

# Palliative Care Discharge Planning Project

Care Planning Sub-Program  
National Workshop  
28 – 29 July 2008

# Researchers

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# Outline

- ❖ Aims
- ❖ Evaluation
- ❖ Findings to date
- ❖ Proposed strategies for change
- ❖ Resources
- ❖ Challenges for our project

# Setting Royal Brisbane and Women's Hospital

- 1000+ beds
- Tertiary hospital – major oncology services
- Consultative palliative care services
  - No beds

Services northern half of Brisbane and most regional areas

# Aim

Develop and evaluate a discharge planning process for patients referred to the palliative care service at RBWH aimed at improving communication between health care providers

# Study Design

- ❖ Collect pre-intervention data
  - Systematic Literature Review
  - Collection of baseline data from patients, carers, health professionals
- ❖ Develop the intervention
  - Informed by the data

# Study Design

- ❖ Implement intervention
- ❖ Evaluate
- ❖ Recommendations
- ❖ Spread the word

# Evaluating

Assessing the pre-intervention discharge process to identify problems and possible solutions

- Patient and carer questionnaires
- Focus groups – hospital & community health professionals (allied health, nursing)
- GP surveys – discharge process, after hours availability, palliative care management
- Patient chart audit – method and timeliness of discharge documents



# Evaluating

Evaluating the efficacy of the intervention by analyzing cohort 1 & 2 data

- ❖ Satisfaction with the discharge process
- ❖ Feedback on the PHR; CC
- ❖ Quality of life and function (week 1, week 8)
- ❖ Service utilization
  - Hospital readmissions data
  - Medicare data

# Findings to Date

## Identifying the problems

### Key issues

- Resource constraints
- Varying degrees of experience of health professionals in palliative care
- Inadequate acknowledgment of palliative care status of patient
- Role definition

# Discharge planning process

## ❖ **Inadequate Discharge Planning processes**

- ❖ often rushed, delayed referrals to PC, inadequate information and wrong sort

## ❖ **Incomplete Discharge Summaries**

- Often crucial information re palliative care omitted
- Inadequate medication information
- ⇒ Creates constant need to supplement information

## ❖ **Delayed communication of discharge summaries**

# Community services

## General Practitioner

- Not always notified prior to discharge
  - Hesitant to act without medical discharge summary
  - Often introduced at late stage – no time for trust to develop
  - Variable experience in palliative care
- 
- ❖ Community nurse not always viewed as member of the palliative care team

## ❖ Patient/Carer

- Pressing issues not addressed
- Information overload
- Inadequate medications information
- Frustrated at re-telling the story
- Carers often underestimate the challenges

Proposed Strategies for change

# Proposed Strategies for Change

## Objectives

- ❖ Encourage relationship building between patient, family and PCS early
- ❖ Plan discharge early. Set date
- ❖ Prioritise palliative medical discharge summaries
- ❖ Timely pharmacy consultation
- ❖ 24 hr care plan to reassure carers

# Resources

*To incorporate the proposed strategies for change we developed:*

1. Palliative Care Plan
2. Case Conference protocol & procedures
3. Patient-Held Record



# Palliative Care Plan

Queensland Government  
Palliative Care Service  
**Palliative Care Plan**  
Facility: RBWH

Page two is mainly relevant for distribution to health professionals before distributing a copy of 1

Control  
 • Choice, dignity  
 • Treatment optional/management plan  
 • Place of death

Out of Hours/ Emergency  
 • Carer support  
 • Medical support  
 • Drugs and equipment

Late  
 • End of life care  
 • Stop non-urgent Rx  
 • Comfort measures, spiritual care  
 • Rattle, agitation

Afterwards  
 • Bereavement follow-up  
 • Family support

• GP

• Community Nursing

• Allied Health

• Palliative Care OPD

• Other

Completed by \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Copies distributed Initials \_\_\_\_\_ Date \_\_\_\_\_  
 PEPSI COLA aide memoire - Adapted from Gold Standards Framework G.N.

MR 6074 v 27/3/2008

Queensland Government  
Palliative Care Service  
**Palliative Care Plan**  
Royal Brisbane & Women's Hospital Health Service District

Page 1 is for distribution to patient, carer and health professionals

LRN: \_\_\_\_\_ (NHS patient identification when here)  
 Family Name: \_\_\_\_\_  
 Given Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex:  M  F

Date of referral: \_\_\_\_\_ Date of Multi-Disciplinary Team Meeting: \_\_\_\_\_ Estimated date of discharge: \_\_\_\_\_ Phase code: \_\_\_\_\_ RUG-ADL: \_\_\_\_\_

Date of discharge: \_\_\_\_\_ Phase code: \_\_\_\_\_ RUG-ADL: \_\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_

1 2 3 4 5

PEPSI  
 • Symptom control  
 • Medication  
 • Compliance / stopping non-essentials  
 • Complementary therapies  
 • Added health support to maximise function within patient's capacity

Emotional  
 • Understanding expectations  
 • Psychological distress  
 • Pains / security Relationships

Personal  
 • Spiritual / religious needs  
 • Quality of life  
 • Patient/carer's agenda

Social Support  
 • Benefits/financial  
 • Care for carers  
 • Practical support

Information/Communication  
 • Between professionals  
 • To and from patient  
 • To and from carer

