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Extended hours community palliative care service

HammondCare

July 2023

END OF LIFE AND PALLIATIVE CARE NETWORK

NSW GOVERNMENT

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Introduction

The HammondCare Community Palliative Care Service is based in a Sydney metropolitan health district, serving a population of 910,260 people representing 12% of the NSW population (Sydney North Health Network, 2016). This initiative focuses on a six-month pilot, between September 2017 and March 2018, aiming to enhance the after-hours support available to the community.

Services

The HammondCare Community Palliative Care Service is provided from three separate sites: Greenwich, Neringah and Northern Beaches. The service can refer to two inpatient palliative care units (PCUs), Greenwich and Neringah. It also provides 24/7 specialist advice to other healthcare professionals who may call for management advice. Each of the three separate community sites have an average of 230 active patients in their homes, linked to the service for advice and support.

The community palliative care team works alongside a range of providers, including the Northern Sydney Home Nursing Service (part of Northern Sydney Local Health District), a local community nursing service; the Department of Veterans Affairs-approved providers; My Aged Care providers; and other community services such as the Aged Care Rapid Response team.

Referrals

Referrals are received by the service from general practitioners (GPs) and other medical specialists via email or fax. Verbal handover often accompanies patients referred from the inpatient setting when seen by in-house or in-reach services. At the time of this pilot, there were on average 130 new referrals per month at each site.

Staffing

At the time of the pilot, each of the three community palliative care teams had:

- on average, 3.5FTE clinical nurse specialists or registered nurses, 1FTE medical staff specialist, 1FTE clinical nurse consultant and 0.2FTE nurse practitioner
- 0.8FTE allied health staff across a range of professions, including social workers, physiotherapists, occupational therapists and pastoral care workers.

In addition, there were an additional 2.5 FTE clinical nurse consultants who provided in-reach services to local hospitals.

Extended hours community palliative care service

Overview

Between September 2017 and March 2018, a six-month pilot was undertaken that involved community palliative care service nurses extending their work schedule to cover weekends. This pilot was called the Extended Hours Palliative Care Service (EHPCS). As part of the EHPCS, nurses took after-hours calls and provided home visits (if required). A toll-free 1800 number was established that could be diverted to the mobile phones of the staff on duty.

Before this initiative was implemented, the community palliative care service nurses worked business hours only, and calls to the after-hours numbers were answered by the rostered after-hours nurse manager (AHNM). The AHNM, who had varying levels of palliative care expertise, was responsible for the safe operation of two hospital sites. The trial of the extended hours palliative care model saw the specialist palliative care community nurses working on weekends to answer the calls and to make calls to patients in the community who were unstable, deteriorating or in a terminal phase (according to the Palliative Care Outcomes Collaborative [PCOC]).

Implementation

The change to the service was communicated to the nurses and after-hours nurse managers. A training day (multiple sessions) was also held, which was mandatory for all staff to attend. Attendance at the training day was covered by the evaluation grant and approved by the HammondCare management. The training day acted as a networking forum, where staff received updates on practical resources, revised flip chart and shared drive folders with community-based care information. They also had the opportunity to role-play taking calls.

The EHPCS was conducted in two phases. In phase 1, a community palliative care service nurse began work at 7am and another at 9.30am rather than the usual 8am start, thereby covering the service for 11 hours rather than the usual eight hours at no extra cost to the organisation.

Phase 2 involved a community palliative care service nurse rostered on Saturday and Sunday between 8am and 4.30pm to answer phone calls, make home visits if urgent and make proactive calls to patients who were considered unstable, deteriorating or terminal. Each Friday a list of patients of concern was collated and provided to the nurse working on the weekend.

Nurses who responded to extended hour phone calls were required to keep a log of all the calls, including subject, outcome and the nurses' subjective assessment of the success of the call.

A 'Plan Do Study Act (PDSA)' approach was adopted for this service, which allowed for amendments to be made during the pilot period, such as ceasing the extended weekday hours (Phase 1), as it was found that most of the calls received were administrative in nature, and therefore added no clinical benefit. The weekend coverage continued for another six months.

