Introducing a model incorporating early integration of specialist palliative care: A study of staff's perspective

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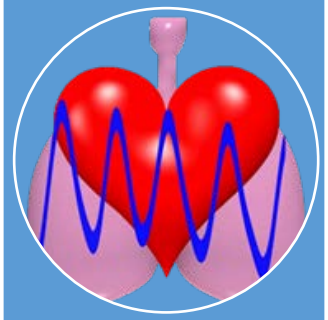
Cabrini

Evolution of Palliative Care

Hospice care

Clinical Specialisation



Broadening Scope

WHO Model

Comprehensive Programmes

The shifting paradigm of palliative care

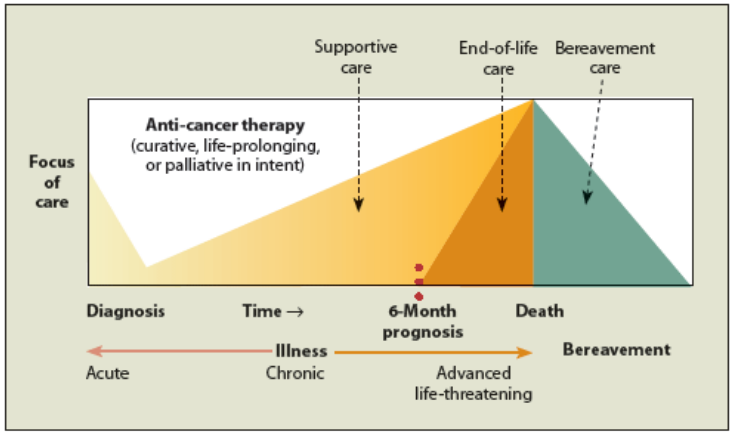


Figure 1: The balance between anti-tumor therapy and palliative care across the continuum of cancer care.

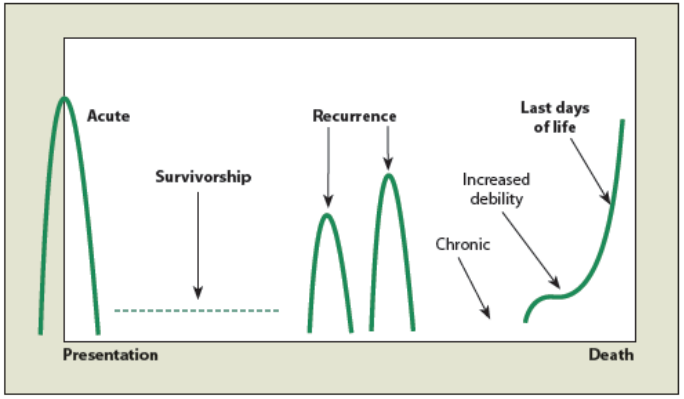
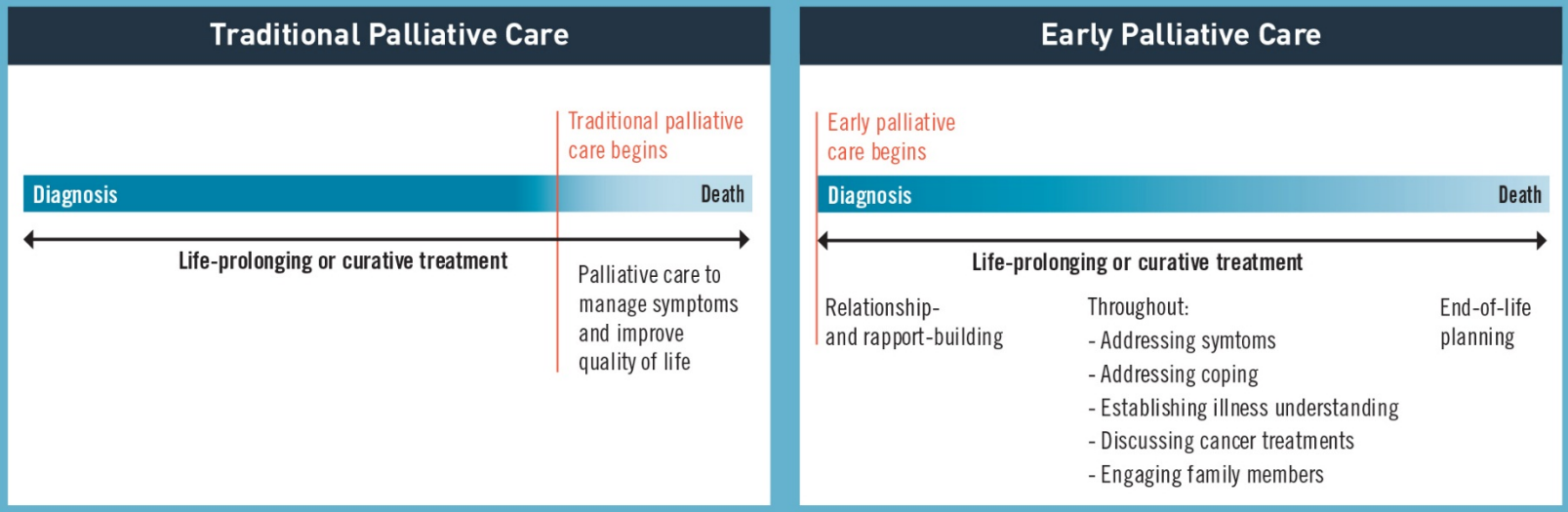


