ANZSPM

The Australian & New Zealand Society of Palliative Medicine Inc. ABN 54 931 717 498

Royal Commission into Aged Care Quality and Safety
GPO Box 1151
Adelaide SA 5001

[By email: ACRCProgramDesign@royalcommission.gov.au]

24 January 2020

Dear Sir/Madam,

ANZSPM submission to Royal Commission into Aged Care Quality and Safety consultation paper 1 – Program Design in Aged Care

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) welcomes the opportunity to make a submission to the *Royal Commission into Aged Care Quality and Safety consultation paper 1 – Program Design in Aged Care*.

ANZSPM is a specialty medical society that facilitates professional development for its members and promotes the practice of palliative medicine, in order to improve the quality of care for people with life-limiting illness. Our members are medical practitioners who provide care for people with a life-limiting illness and include palliative medicine specialists, palliative medicine training registrars and other doctors with an interest in palliative care such as general practitioners, oncologists, haematologists, intensivists, psychiatrists and geriatricians.

ANZSPM has previously provided input into and supports Palliative Care Australia's earlier submission[1] to the Royal Commission on the topic of end-of-life and palliative care provided within the Australian aged care system and also supports its latest submission to this consultation.

Overall, ANZSPM supports the recognition in the consultation paper that an older person with complex needs, a life-limiting illness or at the end of their life should have access to better clinical care within the aged care system and through in-reach services.

ANZSPM has directed its comments on the consultation paper to question 7 on 'specialist and in reach services', below:

How could the aged care and health systems work together to deliver care which better meets the complex health needs of older people, including dementia care as well as palliative and end of life care? What are the best models for these forms of care?

[1] Palliative Care Australia 2019, Submission to the Royal Commission into Aged Care Quality and Safety, PCA Canberra. Available at: https://palliativecare.org.au/wp-content/uploads/2019/11/PCA-Submission-to-the-Royal-Commission-into-Aged-Care-Quality-and-Safety-October-2019.pdf (accessed January 2020)

ANZSPM agrees that older people, including those with complex dementia or chronic health conditions, their carers and families, and staff working with them, should have improved access to specialist expertise relevant to the care needs of the older person.

As outlined in ANZSPM's submission to the Australian Department of Health on the formation of Specialist Dementia Care Units (SDCUs)[2], we support the broad concept of specialised units attached to Aged Care facilities treating those people with the more severe manifestations of behavioural and psychological symptoms of dementia (BPSD) in a dedicated centre with specialist expertise.

However, there should also be an overall greater emphasis in aged care (as suggested on the consultation paper) on integrating a palliative approach to care as well as improved access to specialist expertise. Most residents of aged care facilities are in their final years and months of life, and would benefit from access to palliative care. The configuration of palliative care services should follow the guidance provided in *'Palliative Care Service Development guidelines (2018)'*[3] to match the clinical care with complexity of need, be provided by a multidisciplinary team, and include after-hours access and bereavement support.

What would be required to support in reach of multidisciplinary health teams from the health system in the care of older people with high needs? What other services could be used (24/7 on-call services, embedded escalation to specialists, access to relevant ageing specialists, telehealth or other technological advances)?

In the context of aged care services generally, there is often an assumption that residents of aged care facilities are "clinically stable", and as a result access to key health professionals may not be seen as critical. This assumption fails to recognise the nature of life-limiting illnesses, and indeed multimorbidity which underpins the reason most residents require high level residential aged care services, and by nature of these conditions, their clinical and palliative needs can rapidly change over time and in some instances are complex.

The scope of practice of health professionals (whether doctors, registered nurses or allied health, depending on the issue at hand) which is required, should facilitate regular comprehensive assessment and appropriate skills to respond to these changes. The care should include after-hours management (as needed), and proactively address acute new issues by flexibly and nimbly tailoring management to the new clinical scenarios, in accordance with the preferences, values and wishes of the resident and their families. Future care planning should occur soon after admission into an aged care service and be repeated at key timepoints during admission such as when new clinical symptoms occur, after hospital admissions or when functional ability starts to decline. This planning should include both clinical care planning and advance care planning in conjunction with the persons' caregivers/family.

