Primary Care Partnership
Wimmera PCP
Working together for healthy communities

AFTER-HOURS PALLIATIVE CARE PROJECT EVALUATION

FINAL REPORT

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1 EXECUTIVE SUMMARY

An ageing population and increased prevalence of cancer and other chronic conditions are contributing to the rising demand for palliative care throughout Australia. Ensuring that palliative care is available and accessible to people living in rural areas presents a significant challenge due to barriers including long travel distances and limited specialist support.

Within this context, the Wimmera After-hours Palliative Care Project demonstration project aimed to develop and trial a sustainable model of after-hours palliative care for clients[1] who decide to palliate at home and inform the development of a statewide 24-hour specialist end of life and palliative care telephone advice line.

This final report presents the collective findings of the After-hours Palliative Care demonstration project, led by the Wimmera Primary Care Partnership with funding from the Department of Health and Human Services (DHHS). The demonstration project was implemented using two plan-do-study-act cycles over a six-month timeframe.

Wimmera Primary Care Partnership commissioned Swinburne University of Technology to evaluate the demonstration project. The evaluation featured engagement with partner organisations, file audits, stakeholder interviews, and two case studies that formed the basis of a cost-effectiveness analysis.

Between January and June 2019, only two clients accessed the After-hours Palliative Care service. However, these case studies offer insights into what is involved in providing after-hours palliative care in rural areas and raise important issues that require further consideration to ensure equitable access to safe and quality care.

Summary of findings

This evaluation demonstrates a need for after-hours palliative care for the Wimmera region and indicates that some palliative care clients prefer support at home, which may be more cost-effective than similar support delivered in emergency departments or hospital settings.

The demonstration project highlighted key elements of an after-hours palliative care model for the Wimmera region including clear eligibility criteria and referral pathways, specified roles and responsibilities of the designated palliative care service and local health services, agreed modes of communication, and adequate staff resources. Issues that require further consideration include the availability of trained staff, medication management and equipment provision.

The partnership brokerage session and regular committee meetings were an effective way of establishing and building a partnership to develop and implement an after-hours palliative care model. At the conclusion of the demonstration project, the partnership was maturing and a survey of steering committee members indicated a commitment to continuing the partnership to deliver after-hours palliative care in future.

[1] In reports and correspondence, several terms are used for a person who is palliating e.g. client, consumer and patient. For consistency, this report uses the term client.

Summary of recommendations

On the basis of these findings, it is clear that providing after-hours care in rural areas is feasible but requires strong partnerships between designated palliative care services and local health services to ensure equity of access and the provision of safe, high-quality care.

The capacity to deliver safe and effective after-hours palliative care relies on adequate preparations by the designated palliative care service within hours, including anticipatory prescribing, equipment provision, and training for caregivers and local health service providers.

To achieve the desired outcome of ensuring that home visits outside of business hours are available to palliative care clients living in rural areas as required, we make the following recommendations:

- Update Wimmera Hospice Care's policy to align with the DHHS policy and funding guidelines to ensure the availability of after-hours palliative care support.
- Develop a common after-hours palliative care policy across partner organisations, in line with DHHS policy with provision to fund local health services to provide services as required.
- Continue to develop relationships between the designated palliative care service and local health services to support effective communication and build capacity to deliver palliative care across the Wimmera region.
- Develop clear eligibility criteria and provide information for clients, caregivers and local health services about how to access after-hours palliative care.
- Evaluate the After-hours Palliative Care model over a longer time frame.

2 INTRODUCTION

2.1 BACKGROUND AND CONTEXT

With an ageing population and increased prevalence of cancer and other chronic conditions, demand for palliative care in Australia is rising (Australian Institute of Health and Welfare, 2019). Palliative care refers to 'person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life.' (Palliative Care Australia, 2018, p. 5). Ensuring that palliative care is available and accessible to people living in rural areas presents a significant challenge due to long travel distances and limited specialist support.

The Wimmera and Southern Mallee region in northwest Victoria covers an area of 37,000 square kilometres and is characterised by small communities over large distances. Wimmera Hospice (through Wimmera Health Care Group) is the designated palliative care service serving the Shires of Yarriambiack, Hindmarsh and West Wimmera and the Rural City of Horsham. Wimmera Hospice works with general practitioners (GPs) and the local health services to provide care and support to clients' and their families and carers.

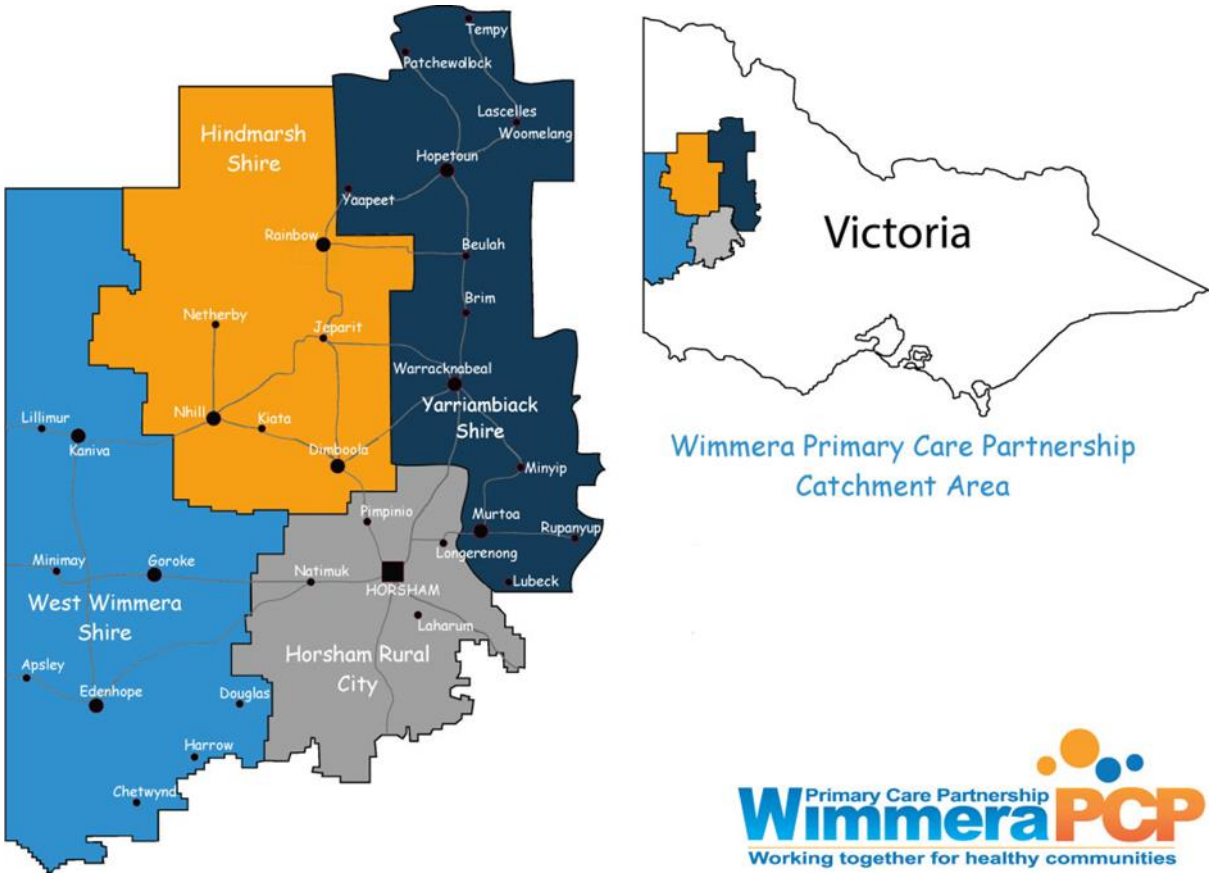

Figure 1: Wimmera Primary Care Partnership Catchment area (http://wimmerapcp.org.au/)

2.2 THE AFTER-HOURS PALLIATIVE CARE DEMONSTRATION PROJECT

After-hours palliative care assesses and manages distressing symptoms and provides reassurance to carers to help clients remain at home, in a familiar environment, and avoid potentially unnecessary presentations to the emergency department (ED). The Wimmera After-hours Palliative Care demonstration project aimed to establish a sustainable model for delivering after-hours palliative care for clients who decide to stay at home in the last stages of their life.

