Service Principles

Specialist Palliative Care in Aged Care (SPACE) Project

Under the Specialist Palliative Care in Aged Care (SPACE) Project, Queensland Health Hospital and Health Services (HHSs) have been allocated funding to improve equitable access to specialist palliative care support in residential aged care (RAC). Each HHS will develop and implement a model appropriate for the local context; however, each model must align with a set of consistent core service principles. The models will support the provision of best practice specialist palliative care in line with the *National Palliative Care Strategy 2018* and the *Aged Care Quality Standards*.

Service principles

Streamlined service

- Connect all RAC providers within the HHS with a single point of contact to support their clinical decision-making in relation to specialist palliative care.
- Communicate clear guidelines and referral pathways that clarify roles, responsibilities and referral processes to all local service providers.
- Collaborate with existing services (e.g. RACF Acute care Support Services (RaSS) or equivalent), RAC staff, General Practitioners, Queensland Ambulance Service, and other members of the care team to deliver a streamlined, comprehensive service with clear governance structures.

Comprehensive, resident-focused, whole person care

- Develop and communicate a shared comprehensive care plan (including plans for deterioration) in partnership with the resident/substitute decision-maker/family members and carers, General Practitioner, RAC staff, and other members of the care team.
- Advocate for residents' care wishes, including spiritual, cultural and relational needs, and incorporate these into care planning.
- Provide a team assessment service (mobile and/or virtual) that enhances choice of care setting for residents.
- Integrated, holistic, equity-oriented care across settings with timely, standardised communication.
- Collaborate with RAC providers to implement advance care planning processes, including discussions, development, sharing and review of advance care planning documents.

Capacity building

- Build capacity of RAC staff and/or General Practitioners through formal and/or informal education, knowledge exchange, and upskilling.

Supporting activities

The below table provides more information about specific activities HHSs may wish to include in the SPACE models to meet the service principles.

Service principle	Supporting activities
Streamlined service • Connect all RAC providers within the HHS with a single point of contact to support their clinical decision-making in relation to specialist palliative care. • Communicate clear guidelines and referral pathways that clarify roles, responsibilities and referral processes to all local service providers. • Collaborate with existing services (e.g. RACF Acute care Support Services (RaSS) or equivalent), RAC staff, General Practitioners, Queensland Ambulance Service, and other members of the care team to deliver a streamlined, comprehensive service with clear governance structures.	- *Provide a single point telephone triage service for RAC providers (incorporated into RaSS triage service where feasible) to support clinical decision-making. Consider after-hours support* - *Develop referral pathways to virtual specialist palliative care services in rural and remote settings* - *Develop shared understanding and role clarification between specialist palliative care service and RAC e.g. RAC staffing profile and skill mix, RAC environment, General Practitioner rounds, specialist palliative care service operating hours* - *Establish a process for holding regular multidisciplinary case meetings with teams from different services and healthcare settings* - *Communicate referral processes and service responsibilities of SPACE model to RAC providers and Queensland Health services (e.g. Emergency Department, inpatient wards) through resources such as a website, brochures, flyers, and information sheets*
Comprehensive, resident-focused, whole person care • Develop and communicate a shared comprehensive care plan (including plans for deterioration) in partnership with the resident/substitute decision-maker/family members and carers, General Practitioner, RAC staff, and other members of the care team. • Advocate for residents' care wishes, including spiritual, cultural and relational needs, and incorporate these into care planning. • Provide a team assessment service (mobile and/or virtual) that enhances choice of care setting for residents. • Integrated, holistic, equity-oriented care across settings with timely, standardised communication. • Collaborate with RAC providers to implement advance care planning processes, including discussions, development, sharing and review of advance care planning documents.	- *Facilitate direct admissions when inpatient care is required* - *Develop processes for the early identification and resolution of potential barriers to discharge following an inpatient admission* - *Provide structured transfer-of-care communication to RAC staff and General Practitioners when inpatients are discharged from hospital* - *Provide routine follow up post-discharge to ensure resolution of care need, fulfillment of required referrals and identification of any complications* - *Link in with virtual services, such as statewide specialist palliative care outreach services or multidisciplinary team meetings, as appropriate* - *Promote development of Advance Care Planning documents and end-of-life planning* - *Assist RAC providers to develop Advance Care Planning policies and procedures in line with Queensland legislation and national and state guidelines Support RAC providers to establish systems and processes that enable all relevant staff to retrieve, review and use Advance Care Planning documents, including promotion of Health Provider Portal registration by RAC GPs and nurses* - *Advance Care Planning conversations and reviews are integrated into all stages of care delivery* - *Support RAC providers to develop clinical governance processes that facilitate improved understanding and quality of palliative and end-of-life care provided within their facilities*

