Pennine GPST in deprivation ST1- Dr Kershaw’s Hospice Palliative Care post

**Placement**

GPST Programme – Dr Kershaw’s Hospice

**Clinical Supervisor**

Dr Matthias Hohmann FRCP MRCGP DipPallMed  
Medical Director, GP Trainer, NLP Practitioner

**Placement based (e.g. ward or department)**

Dr Kershaw’s Hospice (Inpatient Unit), Turf Lane, Oldham OL2 6EU

**Brief description of the department**

Dr Kershaw’s Hospice is a medium-size hospice in Oldham, providing palliative care services for people with life-limiting illnesses. The main base of the post will the 12-bed Inpatient Unit. Admission is usually for complex pain and symptom management and/or care in the final days/weeks of life. The catchment area is mostly Oldham and North Manchester.

The hospice provides day services in the Wellbeing Centre as well as a nurse-led Hospice-at-Home service and a hospice operated domiciliary care service (Caring Hands). Experience of these community facing services will be included.

As part of multidisciplinary working, the hospice has strong links with community and hospital based palliative care services, and experience with those teams may also be available on request.

The hospice premises are base for some external services e.g. Macmillan 1:1 Support team and Christie chemotherapy outreach, offering further learning opportunities.

**Main duties of this post**

The main duties will be ward based on the Inpatient Unit. They include admission, inpatient management and discharge of patients. There is a strong team working ethos and good communication with all members of the multidisciplinary team, patients and those close to the patient will be essential. Attendance of the Oldham Locality MDT meeting on a Thursday morning is strongly encouraged.

The post holder will work side-by-side with the experienced senior doctors and there is ample opportunity for advice, support and learning.

**Typical working pattern in this post**

The post holder will be rostered to work either 9am-5pm or 7am-3pm or 11pm-7pm (Mondays to Fridays). They will also be working 1-in-9 Saturday mornings 9am-1pm. Time in lieu is granted for Saturday morning duties. There are no duties outside these hours.

Twice a month they will have a formal tutorial. Time will be set aside to attend the GP ST teaching on a Thursday afternoon.

**Conditions likely to be encountered during the post**

* Gastrointestinal symptoms (e.g. nausea and vomiting, oral symptoms such as ulceration, constipation, diarrhoea, ascites, hiccupping)
* Malignant bowel obstruction
* Cachexia, anorexia and fatigue
* Pain is a common symptom in palliative care. Recognition of the type, expression and possible causes of pain and its management are important (physical, psychosocial, cultural and spiritual) including complex pain syndromes
* Psychological problems (e.g. insomnia, anxiety, depression, delirium, restlessness and terminal agitation)
* Emergencies in palliative care including:
  + Haemorrhage
  + Hypercalcaemia
  + superior vena cava obstruction
  + spinal cord compression
  + raised intracranial pressure
  + neutropenic sepsis
* Venous thromboembolic events
* Neurological condition (e.g. headaches, seizures, limb weakness), MND, degenerative neurological disorders
* End-stage non-malignant conditions including : COPD, heart failure, respiratory failure
* Respiratory symptoms (e.g. breathlessness, excessive secretions, cough)
* Skin condition including paraneoplastic syndrome (e.g. pruritus, lymphoedema, sweating)
* Dying including terminal agitation and restlessness
* Psychological reactions to loss
* Anticipatory grief (patient and carer) and bereavement support (carer)
* Care giver ‘pressure points and distress’
* Recognition of complex grief signs and symptoms
* Malignant ascites

**Learning opportunities:**

* Effective pain and symptom relief in cancer and non-cancer palliative care patients
* Prescription of Controlled Drugs
* Communication incl Breaking bad news
* Holistic approach to care
* Advance care planning
* Shared decision making / Negotiating management plans
* Ethical decision making e.g. Do Not Attempt CPR / Allow a Natural Death etc.
* Advance Care Planning
* Multidisciplinary team working across the entire system
* Discharge planning
* Certification & verification of death, effective interaction with Medical Examiner and HM Coroner
* Prescribing quality and governance
* Electronic patient records (EMIS Web)
* Effective palliative care in a home / community setting

**GPST competency areas that can be developed within this post:**

The areas covered are from the curriculum statements –

* Primary Care Management of cancer and other palliative conditions.
* Provide person centred care to include physical, social and spiritual needs of the patient and carers.
* Ability to manage symptoms and palliative care emergencies.
* Understand the ethical dilemmas in palliative care

A tutorial will be provided twice a month to allow an increased knowledge base in preparation for the GPST3 year.