Prior to this demonstration project, there were no after-hours medical services available for clients who decided to palliate at home. If help was required outside of regular working hours, clients and their carers sought advice and assistance from local health services, their GP (if the GP agreed to provide such support), District Nursing services, Nurse on Call hotline, After-hours GP hotline, or Ambulance Victoria. Quite frequently, palliative care-specific advice was not able to be given over the phone resulting in the client being taken to the nearest urgent care service or ED. Wimmera Health Care Group has just one ED in the Wimmera region, which means that clients sometimes needed to travel long distances to receive medical care.

Project goal:

Clients of designated community palliative care services will receive effective, supportive and safe face-to-face care when a home visit outside business hours is the most appropriate course of action.

Project Objectives:

1. Establish effective partnerships between local services to deliver after-hours palliative care.
2. Develop and trial an after-hours palliative care model (referred to as “the model”) in the Wimmera region.
3. Evaluate the safety, effectiveness and sustainability of the model.

2.3 KEY STAKEHOLDERS

Wimmera Primary Care Partnership (PCP) received funding from the Department of Health and Human Services (DHHS) to deliver the demonstration project in partnership with local services. Key stakeholders included Wimmera Hospice and the following local health services: Rural Northwest Health, West Wimmera Health Service, Edenhope and District Memorial Hospital, Harrow Bush Nursing Centre, and Woomelang Bush Nursing Centre. Key stakeholders were invited to become project partners and develop the model in a collaborative process, based on their previous palliative care provision experiences, current skill-sets, and capacity.

2.4 GOVERNANCE

A Steering Committee was established to govern the partnership and oversee the development, implementation and evaluation of the model.

2.5 THE EVALUATION

In November 2018, Wimmera PCP commissioned Swinburne University of Technology ('Swinburne') to conduct an external evaluation of the Wimmera After-hours Palliative Care demonstration project.

The purpose of the evaluation was to assess whether the model was realistic and provide recommendations for a sustainable model to link with the statewide 24-hour specialist end of life and palliative care telephone advice line. Swinburne developed a Project Logic (see Appendix A) and Evaluation Plan (see Appendix B) to identify measurable outcomes to guide the evaluation.

The Plan-Do-Study-Act (PDSA) method was employed to develop, implement and evaluate the model (see Appendix C) over two phases from January to March 2019 and April to June 2019. The PDSA method is a well-established framework for undertaking quality improvement activities in health care settings (DHHS, 2010). The PDSA method was ideal for this demonstration project as it allowed for new ideas to be developed and tested within short time frames.

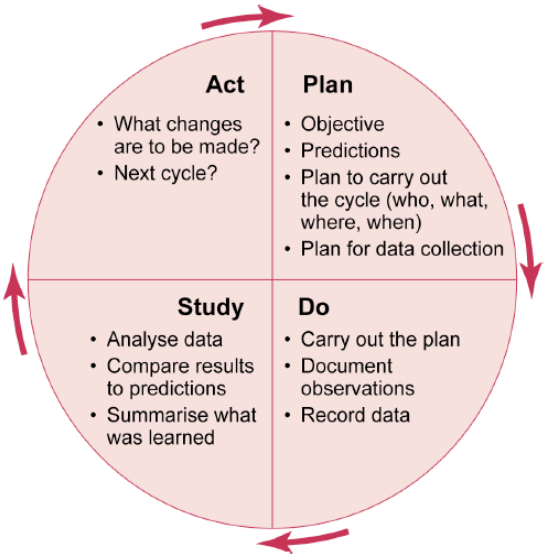

Figure 2. Plan-Do-Study-Act framework (DHHS, 2010)

The Wimmera After-hours Palliative Care Project involved two PDSA cycles:

- In Phase 1, a partnership between project partners was established and a model for the provision of After-hours Palliative Care was developed and tested.
- In Phase 2, the emergent model was refined and further evaluated to develop a safe, effective and sustainable model for delivering after-hours palliative care in rural areas.

See Appendix D for a detailed overview of each phase.

The evaluation used a mixed methods design including qualitative and quantitative data collection and analysis to address the following questions:

1. How effective was the partnership in delivering after-hours palliative care?
2. What are the key elements of an after-hours palliative care model in the Wimmera region?
3. How safe, effective and sustainable was the model?

As it was anticipated that only a small number of clients would require after-hours palliative care, a qualitative approach was selected as the dominant method to provide in-depth insights into the process and outcomes of the project.

This evaluation featured

- prolonged engagement with the services involved in the partnership through attending the partnership brokerage session and regular steering committee meetings;
- an on-line survey of seven project partners;
- telephone and face-to-face interviews with one palliative care client, one carer, three on-call nurses, and three staff from Wimmera PCP;
- the development of two case studies and two digital stories;
- an audit of ED presentations and relevant policies and procedures; and,
- a cost-effectiveness analysis.

3 KEY FINDINGS

The findings across phases 1 and 2 are presented according to the project objectives.

3.1 PARTNERSHIPS FOR DELIVERING AFTER-HOURS PALLIATIVE CARE

3.1.1 Establishing a partnership

A partnership brokerage session was held to determine partners' roles, responsibilities, and expectations. In total, 18 people from ten partner organizations were present at the session. The majority of participants were direct care staff from Wimmera Hospice Care, local health services and representatives from the DHHS and Swinburne. Two organisations were unable to attend and staff from Wimmera PCP acted as their proxies.

At the partnership brokerage session, a primary concern for Wimmera Hospice Care and local health services was the ability of the project to meet their clients' needs. Participants also raised concerns about staff safety and their capacity to deliver after-hours palliative care, as well as the funding and sustainability of the model.

The main outcome from the session was a preliminary model for delivering after-hours palliative care co-designed by partner organisations that was further refined with input from managers of participating services. It was agreed that Wimmera PCP would coordinate the after-hours palliative care trial with a steering committee to provide governance over the partnership. Parameters for the evaluation were discussed with participants expressing a preference for applied research that included process and impact evaluation of client and community-level indicators.

3.1.2 Building the partnership

The Wimmera After-hours Palliative Care Steering Committee was responsible for the development and implementation of a local model to provide After-hours Palliative Care to clients in their home, as per the funding guidelines from DHHS. The steering committee provided support to the participating health services who delivered the after-hours model, and communicated with the Wimmera Southern Mallee Health Alliance, as the Clinical Governance provider, on an as-needs basis.

