Guide to
Collaborative Palliative Care Practice
Service Delivery Model
Introduction

This Guide is a reference for health professionals providing or coordinating care of patients with a life limiting illness.

The purpose of the guide is to promote a whole-of-health-sector approach to collaborative palliative care practice through clearly defining the role of the Department of Health and Human Services (DHHS) Palliative Care Service and Primary Care Providers in supporting the delivery of high quality, needs-based care to patients. The main objective is to ensure that all health professionals providing care for palliative care patients work effectively together to deliver coordinated care of consistently high quality.

Background and context

An external review of the DHHS Palliative Care Service was commissioned by the Department in 2004 to analyse the capacity of the Service to respond to current levels of demand, identify areas of unmet need and compare the Service against National benchmarks. The Review Report, Palliative Care in Tasmania: Current Situation and Future Directions, provided evidence of a gap between supply and demand and identified the need to set future directions for the provision of services. It also recommended that a service delivery model and integrated clinical networks be developed. The Report also outlined the need for clearer delineation of roles based on the patient’s needs and the health professional’s resource capability and capacity.

Palliative Care Australia Standards for Providing Quality Palliative Care for all Australians, published in 2005 define the relationship between specialist palliative care services and primary care providers and focus on a network based approach to service delivery. The standards require that care is coordinated to minimize the burden on the patient, their carer and family.

To address the recommendations from the Review Report and to align with the National Standards, DHHS Palliative Care Service developed and implemented a service delivery model that illustrates and actively encourages collaborative palliative care practice. Collaborative practice that recognises:

- The value of collaboration between clinicians to achieve optimal patient outcomes;
- The importance of primary care services, as patients spend most of their time living in the community;
- That some patients require a range of primary and specialist services to meet their needs;
- The importance of partnerships between patients, carers, families and health professionals to achieve the best outcomes;
- That patients have different needs at different phases of their illness, and services should be responsive to these needs; and
- That families and carers need support during the patient’s life and in bereavement.
What is Palliative Care?

Palliative care is the active total care of patients whose disease is not responsive to curative treatment. It includes the control of pain and other symptoms, and psychological, social, cultural and spiritual support.

The DHHS Palliative Care Service utilises the following definition of palliative care which is based on the 2002 World Health Organisation definition.

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

Palliative care is the responsibility of all health professionals and is delivered by two distinct categories of health professionals:
- Primary care providers; and
- Health professionals who specialise in palliative care.

Palliative care is an active and total approach to the care of a patient with a life-limiting illness; it focuses on enhancing the patient’s quality of life and supporting the family. This is achieved through preventing and relieving suffering by means of early identification, assessment, intervention and treatment of pain and other problems, provision of psychosocial and spiritual support; and care through death and bereavement.

Palliative care is indicated when the focus of care for the patient moves from the cure of the illness to maximising the patient’s quality of life. A palliative approach to care may therefore be implemented at any stage where the effects of the life-limiting illness or treatment begin to compromise the patient’s quality of life - in the physical, psychological, emotional, spiritual or social domains. Palliative care is not simply for the terminal stages, nor does it end when the patient dies.

Palliative care:
- provides relief from pain and other distressing symptoms;
- affirms life and supports patients and families through the progression of the illness;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible;
- offers a support system to help the family cope during the patient’s illness and in their bereavement;
- uses a team approach to assist the family and carers to manage during the patient’s illness and in their bereavement;
- aims to enhance quality of life; and
Palliative care is provided not only to the patient with the life-limiting illness but to their family and carers as needed - together comprising the unit of care. It is also appropriate in supporting family members and carers both prior to and following the patient’s death. For a small number of people, that process may be more complex than anticipated and some may develop significant psychological and emotional issues. It is recommended that the bereaved carers receive follow-up to ensure that potential problems are identified early and referred for specialist care if required.

**Perception vs reality**

... **commonly held myths**

Effective palliative care provides a direct benefit to the patient as well as being an important preventive health intervention for the family. In contrast to some commonly held myths, it is not:

- Only for the final days of a patient’s life.
- “Doing nothing” - even when the underlying condition cannot be cured, clinical intervention to control and manage symptoms may improve a patient’s quality of life. Palliative care is a very active approach to symptom management and patient support.

