Western Bay of Plenty PALLIATIVE CARE SERVICES – a clinician guide

This is a mapping document of the services and supports available for patients with palliative need in the Western Bay of Plenty. It has been compiled to provide information to health professionals working to provide for the needs of their patients.

What is palliative care?

It is important to share the same understanding of the term 'palliative'. The Ministry of Health published the following in the New Zealand Palliative Care Glossary 2015 (full document here).

Palliative Care *is care for people of all ages with a life-limiting or life-threatening condition* which aims to:

- optimise an individual's quality of life until death by addressing the person's physical, psychosocial, spiritual and cultural needs
- support the individual's family, whānau, and other caregivers where needed, through the illness and after death.

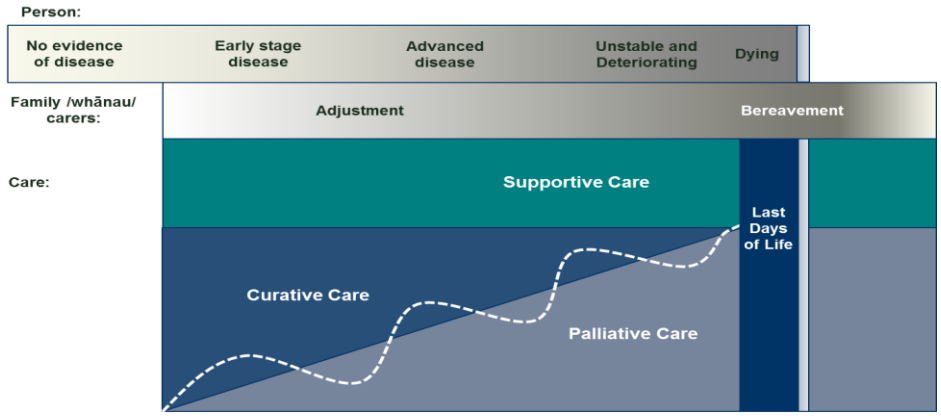
Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may be suitable sometimes when treatments are being given aimed at improving quantity of life.

It should be available *wherever the person may be located.*

It should be provided by *all health care professionals*, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to *meet the unique needs of individuals from particular communities* or groups. This includes but is not limited to; Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless and those in isolated communities (Palliative Care Subcommittee NZ Cancer Treatment Working Party 2007).

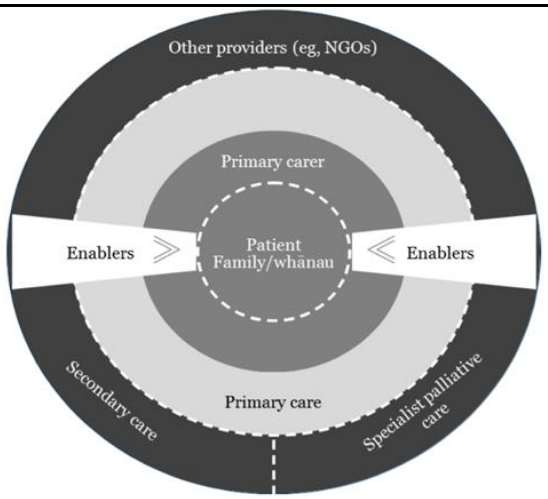
Illustration: Adjustment, support and palliative care for adults



Palliative Care Approach: an approach to care which embraces the definition of palliative care.
It incorporates a positive and open attitude toward death and dying by all service providers working with the person and their family, and respects the wishes of the person in relation to their treatment and care.

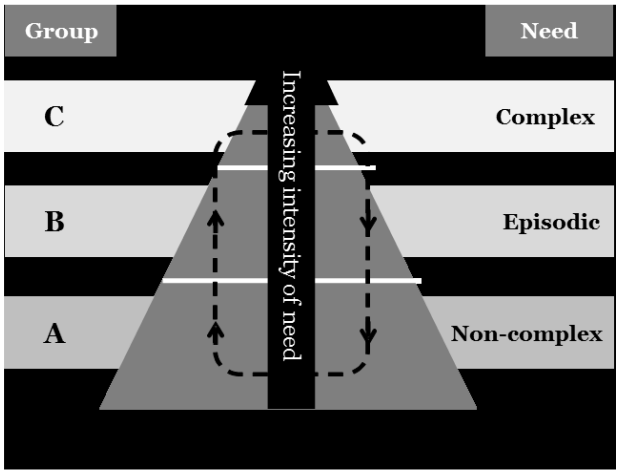
Framework for integrated adult palliative care services in New Zealand

It is also important to share the same understanding of palliative care services. The following is the framework outlined by the Ministry of Health and key palliative care sector stakeholders in 2012 (full document here).



