

Palliative Care

Service Provision in Australia: A Planning Guide

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Service Provision in Australia: A Planning Guide

2nd Edition

contents

Foreword	6
Introduction	7
What is palliative care?	8
Definitions	10
What these guidelines aim to do?	10
Essential elements in a service system	11
Quality and standards	11
Consultation and coordination	11
Patient access to support	12
Continuity and coordination of care	12
Public health initiatives	13
Discharge planning	13
Bereavement support	14
Education	14
Staff support	15
Research	15
Respite care	16

Settings of care	17
Community settings	17
Inpatient designated palliative care beds	18
Acute hospitals	19
Rural and remote areas	20
How many people might require palliative care?	21
Paediatric palliative care needs	22
Other factors that determine staffing levels	23
Staff planning guidelines	25
Medical	26
Nursing	27
Allied health	28
Volunteers	30
Administration	31
Conclusion	32

Organisations which endorse this Planning Guide:

Australasian Chapter of Palliative Medicine - RACP
Australian and New Zealand Society of Palliative Medicine
Australian Council of Social Service
Australian Division of General Practice
Australian Pain Society
Australian Day Surgery Council
Australian Society for HIV Medicine
Breast Cancer Network of Australia
Cancer Nurses Society Australia
Carers Australia
Catholic Health Australia
Clinical Oncological Society of Australia
Haematology Society of Australia and New Zealand
Medical Oncology Group of Australia
Occupational Therapists Australia
People Living with HIV/AIDS
Pharmacy Guild of Australia
Royal Australasian College of Surgeons
Royal College of Nursing Australia
Speech Pathology Australia
The Cancer Council of Australia

foreword

The Council of Palliative Care Australia is pleased to present a national consensus document, *Palliative Care Service Provision in Australia: A Planning Guide 2nd Edition*. This document has been developed in consultation with the members of PCA, key stakeholders, and other organisations.

This Planning Guide is provided to influence palliative care service delivery and improve patient and carer needs over the next decade. It outlines the minimum professional staffing needs required to ensure that palliative care is provided to those people with life-limiting illnesses who need it.

As in the first edition, this Planning Guide needs to be read in conjunction with the current *Standards for Palliative Care Provision*^a and considered within the context of health service planning in each region of Australia. In order to maintain a clear focus, these guidelines refer only to the human resources needed for specialist palliative care provision in Australia at a population level. Support services, and other infrastructure requirements are not included.

It is also assumed in the Planning Guide that there is a resourced and available, general practitioner and community nursing workforce available. PCA advocates that good palliative care can be provided to patients at home by this workforce, supported by a palliative care team, with access to facilities when required.

Palliative care services continue to develop throughout Australia, and the Planning Guide will be updated to reflect this particularly as evidence-based advances are achieved. It will also need to take into consideration changes in primary healthcare levels. However, PCA anticipates this guide will provide a foundation for service planning in the next ten years.

PCA looks forward to working with everyone interested in achieving its vision of *the best palliative care for all Australians who need it* and therefore commends this document to you.

Professor David Currow
President

introduction

Palliative care services have developed in Australia, as they have throughout the world, based on the models that were preferred by local clinical and community leadership and the resources made available by the health care system and/or the community. As more palliative care services have been introduced, and have become part of the health care system, the resources allocated have either been determined by what other similar services have, or what the funders believe they can afford. To date, there have been no guidelines to provide a basis for planning palliative care services.

Lack of such guidelines is problematic for funders and providers of services, as well as health service planners.

Palliative Care Australia is concerned that all Australians have equitable access to the best possible palliative care and that this should not be undermined in any way by where a person lives. So, what kind of resources would be required to provide a consistent standard of palliative care throughout this country?

How much palliative care service provision do we need? What is the workforce we would need to plan for? What kind of structures would need to be in place to make equitable access possible?

The guidelines in this paper are based on a population health approach, and do not provide detailed guidance for resource allocation for various service models which currently exist. When giving consideration to these guidelines, it will be important to be aware that in many instances, existing palliative care services are provided with considerably less resources than recommended by PCA.

