

20.2.2015

Response to DHHS Green Paper: Delivering Safe and Sustainable Clinical Services.

The Tasmanian Association for Hospice and Palliative Care is a member of the Partners in Palliative Care Reference group and supports the document submitted by that group. We would like to make a few additional points which will focus mainly on community based services and nursing services:

Care Planning prior to discharge from hospital:

1. Timely referral is needed through liaison with clinicians in the hospital so that discharge planning starts early in the admission.
2. A detailed care plan is needed, with an understanding that complete care will be provided in the community, mainly by nursing staff with back-up from the GP.
3. Seriously ill people being cared for at home need a full range of services available to them including nursing, OT and physio as well as medical care. Home care with proper equipment prevents multiple re-admissions to hospital. Multi-disciplinary care in the community has to be resourced for this to occur and to prevent the increased costs associated with constant re-admissions.
4. After hours medical services are essential to back-up nursing staff in residential aged care facilities (RACF), in other acute situations that arise and in particular specialist palliative care on-call nursing staff who need access to after hours medical support for emergency medication orders.
5. When people return to RACF to die, clear plans are needed with attached medication orders, which outline procedures to be followed when the patient deteriorates.

With good discharge planning there will be less, and often unnecessary, re-admission to acute care and earlier discharge home.

Medical Goals of care and advance care directives:

1. Conversations about end-of-life need to be held so that decisions can be informed and families caring for dying people at home can be educated in the care of their ill relative.
2. Documentation on the outcomes of these conversations needs to be recorded and utilised so that frequent re-admission to hospitals can be avoided.
3. The RACFs need these tools to manage dying residents so that a clear plan of care is understood and people are not sent unnecessarily to Emergency Departments when an expected deterioration occurs.

Clear goals of care work as a health promotion tool as staff, families and patients all understand how symptoms will be managed and crises avoided, and thus gain confidence in caring for seriously ill patients out of hospital.

Community based services

1. In the community the main health providers are nurses. The GP will visit when needed rather than being the first point of call. It is essential that community nursing services and specialist palliative care services are well-resourced to achieve this.
2. The private hospital system is seldom involved in providing community based care. Item numbers only relate to hospital based care. Partnership agreements involving the private insurers could be negotiated so that government funded services which provide on-going community-based care can get partial recompense for post-acute care.
3. There is also little mention in the document of the non-government care which is given in the community such as Family-Based Care, Anglicare support, community supports and volunteers. Volunteers in particular are an integral part of community palliative care and provide services other than nursing which are of invaluable benefit to families.
4. Community Aged Care packages which have been increased in recent years, are working well, and resourcing needs to be continued.

General Points:

There is mention in the Green paper of services possibly being provided on the mainland prior to discharge home to Tasmania. In a palliative care context this is usually for paediatric care. For this to be successful mainland services need to be aware of what is available in Tasmania in terms of local services when people return home. It can be complicated to find out just what is available where, and mainland services are surprised to find there is good care available in remote places such as Dover or Oatlands.

Educational opportunities need to be funded especially in specialist services for staff to remain well-informed on current issues. Professional development needs to be relevant to the speciality and funds available for staff to travel interstate sometimes for conferences and other educational programmes.

Maintenance of senior nursing positions is important to preserve a career path within nursing, and also applies to senior allied health personnel. Cost saving by abolishing or allowing redundancies with these senior positions is counter-productive as loss of skills affects the training and potential of more junior staff.

Aged Care Services:

RACFs need additional funding for people who are dying. The timing of such an event is difficult to predict, but dying residents need extra care and this needs to be achieved without burdensome paperwork which may delay the provision of this care.

Young graduates have commenced working with residential aged care facilities which gives them good early experience in this expanding field of nursing. However training new staff is always an impost on existing staff and this needs to be considered in allocating funding.