Figure 2: Symptoms across the trajectory of the cancer experience.

Benefits of Early versus Traditional Palliative Care



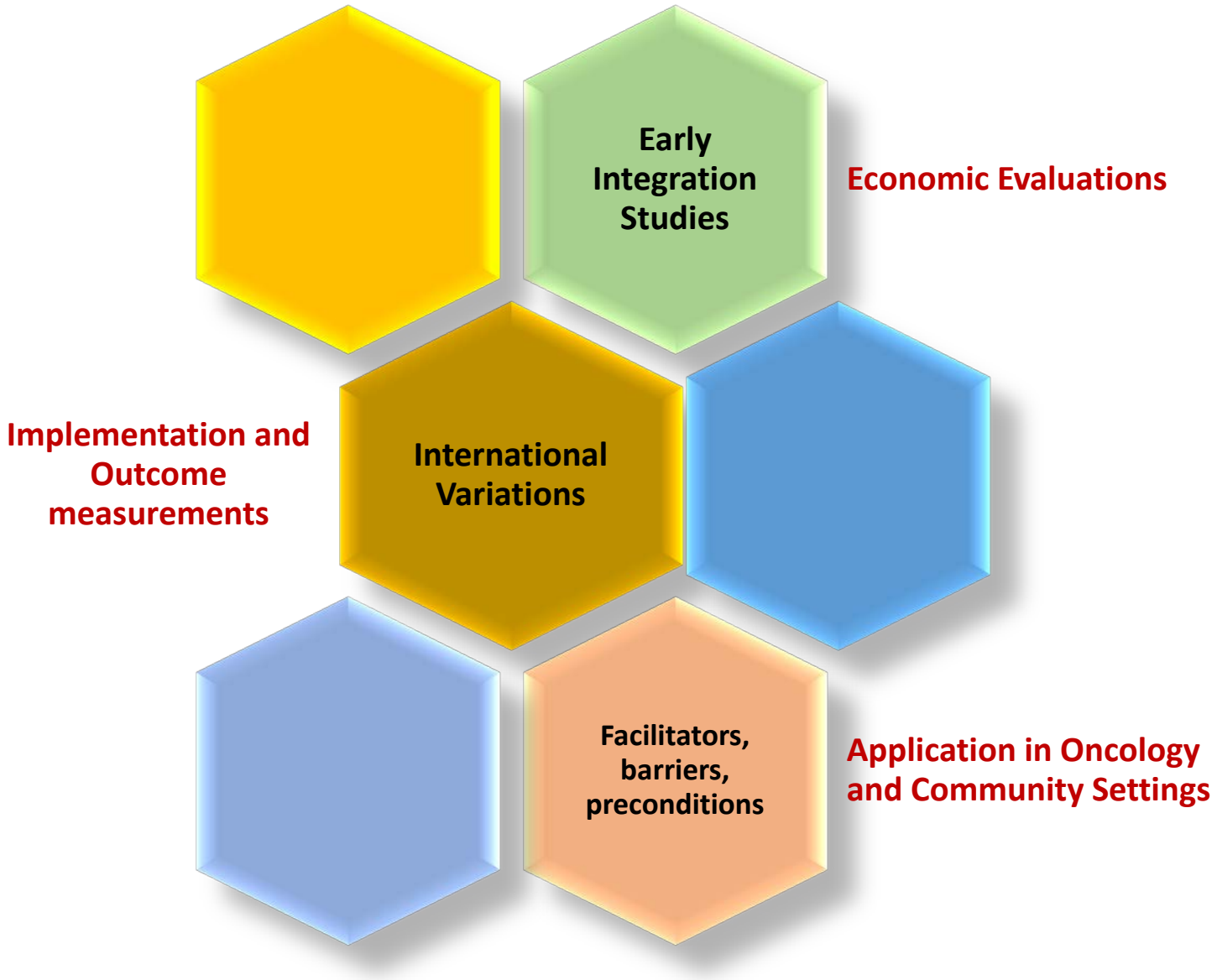
Whereas traditional palliative care typically begins toward the end of life, the early approach begins at the time of diagnosis.