Thirteen partner organisations were invited to participate in the steering committees. Two meetings were held in the first PDSA cycle (Jan-Mar 2019), with a mid-way report presented to the committee in April. Three meetings were held in the second PDSA cycle (Apr-Jun 2019). A minimum of six organizations were represented at each meeting, usually by staff member who had attended the partnership brokerage session. Two organisations were unable to participate from the outset and a further two organisations became unable to participate during the project due to staffing constraints. A summary of attendees and discussion topics from each of the steering committee meetings is provided in Appendix E.

Overall, the steering committee met its objectives and provided a forum to discuss and problem-solve issues that arose when implementing the model during the demonstration project. In the on-line survey, a participant reported that, "the [steering committee] meetings provided a platform for staff to discuss pertinent issues in their area". Participants found that video (n=2) or teleconference (n=1) was the most useful technology to communicate across distance. However, one participant felt that the use of video conferencing was troublesome and not a good use of time.

3.1.3 Partnership evaluation

Four steering committee members completed the partnership evaluation in the online survey. Their responses identified the partnership's strengths and areas for development and offered insights into the benefits and drawbacks of participating in the partnership.

Strengths

The participants acknowledged the investment in the partnership of time, personnel, materials or facilities and felt that the demonstration project added value (rather than duplicating services) for the community, clients or agencies involved in the partnership. They recognised strategies to enhance the skills of the partnership through increasing the membership or workforce development. Partners had the task of communicating and promoting the partnership in their own organisations and felt that collaborative action by staff and reciprocity between agencies was rewarded by management. Within the partnership, there were ways of minimising barriers to the partnership, and strategies to express alternative views, while also recognising and celebrating collective achievements and/or individual contributions. The participants identified a clear need for and commitment to continuing the collaboration in the medium term.

Areas for development

Ensuring that roles, responsibilities and expectations of partners were clearly defined and understood by all other partners was identified as an area of need. The participants were ambivalent as to whether differences in organisational priorities, goals and tasks had been addressed and did not believe processes that were common across agencies had been standardised (e.g. referral protocols, service standards, data collection and reporting mechanisms).

Benefits of participation

The greatest benefit of participating in the partnership was the development of valuable relationships and the ability to have a greater impact than a person or service could have on their own. The demonstration project enhanced the participants' ability to address an important issue, while increasing utilisation of their expertise or services to meet the needs of clients and make a contribution to the community. Through the project, the participants developed new skills and acquired useful knowledge about services, programs or people in the community. Another benefit of participation was the acquisition of financial support and an enhanced ability to affect public policy.

Drawbacks of participation

One of the drawbacks of participation was frustration or aggravation reported by three participants, followed by the diversion of time and resources away from other priorities or obligations. Participants reported feeling left out of the decision-making process some of the time (n=3) or most of the time (n=1); despite this, the participants supported the decisions made most (n=3) or some (n=1) of the time.

Comparing benefits and drawbacks

Overall, three out of four participants reported that the benefits of the partnership exceeded the drawbacks and were satisfied with the way people and organisations worked together to achieve its goals.

3.2 DELIVERING AFTER-HOURS PALLIATIVE CARE IN THE WIMMERA REGION

3.2.1 The need for after-hours palliative care

Emergency department presentations by clients registered with the designated palliative care service for the 12 months prior to the commencement of the demonstration project were collected and analysed.

Between 14 February 2018 and 28 January 2019 there were 25 presentations to the ED at Wimmera Base Hospital, Horsham by clients registered with the palliative care service. In total, 13 unique palliative care clients presented to the ED; nine from Horsham, two from between 30 and 70 kilometres away, and two from over 70 kilometres away.

The average number of presentations per client was 1.9 (minimum = 1; maximum = 5). For the seven palliative care clients who had multiple presentations, the average time between ED presentations = 29.58 (minimum = 1 day; maximum = 109 days).

At triage, 15 presentations were deemed urgent, six semi-urgent, and four non-urgent. Presenting problems (in order of frequency) included: pain, shortness of breath, nausea/vomiting, blood in urine or ileostomy, vascular issues (deep vein thrombosis, leg swelling), decreased oral intake/anorexia, prolapsed stoma, leaking port, and medical or surgical admission.

Overall, 14 presentations (56%) resulted in an admission to the ward, 9 (36%) were discharged home, and two (8%) were transferred to another hospital.

Of the 25 presentations, 12 were out of hours (on a weekend day or outside 9am-5pm). Eight presentations were brought in by ambulance; of these, four were out of hours.

This analysis highlighted that there was a need to offer after-hours telephone support for palliative care clients in the region.

3.2.2 Key elements of the After-hours Palliative Care model

The after-hours palliative care model was co-designed by direct care providers from partner organisations with input from managers. The model was trialled in test phase one and further refined in test phase two (see Appendix C).

Key elements of the after-hours palliative care model included

- a description of the roles of each participating organisation at each stage of service delivery, including Wimmera Hospice Care, local health services and on-call nurses;
- clear eligibility criteria and referral pathways for palliative care clients;
- a definition of what constitutes ‘after-hours’, recognising that small local health services may have reduced operating hours;
- agreed modes of communication between services, including sharing information before and following an after-hours call out;
- policies and procedures for after-hours service provision; and
- resource requirements including on-call staff and vehicles.

3.2.3 Staff knowledge and experiences of delivering after-hours palliative care

Seven individuals from five organisations completed the online survey. Four participants had worked with their organisation for less than four years and three participants for seven years or more. The majority of participants had more than ten years’ experience working with palliative care clients.

General knowledge of palliative care services

On-line survey participants identified a range of primary and tertiary health care services that were involved in providing end of life care in their local area. (See Figure 3).

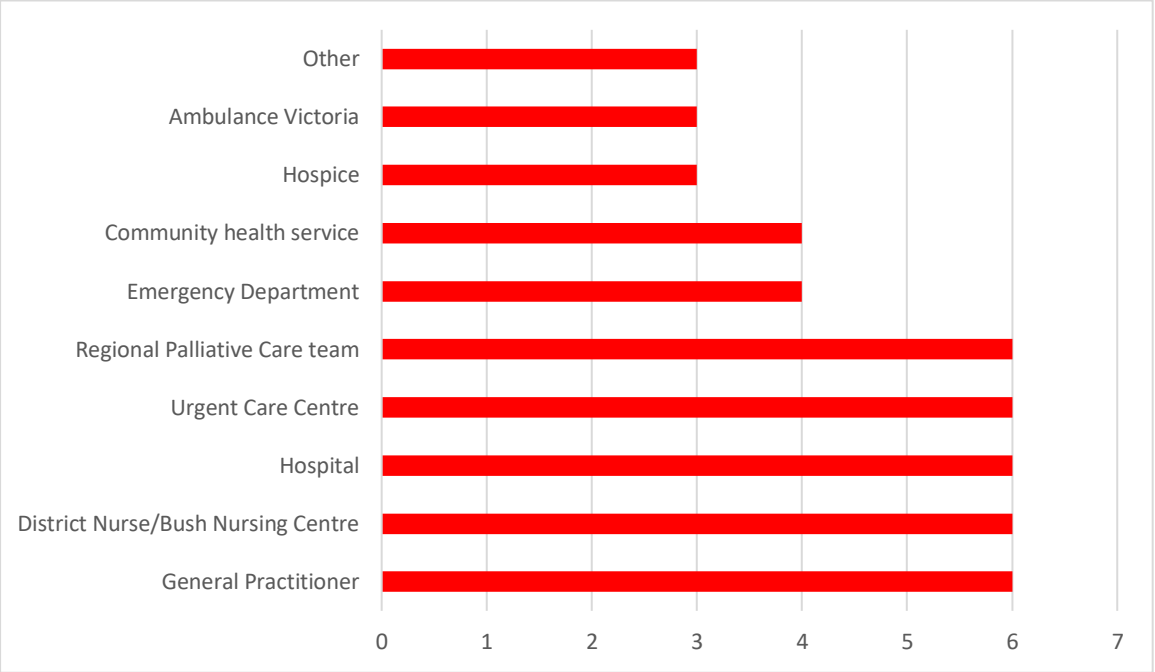

Figure 3: Local services involved in providing end of life care

Five participants correctly identified either Wimmera Palliative Care service or Wimmera Health Care Group, of which the palliative care service is a part, as the designated palliative care service in their area. Additional services identified included Edenhope and District Memorial Hospital, Western District Palliative Care and Grampians Regional Palliative Care.

