EXECUTIVE SUMMARY

1. Background

The South West Perth Collaborative Community Care Project was funded by the Australian Government Department of Health & Ageing from 1st July 2003 to 30th June 2005. It was collaboration between Murdoch Community Hospice and Silver Chain Hospice Care Service. The project manager was Ms Eleanor Roderick, CEO of Murdoch Community Hospice Telephone (08) 9366 1366 Facsimile: (08) 9366 1367, Email: eleanor.roderick@sjog.org.au

The project was conducted jointly by the Murdoch Community Hospice, a 20-bed inpatient specialist palliative care facility south of the Swan River in Perth, Western Australia and the Silver Chain Hospice Care Service the sole community-based palliative care service in metropolitan Perth. The project was restricted to the South Western region of metropolitan Perth, an area serviced by both organisations.

Most palliative care patients utilised the domiciliary palliative care service which is primarily nursing based, but ably supported by a group of local General practitioners with both a special interest in palliative care and significant additional experience in the field. Care Aides, chaplains, counsellors and volunteers are also involved in the domiciliary provision of care. A subset of the patients cared for in the community also, at some point in their illness, experience an admission to the Murdoch Community Hospice inpatient facility and access its specialist palliative care medical staff, nursing and allied health staff and volunteers. Admission to the Hospice was usually for symptom control, to provide a brief period of respite for home carers or in some cases for terminal care. The average length of stay at the Hospice is approximately 12 days and nearly 50% of separations are patients returning to the domiciliary palliative care service or other care setting.

Anecdotally there were infrequent instances when the reason for referral to the inpatient unit was questioned, and there were also examples of discharge back to the community setting where the discharge processes could be improved.

2. Project Objectives

As a consequence it was proposed that the two organisations who were in effect “partners in the care of some of the patients” would trial and evaluate a new interface model that sought to improve the transition between community and inpatient care. This was intended to be a multi-pronged approach to enhance communication, collaboration and coordination between the two services. Involvement of specialised Hospice staff before and after admission was expected to ensure optimal continuity of care for patients and provide “seamless” care from the patients’ perspective. New and improved documentation, relevant to both organisations, was expected to further improve professional dialogue.

Specific objectives initially described in the project tender included improving the continuity of care for patients transitioning between community and inpatient Hospice, increasing awareness and knowledge amongst family doctors in contemporary palliative care delivery, avoidance of perceived “inappropriate” admissions to Hospice and roles in both General Practitioner and collegial education and support including through clinical attachments to the Hospice.

3. Methodology/Description

Extensive review of policies, procedures and documentation relating to the transitions between community and inpatient care settings were undertaken and the need to conduct joint familiarisation sessions between the two organisations was identified. The planned home visits by the Medical Director were severely limited by his unexpected illness and subsequent extended rehabilitation, however the concept was successfully demonstrated in one instance.

Both organisations agreed on the desirability of developing a clinical tool to inform and facilitate the process of negotiating an admission to the inpatient Hospice. Although the trial design and limited numbers both contributed to a failure to identify specific predictors of the need for admission (other than the absence of a home carer) the tool that was developed did contribute towards improved admission processes.

Sharing of clinical case-notes between the domiciliary service and the inpatient unit was trialled. For reasons beyond the control of the project participants, a proposal to develop detailed palliative care management plans could not be implemented. General Practitioner attachments to the Hospice proceeded after an initial delay, and were deemed highly productive.

4. Results

The development and subsequent trial of an Admission Assessment Tool was demonstrated to facilitate the process of admission by structuring and objectifying the negotiation between domiciliary care providers and inpatient staff responsible for prioritising and allocating a limited number of available Hospice beds. Home visits by the specialist palliative care doctors employed in the Hospice were severely limited by the unexpected illness of the Medical Director, however visits by other staff highlighted the need for social work input in the domiciliary setting. This was already recognised by Silver Chain Hospice management and the trialling of social work visits became a substitute project role. The social worker employed part-time at Murdoch Community Hospice was employed an extra day each week in the community setting and the piloting of this was such a resounding success Silver Chain Hospice Care Service management implemented the recruitment and employment of social workers across the whole of Perth metropolitan area before the project’s completion. The trial

of sharing of Home clinical Case-notes resulted in the rescinding of policy which had previously prohibited such sharing, but in selected situations and currently applicable only to Murdoch Community Hospice.

The review of discharge processes from Murdoch Community Hospice back to the community and shared attendance by the staff of each organisation at clinical meetings was successfully introduced.

Evaluations conducted support that the objectives of improving continuity of care for patients and facilitating transitions between community and inpatient settings have been quite successful. It is our clinical impression that the objective of minimising perceived inappropriate admissions to Hospice was also achieved although limitations to trial design were identified.

The proposal to develop and introduce care plans with a dual purpose of informing individual patient care and improving awareness and palliative care education for the family General Practitioners was not able to be implemented because of unforeseen illness.

