Palliative Care in Regional and Rural Australia

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National Rural Palliative Care Program
2004-06
Rural Palliative Care Project

- Strengthening palliative care partnerships
  - Across the care continuum
  - Enhanced direct care delivery
  - Professional participation & education
  - Data management
  - Public and private health care
  - Developing a local model of care
Challenges

- Increased demand for palliative care – non-malignant disease
- Absence of designated palliative care beds, after-hours service and physician
- Unmet need in RACF
- Workforce related issues
- Managing change
Facilitators

• 17 enthusiastic project partners
• A willingness to explore alternative options
• Cross sector support: public & private
• Acknowledgement that palliative care is everyone’s responsibility
• Desire to establish a local palliative care system
Program Plan

• Identified local need
• National Palliative Care Strategy
• Palliative Care Australia Policy
  – Service planning
  – Standards
  – Population based approach
• Palliative Approach Guidelines
• NSW Palliative Care Framework
Primary care

Intermediate

Complex

Specialist palliative care service delivery based on a population based approach with four delineated levels of care

**Complexity of patient need**

**Level and role of specialist palliative care**

1. **Primary palliative care**
   - Provide learning and development opportunities for primary and secondary care providers

2. **Consultation – liaison**
   - Provide consultation and advice to primary and secondary care providers

3. **Shared care**
   - With primary and secondary providers

4. **Direct care**
   - In the community and in designated beds
Project Governance

• Clinical Advisory Groups:
  – Multi-disciplinary care planning
  – After-hours telephone information service
  – Data management & information technology
  – Palliative care delivery acute care - RACF
  – Learning and development initiatives
  – Indigenous community
Multi-disciplinary care

- Multi-agency – multi-disciplinary palliative care meeting
  - Weekly
  - RACF, Public & Private Health Care
  - GP input via teleconference - EPC items
  - Palliative care physician - MSOAP
Multi-disciplinary care
MDT June 05-06

%

June 05-06

PC Patients
Generalist patients
MDT
GP input
EPC
42% of all PC referrals presented at an MDT
After-hours Telephone Support Service
After-hours Telephone Support Service

• Operates from 1700-0830

• Clinical Decision Making Charts
• Procedure Manual
• Memorandum of understanding
• Education
AHTSS Evaluation

- 10% of patients called (n=35)- 55 OOS
- 78% calls made between 1800 -2400
- 6% referred to emergency
- Length calls 12.35 ± 6.33 minutes
- Majority seeking reassurance about symptom management & anxiety
- Cost effective – less than $2000/year
AHTSS Evaluation

• “I would never have chosen to do what I did... and I am not sure I would do it again... but that was what Mum wanted... she didn’t want to go to hospital, she wanted to die at home... but that was so hard for me... especially afterwards.......having someone there was such a relief.....I gave the needle and I think she may have already been dead.....it was such a relief to have someone talk me through”

• Another person commented “As long as that life line was there I felt I could do it”
End-of-life Care Pathway

- Coffs Harbour Health Campus
  - 60% of deaths on 48 bed acute medical ward
  - Project nurse acting as “clinical champion”

- Impacted positively on care
  - Palliative care medications
  - Appropriate nursing care
  - Enhance communication at the end-of-life
  - Promoting collaborative care
  - Reduced complaints
Percentage of deaths managed on the end-of-life care pathway

Outcomes


Difference in end-of-life care provided

- Use of combination analgesics
- Anti-emetic medication used in last 72 hours
- Anti-psychotic medications used in last 24 hours
- Anticholinergic medications used in last 24 hours
- Regular s/c anti-psychotic medications at 72 hours
- Anti-emetic medication used at 24 hours
- End-of-life care pathway
- Identified how family is to be contacted
- Patient’s spiritual needs assessed
- Regular mouth care in last 72 hours
- Pressure relieving devices used in last 72 hours life
- Family informed of tasks following death
- GP informed of patient’s death

