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'Supporting the Connection between Community Nursing & the Palliative Patient'

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OBJECTIVES

- Review the design of the multidisciplinary team and how they practically deliver service in a largely rural, geographic area
- Learn from families how this approach to home palliation benefitted their loved one and aided in the palliation/grief journey.
- Identify how the community nurse fits in the delivery of home palliation and intersects with specialist team

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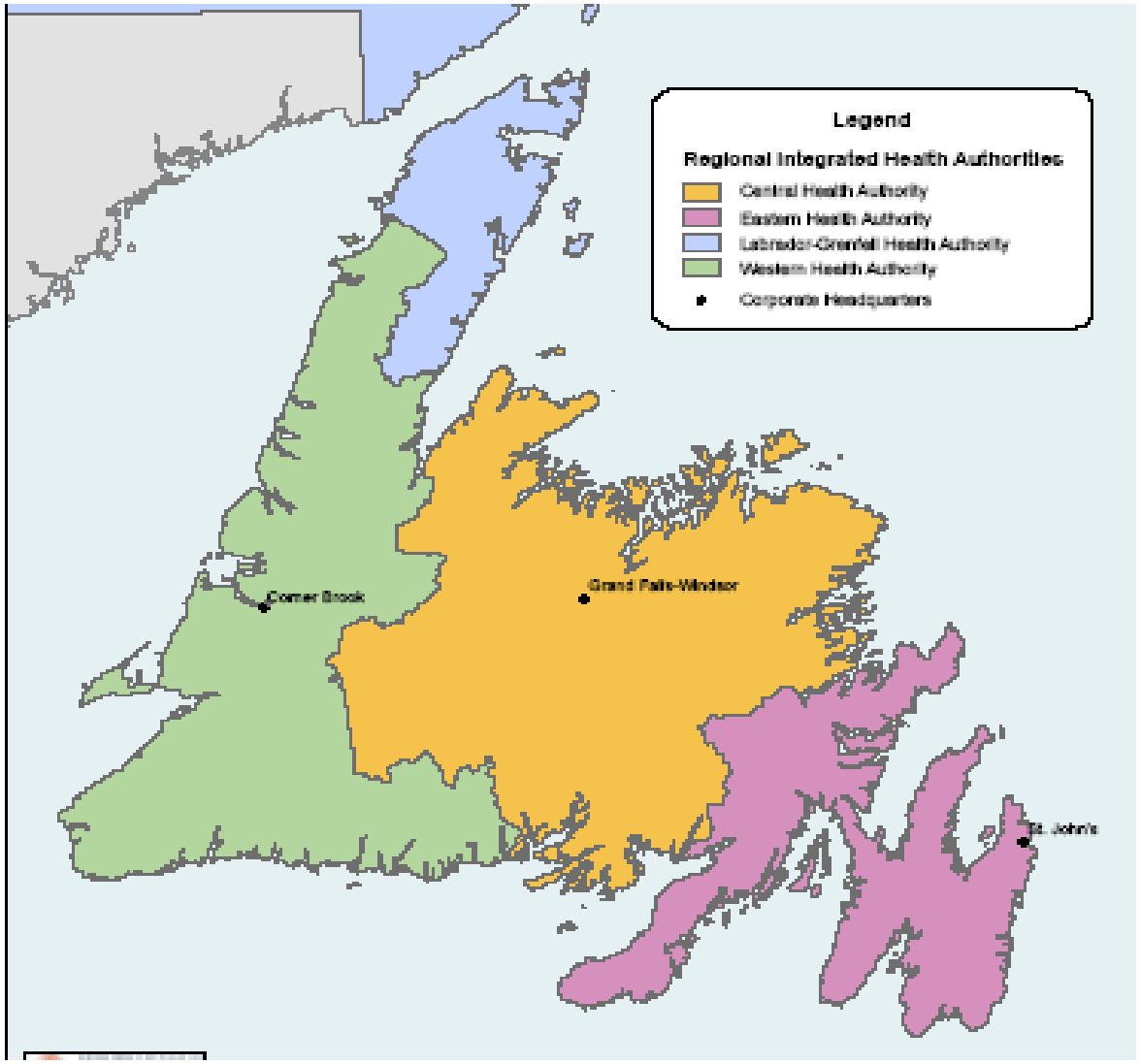
A BIT ABOUT US…



