facilitating palliative care for patients in their place of choice

The majority of people prefer to receive palliative care at home rather than in hospital, but statistics indicate that few patients actually die in their place of choice. The Royal Melbourne Hospital and Peter MacCallum Cancer Centre launched a multidisciplinary team to enable more people to receive end-of-life care in their place of preference, providing specialised palliative care services in the community and facilitating faster discharge of patients from hospital by providing necessary support.

## Background

Supporting patients to die in their place of choice can improve quality of life, satisfaction with care and avoid unnecessary healthcare expenses.

However, despite the presence of palliative care services across metropolitan Melbourne, the proportion of patients receiving end-of-life care at home in their place of choice is progressively falling.

It is known that up to 70 per cent of Australians prefer to receive care at home when dying, yet in 2016, at the time of the project, only 14 per cent of people were actually dying at home, a rate half that of other comparable countries.

Deaths in hospital and unplanned hospitalisations are also on the rise, indicating that patients are missing out on optimal palliative care.

To improve care in the home, reduce unplanned hospitalisations, and address current gaps in service provision for those with advanced illness, an innovative palliative care model was piloted: the ‘Responsive acute palliative intervention and decision assistance’ project or RAPID Assist.

RAPID Assist provided patients with rapid and responsive access to symptom management and expert assessment and intervention, extending hospital palliative care expertise to patients in the community.

Responsive acute palliative intervention and decision assistance project (RAPID Assist)

**Leads** Royal Melbourne Hospital, Peter MacCallum Cancer Centre

**Partners** Melbourne City Mission Palliative Care, Mercy Palliative Care

**Duration** November 2016 – October 2017

**Key outcomes**

* Provided 342 episodes of care to 282 patients in 12 months, with 66 per cent seen on the day of referral
* Supported more people to die in their place of preference, with 89 per cent of the 172 patients seen who died during the project dying at home or in residential aged care – a significant improvement of on the statewide average of 14 per cent
* Avoided 305 hospital bed days by extending specialist palliative care skills to the community and facilitating early discharge for patients seeking to receive care at home



## Key activity

RAPID Assist provided a multidisciplinary clinical service for all Royal Melbourne Hospital and Peter MacCallum Cancer Centre patients in hospital or residing within a 30km radius from the Parkville precinct.

Referrals were received direct from patients, carers, general practitioners, community palliative care and aged care services, as well as from intra-hospital referrals.

The RAPID Assist team consisted of a palliative care physician, nurse and occupational therapist who provided predominantly same-day review for patients with unmet urgent needs, such as uncontrolled symptoms and distress.

The team helped patients and their carers with complex decision-making, goal-setting, interventions and treatment. By providing this service in the home and in the community, RAPID Assist aimed to prevent unnecessary and unwanted emergency department (ED) attendances and hospital admission.

RAPID Assist also helped facilitate early discharge for patients in hospital who wanted to return home for ongoing care in their place of choice. The team provided hospital level care, access to hospital clinicians, and information for patients at home.

They established agreements to work in close collaboration with existing community palliative care providers Melbourne City Mission and Mercy Palliative Care, facilitating a smooth transition for patients, improving continuity of care, and reducing duplication of processes.

## **Outcomes**

* Over 12 months, the RAPID Assist team provided 342 episodes of care to 282 patients, with 66 per cent of patients seen on the day of referral. The top three reasons for referral included for expert palliative care assessment and assistance with advance care planning (56 per cent), symptom management (19 per cent), and to expedite discharge from hospital for terminal care at home (13 per cent).
* 172 of the patients seen by the RAPID Assist team passed away during the project period. 89 per cent of these patients died at home or at a nursing home in their preferred location of care, a significant improvement compared with the statewide average of 14 per cent.
* Following discussion with patients and carers, RAPID Assist arranged for direct admission of a further 9 per cent of patients into inpatient palliative care, where they subsequently died while receiving hospice care.
* Overall, 98 per cent of patients assessed by RAPID Assist who died during the project period did not require potentially stressful and inappropriate admission to hospital, with only 2 per cent dying in acute care.
* By preventing unnecessary hospitalisations and enabling patients to be discharged home earlier, RAPID Assist was able to avoid 305 hospital bed days.

Case study

A community palliative care service was unable to admit a hospital patient with end-stage liver failure until after Christmas. Usually, this would have meant the patient would have had to remain in hospital. However, with support from the RAPID Assist nurse and doctor, the patient was discharged home three days before Christmas. Thanks to RAPID Assist’s relationship with the community palliative care service, the patient was able to access after-hours phone support, which helped her and her family manage her symptoms while at home, preventing an unexpected readmission to hospital.

### Additional benefits

The RAPID Assist team also:

* changed family members and residential aged care facility (RACF) members’ attitudes towards normal dying, which anecdotally led to reduced levels of anxiety, prevented unnecessary hospital transfers, and improved symptom control for patients
* advised on important end-of-life care decisions that RACF staff felt less confident to make for their residents, such as when it was appropriate to cease hospital transfer, set resuscitation limitations, and prescribe additional medications for comfort
* facilitated a smoother transition for patients from hospital to home. The RAPID Assist team could review patients in hospital prior to discharge as well as shortly after they had moved into home care, allowing them to quickly address any symptoms that had become uncontrolled and to check and reinforce symptom management strategies in the home environment
* extended acute clinical skills that would otherwise usually only be available in hospital to patients in the community.

## Key learnings

* The project identified a need for specialist palliative care consultation in RACFs. Data and anecdotal observations collected over the course of the project showed that many RACF staff felt out of their depth when it came to discussing normal death and dying, managing distressing symptoms at the end of a resident’s life, and making decisions about necessary alterations to care plans. Providing specialist palliative care expertise in this setting would help ensure residents are receiving appropriate care.
* The RAPID Assist project highlighted the value of a responsive service. Quick assessment and treatment was key to the team’s success in expediting discharge and preventing unnecessary hospital admissions. Patients also reported that the team’s prompt attendance made them feel their symptoms were managed and that their questions and concerns were addressed quickly and efficiently. The main reasons the team could not see all patients on the day of referral was due to limited service capacity or because the patient was referred out of the normal business hours in which the service operated. There is an opportunity to expand RAPID Assist to incorporate an after-hours service. For example, a nurse could work an afternoon shift and/or some form of after-hours telephone support could be provided for referrers.
* Due to time constraints and the evolution of the program over the project period, clinical staff found it increasingly difficult to maintain accurate data collection. To ensure a true and accurate analysis of the benefits and limitations of a program such as RAPID Assist, a separate staff member should be employed to collect and analyse data, as well as to adjust the parameters of data collection as the program evolves.