

Developing Community Nursing and Allied Health

Notes from Workshop two (24 April 2007)

Background

C&C DHB has commenced the next steps (2007 onwards) in continuing the development and implementation of our Integrate Home and Community Care programme introduced in 2004/2005.

As outlined in the project approach document (available on http://www.ccdhb.org.nz/planning/homecommunity/home_community.htm) a wide sector working party was formed in March to look at the criteria for developing options for the next stages of community nursing and allied health (community therapies) C&C DHB is currently holding workshops with the working party to enable the development of an options paper for consultation.

Working Party

The working party consists of 51 participants. This is made up of two union organizers, 31 participants from the C&C DHB community health services (health care assistants, district nurses, specialist oncology, stoma, continence nurses, physiotherapists, occupational therapists, speech therapists, dieticians, social workers and administration staff) 12 from Primary Health Organisations and six other participants (Care Coordination Centre, Mary Potter Hospice, Package of care providers).

Meetings and Workshops

Initial meeting was held on 19 March 2007 which focused on the introduction and orientation to the development of community nursing and allied health services. Relevant materials in relation to this project was circulated and a presentation to provide context to the Integrated Home and Community Care programme.

The working party met on 24 April for a workshop. The group was formed into four teams with representation from the wide community health and primary care sector.

Four real case scenarios were provided prior to the workshop. The case scenarios included end of life palliative patient, an older persons requiring long term support care, chronic leg ulcer patient, a young diabetes patient. Each team worked through the assigned case scenarios.

All case scenarios identified acute and chronic components, medical and social requirements, myriads of health practioners involved in the care of the patient with multiple funders, setting and services in place.

There were a number of common themes and concepts that emerged from the workshop groups which could form the basis of options, as related to this project, for potential future development. They are as follows

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Common Emerging Themes and Concepts

1. Options for co-location
2. Concept of a lead agency
3. Care Pathways
4. Prompt response service
5. General Practice/primary care having the capacity to start early treatment e.g. IV
6. Discharge planning
7. understanding how allied health's requirement to support secondary in-patient care influences developments
8. Case management in primary care setting

The case studies also highlighted the role primary care could play beyond 'normal' general practitioners, for example, the ability to start early treatments at the general practice level which could avoid hospital admissions for short stays.

Other issues discussed at the workshop, (many of which are outside the scope of this project), were around communication, electronic health information, common assessment and care planning, transport and ambulance service, rapid response versus emergency services, access to services after hours, provider capability, capacity and competency.

The next workshops will focus on the criteria for service options and also other concepts that the working party would like to consider as the project develops into an options development stage.

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The following are detailed notes from the workshop as presented by the teams.

Whilst the case scenarios are a snap shot of a real patient journey, their identity has been altered to maintain patient confidentiality.

Case Scenario One

Joanne (41) lives with her husband Kevin and their two daughters Lorraine and Helen aged 6 and 10. Their immaculate home is filled with Joanne's wonderful artwork. Since Joanne's diagnosis in May 2006, with increased deterioration to her health, the family moved to the adjacent house of Kevin's elderly parents (in their 80s) but they are unable to be physically supportive to the couple. All of Joanne's family lives in Auckland.

After receiving referrals from the GP, the hospice developed a detailed plan of care to support her at home and referred her to the District nurse. The district nurse from the hospital visits Joanne on a daily basis, the Hospice Liaison Nurse visits weekly, daily meal prep was in place and also all necessary equipments were in place. The district nurse developed a plan of care. The family funds a nanny service in the morning privately to get the girls ready for school.

Initially Kevin provided care for Joanne, but had to return to full time work after he had used up all his sick leave. They employed a private home care agency to provide home support the family needed (40 hours a week). The family couldn't continue to afford this care. Joanne was admitted to the Hospice. The Hospice social worker made an urgent referral to the Care Coordination Centre (CCC) on 07 February. Joanne's goal is to live as long as she is able to complete some more art work, to write more letters and enjoy the family at home and her family goal is to have Joanne at home as long as possible. She was discharged from the Hospice with a care plan in place arranged by Care Manager/ CCC.

The Care Plan supported a package of daily personal and household care that included laundry, physical support for Joanne, shopping, after school care for children, evening meal preparation. Further plans included oncology nursing visits, monthly hospice consultant and weekly GP visits.