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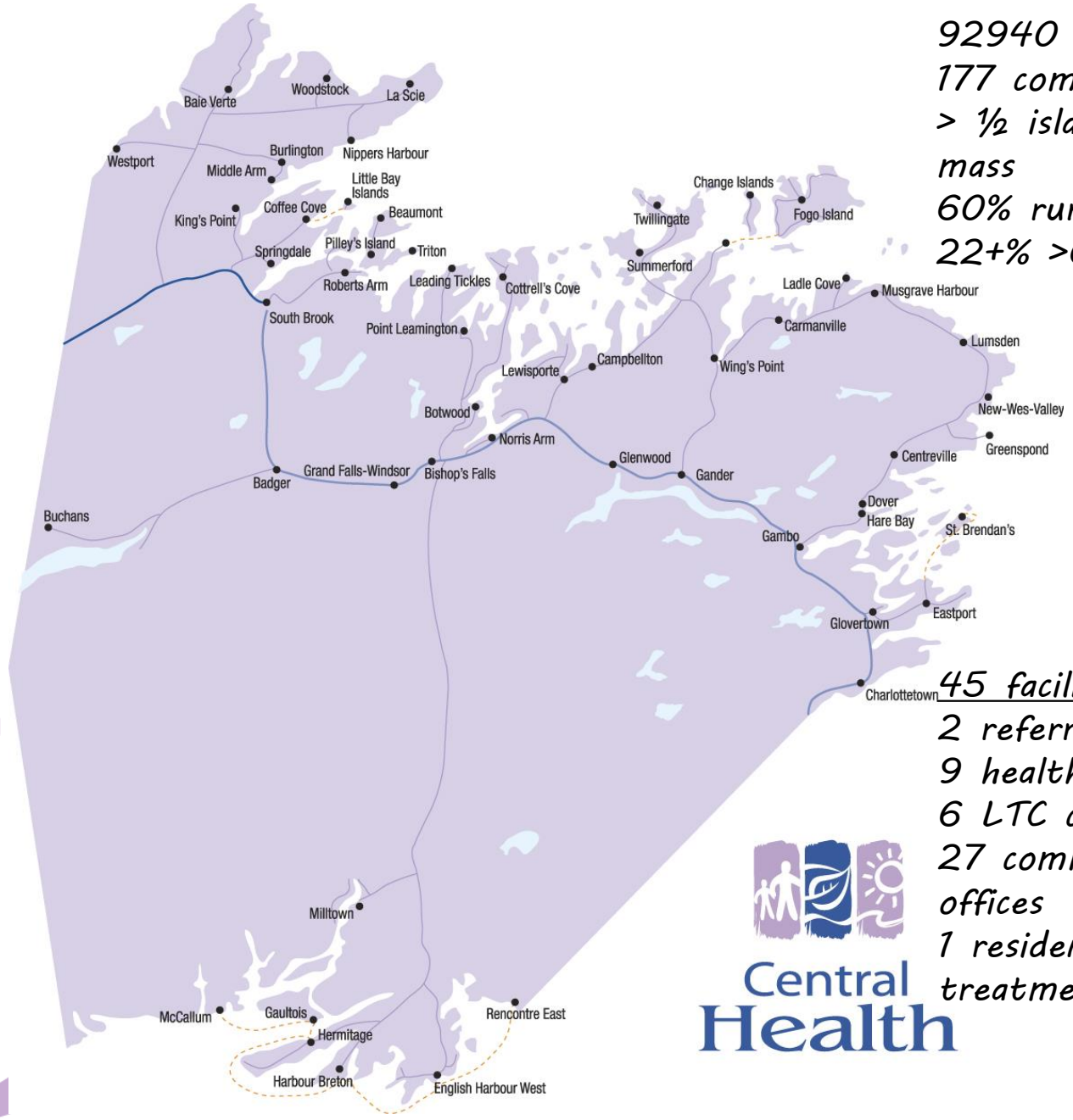

92940 people
177 communities
> ½ island's land mass
60% rural based
22+% >65 y.o

<u>45 facilities:</u>
2 referral centers
9 health centers
6 LTC centers
27 community offices
1 residential treatment center

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STATISTICS

Acute care beds	247
Long term care beds	513
Palliative care beds	14
Bassinets	24
Individualized living arrangements (46 clients)	27
Alternate family care homes (63 clients)	58
Personal care beds (25 homes)	1,197

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STATISTICS - Utilization

Admissions to acute care	8,430
Admissions to long term care	321
Emergency room visits	104,511
Same day surgery	2,141
Operation room procedures	11,713
Continuing Care (HOME CARE) - Home Visits	32,545
Continuing Care (HOME CARE) - Clinic Visits	46,532
Continuing Care (HOME CARE) - Telephone Visits	55,494
Admissions to personal care homes	263
Number of seniors receiving home support	1465
Individuals with disabilities receiving home support	755