What's in a Name?

- Hospice Care
- Palliative Care
- Supportive Care

Hui D et al. Concepts and Definitions. *Support Care Cancer 2013; 21(3):659-685*

CURRENT EVIDANCE



Is there a risk of routinisation of Palliative Care?

Person-Centred Principles

Evidenced Based Approach

EAPC ONLUS

European Association for Palliative Care

Non Governmental Organisation (NGO) recognised by the Council of Europe

Last updated: 21/11/2014

What do hospices do or not do? Participate in the debate!

In a challenging case study from Israel on the EAPC blog today, Professor Nathan Cherny worries that hospices that do not provide life-supporting therapies to patients who are not imminently dying may not be upholding the philosophy of individualised, goal-focused care.

Just how flexible is treatment and care in your hospice or palliative care setting? Are there boundaries? Please blick here to read today's post and share your views and experiences.

Published: 08-01-2013

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Palliative Care Integrated Service Model

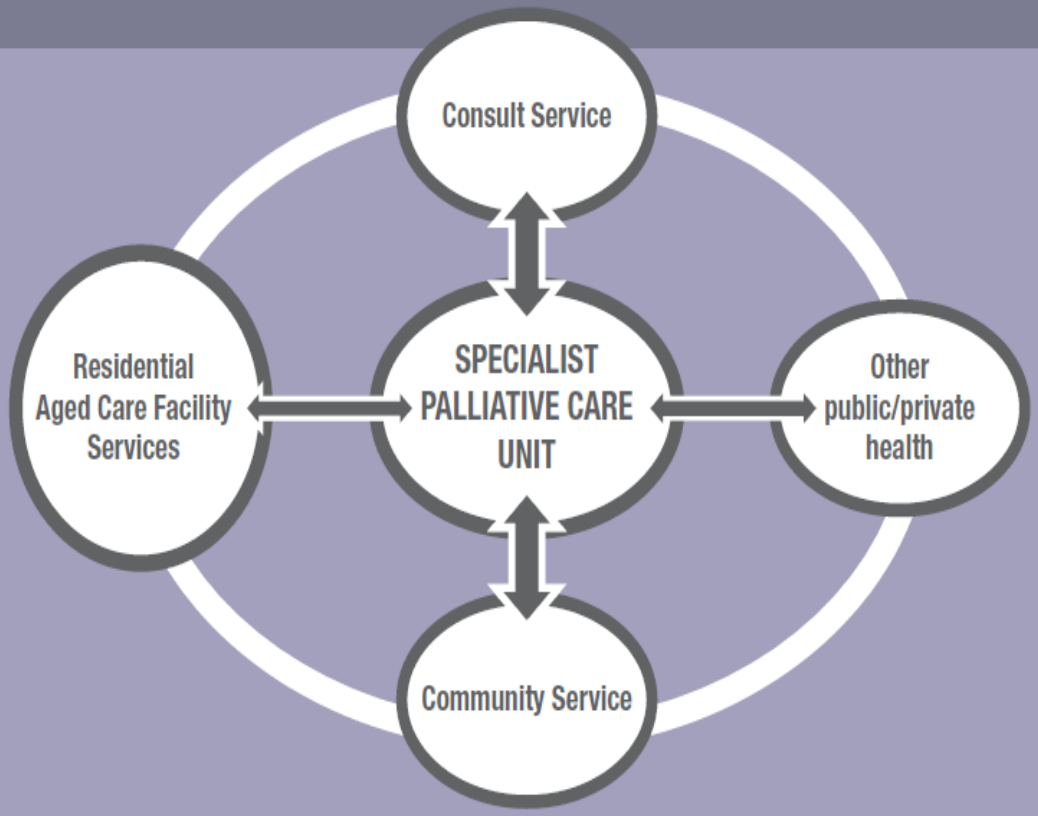


Table 1. Main features of the previous and current model of palliative care.

