‘FIXING THE FIXABLES’ SUPPORTIVE CARE AND HOSPITAL-IN-THE-HOME SERVICES, WORKING TOGETHER.

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KEYWORDS

Supportive care, palliative care, domiciliary, multidisciplinary team

EXECUTIVE SUMMARY

This is a retrospective case review of 17 patients (21 patient encounters) who were cared for by the Supportive Care Service (SCS) and had domiciliary input from the Hospital in the Home (HiTH) team. We will present the outcomes of these patients and explore whether the intervention helped to avoid acute hospitalisation.

INTRODUCTION

The International Association for Hospice and Palliative Care (IAHPC) recently defined palliative care as ‘the active holistic care of individuals across all ages with serious health-related suffering due to severe illness’. This is a broad yet relevant definition; Australians are living longer but are also living with ill health for longer. With that comes significant co-morbidity and often high symptom burden. For many patients living with a life limiting illness, spending quality time at home with family is extremely important. They may also be keen for reversible or ‘fixable’ issues such as infections to be treated or ‘fixed’. The scope of palliative and supportive care is no longer simply to treat symptoms at the end of life but to ensure patients live well during the final phase of their life,

The Supportive Care Service (SCS) at St George Hospital Kogarah, has been operational since April 2023. It was developed as a community facing multi-disciplinary service to care for patients with life limiting illnesses and estimated prognoses of 12-24 months. Initially the service focused on the management of patients with advanced non-malignant diseases, but the scope has broadened over the past year to also include patients with cancer diagnoses. The SCS team members include a Palliative Medicine Specialist, Clinical Nurse Consultant, Physiotherapist, Occupational Therapist, Social Worker, Pharmacist, Dietitian, Speech Pathologist and Clinical Psychologist. Since 2023, we have seen 230 patients with a range of diagnoses including end stage cardiac failure, degenerative neurological disease and end stage respiratory disease.

The Hospital in the Home (HiTH) service is an acute care service that is available to patients 18 years and over who reside in the St George area, The service allows patients to remain home as a substitution for in hospital care and treatment can be a combination of home visits, clinic visits and/or virtual tele-health appointments. Common conditions that are managed by HiTH include cellulitis, pneumonia and heart failure. The benefits of the service are manyfold and are not limited to: providing a safe alternative to hospital admission, reducing infection risks, increasing independence and increasing patient comfort.

This paper demonstrates how 2 community teams working together helped to ensure patients with life limiting illnesses received treatment in accordance with their care goals whilst avoiding acute hospitalisation.

HIGHLIGHTS

- 17 patients (21 patient encounters) known to the SCS were also treated by the HiTH team over a 32-month period between June 2023 and March 2026.
- Most of the patients (66%) received intravenous diuretics at home for management of congestive cardiac failure.

- 71% of the patients avoided acute hospitalisation.

METHODOLOGY

A retrospective case review was conducted over a 32-month period, from June 2023 to March 2026. Information was collated about all SCS patients who had been reviewed by the HiTH team over this time.

Data Collection

Demographic and clinical data were available through the hospital electronic medical record system, Powerchart. We recorded the indication for HiTH involvement, information regarding the HiTH intervention used and whether the intervention helped to avoid acute hospitalisation. We classed 'avoidance of acute hospitalisation' as not requiring an acute admission for at least 28 days after the HiTH intervention had been completed.

Data Analysis

Data from Powerchart was transferred to an excel spreadsheet for further analysis.

RESULTS

17 supportive care patients were referred to the HiTH team over a 32-month period. 2 of the patients had HiTH interventions on more than one occasion, making 21 patient encounters.

65% of the patients were male and the median age was 84.9 years (range 22.2 - 92.6 years). This cohort were a relatively dependent group of patients with an average median AKPS (Australian Karnofsky Performance Score) of 50. 100% of the patients had either an Advance Care Directive or documentation of an Advance Care Planning discussion.

See Figure 1 for the break-down of the primary life-limiting diagnosis of each patient. Most of the patients had end stage cardiac failure (11, 65%).

See Figure 2 for details regarding the HITH intervention for each patient. 66% of patient had intravenous (IV) diuretics at home and 29% had IV antibiotics.

In terms of outcomes, 71.4% of the patients avoided acute hospitalisation within 28 days of the HiTH intervention being completed. Of these 15 patient encounters, 2 patients were admitted to the palliative care unit during the 28-day period. See Figure 3.

CONCLUSION

Patients with life-limiting diagnoses often have clear care goals. They may wish to have reversible or 'fixable' issues treated whilst simultaneously wanting to avoid acute hospitalisation, keen to have as much time as possible at home with family.

Our work suggests that pooling community resources (in this case, supportive care services and the HiTH service) can help to achieve these important patient goals.

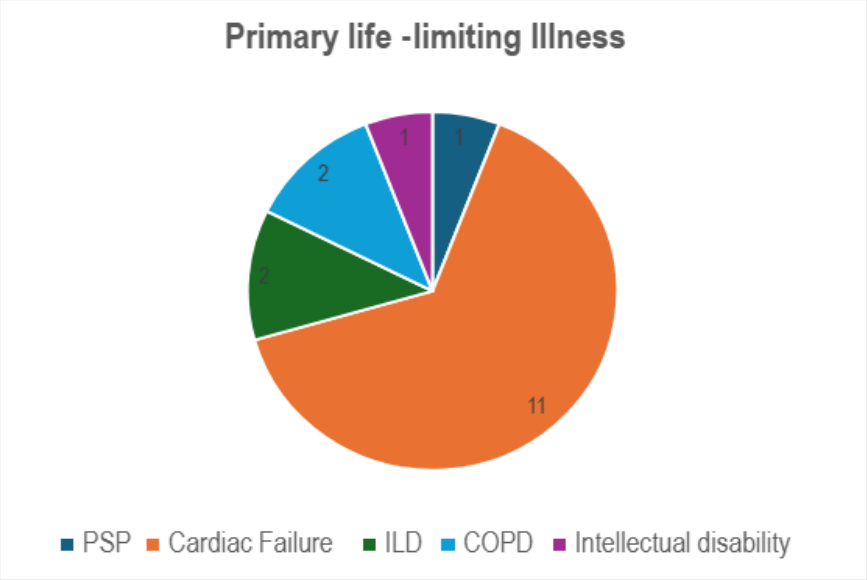

Figure 1: Primary life-limiting diagnoses of the patient cohort.
PSP=progressive supranuclear palsy; ILD=Interstitial lung disease; COPD=chronic obstructive pulmonary disease