The main ways that clients become registered with a palliative care service was through referral from a GP (n=6), allied health professional (n=6) or medical specialist (n=5) or through self-referral (n=5) or referral from a carer, family member or friend (n=5). Other ways that clients may become registered is through a wellbeing coordinator, registered nurse or from the acute ward or cancer centre.

Most participants believed that clients with a life-threatening illness and complex palliative care needs were eligible to become registered with the designated Palliative Care Service. Participants listed a range of services that were available through the designated palliative care service (see figure 4).

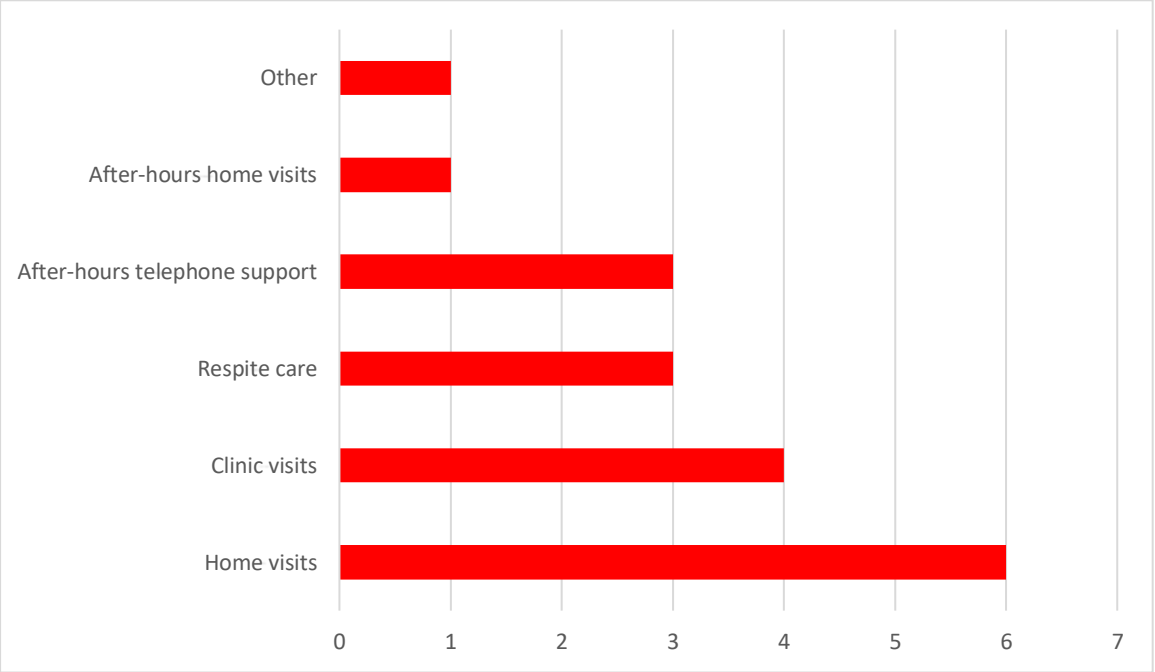

Figure 4: Types of services available through the designated palliative care service.

Knowledge of the demonstration project

Most participants had learned about the demonstration project directly from Wimmera Primary Care Partnership. Two participants heard about the demonstration project indirectly from Wimmera Health Care Group or direct care staff.

During the demonstration project, only one participant had discussed after-hours palliative care with every client. Three participants reported discussing after-hours care with between one and three clients, and three participants had never discussed after-hours care with their clients. Aside from eligibility, factors that influenced participants' decision to discuss after-hours palliative care included identifying (a) clients who might require after-hours due to a deterioration in their condition or (b) those who would find it reassuring to know that after-hours help was available.

Implementation of the model from the perspective of Wimmera Hospice Care

During the demonstration project, Wimmera Hospice Care (n=2) provided information to the local health service about three to five palliative care clients living in their area. Information, such as symptom action plans, was shared by telephone or fax.

From the perspective of Wimmera Hospice Care, after-hours palliative care was provided for deteriorating or dying clients by telephone. The types of care included the provision of information, advice and support regarding medications and equipment. Outcomes of the telephone support included the provision of in-home support from the local health service, liaison with an oncologist to increase syringe driver orders, and on one occasion an ambulance was called and the client was transferred to the ED. Following the after-hours

support, the local health service contacted Wimmera Hospice Care by telephone to provide an update about the client.

Implementation of the model from the perspective of Local Health Services

The survey also included questions about how the model was implemented from the perspective of local health services (n=5). Two participants believed it was the local health service's responsibility to provide palliative care services in their local area; whereas, three participants believed it was Wimmera Hospice Care's responsibility.

During the demonstration project, most local health services (n=4) reported having between one and four palliative clients in their area; one service had five to nine palliative care clients. When working with a palliative care client, two participants always and two participants sometimes knew whether the client was registered with the palliative care service. Participants reported receiving information from Wimmera Hospice Care by telephone or email about palliative care clients in their area with every (n=1) or most (n=2) clients.

Two of the four participants from local health services had provided after-hours palliative care to a client in their area to support carers, provide education or symptom (e.g. pain, distress and confusion) and medication management, or for bereavement support.

One participant reported calling Wimmera Hospice Care for after-hours telephone support between five and nine times for advice for issues including symptom management, medication and a referral to a specialist. Outcomes of the telephone support included the provision of in-home support from the local health service, and on one occasion an ambulance was called and the client was transferred to the ED. Following the after-hours calls, the participant provided an update to Wimmera Hospice Care by telephone and email.

Overall benefits and challenges

Overall, benefits of the demonstration project included:

> "knowing it [after-hours palliative care] was available was a real comfort for the client"

> "the ability to provide the care to the client at home and have the advice and support of the after-hours hospice care team"

> "for the few patients who did trial, the service itself was good"

One participant who had not used the model observed, "[The after-hours palliative care model] looks like a model that could be implemented easily when needed".

The main challenges to implementing the After-hours Palliative Care model included a lack of clients in the local area requiring palliative care and uncertainty about who was eligible for referral. Two participants believed that all clients who were registered with Wimmera Hospice Care were eligible to participate, whereas four participants believed that only clients in the unstable, deteriorating or terminal phases were eligible. One participant was unsure which clients were eligible to participate.

Participants expressed concerns about communicating about the demonstration project and understanding whose role it was to provide after-hours support, which telephone number to use, and how best to disseminate the phone number to the clients.