Funding

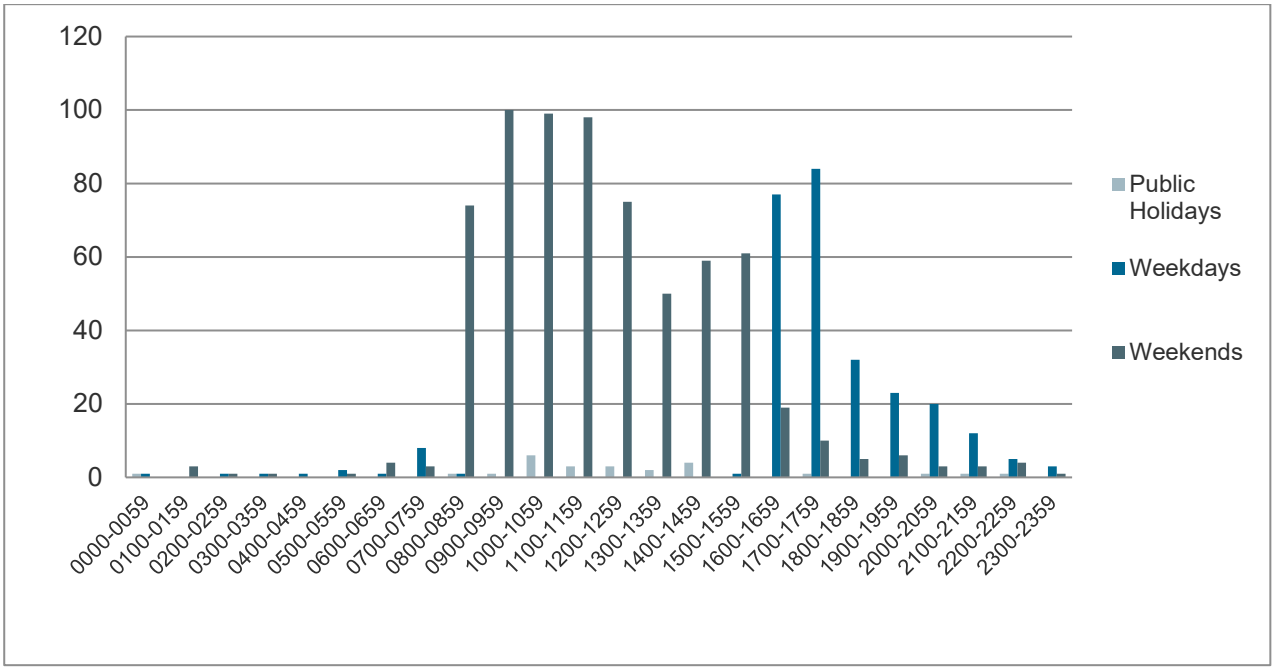
Funding for the EHPCS was provided by:

HammondCare – which paid the staff wages for the pilot (including weekend loading and the accumulation of additional leave). Staff were also funded to attend a training day to learn about the extended hours pilot

The Agency for Clinical Innovation – which funded the project lead, through the partnership and supported research fund, to evaluate the EHPCS one day per week, acquire a laptop and attend a digital health conference for the two study days.

No new staff were funded through the pilot phase.

Figure 1. Calls by hours and days of Extended Hours Community Palliative Care Service trial



Benefits of the extended hours service

The EHPCS reduced the percentage of patients being sent to acute hospitals from 23% to 5%. There was a 50% increase in after-hours inpatient PCU admissions during the EHPCS period, equating to an additional 22 people avoiding acute hospitalisation. Using an acute hospital bed

cost ($2,081 per bed per day*), this represented a saving of $45,782 to the acute hospital budget over six months and an increase in HammondCare bed occupancy.