The **patient, family and whānau** are at the centre of the Framework, with the **primary carer** providing the first level of care. In many cases a family member takes this primary role of coordinating and delivering care and supporting the patient. The primary carer as a family and whānau member is both a provider of care and a recipient of supportive care. **Primary palliative care providers**, usually general practice teams, are the main providers of palliative care. Primary palliative care providers work in an 'integrated approach' with **secondary care services, specialist palliative care services** and **other providers** of care, such as aged-care facilities and home-based support services. The context of all care is that the patient, family and whānau are members of a community.

Enablers of an integrated approach can include a shared electronic record, formalised shared-care arrangements between providers, care pathways and clinical guidelines, cultural support and competency, education and training of primary providers.



The Framework supports a dynamic approach to specialist palliative care, based on the concept that for many people the need for palliative care can be appropriately met by their existing primary palliative care provider. Research shows that **the level of need** can be used to classify patients into three groups (see illustration).

Group A, the largest group, comprises patients whose *needs are met by their primary palliative care providers*, and these patients do not need to access specialist palliative care.

Patients in **Group B** require *episodic access to specialist services*, although these patients continue to have their care managed by their primary palliative care provider in a shared care model.

The smallest group is **Group C**. The needs of these patients are *complex* and do not respond to standard palliative care clinical practice guidelines.

The Framework uses a 'right service, right place, right time' approach, supporting competency development and maximising the skills of all providers.

Aim in the Western Bay of Plenty:
For *all* patients with palliative need to receive timely, culturally-responsive care, closer to home.

Key components to providing quality palliative care:

- **identifying the need**
- **communicating prognosis**
- **planning and providing for the need**

Palliative need can be identified using the following general and clinical indicators:

- **The Surprise Question: 'Would you be surprised if this patient were to die in the next few months, weeks, days'? (Less than 12 months)**
- **General indicators of decline - deterioration, increasing need or choice for no further active treatment GSF prognostication**
- **Specific clinical indicators related to certain conditions GSF prognostication**
- **Poor or deteriorating health associated with a life-limiting condition, as outlined in the SPICT™ tool**

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Key

gaps* - represents where the more significant service gaps exist

PRIMARY CARE

General Practice teams

General Practices (GPs) provide coordination and continuity of all care and are the primary provider of palliative care in New Zealand. GPs have the broadest scope of referral options for specialist care, investigations and prescribing. In most instances, general practices are the starting point for patients' health care needs.

GPs and their teams have a key role in the diagnosis and management of life-limiting and life-threatening conditions. These patients will typically see their GP/NP at a minimum of every 3-6 months (when prescriptions are renewed). GPs may consider the benefits of deprescribing as conditions become advanced.

GPs may offer virtual consults as well as in-person consults. They may cater for home-visits if sufficient notice can be given and capacity within the GP schedule allows. Costs will depend on the practice, but can generally subsidised where cost is a barrier. Where practices have a nurse practitioner, home-visits will often be carried out by them.

Patients who do not have sufficient carer support to remain independent at home, may need to go into residential care. The options around this are outlined in the Aged Related Residential Care section and typically involve the GP team liaising with Support Net or Hospice social workers.

> **TBC (NEW)** A further option for patients to access a short-term respite bed (then either go home or transfer to a long-term residential care bed) is being planned by the DHB, and would be fully funded. Expected to be available during 2022 and be accessed via CCC.

Some GP Practices have a holistic Hauora model. Hauora and Kaupapa services in Tauranga listed here. Hauora's provide health services to the local iwi and wider community, offering a very low-cost access (VCLA) scheme in which all enrolled patients receive subsidised patient visits. Each Hauora may have additional outreach and support services to improve access, reduce barriers and improve health outcomes. This may include Nurse Practitioner house-visits, onsite respite care and walk-in clinics.