- “Commenced only when active treatment aimed at disease control stops” - elements of palliative care interventions and active treatment can be combined during the course of the life-limiting illness.

Palliative care is provided to people of all ages whose illness is not responsive to curative treatment, or who have chosen not to pursue active, curative treatment.

Traditionally associated with cancer care it is now recognised that palliative care should be available on the basis of unmet need, not diagnosis. As a result, it is now increasingly being offered to patients with non-malignant illnesses including:

- neurological conditions;
- end stage renal, cardiac or respiratory failure;
- chronic cardiac and respiratory conditions;
- chronic and severe peripheral vascular disease; and
- congenital degenerative disorders.

- 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.
Who provides Palliative Care?

The settings of care in Tasmania reflect those identified in the National Palliative Care Strategy - home, community settings, residential aged care, designated in-patient palliative care beds and units and acute public, private and rural hospitals.

Tasmania’s current service delivery structure is characterised by primary palliative care and specialist palliative care.

**Primary palliative care**

Primary palliative care is provided for patients across all health care settings. Primary care providers includes all health services and staff that have a primary or first contact relationship with the patient with a life limiting illness. This includes general practitioners, community nurses, residential aged care workers, staff in hospitals (acute, public/private and rural) such as medical specialists, interns, residents, registrars, general practitioners, nurses and allied health professionals.

**Specialist palliative care**

Specialist providers include medical, nursing and allied health professionals who provide specialist palliative care consultation or ongoing care for patients with a life limiting illness. They generally work within palliative care 100% of their time.

The DHHS Palliative Care Service (Service) is a specialist palliative care service providing palliative care to clients across all health care settings and can be accessed 24 hours a day, seven days a week. The Service operates an in-patient unit in Hobart (J.W. Whittle Palliative Care Unit) and three community-based interdisciplinary teams based in Hobart, Launceston and Burnie.

Interdisciplinary teams currently comprise palliative care medical specialists, specialist nurses (CNC and CNs), specialist social workers and pastoral care. Clinical nurse consultants are also located at the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital campuses.

The Specialist Service also:

- coordinates a volunteer service in the north;
- provides funds to non-government providers to coordinate and train volunteers in the north west and south;
- provides additional dedicated palliative care in-patient beds at Calvary Health Care St Luke’s Campus in Launceston.
Palliative care is offered directly to people in need or indirectly through the provision of education, consultancy and information for health professionals. The Service can provide:

- interdisciplinary assessment;
- specialist medical, nursing and social work consultation-liaison, indirect and direct care;
- emotional and spiritual support;
- education for health care providers, patients, carers and consumers;
- volunteers who provide a range of supportive services to patients; and
- grief and bereavement support.

**Working together**

**... palliative care service collaboration**


The Guide describes the unique and interrelated roles of primary and specialist providers and states that care and support should be available to patients and their families in such a way that ensures access to an appropriate level of care, when and where it is required.

To achieve this, service providers need to be able to respond to a diverse range of patient needs, from the simple and uncomplicated, to a high level that utilises the resources of specialist teams. Services for the patient should be responsive and roles of health care providers clearly defined.

In Tasmania, palliative care services are provided by a network of primary and specialist providers, the setting determined by patient choice and need. The relationship between primary and specialist services is mutually supportive.
How is Palliative Care provided?

A new era … Palliative Care Service Delivery Model

The Palliative Care Service Delivery Model provides a framework for palliative care service providers (primary and specialist) to work together for the benefit of patients and their families in the provision of quality integrated palliative care services.

The Model has been developed to build on current processes with regard to access, referral, assessment and care planning, together with implementing a range of new processes to improve overall collaboration, coordination and delivery of high quality, effective services across all settings.

The aim of the model is to achieve integrated palliative care service delivery across all clinical settings and ensure effective patient access to a cohesive palliative care service system through:

- comprehensive assessment of the patient’s needs;
- determining a plan of care;
- improved coordination and collaboration between primary and specialist providers;
- reduced duplication; and
- role clarity.

The model explains the level of involvement of primary and specialist providers in the care of patients with a life-limiting illness. The DHHS Palliative Care Service intent is to work with primary care providers to support the needs of patients, carers and families.