This is not to suggest that such services are substandard in any way, but rather it provides the basis on which a service can review its role in the community it serves, and determine the steps and resources that might be required to reach a greater proportion of patients who might benefit from palliative care, or better address the needs of the people they already see, or both.

What is palliative care?

Palliative care is care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure, and for whom the primary treatment goal is quality of life.

Dying is an integral and inevitable part of life, and quality palliative care helps to enable people to die with dignity and in a setting of their choosing¹. People's needs vary widely as death approaches, but commonly include the need to understand what is happening, resolve issues with family and friends, achieve a sense of completion emotionally and spiritually, and come to terms with significant life changes. Palliative care can support this process by relieving pain and other symptoms, addressing practical and financial problems, and providing appropriate psychological, social and spiritual support.

Palliative care is interdisciplinary care, delivered by coordinated medical, nursing, allied health and social services and integrating the physical, psychological, social and spiritual aspects of care. It recognises the patient and family as the unit of care, and respects the right of each patient to make informed choices about the care they receive. It offers, through a mixture

of specialist and primary care providers, as well as community partnerships, a support system to help people live as actively and well as possible until death. Palliative care also plays an important role in helping the family cope during the patient's illness and in their own bereavement.

The World Health Organisation provides the following guidance:

“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care

¹ Steinhauser, KE; Clipp, EC; McNeilly, M; Christakis, NA; McIntyre, LM; Tulsy, J. “In search of a good death: observations of patients, families and providers”, *Ann Intern Med.* 2000 May 16 132(10):825-32

- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling if indicated
- will enhance quality of life, and may also positively influence the course of the illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”²

A systematic review of published research on the outcomes of palliative care found that, when compared to conventional care, there is evidence that specialist palliative care improves satisfaction of both patients and their carers, identifies and deals with more patient and family needs, and provides

better pain control and symptom management. Furthermore, it reduces the overall cost of care by reducing the amount of time patients spend in acute hospital settings.³

Palliative care must be an integral part of health care provision, and be readily accessible to all in Australia who need it. This document provides population-based clinical staffing guidelines to underpin such a service system. It provides for a model of care that is partnership-based and consultative in the community, and a mixture of direct and consultative care in the inpatient setting. It assumes the provision of advice and consultancy to primary health care professionals, assessment of a proportion of patients and, for those with more complex care needs, involvement in direct care.

It is assumed that the usual infrastructure requirements such as buildings, vehicles, facilities, and the relevant management, administrative and support staff will be included in service level planning, but these needs are not addressed in this document.

For the purposes of this document, the following terms are used to narrowly define care providers and services.

² World Health Organisation Definition of Palliative Care 2002

³ J Hearn, IJ Higginson. Do specialist palliative care teams improve outcomes for cancer patients? A systematic literature review. *Palliative Medicine* 1998; 12: 317-332.

Definitions

A **Palliative Care Provider** is a medical, nursing or allied health professional who provides primary care with a palliative approach to patients with a life-limiting illness.

A **Specialist Palliative Care Provider** is a medical, nursing or allied health professional, recognised as a specialist by an accrediting body (or who primarily works in palliative care if an accrediting body is not available), who provides primary or consultative care to patients with a life-limiting illness.

A **Specialist Palliative Care Service** is a service provided by a cohesive interdisciplinary network of specialist palliative care providers.

What these guidelines aim to do

The clinical staffing guidelines contained in this document provide guidance for service planning that can be applied at the national, state and territory, regional and local levels. Planners, funders and providers of palliative care services are encouraged to plan for the palliative care needs of their populations, and ensure that adequate links exist between the various service components, which will make it possible for all Australians to have access to a high standard of palliative care.

These guidelines are based on the considered view of the Council of PCA and will require validation through implementation, and outcome-focused research. As a result of evaluation and the changing healthcare environment, these recommendations may be subject to future amendment.

essential elements in a service system

Quality and Standards

Palliative care service provision should be based on a quality management approach which includes compliance with the *Standards for Palliative Care Provision*.⁴ They incorporate a number of key principles for services, each of which is briefly described below.