This worked very well for awhile until the carer was unable to visit Joanne. Joanne continued to deteriorate and her care needs continue to increase. The CCC started searching for alternate carers to address her needs through all possible providers but none were available. The family found a registered nurse (at additional cost) who was able to attend however the private/contracted provider mix arrangements could not be met (the CCC was not informed of this registered nurse availability and could have arranged for this additional cost to be covered). The district nurse through personal contacts referred a caregiver to CCC who was able to fill in until Joanne was booked in to go to Hospice. Initially this worked well until the caregiver became unwell. Health Care Assistant provided care during that weekend for the family to cope.

Subsequent to this the GP referred Joanne again to the hospice. She requires a high level of care to enable her to return home and this has not been yet established. She is worried that she will never be able to get back home and enjoy the family and a peaceful death at home.

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1. Where did PT Journey Start?

There are some missing information in the background to the case e.g. active treatment. Assumed the Hospice liaison nurse is the Palliative Care Coordinator.

Self realisation of patient
GP/Diagnosis in May 2006
Primary Care Practice – what diagnosis?

2. Who were involved?

GP, Hospice. District Nursing, Package provider, Care Coordination Centre

3. What were the roles and elements of care?

<u>Roles</u>		
<p><i>Family/Whanau</i></p> <ul style="list-style-type: none"> - Patient - Husband Kevin - Kevin's parents - 2 children - Nanny? 	<p><i>Health Professionals</i></p> <ul style="list-style-type: none"> - Primary Care (GP, Practice Nurse) - Hospice (Consultant, PCC, Social Worker & Team) - CCC - District Nursing - Community Oncology/ Wellington Cancer Centre - Allied Health - Carers 	<p><i>Private Agencies</i></p> <ul style="list-style-type: none"> - Nanny - Private agencies and carers/home support - Private RN

Elements of service:

Assessment: GP, Hospice, Blood & Cancer Centre, District Nursing, agency providing care, SW, Dr
Care Planning x 3: Hospice, CCC, District Nurse
Care management: PCC hospice, CCC, District Nurse, Con, GP?
Care Coordination: PCC hospice, CCC, District Nurse, Con, GP?
Care Support : SW Hospice, District Nurse, PCC, CCC, agency, private nanny/private via agency, Family Whanau & Social Support

Symptom Control

- GP
- DN
- Hospice (PCC/Dr)
- CON

Household Management

- private agency
- CCDHB home help

Nursing Care

- DN, agency HCA

Psycho Social Care

– Hospice Team/ DN

Respite Care

– Hospice

Child Care & Shopping

– private agency

Note: after-hours/ weekend care through District Nursing Services who did daily visits

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4. What Problems Occurred?

- Lack of timely referral
- Multiple of assessment
- Multiple care plans
- Fragmentation of services
- No lead service (key worker)
- Referral vs information
- Caregiver sick – no replacement available/ capacity & capability/competency of providers
- Access to information re: services available
- Hospice role in coordination
- Sharing of available information
- Lack of communication
- Do contracts create barriers?