Service model prior to July 2013	Service model since July 2013
Medical services provided by part time certified specialist[a] staff from external palliative care services and independent noncertified specialist	Medical services provided by certified specialist staff employed directly by organisation. Commencement of comprehensive weekly multidisciplinary meetings in inpatient and community settings
Part-time junior doctor appointment	Three advance trainees[b] allocated from specialist training programmes in palliative and geriatric medicine
Limited consult service (two sessions[c] across a single hospital) to acute hospitals by liaison nurse and contracted doctors	Full consult model developed for acute hospitals (10 sessions across 2 hospitals) including liaison nurse, certified specialist and advance trainee
Limited physician input to support nurses, patients and families in the community service	Full-time certified specialist appointment to support staff, patients and families in the community service and the commencement of weekly multidisciplinary meetings Increased engagement with oncologists, specialist physicians and clinical nurses, acute pain services and psycho-oncology services though the development of a shared care model[d]

Aims

- To enhance understanding of the changing approaches to Palliative Care
- To examine staff views about the effects of introducing early integration into a PCU

Method

- Data from Business Intelligence Unit
- Questionnaire, interviews, focus groups
- Qualitative descriptive research design

Table 2. Participant characteristics.

	Nursing ($n = 19$)	Allied health[a] and administration[b] ($n = 7$)	Medical ($n = 6$)
Age (years)			
⩽35	8	2	0
36–50	8	2	2
> 50	3	3	4
Sex[c]			
Male	3	0	6
Female	14	7	0
Time at current palliative care service (years)			
0.5–2	3	0	0
2–5	9	4	0
>5	7	3	6
Time at another palliative care service (years)			
None	9	3	1
Up to 2	6	2	0
2–5	2	0	1
>5	2	2	4

[a]Includes pastoral care.

[b]Grouped to ensure anonymity of participants; two administration staff participated.

[c]Two nurses did not state sex.

Quantitative Outcomes

Table 3. Scope of change in service model illustrated through activity data.

	January–December 2012	January–December 2014	Difference (95% CI difference)	*p* value[a]
PCU activity				
Separations[b]	594	683		
Occupancy rate	86.7%	87.3%	0.6 (−3.8 to 5.3)	0.77
Presentation of difference and interval estimation				
Malignant	526 (89%)	550 (81%)		<0.001
Nonmalignant	68 (11%)	133 (19%)		
Average length of stay (days)	9 (4–16)	8 (4–14)		0.08
Admission outcomes				
Deceased in PCU	365 (61.4%)	348 (51.0%)	−10.4% (−15.9 to −5.1)	<0.001
Discharge home	157 (26.2%)	233 (34.1%)	7.9% (2.7 to 12.7)	0.003
Discharge to aged care facility	21 (3.5%)	41 (6.0%)	2.5% (0.1 to 4.7)	0.04
Transferred to another PCU	0	4 (0.6%)	0.6% (−0.1 to 1.2)	0.06
Transferred to acute hospital	51 (8.6%)	57 (8.3%)	−0.3 (−3.3 to 2.8)	0.88

CI: confidence interval; PCU: palliative care unit.

Data presented as mean (standard deviation (SD)), median (25th–75th percentile) or number (%).

[a]Tested using Wilcoxon rank-sum test for length of stay, exact test for rates and Chi-squared test for all other comparisons.

[b]The number of separations is used to measure the utilisation of healthcare services. A separation occurs any time a patient leaves due to death, discharge, sign out against medical advice or transfer.

Qualitative Outcomes

Questioning Sustainability of Palliative Care Principles

Table 4. Thematic and category findings and illustration of participants' responses which informed them.