A service model needs to address the following issues (which are aligned with the recommendations in the *'Palliative Care Service Development guidelines (2018)'*:

- Minimal training and continual professional development for RACF and general practitioners in palliative care;
- Capacity to assess the need for, administer and monitor effectiveness/side effects of S8 and S4 medications 24 hours a day;

[2] ANZSPM submission to Department of Health on proposed formation of Specialist Dementia Care Units (SDCUs), January 2018. Available at http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1555468379&sid=

[3] [3] https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-Service-Delivery-2018_web-1.pdf

- Palliative Care can be delivered and adjusted due to changing needs 24 hours a day (with level of service dependent on complexity of need);
- Access to specialist palliative care, dementia, geriatric and/or aged care psychiatry clinicians are essential for those with more complex clinical issues and should have provision for onsite or telehealth clinical assessment. ANZSPM notes that the current funding model for telehealth limits innovative models for RACF specialist support if the geographic distance parameters are not met.

ANZSPM recommends that staff and general practitioners working in residential aged care should be required to receive training in recognising end-of-life and safe palliative care management including symptom management, rationalisation of medications and anticipatory prescribing for predicted symptoms for residents who have palliative care needs and for those who are at the end of life. This may include anticipatory prescribing of opioids and medications to ease distress, pain, nausea and seizures when residents become too weak to swallow. Equipment including syringe drivers and subcutaneous appropriate needles should be available at the RACF. Additionally, subcutaneous medications commonly used in end-of-life care must be readily available after prescription (including after-hours access to pharmacist services or storing of medications safely on-site). In the context of after-hours (24/7) access, ANZSPM suggests addressing access to timely administration of breakthrough medications for control of symptoms. It is concerning that where RACFs have only an on-call registered nurse after hours rather than on-site, patients requiring PRN medications after hours or over the weekend have to wait for the on-call RN to be called in to administer the medications. An adequate RACF model must include capacity to assess the need for, administer and monitor effectiveness/side effects of S8 and S4 medications 24 hours a day.

What is needed to ensure greater uptake of in reach health services (such as specialist palliative care) and aged care specific services (such as Severe Behaviour Response Teams and Dementia Behaviour Management Advisory Services)?

ANZSPM supports the consultation paper's recognition of the need for improved access to specialist expertise as well as in reach services. ANZSPM believes that all patients in RACFs require a patient-centred approach to their care. Residents need access to allied health and therapies which encourage social engagement in a safe environment, as well as physical and emotional well-being. Consideration should be given to resident's "physical, psychological, cultural, social and spiritual experiences and needs" as stated in the National Palliative Care Standards[4]. RACF staff, attending GPs and other health professionals should be conversant with the National Palliative Care Standards with regards to delivering care that is patient-centred, appropriate to the needs of family and carers, and inclusive of bereavement care.

Uptake of in-reach services requires:

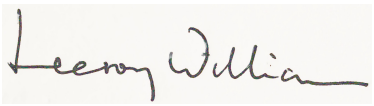
- The assessment skills of onsite staff to be at a mandatory level such that recognition of the need for specialist input occurs in a timely manner;
- A regular assessment model needs to be in place;
- The receiving teams also need to have adequate staffing numbers to meet need, an employment structure which allows RACF visits and sees these as an important part of the service (this is a limitation for some specialist services which are state/territory hospital located) and referral systems that allow a timely response (for example flying squad models);
- A coordinated model which can allow integration of Commonwealth and State funded services will need consideration;

[4] Department of Health (2019): National Palliative Care Strategy 2018. Available at: https://www.health.gov.au/sites/default/files/national-palliative-care-strategy-2018.pdf (accessed January 2020)

- In-reach services need comprehensive clinical information and the ability to assess the resident.

We would be happy to provide further information in regard to our submission should this be of assistance to the Commission.

Yours sincerely,



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