Canberra Health Services

Consultation Paper:

Transition to Acute Palliative Care Ward

Cancer and Ambulatory Support.

Work Area	Author(s)	Contact Details
Cancer and Ambulatory Support	Melissa O'Brien	CHS.CAS@act.gov.au

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1. Introduction

Canberra Health Services (CHS) is focussed on the delivery of high quality, effective, person-centred care. It provides acute, sub-acute, primary and community-based health services to the Australian Capital Territory (ACT)—a catchment of approximately 400, 000 people. It also services the surrounding Southern New South Wales region which includes the Bega Valley, Bombala, Cooma-Monaro, Eurobodalla, Goulburn, Mulwaree, Palerang, Queanbeyan, Snowy River, Upper Lachlan Shire and the Yass Valley.

CHS administers a range of publicly funded health facilities, programs and services including but not limited to:

- **The Canberra Hospital:** a modern 600-bed tertiary hospital providing trauma services and most major medical and surgical sub-specialty services.
- **University of Canberra Hospital Specialist Centre for Rehabilitation, Recovery and Research**: a dedicated and purpose-built rehabilitation facility, with 140 inpatient beds, 75-day places and additional outpatient services.
- **Mental Health, Justice Health, Alcohol and Drug Services:** provide a range of health services from prevention and treatment through to recovery and maintenance at a number of locations and in varied environments for people suffering from mental health issues.
- **Dhulwa Secure Mental Health Unit:** a purpose designed and built facility providing clinical programs and treatment options for people suffering from acute mental health issues.
- **Six community health centres:** providing a range of general and specialist health services to people of all ages.
- **Five Walk-in Centres:** which provide free treatment for minor illness and injury.
- A range of **community-based** health services including early childhood services, youth and women's health, dental health, mental health and alcohol and drug services.

CHS is a partner in teaching with the Australian National University, the University of Canberra and the Australian Catholic University.

On 1 October 2018 ACT Health transitioned into two separate organisations being the ACT Health Directorate (ACTHD) and CHS.

To enable CHS to have a strong focus on operational effectiveness, efficiency and accountability in the health services we provide, CHS is proposing a realignment of functions.

The current organisational chart and the recent Annual Report and the ACT Government Budget Papers provide more detail about CHS.

2. Purpose

The purpose of this paper is to describe a staged approach from the present consultative palliative care service, to a full dedicated acute palliative care ward under the governance of the Division of Cancer and Ambulatory Support (CAS).

Palliative Care aims to relieve suffering in all stages of a life limiting disease and includes:

- Pain and symptom management
- Establishing and implementing care plans in keeping with the patient's values and preferences
- Consistent and sustained communication between the patient and all those involved in his or her care
- Psychosocial, spiritual and practical support both to patients and their caregivers.

3. Current model

The Specialist Palliative Care Service (SPCS) is an inpatient consultative service that supports the care of patients who are referred by their treating team due to having palliative care needs that have not been able to be adequately managed by the treating team. The SPCS does not take over patient care. The SPCS team works in partnership with the treating team to manage symptoms and psychological distress associated with a life limiting diagnosis.

The SPCS provides Medical and Nurse Practitioner outpatient clinics for referred patients who have been identified by their health care team as having specialist palliative care needs that are unable to be met in the community under their current management. This has been extended to include a Nurse Practitioner led Rapid Access Palliative Service to meet urgent and emerging specialist palliative care needs for non-admitted patients who are accessing Canberra Hospital ambulatory services.

As there are no designated beds for acute palliative care, patients requiring palliative care remain in their home wards under the care of their treating team.

4. Rationale for change

The Health Roundtable 2022 Quality of Dying Report indicates that most patients who die at Canberra Hospital experience discomfort or pain; respiratory distress; and restlessness, agitation, or delirium. This could be contributed to by the lack of a dedicated specialist inpatient service and trained nurses caring for complex patients. A dedicated specialist palliative care unit (within an existing ward) will seek to provide for better care for patients with uncontrolled symptoms of a life limiting illness.

A scoping study and ward design for a future Acute Palliative Care ward is currently being undertaken (22/23 Financial Year). A dedicated ward for this service is unlikely to be realised in the next one to two years. Until a physical unit is realised, a transition to an admitted palliative care model is the proposed first step to developing clinical capacity and supporting patients with acute palliative care needs.

Implementation of this transition plan aligns with the CHS value of Progressive. CAS will deliver an innovative solution, within the current 14B footprint, without needing to wait for the physical structure of a purpose build Acute Palliative Care ward.

The staged approach described in this document will support the delivery of inpatient specialist palliative care. Stage 1 will address the needs of medical oncology inpatients who have acute palliative care needs which are better managed by the SPCS. This will also enable CAS to work through the eligibility/intake criteria and business rules to support admission to the SPCS. This stage will also encourage and support the development of the expert nursing skills required in the 14B nursing team to manage patients requiring specialist palliative care intervention.

5. Future model

Scope and Implementation

Implementation of the model will be undertaken as outlined below for each stage.

Stage One:

Four "Acute Palliative Care beds" located within the existing 14B, 28 bed ward footprint will be designated as palliative care beds for patients with acute palliative care needs.