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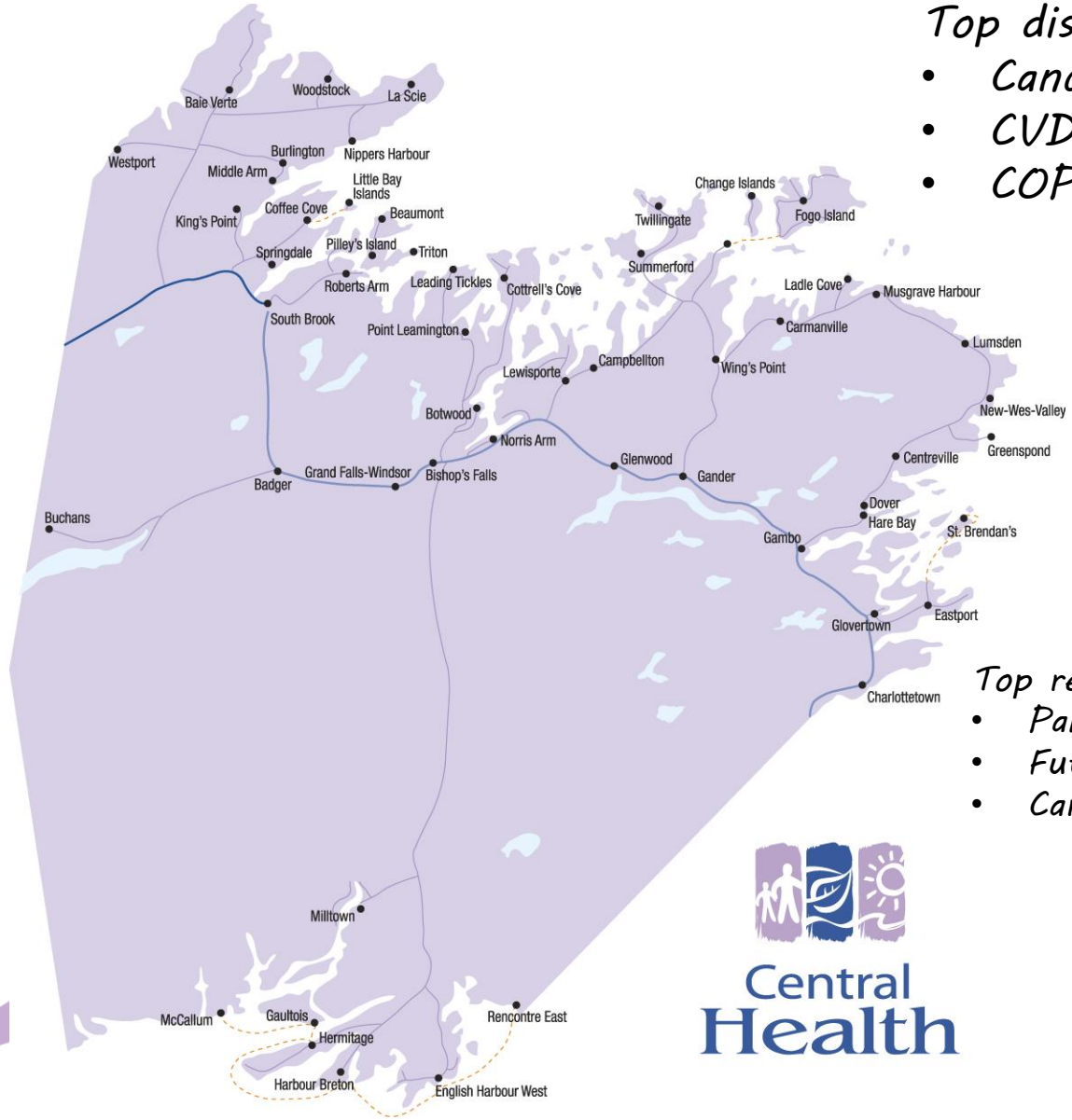
PALLIATION IN CENTRAL NL