Practical challenges reported by health services included the availability of local services through the timeframe to provide after-hours support face to face if deemed necessary, due to annual leave, staff changes and turnover. When care was provided, the main challenge identified was ensuring that the local health service had enough medication and equipment on hand, especially over weekends.

Lessons from the after-hours demonstration project

The demonstration project highlighted to participants that a more consistent after-hours service, supported within and across organisations, was needed. Participants appreciated that after-hours support was available if needed and believed that early planning was the biggest key to the successful provision of after-hours palliative care. One participant reported that, "this is certainly a very much required project, that we as an organisation have benefited greatly from having the support of the team after-hours and being funded adequately to provide care".

3.2.4 The After-hours Palliative Care model in practice

During the demonstration project, two clients received after-hours palliative care. Their experiences are presented below as case studies.

Case study 1: Judy

'Judy' was a 76-year-old woman, with pancreatic cancer, who lived with her husband with the support of her adult daughter who moved in to provide care. Judy lived in her local community for over 30 years and wanted to remain at home, surrounded by her family and friends.

The local health service had a long connection with Judy and usually saw her one to two times per week, either at the health service or at home. As Judy lived out of town, each visit involved a two-hour turnaround time.

Over the last few months of Judy's life, she or her family, contacted the local health service after-hours seeking support 15 times. Initially, most calls could be managed over the phone, however, as Judy's condition deteriorated, she required more visits after-hours to respond to new symptoms and manage pain.

During the stable and unstable phases of palliation, the local health service was well set up to provide after-hours services with an on-call roster established and existing policies and procedures to ensure staff safety. Staff used their own cars and claimed travel expenses as going in to Horsham to pick up a fleet car would take too much time. However, the services' resources were stretched when Judy's condition became terminal and she required daily after-hours care in the last week of her life.

The local health service believed that the After-hours Palliative Care trial was beneficial as it has enabled them to provide care to clients that would have been to emergency or urgent-care services in the past. The demonstration project allowed them to care for Judy and manage challenges that arose with support and advice from the local palliative care service and the oncologist, respecting her wish to die at home.

Case study 2: Helen

'Helen' was a 54-year-old woman with cancer and brain metastases, who was in the terminal phase of palliative care. During an admission to acute inpatient care, her condition deteriorated rapidly one Friday afternoon.

Although, Helen had previously stated that she didn't want to die at home, her son didn't want her to die in hospital, creating a dilemma for Helen's carer and the treating team.

The palliative care service discussed options with the carer and son who agreed for Helen to be transferred to a local residential aged care facility. The palliative care service arranged the transfer that afternoon, providing discharge medications and training for residential aged care staff on how to administer medications using a syringe driver.

Over the weekend, the palliative care service received four after-hours calls, from the aged care facility and Helen's GP to help them manage symptoms, and give advice and reassurance regarding syringe driver management.

The aged care facility was a familiar and quieter environment for Helen, where her family were able to stay with her until her death 36 hours later.

3.3 THE SAFETY, EFFECTIVENESS AND SUSTAINABILITY OF THE AFTER-HOURS PALLIATIVE CARE MODEL

3.3.1 Safety

To our knowledge, no incident reports were filed during the demonstration project. However, two situations related to client safety were identified during interviews with staff.

Situation 1: Medication management.

The first issue related to the local health service's knowledge of the administration of subcutaneous medications and use of syringe drivers. As palliative care is not their core business, some nurses at local health services lacked either training or recent experience and underestimated the amount of medication that would be required. Furthermore, the local health services did not have policies regarding medication dilution and ratios and required support and guidance from Wimmera Hospice Care.

The second issue that arose was about having sufficient medication on hand. Following a review by a physician at Wimmera Hospice Care, the client's medication chart and symptom action plans were revised, with anticipatory prescribing used to manage breakthrough pain. The client and family members were unsure of which scripts to fill, and as the client was not in hospital it was their responsibility to pay for medications, which they may not use.

When additional medications were required, the local pharmacists did not have required medication in stock so the local health service used their own stock. For medications that were not in stock, the client's family member went to get medication from Horsham. Although the local health service reported that the family member was happy to do this, it impacted on the time they were able to spend with their family member and may have posed further safety risks due to the family member driving while distressed.

This situation highlights the need for contingency plans if medications run out or are insufficient to manage breakthrough pain. The client needs a supportive physician or GP to write up additional medications and provide necessary scripts. In this client's case, their GP only wrote scripts following face-to-face consultations, so the oncologist wrote scripts instead. In addition, ways of promptly delivering the medication to the client are essential.

Situation 2: Equipment provision.

Failure of hire equipment (hospital bed mechanics and pump on alternating air mattress) leading to discomfort and risk of pressure injury for the client and risk of injury from manual handling for staff.

As this situation arose on the weekend, the equipment provider was unavailable to service or replace the equipment until Monday. The hire equipment was arranged through Wimmera Hospice Care following an occupational therapy home assessment. Wimmera Hospice Care offered to arrange a replacement mattress, but an egg-shell mattress from the local health service was used instead.

Both of these situations highlight the need to clarify the roles and responsibilities of Wimmera Hospice Care and the local health service.

Some considerations include:

- Wimmera Hospice Care currently write symptom action plans and medication charts and prescribe loan equipment.
- Small local health services may have limited capacity to follow up scripts or equipment failures when providing direct client care.

Good working relationships between Wimmera Hospice Care and the local health service are an essential foundation for the safe delivery of after-hours palliative care. Each service has a different culture and mode of service delivery: while Wimmera Hospice Care has access to a multidisciplinary team, including physicians and allied health, bush nurses are used to being lone workers.

3.3.2 Cost-effectiveness

Based on an analysis of the two case studies, providing after-hours palliative care resulted in an estimated cost saving of $18,522.

Table 3

A comparison of costs of care provision with and without after-hours palliative care

	Case study 1	**Case study 2**
Without after-hours palliative care	$26,196	$5,400
With after-hours palliative care	$11,859.08	$1,215
Estimated total saving	**$14,337**	**$4,185**

Although the After-hours Palliative Care demonstration project indicates cost-savings for the health system, providing in-home palliative care increases the costs for the client (e.g. medication costs), which may impact on equity of access to after-hours palliative care for people on a low or fixed income.

3.3.3 Sustainability

After-hours care policies were obtained from five of the partner organisations to assess the sustainability of the proposed model. According to the *Policy and Funding Guidelines for Health and Human Services* (DHHS 2018-2019, p. 327) every funded community palliative care service needs to provide services outside of regular business hours (with regular working hours being in most cases 7.00 am and 5:00 pm Monday to Friday, excluding public holidays). The minimum after-hours palliative care service required is to have a **telephone advice line** for clients, carers or families and the availability of **health professional visits** to clients, or carers and family should be an available option, if it is safe to do so.

Wimmera Health Care Group is the funded community palliative care service but, contrary to the DHHS guidelines, does not provide an on-call after-hours service. Instead, clients are supported to prepare for how to manage after-hours, with plans developed for after-hours symptom management or how to address medical issues that arise. The **Wimmera Hospice Care After-hours Care for Community Clients** policy states that clients are advised to contact their local hospital, district nursing service, GP, after-hours GP help line or ambulance.

Three local health services had policies that related to the provision of after-hours care:

- Harrow Bush Nursing Centre (HBNC) has policies that cover after-hours return, and after-hours emergencies.
- West Wimmera Health Service (WWHS) has a policy that covers the death of a patient/client and safety and security guidelines for home visits, which cover after-hours return.