The Model recognises that:

- Patients with life-limiting illnesses require different levels of involvement from the specialist palliative care service based on their needs and the primary care provider’s capability and capacity to meet those needs.
- Many patients receive primary palliative care without having any contact with the Specialist Service (Level 1). There is a clear distinction between consultation-liaison (Level 2), shared care (Level 3) and services provided directly by the Specialist Service itself (Level 4).
- The Specialist Service supports palliative care service provision across all four levels.
Palliative Care Service Delivery

The aim is to achieve integrated palliative care service delivery across all clinical settings

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<thead>
<tr>
<th>Specialist Role</th>
<th>Level of Care</th>
<th>Primary Provider Role</th>
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<tbody>
<tr>
<td><strong>Specialist Care</strong></td>
<td>4</td>
<td><strong>Primary Provider Role</strong></td>
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<tr>
<td>- Assesses patient needs.</td>
<td></td>
<td>- Negotiates, agrees and formalises arrangements for the patient’s care with the DHHS Palliative Care Service.</td>
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<td>- Negotiates, agrees and formalises arrangements for care with the patient’s primary care provider.</td>
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<td>- Consults with the DHHS Palliative Care Service and provides care as agreed.</td>
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<td>- Has ongoing high level involvement in the care of the patient.</td>
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<td>- Responsible for coordinating the management of the patient's needs – coordinator of care (lead agency).</td>
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<td>- After hours service provided.</td>
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<td><strong>Specialist Care</strong></td>
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<td>- Shares care with the Specialist Palliative Care Service.</td>
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<td>- May be the coordinator of care (lead agency) as negotiated and agreed.</td>
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<td><strong>Primary Care</strong></td>
<td>2</td>
<td><strong>Primary Provider Role</strong></td>
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<tr>
<td>- Assesses patient needs.</td>
<td></td>
<td>- Responsible for coordinating the management of the patient’s needs – coordinator of care (lead agency).</td>
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<tr>
<td>- Negotiates, agrees and formalises arrangements for care with the patient’s primary care provider.</td>
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<td>- Consults with the DHHS Palliative Care Service if there is a variation to standard protocols of care and if advice is needed.</td>
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<tr>
<td>- Provides episodic assessment, care planning and/or advice to the patient’s primary care provider.</td>
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<td>- Provides after hours service to the patient.</td>
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<tr>
<td><strong>Primary Care</strong></td>
<td>1</td>
<td><strong>Primary Provider Role</strong></td>
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<tr>
<td>- Supports the network of primary care providers through the provision of advice, information, training and professional development and resources.</td>
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<td>- Responsible for coordinating the management of the patient’s needs – coordinator of care (lead agency).</td>
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<td>- Provides after hours service to the patient.</td>
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<td>- Develops palliative care skills through professional development.</td>
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The triangle represents the palliative care patient population
### Level 1

Level 1 palliative care patients have their needs met by primary care providers and are not known to the DHHS Palliative Care Service (i.e. patients have not been assessed by the Service).

**The role of the Specialist Service is to:**
1. Provide training and professional development for primary care providers through provision of resources and information.

**The role of the Primary Care Provider is to:**
1. Assess the patient’s palliative care needs across all domains and take responsibility for coordinating the management of the patient’s needs; and are the designated coordinator of care (lead agency).
2. Provide culturally appropriate palliative care for the patient, carer and family in accordance with the National Standards for Palliative Care, including ensuring:
   - the patient, carer and family are informed and involved in decision making;
   - pain and symptom control;
   - social, spiritual and emotional support;
   - risk assessment;
   - an agreed care plan;
   - after hours support;
   - coordination of patient, carer and family needs; and
   - bereavement support.
3. Consult with the DHHS Palliative Care Service if information is needed or refer the patient for assessment if the patient needs exceed the primary care provider’s capability and/or capacity.

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### Level 2

Level 2 palliative care patients have been referred to the DHHS Palliative Care Service due to an identified unmet need. Upon assessment the Specialist Service will determine in consultation with the primary care provider and the patient that the patient’s needs can continue to be met by the primary care provider with the provision of advice, resources and/or the development of a plan for care. The patient is therefore not admitted to the Specialist Service.

**The role of the Specialist Service is to:**
1. Assess the patient’s needs in consultation with the primary care provider.
2. Consult with the primary care provider to negotiate, agree and formalise arrangements to meet the patient, carer and family’s needs.
3. Provide episodic assessment, care planning and/or advice to the primary care provider.

