ABUNDANT LIFE
EXPERIENCE LIFE IN ABUNDANCE
Victoria Hospital Palliative Care

First Annual Report: Abundant Life Palliative Care Program at Victoria Hospital

A successful public-private partnership

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1. Introduction

In the local communities the hospital is perceived as a place where patients come to die. Victoria Hospital set out to change this perception by implementing a palliative care program. It was hoped that the program would allow the hospital to become a place where patients receive not only physical but also psycho-social and spiritual care. Challenges in societal demographics, finances, resources and human suffering are pushing us towards a new paradigm in health care delivery

Victoria Hospital is a secondary level public hospital located in Wynberg, Cape Town. It is a 160 bed hospital, consisting of 2 medical wards, 2 surgical wards, paediatric ward and an overnight ward. The hospital serves the Southern Suburbs of Cape Town which has an uninsured population of 1 million. The hospital acts as a platform between the primary level Community Health Centres and the tertiary specialized care institution Groote Schuur Hospital. Every month over 3500 patients are seen in the Emergency Department and there are on average 20 medical admissions per day. The Hospital Outpatient Department also sees over 4000 Outpatients per month. The rapid turnover of patients allows for a 100% bed occupancy rate and bed shortages are now the norm.

According to Victoria Hospital mortality statistics from 2007 48.8% of patients die from predicted unavoidable causes every year. Deaths attributed to cardiac failure account for 12% of deaths and COPD for 8%. Every year 683 beds are occupied by Chronic Organ Failure revolving door patients and this attributes huge costs to the already strained hospital budget. At each admission, the patient is seen to by a different hospital team and the focus is on the immediate problem. No future and long term management plan is made for the patient. Due to resource and time constraints patients face the psychological burden of dealing with the incurable nature of their disease and their mortality alone. Eventually the patient dies away from their loved ones in an unpleasant clinical hospital setting. Support for the family and bereavement care is minimal and unsatisfactory. The average cost of admitting a patient is R 1039 per day and the average hospital stay is 2.9 days. Recurrent hospital admissions thus have vast financial implications for the hospital.

Disease	Admission/year (%)	Deaths/year (%)
CCF	33.2	12
COPD	25.7	8.2
Chronic Renal Failure	10.5	3.1
Cerebrovascular disease	21.6	14.8
Cancer	9.6	6.3

Admission and Deaths at Victoria Hospital 2007

Victoria Hospital formed a public private partnership with The Hospice Palliative Care Association, St Luke's and Living Hope Hospice. Through this partnership a Palliative Care Program were implemented to deal with this problem.

It was with this background that we started in 2009 and now we report on how our program has needed to adapt in 2011 to achieve our goals.

Report for 2010

After achieving our pilot project in late 2009 and presenting our findings at the South African Hospice and Palliative Conference we managed to get a grant from USAID through Hospice Palliative Care Association of South Africa. The purpose of this grant was to pay for a palliative Care Co-ordinator and Elizabeth Pitout was appointed to this post. This was our only source of income as we started in January 2010.

Our first 6 months was extremely difficult as both Dr Cupido and Sr Pitout found the going tough and a low level of acceptance of Palliative Care throughout the hospital. We struggled in a number of areas from administration, getting space in the hospital in terms of office space and setting up office. Initially we started Abundant Life in my own office sharing space. It took us a few weeks to secure a storage room which we converted into an office. Another 2 months and we finally secured a telephone and eventually some office filing cabinet and then desk and chairs. Slowly over that time we established our physical presence in the hospital.

During these 6 months we struggled to get good attendance at the group sessions and had between 5 and 8 patients attending on Friday Afternoons and often had less.
Sr Pitout was doing her Palliative Care Training, the work load seemed enormous and the difficulties of establishing ourselves, we both took enormous Emotional Distress and we often needed debriefing and so tended to use each other as no-one else was aware of what we were going through. The number of cases was increasing and by July 2011 Sr Pitout had vowed to quit on numerous occasions. We both took time off work and often needed to take short stress relief to work through how we were coping with dying patients and the struggle to set-up.

Our colleagues in the departments of Social services, Occupational Therapy, Physiotherapy and Dietetics were also taking strain as the work load in the hospital was increasing in general and things became more difficult for them to attend Friday Afternoon Sessions as we had been doing. These departments played valuable roles in helping us but Palliative Care seemed to be inadvertently increasing their work load as cases we picked up needed further input from especially Social Services for Grant in Aid and greater referrals for placements, social assessment and home based care. We clearly developed a new group of patients requiring Wheelchairs as they were not considered before. We had new procedures for controlling stock and collecting wheelchairs and assistive devices that were at patient's homes done by Occupational Service.

What had initially seemed to be an initiative to decrease hospital admissions we were now generating work that seemed to make things busier.

Dr Cupido was now running Palliative Care and the Department of Medicine and clearly the number of patients requiring the service was increasing. Mid way through 2011 a decision was made that Palliative Care should not be a separate entity but needed to be incorporated into the Department of Medicine as the care of patients should not stop at referral for palliation. This meant that all doctors working in the department of Medicine needed to practice Palliative Medicine. An intern was assigned to palliative duty under the eye of Dr Cupido. This made a doctor available to Sr Pitout every day of the week.

