



# PALLIATIVE CARE

*Progress Report 2008  
Action Plan 2008-2009*

NGĀ PEEHITANGA TĀNGATA O TE AO HURUHURI  
NGĀ WHAKARITENGA MO TE TIKA ME TE ORA MORIMORIMATAWHAI

THE TRIALS PEOPLE FACE IN A CHALLENGING WORLD  
CAN BE OVERCOME BY CARING FOR AND LOVING ONE ANOTHER



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## **Acknowledgements**

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- Theresa MacKenzie, LCP facilitator who has recently moved to Arohanui Hospice. The LCP segment on report on progress demonstrates the leadership skills and expertise for promoting best practice care of the dying.

A big thank you to the members on the Waikato Palliative Care Operations Network whose contribution has been valued. It is recognised that much of the progress is a result of the creation of this forum and the individuals' commitment and contribution.

Acknowledgement and thanks to the many other people within and external to the DHB who have contributed to the development of palliative care services within the Waikato.

## **Cover Citation:**

Ngā Peehitanga Tāngata o te ao Hurihuri, ngā whakaritenga mo te tika me te ora morimori atawhai.

The trials people face in a challenging world, can be overcome by caring for and loving one another.

Reverend Buddy Te Whare for the support and citation on the cover page.

## **Executive Summary**

This is the third annual Waikato Palliative Care Operations Network progress report.

The purpose of this report is to summarise:

- the Waikato palliative care progress between 1 July 2007 and 30 June 2008 that aims to enhance service provision to patients with a life limiting illness and their family / whānau
- outline the Waikato Palliative Care Operations Network 2008-09 action plan.

The Waikato Palliative Care Strategy Plan 2005-2010 (Strategy Plan) was endorsed in August 2005. The purpose of the Strategy Plan was to assist guiding local service delivery developments.

The Waikato palliative care goal is to ensure that all providers of palliative care in the Waikato work together with the community to ensure that the New Zealand Palliative Care Strategy (Ministry of Health, 2001) is implemented in the most optimal way for the Waikato district. This is to ensure that all people with palliative care needs and their family / whānau have access to essential palliative care services, provided in a co-ordinated and culturally appropriate way.

The progress report section summarises developments over 2007-08 and work in progress since the endorsement of the Strategy Plan as follows:

- recruitment of the third palliative care physician and development of a 24 hour / 7 day consultancy service and appointment of clinical leadership - achieved
- continue with implementation roll out of the End of Life Liverpool Care Pathway – significant achievement and ongoing
- to promote and develop the Donny Trust Fellow position – achieved and ongoing
- to promote and support primary education and support (explore Waikato PHO links and developments with the HealthRight Chronic Care Management Framework) – ongoing, no advancement with HealthRight over 2007/08
- to continue to promote and develop the link nurse concept with rest homes / continuing care organisations – achieved and ongoing
- to scope and develop requirements for Waikato Hospice community inpatient service, including service framework, workforce requirements, quality processes and systems and funding implications – Waikato Hospice has achieved stage one with Hospice administration facilities completed and capital fund raising almost completed
- additional one-off funding of \$210,000 to support Waikato initiatives

- additional sustainable funding of \$168,826 p.a. to commence implementation of the New Zealand Specialist Palliative Care Service Specifications service components. 2007/08 \$83,413 effective 01/02/08.
- Taumaranui medical specialist palliative care outreach service has increased frequency from bi-monthly to monthly visits. Educational sessions are a component of this outreach service.
- pilot a 24 hour / 7 day integrated specialist palliative care nurse on-call service with PCU and Hospice Waikato (refer Collaborative Care Review) – achieved and ongoing review
- to project manage implementation of the Collaborative Care review quality recommendations – achieved and ongoing with quality nursing group established
- to promote implementation of the DSL recommendations – minimal progress
- to project manage development of a rural hospital / community palliative care role delineation model, complete stock take and review – achieved and ongoing with recommendations from review
- to promote palliative care by working in partnership with Maori health providers to complete a stocktake identifying education needs and support requirements – achieved and ongoing with recommendations
- to establish a Midland region palliative care service specific group under the umbrella of the Midland Cancer Network – achieved and ongoing
- to actively participate and support Lakes DHB request for proposal to develop specialist palliative care outreach services in the Lakes DHB - ongoing, requirements from the NZ specialist palliative care service specifications service components are a priority area for development under the Midland Cancer Network and local DHBs
- to actively participate and support national initiatives – achieved and ongoing.

The 2008-09 action plan builds on progress to date and details the Waikato Palliative Care Operations Network key focus areas for 2008-09.

Key focus areas include:

- continue with implementation roll out of the end of life Liverpool Care Pathway
- to work with Maori health providers to promote recommendations from the stock take
- to explore funding options for general practice network support for Hospice Waikato
- further implementation of LCP plan
- revisit and update paediatric palliative care service
- document how we are working on palliative care improvement

- completion of Waikato nursing scholarship initiatives.
- to promote development of the national specialist palliative care service components as per the Ministry of Health requirements, linking the LCP implementation programme, the Waikato palliative care nursing scholarships and the Midland Cancer Network regional initiatives and DHB planning and funding gap analysis against the NZ specialist palliative care service specifications
- to continue to actively participate and support national initiatives.

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## **Part One – Introduction**

This is the third annual Waikato Palliative Care Operations Network progress report.

The Waikato Palliative Care Strategy Plan (Hewitt, 2005) was developed to provide strategic direction for an integrated and co-ordinated palliative care service for the Waikato district. The plan guides service delivery and development until 2010. This report builds on the 2006 and 2007 Progress Reports (Hewitt, 2006 & 2007), highlights 2008 advancements, and outlines the action plan for 2008-09.

The Waikato palliative care goal is to ensure that all providers of palliative care in the Waikato work together with the community to ensure that the New Zealand Palliative Care Strategy (Ministry of Health, 2001) is implemented in the most optimal way for the Waikato district. This is to ensure all people with palliative care needs and their family / whānau have access to essential palliative care services, provided in a co-ordinated and culturally appropriate way.

The goal encompasses four key result areas:

- integrated and collaborative care
- patient focus on improved access and equity to palliative care services based on identified needs and informed choices
- workforce development to ensure a skilled and competent workforce committed to the palliative care approach
- quality systems.

Each of the key results areas have supporting objectives and strategic initiatives recommended for implementation over the next three years. The supporting objectives are:

### **Integrated and Collaborative Care**

- 1.1 To establish the Waikato Palliative Care Network.
- 1.2 To promote the palliative care approach and inform the public and providers.
- 1.3 To establish formal links between the various service levels and providers.
- 1.4 To ensure there is palliative care clinical leadership.

### **Patient Focus on Improved Access and Equity of Services**

- 2.1 To provide access to culturally appropriate palliative care services.
- 2.2 To continue to improve palliative care services through review, analysis and improvement to the patient journey and parallel processes.

- 2.3 Waikato rural communities to have improved access to palliative care services.
- 2.4 To strengthen the palliative care links and partnerships with general practice.
- 2.5 To provide specialist palliative care advice and support to palliative care patients in resthomes and continuing care organizations.
- 2.6 To establish assessment single point of entry.
- 2.7 To improve clinical care through the development and implementation of clinical pathways.
- 2.8 To maximise scarce specialist palliative care resources and reduce duplication.

### **Workforce and Resource Development**

- 3.1 To ensure all palliative care service providers practice within the palliative care approach.
- 3.2 To ensure there are adequate levels of appropriately trained palliative care staff.
- 3.3 To ensure there are adequate Hospice community inpatient beds for respite and symptom control.
- 3.4 To ensure there is adequate, safe and appropriate equipment to support people in the community.

### **Quality Systems**

- 4.1 To foster a culture of continuous quality improvement that enhances best practice and improves quality of care and services provided.
- 4.2 To develop and implement a transition pathway and process between child and youth services to adult services.
- 4.3 To establish adult child and youth baseline data, appropriate performance indicators, benchmarks and reporting mechanisms to ensure achievement of the Palliative Care Strategy.
- 4.4 Participate in national initiative to improve the quality of palliative care and establish benchmarking.
- 4.5 Waikato DHB planning and funding service should review the Disability Support Link palliative care administrative function for night relief and respite care to resthomes / continuing care organisations.
- 4.6 Waikato DHB planning and funding service should review all palliative care service specifications, rationalise, integrate and establish reporting and monitoring systems.



## **Part Two - Progress Report - 2008**

Part two summarises developments over the last year and work in progress since the endorsement of the Strategy Plan. Components of this section include:

- an overview of the network and new targeted palliative care funding investment
- an update of the key focus areas from the 2007-08 action plan and
- overview of national developments.