Medical Centres. Healthpoint is a website where health services are listed. The filters can be used to match a person's particular needs or preferences with a suitable general practice: Option to select by: area, casual, enrolling, wheelchair access, late night opening, open weekend, open now. Healthpoint and WBOP PHO practices also show which practices are currently enrolling new patients.

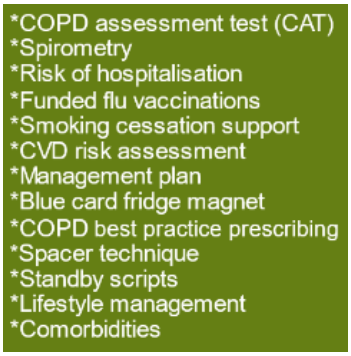
High needs funding. CarePlus funding is a high needs funding scheme to subsidize the costs associated with the management of long-term conditions. This is not limited to palliative conditions with a short prognosis. Under this scheme, several GP consultations are offered either free or at a reduced fee every year to the patient. Additional flexibility is available to fund patients for whom cost is genuinely difficult. All GP practices linked with a PHO can access this fund for their enrolled patients. A care plan needs to be made and kept on the patient management system (PMS), with the option to give a copy to the patient.

A general practice can enrol a patient in Care Plus if they are assessed by a doctor or nurse at the general practice as requiring intensive clinical care because they:

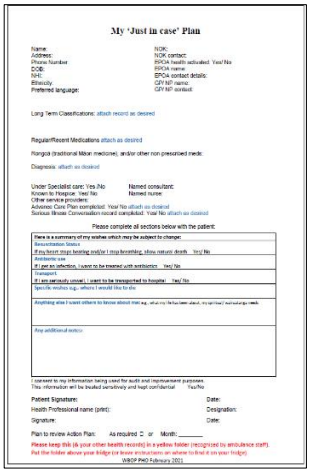
- have a terminal illness (defined as someone who has advanced, progressive disease whose death is likely within 12 months); **or**
- have had 2 acute medical or mental health-related hospital admissions in the past 12 months (excluding surgical admissions); **or**
- have had 6 first-level service or similar primary health care visits in the past 12 months (including emergency department visits); **or**
- are on active review for elective services.

Palliative funding in general practice. WBOP PHO primary care & funding streams . In the WBOP PHO there is a palliative discretionary fund pre-allocated to each practice every quarter. The amount allocated is based on average ratios of palliative patients in general practices. GP practices can use this fund at their discretion to subsidise or fund the cost of palliative consults, prescriptions and home-visits. This fund is generally utilised when palliative needs are high and the patient may be requiring specialist input also (e.g., Hospice). It is not means tested and a pro-equity approach is encouraged.

COPD long term management. There is a primary care COPD programme available to WBOP practices (both PHOs) which addresses COPD management from multiple angles, including late-stage (see picture). This is funded per patient per year and includes training for a practice nurse champion (or GP in smaller practices). Regular respiratory assessments are made to review the patient under best practice guidelines. The blue card fridge magnet has a series of boxes to indicate what kinds of management plans the patient has. One of these options is the Just in Case plan, which would indicate late-stage management of the patient's COPD and a pre-emptive planned approach to a deterioration. GPs access the COPD programme and funding through BPAC.