Themes	Categories	Illustrative responses
I. Questioning the sustainability of palliative care principles	Ia. Reconfiguring acute and comfort care emphases	Palliative is a special area. It's not, sort of, medical surgical patients get better and go home … (it) too much has become acute. It has become more medical. (Nurse 4)
	Ib. Increased specialist palliative expertise	We can do anything for pain management from here (palliative care unit) where previously we would be limited to … a certain amount of things. You would have to actually leave. (Nurse 8)
	Ic. Limited preparation for rapid and ongoing clinical changes and expectations	We were meant to just deal with it and we didn't know what was sort of going on. (Nurse 9)

Effects on patients and families

2. Improved and challenging effects on patients, families and staff	2a. Improved experiences	[The palliative care service] developed a consultative service and that's fine. I think that leads to the early access to palliative care. Early introduction to symptom management. I think that's good. (Medical 1)
	2b. Challenges	For EOLC/symp mgt pts [sic; abbreviations for end-of-life/symptom management patients] they are often 'put aside' as the more acutely ill take priority. (Nurse 10)

Increased Staff stress and varied coping reactions

3. Increased staff stress and varied coping reactions	3a. Stress	I'm too busy running off to do other things … I feel really bad when … I've got one foot out the door when I, instead of being able to stand there and be present to them. (Nurse 11)
	3b. Coping	The patient load seems heavier – because of differing needs. I find I have to adapt my service accordingly – perhaps meeting the younger patients and families more. (Allied health 3)

Disruptive Innovation: New Mind-sets and Behaviours

- *While we may be able to appreciate a disruptive innovation in retrospect, it is debatable whether we can convert our understanding into a formal, repeatable process. In today's turbulent environment, leading disruptive innovation is likely more about best principles than best practices, and requires a disruptive approach to management itself. Down with convention, then, and up with what this author terms LEAPS, an original but potentially very effective way of leading and managing disruptive innovation.*

LEAPS

LEAPS		Strategy
L	Listen	Start with Yourself, Not the Market
E	Explore	Go Outside to Stretch the Inside
A	Act	Take Small Simple Steps, Again and Again and Again
P	Persist	Take the Surprise Out of Failure
S	Seize	Make the Journey Part of the (Surprising) Destination

Some food for thought

- Pervasive uncertainty of Palliative Care
- Shifting work pace demands
- ‘double message’ of early integration
- Objectivity vs. the subjective art of palliative care

