Supplementary Questions*: Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Tuesday 18th May 2021*

Mrs Sheree Staggs, Registered Nurse, New South Wales and Midwives' Association.

Question

1. *In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding the current provision of palliative medicine, nursing and care in Gilgandra and the surrounding area?*

Answer

I will outline the current provision of palliative care services to Gilgandra and district in the form a few patient scenarios.

A patient in their home:
Once a patient has been identified by their GP or other health provider as requiring palliative care a referral to either the community nurses (based in Gilgandra) or to the palliative care team (At Lourdes hospital Dubbo) will be attended.

The Community Nurses will contact the patient and arrange to see them and assess their needs at their home (or where the patient prefers). The community nurse works with the GP to ensure they get treatment for their symptoms. We will refer them to other services if needed such as counsellors. We visit as little or as much as they need and assess their needs every time. We can provide some equipment to help them stay at home for as long as they want or even to die at home if they so choose. All of the equipment has been provided by fundraising by the community for cancer patients. We struggle to provide equipment for those who are palliative from chronic disease not associated with cancer. A patient will require plenty of family support to stay at home, the community nurses will attend to some personal care but services like Hammond Care will provide some in home support towards the last days/week of the patient's life. Community nurses only work business hours 5 days a week.

The Community Nurses work closely with the palliative care team in Dubbo, often sharing patients. When symptoms are complicated we can talk to them for further advice, including a weekly meeting which a palliative care doctor from Sydney dials in if we need. Ultimately the GP is the prescribing doctor while they are at home. There is a Palliative care advice line for patients and carer's for after hour support. This is run by the palliative care clinical nurse consultants (CNC) in the district. The community nurses are often involved with the patient from diagnosis through the treatment and then into the palliative stage.

A patient in Gilgandra MPS:

There is a fantastic palliative care room in Gilgandra Hospital; it has a private court yard, and kitchenette, fold out sofa lounge, TV, Radio and 2 recliner chairs. This room allows family to stay in the room with the palliative patient, a meal is provided for 1 family member at meal times. The on-call doctor and the acute ward nurses provide the palliative care. If symptoms are complicated and

beyond the expertise of the doctor/staff, they will be referred to the Lourdes Palliative care team for advice. Assessment will occur either by videoconference or in person, however this is only a 5 day a week service. If urgent support was needed, advice may be sought from Dubbo Base Virtual-Care. Mostly the nurses can advocate for the patient to ensure they have their needs meet in the way of medication administration. Aged care residents in the MPS will be cared for in their normal rooms as the family can access extra space there if needed.

A patient in the local aged care facility (not the MPS):

With the help of ambulance care plans some patients have been able to die in the hostel, however often the patient cannot be managed in the hostel due to limited staff numbers and experience in palliative care. These patients are transferred to Gilgandra MPS to be managed and palliated.

Question

2. *In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding ways to improve both the access and availability of palliative medicine, nursing and care in Gilgandra and the surrounding area?*

Answer

Access to palliative care in Gilgandra is quite good, however there are some problems and it could be better. I provide palliative care to my community clients and did so for many years when I worked in the acute/ED wards

- When patients are at home in the community they need their GP to do home visits or telephone consults, they are often too unwell to get to the doctor. Willingness to attend home visits would improve patients care when in the palliative stage. Only one of GP's regularly will do home visits if required. There often is a long wait to get an appointment with a GP.
- I have noticed in the last few years more reluctance of GP's to prescribe the necessary medications for patients in the home (and even at times in the hospital) when symptom's increase. I am not a prescriber, however I believe that prescribing narcotics is closely watched and I spend more time trying to advocate for my patients when they need increase doses to manage their pain and other symptoms than I used to in previous years. I'm not sure if this has to do with GP being watched more closely in regards to prescriptions or lack of understanding of palliative care medicine. If I feel the patient is not getting medications they need, I will refer them to the palliative care team. Once they have made an assessment and recommendation, often the GP will follow this regime, however this can take days. There may be many ways to solve this problem, one could be a dedicated palliative care doctor employed for the area that nurses can call for orders (and scripts), they could be aligned with the after hour's palliative care advice line. There are some doctors employed in the area that have an interest in palliative care, however access is difficult.

- Understaffing in the MPS; before our staff cuts were made I believe we did a better job with palliative care in the MPS. Returning the 3rd nurse in the acute/ED ward (and an extra RN on night duty) will help with better provision of palliative care.
- Gilgandra could support a dedicated community palliative care nurse at least part-time to work along with the community nurses. It can take many hours to assess, treat and organise what a palliative patient needs.
- Access to equipment for those who do not have cancer. Most of the equipment we loan to patients to remain at home has been fundraised by the community cancer fundraisers. However not all palliative patients have cancer, many have limited finances to be able to purchase their own equipment. Sometimes we can get equipment through peoples home care packages however often this process takes too long, so they go without.
- RN's in aged care facilities would allow residents to die in their own bed. If private aged care facilities could provide palliative care, there would be less need for the patients to be moved to hospitals for this care. This occurs more often on the weekends and after hours when personal care assistants(PCA) are left to provide the care; managing the symptom's is beyond the scope of PCA' s. Having an RN on each shift in all aged care facilities would help residents to stay in their own beds surrounded by staff they already know.
- Improved access to in home care. Hammond Care provides care in the home in the last days of people's lives, however they too struggle to provide enough staff in the western area. Referral to My Aged Care and the waiting time for services is too long for those in the palliative stage. Even if this process could be expedited, many of the service providers struggle to get staff. Of course not all palliative patients are aged, which makes service provision of personal care harder. Care required to allow people to die at home includes, showering, sponge in bed, pressure area care, eye and mouth hygiene, respite and domestic duties, along with the expert palliative care nurses provide.