Development of community palliative care in Denmark:

Barriers and Facilitators

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1. Palliative care institutions in Denmark

2. Background of the project

3. Summary of the project and the interventions

4. Project evaluation

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Secondary sector

- Palliative care wards
- Palliative care teams
- Hospices
- Hospitals

Primary sector

- General practitioners (GPs)
- Home health-care/community nursing
- Nursing homes
- Municipal institutions providing special palliative care programmes in Denmark (MISPCP)
- Other departments in the community

What?
Palliative care services

Who?
Citzents
Professions
Institutions

How and when?
Structures
Time
2: Preferred place of care and death

- People with life threatening disease want to stay as long as possible in their own home and if possible to die at home.

However

- The wish to die at home decreases the further the person is in the disease trajectory and the more complex the symptoms become.

2: Place of death in Denmark 2007-2011

• 47% in hospital

• 42% at home

2: Challenges in palliative care services in communities (1)

- Most of the professionals have a short education
  - nursing assistant
  - Social- and health care workers

- About 36% of the care organisations have professions with palliative care postgraduate courses or further education

- More than 50% of the care organisations have a resource person in palliative care

However

- The resource persons have great variation in formal contents of tasks and responsibility

2: Challenges in palliative care services in communities (2)

• A need for proactive planning in palliative care

• The different professions have require
  o knowledge sharing
  o clear division of tasks
  o better communication
  o greater respect towards each others knowledge and competencies

• GPs find palliative care complex and have a lack of knowledge about palliative care

• Management problems

Ref.:
Brogaard T. (2011) Home is where the heart is: coordinating care and meeting needs in palliative home care: Ph.d. thesis. Aarhus: Aarhus University. Faculty of Health Sciences. Research Unit and Department for General Practice.
Raunkiaer M, Timm H (2010). Development of Palliative Care in Nursing Homes: evaluation
3: The project aims (2010-2013)

To strengthen and produce connections in community palliative care services to people with life-threatening diseases and their relatives in own home and nursing homes through 4 partial aims.

1. To develop and try out methods to develop competencies

2. To develop and try out structural and organisational frameworks

3. With starting point in the national recommendations and partial aim 1-2 to develop and test an interconnected intervention across community palliative care services and if possible in cooperation with the specialised palliative care institutions

4. To evaluate partial aim 1-3.
3: Design and participants

Design

• Action and intervention research
  1. Planning (meetings, survey, interviews and reviews)
  2. Implementation
  3. Assessment and communication

Participants

• Nyborg Municipality (two geographical areas)
  • Research Unit of Practitioners, University of Southern Denmark
  • PAVI
3: Interventions – practice / organisation

• Identification of citizens with the need of palliative care

• Devise a ‘Palliative Care Trajectory Plan’ (PCTP) to clarify the different professions area of responsibility and tasks

• Interdisciplinary home visits supported by guidelines and team meetings

• Systematic evaluation of the palliative care trajectory and the guidelines

• ‘Discovery form’ (DF) to nursing assistants/social- and health care workers to early discovery of persons who needed palliative care

• The quality of life form: EORTC-QLQ-C15-PAL to identify the need of palliative care
3: Interventioner
- competency development

• Teaching one afternoon for GPs and nurses together

• Course (3 + 2 days) for nursing ass/social and health care workers
3: The Gold Standards Framework (GSF) as a project frame

The goals of the GSF are to provide high-quality care for people in the final months of life by

- Ensuring patients are well symptom controlled
- Enabling patients to live and die well in their preferred place of care
- Encouraging security and support by better advance care planning involving the patient and their family
- Empowering cares through increased communication, listening and by addressing issues proactively
- Educating staff and developing increased competence and confidence

3: The three steps of GSF

1. Identify patients in need of palliative/supportive care towards the end of life

2. Assess their needs, symptoms, preferences and any issues important to them

3. Plan-care, particularly with regard to looking ahead for problems that might arise
3: Step one - identification

GSF
• The Surprise Question: “Would you be surprised if this patient were to die in the next few months, weeks, days?”