Following the development of a plan of care and/or provision of advice from the Specialist Service **the role of the Primary Care Provider is to:**
1. Coordinate and manage all of the patient’s needs using a palliative approach. They are the designated coordinator of care (lead agency).
2. Provide culturally appropriate palliative care for the patient, carer and family in accordance with the National Standards for Palliative Care, including ensuring:
   - the patient, carer and family are informed and involved in decision making;
   - pain and symptom control;
   - social, spiritual and emotional support;
   - risk assessment;
   - an agreed care plan;
   - after hours support;
   - coordination of patient, carer and family needs; and
   - bereavement support.
3. Consult with the Specialist Service if advice is needed or re-refer the patient for further assessment if the patient’s needs exceed their capability and/or their resources.

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**Coordinator of care** – the role involves negotiating with health professionals, patients/carers/families the most efficient way to provide care to the patient; communicating the agreed plan of care; assisting in the transition of care between settings; point of contact for the patient, carer and other health professionals.
Level 3

Level 3 palliative care patients have been referred to the DHHS Palliative Care Service due to an identified unmet need and their condition is likely to be complex and unstable. Upon assessment the Specialist Service will determine, in consultation with the primary care provider and the patient, that the patient’s needs require ongoing support and involvement from the Specialist Service. The patient is therefore admitted to the Specialist Service for ongoing care and a plan of care is developed.

The role of the Specialist Service is to:
1. Assess the patient’s needs and share care with the primary care provider based on those needs.
2. Provide 24/7 support and advice to the patient, carer and primary care provider.
3. Negotiate, agree and formalise the arrangements to meet the patient’s needs with the primary care provider and patient/carer/family – the designated coordinator of care (lead agency) may be a Specialist Service clinician.
4. Provide an after-hours service.
5. Review the plan of care with the primary care provider, patient, carer and family as required.
6. Provide bereavement support.

The role of the Primary Care Provider is to:
1. Share the care with the Specialist Service based on the patient’s needs.
2. Negotiate, agree and formalise the arrangements to meet the patient’s needs with the Specialist Service and patient/carer/family – the designated coordinator of care (lead agency) may be the primary care provider.
3. Review the plan of care with the Specialist Service, patient, carer and family as required.

Level 4

Level 4 palliative care patients have been referred to the DHHS Palliative Care Service due to an identified unmet need and their condition is likely to be complex and unstable. Upon assessment the Specialist Service will determine, in consultation with the primary care provider and the patient, that the patient’s needs require ongoing high level involvement from the Specialist Service. The patient is therefore admitted to the Specialist Service for ongoing care and a plan of care is developed.

The role of the Specialist Service is to:
1. Assess the patient’s needs and take responsibility for coordinating the management of those needs - a Specialist Service clinician is the designated coordinator of care (lead agency).
2. Provide 24/7 support and advice to the patient, carer and primary care provider.
3. Negotiate, agree and formalise the arrangements to meet the patient’s needs with the primary care provider, patient, carer and family.
4. Provide an after-hours service.
5. Review the plan of care with the primary care provider, patient, carer and family as required.
6. Provide bereavement support.

The role of the Primary Care Provider is to:
1. Consult with the Specialist Service and provide care to the patient, carer and family as agreed.
2. Negotiate, agree and formalise the arrangements to meet the patient’s needs with the Specialist Service, patient, carer and family.
3. Review the plan of care with the Specialist Service, patient, carer and family as required.

1 Complex problems are defined as those that are severe and intractable, involving a combination of difficulties in controlling physical and/or psychological symptoms, the presence of family distress and social and/or spiritual problems. They also exceed the resources of the primary care provider to meet the needs and expectations of the patient/carer/family.
2 Unstable is where the patient experiences the development of a new problem or rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment, and/or the family/carers experience a sudden change in their situation requiring urgent intervention by the DHHS Palliative Care Service.
3 Shared Care refers to the collaborative relationship between the primary care providers and the DHHS Palliative Care Service to formulate a plan of care. The shared care arrangements are based on the needs of the patient. Ongoing communication between all parties is required. Within this definition of collaborative care there is a continuum of activity which can range from low collaboration to high collaboration. The level of involvement would be negotiated by the parties involved. Shared care would involve regular consultative activities between the nominated care provider and the DHHS Palliative Care Service.
Practical examples
... illustrative case histories

During the course of a patient’s illness their clinical pathway and management will vary as illustrated below.

