STHM

ANNUAL REPORT 2018

BY MARY CONNOLLY

Background:

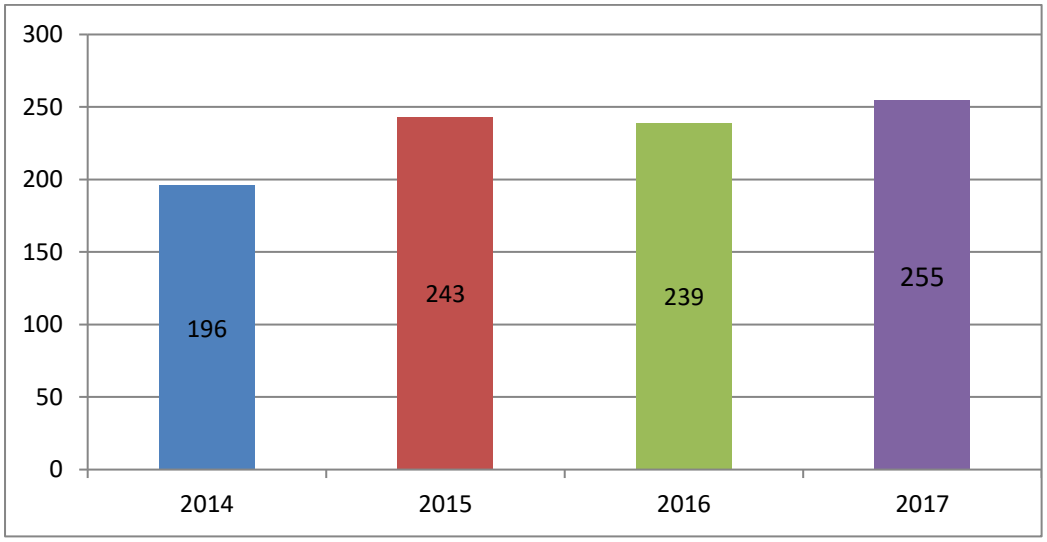
Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO, 2004).
Specialist Palliative Care refers to services whose core activity is limited to the provision of palliative care. These services are involved in the care of patients with complex and demanding care needs. The South Tipperary Hospice Homecare team are a specialist team providing specialist palliative care to patients in South Tipperary and West Waterford.
Our Clinical Lead is Dr. Emmet Walls, Consultant in Palliative Medicine. He attends our weekly MDT meetings, sees patients in both STGH and UHW as outpatients as well as seeing inpatients in both these locations. Out of hours Consultant Specialist Palliative Medical conferral advice is available to us on a 24 hour basis.
We currently have 6.4 WTE Clinical Nurse Specialists in Palliative Care on the nursing team. South Tipperary Hospice Homecare runs a 24 hour 7 day a week service. This availability provides great reassurance to patients and families. There is a designated 0.7 WTE Occupational Therapist for palliative care for South Tipperary who works closely with us.
Central to how we operate is ongoing liaison with the GP and all associated healthcare individuals involved in that patients care. All referrals to our service have to be agreed beforehand by the GP. Most referrals come via the *Specialist Palliative Care Services Referral Form* developed by the *National Clinical Care Programme for Palliative Care (NCPPC).* We liaise closely with all hospitals and individual health professionals associated with the patient's condition/treatment in order to provide a seamless service. As we are fully integrated with all the Specialist Palliative Care services in the Southeast we communicate very closely with the hospital services as patients are admitted there, seen in OPDs or day wards and at the time of their discharge to the community.
All clinical records are now computerised using the *Icare* computer system, providing ready access for all the nursing team at all times.
In 2014 our service began to see patients with non malignant conditions at end of life who were symptomatic other than those with Motor Neurone Disease and Multiple Sclerosis whom we always saw.
Patients are discharged from the service if they are no longer requiring specialist palliative care or do not want our ongoing involvement. In this instance, they are discharged back to their GP with a discharge letter stating same.

Further information on our service can be viewed at: www.sthm.org

Patient Statistics

New patients referred to the service in 2017: **255**

This equates to an increase of **6%** from 2016 figures.

