On The Road Again

Willem Vink – Palliative Care Nurse Practitioner CDHB
Mary Fairhall – Nurse Maude Community Palliative Care

Nuts and Bolts of Exchange

- Rotation dates: 4th Feb 2013 – 3rd June 2013 (4 months)
- Both of us continued to be paid by our own employers
- Mary employed 4 days a week (not Wednesdays) so I went back to the hospital team on Wednesdays
- Both given access to IT systems and received orientation from within the teams

Canterbury
District Health Board
Te Poari Hauora o Waitaha

Why Exchange

- To enhance understanding between hospital and community palliative care teams
- To improve integration between services
- To experience and appreciate each other's work strengths and challenges within respective practice areas
- To explore possibilities of working more seamlessly together
- To improve the patient's palliative journey
- Professional Development

Main Differences

CNS

- *Increasing understanding & further developing practice*
- *Leadership within the speciality area of practice*
- *Contribute to development of policies/audits/standards*
- *Utilise research in clinical care & critique practice guidelines*

NP

- *Well developed practice; generating new approaches*
- *Leadership across settings & disciplines;*
- *Initiate change & facilitate such processes*
- *Influence resource allocation through research findings & help shape nursing practice*

Adapted with permission C. Arkness

Initial Challenges - Willem

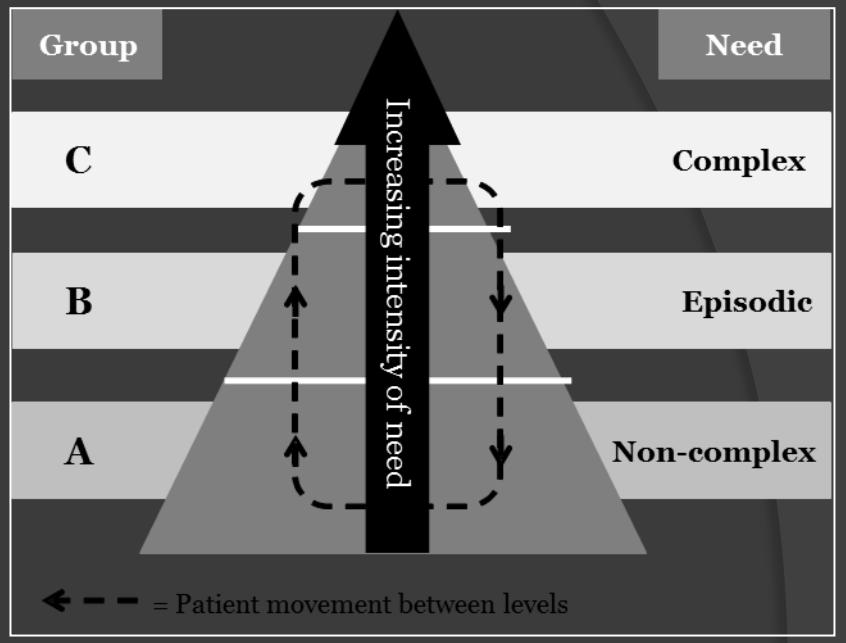
- Understanding how the model/system works
- Nebulous workload –
- Triaging calls & visits
- Finding way around town
- Allowing for travel time
- Random phone calls
- Covering CNS's when sick or A/L
- Working across 2 sites, 2 e-mail addresses….
- Three D/N providers & changing DN's
- Care at home is only as good as DN !
- GP Liaison variable

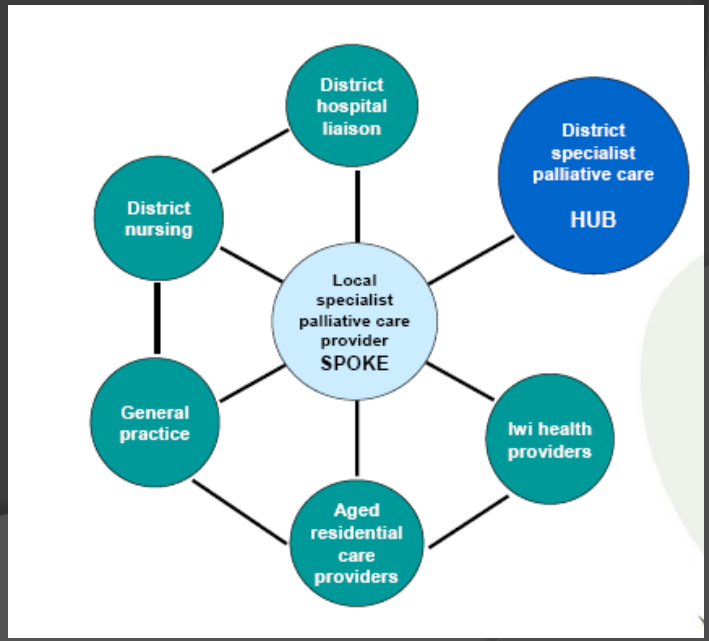
Change in Model

- From “Total Care” to Specialist provider
- Seeing all new referral’s preferably with DN
- Prioritising F/U visits - most complex 5%
- Active list