Top diseases referred

- *Cancer*
- *CVD*
- *COPD/ALS*

Top referral reasons

- *Pain/Symptom Mgmt*
- *Future Care Planning*
- *Caregiver Distress*

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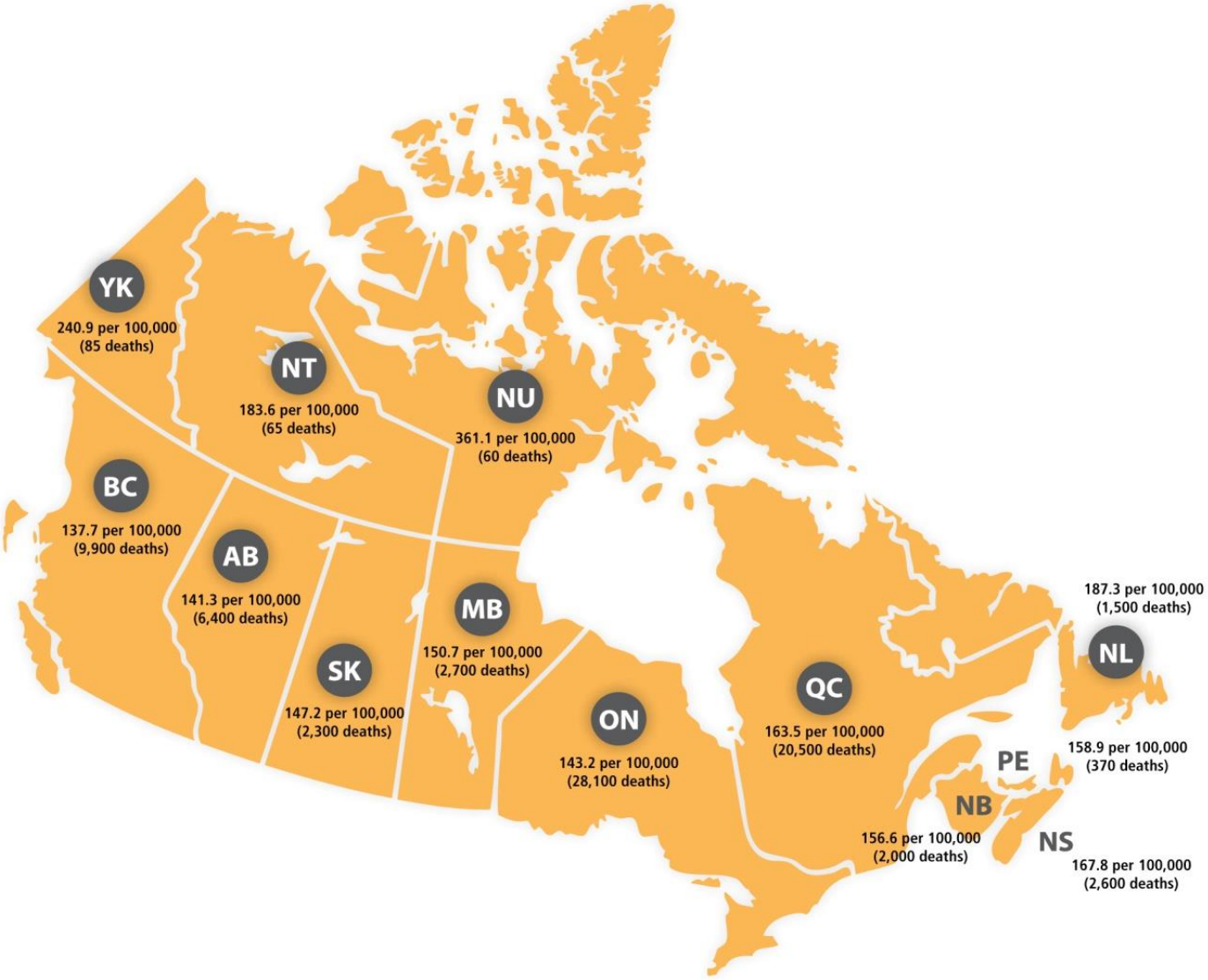
FIGURE 4.4 Geographic distribution of estimated cancer deaths and age-standardized mortality rates (ASMR) by province and territory, both sexes, Canada, 2014



Analysis by: Chronic Disease Surveillance and Monitoring Division, CCDP, Public Health Agency of Canada
Data source: Canadian Vital Statistics Death database at Statistics Canada

An estimated 191,300 new cases of cancer and 76,600 deaths from cancer will occur in Canada in 2014. Lung, breast, colorectal and prostate cancer account for the top 4 diagnosed cancers.

In 2014, an estimated 1,500 people will die of cancer in Newfoundland, and 3,400 new cases will be diagnosed.

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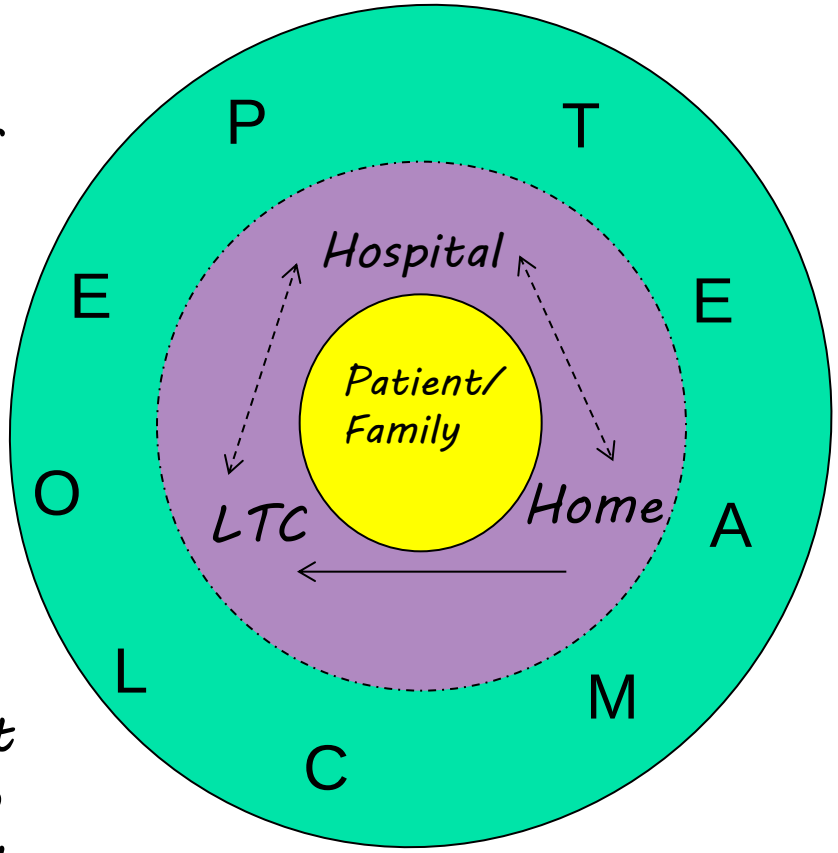
PERSON CENTERED CARE IN PALLIATIVE CARE IN C.H.