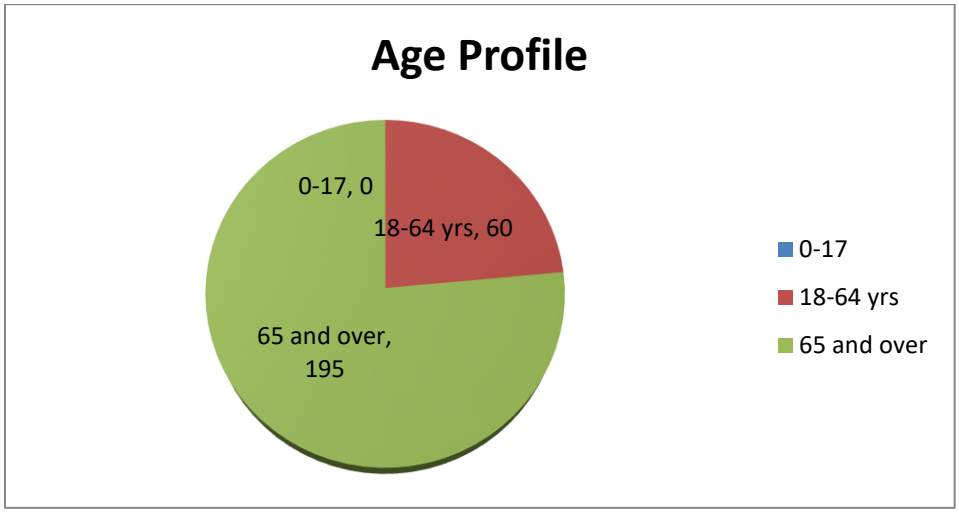


Age Profile of referred patients:

New Patient Age Analysis: 0-17 years 0 patients (0%)

18-64 years 60 patients (24%)

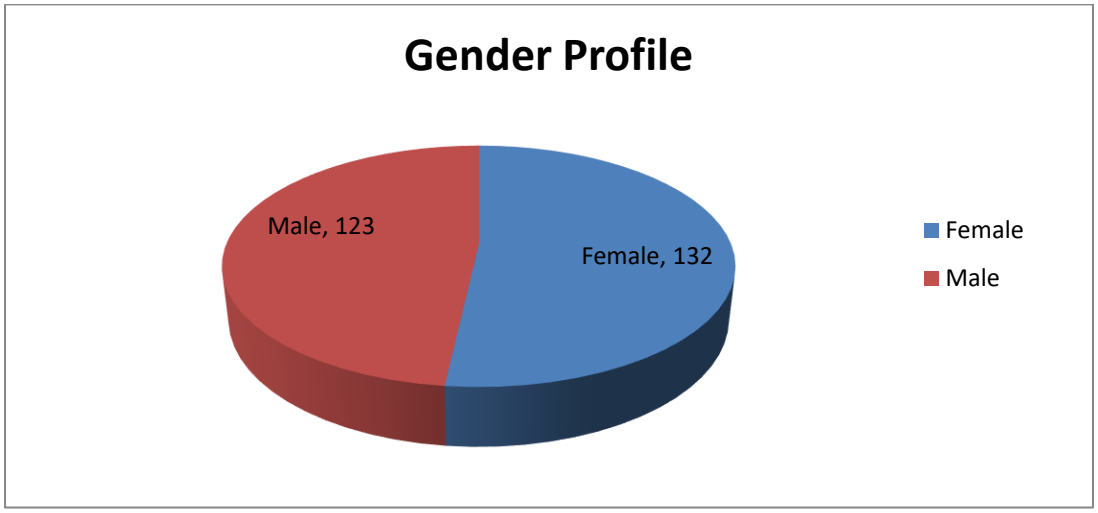
65 and over 195 patients (76%)



Gender Profile of New Referrals:

Female (132 patients): 52%

Male (123 patients): 48%

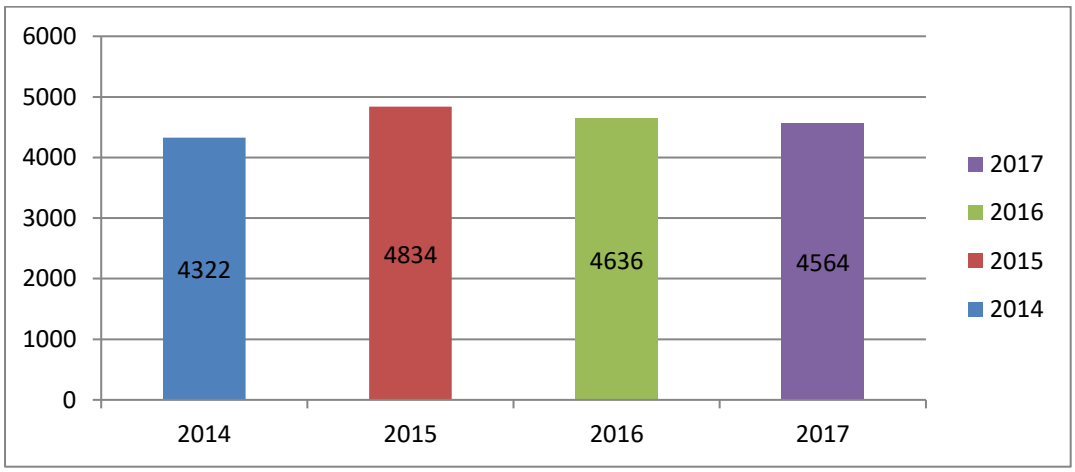


This is almost identical to 2016 figures.

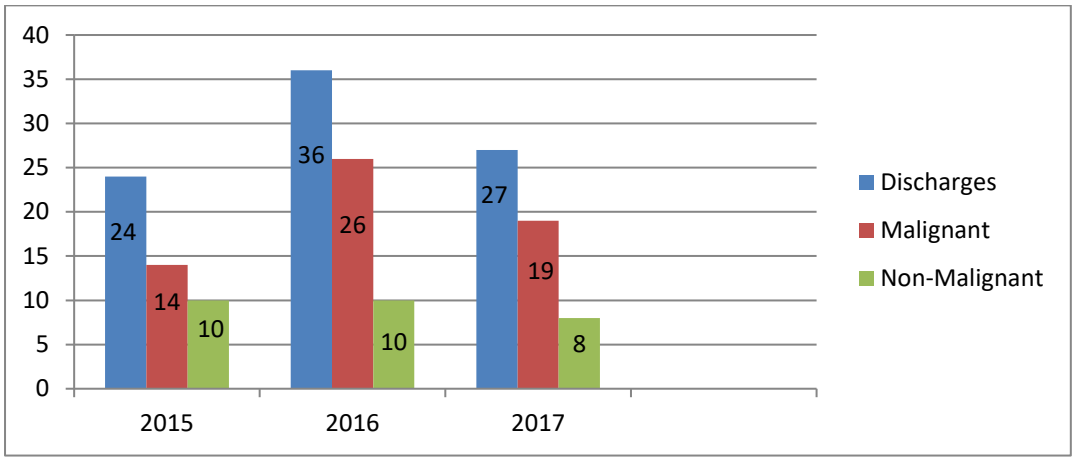
Number of Homecare Visits to patients:

4564 overall visits to patients place of residence throughout 2017

This equates to a decrease of 1.5% since 2016.



Discharges:



Number of discharges from the service: 27

Discharges with a Malignancy: 19

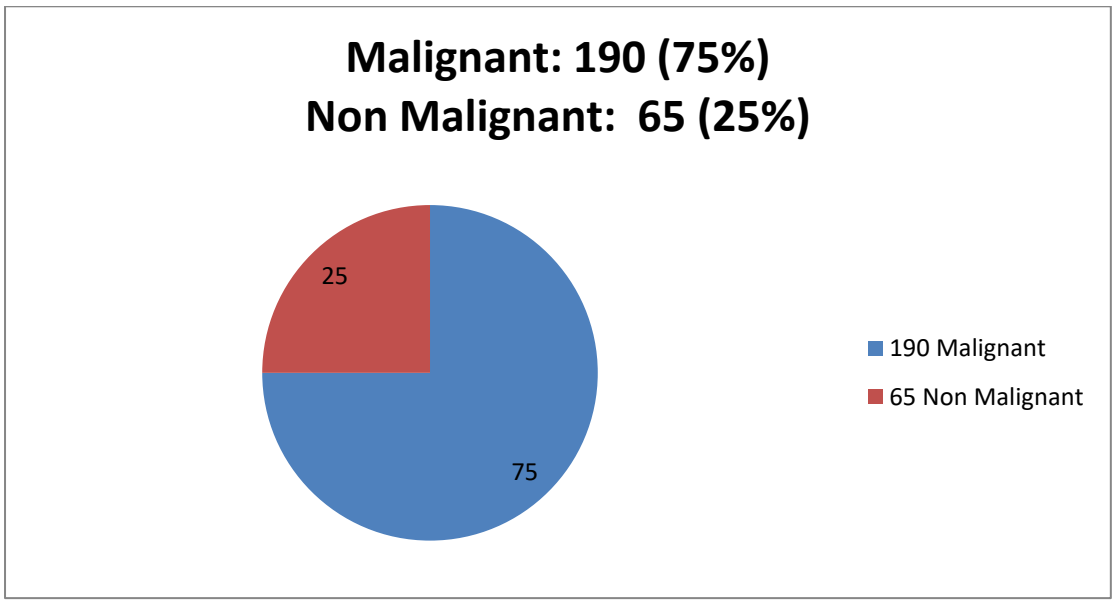
Discharges with a Non Malignancy: 8

Primary Diagnosis of New Patients:

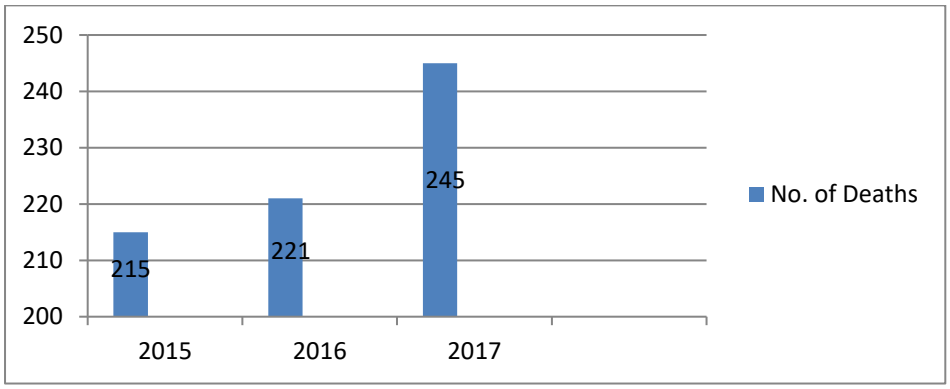
Malignant: 190 (75%)

Non malignant: 65 (25%)

This is exactly the same figures as 2016.



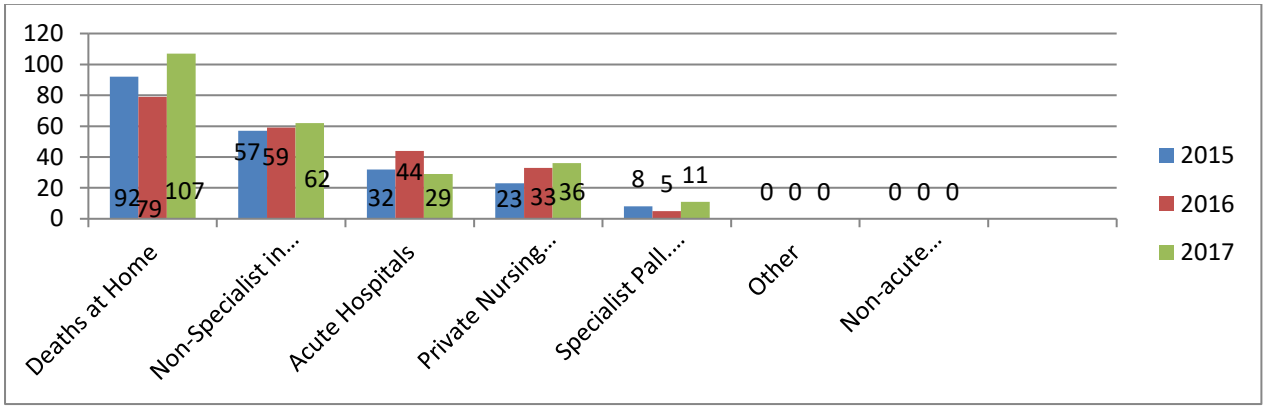
Deaths:



The total number of deaths that occurred of patients referred to our service in 2017 was 245.

This equates to an increase of 10% from the 2016 figures.

Breakdown of Place of Death:



Number of patients who died at home: 107,

Number of patients who died in a designated non specialist intermediate care bed in the community: 62