### ***Waikato Palliative Care Operations Network***

The Waikato Palliative Care Operations Network (Operations Network) was established in November 2005 and has proven to be an effective mechanism for advancing the Strategy Plan. There have been some changes to the membership of the group over the last twelve months these include:

- Sponsor is now the Manager, Midland Cancer Network
- Chair is the Manager Medical, Oncology and Palliative Care Service
- Dr Phil Weston is relieving for Dr D. Singh for Paediatrics.

The following provides more detail on progress made on the above 2007-08 work programme.

### ***2007-08 Target Funding***

There are three allocations of funding for 2007-08 discussed:

- Waikato DHB one off funding initiatives
- Funding for three specialist palliative care service components.

Waikato DHB allocated the following unsustainable cancer control target funding<sup>1</sup> to contribute to the development of palliative care services:

- nurse resource for twelve months to assist with advancing the LCP implementation programme. PCU is the lead for this initiative.
- project officer to support implementation of the collaborative care review recommendations and carry out the rural hospitals and community services' review.
- funding to scope and pilot a specialist palliative care 24/7 nurse on-call service.

In addition, 2006-07 one off funding initiatives that were still in progress at the time of last year's progress report related to the allocation of funding to Hospice Waikato for the provision of equipment for low socio-economic communities (Huntly, Ngaruawahia, Whitianga, Tairua and Coromandel town). Waikato

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<sup>1</sup> Waikato DHB Executive Group endorsement March 2007.

Hospice has purchased the equipment and will be responsible for the management of such.

In addition, one off funding was allocated to an NGO in 2006-07 to develop an integrated psycho-oncology model of care framework and business case which includes services to address palliative care needs. The draft plan was released in August 2007, while the Executive Group supported the concept, the paper as presented was not endorsed. The gap between desired proposed state and available resourcing for prioritisation and feedback from the Executive Group meant that additional resources would be required to rework the proposal. The manager, Midland Cancer Network (MCN), at that point in time did not have sufficient resources to carry on development given other network priorities. It is anticipated that this valued work will be picked up again by the MCN, linked with the national supportive care guidelines. The health professionals view this gap in service as a high priority.

In February 2008, the Ministry allocated Waikato DHB \$168,826 p.a. sustainable funding linked to the New Zealand specialist palliative care service specifications (draft). The 2007-08 funding was backdated to 1 January 2008 - \$84,413. The service requirements are:

- 24/7 specialist support for generalist health professionals (medical and nursing)
- specialist palliative care education and support for generalist health professionals
- end of life programmes such as the Liverpool care pathway (LCP)
- gap analysis of current services against the new specialist palliative care service specifications.

Waikato is unique in that there are two specialist palliative care providers. It was recognised that further planning and prioritisation is required on where and how to allocate the limited funds on a sustainable basis. Based on this, Waikato allocated the 2007-08 funds for one off nursing and general practice 'scholarships'. There were no general practice applications, therefore the total funds for 2007-08 was allocated to nursing initiatives to:

- 'fast track' the LCP implementation plan over and above the baseline allocated resource
- develop a core specialist palliative care nursing package for generalist health professionals.

The 2008-09 funding is allocated to support the above initiatives as well as administration support of the LCP database and development of a core specialist palliative care medical package for generalist health professionals. In essence specialist palliative care resources are needed to back fill current incumbents to

be released to meet the development phase of the Ministry of Health Crown Funding Agreement service requirements. A review and evaluation will occur towards year end that will enable prioritisation of the limited funds on a sustainable basis. Waikato DHB supports and links with Midland regional developments, as discussed further on in this report.

### ***Palliative Care Physician Joint Initiative***

The Strategy Plan recommendation:

3.2 To ensure there are adequate levels of appropriate trained palliative care staff.

#### ***Strategies***

- b) employ a third palliative care physician
- c) appoint a Clinical Director 0.2 fte
- d) implement a 24 hour / 7 day week on-call consultancy roster and services
- e) specialist palliative care physician to have sessional time in Hospice Waikato service
- g) promote and develop medical staff education and training programmes in palliative care
- h) as required increase support to district hospitals and communities in terms of outreach clinics
- i) development of the palliative care approach with other specialties and district hospitals.

A third palliative care consultant, Dr David MacKintosh, and clinical director Dr Alan Farnell have been appointed.

A specialist palliative care medical on-call roster has been implemented for Waikato and Lakes DHB. Hospice Waikato purchases 0.5 FTE of the specialist palliative care medical service. The operational logistics and relationships to meet Hospice Waikato medical requirements are slowly developing. Discussions have occurred and Hospice Waikato has documented preferred requirements. This will need to change when Hospice Waikato opens the on site community based hospice inpatient service. The twice-weekly clinical meetings and required visits to patients are working well.

The frequency of outreach service to Taumarunui has increased to monthly for medical specialist palliative care consultants (was bi-monthly supported by monthly specialist PCU nurse visits). Educational sessions are a component of this outreach service.

## End of Life Pathway Programme

The Strategy Plan recommendation:

2.7 To improve clinical care through the development and implementation of clinical pathways.

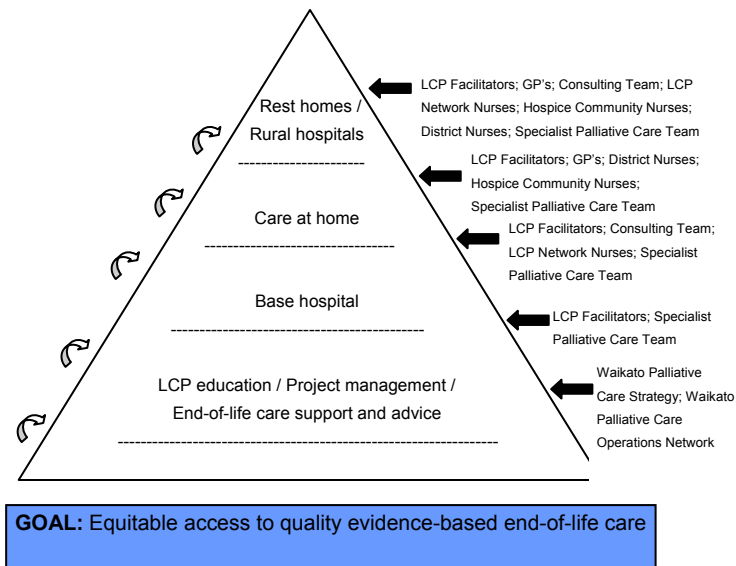
a) End of Life Liverpool pathway (LCP) is implemented. Initially pilot in one or more settings.

The LCP is seen as a key component and best practice concept in improving delivery of end of life care to patients and family / whānau.

The Waikato Palliative Care Network's Liverpool Care of the Dying Pathway (LCP) project commenced in November 2005<sup>2</sup>. Waikato has embraced the concept of the LCP and is registered with the LCP project, Royal Liverpool Hospital, UK (lead centre). The Palliative Care Unit (PCU) led the LCP pilot in an acute setting, Waikato Hospital. PCU has dedicated LCP nursing resource. A locally adapted care pathway was lodged with the lead centre in July 2006.

The Waikato Palliative Care Operations Network endorsed the LCP model and this forms the direction for implementation across the district.

Waikato End of Life Pathway Implementation Plan 2006-2010



Last days of life programmes, such as the LCP, are one of three new purchase units recommended in the Ministry of Health's national 'Specialist Palliative Care

<sup>2</sup> For further detailed information, please refer to the Waikato Palliative Care Progress Report 2006 appendices.

Service Specifications' that were released in February 2008 – ratification pending.

The Waikato DHB now has seventeen collaborating sites registered with the LCP Central Team in the United Kingdom (Appendix 1 – Table 1). Retrospective audits of current documentation have been completed in 11 of these sites. These audits provide a measure of the quality of documentation, not necessarily a measure of quality of care. In this climate of outcome-based care and clinical governance initiatives, it is essential to recognise within the audited practice settings that although there may have been a high standard, if this has not been documented then in essence care cannot be measured (Ellershaw & Wilkinson, 2003). Analyses based on data collected from three sites post-LCP implementation have consistently demonstrated significant improvements in the documentation of the care of dying patients and their family/whanau in hospital and residential care settings in the Waikato district.

The implementation of the LCP is a staged process, requiring dedicated human and time resources to ensure success and sustainability. The number of people who have been cared for on an LCP in their last days of life in hospital, residential care and community settings in the Waikato district are documented in Appendix 1 - Table 1. These numbers are dependant on the level of implementation and the number of expected deaths.