* Statistical difference at \( p<0.05 \)

Professional Participation

A range of targeted learning and development strategy:

(n=148)

- General Practitioners
  - Field placements (n= 18)

- Acute health care providers
  - Link nurse role – 40 hours (n=25)

- RACF - Palliative approach
  - Care assistants – skill development – 16 hours (n=200)
  - Link nurse role – 40 hours (n=25)
Learning & Development

- Medical
- Nurses
- Care Assistants
- Events

TOTAL
Symptom management
Decision making at the end-of-life
Planning Day
Palliative Approach
### Demographic data and diagnoses of residents at time of death

<table>
<thead>
<tr>
<th>Sample</th>
<th>2003 (n=39)</th>
<th>2005 (n=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>84 years</td>
<td>87 years</td>
</tr>
<tr>
<td>* Male</td>
<td>39%</td>
<td>23%</td>
</tr>
<tr>
<td>* Female</td>
<td>62%</td>
<td>77%</td>
</tr>
<tr>
<td><strong>Primary Diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Malignancy</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>* Cognitive impairment</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>* Cardiovascular disease</td>
<td>31%</td>
<td>23%</td>
</tr>
<tr>
<td>* Respiratory disease</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>* Neurological condition</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>* Other/fragility</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Malignancy</td>
<td>8%</td>
<td>21%</td>
</tr>
<tr>
<td>* Cognitive impairment</td>
<td>54%</td>
<td>51%</td>
</tr>
<tr>
<td>* Cardiovascular disease</td>
<td>59%</td>
<td>61%</td>
</tr>
<tr>
<td>* Respiratory disease</td>
<td>21%</td>
<td>16%</td>
</tr>
<tr>
<td>* Neurological condition</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>* Fragility</td>
<td>67%</td>
<td>79%</td>
</tr>
<tr>
<td>* Musculoskeletal conditions</td>
<td>31%</td>
<td>30%</td>
</tr>
<tr>
<td>* Other</td>
<td>56%</td>
<td>65%</td>
</tr>
</tbody>
</table>

*Total responses >100% indicate more than one secondary diagnosis

# No statistically significant difference found between the two groups
Number of symptoms experienced in the last 72 hours

- Zero
- One
- Two
- Three
- Four

2003 (n=39) vs 2005 (n=43)
Differences in end-of-life care provided

- PRN anticholinergic used at 72 hours
- Central nervous system medications used at 24 hours
- Analgesics used at 24 hours
- Respiratory medication used at 24 hours
- Residents care reviewed by specialist palliative care team
- Residents care reviewed at a multi-disciplinary care planning meeting
- Pain assessment tool used
- Given break through analgesia for pain
- Other causes of restlessness considered
- Regular assessment respiratory tract secretions
- PRN opiate given for dyspnoea

* Statistical difference at p<0.05
Outcomes

• E-o-L care pathway in acute care and the intervention in RACF has enhanced the delivery of evidence based end-of-life care in these two settings

• Establishing a multi-agency MDT has been critical to the overall projects success:
  – networking,
  – increasing palliative care competencies and confidence
  – an important forum for action learning

• Generalist providers can successful deliver an AHTSS

• That a local palliative care system is being to emerge
Organisation of Health Care

- Formalise partnerships across care continuum
- Integrated network agreements
- Clinical information systems

Resources

- Individualised Support
- Leadership
- Policy
- Funding
- EPC

Health System

- Positive Policy Environment

Community

- Patients & families
- Support

Palliative Care Team

- Needs based Interactions
- Individualised

Better Outcomes for Palliative Care Service Delivery

Figure 2: Wagner’s adapted Chronic Care Model, as applied to palliative care
Strengthening partnerships

Significant outcomes
Conclusion

• Service advancements achieved through this collaborative project demonstrate the gains that can be made through the strengthening of local partnerships.

• Relevance to parts of rural Australia where the economies of scale dictate that novel approaches be considered to make the best use of scarce health care resources.