Square of Care Approach (CHPCA)



<u>One</u> Referral; Any Age, Any Location; Any Source

Patient has to consent to referral

Team goes 'with' the patient

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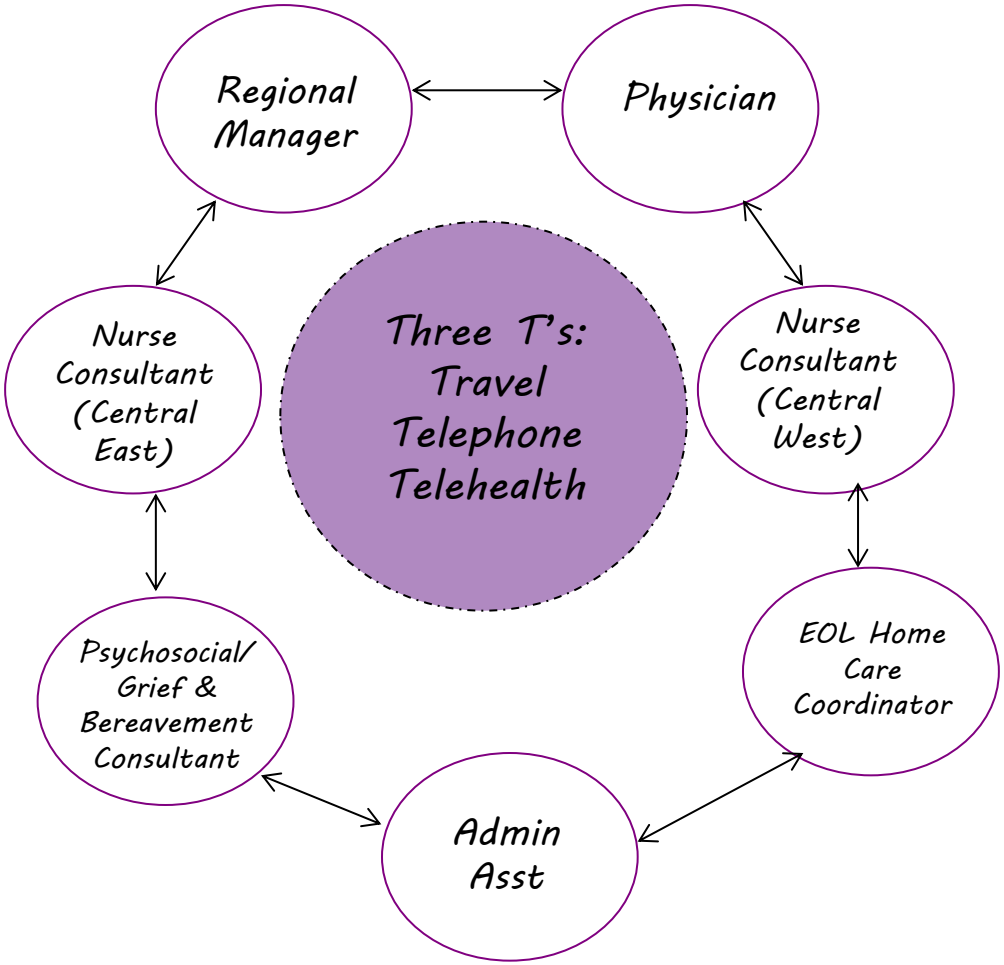
MULTIDISCIPLINARY PEOLC SPECIALIST TEAM



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FUNDAMENTALS

- Community Nursing maintains primary case management of patient
- Death at home planning requires full participation of patient, family, physician, community health nurse and palliative team
- Supportive education to both families and community health nursing/partners is key
- Regional PEOLC Standing Orders are a key source of 'on the ground' clinical supports