Consultation and coordination

Professional support networks are critical to the provision of quality palliative care.

Many terminally ill patients are appropriately cared for by primary health care practitioners, usually general practitioners and community nurses. These practitioners need to be able to refer patients to specialist services where necessary. For many patients, this will be for assessment and periodic review, with responsibility for ongoing care remaining with the primary health practitioner. For patients with more complex care needs, ongoing care may involve a specialist palliative care service in conjunction with the primary health care service.

Guaranteed 24-hour access to support, advice and consultation from specialist palliative care services is essential to

ensure the quality and consistency of such care, and build practitioners' skills and confidence. Regular contacts between specialist palliative care services and primary health providers will support these processes and reinforce appropriate and timely referral patterns.

In many rural and remote areas, palliative care providers, often part-time palliative care nurse coordinators, have been asked to work in isolation. All palliative care providers should have guaranteed and formalised links with a comprehensive specialist palliative care service. Every palliative care provider should be able to identify a full network of specialist palliative care service providers (medical, nursing, allied health, psychological support and counselling etc) for support, advice and consultation, even if not in close geographical proximity. No palliative care practitioner should be working in isolation. Specialist palliative care services should be responsible for supporting such arrangements, but these initiatives will need to be initiated and supported by government policy and funding.

⁴ Palliative Care Australia, *Standards for Palliative Care Provision* 3rd Edition, 1999

Patient access to support

Care planning for each patient receiving palliative care, whether from a specialist or a generalist service provider, must include 24-hour access to appropriate advice or service provision to cope with emergency or crisis situations or to provide advice to primary care services. 24-hour access is required for the *admitted patients and families*⁵ of a service and their primary carers (family or other), *not* for new referrals or the general public.

A system-wide infrastructure of established links needs to be in place across the specialist palliative care and primary care service systems (eg involving local hospitals, general practitioners, nurses, specialist metropolitan palliative care services, etc) to support planned care and 24-hour access for patients, and families through their health professionals.

Continuity and coordination of care

Patients and families need to experience a seamless service system, with smooth and timely transitions from one service or element to another. This includes:

- timely referral to a palliative care service (preferably not in crisis);
- speedy and straightforward admission to appropriate inpatient care where this is needed;
- speedy and straightforward transfer from acute care to an appropriate palliative care service setting, where this is needed;
- continuity of clinical and allied health carers across the various care settings; and
- coordination of care with other medical, health and community services.

⁵ Admitted patients are those who have been assessed, accepted as a patient, and registered with a palliative care service.

Public health initiatives

An essential element of both patient access to support and the delivery of a seamless service system is the successful provision of public health initiatives. These are also known as health promotion offerings or approaches. Public health initiatives consist of organised social efforts by government and health services, in partnership with communities, to improve health and lessen disease. In recent times, these efforts have occurred through public education, community development, the enactment of laws, and the creation of safe and supportive environments. These types of initiatives are important components in the provision of any comprehensive medical and health service. A public health approach in palliative care is no exception to this contemporary philosophy and includes:

- *community development* to involve schools, churches, clubs and workplaces in the care of those living with loss, life-threatening illness and caregiving
- *community education* in death, dying, loss and caregiving
- *prevention strategies* aimed at the social morbidities associated with living with loss, life-threatening illness and caregiving (eg depression, social stigma and rejection, sexual health, domestic abuse, social isolation and stress, etc)
- *social policies, practices and advice* that assist in the creation of supportive family, work and community environments.

Discharge planning

Discharge planning is an essential part of palliative care in the inpatient setting and elements of the process will also be appropriate in the community setting. This process involves working with patient and family to help them address and adjust to their changed social and financial circumstances, negotiate benefits and other forms of welfare support, and identify and consider options open to them, as well as managing the clinical aspects of care.