We had one volunteer Taylor DesRosier from America and she collated our Data and assisted Dr Cupido in writing up our program to prove the benefits to the hospital.

By end of 2011 we had survived the year and had still not managed to raise much funds but had secured the following;

1. A presence in the Hospital, Abundant Life had an office with telephone and equipment
2. A referral process was in place
3. Staff were becoming more aware of Palliative Care
4. We established our systems and knew we needed to change to improve
5. We needed more staff to assist
6. Developed better relationships with our partners St. Lukes Hospice, Living Hope Hospice, Hospice Palliative Care Association SA.
7. We had started understanding the Home Based Care system and referrals were improved
8. We were not able to achieve the HPCA organisational rating system as we did not fit into their system.
9. We also lost a number of initial support e.g. our spiritual carer, our minister from the church, but had gained a few new volunteers, Santa our Candy Stripe Lady, Tersia our Counsellor from Hope House.
10. The most important structure in place has been our Data Base which HPCA ensured that we complied with and this has helped us see the difference as well.
11. The Hospital Administration could see the benefit Abundant Life had added to the hospital.

Plan and report for 2011

1. Grow the team

   Fatima Gallow was employed as our Resource Development Officer and was based in Dr Cupido's office as we had no other space in the hospital. Her roles included contacting patients on a 2 weekly basis to have continued contact with patients. She became the contact person for patient queries and organising medication, assistive devices and making bookings for them to see Sr Pitout or the doctor.

   She also did the Data Capturing ensuring that we kept up to date and complied with HPCA.

   She organised the patient folders and set up all our filing systems getting our organisational structures in place. Arranging standard operational procedures and setting up systems that we had created but were not documented in the 2010.

   Fatima helped us revolutionise our availability to our patients as Sr Pitout worked 5 hours a day and she was working a full day. She took a number of duties away from Dr Cupido and this allowed him to concentrate on Patient Care not Administration.

Unfortunately she did not make much progress on the Fund Raising side as patient numbers continued to increase and we believed our main focus was the patients.

Volunteers were needed as clearly without raising funds we would not be able to employ any extra staff. **Joy Hunter** a psychology student was referred to us by Professoe Bongani Mayosi, as she had an interest in Heart Failure and was doing her Master in Palliative Medicine. She visited and was so impressed she decided to volunteer and base her Masters Research at Abundant Life. This provided us with another Counsellor and Joy was also keen to do home visits. This clearly has added much strength to our counselling side.

Tersia continued her counselling sessions at our Friday Afternoon sessions.

Dr Roslyn Doyle was referred to us from Living Hope Hospice. A pleasure to have a doctor from Australia Volunteer her services for 6 months and this took our program to another level. Again not an easy process as space was limited and Sr Pitout now had to share her office with Dr Doyle but we had no choice. This lead to a revolutionisation of our service as we now had a doctor available to patients every day for 5 hours. After she was here for 2 months and understood our program we had to change.

In November 2011 I was contacted by **Rebecca** a Social Work graduate from the University of Western Cape and she had read about Abundant Life on the internet and offered her services as a volunteer. This has added a new dimension to our services as we now were attracting people without advertising. This has impacted on our Hospital Services as our overloaded Social Services now see us as the provider of professional assistance.

2. The Changes

Friday Afternoon sessions became group meetings every second Friday. We no longer saw patients for medication or assessments. We merely used it as a support to generate discussion and patient participation. They started asking how we raise funds, what it gets used for, who pays the staff as the service was so amazing. What was government doing as this should be expanded to other hospitals. Eventually the patients took action they started raising funds on our behalf.

Patients were now being assessed on a daily basis and Dr Doyle and Sr Pitout were seeing more patients as they were able to do Ward Rounds and started reviewing patients in the wards prior to them being referred to Palliative Care. They started offering nurses and doctors advice regarding pain management and symptom control for patients. Palliative Medicine was now being integrated into the ward as their presence was felt and the staff became more open to suggestions and finally started noticing how effective, simple care measures were. Patients were appreciative of the improve care. Quality of Care in the Medical Wards at Victoria Hospital improved and Palliative Care became more respected and relationships continue to improve.

After Dr Doyle left we needed a replacement for her and Dr Frank Luker who had already taken to the palliative care approach with great enthusiasm and was also doing home visits. Dr Luker agreed to become the next Palliative Care Doctor and is now available to Sr Pitout on a daily basis. Dr Cupido, Dr Luker, Sr Pitout doing home visits has lead to our interns doing the same as this quality of care is now considered the norm. This year Dr Lukhna one of our interns joined in the home visits and so we are revolutionizing Palliative Medicine.

Acknowledgment

This program would not have been possible without the support from staff at Victoria Hospital, the Hospice Palliative Care Association, and St Luke's and Living Hope hospice.

The following people are to be acknowledged:

Victoria Hospital: Dr Petro Frankenveld, Dr Katherine Krige, Ms F Salie, Ms R Isaaqs, Ms C Otto.

HPCA: Mrs Maria Demjan, Dr Liz Gwyther

St Luke's & Living Hope hospice: Dr R Krauser, Ms J Rixon, Sr M Tucker, Pastor John, Sr E Pepper, Michelle, Nisha

I've told my children that when I die, to release balloons in the sky to celebrate that I graduated.

For me, death is a graduation." *Elizabeth Kubler-Ross*