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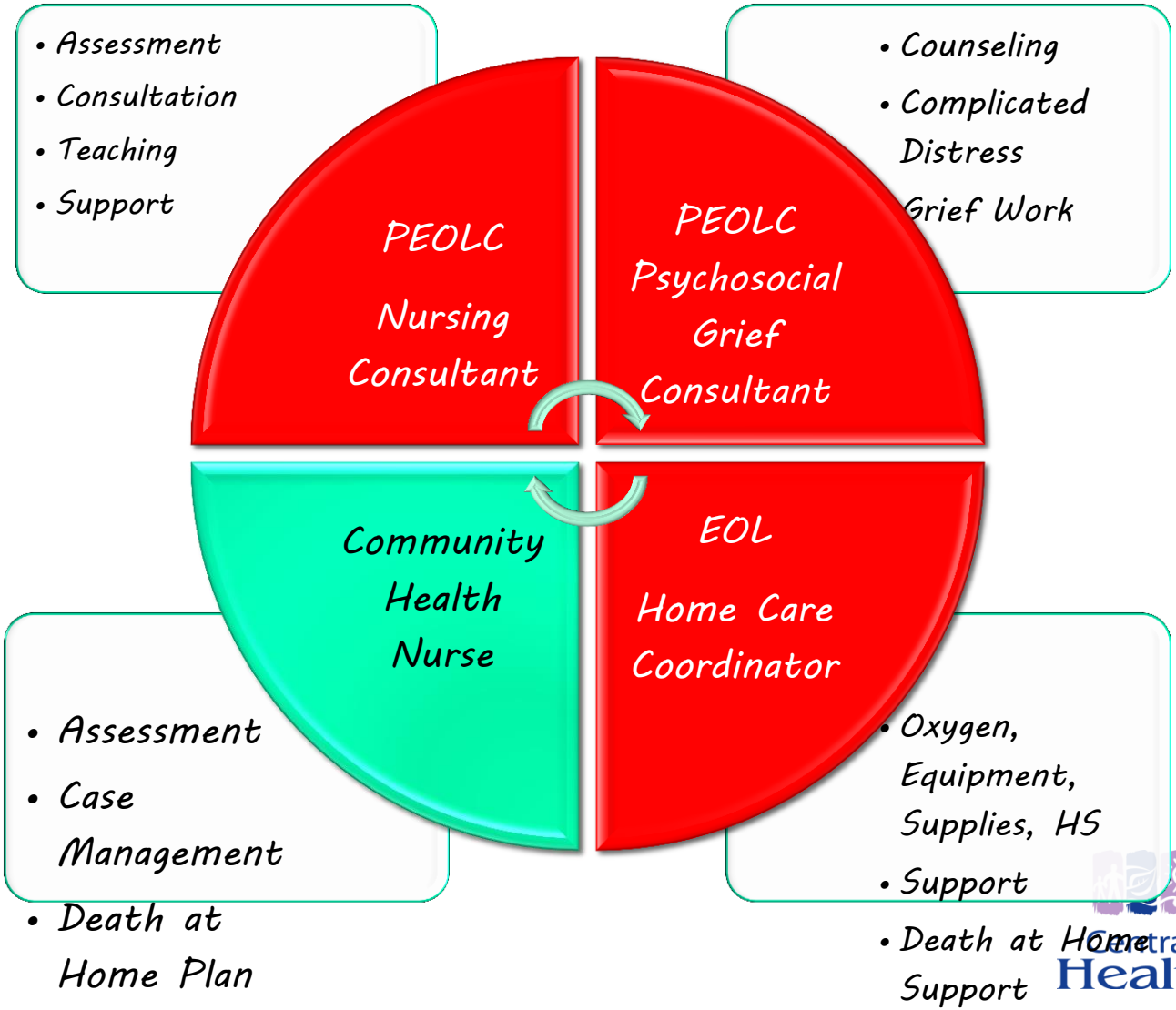
CIRCLE OF CARE