Number of patients who died in an acute hospital: 29

Number of patients who died in a private nursing home: 36

Number of patients who died in a specialist palliative care inpatient unit: 11

Number of patients who died in other: 0

Number of patients who died in a non acute hospital bed: 0

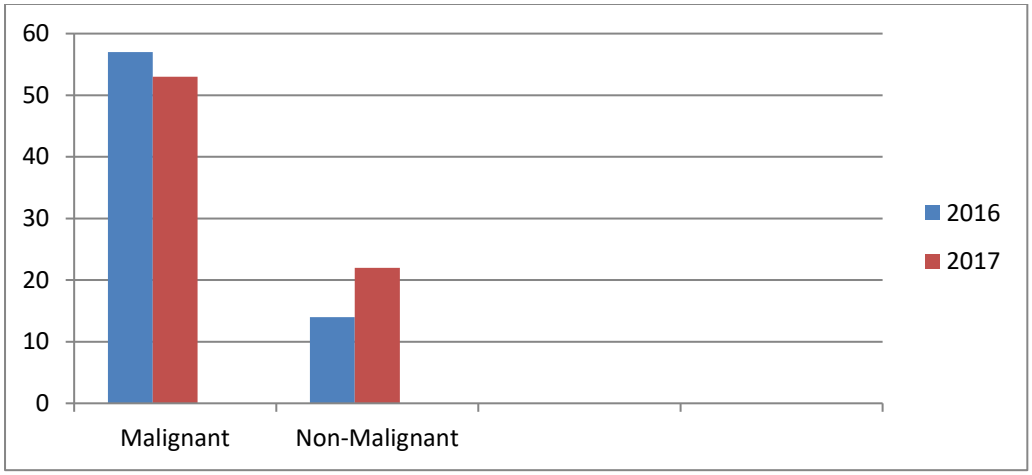
Night Nursing Service

This continues to be an integral part of the care of the dying patient at home. We continue to get great support both from the Irish Cancer Society (ICS) who fund the night nurses for those with a malignant diagnosis and the Irish Hospice Foundation (IHF) who fund those patients who require night nurses who have a non malignant diagnosis. The Irish Motor Neurone Disease Association (IMNDA) fund nights for those with a diagnosis of MND. The ICS manages the night nursing service irrespective of the funding.

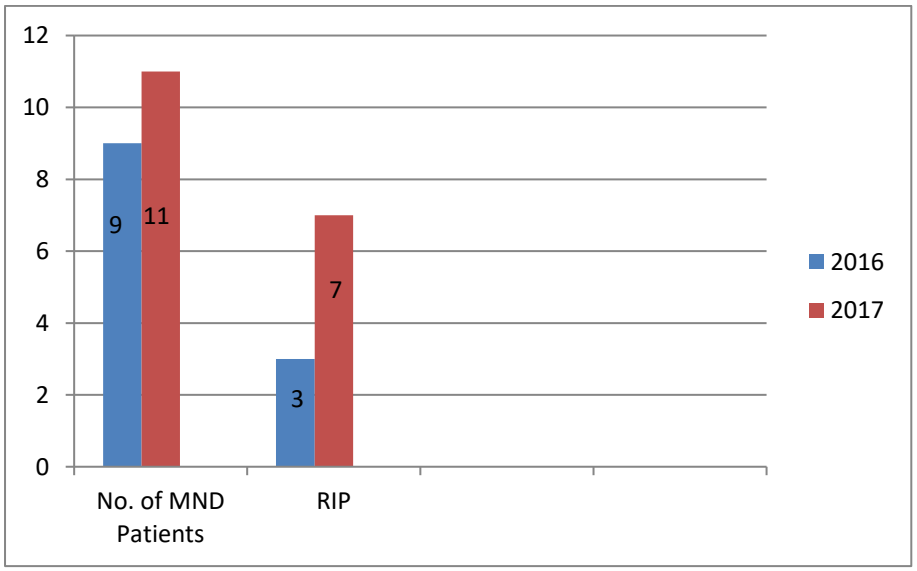
We looked for night nurses for 58 malignant patients and 53 of them got a night nurse with a total of 280 bookings.

We looked for funding from the IHF for night nurses for 23 non malignant patients and of these, 22 patients accessed the service with a total of 115 nights.

No. of Patients who used Night Nursing:



Motor Neurone Disease Patients



Motor Nuerone Disease (MND) patients make approximately 11% of our patient cohort in 2017.

Throughout the course of the year we had 11 patients and 7 of those died in 2017.

Management of MND continues to be through a Multidisciplinary approach. We liaise very closely with the GP, PHN, Physio, SLT, Dietician, MNDA Nurses, Equipment Reps and Neurology teams to provide appropriate care to this cohort of patients.

Paediatric Referrals

We received no paediatric referrals to our service in 2017.

Our Paediatric Algorithm is in place. See Appendix 1.

A Paediatric Risk Register was submitted by the 3 consultants in Palliative Care on behalf of the 4 Community Homecare Teams in CHO5 to the Risk Register Manager in Q4 2017.