Pathway - Level 1

Example 1: The patient is a 76 year old man with chronic renal failure. He is cared for by his general practitioner and renal physician, is on a renal dialysis program and has been managing on peritoneal dialysis for the past 5 years. He becomes weaker and develops recurrent bouts of peritonitis. He is offered haemodialysis but he feels he is too frail to continue and following discussion with his family makes the decision to stop treatment. His doctors concur and he remains at home with his family. His general practitioner and the renal team manage him at home with community nurse support. He dies of sepsis in a few days. (level 1)

Pathway - Level 1, 3, 2, 4

Example 2: The patient  is a 17 year old female with a Ewings Sarcoma. She is initially managed by the paediatric oncologists and a lot of her management has been shared between Hobart and Melbourne. (level 1)

She develops severe pain and becomes emotionally distressed when her symptoms are not controlled. The hospital specialist palliative care team is called in to help manage her pain and distress and is reasonably successful. (level 3)

With a pain management care plan in place she is able to continue on with her treatment under the supervision of the paediatric team and her general practitioner who monitors her out of hospital care, using the care plan set in place by the specialist palliative care team. (level 2)

Unfortunately, the disease escapes oncological control, spreads to her spine and she becomes paraplegic and has severe distress and an escalation of pain. There is patient and carer distress and she is hospitalised once more. The specialist palliative care team is asked to help and take the lead role in managing her pain and symptom control issues. Once her symptoms are managed and she is comfortable she returns home, and later dies at home. The specialist palliative care team remains the lead agency in clinical decision making and negotiates with her general practitioner and the community nurses over care in the home. (level 4)

Pathway - Level 1, 4, 3

Example 3: The patient is a 60 year old man with a small cell lung cancer. He received his initial treatment from the medical oncologists and for 15 months was doing well. His cancer redeveloped and became chemotherapy resistant and he was mainly being cared for at home with his general practitioner and the community nurses providing care. (level 1)

He became weaker and needed more help at home but when he became confused his family needed assistance and his general practitioner asked that he be admitted to the palliative care unit. Once admitted he was found to be hypercalcaemic as well as having significant pain and depression. These were treated and support was also provided to the family. (level 4)

His condition stabilised and his family felt strong enough to manage him at home. A care plan was developed in conjunction with his general practitioner and the community nurses who felt they would be able to manage his needs at home with backup as needed from the specialist palliative care service. He returned home and remained there until his death. The general practitioner and the community nurses managed his care at home with support from the specialist palliative care team. (level 3)
Our goal … Integrated Palliative Care Networks

In the National Guide to Palliative Care Service Development (2005), development of appropriate networks between primary care providers and specialist services is seen as crucial for the provision of high quality, effective care across all settings.

Formalised and ongoing links between health care providers are essential if improvements in patient care are to be made at the critical interfaces between primary and specialist care. There is significant evidence that supports the concept of a coordinated team approach to managing patient care, particularly in the case of palliative care and chronic illness.

Our goal is to continue to develop and strengthen the existing linkages between health care providers and form integrated palliative care networks to provide seamless care for people with a life-limiting illness.

Through the implementation of the Palliative Care Service Delivery Model and integrated networks, the provision of high quality, effective care across all health care settings will be enhanced.

The development of networks across the State’s three regions has been specifically designed and targeted to suit local needs and circumstances.

The creation of multidisciplinary teams (a team of specialist and primary health care providers who work together to develop and implement a plan of care for a patient) enhances coordination and provision of care to patients and their families. Team membership potentially includes nurses, allied health professionals, specialist medical staff, general practitioners and other community based clinicians.

Integrated palliative care networks:

- create effective and efficient communication links between health professionals, patients, carers and families;
- provide a seamless service for patients requiring palliative care;
- coordinate service provision across hospitals, palliative care inpatient facilities and primary care settings through improved collaboration;
- ensure the standard of care is of an equally high standard irrespective of the patient’s place of care;
- promote the palliative approach through a program of continuous professional development; and
- improve access to specialist advice and support for primary care providers.