Bereavement support

Bereavement support is a core component of a palliative care service, available to all relevant family members, both before and after the patient's death, to support them through the acute phase of grief. It includes routine and ongoing risk assessment. Palliative care services also need to create partnerships with local community networks to enhance bereavement support. People with complicated grief or prolonged needs may need to be referred to specialist bereavement counselling or psychiatric services.

Education

The staffing guidelines in this document cater for direct clinical service provision and training. Planning also needs to make provision for education, including formal as well as informal in-service education, and involvement in undergraduate and post-graduate academic education across the fields of medicine, nursing and allied health. This involvement is essential to support the ongoing provision and improvement of palliative care services.

Up-skilling of primary health care practitioners is also a pivotal role for specialist palliative care services. Much of this will occur informally, through the provision of consultancy and advice.

Staff support

Work in palliative care is challenging and demanding. It is therefore imperative that staff are adequately supported in reflecting on their practice and in dealing with emotional and spiritual issues. This should be part of routine staff support, not just a response to crisis. Such support needs to be adequately resourced.

Research

The larger, (usually metropolitan-based) comprehensive specialist palliative care services should be adequately resourced to initiate and/or participate in research in palliative care.⁶ Education and research are the most important platforms from which the quality of palliative care available to all Australians will be improved. The advancement of scholarly knowledge within the field has been predicated upon a synergistic relationship between research and practice. Research in the palliative care setting encourages a high practice standard and decreases isolation in practice. A community-based service research strategy should devise methods for enabling therapeutic and theoretical advances to be made, and should support a coordinated funding and publication resource. Research should be linked to the education (page 14) and staff support provisions discussed previously (page 15), as well as academic/teaching facilities, and local providers.

⁶ Separate consideration should be given to data collection and management. Contemporary service allocation policy demands the collection of data as a feedback mechanism for justifying funding allocation and responsible use. The data collection function, particularly as a **clerical capacity**, must be funded appropriately through a percentage EFT allocation within each setting. Clinicians no longer have the capacity to undertake these tasks and their use as data managers is not a sound use of comparatively expensive resources. Collection of research data should be project funded.

Respite Care

Supporting families and friends to provide care in the community requires health services to have flexible and committed resources to provide timely breaks for carers. Ideally a choice should exist for respite care to be provided in the patient's home or in an appropriately skilled inpatient unit or day respite facility at no cost to families or the patient. The resources required to provide day respite facilities are not addressed within this document.

settings of care

Palliative care service provision occurs across three settings:

- community settings
- designated palliative care beds in hospices
- acute hospitals.

Palliative care is provided in the environment of the patient's choice, where possible. Some people in the course of their illness will receive palliative care in all three settings, whilst others may be seen in only one setting, depending on their needs.

Quality of care is enhanced when patients are able to be seen by the same staff across the various settings of care. This Planning Guide supports a model of care that facilitates continuity of care.

Community settings

Community settings include the patient's private home or a community living environment such as an aged or supported care facility. Home is the setting in which many people choose to receive care, and in which a significant proportion prefer to die. Resource allocation at a community service level will need to consider issues such as travel time, difficulties locating the patient, the provision of health promotion initiatives, and so on.

In the tables that follow staffing levels have been specified per 100,000 population. This figure may need to be modified to accommodate geographical or local community issues (e.g. rural and remote or disadvantaged communities).

Inpatient designated palliative care beds

Inpatient beds used specifically for palliative care patients may include a variety of configurations and settings including beds in a rural community hospital, designated beds in a teaching hospital or a purpose-built hospice.

In the tables that follow staffing levels have been specified per 5 beds.

Previous crude estimates of the requirement for palliative care beds were thought to be based on models from the United Kingdom, which not only excluded patients with a non-malignant disease from hospices, but also were based on a different culture and health system. Australian experience over more than 20 years has allowed appropriate refinement. It is estimated that in a population of 100,000, 295 patients will require an average of 7 inpatient palliative care bed days each year.⁷ Based on an occupancy level of 85%, a minimum of 6.7 designated palliative care beds is recommended per 100,000 population.

