ENABLING SHARED PALLIATIVE AND END-OF-LIFE CARE IN THE BALLARAT COMMUNITY

Many people prefer to receive palliative and end of life care in the comfort of their own home rather than in hospital. Nevertheless, statistics indicate that many people actually die in hospital. Ballarat Hospice Care (BHCI) and Ballarat Health Services (BHS) conducted a joint research project to strengthen systems to enable joint patients to return home from acute hospital in a timely, smooth, safe and sustainable manner for ongoing palliative or end of life care, if they want to.

BACKGROUND

Patient-centred care is about providing the best care possible under consideration of patient needs and preferences. This includes being cared for and dying in one's place of choice. Being cared for and dying in one's preferred location is considered an integral part of living and dying well. Many people wish to die in their home as they often have a strong connection to this place. Home offers a sense of belonging and social connection, familiar people, objects and surroundings, which is especially comforting for such an important time.

However, when approaching the end of life, planned hospital admission as well as unexpected presentation to the Emergency Department and hospital stays are common.

To limit preventable visits to the Emergency Department and inpatient hospital stays, and support the timely, smooth, safe and sustainable return of people with an advanced life-limiting illness back to home, the Rapid Discharge research project was conducted to

- to develop a shared acute hospital and community model of palliative and end of life care
- identify local barriers and their solutions to returning home
- identify and strengthen local enablers to return home.

Sustainable integration of services to meet the choices of people requiring palliative care and wanting to be discharged from acute hospital to home for ongoing care and to die at home: Rapid Discharge

Lead: Ballarat Hospice Care Inc.

Partners: Ballarat Health Services; Grampians Regional Palliative Care Team (Ballarat Health Services)

Funding: Victorian Department of Health and Human Services, 2019 Palliative Care Service Innovation and Development Grant

Duration: September 2019 – July 2021

Ethics: Approved by the *Ballarat Health Services and St John of God Healthcare Human Research Ethics Committee* (ERM 64367)

Key outcome: A Ballarat Hospice Care and Ballarat Health Services joint framework for shared palliative and end-of-life care in the Ballarat community, encompassing the following elements

- Context-specific definition of patient-centred care
- Model of initiation and execution of shared BHS acute hospital and BHCI community dwelling palliative and end of life care
- Pathways for optimal shared patient-centred care under consideration of a patient's preferred place of care and death for planned and unplanned events
- Procedures for optimal transfer of care between Ballarat Hospice Care Inc. and Ballarat Health Services

BALLARAT HOSPICE CARE INC
Research

KEY ACTIVITIES

Realist review of the international healthcare literature on barriers and enablers to the discharge of patients at the end of life to home

Identification of local barriers and enablers through
- a governance and procedural document audit
- a retrospective BHS and BHCI record audit and prospective BHCI record audit
- a hospital healthcare worker survey
- qualitative interviews with patients and bereaved carers
- expert consultations
- consumer consultations

Development of enabler resources

Strengthening systems at BHCI to
- strengthen staff, partnerships and resources in readiness to respond to discharges from acute hospital
- enable response to hospital discharge not only during office hours but also after hours, on weekends and public holidays
- respond effectively and efficiently to receive and accept the referral of new patients who wish to leave hospital to receive end of life and palliative care at home

Trialling of health care providers utilising shared electronic patient information management system (PalCare)

OUTCOMES

Framework for shared palliative and end-of-life care in the Ballarat community, encompassing the following elements:
- Context-specific definition of patient-centred care
- Model of shared BHS acute hospital and BHCI community dwelling palliative and end of life care
- Pathways:
  - → Pathway A: planned or expected event pathway for community dwelling palliative and end of life care - collaborative and aligned care, communication and information flow
  - → Pathway B: unplanned or unexpected event pathway for community dwelling palliative and end of life care - collaborative care, communication and information flow to achieve the most appropriate place of care
  - → Pathway C: unplanned or unexpected event pathway for community dwelling palliative and end of life care - collaborative care, communication and information flow when requiring BHS Emergency Department care
- Procedures:
  - → Transfer of care process & tool from BHCI to BHS
  - → Transfer of care process & tool from BHS to BHCI and the patient GP (also guiding BHCI nursing staff through the process of preparing the discharge of a palliative care patient to home)
  - → Direct admission and transfer of care to BHS Palliative Care Inpatient Unit Gandarra

Education materials pack for patients, carers and families, health professionals and community

Program of work for Rapid Discharge Implementation, Sustainability and innovation Program (Quality improvement program)

KEY LEARNINGS

- When developing concepts around shared care for palliative care patients, the focus needs to be on the patient journey as the disease progresses, and at hospital admission and discharge as reoccurring and likely events rather than singular events. It also needs to be recognised that many service providers, healthcare professionals and care teams are ready, prepared and involved in supporting patients and carers to achieve being cared for at home, such as GPs and Specialists, Ballarat Hospice Care, Ambulance Victoria paramedics, the Emergency Department care team, acute inpatient ward care teams and the palliative inpatient unit care team. These two insights lead to the learning that instead of looking at the segmented involvement of service providers or care teams, we need to focus on the patient journey and understand care as a continuum. This puts the emphasis on the continuity of care, and therefore on the transfer of care between services and the handover not just of the patient, but of all relevant information about this patient's family and carers from one care service team to another.
- In order to achieve patient preferences, collaboration in the form of communication between healthcare service providers, healthcare professionals and care teams is critical: Relevant information about the patient and events need to be relayed in a timely, efficient and effective manner. Hence, patient-centred care is about enabling the rapid understanding of
  - → a patient's healthcare needs and history
  - → recent health events
  - → medication, therapies and equipment
  - → involvement of healthcare providers
  - → and above all, the patient's preferences

  through communication.
- This can't be accomplished without the patient and their family and carer playing an active role in planning and decisions. For healthcare professionals and healthcare services to be able to work together and share information, it is critical that people identify that they have preferences and plans for palliative and end of life care and are linked into community services such as Ballarat Hospice Care. Hence, patients and carers need to be empowered and supported to enable this communication and transfer of information.

Why this project?

A BHCI patient in their late 50s had stated the preference to be cared for and die at home. After a 'failed discharge' from hospital to home, the patient was transported back to hospital via ambulance and re-admitted the next day. It was soon recognised that death was imminent but safe transport back to home was not feasible. The person died in hospital.

A formal transfer of care and handover process put in place before the patient leaves hospital for home, facilitating communication and the immediate exchange of relevant information between BHCI and BHS care teams could ensure a BHCI Specialist Palliative Care Nurse supported by information from the hospital team visits the home to assess and prepare it and the family and carers in readiness for the patient's arrival home. It is hoped that this collaboration between hospital and community health carers may join efforts to support the patient to achieve their preference to be cared for and die in the comfort of their own home.

A step by step procedure for BHS and BHCI to join efforts, including a handover process and tool was developed as part of the Rapid Discharge project.

For more information:

- Contact us via research@ballarathospicecare.org.au or on (03) 5333 1118
- Visit the Rapid Discharge Research Project website: https://ballarathospicecare.org.au/who-we-are/research/research-rapid-discharge