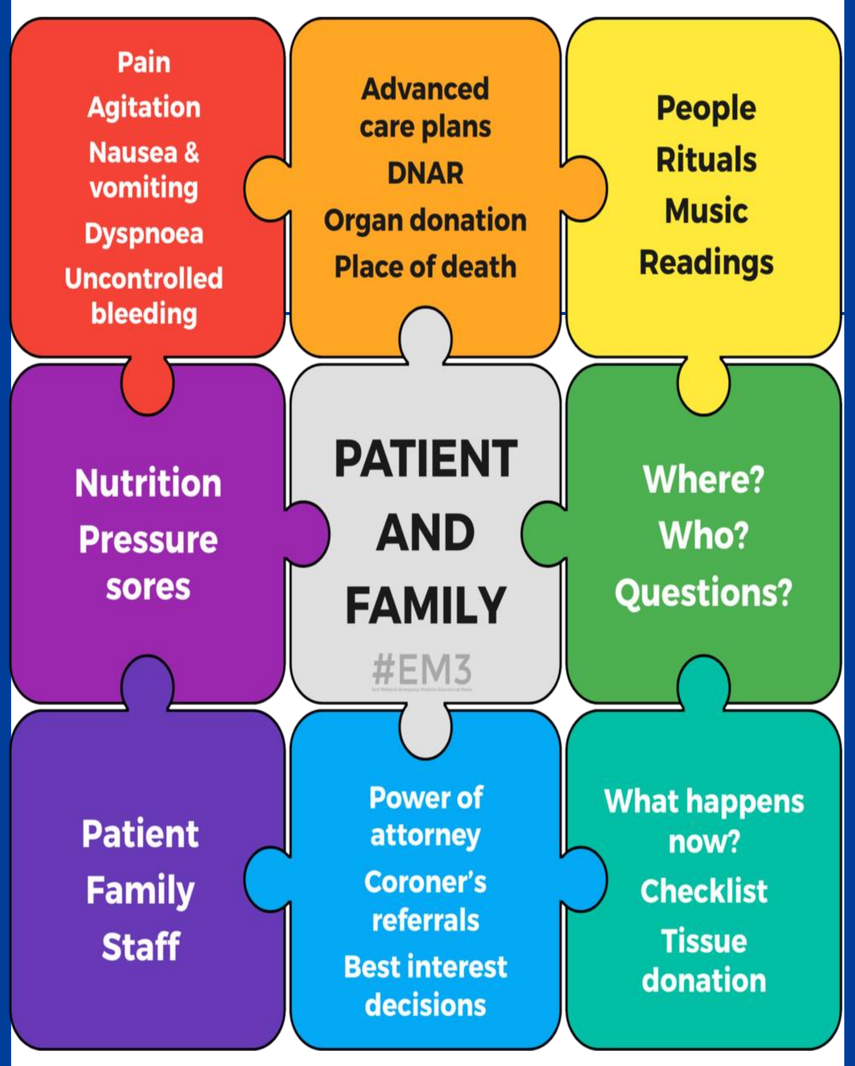
To measure the standard of care provided to patients who had a natural and expected death whilst in a secure care unit at Roseberry Park Hospital since the publication of *One Chance to get it Right* in June 2014.

Mallard Ward is a low secure psychiatric ward for older age men suffering from cognitive difficulties and significant physical comorbidity in addition to a severe and enduring mental illness. The patient population is such that it will remain the most appropriate placement for some patients until their death. It is therefore vital that staff members on Mallard Ward, and indeed in all parts of the Trust, are aware of the priorities for care of the dying person and that care is provided in accordance with these priorities.

Background

The Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations, published *One Chance to get it Right – Improving people's experience of care in the last few days and hours of life* in June 2014. This document laid out five priorities for care of the dying person focussing on sensitive communication, involvement of the person and relevant others in decisions and compassionately delivering an individualised care plan.

- Recognise & communicate the possibility of death
- Sensitive communication with patient and important persons
- Patient involvement in decision making around treatment and care
- The needs of family and others are explored and met
- Individualised end of life care plan is agreed and carried out.



Method

The data collection tool was adapted from *End of Life Care Audit: Dying in Hospital*, a national clinical audit commissioned by Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. Data was collected from both electronic and paper records. No patient identifiable data was collected.

Results

- There were three natural and expected deaths in secure care
- All the 3 patients were resident on Mallard Ward
- Cause of death was cancer for 2 patients and heart failure for 1 patient
- 2 out of the 3 patients died on Mallard Ward while1died on the medical ward of the acute trust hospital
- There was documented evidence that all 3 patients were likely to die in the coming days or hours
- End of life care discussion was held with the nominated persons in 2 of the 3 patients.
- There was documented evidence that the needs of the nominated person was explored and met
- Discussions were not held with any of the patients due to lack of capacity.
- All 3 had an individualised care plan which was followed.

Conclusion

The national audit compares performance of only acute NHS Trusts with no data to reflect the performance of mental health hospitals. It is imperative that mental health services work in collaboration with physical health and palliative care services so they are able to continue providing a high level of care to this patient group. Clinicians and staff involved in the care of dying patients also need to be adequately trained.

References

'One chance to get it right', June 2014.
Improving people's care in the last few days and hours of life:
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Treatment and care towards the end of life: Good practice in decision making – General medical council.

Nice quality standard 13:
End of life care for adults, published 28 November 2011.
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