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**TITLE :** **PALLIATIVE CARE PROGRAM**

**DISTRIBUTION:** **ALL PUBLIC HOSPITALS & HEALTH SERVICES IN WESTERN AUSTRALIA**

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### **1. Purpose**

Palliative care is the specialised care of people who are dying. The purpose of this bulletin is to provide the guidelines for the management and reporting of patients who are classified as receiving palliative care.

### **2. Background**

An episode of palliative care occurs when a person's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person.

Interventions such as radiotherapy and chemotherapy are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

Palliative care is an episode of care:

- provided for a person with an active, progressive, far advanced disease with little or no prospect of cure; and
- for whom the primary treatment goal is quality of life
- which is evidenced by:
  - ◆ multidisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the person ; and/or
  - ◆ a grief and bereavement process for the patient and their carers/family.

*Admitted palliative care* may be delivered:

- in a designated unit; or
- according to a designated program; or
- when the principal clinical intent is palliation.

*Non admitted palliative care* is delivered in the person's usual place of residence including aged care residential facilities.

### 3. Purchasing Specifications

The funding of palliative care services is divided into two broad categories: Admitted care and non-admitted care.

- 3.1 Admitted Care:** Palliative care services for those who have been admitted to a hospital or licensed hospice facility. Emphasis is on alleviation of symptoms and the enhancement of quality of life. Funding is based on a fixed price per bedday.
- 3.2 Non admitted Care:** Palliative care services provided in the person's usual place of residence including aged care residential facilities. Services are provided by a multidisciplinary team of trained staff and volunteers 24 hours a day, 7 days a week where possible. Day respite palliative care services (for the patient or their significant carer<sup>1</sup>) provided in a hospice or designated hospital area that does not involve an admission to the facility, is purchased within this category. The funding of day respite is also based on an agreed price per day of delivered care.

In localities where non-admitted palliative care services (other than day respite) are being developed, these have been block funded. As improvements in the frequency and quality of reporting are achieved, it is the intention of the DOH to progress towards purchasing non-admitted palliative care services in units of day of delivered care.

### 4. Reporting Methods for Palliative Care

All palliative care providers are required to report palliative care service activity as specified in their Service and Financial Plans (SFP) or Contracts using the following guidelines.

Reporting admitted patient activity should continue via the Hospital Morbidity Data System as denoted below:

#### 4.1 Admitted palliative care episodes

The treating medical officer is responsible for the designation of the care type during a hospital admission ie, acute, *palliation*, rehabilitation, psychogeriatric, maintenance care.

It should be noted that the Health Insurance Act requires medical officers to complete an Acute Care Certificate if a patient has been in hospital for more than 35 days and is not classified Nursing Home Type Patient (NHTP). This certificate is to differentiate between NHTPs and other patients. The completion of an Acute Care Certificate by a medical officer does not preclude the patient from receiving treatment classed as rehabilitation, palliation or psychogeriatric care.

The variables *patient type* and *type of episode of care* in the data reported to the Health Information Centre for the Hospital Morbidity Data System (HMDS), record information on different levels of acuity. Hospitals reporting to the HMDS using HA22 forms or the HCARE system should follow the instructions in the *Hospital Morbidity Data System Reference Manual, July 2002*.

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<sup>1</sup> A significant carer is defined as someone whom the patient relies on to remain at home.

When an in-patient with an episode of care classified as palliative is required to have other treatment in the same hospital, they should be counted as being on leave for the day or days they are receiving acute care. An acute episode is recorded for the day(s) of the procedure. An acute DRG is allocated for the portion of the episode related to the surgery. (*Refer 'Admission Policy for WA Hospitals' 17/3*)

The correct designation of type of patient care is assessed from entries documented in the patient's medical records.

#### **4.2 Non admitted activity**

All care provided in the patient's home or usual place of residence should be reported as palliative care activity. For Health Services, activity should be reported as specified in SFPs via the Monthly Progress Reports. Not-for-profit providers should report activity as specified in their Health Service Contracts. All rural providers should report volume of activity as a *day of delivered care*.

A *day of delivered care* occurs when one or more members of a multi-disciplinary team provide one or more services in the patient's home on any one day. One day is a 24 hour period commencing at 00:00 hours

#### **4.3 Recording non -admitted activity in HCARE**

Health Service providers can record occasions of service for palliative care clients under the service provided code. The code for palliative care is "18" and is described as 'related to a service which is specifically structured to give home based palliative care and to which the client care is transferred.' This may include a separate service provided by the same organisation. The same code is used in the Ambulatory, Other Patient and Domiciliary (AOD) and the Community Health (CH) modules of HCARE.

A *day of delivered care* may be derived from occasions of service recorded on HCARE. For example:

- If there were three occasions of service recorded by one or more members of a multidisciplinary team on a particular day (see definition of a day in 4.2) it is regarded as *one* day of delivered care **not** *three* days of delivered care.
- If a palliative care patient was attended by *one* member of a disciplinary team (eg community/domiciliary nurse) whose visit commenced at 23:50 on Wednesday and finished at 00:30hrs Thursday, it would count as *two* days of delivered care.

Health Services must **record** palliative care occasions of service so they are captured on the HCARE system. If difficulty is experienced in **reporting** '*day of delivered care*' in Monthly Progress Reports, this must be discussed with the Palliative Care Purchasing Manager, Royal Street, East Perth.

#### **4.4 Reporting using the West Australian Rural Palliative Care Database (WARP CD)**

The WARP CD holds information for both admitted and non-admitted care provided to individual patients -. The following WARP CD sites should report as directed by the DOH, Purchasing Manager for palliative care:

- Albany
- Bunbury
- Bridgetown
- Broome
- Carnarvon
- Collie
- Denmark
- Geraldton /Midwest
- Kalgoorlie
- Katanning
- Plantagenet (Mt Barker)