  On hold (criteria)

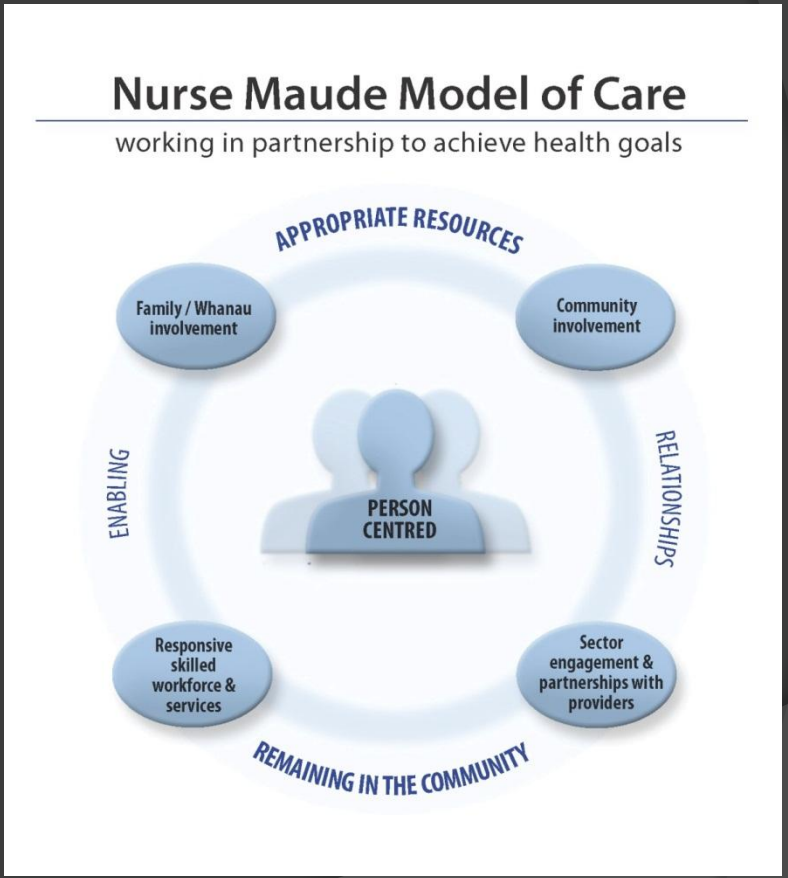
  ARCF
- Discharging patients
- Understanding the role of the MDT
- Referrals to from & processes





Matching Up

- Organizational values
- Service integration
- National guidelines (needs assessment phase 2)
- Strategic planning



Current Model-my thoughts

Strengths	**Weakness**
MDT **Community PC physician** **Experienced practitioners** **Hospice inpatient unit** **Increased integration between Hosp/com** **Accesses to concerto** **Joint visits** **Gp letters**	**Nebulous nature of workload** **ARCF** **Leave cover** **1st visit time-consuming** **Little time for CNS's research/education**
Opportunities Refine model further/adapt to it ARCF Workforce development Collaborative approach eg Chemo outreach, HF nurses IT, smart phones/tablets & software	Threats Challenge status quo "Holding onto" patients

Tensions & Current Model

- Seeing patients versus providing education, ARC visits, research, professional development
- Between “doing it yourself” and “teaching others how to do it”
- Level of skill required to make sound clinical decisions
- Active vs ‘On hold’ list
- Management of priorities and time

Learning's

- Seeing people in their “space”
- Developing longer-term relationships
- Still a fear of caring for their loved one at home when it becomes difficult ?night support
- Reminded how quickly it can unravel - no matter how well we think we have communicated
- Complex case management VC (excellent) ensuring accountability and safe practice
- Seeing the “bigger picture” for PC across region
- More informed re strategic planning/governance

Reflective Practice

- Extended my practice
- Clinical decision making grown
- More reliant on own assessment : confidence/responsibility/ consequences
- Time management
- Constantly prioritizing

What will I take back to the hospital setting?