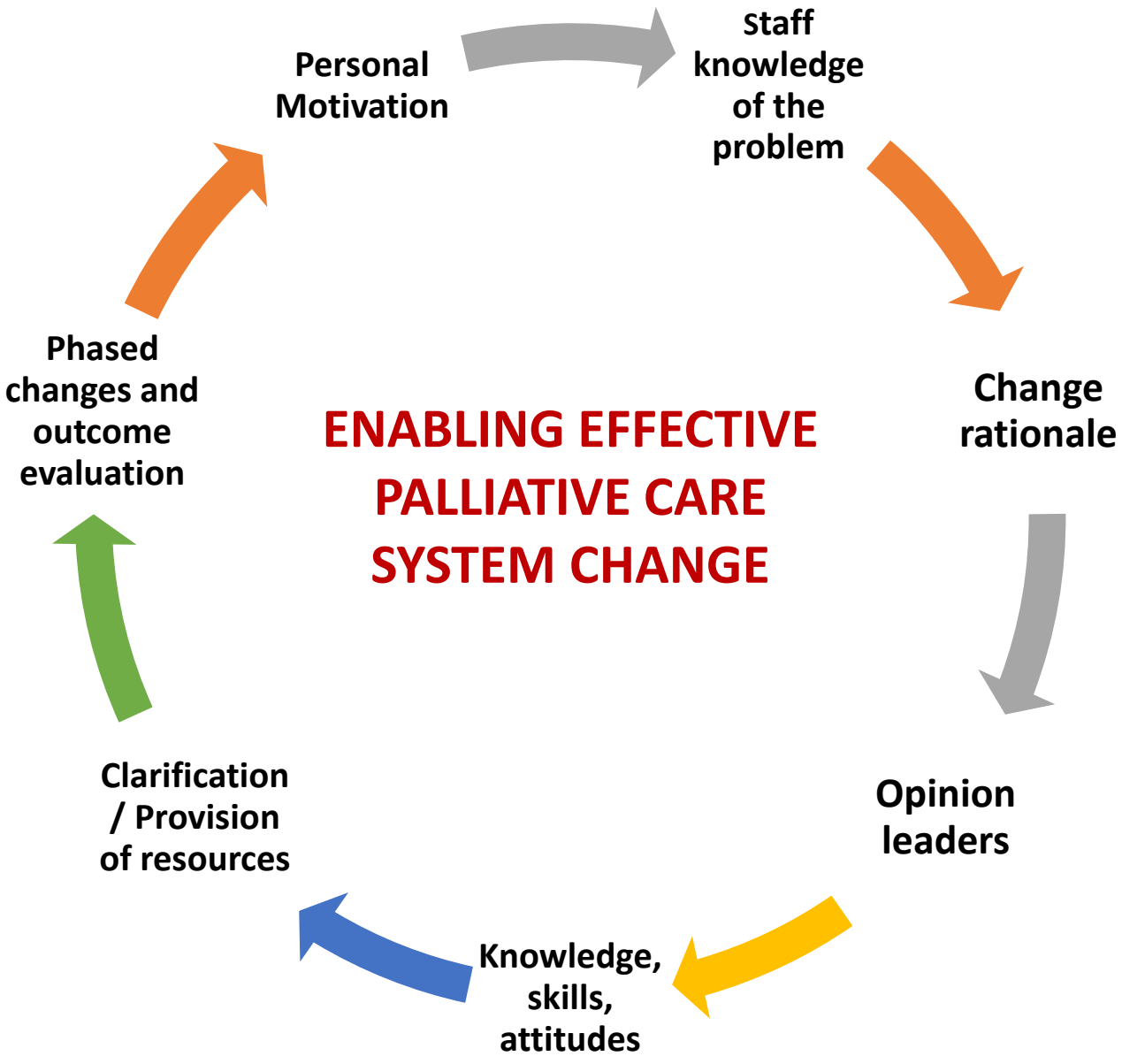
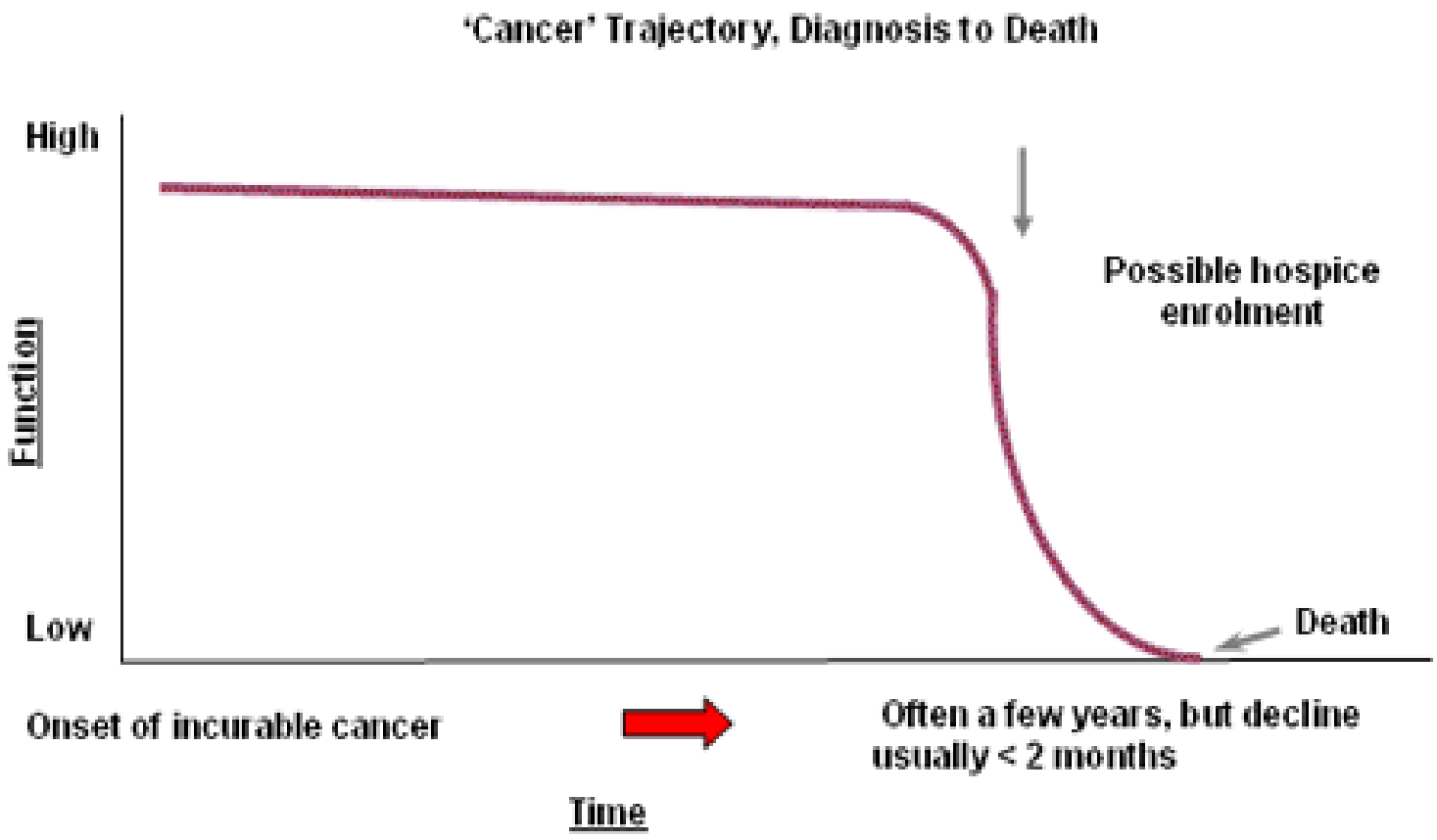