14B was designed with the needs of palliative care patients in mind. The ward has 10 single rooms which include carer zones to support the presence of family or carers. Access to the outdoor spaces and a large dining area also supports the needs of the patient and family/carers and their unique preferences.

Admission to Acute Palliative Care (APC) Beds:

- Patients admitted under cancer services who have acute palliative care needs and who are known to the SPCS and accepted for admission by the SPCS team will be eligible for admission to APC beds.
- Admission to the APC beds will be triaged by the SPCS based on clinical need and bed availability.
- During Stage One, patients will not be able to be admitted under palliative care for their acute palliative needs directly from the Emergency Department. An initial

admission under a cancer services team and then a SPCS consult will be required prior to acceptance.

The clinical team:

Patients who are accepted into the APC beds will be co-admitted under the medical oncology team and the SPCS team. This arrangement will enable the SPCS team to direct care, including prescribing medication, initiating changes to goals of care, and ordering of appropriate diagnostics, to ensure the optimal treatment of the patient's acute palliative care symptoms. Bedside SPCS assessment of patients admitted under palliative care in Stage One will include input from palliative medicine specialists, palliative care registrar, palliative care nurse practitioner, and the palliative care psychosocial team depending on patient needs. The general nursing, allied health and psychosocial needs of patients admitted within these four acute palliative care beds will continue to be provided by 14B ward staff.

It is proposed that support for the inpatient medical team will be provided by the Radiation Oncology Junior Medical Officer (JMO).

On call and cover arrangements:

The on-site after hours and weekend medical support of the acute palliative care beds will be provided by the medical oncology JMO and registrar. The on-call palliative care medical officer will provide 24-hour phone support for patients in the acute palliative care beds.

Leave cover for the CHS palliative care staff specialist will be provided by a combined pool of Clare Holland House staff specialists, and the SPCS nurse practitioner. However, increased support from medical oncologist may be required during periods when the palliative medicine specialist is unavailable on leave.

Education and support:

Further education and support for nursing staff on 14B, who will provide care to the patients in the palliative care beds will be offered through planned education sessions with the SPCS and bed-side education when needed and available.

Commencement: As soon as possible following consultation.

Stage Two:

Enhancement of the four bed Stage One footprint.

In this stage, the designated palliative care beds will be increased to six.

Stage two will commence following the funding and recruitment of additional FTE Palliative Care Consultant and Nurse Practitioner staff. In Stage Two, patients would be admitted to

the designated palliative care beds under the care of the Palliative Care consultant as the primary care team. In this stage, the Palliative Care team will take over primary responsibility for the patient and lead the clinical management of the patient. This may require ongoing consultation or a shared care model with other medical specialties dependent upon the disease process and needs of the patient. Patients will be able to be admitted under palliative care for their acute palliative needs from the Emergency Department during this stage.

Commencement: Stage Two could commence as soon as the medical staff can be funded and recruited – as soon as possible.

Stage Three:

Stage Three will be the construction and commissioning of a dedicated 12 bed inpatient Acute Palliative Care ward.

Through all three stages of this phased implementation, once the patient's acute symptoms have been managed, they may return to the referring service, particularly under a shared care model. It Is important to note that patients requiring Acute Palliative Care may not be classified as being at the end of life. Admissions under this model will usually be for patients who have complex palliative care needs requiring specialist input which may include management of physical symptoms or psychosocial and spiritual needs.

6. Benefits of the future model

The benefits of this model are:

- There is no need to delay the introduction of Stage One of the Acute Palliative Care inpatient service until a dedicated Acute Palliative Care ward is constructed and commissioned;
- Providing a designated ward location for acute management of palliative patients with specialist palliative care needs, reducing the need for this care to be provided in general inpatient wards;
- Improved coordination between and integration of different specialists and services to support patients with complex palliative care needs; and
- Capacity and capability building of clinical staff within 14B, which will ensure established staff with palliative care skills will be ready when the Acute Palliative Care ward is built and commissioned.

7. Implications for not undertaking the change

Care will continue to be provided by admitting care teams, with palliative care advice being provided in a consultative model. This limits the effectiveness of the palliative care service

and patients may not receive dedicated support and clinical treatment under the direct care of the SPCS team.

8. Consultation methodology

This proposal provides more detail in relation to the staged transition to an Acute Palliative Care ward. There are still details that need to be determined and your feedback, suggestions and questions will assist in further refining the approach to delivering an Acute Palliative Care inpatient service.

In particular we are seeking responses to the following questions:

1. Will this staged approach deliver collaborative care to patients with acute palliative care needs?
2. Without a designated acute palliative care ward, are there other alternatives to delivering this service other than those outlined in this proposal?
3. Do you have any concerns about the proposal so far, if so what are they?
4. Do you have any other feedback you would like to be considered in relation to the transition to an Acute Palliative Care ward?

Feedback is due by close of business Friday, 21 April 2023 and can be provided via email to CHS.CAS@act.gov.au

For any further information relating to the transition to an Acute Palliative Care ward and subsequent consultation process, please contact CHS.CAS@act.gov.au.