Figure 2. Extended Hours Palliative Care Service in action

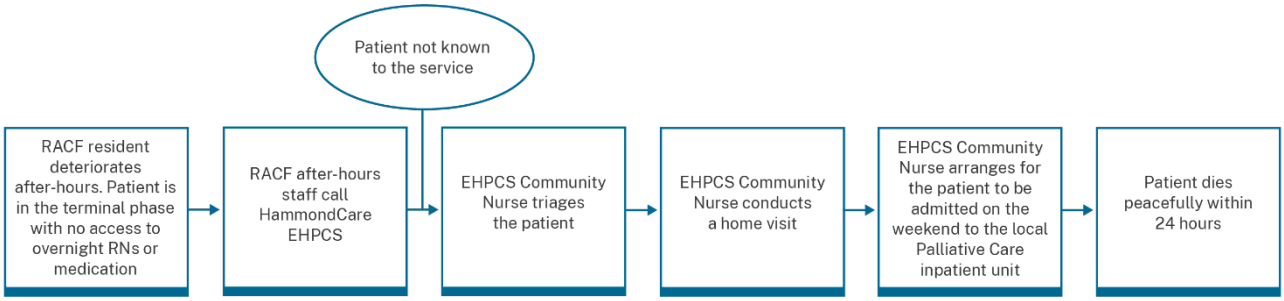
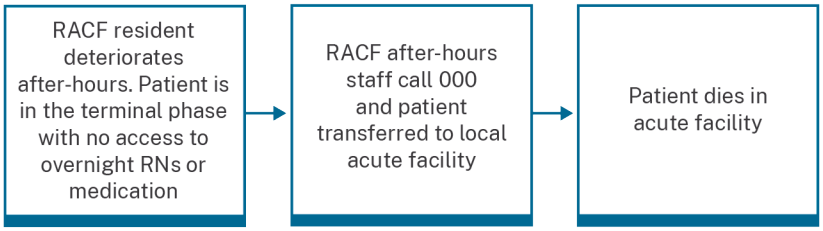


Figure 3. Patient journey if there were no Extended Hours Palliative Care Service



Tables 1–3 highlight the EHPCS after-hours caller location, caller type and the reason for call.

Table 1. Extended Hours Palliative Care Service caller location

Residence	Number	%
Hospital	77	10
Private home	624	84
Residential aged care facility	46	6

Table 2. Extended Hours Palliative Care Service caller type

Caller type	Number	%
Personal carer/relative/friend	452	61
Healthcare worker	158	21
Patient	137	18

* Australian Institute of Health and Welfare 2020. Health expenditure Australia 2018–19. Health and welfare expenditure series no.66. Cat. no. HWE 80. Canberra: AIHW.

Table 3. Reason for call to the Extended Hours Palliative Care Service

Reason for call	Total	%
Symptom	373	34
Equipment issue	26	2
Health professional enquiry	52	5
Notification of death	15	1
Deterioration	131	12
Medication-related	219	20
Support/other notification	290	26

The immediate outcome of each occasion of service was recorded for all calls (see Table 4 for detail). The primary goal of avoiding acute hospitalisation was achieved for **85%** of callers.

Table 4. Outcome of call to Extended Hours Palliative Care Service

Outcome of occasion of service	Number	%
Stayed at home/residential aged care facility	634	85
Admitted to palliative care unit	46	6
Went to emergency department/called ambulance	37	5
Died	22	3
Called home visiting doctor service	7	<1
EHPCS home visit	6	<1

Patient, carer and family experience

Below are some quotes from patients, carers and family members on their experience of the EHPCS.

- “Pleased to know someone was there 24/7.”
- “Pain under control and much better.”
- “Very helpful; gave me medication advice then rang again the next morning to see how things were going.”

Staff experience

Following the EHPCS pilot both doctors and nurses were interviewed, and their responses were analysed thematically below.

Nurse responses

Positive

- “Not as bad as I thought.”
- Improved confidence and skills
- Overall improved service
- Proactive calling – “I don’t worry about my patients now.”