• Psych-liaison consultation

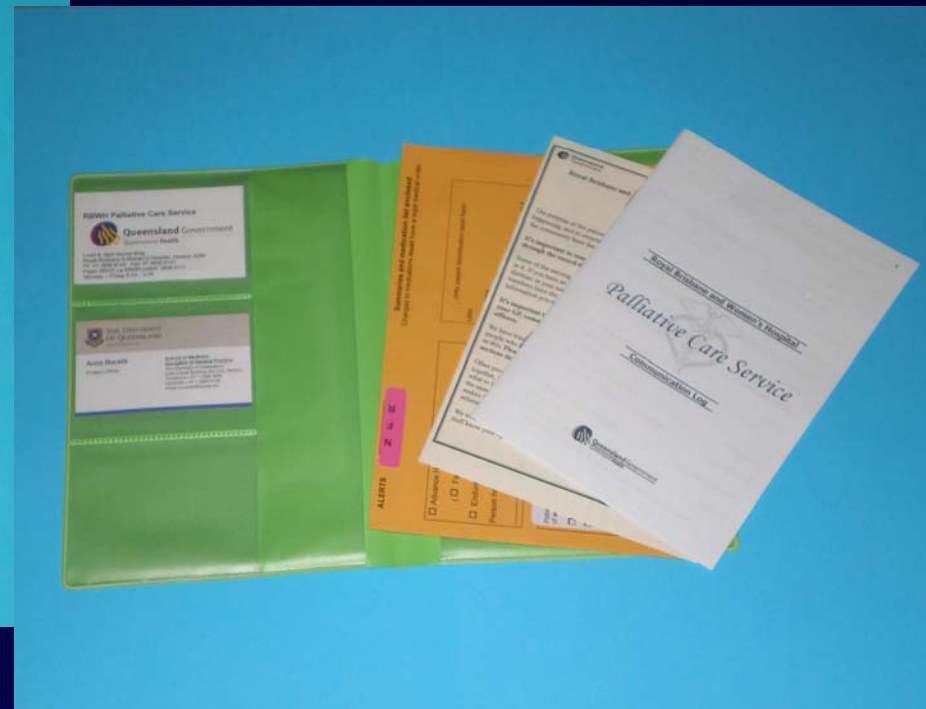
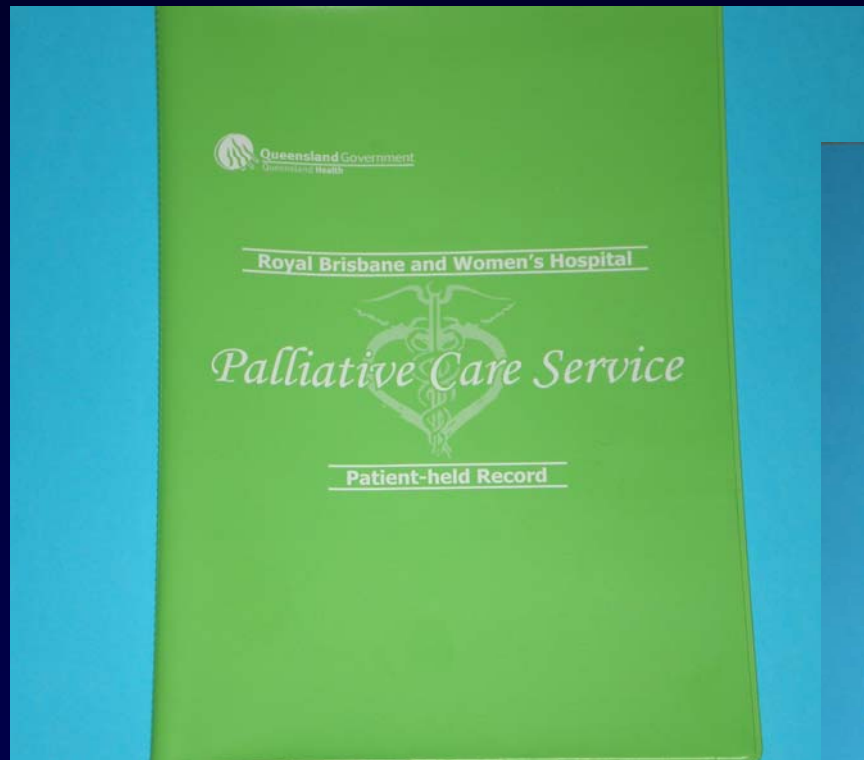
• GP case conference  
 • Family meeting Preferred Date: \_\_\_\_\_

Care strategies and/or support required

Done

PALLIATIVE CARE PLAN

# Patient-Held Record



# PHR - Structure

*Three components*

- Clinical Information Envelope
- Communication Booklet
- Wallet

# Case Conference

- ❖ Multi-disciplinary teleconference
- ❖ Billable service
- ❖ Admin load reduced
- ❖ Participants provided with documentation

# Challenges for our project

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- ❖ PC service is consultative- has no “control” of their patient population
- ❖ Therefore no control over when patients actually discharged
- ❖ Staff stretched and stressed
- ❖ Normal high attrition rate

# Challenges for the project

- ❖ Patient tracking can be difficult
- ❖ Patients don't always have a GP and/or community nurse
- ❖ Difficulty obtaining information about pt death prior to contacting carer for 8 week follow-up

Some Solutions



# Challenges for the project ~ Solutions ~

## Working with RBWH

- ❖ MOU with RBWH
- ❖ Clearly document project procedures
- ❖ Checklists
- ❖ Monitor, analyse project activities
- ❖ Modify and clarify project procedures

# Challenges for the project

## ~ Solutions ~

- ❖ Recruiting – increased the pool
  - Broadened the territory:
    - Brisbane metro → and beyond
    - Oncology ward only → plus medical
  - Analysed ineligibility data
  - Calling on assistance from the carer

# Challenges for the project

## Solutions ~ working with the staff

- ❖ Learn their ways
- ❖ Maintain a presence
- ❖ Regular communication
- ❖ Show of support
- ❖ Encouragement & positive feedback – PCS & ward staff

The long term

# Sustainability

Embed the process into normal care

Ensure records compatible with RBWH records

# Benefits of the Intervention