Service principle	Supporting activities
Capacity building • Build capacity of RAC staff and/or General Practitioners through formal and/or informal education, knowledge exchange, and upskilling.	- *Identify priority areas for education via a learning needs assessment* - *Support RAC providers to develop and implement education plans to ensure staff can access relevant education* - *Explore innovative ways of delivering education and capacity building activities* - *Engage with statewide Queensland Health services (e.g. Office of Advance Care Planning, Centre for Palliative Care Research and Education)* - *Promote evidence-based resources (e.g. End of Life Directions for Aged Care, palliAGED, CareSearch)* - *Consider clinical and non-clinical staff in education plans, including nursing staff (Registered Nurses, Enrolled Nurses, Assistants in Nursing), support staff (Personal Care Assistants, First Nations Health Workers), and after-hours General Practitioners*

Definitions

Term	Definition
Advance care planning	The process of planning for future health and personal care, whereby the person's values, beliefs and preferences are made known so they guide decision-making at a future time when that person cannot make or communicate their decisions.[1] Queensland Advance Care Planning forms include the Advance Health Directive (AHD), Statement of Choices, Enduring Power of Attorney (EPOA) (Short and Long), EPOA revocation, and AHD revocation.
End-of-life care	Care needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness, frailty or old age. Many experience rapid changes and fluctuations in their condition and require support from health services, family and carers.[2]
Palliative care	An approach that improves the quality of life of patients, their carer/s and family members facing problems 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.[2] ***Specialist palliative care*** is provided by a professional palliative care team or service with recognised qualifications or accredited training in palliative care, providing consultation services to support, advise, educate and mentor specialist and non-specialist teams to provide end-of-life and palliative care and/or to provide direct care to people with complex palliative care needs.[2] ***Generalist palliative care*** is provided as part of standard clinical practice by any healthcare professional who is not part of a specialist palliative care team. In the community, this includes general practice teams, allied health teams, and RAC staff. Providers of generalist palliative care have defined links with specialist palliative care teams for support and advice, or in order to refer people with complex needs.[3]
Relational needs	A person's unique needs with respect to their relationships with others. It is important that the people who are significant to the resident are included and recognised in their healthcare. Use a culturally safe, inclusive approach that considers the interpersonal needs of all residents including those who identify as LGBTQI+.
Residential aged care	Residential aged care (RAC) is for senior Australians who can no longer live in their own home. It includes accommodation and personal care 24 hours a day, as well as access to nursing and general health care services.[4] The following types of RAC in Queensland are in scope for the SPACE project: • Commonwealth Government-subsidised RAC facilities (both public and private) accredited through the Aged Care Quality and Safety Commission • Queensland Health Multi-Purpose Health Services • National Aboriginal and Torres Strait Islander Aged Care Programs
Substitute decision-maker	A substitute decision-maker is a general term used to describe a person who has legal power to make decisions on behalf of an adult when that adult is no longer able to make their own decisions.[5]
To palliate	To make a disease or its symptoms less severe without removing the cause.[2]

[1] Aged Care Quality and Safety Commission. (2020). *Glossary of Terms, Acronyms and Abbreviations.* https://www.agedcarequality.gov.au/resources/aged-care-quality-and-safety-commission-glossary
[2] Palliative Care Australia. (2018). *National Palliative Care Standards 5th Edition.* https://palliativecare.org.au/standards
[3] Gold Coast Health and Gold Coast Primary Health Network. (2018). *Palliative Care Model of Care.*
[4] Australian Government Department of Health. (2020). *About Residential Aged Ccare.* https://www.health.gov.au/initiatives-and-programs/residential-aged-care/about-residential-aged-care
[5] Office of Advance Care Planning. (2020). *My Care, My Choices: Advance Care Planning – FAQ.* https://metrosouth.health.qld.gov.au/acp/faqs