ISRCTN14361072 https://doi.org/10.1186/ISRCTN14361072

The feasibility of a care pathway to improve care for older patients at the end of life

Submission date
22/06/2020

Recruitment status
No longer recruiting

Registration date
25/06/2020

Overall study status
Completed

Last Edited
13/08/2021

Condition category
Other

[_] Prospectively registered
[_] Protocol
[_] Statistical analysis plan
[X] Results
[_] Individual participant data

Plain English summary of protocol
Background and study aims
Palliative care needs of older patients at the end of life are often not identified timely during hospital admissions. Additionally, people's wishes and preferences are not discussed with health care professionals and consequently care is not personalized to their need. This can result in unwanted hospital readmissions and people not dying at their prefered place. In this study, we developed a transitional care pathway with the aim to improve timely identification of needs, timely discussions about preferences and expert treatment and follow-up of palliative care needs with the aim to prevent hospital readmissions and improve the number of people dying at their preferred place. Before we can research if this care pathway improves these outcomes, we researched if all the parts of the intervention were feasible. In other words, if it is possible to carry out the protocol we developed within the hospital and surrounding primary care organisations.

Who can participate?
Patients of 60 years or older who were acutely hospitalized and needed palliative care could participate.

What does the study involve?
Participants were seen by a palliative care team during hospital and discussion were held about their preferences and needs. After discharge, the palliative care team followed the patients at home and a personalized care plan was developed. Participants were asked to answer questionnaires about their health and quality of life at the start of the study, two weeks, one month, three months and six months after hospital discharge.

What are the possible benefits and risks of participating?
Benefits for participants were that they had the opportunity to discuss their need and preferences and would receive care in accordance with these preferences. Furthermore, an expert palliative care team would be involved in their care in both the hospital and home setting. Some people feel uncomfortable discussing the end of life and there was a risk of experiencing negative feelings about these discussions. Furthermore we asked questionnaires which could take up some time.

Where is the study run from?
OLVG oost hospital in Amsterdam in the Netherlands.

When is the study starting and how long is it expected to run for?
June 2017 to July 2018

Who is funding the study?
ZonMw (The Netherlands Organisation for Health Research and Development), grant number 844001103.

Who is the main contact?
Isabelle Flierman, M.D., i.flierman@amsterdamumc.nl

Contact information

Type(s)
Scientific

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Additional identifiers

EudraCT/CTIS number
Nil known

IRAS number

ClinicalTrials.gov number
Nil known

Secondary identifying numbers
Nil known

Study information

Scientific Title
Feasbility study of a transitional care pathway for older patients at the end of life

Study objectives
A transitional care pathway will improve care for older patients at the end of life and reduce hospital admissions and improve the number of patients dying at their preferred place. In this study we researched the feasibility of the transitional care pathway before testing this hypothesis in a larger randomized trial.

Ethics approval required
Old ethics approval format

Ethics approval(s)
The study protocol was judged by the medical ethical board of the Amsterdam UMC, location AMC and exempted from assessment according to the Medical research Involving Human Subjects Act. Reasons given were that the focus of this study was to see if components of the intervention were feasible, mainly on professional and organisation of care level and not on patient outcomes. Furthermore, patients were aware of the care they would receive and could choose to participate while knowing what the intervention entailed.

Study design
A mixed-method feasibility study

Primary study design
Interventional

Secondary study design
Non randomised study

Study setting(s)
Hospital

Study type(s)
Quality of life

Participant information sheet
Not available in web format, please use contact details to request a participant information sheet

Health condition(s) or problem(s) studied
Older patients in the last year of life

Interventions
In this study we tested the feasibility of a transitional care pathway. To achieve the care pathway, interventions were done on health care professional level. The interventions included:
1. Training modules on timely identification of palliative care needs and advance care planning
2. Formation of transitional palliative care team that followed patients within the hospital and in their home setting
3. Implementation of protocols on interprofessional and transitional collaboration

Patients are included during an acute hospital admission. After providing written consent they will have a consultation with the newly formed transitional palliative care team who will perform an advance care planning conversation. During this consultation, the first baseline questionnaires will be obtained. These questionnaires include The questionnaires included the

EuroQol-5D+, the Palliative outcome scale and the Edmonton Symptom Assessment System. The patients are discussed in a multi-disciplinary meeting by the palliative care team after which a personalized care plan is made and given to the patient. In addition, this plan is also sent to their primary care professionals. After discharge, the patient is followed up by the palliative care team until necessary.
Patients are followed for 6 months or until death. During this time questionnaires and data on health care usage are obtained through telephone interviews at 2 weeks, one month, three months and six months post-discharge.

Intervention Type
Mixed

Primary outcome measure
Feasibility of different study components measured on:
1. Patient recruitment. This was measured by how many patients we could recruit within six months
2. Data collection. This was measured by registering for how many of the included patients outcome data was known on hospital readmissions and place of death, which were the intended outcomes for the trial following this feasibility study. Furthermore, we assessed how many questionnaires were completed at baseline, two weeks, one month, three months and six months post-discharge. The results of the questionnaires were not part of this study, but solely if the intended data collection was feasible and patients were able to answer all questionnaires
3. The patient burden of answering the questionnaires was measured with a 10-point Likert scale
4. Implementation of study components and protocol adherence. This was measured by registering if all intended components of the study were performed for each included patient

Secondary outcome measures
1. Experiences of professionals with the training modules measured with a survey amongst participants after the training modules which took part during the first month of the trial
2. Professionals' acceptability of the study measured through semi-structured qualitative interviews between March and July 2018

Overall study start date
01/06/2017

Completion date
01/02/2019

Eligibility

Key inclusion criteria
Patients:
1. Eligible patients were older than 60 years
2. Admitted for at least 48 hours
3. They were judged to be in need of palliative care if their physician answered the Surprise Question (would I be surprised if the patient died in the next 12 months) with 'No' and if there were two or more criteria present from the Supportive and Palliative Care Indicators Tool™

Professionals:
Professionals could participate in semi-structured interviews if either
1. A patient of theirs was included in the study

2. They participated in the training modules
3. They are part of the transitional palliative care team

Participant type(s)
Mixed

Age group
Senior

Sex
Both

Target number of participants
50

Total final enrolment
56

Key exclusion criteria
1. Patients who lived outside a set postal code area because the transitional palliative care team would not be able to perform home visits
2. Cognitive impairment (Mini-Mental State Examination <15)
3. No proficiency in the Dutch language
4. Did not provide consent

Date of first enrolment
01/02/2018

Date of final enrolment
31/07/2018

Locations

Countries of recruitment
Netherlands

Study participating centre
OLVG oost
Oosterpark 9
Amsterdam
Netherlands
1091AC

Sponsor information

Organisation
Netherlands Organisation for Health Research and Development

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Sponsor type
Government

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ROR
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Funder(s)

Funder type
Government

Funder Name
Netherlands Organisation for Health Research and Development

Results and Publications

Publication and dissemination plan
Planned publication in a high-impact peer-reviewed journal.

Intention to publish date
01/08/2020

Individual participant data (IPD) sharing plan
The datasets generated during and/or analysed during the current study are not expected to be made available due to the fact we did not specifically ask consent from participants to share raw data with other researchers. However the results of this study will be published in a peer reviewed journal which we did ask consent for.

IPD sharing plan summary
Not expected to be made available

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Results article		15/09/2020	13/08/2021	Yes	No