The key elements of integrated palliative care networks are:

- state-wide stakeholder consultation;
- network resources;
- network processes;
- network meetings/forums; and
- professional development.
Integrated Palliative Care Network

**WHY**
To effectively support people in need of palliative care, their carers and families as the unit of care.

**WHO**

- **Specialist Providers DHHS**
  - Palliative Care Service
  - Community Teams - South, North, North West
  - Inpatient Units
  - Hospital in reach

- **Primary Care Providers**
  - General Practitioners
  - Medical Specialists
  - Community Nurses
  - Residential Aged Care Staff
  - Acute Care Hospital Staff private/public
  - Rural Hospital Staff
  - Allied Health Professionals

**WHAT**

- Network Resources
- Network meetings
- State-wide stakeholder consultation
- Network Processes
- Professional Development Program

**WHERE**

- Palliative Care Inpatient Units
- Rural Hospitals
- Community Settings
- Acute Hospitals
- Private Hospitals
- Residential Aged Care Facilities
How to access the DHHS Palliative Care Service

Referral to the DHHS Palliative Care Service

Patients are generally referred to the Specialist Service due to an identified unmet need. Reasons for referral include:

- Where identified needs (physical, social, emotional, psychological, cultural or spiritual) exceed the capacity (knowledge, resources, facilities) of the primary care provider.
- Where patient needs exceed the resources of the patient/carer/family.
- Where the patient experiences the development of a new problem or an increase in the severity of existing problems, either of which require a change in management or emergency treatment, and/or the family/carers experience a change in their situation requiring intervention by the Specialist Service.
- Where as appropriate to the needs and wishes of the patient, their carer/s and family discussion and documentation about end of life care could be enhanced by a referral.
- Where the patient, family or carer require further emotional/psychological or bereavement support.

The level and complexity of the need, as well as the strengths and limitations of the patient, their carer and family will determine the appropriate level of service response for the patient.

A referral to the Specialist Service can be made by the primary care provider, the person with the life-limiting illness, a family member or carer.

If the referral is not from a health professional, the Specialist Service will validate the referral with the patient’s general practitioner or medical specialist prior to accepting the referral.

Patients referred to the Specialist Service need to meet the following criteria:

- have been diagnosed with a life-limiting illness;
- agree to being referred to the Service (or where incapable of agreeing, agreement must be sought from the patient’s legal guardian); and
- are generally aware of their diagnosis (this may not be appropriate for special needs patients - special consideration needs to be given to children and young adults, temporarily or permanently incompetent adults and people with special needs related to their cultural beliefs).

A referral to the Specialist Service can be made:

- on the DHHS Palliative Care Service Referral Form;
- by phone;
- by fax;
- by letter;
- verbally; or
- by email.

Referral forms are available from your Palliative Care Team and on the DHHS Palliative Care Service website. Please telephone or fax if the referral is considered to be urgent.
Referral Pathways

**Referral to the PC team**

- Referral from a Dr, other health professional, patient, carer, family etc.
- Received by PC Service Admin.
- Referral registered
- Duty Officer (clinician) reviews referral
- Dr referral?
  - Yes: Urgency determined
  - No: Duty Officer gains consent from the patient to contact the patient’s Dr.
- Priority allocated
- Referral discussed at daily team meeting
- Referral allocated to a clinician
- Assessment may involve one or more clinicians – medical/nursing/social work

**Referral to a PC Medical Specialist**

- Referral from a GP or Specialist to the PC Medical Specialist
- Received by the PC Medical Specialist
- Sends to Service Admin.
- Patient’s Dr contacted regarding the referral
- Referrer/patient advised of assessment outcome
- Patient’s Dr advised of assessment outcome
- If referrer not the patient’s Dr
- No

Palliative Care
Assessment by the DHHS Palliative Care Service

All referrals received by the Specialist Service will be reviewed by the Service’s interdisciplinary team (medical, nursing and social work).

Self-referred patients will be asked for consent to contact their general practitioner/specialist in order to obtain further health information and to facilitate ongoing collaboration.

Contact with the patient will be made by the most appropriate Specialist Service clinician as soon as possible, depending upon the urgency stated. If this is not possible due to a large number of urgent referrals, the referrer and the patient will be contacted and advised an estimated time in days when the patient will be assessed. If the patient’s condition changes, the referrer should notify the service and request an urgent assessment.