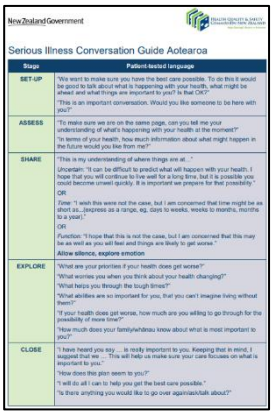
Just in Case action plans - for patients with unstable conditions. Just in Case plans are for patients who are in an unpredictable or unstable phase of their cancer or long-term condition. Plans are developed between a patient and their primary provider (GP/NP) and written to reflect the wishes of the patient and their likely future needs. The Serious Illness Conversation Guide supports a quality Just in Case plan being developed (see page 7). The management of a future exacerbation, deterioration, or distressing end-of-life symptoms can be documented in the form of an action plan and relevant anticipatory medications prescribed. The JIC plan connects the patient and carer with primary care and gives St John ambulance personnel the information needed to enable appropriate care (particularly out-of-hours) St John right care approach. Whānau/family are involved wherever possible. The Just in Case plan template can be found on HealthPathways Midland (under Last days of Life > Information for Health Professionals) – *generic password for Midland Health Pathways on page 7 below,* BOPDHB website with guide, One Place and the WBOPPHO Portal. Just in Case plans should be sent to Health Records as an e-referral via BPAC for upload and 'alert' to CHIP/MCP. If this is not possible, fax a hard copy to Health Records on 07 571 3179. The patient keeps a copy on top of their fridge.


My 'Just in case' Plan

Hospital clinicians can also develop Just in Case plans with their patients – the GP is then asked to review the plan with the patient and countersign the prescriptions and plan (or make a different plan) within two weeks. The new copy needs to be uploaded to CHIP/MCP and given to the patient – to keep on top of their fridge).

Advance Care plans *(Te whakamahere tiaki i mua i te wā taumaha)*. Advance care planning is the process of thinking about, talking about and planning for future health care and end of life care. The Health Quality & Safety Commission provide resources to support clinicians and consumers (myacp.org.nz). Electronic versions can be used or printed and are available here with videos and instructions of how to complete them. There is a link on this page outlining the options for sharing/uploading the ACP in the BOPDHB region (patients/families have options to request upload to MCP/CHIP and their patient portal as well as the GP team).

The Serious Illness Conversation Programme offers training and a conversation guide to support clinicians to have quality conversations with their patients. Having these conversations early and finding out what matters most to the patient is associated with better outcomes for them and their whānau/family. The conversation guide is designed to support quality conversations both inside and outside of the hospital. There are various helpful resources on the HQSC website. The Serious Illness Conversation Guide and training supports quality Just in Case plans and Advance Care Plans.



Information for clinicians and patients

Midland Community Health Pathways provides clinical guidance on palliative and end-of-life care. Pathways are localised to each region (or in the process of being).

Generic Username: midlanduser and Password: midlandpassword

Health Navigator NZ provide easy to understand resources for patients and their whānau/families in various languages. A range of palliative care topics are covered via their website to advise patients and their carers to go to or print off for them.

Out of Hours (OOH) Support

Patients with end-of-life care needs should be able to contact their primary provider, *or another informed clinician* as per Royal NZ College of GPs Quality indicator. This may be done by nominating Hospice, having a Just in Case plan available, handing over to a GP colleague or locum doctor, or providing the patient/whānau with the GP's OOH/mobile number. GPs can also provide this number to hospital telephony.

Access to primary care support for the management of other palliative needs is more limited. Overnight there is little primary care support whatsoever. Since St John operate 24/7, palliative need management can be outlined in a Just in case plan, allowing ambulance personnel to be informed clinicians of the patient care.

OOH primary care support is recognised as a service gap.

Second Ave Health Accident and Healthcare is open 0800-2100 7 days a week. 19 Second Avenue, Tauranga, Ph: 07 577 0010. The clinic is privately staffed during the day and weekend, with GPs rostered to cover 1800-2100 Mon-Fri. Some of the GP cover are rostered on-call, to cover the clinic if needed or attend a home-visit. Medical staff can access community CHIP (clinical health information portal), alerts and Just in Case plans, but not GP consultation records.

Home-visits generally cost $250, paid privately.

Accessing syringe drivers

Currently syringe drivers can only be accessed through Waipuna Hospice and some Aged Residential Care homes (outside of the hospital). This is another recognised service gap.

If the patient is not already known to Waipuna Hospice an urgent referral (verbal and electronic) can be made to do this (see Specialist Community Palliative Care/ Hospice section). Waipuna Hospice will request the GP prescribes the medications for the syringe driver.