It is the network's belief that Thames hospital is the first rural hospital in New Zealand to implement the LCP in all areas – two wards and the emergency department. A district-wide implementation for Thames-Coromandel is in progress, with Thames general practitioners (GPs) and two residential care facilities using the LCP with the support of the Thames' district nurses. We also believe this is the first district approach to LCP implementation within a DHB region in New Zealand.

Hospice Waikato have embraced the LCP and are now supporting GPs in Cambridge, Ngaruawahia and Hamilton East to deliver evidence-based end-of-life care to people dying in their own homes.

The Waikato Primary Health Organisation and Pinnacle, agreed to pilot the LCP with GP's in Cambridge and Ngaruawahia in July 2007. The numbers of deaths in these two areas proved to be low, and a decision was made to extend the use of the LCP by GP's in the community alongside those residential care facilities who the GP's were also providing services for. This has enabled the roll out of the 'community LCP' to regain traction and momentum.

Facilitating buy-in from two major residential care organisations – Guardian and Radius – has proved to be a successful method of implementing the residential

care LCP in a number of sites (Appendix 1 - Table 1). This approach to LCP implementation ensures standardisation of practice, facilitates access to specialist palliative care support and advice, and promotes best use of the LCP rest home liaison resource by enabling joint education sessions for residential care staff from different facilities.

The LCP provides opportunity to continuously monitor and improve quality of care using the 'LCP Reflective Data Cycle' (RDC) – a comprehensive Excel spreadsheet developed specifically for this purpose by the Arohanui Hospice LCP team in Palmerston North. The resources to manage the RDC include time (dependant on the amount of data), access to a computer and skills and training for inputting data and data analysis. The RDC provides access to information about:

- place of death
- the number of patients on an LCP per site (Appendix 1 - Table 2)
- the proportion of people dying on an LCP from malignant versus non-malignant disease (Appendix 1 - Table 2)
- the number of hours on an LCP
- demographics such as age, gender (Appendix 1 - Table 2) and ethnicity and symptom burden.

Much of this information fulfils the reporting requirements of the Ministry of Health's 2008 'Specialist Palliative Care Service Specifications'. Due to limitations on LCP facilitator resourcing, only a portion of hospital LCP data has been entered in Waikato's RDC. An example of the data that the RDC has the potential to provide is in Appendix 1 - Table 2. A short-term solution for the allocation of administration support to maintain Waikato hospital's RDC is planned for 2008-09 to enable long-term support to implement the RDC in all LCP care settings.

## **Hospital LCP**

Following registration as an international collaborator with the LCP Central Lead Team in the UK and the adaptation of the 'Hospital version' of the LCP, a pilot project of three inpatient wards in Waikato hospital was undertaken from October 2006 – December 2006. Pre- and post-LCP implementation audits (Hewitt, 2007) demonstrated a significant improvement in the documentation of the care of dying patients and their family/whanau. Since this time, ten wards in Waikato hospital have successfully implemented the LCP. These are wards 2, 12, 22, 23, 25, 5, 58, HDU, and both Coronary Care Units. Consultant buy-in was established prior to educating >80% of staff in each ward.

The Waikato hospital LCP network nurses' group has been central to the sustainability of the LCP. The 'terms of reference' for this group require these ward representatives to train new staff in their areas on how to use the LCP. They meet monthly to discuss any issues that have arisen with the LCP and receive additional end-of-life care education.



To determine the percentage of patients cared for using the LCP, data was analysed from Ward 25 (a malignant disease care setting) and Ward 23 (a non-malignant disease care setting) from October 2006 – October 2007 (refer appendix 1). In Ward 25, 45% of all patients who died during this 12 month period were cared for using an LCP and in Ward 23, 29% of all patients who died during the same twelve month period were cared for using an LCP.

In context, the UK's National Care of the Dying Audit – Hospital (NCDAH) Summary Report 2006/2007 of 118 UK hospitals deemed to have the potential to participate (i.e. had implemented the LCP) found “on average 15% of all patients who died between September 1, 2006 and November 30, 2006 in participating hospitals were cared for using an LCP”. (Marie Curie Palliative Care Institute, 2007, p. 6). This percentage was noted to have been dependant on the number of expected deaths and the level of implementation.

As previously mentioned we believe Thames hospital has been the first rural hospital in NZ to implement the LCP in its entirety. This includes both wards (5 and 6), and the emergency department. Thames hospital's pre- and post- LCP implementation audits have also demonstrated an improvement in the documentation of the care of dying patients and their family/whanau. Once again, buy-in was established from the consultants prior to educating >80% of the hospital staff on the use of the LCP. Thames hospital staff were very receptive to this practice change. Michaela Assmus, the LCP Network Nurse champion in Thames hospital, provides monthly reports to Waikato's LCP Project Coordinator.

## **Community LCP**

“A full range of essential services ensures access for people to choose the option of dying at home and having access to a range of community based services and access to specialist services when required” (Waikato Palliative Care Strategy Plan, 2005, p.14.).

Cambridge and Ngaruawahia GPs were introduced to the LCP in collaboration with Hospice Waikato's community-based nurses to enable the delivery of evidence-based end-of-life care in patient's homes. In response to the GPs enthusiasm, this introduction was accompanied by the rollout of the LCP in all residential care facilities in Cambridge. To-date, 13 patients have been cared for on an LCP in their own home by Hospice Waikato's community-based nurses in collaboration with Cambridge GPs. The LCP document is left in the patient's home to enable visiting health care professionals to document their care at each visit, thus facilitating the seamless transfer of information.

With a view to implementing the LCP across an entire Waikato district, Thames GPs, their practice nurses and district nurses were introduced to the LCP for the community immediately following the establishment of the LCP in Thames hospital. To-date one patient has been cared for in their own home using an LCP in Thames. Planning to introduce the LCP to the remainder of GPs and their practice nurses within the Thames/Coromandel district is under way. Vanessa Wit, CNL -Thames Community Services, provides monthly progress reports to Waikato's LCP Project Coordinator.

## **Residential Care LCP**

“People already in a residential care setting who either develop a terminal illness or become terminal...are likely to stay in residential care and will need access to palliative care services” (NZ Palliative Care Strategy, 2001, p.38).

One of the main issues identified in the Waikato Palliative Care Strategy Plan is fragmentation of services with and between providers resulting in variations in standards of practice. A particular area of concern is the delivery of quality palliative care to patients in resthomes and continuing care organisations.

The majority of people requiring palliative care are older people. Approximately 80% of Waikato DHB palliative care patients are aged 65 years or more and the growth of older people are projected to continue. This is likely to increase demand for palliative care. People admitted and dying in residential care is increasing and is expected to continue to grow because of the ageing population and less support due to changing family structure. The Waikato Operations Network, primary health and resthomes / continuing care organisations need to work together on strategies to improve the quality of palliative care services and reduce the impact on scarce resources with this anticipated growth. PCU has a 'link nurse' that works in partnership with the LCP facilitator and resthomes.

There are sixty residential care facilities across the Waikato district. Eleven residential care facilities have provided letters of endorsement and are registered under Waikato DHB's LCP project with the LCP Central Team in the UK. Two major organisations, Guardian and Radius, have registered all of their residential care facilities in the Waikato district (Appendix 1- Table 1). This bodes well for standardising the delivery of evidence-based best practice care to dying residents. Two additional residential care facilities – Oakdale and Windermere in Cambridge – are rest home level care facilities only and, although pre-implementation audits were not completed, because they access services from Cambridge GPs we felt it important to include these facilities in the Cambridge residential care LCP roll-out. Pre-LCP education was provided to >80% of staff in all facilities.

LCP staff education in residential care is complemented by the delivery of the NZ Hospice 'Carer Education' and 'Subcutaneous Syringe Driver Education' packages.

## **Forward Planning**

Wards 8 (neurosurgery) and Wards 6, 16 and 26 (orthopaedics) will be approached next in Waikato hospital.

Two specialised areas of acute care – renal and the intensive care unit – have both very recently had LCP's released after pilot studies of these documents in the UK. These are two areas with high numbers of patient deaths, and will be well worth considering.

Implementing the LCP in Guardian and Radius residential care facilities across the DHB will continue. Targeted approaches will continue to be made, in collaboration with Hospice Waikato community nurses, towards Hamilton City GPs in association with the residential care facilities the GP's attend.

