ANZSPM

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

Royal Australian College of General Practitioners
[By email: standardsforracf@racgp.org.au]

12 November 2019

Dear Sir/Madam,

ANZSPM feedback on draft RACGP Standards for general practice residential aged care

The Australian and New Zealand Society of Palliative Medicine (ANZSPM) appreciates the opportunity to make a submission to the Royal Australian College of General Practitioners (RACGP) with respect to its draft Standards for general practice residential aged care (the draft Standards).

ANZSPM has consulted with members working in residential aged care facilities (RACFs) to provide feedback to RACGP on the draft Standards, which was broadly supportive. General feedback included positive comments that the draft Standards reference advanced care planning, ways to make sure residents can be reviewed routinely and urgently 24/7, and promote good communication between RACF staff and general practitioners.

It was, however, noted that there is limited reference to palliative care in the draft Standards. As almost all residents in residential aged care are likely to require palliative care at some time during their stay, we recommend that specific reference is made to the National Palliative Care Standards 2018[1] which we consider would enhance the overall standard of care in residential aged care.

Specific comments from members included the following:

- 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. RACF staff and attending GPs 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.

- Improving the means of communication of clinical information to address limitations arising from silos of care, different electronic systems, security and privacy concerns is essential. Standards around enabling this flow of communication as in this document are a start.

- Staff and general practitioners working in residential aged care would benefit from 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

[1] http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-National-Standards-2018-factsheet_v2.pdf

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).

- References in the draft Standards to management plans are very general and broad, which could result in generic plans being relied on that do not provide the required clarity of plans in managing the terminal stages of an illness, including specific detail around matters such as symptom control and escalation plans.

- It would be useful to include discussion about family liaison. For example, family and carers can play a critical role in coordinating appointments and providing support for elderly patients with dementia or for patients with complex health issues. Including carers in the setting of a family case conference with RACF staff present is essential for greater awareness and understanding and to facilitate background information for the attending GP, and facilitate shared decision-making and allow for response to their health concerns and information needs.

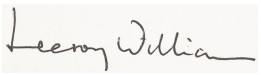
- Consideration about the role and indication for transfer for acute care hospital is essential for all residents who have been identified as having palliative care needs, and this may need to be reviewed over time as the resident deteriorates.

- In the context of after-hours (24/7) access, it was suggested to address access to timely administration of breakthrough medications for control of symptoms (particularly S8 medications). 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.

- Addressing the appropriate equipment, training for and provision of palliative care is also important. For example, reference to a minimum standard of palliative care nursing expertise available to the RACF to help guide good end of life care, including someone familiar with (and able to safely manage) syringe drivers. It was noted that some RACF staff may be anxious about end of life care and training in this area is important.

We welcome the opportunity to discuss these points in further detail if that would be of benefit to the consultation.

Yours sincerely,



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