

We need to talk about Palliative Care

Scottish Ambulance Service

1 What has been your experience in terms of access to palliative and end of life care?

Generally our experience has been positive in Scotland, in comparison with other UK countries.

2 How could it be ensured that access to palliative and end of life care is equitable and available in all areas and for all types of terminal illnesses?

Bring forward plans to provide Anticipatory Care Planning across all disciplines, and embed palliative care processes into them.

3 Can you identify any areas in terms of access to palliative and end of life care that should be focused on as priorities?

Full implementation and support for revised DNACPR policies would be beneficial, including notification and requirement to review after a set period.

Access to support for crews, particularly in the out of hours period is a challenge, where out of hours services are unlikely to attend an expected death. If there is further distress and deterioration, a 999 call may be made and often SAS will be unaware of the DNACPR prior to arrival on scene, even if the out of hours service has been contacted; communication and access to up to date patient records are vital; this puts crews in an extremely difficult position with no access to support.

Generally we are responding to these calls as a 999 emergency and we are unable to leave crews in attendance indefinitely. Direct referral access to hospices or other services for SAS would be beneficial.

Lack of awareness of DNACPR or, in some cases, due to obvious family distress, no reference to any DNACPR being in place, may result in a 999 call and attendance by crews. Where information is not passed on or not easily accessible for crews to determine if DNACPR is in place, this may result in patients being transferred to A&E with crews feeling they have no other option.

Equally, crews could be placed in a difficult situation and feel pressured to attempt resuscitation where no prior notification has been given and they are only informed of a DNACPR by distressed relatives who have called 999 for help.

4 When is the right time to begin discussing options for Palliative Care, who should be party to that discussion, who should initiate it and where should it take place?

It should involve GPs more; it should begin at a very early stage, prior to hospitalisation and be part of a wider care plan that is accessible to

any potential health and social care staff.

5 What works well in discussing palliative and end of life care and how is good practise communicated? Where do the challenges remain?

Early agreement on plans, prior to emergency events, is critical. Failures occur when inter-departmental, inter-professional communication fails. SAS crews have access to EPCS and ECS via mobile data terminals in the ambulance. However, the infrastructure around this is cumbersome and as a result, crews are not routinely accessing this information, particularly if they are responding to a 999 call for a patient in potential cardiac arrest. Access to anticipatory care plans and palliative care plans has been established as an effective principle so there is merit on continuing to improve the ease of access and the sharing of information between health and social care professionals.

6 What is the role of anticipatory care plans in supporting Palliative Care discussions and how can their uptake be improved?

Palliative Care processes are really ACP, so the two should be conducted and planned for integrally. A single, ACP template and process could be developed for NHSS.

7 How should information about Palliative Care be made available to patients and their family during any initial discussions and how easily available is this information?

There is good information available on websites such as SHOW, with many supporting sites. Further information could be useful in GP surgeries.

8 What training and support is provided Health and Care staff on discussing Palliative Care with patients and families and are there any areas for improvement?

Palliative care and Bereavement are two areas where OOH NHS staff could feel exposed.

9 How do Health and Care organisations ensure that the discussions about palliative and end of life care are taking place at the right time?

There is support and expertise for this throughout the palliative care community, however it is not used as well as it could be by those not routinely involved. There could be closer links between Palliative care teams and SAS Ambulance Control Centres, which would be beneficial to patients and families. There is also potentially a role for our specialist paramedics when it comes to delivering certain aspects of palliative care particularly during the OOH period.

10 What are the challenges in recording and documenting Palliative Care priorities and how well are those priorities communicated between different health and care providers?

Keeping them up to date and documented can be difficult. Communication between providers needs to be improved, via greater use of Key Information Summaries. ACP needs to be linked to KIS, easier to access and used much more than at present.

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