Alongside the completion of the Thames/Coromandel district roll out of the LCP to GPs and residential care facilities, planning has begun to implement the LCP in Taumarunui hospital, alongside GPs and residential care facilities.

The final words for the 2008 LCP project report are written by Dr. David MacKintosh - the newest member of Waikato's hospital-based specialist palliative care team:

*"Although I have known about the LCP for a number of years I have not had the opportunity of working with it until this year. I carried with me into the experience a number of prejudices relating particularly to anticipatory prescribing. They were founded in experiences with anticipatory prescribing in in-patient palliative care units which had been less than satisfactory. Based, albeit, on a limited experience with the pathway, I have found the process to have been professionally reassuring and my prejudices to have been largely just that. In addition, the nature of the documentation has simplified and clarified assessment of care already delivered and ongoing patient needs. When my time comes I will probably sign myself up!!!"*

– Dr David MacKintosh, MB ChB FChPM

## **Waikato Hospital Discharge Planning**

During 2007, because of a number of difficulties with discharges, Sandi Haggart, Clinical Nurse Specialist, Palliative Care Unit, undertook a project with the Ward

25 nursing team. The project group developed a checklist for discharge, provided ward education, and then completed an audit. The audit proved disappointing, of 30 discharges, only 10 had a completed checklist, 3 an incomplete list, and 17 had either no checklist in the notes or had a blank form.

As a result, in August 2007 Sandi Haggart met with Chris Baker, CNM, and Gabby Reynolds, CNE, from Ward 25. The Ward 25 representatives decided that the ward needed to drive the programme to improve discharge planning, they wanted to expand it across all the disciplines in the ward by setting up a ward group. They identified a number of strategies and it was left to the ward to manage the process from that point.

In 2008 PCU have again had recourse to bring to the wards attention some significant problems with patient discharge. The lack of planning and lack of information conveyed to the community providers has created stress for patient and families, and considerable extra work for the community staff to resolve problems.

In discussing some of these with Chris Baker, CNM, he has talked of getting the discharge planning group up and running. The CNS group from PCU have had to closely monitor recent discharges, but are aware that this also decreases ward involvement and limits the development of ward staff in identifying and dealing with even the routine discharges. PCU expect to be involved in complex discharge planning alongside the ward staff but the ward should be at a point where they can manage the process once any specific problems are identified and advised on.

Margaret Stevenson, Palliative Care Co-ordinator, has raised concerns at the oncology quality meeting and again been assured by the CNM that the ward will manage the process. PCU have also identified the need to work closely with junior medical staff around discharge planning.

This issue of quality discharge planning is not isolated to Waikato Hospital ward 25: Refer to rural hospitals report.

### ***DSL Project Recommendations***

In November 2005, the Waikato DHB Board endorsed one-off funding for the formal review of the current Disability Support Link (DSL) palliative care support service. In February 2006, the Operations Network led the review. This was in response to the Strategy Plan recommendation:

4.5 Waikato DHB planning and funding service should review the Disability Support Link (DSL) palliative care administration function for night relief and respite care to rest homes/ continuing care.

The DSL Review Report (Fitness J. & Hewitt J. 2006) provides an overview of the project findings and recommendations for improvement initiatives. The project recommended that DSL remain the lead provider that manages and administers the palliative care support services contract for the Waikato DHB. The report also recommended improvements to the current systems and processes to be implemented to enhance the quality of the services. The following recommendations can occur with a small additional investment.

The quality improvements will include:

- the proposed eligibility criteria, assessment and referral tool and guidelines are approved and implemented. Training and information is provided to referrers on the new tools and guidelines. These tools / guidelines will reduce the need for DSL to refer back to the referred and / or make contact with PCU for advice
- DSL utilise increased contracted funds to employ a 0.5 fte for administration of the service co-ordination. Funding would come from the sustainable funding increase of 2006-07
- PCU continue to provide DSL clinical support and guidance
- improved data collection through the development of a minimal data set
- Waikato DHB planning and funding clarify with DSL contractual reporting and monitoring requirements in relation to palliative care support services
- DSL explore the option of referrals routed through the Referral Co-ordination Centre.

The data in the following Table 1 is based on information held for the period 1 September 2007 – 29 February 2008.

8.7% of clients (patients) were assessed for Disability Support Services' aged residential care following the six-week review. The rationale for this transfer of funding stream was when information gathered indicated a changed status to longer term support need. This process meant that the client transferred from short term fully funded care to long term means and asset tested for subsidy care.

**Table 1: DSL Palliative Care Client Numbers 1/9/07-29/02/08**

	Sept 07	Oct 07	Nov 07	Dec 07	Jan 08	Feb 08	Average Day Stay
<b>New Referrals</b>	14	18	17	19	10	21	
<b>Carer Support</b>	2	6	7	6	3	7	<b>25</b>
<b>Rest Home</b>	3	0	1	1	2	5	<b>21</b>
<b>Hospital</b>	6	10	8	14	5	11	<b>25</b>

Progress on any recommendations of the 2005-06 DSL review has been limited.

### ***Collaborative Care Review Project Recommendations***

In November 2005, the Waikato DHB Board endorsed one-off funding for the formal review of collaborative care services. In February 2006 the Operations Network led the review of the Waikato palliative collaborative care (Collaborative Care) model. This was in response to the Strategy Plan recommendation.

- Waikato rural communities to have improved access to palliative care services.
- To formally review and evaluate the current collaborative care service and make recommendations for the future.

In 2007-08 a project officer was employed to help facilitate implementation of the recommendations with the exception of the 24/7 integrated on-call nurse service which is discussed later. The majority of the recommendations have been implemented (Appendix 2) with a palliative care quality nursing group to be established.

### ***Specialist Palliative Care Nursing Out of Hours Service***

The direction for the provision of a 24-hour, seven days a week specialist palliative care nurse on-call service for generalist health professionals has come from:

- the New Zealand Palliative Care Strategy (Ministry of Health, 2001)
- the Waikato Palliative Care Strategy Plan 2005-2010
- the New Zealand specialist palliative care service specifications.



To align with the Strategy Plan vision of a community based model of palliative care services, the aim was to have one after hour's specialist palliative care nurse telephone support service for general health professionals. However, the project was unable to develop an integrated service provider pilot. A full project report is available on request.

The aim was to build on the existing Hospice Waikato and PCU nursing services. The service that was piloted from 1 March – 30 June 2008 was a specialist palliative care nursing after hour's service for generalist health professionals caring for adult palliative care patients within the Waikato district. The after hours service operated 1700 to 0830 Monday – Friday and weekends (Friday 1700 – Monday 0830) and is provided by Hospice Waikato nurses either physically on duty or rostered on call. The service is consistent with other parts of New Zealand where there are community based services without a hospice inpatient unit.

The purpose of the pilot was to assess the level and nature of the demand for specialist palliative care nurse services to generalist health professionals across the Waikato district after hours, and to identify any issues that needed to be resolved in order to implement the service on a permanent basis.

This project ran in parallel to the implementation of the medical specialist palliative care 24/7 on-call service for general health professionals caring for palliative patients.

During the pilot, one GP contacted the service, and two district nurses and two hospitals contacted Ward 25 directly. It is recommended that the service continue on a permanent basis, with a review of how the service will operate when Hospice Waikato opens its community based inpatient service.

## ***Rural Hospitals Community Based Services Review***

The Waikato Palliative Care Strategy Plan recommendation;

2.3 Waikato rural communities to have improved access to palliative care services included the strategy (2.3b) to review and evaluate the current rural hospitals and make recommendations for the future in relation to palliative care. This aspect of work has strong links with the collaborative care review.

There is increased recognition from providers and the public that access to health care for individuals living in rural and remote areas of Waikato is problematic. The Waikato rural hospitals and community based services as per the national definitions are generalist health providers of palliative care.

In 2007-08, a project officer was employed to identify what palliative care services are available within each rural hospital and community based service, how they link with primary and community services and the two specialist palliative care providers. This review proved to be more complex and time consuming than originally anticipated due to the differing stakeholder perspectives, the number of variations in practice, and the need to gain clarification of realistic improvements to palliative care services.

At the time of writing this annual report, the draft project findings and recommendations are out for consultation.

Draft key themes of the findings included:

- a need to link local services and standardise the systems across the Waikato
- reduce duplication of effort, share developed initiatives across the district
- community equipment management is fragmented
- under utilisation and value of Hospice Waikato within the collaborative care model
- Tokoroa has less access to specialist palliative care in the community, with no collaborative care model working with district nurses
- need to continue LCP implementation programme across the district
- need to improve hospital discharge planning
- continue to strengthen the multiple service providers relationships and working as a multi disciplinary team.

