

COMMENTARY

Commentary on Jack B, Baldry C, Groves K, Whelan A, Sephton J and Gaunt K (2013) Supporting home care for the dying: an evaluation of healthcare professionals' perspectives of an individually tailored hospice at home service. *Journal of Clinical Nursing* 22, 2778–2786

A combination of population ageing and increasing complexity of care, combined with the need to deliver cost effective treatments, is driving the development and evaluation of novel models of palliative care (Evans, Harding, & Higginson, 2013). The article by Jack et al. (2013) adopts a mixed methods evaluation to explore the perceptions of community based clinicians about an expanded home based service for patients with palliative care needs that includes: i) an accompanied transfer home process ii) a medically led multi-disciplinary specialist palliative care crisis intervention service; and iii) in home hospice aides (composed of registered nurses and care assistants).

What is evident from the evaluation is that this additional layer of practical support increased the capacity of the existing health care team to deliver care that was responsive to the patient and their care givers' unique needs. It also appears to better support people living alone who wish to remain at home. While this evaluation is limited to the perceptions of health professionals, it suggests that the addition of these extra care elements enables more people to remain at home for longer. Although this evaluation focuses almost exclusively on processes of care and the outcome of place of death (home setting or other), rather than explicitly reporting on the quality of end of life care, it is important work that provides us with insights into the feasibility of potential strategies that enable people to remain at home for longer.

These findings concur with evidence from a recent rapid review of models of palliative care which identified a number of important elements of care including : (1) access to specialist palliative care knowledge and expertise; (2) case management, coordination and promotion of communication across care settings; (3) providing support for home based care including after-hours access; (4) tailoring and targeting services to the target population and setting, particularly when addressing cultural needs; (5) considering workforce issues across the care continuum; (6) collaboration across the healthcare continuum including home, community, acute and residential aged care; and (7) better integrating health and social services to support palliative care in the community (Lockett, In press).

While the lack of patient and care-giver reported outcomes or perspectives is an acknowledged limitation of the work by Jack et al. (2013), it is important that future studies better utilise relevant patient reported palliative care outcome measures (Antunes, Harding, & Higginson, 2014). Steinhauser et al. (2000) noted over a decade ago that dying at home was considered least important by patients nearing the end of life, with this finding confirmed more recently by another large Canadian study (Heyland et al., 2006), suggesting that dying at home may not necessarily be the most appropriate proxy measure for service quality. Integrating patient and family measures of importance, patient reported outcome measures, service delivery processes and cost analyses to develop and implement optimal models of care for those requiring palliative care is an important next step.

References

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