The minimum levels specified above will need to be supplemented with additional resources in rural and remote areas, to ensure ease of geographical access; in lower socio-economic areas, where lower income and workplace inflexibility are more likely to limit the ability of family/carers to provide home-based care; and for people with more complex needs, e.g. complex care issues for those with advanced HIV/AIDS or MND.

These recommendations are for specialist palliative care inpatient beds and assume that as patients are stabilised they will return to more appropriate levels of care-discharge to home under community palliative care providers, transfer to an aged care facility or other sub-acute clinical environments.

⁷ The average length of stay per episode is about 14 days, however, it is expected that not all patients will require inpatient care. Therefore, the recommendation of 6.7 designated palliative care beds is conservative.

Acute hospitals

A significant proportion of anticipated deaths still occur in acute hospitals and many patients are identified as needing palliative care while in an acute hospital. Some will also be admitted during the course of palliative care to receive treatment for an acute medical or surgical condition, or for symptom control. For many patients, particularly those with cancer, the initial diagnosis, or the recognition that cancer has recurred or is now progressive occurs at a hospital or outpatient clinic. The availability of specialist palliative care practitioners within hospital and clinic settings is likely to increase the timeliness and rate of referral to palliative care services and to improve the symptomatic management of these patients.

Allied health staff with specific interest and skills in palliative care need to be designated to have specific responsibilities for addressing the needs of these patients.

Specific roles for palliative care in the acute setting include:

- assessment, symptom management and consultation;
- discharge planning for all palliative care patients; and
- education of health care providers throughout the hospital.

To be considered as providing comprehensive cancer care, every cancer care centre must have active, interdisciplinary specialist palliative care service participation.

Rural and Remote Areas

For about a quarter of the Australian population, home is in small towns, or isolated communities. Many people prefer to receive their care at the end of life in familiar surroundings. For Indigenous Australians it is important to return to spiritually meaningful places when facing death, even though this may require considerable travel and upheaval for both patients and carers.

Health care in rural and remote settings is provided by primary health carers, who require appropriate support for their various specialised roles.

Individual health care practitioners in these areas may not be required to provide palliative care very often, sometimes as infrequently as once or twice per year. In order to provide a high standard of palliative care, local health care workers need access to specialist palliative care providers who can assist with the development of an appropriate care plan, including clinical

management. Timeliness and good anticipatory management is an important consideration, as supplies of medications and equipment may take considerable time to be transported.

To facilitate timely access the rural or remote health service should have a formal service agreement with a specialist palliative care service. This will assist with building the relationships and understanding needed to provide advice appropriate to the circumstances of the patient and the health care practitioners, and the opportunity to build on local knowledge and skills as these develop.

how many people might require palliative care?

The clinical staffing guidelines are based on a number of assumptions and estimates. In relation to activity and appropriate use of resources it has been determined (based on best available empirical evidence) that palliative care services should be involved in:

Cancer patients

- The assessment of 90% of patients within the area that die from cancer
- An ongoing consultative capacity for approximately 70% of cancer patients
- Direct care for 20% of cancer patients.

Non-cancer patients

- Referral for assessment of 50% of patients expected to die from non-malignant diseases
- An ongoing consultative capacity for 30% of these
- Ongoing direct care for 10% of these.

Current data on cancer and non-cancer deaths demonstrates that there are approximately 187 deaths from cancer and 187 expected deaths from other causes per 100,000 population per year progressive predictable life limiting illness.

Table 1: Current and expected deaths per 100,000 population and referrals to palliative care services annually

Diagnosis Group	Actual Deaths	Current referrals per 100,000	Recommended referrals for assessment per 100,000	Ongoing consultancy per 100,000	Direct Care per 100,000
Cancer	187	94-168 (50 - 90%)	168 (90%)	131 (70%)	37 (20%)
Non-Cancer	187	17-30 (9 - 16%)	94 (50%)	56 (30%)	19 (10%)
TOTAL	374	111-198	262	187	56

As there is clearly a gap between the current referral rates and those anticipated using contemporary estimates, adoption of these baseline figures for planning and resources in clinical palliative care services will need to be progressive and subject to ongoing review and refinement.