**Maintaining an ethical approach**

Ethical challenges are common where patients are faced with life-limiting illness, and quality of life is a highly individual concept. The post holder will gain better understanding of different values and belief systems and how this impacts on best interest decision making. There will be opportunity to gain profound understanding of the Mental Capacity Act 2005 and its requirements and tools.

**Communication and Consultation**

Good communication is essential in palliative care. The post holder will have opportunity to develop their verbal and non-verbal communication skills when consulting patients and their families. This includes effective communication of ‘bad news’ incl disease progression, general deterioration, impending death. The Clinical Supervisor is an experienced GP and GP Trainer and offers opportunity for joint consultation and feedback on consultation skills.

Mutual agreement of a management plan and shared decision making are essential in palliative medicine, and the doctor will be able to develop his/her skills and become a more effective consulter.

There will be opportunity to develop communication skills for the benefit of enhanced continuity of care, especially where a patient moves across different care settings. The hospice creates and updates patients’ EPaCCS record, an electronic palliative care handover and information sharing system on the GM Care Record that is used across all settings including primary care.

**Data gathering and interpretation / Clinical examination skills**

Key to effective palliative care management is detailed history and clinical examination. Investigations and/or acute admission are not always appropriate. The underlying cause of many palliative care symptoms can be narrowed down by understanding their specific patterns of presentation. This post presents an excellent opportunity to develop such “non-invasive” diagnostic skills.

**Making a diagnosis/decisions**

The GPST will develop skills in making management plans with patients. The GPST will be able to present their proposed management plans to senior clinicians and discuss clinical reasoning behind their decisions to further develop their type 2 reasoning skills. These discussions will form the basis for feedback and assessment.

**Clinical management**

The post holder will work side-by-side with experienced senior doctors on a daily basis. The GPST will discuss management plans for new patients with a senior clinician allowing feedback and completion of workplace based assessments. He/she will learn the management of common palliative care symptoms (including pall care emergencies), both pharmacological and non-pharmacological. The GPST will gain experience in the emergency assessment and management of acutely symptomatic patients, either in the form of new admissions or the deterioration of existing patients. There is opportunity to gain experience in the construction of holistic management plans with support for both the patient and those important to them.

The GPST will work with other professionals such as clinical nurse specialists, pharmacists and allied health care professionals.

The GPST will also be encouraged to reflect on the management of patients. As well as providing a learning avenue for the post holder, this will encourage them to highlight how things could be done differently.

**Maintaining performance and learning.**

The trainee will be expected to attend the GPST teaching programme. They will have a regular tutorial with their supervisor. Ad-hoc training and teaching is part of daily routines as junior and senior doctors work side-by-side with each other. The hospice is a place of excellence for reflective learning and will assist the post holder on their journey to becoming a reflective practitioner. This includes regular ‘Schwartz Rounds’ to explore the emotional and psychological impact of palliative and end-of-life care provision on the individual practitioner and the team. A regular journal club is planned.

**Working with collegues and teams.**

The GPST will gain experience working as part of a MDT and coordinating the care for each patient. The GPST will learn to recognise the limits of their ability to provide holistic care and recognise the value of input from other health care professionals. Post holders will gain experience in making appropriate referrals when the limit of their expertise is reached.

The GPST will attend the daily handover meeting and will be responsible for presenting hospice patients at the weekly Locality MDT meeting. There is opportunity for developing good handover techniques and appropriate referrals.

**Practicing holistically, promoting health and safeguarding**

Palliative care is necessarily and always holistic in nature. The post holder will gain a deeper understanding of non-physical causation of symptoms, and how to integrate emotional, psychological, spiritual and social factors into their assessment. They will have the opportunity to enhance their knowledge and skills in understanding prognosis, diagnosing dying and appropriate ceilings of care. He/she will be able to understand better the role of families and informal carers, as well as their support needs.

**Community Orientation**

The GPST will gain insight into the breadth of local palliative care services available in the community. There will be opportunity to shadow the Hospice-at-Home service and/or community palliative care services, gaining 360-degree insight into strengths and weaknesses of palliative care provision in the community, and how it contrasts to hospice based care.

They will learn how to refer to local organisations and coordinate care provision between them, including the use of other members of the MDT to coordinate this care when needed. The GPST will be encouraged to learn about and reflect upon gaps in service provision that they encounter when trying to coordinate ongoing outpatient care for patients. This may lead to quality improvement work in liaison with other organisations.

Last updated Sep 2022. Next review due: July 2024