Palliative Care Community Homecare Package Procedure

1. Guiding Principles

Effective: 08 December 2020

In line with the WA End-of-life and Palliative Care Strategy 2018-2028, consideration with respect to the provision of delivering an equitable service is paramount. Delivering equitable end-of-life and palliative care across WA is challenging. A strategic, integrated, coordinated and collaborative approach is essential.

The procedure provides direction for the provision of community-based support services for palliative care patients who are under the care of the Regional Palliative Care Team, approaching end of life, and their wish is to stay at home for as long as possible. Eligibility criteria include the following:

- Palliative care patients under the management of the Regional Palliative Care Team; and
- Palliative care patients who are waiting for a National Disability Insurance Service (NDIS) access decision or approved NDIS plan or Home Care Package (HCP) to commence; or
- Palliative care patients, who are at risk of hospital or residential aged care admission because of no access to domiciliary care services; or
- Palliative care patients who have been tested and assessed as not eligible for NDIS or HCP; or
- Palliative care patients for whom supports provided via NDIS or HCP community care packages do not meet their palliative care community home care needs; or
- Palliative care patients who are deteriorating too quickly to progress an application for a package; or
- Palliative care patients who are children at risk of hospital admission.

The patient must be assessed using Palliative Care Outcomes Collaboration (PCOC) assessment tools contained in the PCOC Assessment and Clinical Response Form including the:

- Palliative Care Phase – clinician rated assessment and defined as Stable, Unstable, Deteriorating and Terminal;
- Resource Utilisations Groups – clinician rated assessment of Activities of Daily Living (RUG-ADL) dependency;
- Australia-modified Karnofsky Performance Status (AKPS) – clinician rated assessment of performance relating to work, activity and self-care;
- Palliative Care Problem Severity Score – clinician rated assessment of pain, other symptoms, psychological / spiritual and family /carer; and
- Symptom Assessment Scale – patient rated assessment of the patient's level of distress relating to individual physical symptoms.

Wherever possible, a prognostic timeline should be provided. The clinical assessment tools help identify common palliative symptoms, clarify functional status and will identify the level of distress of the patient, family and carer that necessitates additional support.

2. Procedure

2.1 The Regional Palliative Care Clinician (the Clinician) assesses the patient's circumstances, to identify pathway options for accessing homecare support. When NDIS and HCP are assessed as viable options, support is provided to the patient to make an application for relevant funding. In circumstances where the patient is deteriorating too quickly to make an application for NDIS or HCP this should be clearly indicated in the application. Where the patient's circumstances fit the criteria for other funding pathways, the Clinician will assist with applications e.g. Carer Gateway.

2.2 The Clinician assesses the patient using the PCOC Assessment and Clinical Response Form and confirms that the patient has scored:

- An AKPS score of approximately 50 or less; and
- RUG-ADL score of 8 and above, indicating significant support needs.

An application can also be made if the patient's current AKPS and RUG- ADL **does not** meet these scores and the patient is on a rapid trajectory of decline. A Clinician's assessment of the AKPS and RUG-ADL score of two weeks prior and projected for two weeks ahead needs to be submitted for consideration.

2.3 If the Clinician assesses the patient's needs and determines they are urgent, exceptional, complex or compassionate circumstances prevail, an application can occur. These may be identified as:

- Financial hardships / lack of capacity to pay for own support;
- Complex clinical needs;
- Inadequate or stretched family and carer / informal support;
- Social isolation;
- At risk of abuse by carer;
- Lack of flexibility of support to meet care needs;
- Ineligibility /access barriers to other supports; or
- Risk of avoidable admission or adverse health outcomes if care needs are unmet;
- Seeking a co-funded arrangement.

2.4 Where appropriate, a Clinician assesses levels of carer stress using the Carer Strain Index (CSI) assessment tool.

2.5 The Clinician, on behalf of the patient, then lodges an Application to the Palliative Care Program, outlining detail of the specific needs, urgency and exceptional, complex or compassionate circumstances.

2.6 The Clinician / Palliative Care Program liaise with the various service providers to determine what community homecare services are available.

2.7 The Clinician / Palliative Care Program in consultation with patient, family and carer determine the most suitable service provider.

2.8 If there are no local service providers, the Clinician will liaise with the local regional team to facilitate the delivery of domiciliary services either through WACHS Multi-Purpose Service (MPS) workers providing CHS workers or community patient care assistants, if possible.