- Pushing for clearer info on referrals and informing patient of referral
- More decisive
- Seeing the “bigger picture” for PC

Clinical Nurse Leader/ NP

- Advanced skills
- First port of call - clinical problems
- Professional development
- Service development
- Research coordination
- ? Just community or across service

ARCF

- Huge need and will continue to increase - LCP is improving EOL care
- Often feel they can't manage complex patients
- Funding gap $125 per day Hospice $??
- Difficult for CNS's to do justice education/clinical

Options

- One CNS dedicated to developing clinical skills
- Or perhaps rotating a CNS
- Identifying the "champions" within the facility

Future Development

- Fine tuning current model
- Continue with IT development – smart phones/ tablets/ appropriate software
- First visits – simplify further ?
- DN taking greater responsibility
- ? Clinical nurse leader/NP
- ARCF
- Strategic planning
- Workforce

Challenges – Mary

- Lack of knowledge and confidence by hospital staff around good palliative care
- Lack of streamlined and structured discharge planning
- Lack of interest and commitment to what happens to the patient once they are discharged
- Lack of understanding by some staff (K.W. example)
- Sometimes only there to sort pain control, sometimes there to sort everything

Challenges - Mary (cont'd)

- Some burnt out people working in DHB… as well as some very inexperienced staff
- Some days (not all) felt I was back at square one - treading water/making no progress – so many new people to educate and re-educate re discharge planning and palliative care….
- Complexity of many doctors/teams/disciplines working with one patient (palliative care suggestions can get lost in the mix) a lot of people to communicate with!

Challenges – Mary (cont'd)

- Surgeons wanting to discharge patients as soon as surgery isn't an option
- Educating one-on-one in a big hospital - huge
- Things you ask (and document) to be done (e.g. documenting effectiveness of new opiate dose) not being done. You find your request 6 pages back in the notes, not read…
- **At the cutting edge of cure vs palliative care!** e.g…people with new diagnoses being told they only have hours or days to live

Challenges – Mary (cont'd)

- Challenge of people with long lifespans & palliative diagnoses
- Having challenging conversations with patients/families/medical, nursing and allied staff for the above reasons
- Registrars/Consultants delaying decision that patient is palliative, sometimes until day of discharge or day of death!!
- Registrars not wanting to let their patients die. Lots of education to medics needed
- D/C Referral form gets lost in patient's notes and never faxed,
- Or worse, never written at all….frequently

Celebrations - Mary

- A great learning experience! Broadened my palliative care knowledge in all sorts of ways e.g. more confident with Fentanyl
- Being at the cutting edge of cure vs palliative care!
- Loved sorting/sifting through patient's stories and wishes
- Some wards are highly functional e.g. Oncology
- Liked the variety of wards/environments and different medical conditions
- Can see patients daily

Celebrations - Mary (cont'd)

- More time to spend with patients & their families, to listen well to what they want and then help them plan their care going forward
- Late in the day referrals – could give telephone advice to staff to tide the patient over until they could be seen the next day
- Great to have some space to develop the CNS role
- Loved keeping fit and walking the stairs

Celebrations - Mary (cont'd)

- Great working with the highly skilled and welcoming members of the hospital Palliative Care Team. They each taught me a great deal
- Loved having Concerto at my fingertips anywhere/ any ward
- LOVED hospitals teams data base system, with drop-down boxes you just click, saved so much time
- Opportunity to try new Tx eg Targin
- Great professional development – would recommend it to anyone!

Key to better patient flow

- GOOD REFERRALS is the key, with best info available included
- Anything urgent, pick up the phone
- We are streamlining communication between the two services all the time – meet together twice monthly, Kate and Willem having some crossover is beneficial
- Better IT system at NM (on the way!). I dream of Concerto at my fingertips in the community

Key to more cost-effective and better patient flow (cont'd)

- Keep doing ward teachings to explain discharge planning and referral writing for palliative patients to nurses and allied staff across the DHB
- Have to convince all staff to take an interest in what happens to the patient once they leave the hospital door. It is part of holistic care!

Recommendations: hospital

- Learning package accessible via Intranet for nurses and allied staff around palliative care and discharge planning at ward level
- Ongoing education sessions by Pall Care Team to hospital doctors about how things work in the community
- Also, realistic expectations given to the patient about support they will get on discharge
- Develop a discharge planning tool which could go with the referral forms, which prompts to and asks questions of the person completing the form

Recommendations (cont'd)

- Ongoing education sessions by Pall Care Team to hospital doctors about how things work in the community
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- Recommend to my colleagues to always check bloods on Concerto

Summary

- Our professional growth was huge. We got to:
  - Experience walking in someone else's shoes
  - Learn new clinical and communication skills
  - Understand what resources each work place can offer and share with the other

  Both of us came out inspired further about palliative care and relief of suffering for those with life-limiting illnesses