- Increased mutual respect between After Hours Nurse Manager and community nurses
- Increased community team cohesion

Negative

- Affected personal life
- Disrupted weekday team
- Had to rely on others' assessment (patients or caregivers)

Challenges

- Unclear goals of care
- Inadequate documentation
- Phone system unreliable

Doctor responses

- Workload changed – the number of calls to them went down but admissions to PCUs went up but these were appropriate, e.g. "massive change, needs are being met".
- Improved service – proactive calling and patients appreciative, "(before) sometimes I would just ask for the patient's number and call them directly myself".
- Use of ISBAR commended, "I don't care if the nurse doesn't know what to do, just give all the information".

Tips for others

- Prepare the staff adequately with consultation, education and mentoring so they are confident about taking calls
- Develop resources that staff can easily access
- Educate all staff in any setting to:
  - document goals of care clearly
  - use ISBAR to communicate
- Identify champions of the model. It allowed staff to appreciate the roles of others in the organisation
- Ensure reliable ICT support.

Next steps

The EHPCS model piloted has now evolved. A dedicated after-hours nurse position has since been funded by HammondCare out of the community palliative care service budget. This position covers the weekday evenings and weekend days. At all other times the calls are diverted to the PCU nurses who have been trained in taking these calls. When the current dedicated after-hours nurse is on leave, the AHNM who is on duty takes the calls or they are diverted to PCU nurses.

Many of the systems implemented in this pilot are ongoing, including the data collection (with the exception of the subjective assessment of whether their intervention prevented unwanted hospital admission).

Supporting documents

Keall R & Lovell M. Extended-hours palliative care service with a hospital-avoidance and enhanced-care approach: report of a quality improvement project. Int J Palliat Nurs. 2020 Jun 2;26(5):222-228. doi: 10.12968/ijpn.2020.26.5.222.

Acknowledgements

Robyn Keall, Nurse Practitioner HammondCare (Community Palliative Care), PhD

Professor Melanie Lovell, Medical Staff Specialist, HammondCare, MBBS, PhD, FRACP, FAChPM

Appendix

Alignment with the Clinical Principles for End of Life and Palliative Care Guideline

Key Action area		Evidence
1. Screening and identification	✓	Nurses in receipt of extended hour phone calls were required to keep a log of all the calls, what they were about, the outcome and their subjective assessment of the success of the call. During the pilot the patients were screened for suitability as being unstable, deteriorating or terminal phase (according to PCOC).
2. Triage	✓	Nurses were aided by flip chart to support consistency in the triage of suitable patients and improve outcomes for clients. Outcomes from the triage process in the pilot included: • stayed at home/residential aged care facility • admitted to palliative care unit • send to emergency department / called ambulance • died • called home visiting doctor service • EHPCS home visit.
3. Comprehensive Assessment		
4. Care Planning	✓	The pilot involved the community palliative care nurse answering phone calls, making home visits (if urgent) and making proactive phone calls to patients who were considered unstable, deteriorating or terminal. Each Friday a list of community patients of concern was collated and provided to the nurse working on the weekend.
5. Open and Respectful Communication		
6. Symptom Management	✓	Top reasons for EHPCS phone calls in pilot phase included: • Symptom management – 34% • Medication - 20% • Deterioration – 12%
7. 24/7 Access to Support	✓	In Phase 1, a community palliative care service nurse began work at 0700hrs and another at 0930hrs rather than the usual 0800hrs, thereby covering the service for 11 hours rather than the usual eight hours at no extra cost to the organisation. Phase 2 involved a community palliative care service nurse rostered on Saturday and Sunday 0800–1630hrs to answer phone calls, to make home visits if urgent, and to make proactive calls to patients considered unstable, deteriorating or terminal. Each Friday a list of patients of concern was collated and provided to the nurse working on the weekend.

8. Place of Death	✓	The EHPCS model is provided to patients in RACFs, DVA approved providers, My Aged Care providers and other community services such as Aged Care Rapid Response team to ensure that palliative care patients can remain in the location of their choosing, where possible.
9. Grief and Bereavement Support		