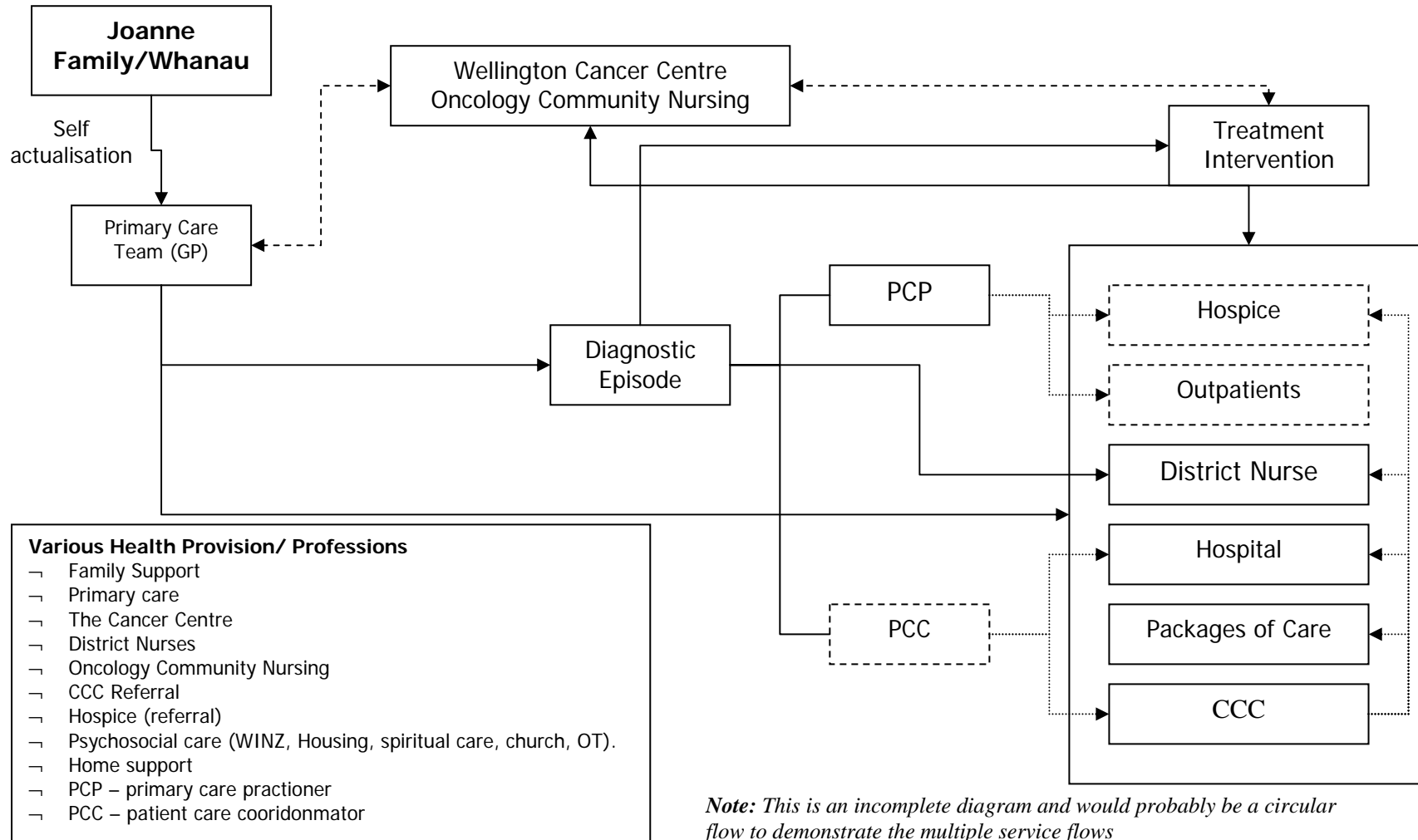
5. How could the patient journey be easier or smoother?

- Single care plan
- Lead agency/ key worker
- Clarity of roles
- Good communication
- Information System
- MD/Multi team meeting

6. Who would Joanne like to see as the primary relations person?

- Who she has confidence/trust in to provide
- This is about a seamless service not an individual person!!
- Patients should not have to navigate their own pathway

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Case Scenario Two

On 08 March 2007, Susan (80) was readmitted to ward 6 for rehabilitation following surgery and subsequent placement of an ileostomy. In early December 2006 Susan fell off her bath board and had been to her GP but the pain had got worse. On Christmas Day she was admitted and has had a long and complicated hospital stay. She lives alone and prior to admission has been independent; she is a motivated and determined person. She wished to return home and her rehab has been focused on how this could be achieved.

Susan has experienced significant weight loss due to recent poor health and surgery; she has been seen and monitored by a dietician whilst in hospital. Physiotherapy, Occupational Therapy (OT), Dietetics and Social Worker assessment have been completed in preparation for her discharge. This included home visits by OT and Social Worker. Susan was able to manage many tasks but became very tired very easily. This may partly be due to her malnutrition secondary to colitis and muscle weakness both expected to improve overtime with ongoing exercise program.

On 22 March the Social Worker made a referral to the Care Coordination Centre (CCC) for long term home support package. The CCC conducted the screening and the social worker helped the client to complete the Contact Assessment. Care Manager will visit Susan at home within the next six weeks.

