EVALUATING PALLIATIVE CARE SKILLS FOR COMMUNITY MATRONS

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The role of the community matron was developed to improve standards of care for people with complex long-term conditions. Initial emphasis was to support patients to help take control of their condition and reduce unnecessary use of urgent care services and hospital admissions. The community matron caseload requires skill to balance the risks involved in keeping people in their own homes. Recent audits show that end-of-life planning and palliative care are crucial aspects of their work so matrons need training and support to ensure positive outcomes for patients at the end of life.

INTRODUCTION

The DH (2005a) has identified nine specific areas of professional development needed to support community matrons:

- Undertaking clinical practice at an advanced level;
- Leading complex care coordination;
- Proactively managing complex long-term conditions;
- Managing cognitive impairment and mental health well-being;
- Supporting self-care, self-management and enabling independence;
- Providing professional practice and leadership;
- Identifying high-risk patients, promoting health and preventing ill health;
- Managing care at the end of life;
- Undertaking interagency and partnership working.

The advanced practice component of the community matron role requires the ability to work autonomously to diagnose and treat illness, prescribe medication and use clinical and diagnostic reasoning to refer to other healthcare professionals. However, there is also a need to ensure that patients nearing the end of life are supported, through choice, to stay at home in their final days.

The challenges community matrons regularly face when working with patients who have different diseases with different trajectories at the end of life, and who often have several coexisting health problems, is knowing when to begin end-of-life discussions and when is it appropriate to introduce the advanced care plan or Liverpool Care Pathway.

DEVELOPING COMMUNITY MATRONS

To support them in developing the necessary levels of practice, community matrons appointed in NHS South of Tyne and Wear, which incorporates Sunderland Teaching PCT, Gateshead PCT and South Tyneside PCT, have their training needs assessed using a personal development plan. They are supported to undertake advanced decision-making and clinical skills courses, advanced nurse prescribing and workshops and updates on many specific long-term conditions, and managing cognitive impairment as a large proportion of patients suffer from some degree of mental health problems.

End-of-life care aims to assist those with advanced, progressive, incurable illness to live as well as possible until they die. It also enables services to identify and meet the supportive palliative care needs of both patient and family during the last phase of life and through bereavement. Not only does this include management of pain and other symptoms but the psychological, social, spiritual and practical support required.

The approach to ‘end of life’ can be difficult to identify and should be considered as soon as possible, as a critical issue of good end-of-life care is to recognise and plan appropriately (DH, 2008).

Building on the Best (DH, 2004a) committed the DH to take forward training programmes so that all patients nearing the end of life, regardless of diagnosis, have access to high-quality palliative care and can live and die in the place of their choice.

A project was developed across NHS South of Tyne and Wear to support and build on staff’s existing knowledge and improve community matrons’ confidence and competence in addressing their clients’ palliative care needs. A retrospective audit of the community matron combined caseload over a 12-month period was undertaken to:

- Early referral to a community matron for patients with long-term conditions will allow for supportive self-management and proactive case management. If patients are referred late in the disease process there is insufficient time for advanced care planning and to support end-of-life choices.
- End-of-life discussion and care planning were achieved with less than 50% of deaths in the three PCTs audited.
- Lack of openness and discussion about death and dying has adverse consequences including an increase in fear and anxiety, inappropriate interventions and lack of choice.
- The community matron plays an important role in palliative care and needs to work closely with specialist palliative care teams.

IMPLICATIONS FOR PRACTICE

- Early referral to a community matron for patients with long-term conditions will allow for supportive self-management and proactive case management. If patients are referred late in the disease process there is insufficient time for advanced care planning and to support end-of-life choices.
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BACKGROUND

- The advanced clinical role of the community matron was developed to improve standards of care for people with complex long-term conditions (DH, 2004b).
- A range of guidance was produced to ensure consistent development and implementation of the role nationally (DH 2006a; 2006b).
- The role can be diverse, as caring for and case-managing patients with complex long-term conditions can be extremely complicated.
- There is a growing need to ensure patients approaching the end of life are supported, through choice, to stay at home in their final days.
- The End-of-Life-Care Strategy (DH, 2008) identifies that patients and their carers should receive coordinated, high-quality care and support during the last days of life.

THE AUDIT

A simple audit tool was designed to establish the number of deaths across the community matron’s caseload from 1 April 2007 to 31 March 2008. During this time there had been no formally agreed standards on use of Advanced Care Plan or Preferred Place of Care documentation to support care planning for patients at the end of life. Some staff had received training or had previous experience and there was an expectation that the community matrons use known initiatives to support care planning.

Data was coordinated and collated by the administrative team attached to the community matron service and the audit was conducted over a two-week period. It was to be used to establish the length of time a patient may have been on the caseload prior to death and whether there was evidence to support advance care planning.

A total of 51 community matrons were in post across NHS South of Tyne and Wear PCTs at the time. Of these, 36 were included in the audit; two were on sick leave, three on holiday and 10 had not been in post throughout the 12-month audit period.

