Palliative Care in the Community: The Role of the Advanced Practice Nurse as an Anchor for Family Physicians Providing End-of-Life Care in the Home

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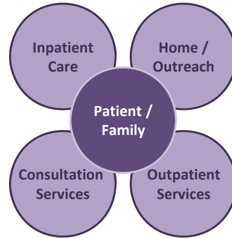
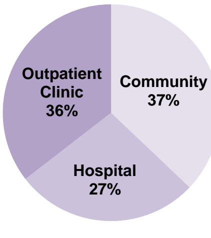
- Majority of patients with terminal illnesses wish to be cared for, and die, at home[1]
- Home palliative care has been shown to increase the likelihood of a home death[1]
- Home palliative care, and specifically palliative nursing visits, have been shown to decrease health care costs[1,2]
- The Freeman Centre's interdisciplinary care team provides palliative care for patients and families in a variety of settings, including their home
- The Freeman home / outreach team is anchored by a full-time palliative care trained Advanced Practice Nurse (APN) and consists of family physicians providing 24 hour/day, 7 day/week 'on-call' service

Freeman Centre Model of Care



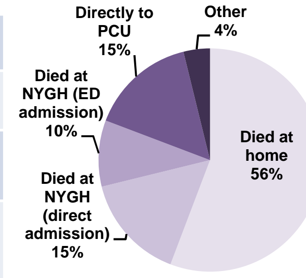
Referral Sources to Home/Outreach (2016)



Home Visits (2016)

Visits from CNS alone	515
Telephone Follow-ups	826
Visits with physicians	198
Visits with CCAC primary nurse or case coordinator	45

Discharges from Home/Outreach (2016)



Benefits

- Increased patient & family satisfaction[1]
- Continuity of care
- Increased likelihood of home death[1]
- Reduced symptom burden for patients[1]
- Cost savings - decreased ED visits and hospital/PCU deaths[1]

Challenges

- Provision of 24-hour MD/APN coverage
- Lack of palliative care trained APNs
- Adequate community supports & funding: nursing, PSW, spiritual care & bereavement care
- Family physician comfort/interest in shared care model

Supporting patients and families on their journey

1) Freeman Centre receives referral and APN triages

2) Inform family physician of referral and establish level of involvement of care

3) Connect with CCAC regarding support (RN/PSW visits, equipment)

4) Set up initial home visit (+/- CCAC) to develop care plan. Assign home/outreach physician

5) During initial visit, discuss goals of care and confirm code status

6) Use assessment tools: ESAS and PPS

7) Develop back-up plan (Palliative Care Unit [PCU] application) if care at home becomes unsafe

8) APN works with primary CCAC nurse and act as "eyes and ears" of physicians through shared care approach

9) Mentor CCAC primary nurses to enhance symptom assessment skills and management

10) Highlight 24 hour physician on-call service for patients and families

11) Educate patients and families on signs and symptoms at end-of-life

12) Coordinate with physicians re: Symptom Relief Kit (SRK) for patients PPS <30% and confirm EDITH protocol

13) Educate patients and families about subcutaneous medications

14) Review contact information and discourage 911 calls at time of death

1. PATIENT STORY

- 59-year-old male diagnosed with metastatic lung cancer. Multiple visits to ED due to seizure activity. Family physician referred patient to Freeman home/outreach team for pain and symptom management. Shared care established between family physician, APN and home/outreach physician
- PPS 50% - history of falls at home, increasing confusion and seizures

2. ISSUES

- Goals of care not discussed
- Family requested that disease progression not be discussed with patient
- Patient and family requested active medical management
- Unclear expectations about active treatments
- High risk for recurrent seizures, falls, and cord compression

3. ACTIONS

- Utilized skills to manage physical symptoms such as seizure activity in the home
- Collaborated with CCAC to initiate weekly nursing visits and discuss goals of care
- Provided appropriate resources to support patient at home (i.e. hospital bed, who to call in urgent situations, 911 vs. home/outreach physician)
- Ongoing communication about hopes and fears post-treatment
- Respected family's non-disclosure wish but discussed advanced care planning and initiated conversation about back-up PCU

4. OUTCOMES

- Organized family meeting re: care plan; family agreed to comfort-based approach
- SRK in the home and education re: medication administration
- Provided anticipatory guidance as end of life approached
- Communicated back-up plan if unsafe situations arise (i.e. direct transfer to inpatient NYGH, PCU placement)
- Patient died at home with family at bedside

References

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