Susan has difficult access with many steps and slopes to her Wellington home and on discharge (02 April) was ambulance transferred home. Susan plans to move to her other home in Newtown later this year. This will require modifications to the house and she is entitled to additional funding support from WINZ which the social worker is assisting her with.

Susan's initial care plan included follow up from community physiotherapy, twice daily visits for personal care, meals on wheels for lunch time and extra assistance with shopping and some household management. Although Susan is independent with colostomy cares, some complex nursing hours will be provided to ensure she is still continuing to manage these cares independently. It is expected that the Stoma Nurse will be providing support in monitoring in the community also.

Previously Susan had received some care support from a provider. The CCC contacted in the first instance this provider to arrange for the packages of care however this provider was unable to provide the service. Another provider was able to provide this long term package for 5d/wk which was deemed not suitable and an alternate provider was able to provide the packages of care (7d/wk) from 16 April. The CCC also contacted Community Health Services for short term care but they were unable to provide any services until 09 April. Community Health Services are not contracted to provide long term care.

On 05 April Susan missed her pain clinic appointments as the ambulance was late. She agreed with CCC that she was not coping well at home and the Social Worker had advised her to go into respite care. The CCC arranged for respite care and the ambulance picked Susan up at 5 pm. Susan is expected to get home with support packages in place on 19 April.

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Dec-06	Home		
Dec-06	GP	<i>Ax, diagnosis, referral?, prescription/advice (prev known to GP)</i>	<ul style="list-style-type: none"> • Nurse referrals accepted
25 Dec-06	Ortho/Med	Ambulance Services, ED <i>Pick up, transport, Referral – (diagnostics, specialist, bed space)</i>	<ul style="list-style-type: none"> • Cascade of conduct • Referrals to prevent admission (or contacts given) • Access/transport
Jan-07	Rehab	PT, OT, SW, Dietitian, Nurses, Medical Staff	
Feb-07	Surgical	PT, OT, SW, Diet, Nurses, Medical, Stoma Assessment, Treatment, Rehabilitation, Nutritional education, wound care, stoma education	
Mar-07	Rehab	PT, OT, SW, Diet, Nurses, Medical Staff, Stoma, CC, Ambulance services CCC Referral <i>Ax referral, case mgmt, establish care package</i>	<ul style="list-style-type: none"> • Step down accommodation
Apr-07	Home	Comm PT, HCAs, Stoma, CCC, Care providers, GP, MOW	<ul style="list-style-type: none"> • Access to admission info to primary care providers • Ability to contact CCC • Slow/No D/C info • Package of care in place for D/C (not in this case) • Community diet referral • Continuity of care provision
			<ul style="list-style-type: none"> • Pt transport service

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Case Scenario Three

Des (76) a very cheerful man, gets out and about, does the shopping and ironing and household chores, lives with his wife and two dogs who go on holiday in their caravan by the sea for several months at a time. Des is the sole carer for his unwell wife who has insulin controlled diabetes and recently diagnosed with leukemia.

In his early 50s Des had two myocardial infarctions, smoked heavily for 55 years and gave it up five years ago. He has had coronary artery vein crafts and had angioplasties previously in both legs. The cardio and vascular surgeons can no longer help him. He has managed his leg ulcers himself for several years but can no longer manage to look after himself.

Des is on medication for cardiac, high blood pressure, and pain. He doesn't always take his medication. He has a large inoperable aortic aneurysm and unstable angina. His only son just died of a coronary at the age of 43 leaving a wife and two children of 3 years and 4 months.

Des was referred to district nursing services by his GP to manage his wound care which has worsened. Des identified the following as his needs.

- Keep mobile
- Keep infection under control
- Keep odour under control
- Support him to 'patch up' when necessary
- Help him sleep / control pain
- Enable him to keep going on holiday
- Keep the pain under control

Background

Des (76) and wife Audrey (70). Their only son died recently have daughter in law and 2 small grandchildren living close by. Des is main carer for his wife who is diabetic and has recently been diagnosed with leukemia.

Social

- Independent – has goals
- Little family support
- "patch up"
- Wife's support needs are? Any barriers been met?
- Financial status

Physical

- What can wife do?