- At Edenhope and District Memorial Hospital, the Medical Clinic, After-hours Service policy advises patients to present at the Hospital's Urgent Care Department where clients can see an on-call doctor after-hours. Although EDMH offers palliative care visits by district nurses the service is not available after-hours.

The after-hours palliative care model trialled in the demonstration project was consistent with the *Policy and Funding Guidelines for Health and Human Services* (DHHS, 2018-2019). However, some adaptations will need to be made to policies at Wimmera Hospica Care and local health services to ensure they align with DHHS policy and the After-hours Palliative Care model.

3.4 LIMITATIONS

This evaluation provides insights into the development and trial of an after-hours palliative care model in the Wimmera region. Given that only two clients received after-hours palliative care during the trial period, the findings should be interpreted with caution. Furthermore, the response rate to the survey was low (n=7), but typical for an online survey, therefore the results are not necessarily generalisable across the partner organisations.

4 CONCLUSIONS AND RECOMMENDATIONS

The After-hours Palliative Care demonstration project enabled two clients of Wimmera Hospice Care to receive effective, supportive and safe face-to-face care when a home visit outside business hours was the most appropriate course of action.

The following conclusions and recommendations are based on the objectives of the demonstration project.

4.1 PARTNERSHIPS FOR DELIVERING AFTER-HOURS PALLIATIVE CARE

The partnership brokerage session enabled partner organisations from across the region to come together and co-design the After-hours Palliative Care model. Having direct care staff at the session was especially useful in designing a model that could be readily implemented by health services.

Organisations who attended the partnership brokerage session more likely to participate in the steering committee, which provided useful oversight of the implementation of the After-hours Palliative Care model and a forum for communication and review.

The partnership has many strengths and the demonstration project supported the development of relationships between organisations and increased knowledge, skills and capacity of organisations to meet the needs of palliative care clients living in their community. By working together, the partnership achieved more than each organisation could on its own. Overall, the partnership is moving in the right direction but needs time to further develop.

Recommendations for future partnership brokerage sessions

- Invite a mix of managers and direct care staff, where possible, to demonstrate high level support for the project, while gaining practical insights into health care provision.
- Establish clear mechanisms for communicating the outcomes of the partnership brokerage session between those who attended and other key stakeholders within each organisation.
- Identify project leads within each organisation to champion the project.

Recommendations for building partnerships

- Include an element of continuing professional development at each meeting to ensure that all participants feel like their ongoing participation in the steering committee is worthwhile.
- Videoconferencing was the most useful technology to communicate across distance.
- Fund backfill so that direct care staff from small services can attend steering committee meetings.

Recommendations for sustaining partnerships

- Clarify the roles and expectations of partner organisations.
- Standardise policies and procedures across the partner organisations (see 4.3).

4.2 DELIVERING AFTER-HOURS PALLIATIVE CARE IN THE WIMMERA REGION

Within the Wimmera region, there are a range of primary and tertiary health services that are involved in providing end of life care. In addition, there are staff with considerable experience working with palliative care clients. Staff were aware of how to refer clients with a life-threatening illness and complex palliative care needs to the local designated palliative care service, who provided a range of services including home visits, clinic visits, after-hours telephone support and respite care. However, staff were unclear of the eligibility criteria for the demonstration project.

Recommendations

- Raise awareness of palliative care and eligibility criteria for registering with the designated palliative care service.
- Roles and responsibility for providing after-hours palliative care should be clearly outlined, and adapted as necessary.
- When a client becomes registered with the palliative care service, all members of their treating team, including the client's GP and local health service, should be notified and documented in the client's file/s.
- Clarify who is eligible for after-hours palliative care and inform all eligible clients of the availability of after-hours palliative care and contact information (see Appendix G).

- For clients who wish to be cared for at home, adequate preparations should be made by the designated palliative care service within hours, including:
    - The development of a symptom action plan covering common symptoms such as pain, shortness of breath, nausea as well as symptoms unique to the client.
    - The prescription and provision of enough required medications and check whether there is a local physician who review medications and can write up scripts as needed and a pharmacy to supply required medications. When anticipatory prescribing is used, the client/caregiver should be given clear, written instructions about which scripts to fill and when.
    - A home visit by an occupational therapist and provision of necessary equipment.
    - An assessment of the client's social supports to confirm their willingness and ability to provide care and establish a contingency plan if they need further support e.g. in-home respite or residential care.
    - Training for informal care-givers and local health service providers in medication administration, pressure care, equipment use etc.
    - The symptom action plan, medication chart and other care requirements must be handed over to the local health service. During the demonstration project, the telephone was used most often, which enabled timely communication and immediate feedback.
- A single phone number for after-hours palliative care would be beneficial for the client, carer or local health service. The call centre operator would connect the client with the right services to meet their needs in a timely manner. This project identified weekends and public holidays as particularly vulnerable times for clients.
- After a local health service calls for After-hours support, the designated palliative care service should call the local health service (if they haven't already heard from them), within the next 24-hours. During the follow up call, the designated palliative care service can proactively assess the effectiveness of any interventions and update the symptom action plan for the client, and provide the local health service the opportunity for reflection or debriefing, as required, to build their capacity to provide palliative care.

4.3 SAFE, EFFECTIVE AND SUSTAINABLE AFTER-HOURS PALLIATIVE CARE

The demonstration project indicated that it was possible to provide safe after-hours palliative care and that such care was cost-effective. However, providing after-hours care relied on the availability of trained nursing staff and a local physician to review medications and write up scripts as needed. The DHHS Policy and Funding guidelines state that every funded community palliative care service needs to provide services outside of regular business hours, with a telephone advice line as a minimum. Currently, the Wimmera Health Care Group policy does not comply with the DHHS policy and funding guidelines. In addition, local health service policies will need to be updated to ensure that they align with DHHS policy and the After-hours Palliative Care model.

Recommendations for safety

- Staffing
    - Build rapport and relationships to support effective communication across partner organisations and sister-sites about the After-hours Palliative Care model.
    - Casual staff need to be available to provide cover for staff who are on leave or have symptoms of acute infection (e.g. a cold).
- Medication
    - Develop common policies and procedures for the supply, administration and safe disposal of medications across partner organizations.
    - The designated palliative care service should provide training as needed and regular refreshers to local health services about effective use of syringe drivers and subcutaneous medications.
- Equipment
    - Hire equipment must be checked regularly to ensure it is functioning effectively.
    - A back-up foam mattress should be held by local health services or supplied to the client in case the alternating air mattress fails.
    - Train care-givers in the safe use of equipment.

Recommendations for cost-effectiveness

- Given that only two clients received after-hours palliative care, this needs to be further evaluated over a longer period of time (e.g. 12 months to 2 years).
- Subsidise medications for clients who choose to palliate at home.

Recommendations for sustainability

Develop a common after-hours palliative care policy across partner organisations, in line with DHHS policy and funding guidelines, to clarify roles and responsibilities in the provision of after-hours palliative care. The policy should consider funding for local health services to provide services as required and specify the roles of GPs and Ambulance Victoria in supporting after-hours palliative care.

