AUDIT OF REFERRAL OF AIDS PATIENTS FROM HOSPITAL TO AN INTEGRATED COMMUNITY-BASED HOME CARE PROGRAMME IN KWAZULU-NATAL, SOUTH AFRICA

Laura Campbell, *MB ChB, MFamMed, Dip Pall Med, Dip MH*
Honorary Lecturer, Department of Family Medicine, University of Natal, Durban

Aim. To maximise access of hospitalised AIDS patients to an integrated community-based home care (ICHC) programme.

Objectives. To determine optimal standards for referral, to review current practice in relation to standards, to implement changes necessary to meet standards, and to reassess the functioning of the referral system after intervention.

Design. Prospective collaborative audit using review of referral forms, interviews and focus group discussions.

Setting. Port Shepstone health district, KwaZulu-Natal, South Africa.

Subjects. Staff ICHC team, South Coast Hospice, and staff at Port Shepstone Hospital.

Results. The referral system was suboptimal in terms of process, structure and awareness of function. Problems were reliance on a single co-ordinator, inappropriate referrals, and nonspecific documentation. There was also a cumbersome process of communication between the hospital and the ICHC team. Hospital and patients were unclear of the role of the ICHC. Changes included training nurses to increase the number of co-ordinators, production of written referral criteria, a patient information pamphlet and specific documentation. Communication channels were streamlined. Reassessment indicated that referral standards were being met.

Conclusions. The referral system was initially suboptimal but was improved to meet standards. We recommend ongoing data collection and peer audit.

INTRODUCTION

The prevalence of HIV infection in South Africa is estimated to be among the highest in the world. There are an estimated 1 700 new infections daily and 10% of the adult population is already infected.[1] Recent sero-prevalence studies in the province of KwaZulu-Natal indicate that 36% of adults are infected.[2]

Over the last few years the largely silent HIV epidemic has shifted to a more visible AIDS epidemic. The existing health system is already overburdened and home-based care has been declared a national priority.[3] Despite this there are no national standardised guidelines on home-based care readily available and funding for NGOs carrying out this role is very limited. In response to the desperate need South Coast Hospice, a non-governmental organisation, began an integrated community-based home care (ICHC) programme in 1997. In this programme caregivers take hospitalised patients home and offer care at home. The programme has three teams to cover an area of 600 km^2 and relies heavily on volunteers and donations. Care offered includes counselling, cleaning of wounds, bathing, oral hygiene, symptom control and support in taking medication. Since 1997 referrals from the hospital were screened by a hospital/ICHC co-ordinator, a full-time nurse based at the hospital, before being accepted by the ICHC team. Given the exponential increase in numbers of patients and the lack of national guidelines for referral to home-based care, an audit of referral was carried out to assess if the referral system was ensuring maximum accessibility for hospitalised patients.

OBJECTIVES

The objectives of the audit were as follows:

- to determine optimal standards for referral of hospital inpatients with AIDS to an ICHC programme
- to review current practice in relation to optimal standards
- to identify changes needed in practice standards, to implement changes, and to re-measure practice after intervention
- to use this audit as an opportunity to draw up a programme for staff update and training and to

enhance knowledge of AIDS sufferers and their families with regard to the disease
- to make recommendations to the Department of Health (DOH) on guidelines for referral.

METHODS

Permission for the audit was obtained from the Director, South Coast Hospice, and Medical Superintendent, Port Shepstone Hospital. The audit was prospective, collaborative and took place from November 2000 to March 2001. The hospice doctor co-ordinated the audit and methods employed were:

- review of referral forms of consecutive patients referred to the ICHC during the study period
- focus group discussions between hospital representatives and the ICHC team
- interview of hospital and ICHC team members individually.

The doctor facilitated the focus group discussions between hospital representatives and ICHC team members in order to set optimal standards for referral. After standards had been set the doctor interviewed hospital nurses and ICHC team members using a non-directive approach to assess their opinion on the referral system in relation to the standards. Factors in the referral mechanism that did not meet optimal standards were identified in January 2001. A further discussion was held to identify changes needed and methods to implement changes in order that optimal standards would be practised. Changes were implemented and a further focus group discussion took place in March 2001 to reassess the functioning of the referral system after intervention.

RESULTS

Following a focus group discussion in November 2000 the optimal standards for referral were established (Table I).

A review of patient referral forms and interviews indicated that the referral system was not meeting the standards. Problems centred around the process and structure of the system and around awareness of the role of the ICHC programme. In terms of process a main problem identified was that referrals had to be screened by a hospital/ICHC co-ordinator, and given the expanding numbers of patients she could no longer manage to carry out this service. There were problems with communication between the hospital and ICHC team. The nurses tried to telephone the team but found that they were often unavailable, and faxed referral forms were not always available to the team.

