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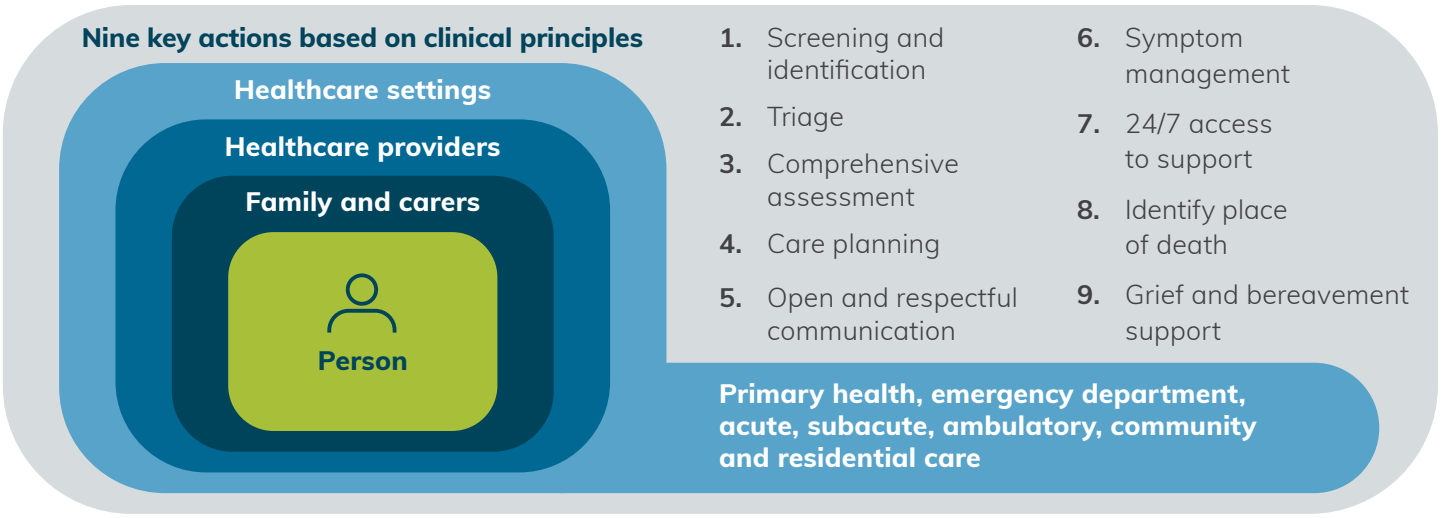
End of life and palliative care

Organisational models

This document provides organisational models for end of life and palliative care. It aligns with the *Clinical Principles for End of Life and Palliative Care Guideline* and supports the *NSW Health End of Life and Palliative Care Framework 2019–2024*. It is informed by evidence on models of palliative care.



Fundamentals underpinning end of life and palliative care

Shared decision-making The patient's values, goals and preferences are central to healthcare decisions made by the patient, their family, carers and clinicians.	**Person-centred care** The patient's physical, psychological, social and spiritual issues are assessed and managed to support communication, coordination of care and decision making for patients, families and carers.	**Integrated cohesive care** Using a holistic approach, management and advance-care planning is assessed across different specialities and care settings. Communications and documents are shared between the patient, their family, carers and clinicians.	**Cultural capability** Based on equity, autonomy, empowerment and trust, this focuses on humane and seamless care with an emphasis on living and cultural respect.
Digital health technology Connecting the patient, family, carers and healthcare providers to support end of life and palliative-care service delivery across different specialties and care settings.	**Governance** This provides processes and mechanisms including agreed leadership and accountability underpinned by appropriate policies and procedures.	**Quality improvement** Regular local review and improvement processes support good clinical practice and service development.	**Data evaluation and monitoring** This checks the quality of care and guides improvements in local models of care and their implementation in practice through the collection and monitoring of data.

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Options for organisational models

The following organisational models outline different options that health services can use to support the delivery of end of life and palliative care. Some services may use hybrid models which could combine different options to suit local needs. Where available, all models listed below include Aboriginal and multicultural health workers and volunteer coordinators as key members of the multidisciplinary team.

Regardless of which model is selected, there are common elements of care:

- assessment
- symptom management
- psychosocial care
- patient-care plans
- end-of-life care planning
- coordination of care.

Interventions delivered by team members include monitoring a patient's status, clarifying the illness experience, providing symptom management and psychosocial care. It also includes executing complex care procedures, coordinating care, supporting quality of life, educating the patient, their family and caregivers and responding to their needs. It involves collaborating with other providers, including referrals and case conferences.

Model 1: Multidisciplinary team

Multidisciplinary teams (with or without palliative-care trained members) within healthcare services organise patient-centred end of life and palliative care. This model is centred around the patient to streamline transitions of care between hospital and community settings. It can be adopted in rural, regional or metropolitan settings and care can be delivered face to face or virtually.

The multidisciplinary team may include:

- nursing
- physicians
- mental health clinicians
- pastoral care
- occupational therapy
- general practice
- psychology
- physiotherapy
- social work
- pharmacy
- dietetics
- speech pathology
- administrative staff.

Model 2: Specialist palliative care

Palliative-care trained members of a specialist team deliver assessment and interventions. This model optimises the coordination of care through physical co-location of team members in an inpatient and/or community setting. This specialist team may also provide a consultative service to other care providers. The team includes: doctors, nurses and allied health professionals.

Model 3: Primary healthcare

Primary healthcare practitioners are responsible for the coordination and continuity of care. They also make referrals to secondary care, such as specialist palliative-care services. A general practitioner plays a key role in patient-centred treatment and management decisions.

This model focuses on prevention, early assessment and reducing hospitalisation. It is a partnership model between local health districts, specialty health networks and primary healthcare practitioners. This model can be delivered in all areas.

Model 4: Nurse-led palliative care

Senior nurses in community and clinic settings lead care. Nurses have primary responsibility for an allocated patient caseload. They work in conjunction with other relevant healthcare professionals. These senior nurses may also provide a consultative service to other care providers. This model is suited to areas where specialist medical care may not be readily available. Care may be delivered face to face or virtually.