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Considerations for the future management (case typifies someone with long term chronic conditions and how they need to be supported over a long period of years)

- both Des and wife need comprehensive assessment
- initiated by GP/anyone as main primary relations
- Services need to be streamlined, to decrease fragmentation – palliative approach to care
- Co-location of services/ level of resource – is it wise to fragment small services eg community OT
- Specialty maintained/ at secondary level
- going to require long term help and ideally be monitored on a regular basis by case manager
- shared clinical record
- duplication needs to be 'stamped on'.
- Primary/secondary services need to be highlighted/known by CCC

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Case Scenario Four

John is a young man (35) who is diabetic and is seen regularly by his practice nurse. He finds it hard to control his diabetes. He has developed an infection in his leg which was very painful and he saw his GP who started him on oral antibiotics. John returned to his GP a few times because his symptoms got worse (pain and worsening mobility) and his GP referred him to A&E for assessment.

He was admitted to the short stay unit (SSU) for 48 hours to start IV antibiotics. This was then carried on by the district nursing service at home, following a referral from the Patient Care Coordination Service via the CCC. He also received some walking aids following an assessment by a physiotherapist while he was on the SSU. He had a follow up appointment with his GP and finished his course of antibiotics orally.

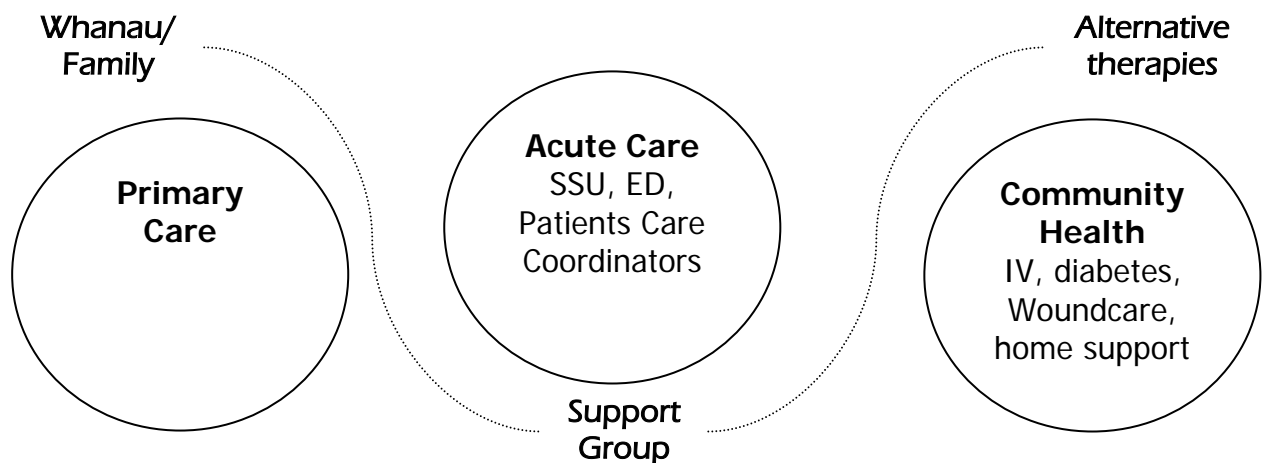
1. Where did PT Journey Start?

Journey begins at GP practice. Possible involvement of diabetes service?
Primary health environment – long term relationship with GP
also journey starting at identification of illness by patient, whanau, friends, GP, nurse...

2. Who were involved?

Patient, GP & practice nurse, lab staff, SSU staff (incl. PT), district nursing, A&E, equipment services, ? diabetes health service, diabetes nurse, specialist dietician, CCC, PCCS
Not known: the social situation – family, friends, employer, WINZ, if patient has considered alternative treatments, patient cultural background
Possible: the infectious diseases physician, ACC, interpretation services