• General indicators of decline - deterioration, increasing need, or choice for no further active care

• Specific clinical indicators related to certain conditions.

Project
• DF to nursing assistants and social- and health care workers
3: Step two - assessment

- EORTC-QLQ-C15-PAL
- Conversations with the ill person and relatives
- DF to nursing assistants social- and health care workers
3: Step three – plan-care

- Interdisciplinary home visits
- Team meetings
- Other C’er
- Plans and agreements
- PCTP
- Care in the dying phase
- C7
- Care support
- C6
- Communication
- C1
- Coordinating
- C2
- Control of symptoms
- C3
- Continued learning
- C5
- Agreements/plans for after hours
- PCTP
- EORTC-QLQ-C15-PAL
- PCTP
- DF
- Medicine
- Everyday practice
- Competency development
- Evaluation of the palliative care trajectory
- Relatives / bereaved
- PCTP
- Relatives / bereaved
- PCTP
**Forløbsbeskrivelse og tværfaglige indsatsområder i palliative forløb**

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**HJÆLPERE/ASSISTENTER**
- Tidlig opsporing
  - Opsporingsskema
- Evt. deltagelse i tværfaglige hjemmebesøg
  - Guide
- Personlig pleje
- Observationer
- Tilbagemelding til sygeplejerske
- Evaluerings af palliative forløb
  - Guide

**SYGEPLEJERSKER**
- Koordination af forløb
  - Tværfaglige hjemmebesøg med praktiserende læge mhp. plan/aftaler
    - Guide
    - EORTC-QLQ-C15-PALL
- Overvej:
  - Præst
  - Vågekone
  - Aflastningsplads
  - Fys., ergo., socialrådgiver

**PRAKTISERENDE LÆGER**
- Tovholder på medicinsk behandling
  - Tværfaglige hjemmebesøg med sygeplejerske mhp. plan/aftaler
    - Guide
    - EORTC-QLQ-C15-PALL
- Overvej:
  - Forslag til soc.med. sagsbehand. (LÆ 165)
  - Terminalansøgning
  - Grön recept
  - Tryghedskasse
  - Palliativt Team andre professionelle
  - Åben indlæggelse
  - Øget tilgængelighed (udveksling af tlf.nr.)
- Evt. evaluering af palliative forløb
  - Guide
- Kontakt til efterladte ca. 8 dage – 30 dage efter dødsfald mhp. samtale
4: Project evaluation

• Five focus group interviews with 21 professionals

• Survey of the competency development - 88 nursing assistant / social- and health care worker

• Survey with 13 bereaved
4: Project evaluation - facilitators (1)

GSF
- Increased the professional overview
- Contributed to early palliative care
- Increased palliative care to people with non-cancer diseases and very modest people

The local developed intervention tools
- PCTP had increased the professional confidence because of
  - structured palliative care trajectory
  - clarified division of responsibilities between nurses and GPs
- The guidelines for the interdisciplinary home visits
4: Project evaluation - facilitators (2)

EORTC-QLQ-C15-PAL contributed to

- better dialog with the ill person
- opening up for talks about palliative care
- allowing the ill person to speak about problems
- bringing the ill persons often surprising own judgement to the nurses
- the nurses experiencing to have an overview
- the questions being easy to remember and use in other connections
4: Project evaluation- barrierers (1)

- Reorganisations and cost savings in the municipality
- Difficulties in changing everyday routines in professional practice
- Lack of continuous reflection processes about the interventions
- The IT systems were insufficient
- Many and to comprehensive interventions at the same time
- Competing projects
4: Project evaluation - barrierers (2)

• Lack of concrete management endorsement at different levels

• Lack of commitment among some of the professionals to work with the interventions

• The fact that GPs are self-employed and organized to the Danish regions, whereas nursing homes etc are a part of the municipality made differences in project commitments
Selected references


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