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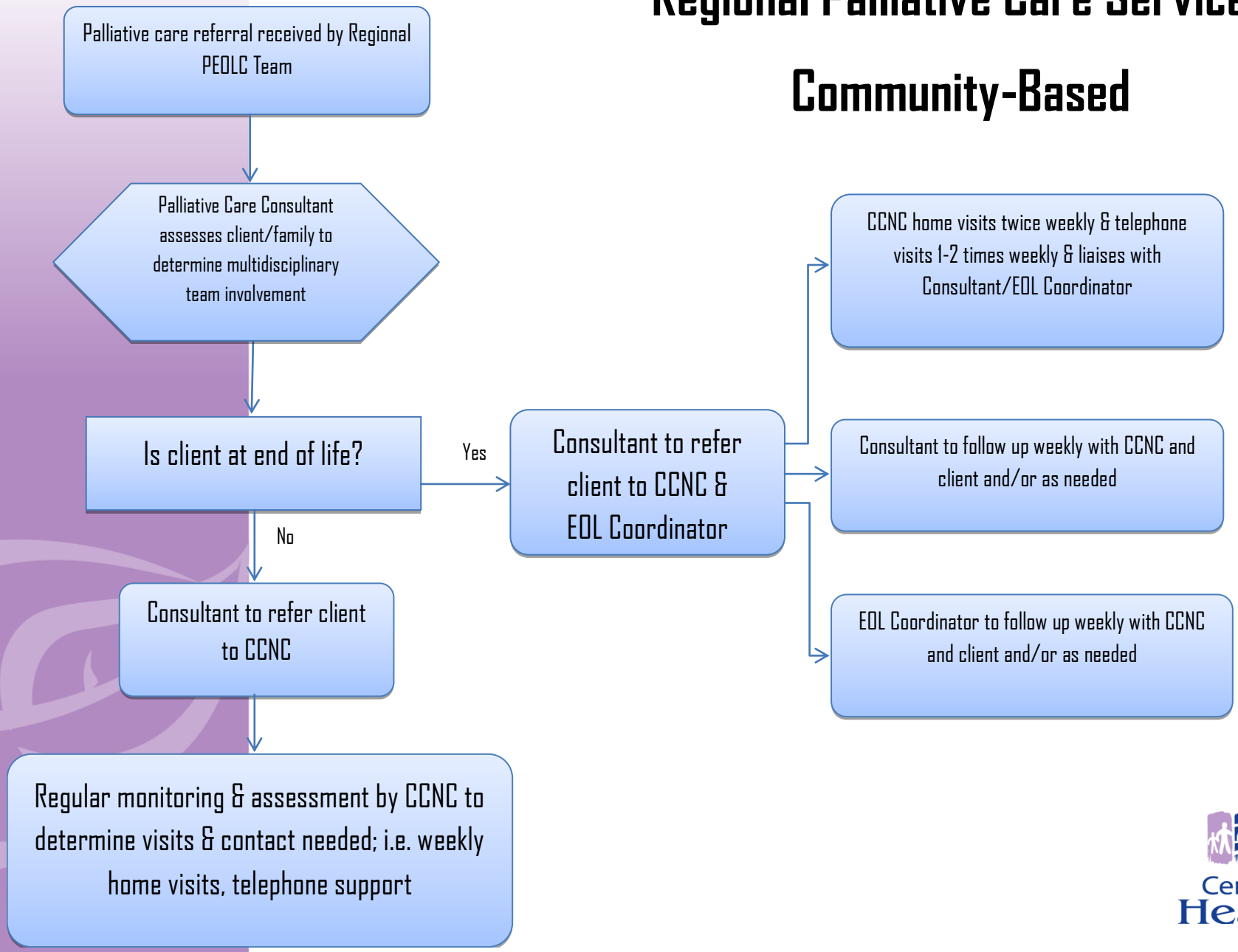
Regional Palliative Care Services

Community-Based



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MEETING THE NEED

Year (July-July)	Number of Clients Referred	Average days followed by consult team	Estimated Savings
2012-13	238	70 days	$1·2 million
2013-14	263	44 days	$1·3 million
2014-15	320	51 days	$2·2 million

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NUMBER CRUNCHING….

YEAR EOL Home Care 28 day Program (Apr-Apr)	No. of Clients	Length of Service Days	Costs of Equipment/ Drugs/Home Care Cost	Professional Staff Cost based on 20hours per client	EOL Home Care Program TOTALS	Average cost per EOL client for full community program	Bed Days Saved (avg cost $1000/day/ bed /person) CIHI reference
2014	95	29.1	$22,663 $4690 $45,407	$91,200	$163,960	$1725	2309 = $3,163,330
2015	99	36.9	$19,184 $6869 $90,343	$95,040	$211,436	$2135	3665 = $5,023,667

**Data from CIHI (2015), indicates that the average length of stay for palliative patients in acute care is 7 days and 0·9 days as ALC· This is a cost of $9595·00·

*Palliative care patients are 5 times more likely to have 3 or more stays with a cumulative length of 30 days or greater· These numbers are greater than clients with acute medical conditions like Chronic Obstructive Pulmonary Disease and Congestive Heart Failure 2·7 and 4·1 respectively· Palliation in the acute care system has been necessary because of the lack of integrated palliative care services in the community· These numbers are further compounded by challenging geography· Common characteristics of high users of acute care are those who live in rural areas· It is reported that 21-24% of high use patients live in rural areas (CIHI, 2013)·