Draft recommendations are incorporated into the 2008-09 action plan but are summarised as:

- improved integration of services with each area to have documented mechanisms of working together that includes a list of services and providers and associated links
- Tokoroa community to have equal access to collaborative care services
- a district wide quality nursing group (district nurses and rural hospital staff) is established
- improved discharge planning system and processing of palliative care patients from rural and Waikato hospital(s)
- specialist palliative care providers continue to develop core education package for generalist health providers within the rural hospitals and community based services
- clear, transparent and formalised out of hours patient care plan, including generalist providers access to specialist palliative care support and advice service

- continue the end of life LCP implementation programme rollout with completion of Thames, then commence Taumarunui, then Te Kuiti and lastly Tokoroa.

### **Hospice Waikato Facilities**

Hospice Waikato completed the purchase of a motel / conference centre, based in Hamilton in December 2006. The aim of this strategic initiative is to bring all Hospice Waikato services onto one site and give Hospice the flexibility to develop inpatient services as recommended in the Strategy Plan. This long-term initiative will provide the foundation for enhancing Hospice services to align with the Strategy Plan recommendation:

3.3 To ensure there are adequate Hospice community inpatient beds for respite and symptom control.

### **Strategies**

- a) Waikato DHB and Hospice Waikato need to consider and address the current level of community Hospice inpatient beds, four is inadequate, and strategies to increase to 10 should be explored as the Waikato DHB model of care is developed.
- b) Explore long-term facility / management options for community inpatient respite and symptom control beds for the Waikato district.
- c) Develop and strengthen Hospice community inpatient respite and symptom control services to ensure best practice and excellence in standards.

In addition to purchasing the facilities, Hospice Waikato has launched a capital fund raising programme<sup>3</sup> to upgrade the administration service facilities and new build for the inpatient facility. Hospice Waikato has raised all but the last \$1million capital funds required. As a result of this amazing community fund raising effort, stage one has been completed with the Hospice Waikato team moving into the new administration building in March 2008.

### **Supporting General Practice**

A key recommendation of the Strategy Plan is:

2.4 To strengthen the palliative care links and partnership with general practice.

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<sup>3</sup> Target \$7million

The Palliative Care physicians have actively supported this recommendation through providing support and educational opportunities for general practice.

The 2007-08 plan recommendation was to explore with Waikato Primary Health the feasibility of a palliative care initiative utilising the HealthRight Chronic Care Management Framework. This initiative would follow the initial round of pilot projects. Discussions did occur, but Waikato PHO indicated at that point in time they were not in a position to advance in the near future.

### **Maori Health Providers Stocktake**

This project commenced in November 2007 with the aim of completing a stocktake identifying the education and support requirements Waikato Māori health providers have in relation to palliative care. A copy of the full report is available on request.

The aim of this project was to promote palliative care by working in partnership with Māori health providers to complete a stocktake identifying their education and support requirements. This would be done through achieving the following objectives:

1. ensure Maori health providers are aware of the palliative care approach with links to supporting essential<sup>4</sup> services and systems
2. identify current Maori health provider links with other generalist and specialist palliative care providers and vice versa
3. how do Māori health providers provide / or refer to palliative care support services for people?
4. how do specialist palliative care providers link with Māori health providers?
5. to complete a stocktake of Waikato Māori health provider education and support needs in relation to palliative care
6. to complete a stocktake of Waikato palliative care services responsiveness to Māori<sup>5</sup>
7. analysis of findings, with a final report provided to Waikato Palliative Care Operations Network and Waikato Māori health providers.

From January-May 2008, Te Puna Oranga met with 11 Waikato Māori health providers to discuss their education and support needs in relation to palliative care. The findings are broken down into the following categories:

- provision of services by Waikato Māori providers regarding palliative care

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<sup>4</sup> Essential services include assessment, care co-ordination, clinical care, support care, education and advice

<sup>5</sup> This may include the development of Māori health plans, and Māori health policies that services use to enhance their services to Māori.

- awareness of the Waikato DHB Palliative Care Strategy
- linking with specialist palliative care services
- education and support needs
- palliative care resources
- funding
- improving palliative care for Māori
- current palliative care services within the Waikato DHB.

Recommendations from the stocktake are as follows:

1. To continue to promote palliative care by working in collaboration with Māori health providers
2. The development of palliative care education and information resources for Waikato Māori providers, and Māori whānau moving through the palliative care system.
3. The establishment of a strengthening relationships network between Waikato specialist palliative care services and Waikato Māori health providers, through primary services.

Progression towards the implementation of the recommendations are advanced in the 2008-09 action plan section.

### ***Donny Trust Fellowship***

Waikato has been successful in attracting a Donny Fellow this year. The following summary outlines the development of the Waikato Donny Fellowship programme developed jointly by Ross Lawrenson, Professor of Primary Care and Head of Waikato Clinical School, Dr Alan Farnell, Clinical Director Palliative Care, and Steven Lillis, Senior Lecturer in General Practice (GP) and Primary Care. The outcome was development of a more attractive package for an advanced GP trainee. The School of Medicine has been involved to develop a programme of research projects for this trainee. The Royal New Zealand College of General Practitioners has approved this position as part of accreditation.

### **Background**

Most people in the terminal stages of illness prefer to die at home. One of the commonest problems for patients at the end of life is the need for palliative care; this is particularly true for patients with cancer but can also apply to people with other chronic diseases such as heart failure, chronic respiratory disease and some patients with chronic neurological conditions. If there are appropriate facilities and expertise available locally then the needs of patients can more often be met without recourse to admission to hospital or a hospice. In order to help ensure that there is capacity in the community we believe that we need more general practitioners who are trained and experienced in the management of

palliative care. We also believe there is a need to determine the needs of terminally ill patients for palliative care, particularly those living in rural areas.

## **Proposal**

The Waikato Clinical School in conjunction with the palliative care service of Health Waikato will employ a doctor who is either vocationally trained in general practice or intends to work and complete their training for vocational registration in general practice. The doctor would spend 12 months being trained in the management of palliative care and gaining experience working in the specialist palliative care service of the Waikato Oncology Department. The successful applicant would also be required to carry out a research project that would explore the needs of rural palliative care patients. This research would be designed and supervised by the Department of General Practice and Primary Care.

## **Clinical training in palliative care**

The doctor would undertake clinical training in palliative care. This would include a 4/10 clinical responsibility to the Health Waikato Palliative Care Service supervised by the specialist in palliative care Dr Alan Farnell. Clinical responsibility would include outpatient clinic attendance, caring for in-patients on the wards in Waikato Hospital, and involvement in the pain clinic. The Fellow would also be encouraged to work with the Waikato Community Hospice, the district nursing service and other community based providers. Attendance at an appropriate conference would also be supported during the fellowship.

## **Research Project**

The registrar would undertake a research project looking at the palliative care needs of patients in rural practices. The Fellow would identify all the palliative care patients in between 6 and 10 rural practices (defined as practices that are eligible to receive rural payments). Patients and their carers would be interviewed and using semi-structured questionnaires the needs, concerns and aspirations of palliative care patients and their carers would be ascertained. Interviews would also take place with the general practitioners and community nurses involved in the care of these patients. The results of this qualitative study would be published in a relevant peer reviewed journal and recommendations for DHBs would necessarily result from its findings.

## **Teaching**

There would be a teaching commitment that would entail teaching general practice registrars about palliative care and involvement in providing continuing professional development for experienced vocationally registered practitioners.



## **Supervision**

The successful fellow would be supported and supervised through the year by the Head of the Palliative Care Service, Health Waikato and the Senior Lecturer in General Practice and Primary Care at the Waikato Clinical School.

The Waikato Clinical School would provide administration, accommodation, and office space.

The school would aim to recruit either a General Practitioner who had just completed their vocational training, or an experienced general practitioner. Consideration would be given to employing or engaging a junior doctor who had clear intentions of entering general practice after relevant hospital training.

## **Budget**

Salary for Research Fellow for 12 months - \$100,000.

Support for clinical training including travel expenses, relevant books etc \$1000.

Support for research including office facilities, computer, research supervision and research facilities - \$15,000.

Dissemination costs including attendance at relevant conferences \$2,500.

Appointment costs including advertising - \$1000.

Total budget - \$119,500.

## ***Links with the Midland Palliative Care Network***

The Midland Cancer Network (MCN) was endorsed and established in 2006 with supporting management infrastructure.