3. What were the roles and elements of care?

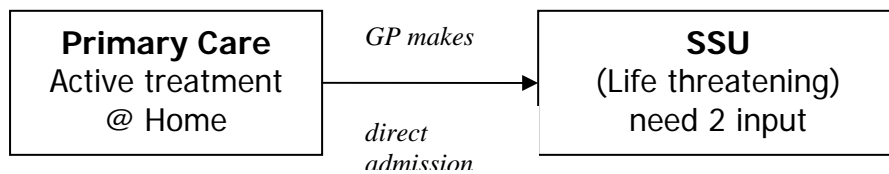


Ongoing care /involvement
e.g. infectious disease, diabetes services, podiatrist

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<u>Roles</u> <ul style="list-style-type: none"> - GP, practice nurse, - DIABETES services (incl some allied health) - Health promotion - Pharmacist - IV home nursing, Wound management 	<u>Elements of service:</u> <ul style="list-style-type: none"> - advice/education - home support - treatment (acute) - treatment (prevention/monitoring) - service coordination
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4. How could the patient journey be easier or smoother?



"serious diabetic complication pathway"

- Establish GP support link with specialist consult service to GPs
- Establish pathway e.g. CORD/DVT

5. Who would John like to see as the primary relations person

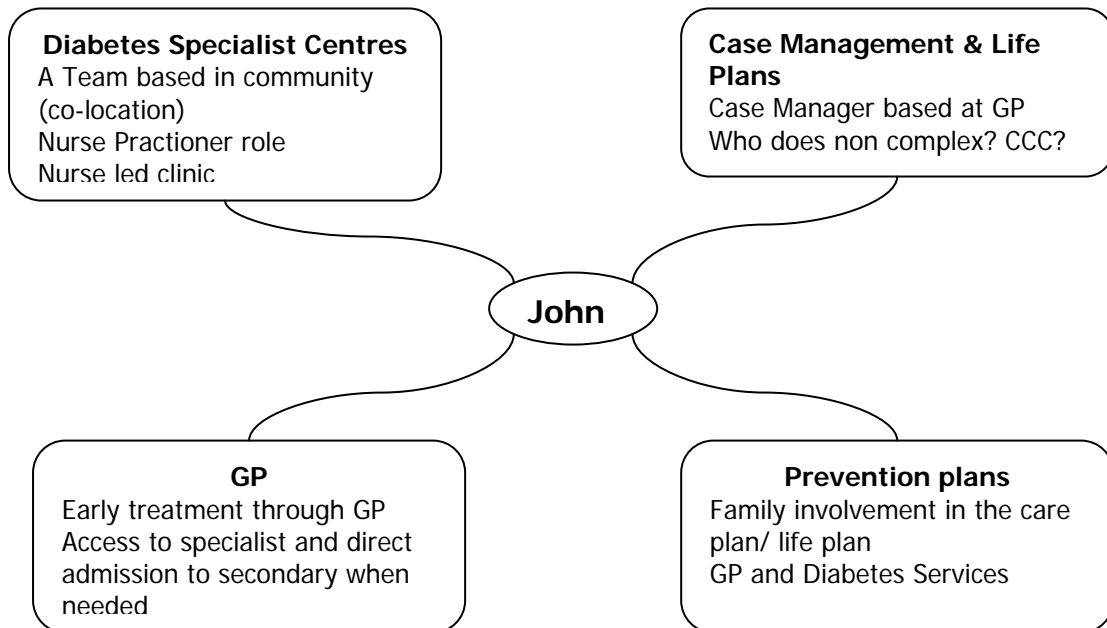
General Practice (overall oversight of care)

(+) = increased knowledge of client and their background/ (-) = cost to patient

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How could these services be structured to best support the service delivery



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Parked Items

- Previous package of care – what, why, how
Please see the service specification in

http://www.ccdhb.org.nz/planning/homecommunity/home_community.htm

Outside project scope/ Other projects to consider

- Information library – services
- Routine alert system to GPs re admission/ DC
- Electronic health records

Items addressed through options development

- | | |
|-----------------------------------|--------------------------------|
| • Rapid post D/C (long term) care | consider at option development |
| • Step down accommodation | consider at option development |
| • Fragmentation | criteria for options |
| • Resource in community | consider at option development |
| • Emergency services | criteria for options |
| • Level of care – interim | consider at option development |
| • Ownership of patients | consider at option development |
| • Ability to access GP services | consider at option development |

Items addressed through service specification

- | | |
|--------------------------|--------------------------------|
| • Payment and conditions | consider at option development |
| • Capacity issues | criteria for options |
| • Workforce development | criteria for options |