Specifically, the policy should include procedures to ensure:

- Provision of telephone advice and secondary consultation as required
- Provision of home visits, if required and safe to do so
- Effective communication between services
- Client and staff safety
- Respect for carer's and family needs and capacity
- Bereavement support
- Return of equipment and safe disposal of unused medication
- Reporting requirements (e.g. for the coroner)

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Appendix A: Project logic

Situation	Inputs	Activities	Outputs	Short-term and medium-term outcomes	Long-term outcomes
The Department of Health and Human Services (DHHS) seeks to ensure that all clients of designated community palliative care services receive home visits outside business hours when it is appropriate and safe to do so. However, rural palliative care teams face barriers to providing after-hours services.	Funding from DHHS Leadership from Wimmera PCP Partner organisations and resources e.g. staff, cars, equipment, etc. External evaluation from Swinburne University of Technology	Partnership brokerage session with Yeshe Smith Establish Steering Committee Develop model of care Conduct two Plan-Do-Study-Act cycles to deliver, evaluate and refine the model of care Conduct interviews with carers and on-call nurses Collect and analyse quantitative data	Partnership established between Wimmera PCP and local services Meeting minutes Mid-way report Final report An effective and realistic model of care Digital stories or case studies based on interviews with carers and on-call nurses Recommendations to inform:	Service providers and staff participate in the design of model of care. Organisations and staff members are satisfied with the partnership. Palliative care clients receive after-hours support appropriate to their needs. Clients/carers report satisfaction with the after-hours support. On-call nurses are safe and feel supported during	People receiving palliative care who wish to remain at home are able to do so. After-hours support is available to all people receiving palliative care in rural areas. Reduced avoidable admissions to emergency departments. Reduced avoidable call outs to Ambulance Victoria.

		Conduct staff/partner survey Review policies and procedures	- policies and procedures to ensure a sustainable model of care; and - the statewide 24-hour specialist end of life and palliative care telephone advice line.	after-hours home visits. Available resources are utilised in an efficient manner to provide after-hours care.	

External factors: Phase 1 will be conducted during the Christmas/New Year holiday period.

Appendix B: Evaluation Plan

Objectives	**Questions** What questions do you need to ask to determine that your objectives have been met?	**Information Required** What information do you require to answer each of these questions?	**Data Source** How will you collect this information?
1. Establish effective partnerships between local services to deliver after-hours palliative care.	Were all relevant organisations involved in the brokerage session? Did the partner organisations meet regularly throughout the project? Were key decisions about the model communicated effectively throughout the project?	List of partner organisations and participants involved over time Meeting dates and agendas Communication (e.g. emails) Partners assessment of the process and outcomes of the project	Feedback from brokerage session Meeting minutes Reflections on brokerage session and steering committee meetings Post-survey of partner organisations and participants
2. Develop and trial an after-hours palliative care model in the Wimmera region.	Was model implemented as planned? Who was involved in the trial (clients, on-call nurses, organisations)? How effective was the model from perspectives of clients, carers, on-call nursing staff and organisations? Did implementation of the model reduce calls to Ambulance	Model Number of clients Client demographics Staff involved Calls – number, reasons, outcome, support requested Home visits - number, reasons, outcome, support requested	Model audit tool (process) Client records Ambulance Victoria calls data Hospital emergency department admissions data Semi-structured interviews with carers, on-call nursing staff, and partner organisations Post-survey of partner organisations and participants

	Victoria and Hospital admissions? How was the model revised after Phase 1?		
3. Evaluate the safety, feasibility, and sustainability of the After-Hours Palliative Care model.	Did any adverse incidents occur during the trial? What costs were incurred during the trial? How can the model and lessons from the trial be sustained?	Incidents that occurred during the trial period Costs associated with on-call shifts, travel, and medications Relevant policies and procedures	Incident reports Semi-structured interviews with clients, carers, on-call nursing staff and partner organisations Wimmera PCP finance records Qualitative analysis of existing policies and procedures Post-survey of partner organisations and participants Policies and procedures

Appendix C: After-hours Palliative Care model

Demonstration Project – Wimmera After-hours Palliative Care Project – Test Phase 2

GOAL

- Test a model of after-hours palliative care for selected clients who are not currently offered in-home support outside business hours
- The clients will receive effective, supportive and safe face-to-face care when a home visit outside business hours is the most appropriate course of action

ELIGIBLE CLIENTS

- Palliative Care clients who are registered with a Palliative Care Service in the state of Victoria

BEFORE A CALLOUT

Role of Wimmera Hospice Care

- Communicate Palliative Care clients details to their LHS

Role of Patient's Local Health Service (LHS)

- Confirm with Palliative Care Service that the client is registered with them
- Outline to eligible clients what may happen as part of the After Hours Palliative Care Service
- Determine a nurse-on-call roster based on your after-hours policy and staff availability and refer to own organisations safety procedures/policy for after-hours service provision

THE CALLOUT

- Determine what course of action is required (is a visit required or can sufficient support be given over the phone)
- Additional phone support is available at any time during the callout from WHCG Staff, Carmel and Clare (please let Carmel & Clare know when you have a palliative care client that may require a call out so that they are aware they may be called during this time)
- Refer to the triage protocols as needed

AFTER A CALLOUT

Role of Patients LHS

- Update Wimmera Hospice Care in the day following a call out
- Update all other interested parties noted on care plan
- Raise an invoice for costs involved with callout to Wimmera PCP - costings will be based on nursing 2019 EBA and travel calculated at the current ATO rate.

Appendix D: PDSA Phases

Phase 1: PDSA 1 January – March 2019

Plan

A model for the delivery of after-hours palliative care was developed in collaboration with representatives from local palliative care services and health services who attended a Partnership Brokerage session facilitated by Yeshe Smith on 15th November 2018.

The After-hours Palliative Care model was refined through consultation between project officers at Wimmera PCP with services and presented at a Steering Committee meeting (see Appendix C)

Swinburne developed a Project Logic (see Appendix A) and Evaluation Plan (see Appendix B) to identify measurable outcomes to guide the evaluation.

Do

The model was tested in practice over a three-month period. Relevant health services who were involved in testing the model agreed to participate and confirmed they had the staff capacity and resources to provide after-hours care to local palliative care clients. Wimmera Hospice Care staff identified suitable clients for the project. At first contact, Wimmera Hospice Care staff asked the client (or their next of kin) for their consent to be involved in the project and liaise with their local health service.

Study

A mixed methods approach, that involved the collection and analysis of quantitative and qualitative data, was used to evaluate the process and outcomes of the project in relation to the three stated objectives (see Appendix B):

1. Establish effective partnerships between local services to deliver after-hours palliative care.
2. Develop and trial an after-hours palliative care model in the Wimmera region.
3. Evaluate the safety, effectiveness and sustainability of the After-hours Palliative Care model.

Act

The last part of the process brings together lessons from the whole PDSA cycle. A mid-way Phase 1 report (written and verbal) was presented at a Steering Committee meeting on 3 April 2019. Participants were invited to give feedback on the process and outcomes and suggested revisions to the model, which were tested in the next PDSA cycle (NHS, 2018).

Phase 2: PDSA 2 April – June 2019

PLAN

Revisions to the model were finalised and Wimmera PCP communicated with partner organisations and staff about key changes to the model and relevant procedures.

The evaluation plan was updated to incorporate changes to the model and related outcomes.

DO

The revised model (see Appendix C) was tested in practice over a three-month period.

STUDY

The mixed methods approach, utilised in Phase 1, was repeated to evaluate the process and outcomes of the project.