Increased collaboration and cooperation between staff of the two different organisations was achieved and strategies explored for the maintenance of this improved professional working relationship. General Practitioner attachments to the Murdoch Community Hospice were demonstrated to benefit not only the participants but also the community patients.

5. Discussion

Although the outcomes of this project were not exactly as envisaged in its initial conceptualisation, significant achievements were realised. The development of an Admission Assessment Tool was more complex and challenging than we imagined, and although it did not achieve the goal of objectively describing and predicting the need for admission, the increased awareness it engendered did positively influence the processes of consideration of admission as a care option, and negotiation between the domiciliary and inpatient staff responsible. In essence it resulted in staff from two different organisations better “talking the same language”. This will be an ongoing aspect of care management for the project participants, and although the tool may not be universally applicable in other palliative care contexts and settings, a similar process may be beneficial. Other agencies attempting a similar strategy would most likely benefit from adopting the framework of our Admission Assessment Tool and building onto that with locally relevant additional or modified data acquisition and analysis.

Limitations to the project achievements were thrust upon it by the unexpected illness of one of the key personnel, and although consideration had been given to strategies for minimising the impact of a variety mishaps, it is inevitable that the character of such a project will be changed by such an event. The substitution and highly

successful implementation of domiciliary social worker involvement with the Silver Chain Hospice team was a most welcome outcome.

The employment of social workers to supplement the roles of nursing and other staff in the community, the use of the Admission Assessment Tool to facilitate admission processes, the collaboration between nursing and medical personnel in attending relevant meetings of the opposite team and in sharing case-notes are all sustainable achievements that can be continued with existing resources. Client and staff satisfaction surveys and opportunities for regular joint meetings and clinical activities are expected to be incorporated into routine practice.

6. Conclusion

The following recommendations arise from the experience of this project:

1. Further work should be undertaken in a variety of palliative care models and settings to elucidate in more detail the reasons behind changes from domiciliary to inpatient care.
2. The insights obtained from 1.1 should be used to inform the further development of innovative and effective models of care delivery for various sectors of the Australian community.
3. Murdoch Community Hospice and Silver Chain Hospice Care Service consider all future opportunities to promote shared medical, nursing and allied health expertise and experience by blurring the distinction between domiciliary and specialist inpatient care settings.
4. In the interim, regular combined meetings should occur between Silver Chain Hospice Care Service and Murdoch Community Hospice staff, who are effectively partners in the care of a common cohort of clients, with the objective to share clinical knowledge, experience and practical approaches to maximise the palliative care benefits to patients and families.
5. Future opportunities and funding sources need to be identified to allow implementation of the proposed detailed management plans to assist General Practitioners and others in the delivery of optimal palliative care.
6. Regular opportunities should be sought for General Practitioners to undertake clinical attachments in the palliative care field, and such opportunities and programs are flexible and varied in content and duration.
7. Future projects in the clinical palliative care context should adopt the ongoing evaluation technique of a diary recording events and attitudes supplemented by periodical staff satisfaction surveys to inform the development, progress and final implementation of the project.

MAIN MESSAGE

What we did

- Trialled various ways to improve the interface between the domiciliary palliative care service and the specialised inpatient Hospice and contributed to the development of educational opportunities for General Practitioners in the community.

What has been learned?

- The transition of patients between inpatient Hospice and community care settings has been improved, and the processes facilitated by changing the way health professionals communicate about the need for admission.
- Flexibility and variation in content and duration of clinical attachments for GPs is desirable to maximise the capacity for some GPs to manage patients in their own practice better, and for others to embark on significant roles with community palliative care providers.
- An unforeseen but welcome outcome was the trialling and implementation of social workers employed in the domiciliary palliative care service to supplement the roles of domiciliary nurses and the Hospice-based social worker.

What is useful to other projects/communities?

- Further work should be undertaken by a variety of palliative care providers to further our understanding of the transitions between community and inpatient palliative care.
- The process of examining the admission and discharge processes has the effect of improving continuity for patients through increased awareness by staff in each setting.
- A structured framework in the form of a written learning guide that identifies the breadth of palliative care topics which a GP may wish to address complements learning opportunities.
- GP learning opportunities need to be flexible in content and duration to allow some of the more suited participants to adopt a more advanced role in community palliative care provision.

What have been the benefits of disseminating information about this project?

- Dissemination of information about this project within the two organisations involved and amongst the GP networks assisted the project.

What needs to happen in order to sustain the key achievements of this project?

- Significant achievements resulting from changes to policy and practice have already been incorporated into routine practice in the two organisations involved.

What resources did you develop and are they available to others?

The Admission Assessment Tool and the Medical Learning Guide are both available in pdf format on request from the Project Manager eleanor.roderick@sjog.org.au .