ENABLING EFFECTIVE PALLIATIVE CARE SYSTEM CHANGE
Personal Motivation
Staff knowledge of the problem
Change rationale
Opinion leaders
Knowledge, skills, attitudes
Clarification / Provision of resources
Phased changes and outcome evaluation

Table 5. Core challenges and staff recommendations.

Challenges as identified by staff	Potential solutions
Inadequate communication to staff with the transition to a new model of care	Communicate major changes in service model and delivery through multiple sources (e.g. emails, talks, meetings, discussion groups, posters), ensuring that all staff are aware of changes. Provide information on background and roles of new leaders to assist staff in understanding their responsibilities.
	Provide clear rationales for early integration including a more acute approach to symptom management of care to staff more familiar with a 'comfort only' approach of hospice care.
Unclear expectations	Clearly state new expectations of competencies required regarding the assessment and management of symptoms. Allow time for discussion and consolidation of information.
Insufficient training for skill set required to meet patients' need	Assess existing staff skills. Allow this to inform a phased approach to staff education and skills training to meet requirements of working within a new model of care. Create a culture where staff are able to safely express any limitations of knowledge or skill and can seek help.
	Recognise that staff require time and support to adjust. Offer support to experienced, more senior staff to ensure staff retainment.
Staff fatigue and unprocessed grief	Recognise the challenges that arise from the duality of providing acute care alongside end-of-life care. Ensure formal and informal staff support rituals are established.

What happens when we change the 'service trajectory'?



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Evidenced Based Approach

Dame Cicely Saunders

Founder of the modern hospice movement

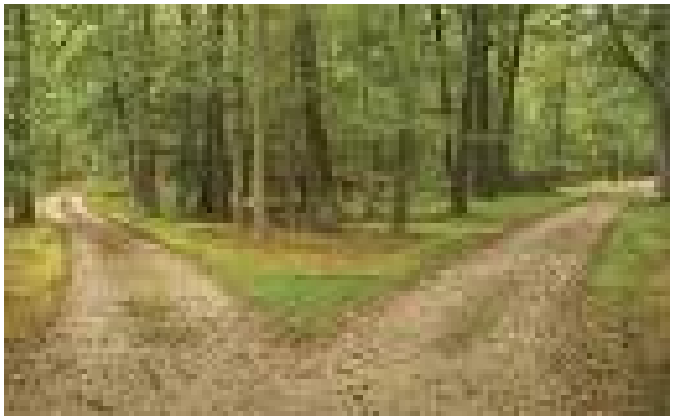
Photograph by Carolyn Djanogly National Portrait Gallery, UK

Opened the first modern hospice, St Christopher's in South London in 1967

Died 14 July 2005

"…bitter anger at the unfairness of what is happening (at the end of life) and above all a desolate feeling of meaninglessness.

Here lies, I believe, the essence of spiritual pain."



"You matter because you are you, and you matter to the last moment of your life."

Original Article

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