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WHAT MATTERS MOST

I DON'T LIKE HOSPITALS

I CAN BE WITH MY FAMILY

I WANT MY DOG WITH ME

I CAN EAT MY FAVORITE FOODS

I WANT TO MAKE MY OWN DECISIONS

I WANT PRIVACY, HOSPITALS ARE TOO CROWDED

I DON'T WANT TO GO TO 'THAT' ROOM

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CASE STUDY

- 60 y·o female with liver cancer; poor prognosis (days to weeks)
- Several visits to ER in previous 2 months for undiagnosed symptoms· Admitted to hospital· Given dx & poor prognosis
- Client wanted to return home - PALLIATIVE/END OF LIFE CARE TEAM consulted

Palliative Team	Community Nurse
Assessment in hospital	Contacted/Visited client/family
Equipment/Supplies sent home	Gleaned history/learning from team
Teaching to family	Regular care/follow-up
Referral to Community Nurse	Extra consulting required on terminal delirium/deterioration

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CASE STUDY CONT'D

- Prepared appropriate paperwork for death at home planning
- Extra family support required during weekend crisis
- Regular visits by both Community Nurse and Palliative Consultant
- Palliative Consultant liaised between Physician and Community Nurse for symptom support

CONCLUSION:

Client died at home, as per goals of care peacefully

Family appreciative of collective efforts

Smoother bereavement process

Community Nurse felt supported and educated in process, learning best practices in PEOLC

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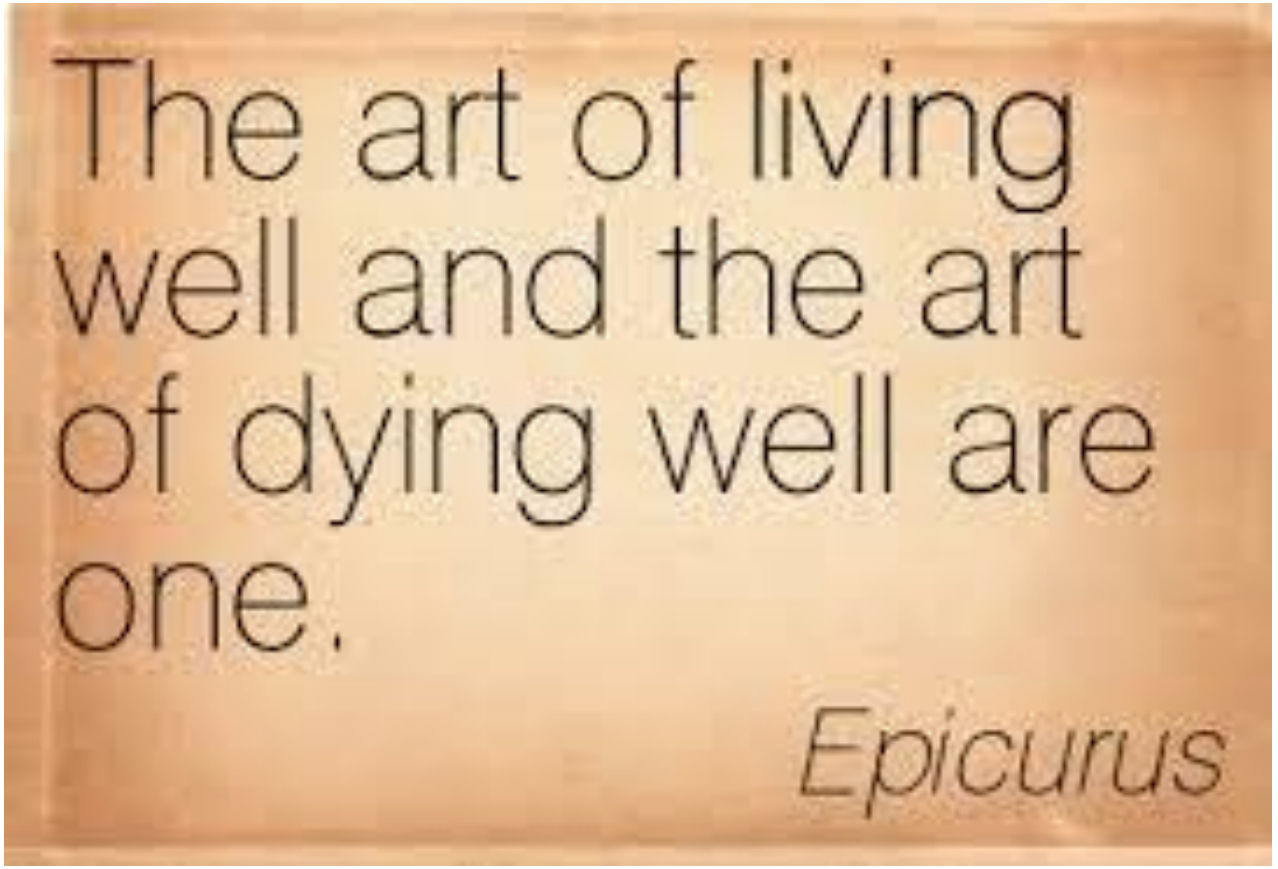
Questions or Comments?



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