The Waikato Palliative Care Operations Network recommends a regional service group be established to look at regional palliative care initiatives. A Midland Cancer Network palliative group meet in December and agreed that the MCN would facilitate regional collaboration on:

- end of life programme LCP
- core education programme for generalists
- gap analysis against the NZ specialist palliative care service specifications (lead by DHB planning and funding portfolio managers).

## **Adolescent / Young Adult Oncology / Haematology Service**

The Ministry of Health has developed draft Adolescent / Young Adult Oncology / Haematology Service Specifications (AYA OHS) (tier 2). The aim of the service specifications is to optimise care directed to the specific needs of adolescent and young adult patients by partnering the paediatric and adult oncology / haematology tertiary services. This service includes the palliative care continuum.

In addition the service specifications recommends care co-ordination and AYA advisory group be established, this has occurred under the umbrella of the Midland Cancer Network. Ellyn Profitt has been appointed as the AYA OHS clinical nurse specialist.

## **National Work Programme**

The Ministry of Health Cancer Control work programme includes palliative care, and the following is a summary of work in progress or about to commence.

### **National Palliative Care Definitions**

A subcommittee of the National Cancer Treatment Working Party (NCTWP) has completed development of a national definition for palliative care, including generalist and specialist.

### **National Leadership in Palliative Care**

The Ministry of Health, Cancer Control Council, and Chair of the Palliative Care Advisory Committee have decided to advance national leadership. The Cancer control Council is working with a palliative care subgroup to develop terms of reference for its palliative care group (provisionally called the Palliative Care Council) and the Ministry will work with members of the New Zealand Palliative Care Working Party terms of reference.

### **National Specialist Palliative Care Service Specification**

The Ministry of Health created the national palliative care service specifications in 2001 as part of a nationwide service framework. The palliative care community agreed that the service specifications did not adequately define the appropriate scope of palliative care services. New service specifications were needed to describe a full range of services, incorporating community care, hospital care, hospice care and their interrelation with one another.

A national Palliative Care Service Specifications Review Group (PCSSRG) was established (March 2006) under the umbrella of the National Cancer Treatment Working Party (NCTWP). The final draft specifications have been released supported with DHB funding to contribute to specific service component development. The draft specifications will go through a ratification process. It has been proposed that there will be a Ministry of Health work group to complete a gap analysis against the new service specifications.

### **The Palliative Care and Cancer Nurses Education Group**

A specialist cancer / palliative care nursing education work group has been formed. A draft educational framework for palliative care and cancer nursing specialties is in progress, including working on competencies and future options.

### **Establish a National Approach to Palliative Care Medical Training**

A proposal to establish a training pathway in specialist palliative medicines and training opportunities in palliative medicine for other doctors has been agreed. Auckland and Capital and Coast DHBs will be approached to be lead DHBs in progressing the programme.

### **Palliative Care Medications Work Group**

This group has prioritised access as the main concern for action, with a focus on exceptional circumstance processes.

### **The Syringe Drive Advisory Group**

This advisory group expects a decision in 2008/09 from the DHBNZ procurement committee regarding replacement syringe drives.

### **Palliative Care Data Work Group**

NZ Palliative Care Working Party plan to recruit members in 2008/09 for a Palliative Care Data Work Group, which will contribute to the data definition workstream in the Cancer and Palliative Care Information Systems project.

### **Supportive Care**

A working group is developing Guidance for Improving Supportive and Rehabilitative Care for Adults with Cancer in New Zealand. The draft guidelines will come out for consultation in 2008/09.

## **Part Three – Action Plan 2008-2009**

This section takes a planned and phased approach towards achieving the Waikato Palliative Care Strategy Plan goal and recommendations. This year there is no dedicated project resource to support the network. The aim is that quality improvements will form part of core service delivery. There is a risk that improvements will progress at a slower rate with the advantage of greater buy in of those delivering services. The Waikato Palliative Care Operations Network 2008-09 Action Plan builds on progress made over the last thirty months.

The 2008/09 key priorities are:

- to work with Maori health providers to promote recommendations from the stock take
- to explore funding options for general practice network support for Hospice Waikato
- further implementation of LCP plan
- revisit and update paediatric palliative care service
- document how we are working on palliative care improvement
- completion of Waikato nursing scholarship initiatives.

Key Results Areas	Medium to Long Term Objective	Annual Objective 2008/2009	2008/2009 Performance Measures
<b>Integrated and Collaborative Service</b>	1.1 Midland Palliative Care Network	<ul style="list-style-type: none"> <li>a) Participate in MCN regional palliative care initiatives:</li> <li>b) EOL LCP work shop</li> <li>c) Specialist palliative care nursing and medical education for generalists</li> <li>d) Gap analysis against specialist palliative care service specifications (link to 4.6)</li> </ul>	Active participation by Waikato to meet MoH requirements by 30 June 2009
<b>Patient Focus on Improved Access and Equity of Services</b>	2.3 Waikato rural communities to have improved access to palliative care services	<ul style="list-style-type: none"> <li>a) DHB Planning &amp; Funding work with Tokoroa and Hospice Waikato to explore options to implement collaborative care in Tokoroa community</li> </ul>	Strategy identified to implement Hospice Waikato resources into Tokoroa
	<p>(1.3) To establish formal links between the various service levels and providers</p> <ul style="list-style-type: none"> <li>a) To develop a model that describes the various levels of service, delineates expected resources &amp; capability of generalist and specialist services (links to 1.1, 2.4 f and 4.6)</li> </ul>	<ul style="list-style-type: none"> <li>b) Each 'T' hospital and community based service area to document generalist, specialist and support services, system links, referral processes and after hour's plans.</li> <li>c) Document how we are working on palliative care improvements.</li> </ul>	All stakeholders are aware of what services and how to access

Key Results Areas	Medium to Long Term Objective	Annual Objective 2008/2009	2008/2009 Performance Measures
<b>Patient Focus on Improved Access and Equity of Services continued</b>	2.4 To strengthen the palliative care links and partnerships with general practice	(a) PCU engage in discussions with the 4 PHOs to develop a palliative care continuing education plan for primary (b) PCU engage in discussions with Waikato Post Graduate Medical Programme to provide palliative care continuing education	4 Primary CME sessions by 30 June 2009  PCU participate in Post Graduate Medical Programme during 2008-09
	2.7 To improve clinical care through the development and implementation of clinical pathways - Liverpool Care of the Dying Pathway Implementation Plan (links with 2.4 and 2.5 concepts)	(a) Complete Thames Hospital and community roll out (b) Implement Taumarunui Hospital, primary rest homes and community (c) Specialist palliative care nurse scholarship for LCP extension implemented (d) Implement Waikato Hospital Wards 8, 6, 16, 26 (e) Participate in MCN LCP workshop	Implementation roll out plan achieved by 30 June 2009

Key Results Areas	Medium to Long Term Objective	Annual Objective 2008/2009	2008/2009 Performance Measures
<b>Workforce and Resource Development</b>	3.1 To ensure all palliative care service providers practice within the palliative care approach	(a) Provide education to Māori health providers in the palliative care approach to build capacity and capability (links to 2.1) (b) Provide directory of palliative care services and resources to Māori health providers	Hui held between Waikato Palliative Care Services and Maori health providers completed by 30 June 2009  Directory and resource pack developed and delivered to Māori health providers completed by 30 June 2009
	Donny Fellowship	(a) Continued development and promotion of the Donny Fellow programme	Donny Fellow programme evaluated as altered as required
	Education and support for generalists	(a) Specialist palliative care services continue to develop core education package for generalists (b) Specialist palliative care nurse scholarship for education package extension implemented (c) Participate in MCN work programme	Specialist core education package developed by 30 June 2009
	3.2 To ensure there are adequate levels of appropriately trained palliative care staff (medical staff for	(a) Explore options and funding implications for general practice network support for Hospice	Intermediate level medical staff options are explored and the preferred option identified with implications for implementation

	intermediate level – k, l, m)	Waikato	by 30 June 2009
	3.3 To ensure there are adequate Hospice community inpatient beds for respite and symptom control (Hospice Waikato lead for project management of the process)	(b) To scope and develop requirements for Waikato Hospice community inpatient service, including service framework, workforce requirements, quality processes & systems and funding implications	Hospice community inpatient service model of care, service delivery framework and implementation / change management plan is developed by 30 June 2009