Palliative care services should be provided within a service system that aims to achieve a smooth transition or overlap between curative treatment and palliation. Palliative care services planning should be based on the expectation that a median and average time from referral to death is six months for the population as a whole.

There are other factors that govern the number of staff, staffing ratios and range of services and expertise required in a specialist palliative care service.

Paediatric palliative care needs

Health care planners at the state and territory level should be aware that children who are dying (and their families) have particular needs often different to those of adults.

The duration of life-threatening illness of a child is significantly longer than that of an adult and in some cases could be 15 or more years. During this period care needs will vary considerably, but will include periods where intensive medical and therapeutic support is required, eg cystic fibrosis. Care needs can be predicted to increase over time where children have chronic progressive disorders such as muscular dystrophy.

Grief and loss counselling and bereavement support in paediatric palliative care is an important component of care which requires specific expertise.

Overall, specific consideration needs to be given to the care requirements of children with a progressive terminal illness and the needs of their families. Specialised services, and additional resources will be needed to support the work of palliative care and primary care service providers in the paediatric setting.

Other factors that determine staffing levels

Factors which indicate potentially more resource-intensive provision of palliative care and which should inform higher staffing levels include:

- Disease/Condition (eg caring for a patient with Motor Neurone Disease is generally more resource-intensive than caring for a patient of the same age and sex with cancer)
- Demographics (younger people often require more support)
- Services where there are high numbers of admissions with patients or carers in crisis
- Time (eg above or below the average 6 months estimated duration for palliative care, the additional time in transit required due to geographic expanse)
- Special skills (for condition-specific treatment eg HIV/AIDS)
- Number of individuals dying without spouse/partner, carer or in-home support
- Infrastructure limitations (such as geographic spread of services)
- Cultural differences (cost of providing interpreters and longer consultations required)
- Differences in family support required
- Distance and remoteness may also influence staffing levels. In particular, some economies of scale may not be achievable in services catering for small populations spread over wide geographical areas, and higher staffing numbers may be needed
- Level of public health commitment/initiatives (facilitating community awareness, development, education or partnerships as well as staff training for these activities)



staff planning guidelines

The following tables provide staffing levels using a population based approach. Specific levels for specialist staff are given and are expressed on a per 100,000 population basis to allow them to be interpreted and applied at a local level, taking into consideration local issues and requirements.

The guidelines assume that the palliative care service will be working alongside the referring service. The guidelines also acknowledge that the specialist palliative care service will have varying levels of involvement with patients, and that the involvement with any particular patient may vary over time in conjunction with the changing level of their need.

Day centres have not been a central part of palliative care service provision in much of Australia, and appropriate staffing profiles are yet to be defined. Whilst a desirable addition to the palliative care service system, day centres have not been included in the following tables, thus establishment of a day centre would be expected to require additional staffing.

The guidelines relate only to clinical staffing and specialised palliative care support positions. They do not cover infrastructure resources such as administration and hospice services staff, capital requirements such as buildings, computers, cars, and so on.

The clinical staffing guidelines presented here are based on the long-standing and well accepted recommendations that specialist palliative care must be provided through an interdisciplinary team framework. This requires more than the medical and/or nursing staff that are currently provided in some areas.

These guidelines provide descriptions of the role and function of each of the disciplines included and make recommendations for the levels of staff required, based on the population based formulae discussed above.

Where there is an expectation that members of the discipline will function across all service settings a single staffing estimate is given. Where it is usual for staff to function within one setting, different levels have been given for each such setting.

Medical

Quality of care for palliative care patients is dependant upon access to specialised palliative care medical practitioners. In addition, a number of advanced training positions must be made available to ensure the ongoing development of the specialty and to enable future clinical service requirements to be met.