Additional methods were used to evaluate the project as a whole, including:

- a survey of staff, steering committee members and managers from partner organisations, which incorporated selected questions from the VicHealth Partnerships Analysis Tool and the Partnership Self-Assessment Tool.
- telephone and face-to-face interviews were conducted with three staff from Wimmera PCP, three on-call nurses and one client and one carer to obtain in-depth information about their experiences delivering or receiving after-hours palliative care.
- information from the interviews was used to develop case studies or digital stories.
- an analysis of costs associated with the project and relevant policies and procedures to determine feasibility and sustainability.

ACT

This final report includes recommendations for sustainability of the model and the state-wide 24-hour palliative care advice line. It will be presented at the Steering Committee meeting in 19 September 2019.

The presentation will feature Digital Stories as a means of sharing outcomes of the project from different perspectives (such as the on-call nurse, client, and staff member/s from organisations involved in the partnership and project).

Appendix E: Summary of steering committee meetings

Table 1

Participation in steering committee meetings by partner organisations

	5 Dec 2018	6 Feb 2019	6 Mar 2019	3 Apr 2019	1 May 2019	6 June 2019
Wimmera Primary Care Partnership	Y	Y	-	Y	Y	Y
Department of Health and Human Services	Y	Y	-	Y	Y	Y
Swinburne University of Technology	Y	Y	-	Y	Y	Y
Harrow Bush Nursing Centre	Y	Y	-	Y	Y	Y
Grampians Region Palliative Care Consortium	Y	Y	-	Y	Y	-
Rural Northwest Health	Y	Y	-	-	Y	-
Wimmera Health Care Group	Y	-	-	Y	-	Y
West Wimmera Health Service	Y	-	-	Y	-	Y
Consumer representative (C)	-	-	-	Y	Y	Y
Western Victoria Primary Health Network	Y	Y	-	-	-	-
Edenhope District Memorial Hospital	Y	-	-	-	-	-
Woomelang Bush Nursing Centre	-	-	-	-	-	-
Grampians Region Palliative Care Team	-	-	-	-	-	-
Total number of organisations	10	7	-	7+C	6+C	6+C
Total number of participants	16	11	-	13	9	10

Date: December 5th 2018

Discussion topics:

- A recap of the planning and brokerage session on 15 November,
- Draft model for after-hours service delivery including reviewing flow chart step-by-step, roles and responsibilities and safety and risk,
- The evaluation, and
- Terms of reference for the Committee.

Date: February 6th 2019

Discussion topics:

- Actions and responsibilities delegated at the previous meeting,

- The updated flow chart for the after-hours palliative care response,
- Updates from each health service of current status regarding eligible clients, available staff, and what hours will be covered by the After-hours Palliative Care model.
- Evaluation, terms of reference, and monthly meeting schedule were confirmed by participants.

Date: March 6th 2019

Participants: Meeting cancelled due to community event.

Although the meeting on was cancelled, a Consumer Representative was introduced via email with an opportunity for committee members to meet them at the April meeting. Kaye Chilver, who has been a carer in recent times, was welcomed onto the Committee. Kaye plans to attend the next meeting.

PDSA 2

Date: April 3rd 2019

Discussion topics:

- New committee members were introduced. Kaye Chilver has joined the Steering Committee as a consumer and Krista Fischer has joined as a new staff member and project worker for the Wimmera PCP
- Swinburne presented the mid-way report
- Project update - PCP provided an update on their meeting with DHHS and Wimmera Hospice. In this meeting stakeholders discussed and clarified the eligibility of all registered hospice clients and improvement in communication between hospice and the relevant local health services of registered clients.

Date: May 1st 2019

Discussion topics:

- Emergency department presentations – data to be collected from the Urgent Care centres of WWHS, EDMH and RNH, and the ED in Hamilton and Naracoorte. The timeline to be set 12 months before the project and then time during the project.
- Demonstration project flowchart – this was distributed to the members of committee
- Call outs – Carmel and Clare from the Wimmera Hospice have both offered their mobile numbers for the after-hours hours phone support for health professionals making a visit after-hours

- Health services updates i.e. staff change, client's status, and potential clients
- General Information about webinar on Voluntary Assisted Dying; Caring at Home program with resources; and Program of Experience in the Palliative Approach training

Date: June 6th 2019

Discussion topics:

Members of the committee provided updates for their respective services:

- Wimmera Hospice had approximately 30 patients, with a couple of them being monitored for end-of-life care. Staff that provided after-hours phone support were asked to provide invoices for their services
- RNH's staff who were involved in the partnership brokerage session have left the organisation, and they are unable to further participate in the project
- HBNC reported their client has stabilised and there have been no after-hours calls in the previous month.
- WWHS could potentially have a client, who was currently receiving treatment in Warracknabeal hospital
- Swinburne have started interviews for digital stories and presented illustrations for the After-hours Palliative Care model (see Appendix G).

Appendix F: Cost effectiveness assumptions and calculations

A cost-effectiveness analysis was performed based on the actual delivery of after-hours palliative care during the demonstration project, based on invoices submitted to Wimmera PCP, and the estimated costs if an ambulance was called and the client was taken to the emergency department (ED).

Assumptions

Hospital[2]

1. Average cost ED presentation (2016-17) = $400
2. Average cost per bed day (2016-17) = $1,800

Ambulance costs[3]

1. Emergency road transport fees = $1,866
2. Non-emergency road transport fees = $577

Residential aged care costs[4]

1. Basic daily fee $51.21 + Means tested fee $0 + Accommodation $87.58 = $138.79

Episodes of care

1. Single day = ambulance + ED presentation
2. Multiple consecutive days = ambulance + ED presentation + admission

[2] Wimmera Health Care Group (2019)
[3] Retrieved from https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-fees
[4] Retrieved from https://www.myagedcare.gov.au/fee-estimator

Case study 1: Judy

	With after-hours palliative care						**Without after-hours palliative care**	
Episodes of care	Day of service	LHS on-call nurse	Transport	WHCG on-call	ED	Ambulance	Hospital	Ambulance
1	Monday	377.89	29.18	222			400	1866
2	Saturday	305.59	42.90	222			400	1866
	Sunday	305.59	42.90	222			1800	
	Monday	404.51	20.59	222			1800	
3	Sunday	377.90	29.17	222			400	1866
4	Thursday	404.51	20.60	222			400	1866
5	Monday	404.51	20.60	222	400	1866	400	1866
6	Thursday	377.89	29.17	222			400	1866
	Friday	338.57	20.59	222			1800	
	Saturday	377.90	29.17	222			1800	
	Saturday	377.89	29.18	222			1800	
	Sunday	368.31	29.17	222			1800	
	Monday	377.89	No travel	222			1800	
	Tuesday	307.14	No travel	222			1800	
	Tuesday	377.89	No travel	222			1800	
	Admin.	435.88	-	-				
SUB-TOTALS		5919.86	343.22	3330	400	1866	15000	11196
TOTALS						**$11,859.08**		**$26,196.00**

Case study 2: Helen

	With after-hours palliative care						**Without after-hours palliative care**	
Episodes of care	Day of service	Residential Aged Care	Transport	WHCG on-call	ED	Ambulance	Hospital	Ambulance
1	Thursday	138.79		222		577	1800	
	Friday	138.79		222			1800	
	Saturday	138.79		222			1800	
SUB-TOTALS		416.37		666		577		
TOTALS						**$1215.37**		**$5400**

Appendix G: Example illustrations for an information sheet for palliative care clients