A comprehensive assessment of the patient’s needs will be conducted.

Following the assessment the person making the referral will be contacted by the Specialist Service clinician to:

• advise regarding findings/outcome of the assessment; and
• negotiate arrangements for the ongoing management and coordination of the patient’s care and the level of involvement or the role of the primary care provider and specialist service in the care of the patient. This may be consultation only (Level 2) or ongoing shared care (Level 3) or a more involved role (Level 4) as per the Palliative Care Service Delivery Model. This provides role clarity and prevents duplication by health professionals.

Patients are reviewed weekly at the Specialist Service clinical review meeting to determine ongoing care needs and any issues around the care of the patient. Primary care providers may be invited to attend these meetings if a more detailed discussion is required.

Patients may also move between Levels as their care needs change. Changes will be discussed with the primary care provider/s and the patient and their family/carers.

Patients assigned to Level 2 may be re-referred to the Specialist Service at any time.

The Specialist Service provides a 24 hour, seven day a week on call service to primary care providers and Level 3 and Level 4 patients.
Contact Information

For further information about the DHHS Palliative Care Service, contact your nearest Community Palliative Care Team office:

South - Palliative Care Service
1st Floor, Peacock Building
Repatriation Centre
90 Davey Street,
Hobart, Tasmania 7000
Ph: 6224 2515
Fax: 6224 2451
Email: palliativecare.south@dhhs.tas.gov.au

North - Palliative Care Service
J.L.Grove Centre,
33-39 Howick Street
Launceston, Tasmania 7250
Ph: 6336 5544
Fax: 6336 5529
Email: palliativecare.north@dhhs.tas.gov.au

North West - Palliative Care Service
Community Palliative Care Team
Level 3, Parkside, 1 Strahan Street
Burnie, Tasmania 7320
Ph: 6440 7111
Fax: 6440 7331
Email: palliativecareservicenw@dhhs.tas.gov.au

J. W. Whittle Palliative Care Unit
Lower Ground Floor, Peacock Building
Repatriation Centre, Hampden Road
88 Davey Street,
Hobart, Tasmania 7000
Ph: 6220 2400
Fax: 6222 7334
Email: palliativecare.south@dhhs.tas.gov.au

Volunteer Services

South
Hospice Care Association Inc.
Ph: 6224 3808
Email: hospice@netspace.net.au

North
Volunteer Support Service
Ph: 6336 5544
Email: palliativecare.north@dhhs.tas.gov.au

North West
Hospice Care Association Inc.
Ph: 6440 7110
Email: hospice.burnie@dhhs.tas.gov.au

DHHS Palliative Care Service website:
www.dhhs.tas.gov.au/palliativecare
Resources

**Websites:**
- Palliative care Australia - www.pallcare.org.au
- Caresearch - www.caresearch.com.au
- Current Learning in Palliative Care - www.helpthehospices.org.uk

**Websites with clinical information:**
- Caresearch www.caresearch.com.au
- International Association for Hospice Care - http://www.hospicecare.com/
- Palliative drugs information - www.palliative drugs.com
- Centre for Palliative Care Research and Education - http://www.cpcare.com/
- The End of Life Physician Education Resource Centre (EPERC) http://www.eperc.mcw.edu/
- The Edmonton Palliative Care Program of the University of Alberta - http://www.palliative.org/PC/ClinicalInfo/ClinicalIdx.html
- Palliative and supportive care - http://www.medicine.ox.ac.uk/bandolier/booth/booths/pall.html
- Centre to Advance Palliative Care - http://www.capc.org/

**Websites with information for patients:**
- Caresearch – www.caresearch.com.au
- NHS clinical knowledge summaries - Patient Information Leaflets - http://cks.library.nhs.uk/home
- People Living with Cancer - http://www.plwc.org

**Publications:**
- Palliative Care Expert Group, Therapeutic Guidelines: Palliative care, Version 2 2005, Melbourne. CD ROM also available
- Woodruff, R., Palliative Medicine: evidence-based symptomatic and supportive care for clients with advanced cancer, Melbourne: Oxford University Press, 2004
- Palliative Care Australia, Standards for Providing Quality Care for all Australians, May 2005.
Palliative Care