Specialist palliative care medical practitioners provide consultancy to general practitioners, to other specialists (eg physicians and surgeons), may provide support and supervision for other members of the interdisciplinary team and contribute to education and research to improve the quality of palliative care.

Table 2: Medical staffing levels for palliative care services per 100,000 population

Positions	Community-based service*	Acute hospital consultative service**	Palliative care designated beds***	Comments
MEDICAL				
Palliative care specialist	←	1.5	→	Specialist and registrar positions have both community and inpatient responsibilities.
Registrar	←	1.0	→	
Resident medical officer	–	–	0.25	Resident positions attached to designated palliative care beds only.
Liaison psychiatry	←	0.25	→	It is expected that between 30 - 50% of referrals will have a diagnosable mental illness.

* EFT per 100,000 population

** EFT per 125 beds

*** EFT per 6.7 beds (within acute hospital, hospice etc)

Nursing

Specialist palliative care nurses provide both direct care and consultative services to palliative care patients and their informal and professional carers.

The clinical nurse consultant in a specialist palliative care service provides consultative support to generalist community and acute care nurses, provides direct care to patients with complex needs and contributes to

the undergraduate and postgraduate training of nurses and others.

Skill mix within designated units should take into account the level of dependency of patients, the complexity of needs and the availability of allied health support.

A significant proportion of registered nurses in all settings should have postgraduate training in palliative care.

Table 3: Nursing staffing levels for palliative care services per 100,000 population

Positions	Community-based service*	Acute hospital consultative service**	Palliative care designated beds***	Comments
NURSING				
Clinical Nurse Consultants (CNC)	1.0 plus 2 Clinical Nurses	0.75		Community and acute care consultation teams require CNC level nurses to act independently, provide consultation to primary carers (nursing and medical), and to coordinate, monitor and review patient care. Clinical Nurses are senior palliative care nurses who work under the direction of the CNC.
Registered and enrolled nurses			6.5 hours per patient per day	Designated palliative care beds require a mix of direct care. This care will include CNC, Clinical Nurses, RN and EN level staff, with a predominance of RNs over ENs. Patient carers may also be part of the staff mix.
DISCHARGE LIAISON	←	0.25	→	This role could be included in a nursing or social work position.

* EFT per 100,000 population

** EFT per 125 beds

*** EFT per 6.7 beds (within acute hospital, hospice etc)

Allied Health

Palliative Care Australia endorses international expert opinion that interdisciplinary palliative care teams comprising allied health personnel in addition to medical and nursing staff are an essential component of comprehensive quality palliative care for all.

In the acute hospital setting, allied health staff need to be specifically designated as part of the palliative care team, rather than a rotation as part of an existing hospital department.

The professional mix may vary depending on the skills and training of

individual team members, however the allied health team must be able to provide:

- psychological support;
- group and family work with patients or in bereavement;
- social support include public health initiatives;
- team support and development;
- practical, financial and social reorientation and benefits;
- discharge planning; and
- bereavement, assessment, referral and support.

Table 4: Allied health staffing levels for palliative care services per 100,000 population

Positions	Community-based service*	Acute hospital consultative service**	Palliative care designated beds***	Comments
ALLIED HEALTH				
Psychology	0.25	0.1	0.1	
Social work	0.5	0.25	0.25	
Bereavement support	0.25	0.1	0.1	
Pastoral care	0.25	0.25	0.25	Pastoral carers offer spiritual support that is quite distinct from the psychological and social support offered by other professionals.
Speech pathology	0.2	0.2	0.2	Speech pathologists assess and treat swallowing dysfunction, and support communication skills, particularly for people with worsening physical disability.