Key Results Areas	Medium to Long Term Objective	Annual Objective 2008/2009	2008/2009 Performance Measures
Quality Systems	4.1 To foster a culture of continuous quality improvement that enhances best practice and improves quality of care and services provided	<ul style="list-style-type: none"> <li>a) Continue with PCU / Ward 25 discharge improvement</li> <li>b) Explore opportunities to improve discharge planning for palliative patients from all Waikato and rural hospital areas</li> <li>c) Quality nursing group established</li> </ul>	Improved discharge planning and communication demonstrated
	4.2 (& 1.3b) To develop and implement a transition pathway and process between child and youth services to adult services	<ul style="list-style-type: none"> <li>a) Child services identify a timeframe to develop the transition pathway and process</li> <li>b) Revisit and update paediatric palliative care services</li> </ul>	Child Services identify timeframe by 30 June 2009
	4.5 Waikato DHB should review the DSL palliative care administration function for night relief and respite care to resthomes / continuing care	<ul style="list-style-type: none"> <li>a) DSL and Planning and Funding implement recommendations of DSL review</li> </ul>	DSL recommendations implemented by 30 June 2009
	4.6 Waikato DHB should review all palliative care service specifications, rationalise, integrate and	<ul style="list-style-type: none"> <li>(a) DHB Planning &amp; Funding complete gap analysis against new specialist palliative care service</li> </ul>	Participate in development of national service specifications

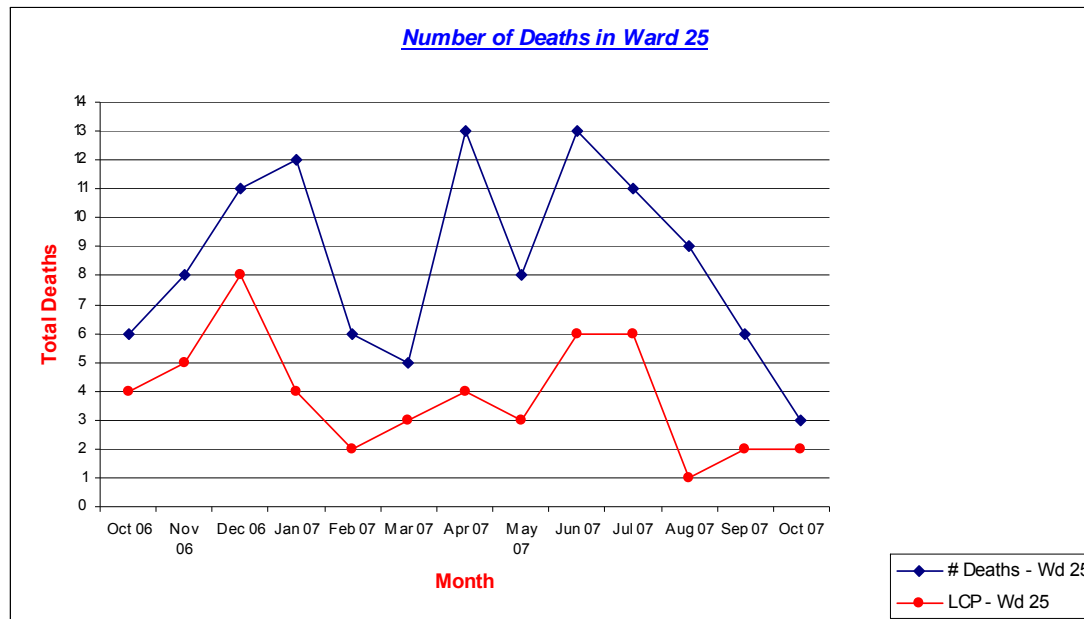
	establish reporting and monitoring systems	specifications (b) Implement resources to support the LCP database	
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## Appendix 1 – EOL LCP

Graph 1:

### Number of Deaths in Ward 25

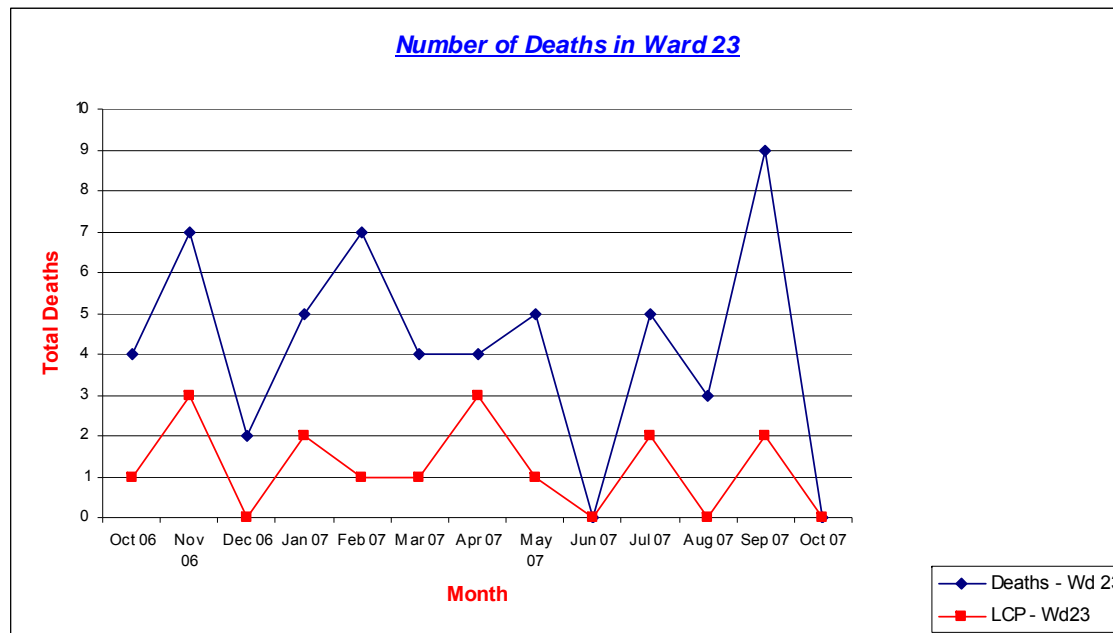
Cases	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Grand Total
Deaths - Wd 25	6	8	11	12	6	5	13	8	13	11	9	6	3	111
LCP - Wd 25	4	5	8	4	2	3	4	3	6	6	1	2	2	50



## Graph 2:

### Number of Deaths in Ward 23

Cases	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07	Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Grand Total
Deaths - Wd 23	4	7	2	5	7	4	4	5	0	5	3	9	0	55
LCP - Wd 23	1	3	0	2	1	1	3	1	0	2	0	2	0	16



Formatted by Evonne Manders, Waikato DHB.

**Table 1: Analysis of first 100 Liverpool Care Pathways (LCP) in Waikato Hospital using data from the LCP Reflective Data Cycle.**

<b>Report</b>	<b>Data Analysis</b> (n=100)
Ratio - Male : female	50 : 50
Average age of patients cared for on an LCP in Waikato hospital	72.7 yrs (Range: 19 – 95yr)
Number of LCP's missing from patients notes	2
Number of patients commenced on an LCP then taken off	12 / 100
Time to death* of patients taken <u>off</u> the LCP (n=12)	1 – 23 days (*one patient currently still alive after 10 months)
Average time on an LCP for patients who died in Waikato hospital	47.4 hours (Range: 1 – 228 hours)
Ratio – malignant : non-malignant disease	53 : 45 (2 x diagnosis data missing)

**Table 2: LCP registered sites**

<b>Waikato District Health Board</b> <b>Liverpool Care Pathway (LCP) Implementation Progress: Oct 2006 – May 2008</b>					
<b>Site registered with LCP Central Team (UK) under Waikato DHB Project</b>	<b>Letter of endorsement Y / N</b>	<b>Specific LCP education delivered to &gt;80% staff Y / N</b>	<b>Pre-Audit Completed</b> n=20 for hospitals n= 20 for community n=10 for Res Care	<b>Post-Audit Completed</b> n=20 for hospitals n= 20 for community n=10 for Res Care	<b>Number of LCPs</b>
1. Waikato Hospital (10 wards)	Y	Y	20	20	189
2. Waikato Hospice - Community	Y	Y	20	-	13
3. Thames Hospital (2 wards & ED)	Y	Y	19	20	33
4. Thames District Nurses - Community	Y	Y	17	-	1
5. Raeburn - Res Care (Cambridge)	Y	Y	10		4

6. Resthaven - Res Care (Cambridge)	Y	Y	10	10	20
7. Lifecare Res Care (Cambridge)	Y	Y	10	-	10
8. Oakdale Res Care - (Cambridge)	N	Y	-	-	1
9. Windemere Res Care - (Cambridge)	N	Y	-	-	2
10. Atawhai Assisi - Res Care (Hamilton)	Y	Y	10	-	3
11. Guardian at Tararu - Res Care (Thames)	Y	Y	10	-	
12. Guardian at The Booms – Res Care (Thames)	Y	Y	10	-	
13. Guardian at Rossendale – Res Care (Hamilton)	Y	On hold	-	-	
14. Guardian at Eventhorpe – Res care (Hamilton)	Y	Y	10		8
15. Radius Windsor Court –	Y				

