Palliative care ward for the elderly

SIR—We found it interesting to read the research letter by Twomey et al. [1]. We have had a palliative care ward for the elderly in Portsmouth for nearly 20 years as part of the Department of Medicine for Older People [2]. It has 8 beds funded in summer and 14 in winter, although we often have to open our unfunded beds. We look after patients who are dying from any cause and those needing management of symptoms before moving to rehabilitation or continuing care, either at NHS or in a rest or nursing home, or the patient’s home.

We have been using the Liverpool Care Pathway for nearly 3 years and find it a very useful tool. However, its use on other wards in the trust remains limited by the need for continuing education of the staff in the use of the pathway and in recognising symptoms of dying. Many medical staff are reluctant to change the focus of treatment from active to palliative, even when the patient, relatives and nursing staff have recognised the need. Communication between staff and the patient and their family about prognosis is often found difficult and decisions are left to the next consultant ward round. This means that the patient’s symptoms are left unassessed and untreated and transfer is too late, while another course of e.g. antibiotics is tried.

Education for medical students and trainee doctors needs to include information on recognition of dying, symptom assessment and treatment, and the fact that a good death is as important an outcome as an accurate diagnosis and effective therapy.

We, too, receive patients direct from the Medical Assessment Unit who have come in from local care or nursing homes, and are in the process of dying. The usual reason given for admission is for rehydration or investigation, because their symptoms have not been recognised as part of a predictable deterioration of a known illness in time for an end-of-life plan to be negotiated with the patient and their carers. Perhaps the way forward is for any patient leaving the hospital or an out-patient clinic with a diagnosis of an illness likely to deteriorate in the next year to be recommended to their GP for the Gold Standards Framework.

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Reply

We welcome the response of Vardon and Efthimiou in which they refer to experiences that echo many of the concerns we highlighted in our recent research letter [1]. There is little doubt that the chief obstacle to the delivery of appropriate care to patients who are dying is the failure of health professionals to recognise, and not infrequently to accept that a patient’s death is both likely to occur and appropriate.

To address this ongoing dilemma requires something of a culture shift amongst medical practitioners in particular, while in addition there is a desperate need to develop the inclusion of training in care provision during the last stages of life into ongoing education of all health professionals.

The NHS End of Life Care Programme, now established as government policy, is driving forward the campaign to improve care at the end of life. It promotes the use of the Liverpool Care Pathway, the Gold Standards Framework and the Preferred Place of Care tools, all of which have been developed for use in the community, care homes, hospices and/or acute hospitals. As a national and government supported initiative, it is to be hoped that the extent of the use of these tools will continue to increase across all care settings.

We particularly agree that for patients transferred from nursing homes to acute care close to the end of their lives, the failure to recognise that symptoms may be occurring as part of predictable deterioration leads to inappropriate hospital admissions. There is a definite need for regular monitoring of the overall condition of patients in the community or in care homes so that patients, their families and all primary care professionals can discuss a plan of care, should they deteriorate. The Gold Standards Framework, already in use in care homes, would indeed facilitate such practice.

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