2.9 Communication of whether the application has been approved by the Executive Director of Nursing & Midwifery (EDNM) will be conveyed to the Palliative Care Program and the Clinician within two business days, where possible. If approved, funding is made available and the service providers are notified to commence service delivery and invoice the Palliative Care Program.

2.10 The community homecare package will initially be approved for 6 weeks, with a review required at 4 weeks to determine future care needs, unless self-funded.

2.11 Updated requests may be initiated, as a result of changing needs of the approved community homecare package and are to be provided as an attachment to the original application.

3. Definitions

AKPS	The Australia-modified Karnofsky Performance Scale, a measure of the patient's overall performance status or ability to perform their activities of daily living.
Clinician	Any member of the regional specialist palliative care team who has direct involvement with the patient.
Co-funded	An arrangement in which the patient/family contribute to the care costs of HCP. This can occur in circumstances in which the family can afford to contribute, or when the care request is in excess of the funding that is usually provided.
HCP	Home Care Packages are a Commonwealth funded support for older Australians with more complex care needs.
NDIS	The National Disability Insurance Scheme is a scheme by the Australian Government that funds support and services associated with disability.
Palliative Care	WHO Definition of Palliative Care.
Palliative Care Program	Central Palliative Care Program team to guide and support the growth and delivery of regional palliative care services.
Regional Palliative Care Team	A specialist palliative care service consisting of clinical nurses, social work and aboriginal health workers.
RUG-ADL	Resource Utilisation Group Activities Daily Living (RUG-ADL) Inform us about the patient's functional status, the assistance they require to carry out these activities and the resources needed for the patient's care.

4. Roles and Responsibilities

4.1 The Clinician assists the patient, family and carer to apply for the palliative care community package; compiles the needs assessment and ensures that the patient meets the assessment requirements enunciated in 2.2.

4.2 The Palliative Care Program endorses the application and submits to the Executive Director of Nursing & Midwifery for approval.

4.3 The Executive Director of Nursing & Midwifery communicate his/her decision, where possible, to the Palliative Care Program within two business days.

4.4 The Palliative Care Program / Regional Social Worker liaise with the various service providers to ensure that community services are rendered as soon as the approval is received. This can be delegated to other palliative care team members depending on the resources available in the region.

4.5 If there are no local service providers, the Clinician will liaise with the local regional team to facilitate the delivery of domiciliary services either through WACHS Multi-Purpose Service (MPS) workers providing CHS workers or community patient care assistants, if possible.

4.6 All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

Regional Palliative Care Coordinators are required to:

- Ensure that appropriate training and education are provided regarding adherence to the procedure including clinical assessment tools and recording patient information in ePalCIS; and
- Monitor that the process as stipulated in the procedure is followed to its entirety and all WACHS staff are reminded that compliance with all policies and guidelines is mandatory.

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

Evaluation, audit and feedback processes are to be in place to monitor compliance. Results are to be monitored through site, regional and area governance mechanisms.

8. Standards

National Safety and Quality Health Service Standards 2.4; 2.8; 2.9; 2.10

9. Legislation

Voluntary Assisted Dying Act 2019
Aboriginal Communities Act 1979
Medicines and Poisons Act 2014

10. References

1. Australian Commission for Safety and Quality in Health Care, National Health and Medical Research Council. Australian guidelines for the prevention and control of infection in healthcare Canberra, ACT: NHMRC; 2010: Accessed 27 November 2012.
2. Australian Commission on Safety and Quality in Health Care, 2013. Safety and Quality of End-of-life Care in Acute Hospitals: A Background Paper. ACSQHC, Sydney.
3. Australian Institute of Health and Welfare, 2017a. Palliative care services in Australia – Service provided by palliative medicine specialists. AIHW, Canberra
4. Dean E. Smooth transitions. Nursing standard (Royal College of Nursing (Great Britain): 1987). Feb 13-19, 2013;27(24):20-22
5. Australian Commission for Safety and Quality in Health Care. National Safety and Quality Health Service Standards Second Edition. Sydney, NSW:
6. Australian Commission for Safety and Quality in Health Care; 2017.

11. Related Forms

PCOC Palliative Assessment and Clinical Response Form
WACHS RUG-ADL Assessment Form - extended assessment tool
Palliative Care Referral Form
Care Plan for the Dying Person - Community
Carer Strain Index

12. Related Policy Documents

Palliative Care Outcomes Collaboration – Clinical Manual

13. Related WA Health System Policies

Clinical Deterioration Policy

14. Policy Framework

Clinical Governance Framework

This document can be made available in alternative formats on request for a person with a disability

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