Community matrons participating in the audit identified the number of patient deaths in their caseloads and submitted information on each patient. A total of 241 deaths were identified, although not all returns contained all data requested, so not all results total 241.

RESULTS

Of the 241 deaths, 59% occurred in hospital, 25% at home and 3% in a hospice. This is consistent with national figures (DH, 2008) which show that most deaths (58%) occur in NHS hospitals, with around 18% occurring at home and 4% in hospices.

Although the audit did not aim to identify the actual cause of death, information was collected on patients’ conditions and the recordable reason for referral to the community matron service. Whereas most had multiple co-morbidities, only 4% of deaths were due to cancer, with respiratory disease accounting for 38% and heart disease for 48%.

End-of-life care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. While patients with cancer have had access to a variety of supporting healthcare services such as Macmillan nursing support, Marie Curie nurses and specialist palliative care services, more emphasis is now given to ensure those dying of other conditions receive the same level of care.

Fewer than 50% of the deaths across each of the three PCTs contained evidence that end-of-life discussions and care planning had been achieved.

The End-of-Life-Care Strategy (DH, 2008) notes that lack of openness and discussion about death and dying has adverse consequences including:
- People may be unnecessarily frightened about the process of dying;
- Close relatives of people approaching the end of life may be unaware of their wishes and how best to help and support them;
- Inappropriate interventions may be tried if professionals may exclude them from involvement;
- Fear of the unknown may make people avoid those who are ill for fear of ‘upsetting them’ or ‘making them worse’;
- Lack of public and professional discussion about death and dying may be one reason why this area has had low priority from health and social care services;
- Ignorance among professional and family carers may mean opportunities to improve quality of life and restore independence are missed;
Lack of knowledge among family members of the financial implications for the bereaved following a death and what needs to be put in place ahead of the event; Lack of public and professional discussion about grief and loss results in the isolation of bereaved people.

The need for a personalised care plan for all community matrons’ patients is integral to the planning and evaluation of care. Those approaching the end of life also need to have their individual needs assessed and their wishes and preferences discussed, with an agreed set of actions reflecting their choices about their care recorded in an individualised care plan.

The plan should be subject to review by the multidisciplinary team, the patient and carers as and when the patient’s condition, or wishes, change. For optimum effectiveness the plan should be available to all who have a legitimate reason to access, it, for example out-of-hours and emergency services (DH, 2008).

DISCUSSION

Although the audit was small-scale the results conclude that on average each community matron could expect to have up to seven patient deaths per year which demonstrates how important this role can be in supporting patients, relatives and carers at the end stages of life.

The DH (2005b) says community matrons could come from any branch of nursing. Across the three PCTs the community matrons have a mix of nursing backgrounds including district nursing, acute emergency care, clinical specialties, health visiting, nurse practitioner roles and practice nursing. Each has brought a wealth of experience and knowledge to the community matron role. However the main challenges they have faced have been switching from a reactive to a proactive service and meeting the needs and expectations of patients across the whole range of the nine competency domains (DH, 2006).

While death is inevitable it does not necessarily constitute a failure of care. The DH (2006) identifies three key areas for development in the community matron role:

- To ensure individuals and groups are supported appropriately when experiencing significant life events and transitions;
- To support individuals through bereavement;
- To support individuals through the process of dying.

Providing end-of-life care can provoke strong emotions, and while healthcare professionals might be expected to develop the necessary knowledge, skills and attitudes to deliver end-of-life care with experience, it is not always the case. Some may feel uncomfortable in this role or be unable to fulfil it effectively (DH, 2008).

Following this audit an education and training programme was developed with the help of the specialist palliative care team to build on the community matrons’ existing skills. Some had already undertaken palliative care courses or training on end-of-life issues and the use of the pathways and care plans. However, it was agreed that a communication skills training workshop, with the aid of professional actors, would enable the community matrons to face their own attitudes and views of death and dying in a supported, learning environment. This would provide a benchmark for training across the team.

This three-day reflective study event was mandatory for all community matrons and they were given supported study time. This foundation-level training helped to identify those who already had advanced-level skills and those who required further support and development. It was also an opportunity for the team to share their experiences and support each other.

Further training and development in the verification of expected death and on the use of Do Not Attempt Resuscitation orders and advance care planning is ongoing across the team.

CONCLUSION

The community matron role is crucial in palliative care. It is therefore imperative that they are able to deal with the challenges they face with end-of-life initiatives and working with patients who face end-stage illness across the full spectrum of disease. All community matrons need to develop and enhance their role and work closely with palliative and specialist palliative care teams.

This small-scale audit has provided information to support the need for training and development in this area of care. We expect to repeat it annually to ensure the learning and development has been applied appropriately. This will allow us to monitor patients nearing their end of life, ensuring they have appropriate advanced care planning and open discussions to choose their preferred place of care at the end stage of their life.

REFERENCES


Department of Health (2005b) Supporting people with long-term conditions: An NHS and Social Care Model to Support Local Innovation and Integration. London: DH.

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