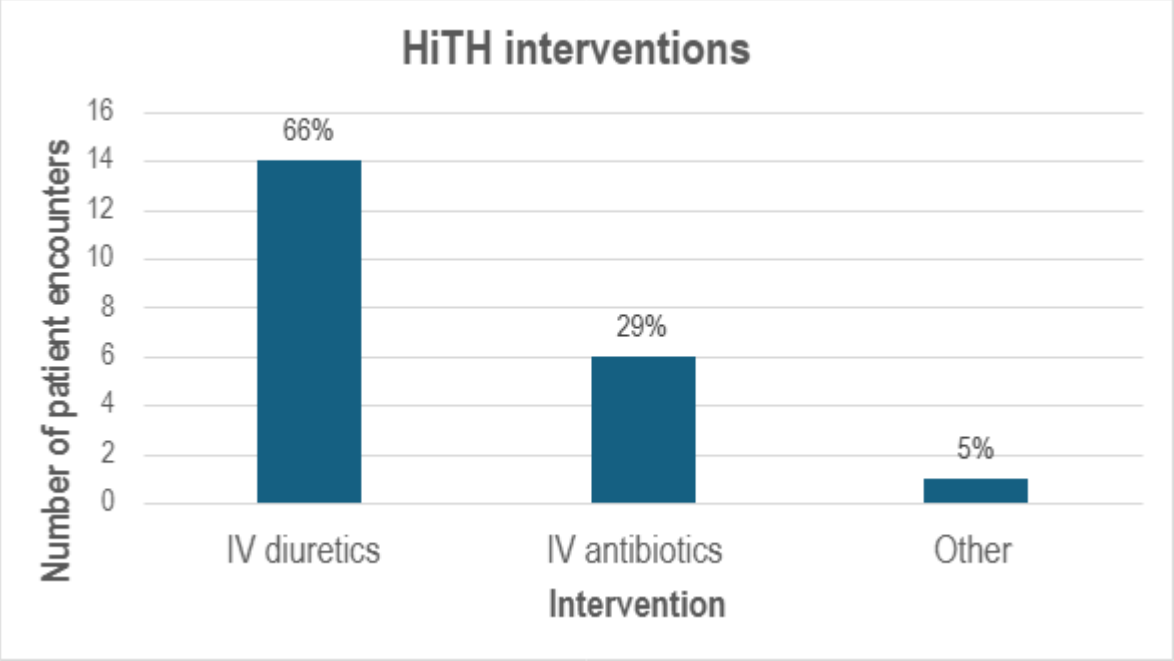

Figure 2: Hospital-in-the-home Interventions

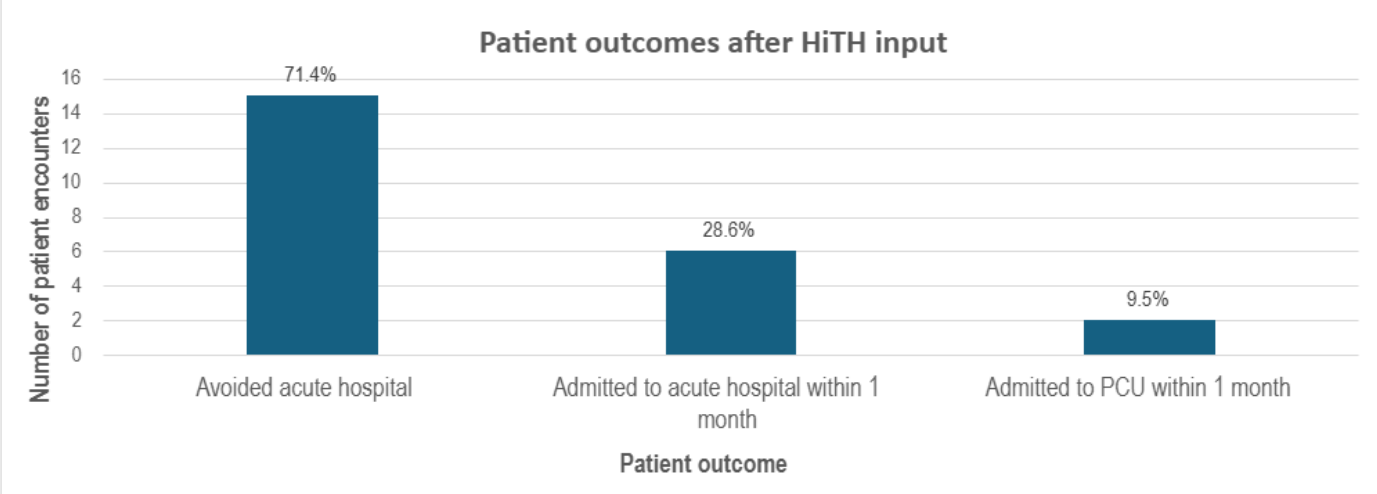

Figure 3: Patient outcomes following Hospital-in-the-home input.