Res Care (Hamilton)					
16. Radius St Joans – Res Care (Hamilton)	Y				
17. Radius Maeroa Lodge – Res Care (Hamilton)	Y	Y	10		3



## **Appendix 2 – Summary of Collaborative Care Review Project Recommendation**

Recommendation	Integrated Services	Achieved	In progress
1. Develop a process to ensure all patients receiving collaborative care have an identified care coordinator	<ul style="list-style-type: none"> <li>The project group agreed that the District Nurse or the GP is the recognised patient care coordinator in the Palliative Collaborative care model for rural areas. Contact details of the coordinator are recorded in both the DNS care plan and the Care Communication booklet which stays with the patient and is available for other providers e.g. Hospice collaborative care nurse</li> <li>This process and the roles and responsibilities will be documented in the 'Management of Palliative care patient's guidelines' for District Nurses, currently being developed by the Collaborative care working group</li> </ul>	✓	
2. To review, standardise and integrate information and documentation between the providers of palliative collaborative care	<ul style="list-style-type: none"> <li>The Hospice Collaborative care nurse completes a comprehensive psychosocial assessment with the patient and their family/whānau which is on file at Hospice base office</li> <li>The District Nurse Service completes a generic clinical care assessment and care plan that is on file at community services base</li> <li>These are standardised within the individual services and the work group did not consider at this stage that integrating the assessment forms to be advantageous</li> <li>There is a Care Communication booklet originally created by PCU. This is used regularly by the Hospice home care nursing teams and PCU. It is a client held record that providers are able to record their visits in and information for patients and families/whānau. This assists patients and families to have a clear understanding of the treatment plan and know the role of those involved in their care. After hours care with clear communication on medication and contacts is documented. It</li> </ul>	✓	

	also has the potential to provide a communication mechanism between the collaborative care team. The cost of \$1.25 per booklet is shared between the 2 services		
No. 2 continued	<b>To implement</b> <ul style="list-style-type: none"> <li>The work group agreed that the care communication booklet be adopted and implemented as a standard communication tool to be used in the collaborative care model</li> <li>PCU, DNS and Hospice managers will deliver combined road shows over the next 6 months to rural DNS and GPs remarketing the collaborative care model, introducing the guidelines for the management of palliative patients for DNS (date) and the introduction of the care communication booklet</li> <li>Patient and family/ whānau information is provided with information from both PCU and Hospice. The work group considered this to be an opportunity and quality activity to revise and integrate an information pamphlet focused on a palliative care team approach.</li> </ul>		<b>Ongoing</b>  The working group is continuing to meet monthly to achieve this.
3. Inform the public and providers on what to expect from Waikato DHB palliative collaborative care services	<ul style="list-style-type: none"> <li>An integrated Waikato DHB palliative care directory is available on the webhealth.co.nz site. This informs both public and professionals of: <ul style="list-style-type: none"> <li>⇒ local and national palliative care strategies including a definition of palliative care</li> <li>⇒ what palliative care services are offered by each provider, including Collaborative care provider roles and how to access services</li> </ul> </li> </ul>	✓	
4. To determine the RRC as the single point of entry for	<ul style="list-style-type: none"> <li>The group agreed that both services continue to provide dual access points for referral however they will ensure that all referrals once received by whichever entry point, hospice, PCU</li> </ul>		

collaborative care services	<p>or Referral Coordination Centre will be faxed through to the Regional Referral Centre (RRC). This will enable the accurate tracking of collaborative care referrals information via the RRC</p> <ul style="list-style-type: none"> <li>A referral pathway has been developed and will be distributed to Clinical Nurse managers to introduce to their teams and this will be located in both Hospice and DNS desk files and as appendix in the management of palliative care nurses guidelines)</li> </ul>	✓	
Recommendation	Improved access to service	Achieved	In progress
5. A review and update of the Memorandum of Understanding (1996) between RH&CBS and Hospice Waikato will be undertaken	<ul style="list-style-type: none"> <li>This document has not been sighted since the collaborative care model was first introduced. Both parties now agree that the ongoing relationship opportunities are taking place as defined in the work programmes now being developed as a result of the Palliative care strategy.</li> <li>As a result both parties are agreed that the MOU is obsolete in its current form. Both managers/CEO of these services have made a commitment to meet on an informal and formal basis</li> </ul>	✓	
6. Hospice Waikato and RH&CBS work collaboratively to support the extension of the collaborative care model to Coromandel Town, Whitianga, Tairua and Whangamata	<ul style="list-style-type: none"> <li>The extension of Collaborative care services to these areas is reported by both services as working effectively. A Hospice Collaborative care nurse has been employed since August 2006 and has been involved with 86 patients and 172 family members over that time.</li> </ul> <p><b>Key findings</b></p> <ul style="list-style-type: none"> <li>MDT to strengthen relationships between hospice and District nurse</li> <li>services, refer to Waikato Rural Hospitals and Community Palliative Care Project report</li> </ul>	✓	

<p>7. Consider the options and implications of introducing a full range of specialist palliative care service components to the Tokoroa community</p>	<ul style="list-style-type: none"> <li>• Gap in the full range of specialist Hospice services - e.g. bereavement groups, counsellors, social work. Providers do access Rainbow Place.</li> <li>• Recommendation that the Tokoroa community has equitable access to specialist palliative care services</li> </ul>		<p><b>Ongoing</b></p> <p>Refer to Waikato Rural Hospitals and Community Palliative Care Project report</p>
<p>8. Develop a formal understanding of when, if ever, collaborative care may be considered within the Hamilton and hinterland areas for complex palliative care patients under the care of DNS</p>	<ul style="list-style-type: none"> <li>• Hospice does not wish for this to be standard practice, irrespective of funding. Exceptions have been made for complex patients on a case-by-case basis.</li> <li>• This has only involved two cases in the last 12 months and Hospice is willing to be contacted about complex patients as and if the need arises.</li> <li>• It has generally been enquiries for advice, family issues and equipment needs.</li> <li>• The process of determining if collaborative care is appropriate has been discussed and agreed in the work group and will be documented in the Management of Palliative care guidelines for DN's. The process will include the DN seeking approval from both the Community services and Hospice Clinical Nurse manager.</li> </ul>	<p>✓</p>	

Recommendation	Workforce and resource development	Achieved	In progress
10. To improve clinical care through the development and implementation of clinical pathways	<ul style="list-style-type: none"> <li>• The Liverpool End of Life Care Pathway implementation plan is progressing as per the Waikato Palliative Care annual plan 2007/08.</li> <li>• Waikato Hospital Palliative care guidelines (under Clinical guidelines on the intranet)</li> <li>• National Referral and Discharge (Hospital based services)</li> <li>• The Collaborative Palliative Care guideline for District Nurses, Hospice Nurses and Palliative Care Unit was revised in 2006. After review by the work group some minor changes were made and it will be formalised as an appendices to the Management of Palliative care patients for DNS</li> <li>• All Clinical Nurse Managers of the District Nursing service will be responsible for reorientation of their teams to this document to ensure standardised practice following the roll out.</li> </ul>	✓	Ongoing
11. Develop specialised educational packages for staff working within palliative care teams	<ul style="list-style-type: none"> <li>• New NZ Palliative care service specifications and funding will address this. National Higher medical training and competencies for specialist nurses</li> </ul>	✓	Ongoing

Recommendation	Implementation of Quality Systems	Achieved	Ongoing
<p>12. Develop and implement a baseline data set that captures relevant data from integrated palliative care services</p>	<ul style="list-style-type: none"> <li>• Identified as a minimal data-base set by both Waikato DHB and Hospice Waikato is:</li> <li>• Numbers of new collaborative care referrals, discharges and/or deaths per annum by domicile and ethnicity</li> <li>• Questionnaire to referrers to collaborative care to gain baseline data on referral practices</li> <li>• Audit the use of Collaborative Communication booklets as communication tool between the providers of collaborative care</li> </ul> <p>This information will trend demand to support workload management service planning, and workforce development.</p>		In progress
<p>13. Develop a suitable collaborative care reporting and monitoring system, with agreed frequency of auditing.</p>	<ul style="list-style-type: none"> <li>• As above</li> </ul>		