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Senate Inquiry into Palliative Care in Australia
Parliament House
CANBERRA

Dear Senators,

My comments and those of several stakeholders on the recent Aged Care Reform Package:

The care provided for people in residential aged care is at crisis point.

The problems are:

1. There is no statutory requirement that there be registered nurses (RNs) available 24 hours a day. This means that no emergency medications or reasonably directed care is available 24 hours a day. If a patient gets into pain, breathlessness, vomiting or diarrhoea when there is no RN on duty the patient may have to wait many hours to get relief. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

2. There are no mandated minimum levels of trained (or other) staff so the skilled care of patients is inadequate. With nobody to monitor what is happening to patients medical crises arise which could have been prevented with proper care. These lead to presentations to emergency departments and lengthy hospital admissions. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

3. GPs are not visiting RACFs and, when they do, there is poor information and coordination with nursing staff because of insufficient numbers of RNs. The RNs are run off their feet the whole time. This has resulted in many GPs, who would like to look after their patients in nursing homes, giving up. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

4. Remuneration for GPs visiting RACFs is utterly inadequate. It must realistically compensate them for leaving busy surgeries to attend. Otherwise they either don't attend, or they have to rush through and give poor service to the patients. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

5. The provision of skilled palliative care assessment and treatment is not adequately funded. Palliative care services do not have adequate funding to provide specialist palliative care doctors to visit RACFs. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

6. The provision of $1.9 million over 5 years for PEPA to up-skill nursing home staff in palliative care or the palliative approach is hopelessly inadequate if it expects to give staff any proper understanding of palliative care. It would possibly allow some input into a small number of staff, but staff change so frequently that one wonders if anything would be achieved. I cannot see how it could do what is hoped for it. **THE PACKAGE DOES LITTLE TO IMPROVE THIS.**

7. $19.8 million for specialist palliative care and advance care planning advisory services to build better links between aged care and palliative care services should be spent on adequately funding existing palliative care services to allow them to visit nursing homes. This should be for medical, nursing and allied health, especially social work and psychology visits. If palliative care services were funded to each have at least one palliative care nurse practitioner to visit nursing homes in their area and establish end-of-life pathways and educate staff this would be a big step toward improving the situation. **THE PACKAGE COULD HELP WITH THIS.**

8. Because of poor staffing and inadequate medical supervision (GP, geriatric and palliative care) it all gets too much for staff and they transfer patients to emergency departments in acute hospitals. Some hospitals have adopted the excellent GRACE model to fast track these presentations from RACFs and get them back as quickly as possible with good reporting of results. This should be available at every hospital with an emergency department. **THE PACKAGE DOES NOTHING TO PROMOTE THIS SYSTEM.**

9. There is currently the situation where state governments have reduced the number of beds in hospices (palliative care units) as a cost saving measure. This means that patients who become stabilised in these units are routinely transferred to nursing homes to die. These places are totally inappropriate and inadequate to care for these complex patients at this time. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

10. Supply of private social work and psychologist services to RACFs is currently restricted by their having only a small number of visits able to be rebated. The Chronic Disease Management scheme, the only government initiative which currently funds residents in RACFs allows a maximum of 5 Allied Health Services a year. The rebate is also significantly lower

($51.95) than through other initiatives (such as Better Access Initiative where psychologists can claim $104.55 for out-of-rooms consultations), (still well below the recommended hourly rate set by the Australian Psychological Society of $218 per hour). This significantly lower rebate forces psychologists to either charge patients in palliative care with out-of-pocket expenses and/or to only provide services in consulting rooms. **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

The item numbers for mental health interventions should also include aged care interventions. Both psychologists and social workers can do a great deal to help these patients with coordination of care. "A range of initiatives to encourage aged care providers to enter into partnerships with public and private sector health care providers for delivery of short term, more intensive services." **SOUNDS GOOD. PRIVATE PSYCHOLOGISTS AND SOCIAL WORKERS COULD DO A LOT TO ASSIST.**

11. Carers of dying patients in the community desperately need access to respite beds for a few days break. Then they can go on caring at home for longer. A great cost saving measure! **THE PACKAGE DOES NOTHING TO CORRECT THIS.**

12. RNs in RACFs have to spend too much of their time doing administration tasks. There is an urgent need for more bedside nurses, not more nurses as administrators. **THE PACKAGE COULD MAKE THIS SITUATION MUCH WORSE**

<u>Recommendations:</u>

1. Mandated levels of staffing both RNs, ENs and assistants for all RACFs.

2. Mandated 24 hour cover with RNs.

3. Stop trying to solve the problem with GPs. This is now out-dated. For those few who remain interested in doing visits to RACFs the Commonwealth needs to trebble or quadruple the rebate for nursing home visits for GPs.

4. Medicare item numbers for practice nurses to visit RACFs. They can then liaise with their GP and palliative care and geriatric specialists.

5. Create a separate category of GPs, with increased training in aged care including geriatrics, psych-geriatrics and palliative care such as the proposed masters degree in palliative care of Prof Chris Poulos's faculty, University of NSW. This would go with increased item numbers for these

more highly qualified and specialised GPs. Knowing better what they are doing would give GPs better job satisfaction and sense of mastery. Otherwise the whole situation is utterly depressing.

6. Every palliative care service must be adequately funded and required to provide palliative and end-of-life care for residents of RACFs. This includes medical, nursing and allied health services, especially social work.

7. Every Palliative care service should have a nurse practitioner designated to prepare EOL pathways for all RACF patients approaching the end of life.

8. Increase the beds in hospices to allow them to continue to care for palliative care patients and not transfer them to nursing homes.

9. Establish the GRACE system for triage and management of RACF presentations in every hospital with an emergency department.

10. Fund States to allow them to increase beds in hospices to stop the transfer of their patients to nursing homes and fund these hospices to have step-down units where longer-stay patients can be monitored by palliative specialists such as that in HammondCare's palliative care suite model.

11. Fund RACFs to have palliative care suites such as HammondCare's model Bond House. In this the patients are monitored by specialist staff from a nearby palliative care service and the service is overseen by a palliative care trained RN.

12. Fund palliative care services to follow up their patients transferred to nursing home as in Calvary's social worker-driven model (Kogarah, NSW).

13. Fund psychological and social work services in line with Better Access initiatives, which doubles the rebate of Chronic Disease Management initiative, allowing up to 10 sessions per annum. Psychologists and Social Workers can also provide education and training to staff in RACFs in how to best look after the wellbeing needs of residents in palliative care as well as assist these patients with coordination of their care. Without the support from the Government in introducing a new range of initiatives to encourage aged care providers to engage with private health care providers this goal will not be achieved.

14. Make respite beds available for patients dying in the community to give carers a break - A cost saving measure!