There was no standardised means of communication. The ICHC team stated that they sometimes came to the ward and no one was available to brief them; also, when they came to take a patient home they had to wait while the patient got dressed and collected medication. This was frustrating as the team was very busy. The team occasionally had inappropriate referrals and patients were being referred by nurses, doctors or occasionally by their families. The ICHC team visited the hospital on set days so

TABLE I. STANDARDS SET AFTER FOCUS GROUP DISCUSSION, NOVEMBER 2000

STANDARD SET	
Patient education	All HIV-positive clients should be aware of the role of the ICHC and be given a patient information pamphlet
Hospital staff education	All involved hospital staff should be aware of the role of the ICHC and be confident in referring clients
ICHC team education	The ICHC team should be confident to accept clients and have an understanding of their medical, social and psychological problems
How should the team be contacted?	Hospital/ICHC co-ordinator should use fax or cell phone, or telephone hospice inpatient unit and leave a message
Who should refer?	A doctor
Which patients should be referred?	Stage 3 and 4 AIDS patients* Patients living within the ICHC catchment area Patients with active TB must be on TB medication and have a DOTS supporter
What documentation should be completed?	A written referral form for the ICHC completed by the hospital/ICHC co-ordinator
Who decides who is accepted or rejected?	The hospital/ICHC co-ordinator
How long should it take before the client is reviewed by the ICHC team?	The ICHC team should see the client within 24 hours of being contacted
Should all clients be taken home by the team?	If possible the team should take the client home (preferably within 3 days of referral) The home visit must be used as an opportunity to educate relatives on the disease and to discuss the ICHC

* As funding for the ICHC was limited the group felt that the ICHC team only had the capacity to deal with patients who needed immediate care.
TB = tuberculosis; DOTS = directly observed short course therapy.

patients sometimes had to wait up to a week before being reviewed and taken home.

In terms of structure, the referral documentation used had been designed for patients with cancer, so certain important data fields were missing and some were inappropriate. Missing data fields were date of birth and identification number, which are needed for the social worker to access grants. Inappropriate data fields pertained to radiotherapy and chemotherapy. There were no written criteria for referral, nor was there a map indicating the catchment area of the ICHC team.

Nurses perceived that some patients were unaware of the function of the ICHC programme and nurses had to explain the concept of home-based care to patients and their families. A few members of the ICHC team felt that they would like to be updated on aspects of caring for AIDS patients.

Actions taken included training all nurses in charge of wards on the role of the ICHC, referral criteria and the catchment area. This meant that more people were available for screening of patients before referral and the referral system did not have to rely on one person. All referral forms were to be faxed through from the hospital to hospice and placed in a designated file for the ICHC team. Nurses were requested to contact the ICHC team only when the patient was ready for discharge so that the team did not have to wait in the ward. Written referral criteria and a map were produced, laminated and placed in each ward.

More appropriate referral forms were designed by the nurses and the ICHC team. A patient information pamphlet on the role of the ICHC was produced. An in-service training programme was drawn up for the ICHC team by the hospice trainer.

A further review took place in March 2001. Twelve patients had been referred. All had been appropriately referred by doctors and screened by the nurse in charge of the ward. All had adequate documentation and the ICHC team had received a faxed copy of the referral form for each client. Nurses felt that patients and their families were more aware of the role of the ICHC and that the patient pamphlet was useful. An in-service training programme had been initiated for the ICHC team. The only standard not met was that the clients were not taken home within 3 days of referral. The ICHC team had been unable to meet this standard and it was felt to be unrealistic. Instead the team agreed to telephone the ward and let the nurse know when they could come to review the patient.

DISCUSSION

Given the increasing numbers of patients with AIDS and government commitment to home-based care it is of concern that funding to programmes, which are operating home-based care, is extremely limited and there are no standardisation policies on the function of home-based care programmes readily available. Home-based care programmes may differ, so results of this audit may not be generalisable to other programmes. There are regular audits of care offered in the ICHC programme and audit of referrals should be integrated into existing audit structures. A data collection system for ongoing review of referrals was initiated (all data are now being captured on a computer programme). A review of referrals from peripheral clinics to home-based care may also be useful. An extension of this audit to other health facilities is recommended. A peer audit with other institutions offering home-based care may enable a consensus document on referral to be drawn up for the DOH.

CONCLUSION

Following this audit the process and structure of the referral system improved. Awareness of referral criteria and knowledge of home-based care also improved. An ongoing assessment of referrals was recommended. A further review is recommended in early 2002 as one of the standards set was altered and not assessed. Results from this audit may not be generalisable to other home-based care programmes and peer audit is recommended to produce a consensus guidelines for referral from a hospital to a home-based care programme.

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