Positions	Community-based service*	Acute hospital consultative service**	Palliative care designated beds***	Comments
Dietician	←	0.2	→	Dieticians with a particular skill and interest in palliative care can enhance quality of life by planning enjoyable and attractive food within the constraints imposed by the patient's condition.
Physiotherapy (PT)	0.4	0.2	0.2	PT and OT are valued by patients for providing practical help and positive intervention. Ideally the two will work closely together.
Occupational therapy (OT)	0.4	0.2	0.2	<ul style="list-style-type: none"> • PTs help to keep patients mobile and safe, as well as providing short-term symptom relief for people with lung congestion, etc • OTs work with both patients and carers to promote the patient's function, safety and independence in the home and hospital environment • Lymphoedema symptom relief is shared between PT and OT.
Pharmacist	–	0.25	0.1	Both of these positions would have a role in supporting the community-based team. An extensive network of community pharmacists provides valuable primary healthcare for palliative patients in the community by assisting with advice, documentation of medication histories, dosage compliance, and the disposal of medications not required.
Music therapy, art therapy, and/or massage, narrative, diversional, complementary therapies etc	0.5	–	0.25	<p>These therapies can significantly increase quality of life and provide positive, normalising activities. The appropriate mix will depend on locally available skills and needs.</p> <ul style="list-style-type: none"> • Music and art therapy are professional degree courses, and include a high level of training in psychological and communication skills. • Complementary and other therapists have widely varying levels and types of training, and practitioners' skills will vary. <p>Much can be done in these areas at a group level, rather than one-to-one contact.</p>

* EFT per 100,000 population

** EFT per 125 beds

*** EFT per 6.7 beds (within acute hospital, hospice etc)

Volunteers

The use of volunteers in various palliative care service models is both traditional and innovative. It is important to acknowledge that volunteers do not replace clinical services, but complement them. Volunteers, while unpaid, are in all other respects like other employees.

The resources needed to support volunteers are substantial. Their time is free, but not the infrastructure to support them, thus the following table is based on volunteers employed rather than population. The volunteer requirements for a palliative care service

on a population basis will vary according to the service model and local community resources and expectations.

The following staffing recommendations assume that each volunteer provides 4 hours per week, community and inpatient volunteers are providing direct patient support; and inpatient volunteers have some informal support and supervision from other professional staff. Volunteers are also crucial elements in any public health approach that involves community partnerships.

Table 5: Coordinator of Volunteers per number of volunteers employed

Positions	Community-based service	Acute hospital consultative service	Palliative care designated beds	Comments
COORDINATOR OF VOLUNTEERS	1 per 40 volunteers providing direct patient support	1 per 50 volunteers providing direct patient support	1 per 50 volunteers providing direct patient support	The role of the Coordinator of Volunteers includes: <ul style="list-style-type: none"> • providing psychological and social support as well as practical coordination and supervision • screening, recruitment, training and debriefing • attention to the specific occupational health and safety issues, together with quality of service issues, for volunteers.
	1 per 65 “process” volunteers (e.g. routine practical tasks)	1 per 65 “process” volunteers (e.g. routine practical tasks)	1 per 65 “process” volunteers (e.g. routine practical tasks)	

Administration

Administrative support is needed in all settings of care, but specific needs will vary depending on the particular service model. No attempt has been made to quantify the administrative resource requirements of palliative care services in this document, however experience suggests that palliative care services established with inadequate infrastructure and administrative support resources may either flounder, or provide inferior service as clinicians struggle to perform tasks for which they are unprepared. As noted elsewhere in this document, the use of clinicians to perform administrative support roles is an overly expensive option.

It is currently recommended that resource allocation formulae for administrative support in generalist health care settings be used to inform the requirements of palliative care services.

Conclusion

This document, some 12 months in preparation, is by no means complete or exhaustive. Palliative Care Australia acknowledges the need to monitor palliative care service development, models of care and service expansion, with particular emphasis on resultant outcomes for the Australian community.

It is our intention to complement this Guide with further discussion papers focussing on:

- The short to medium term vision for palliative care service development in Australia
- Outcome measures in palliative care, and
- Models of care delivery.

PCA is also committed to achieving endorsement for the principles embodied in this document from the broader health care sector.

Constructive comments are welcomed by PCA and should be directed in the first instance to:

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