Te Ahunga Whānau programme

A long-term conditions programme service where registered nurses and Kaiāwhina to work in partnership with general practice teams in providing a mobile community service to people and their whanau through a whānau ora model. Kaiāwhina, under the direction and delegation of the RN partner, support people in their programme to identify their own goals and work in partnership with the team to achieve their goals. The goals are owned by the patient and whanau. Education on advance care planning, Just in Case plans, and improving quality of life has been included. The purpose is to provide patient-centred care to those referred to the programme and work to achieve health equity for Māori. This started as a pilot with some WBOP PHO practices in the BOP, and is now in the process of being rolled out further.

Supplementary nutrition

The management of cachexia is individualised and requires clinical input – by their GP (if not already in hospital). An oral liquid feed, e.g., Ensure powder is fully funded on prescription with Special Authority. Adding the powder to smoothies tends to be recommended by dieticians.

COMMUNITY CARE

Community Care Coordination: CCC works in partnership with local healthcare services to navigate the needs of patients and link them with the most appropriate service. Most referrals are for home-based community supports, district nursing and ACC wound care. They also work closely with Community Allied Health (OT, PT, SW, SLT, Dietician), the Community Geriatric Team and Support Net. New referrals must be from a registered health professional. Referrals do not require a specific service to be identified, as the CCC will endeavour to coordinate appropriate community support options by the concerns outlined by health professionals also.
Referrals are made via 0800 267 222 or admin@bopccc.org.nz
Hours: Monday–Friday 7:30 AM – 5 PM and Saturday 8 AM – 12 PM

Community Allied Health Services: Comprises physiotherapy (PT), occupational therapy (OT), social work (SW), speech and language therapy (SLT), dietetics, and equipment provision. Rapid Response assessment option. Referrals for CAHS are triaged in a priority system: high risk (usually same or next day response), moderate risk and low risk. Refer via CCC (above).

- Physiotherapy (PT): Work with patients and their family/ whānau, and collaboratively with other health professionals. Offer expertise in relation to balance assessments and mobility around the home, manual handling techniques, and exercise programmes to maintain functional strength, joint mobility and promote wellbeing. Mobility aids or other assistive equipment options can be considered if required. Provide respiratory education and techniques to help manage breathlessness, disordered breathing patterns, and secretion management. On occasion devices such as a cough assist machine may be provided.
- Social work (SW): for psycho-social assessments, liaison across services, education and advocacy for patients and their whānau, help to navigate and facilitate patients' access to financial support, homecare packages or aged residential care, carer support and funeral planning.
- Speech and language therapy (SLT): for all challenges related to speech, oral cares, language, voice and swallowing. Patients with tracheostomies. Palliative care patients may include neurological degenerative disease (e.g., Parkinson's disease. Huntington's disease, Motor Neurone disease, Amyotrophic lateral sclerosis (ALS)), head and neck cancer, dementia. SLT work holistically and in close liaison with MDT, hospice, rest homes, Idea services (IHC) and in patient's homes
- Dietician: for enteral feeding needs e.g., nasogastric or PEG
- Occupational therapy (OT): Assessment for strategies and equipment, depending on an individuals need, to maximise safety and independence. Equipment options can be considered if safety is an issue for the patient or carer(s) e.g., if a patient cannot get in and out of normal bed or requires assistance with transfers, a high/low hospital style bed may be considered. If patient needs this for respiratory issues, suggest purchasing an adjustable back rest. See also the Equipment section below and the Products and Equipment section on page 13.
- Equipment/ Housing modifications (e.g., rails and ramps) have MOH-funded criteria for longer term enablement (up to 5 years) and does not fit with palliative patient cases with short prognosis e.g., 1 year or less. The Ministry of Health does not provide funding for housing modifications (including rails) that cost under $200. Equipment that costs under $50 is also not covered. Clients need to buy privately from a hardware store or mobility shop.

- District nursing services
    - DNs cover oncology-related supports such as management of PICCs, Porto-caths, subcutaneous PEGs palliative service scope. Palliative wound care is also provided e.g., vascular wounds, pressure sores.
    - DNs provide primary palliative care to patients under their care but do not accept referrals solely for palliative care. They do not manage syringe-drivers.
- Short-term Home-care services (e.g., personal care, home management, medication oversight, personal care, etc). Short term services (STS) provide 6 weeks of support based on the patient's current need. CCC review the patient at 4 weeks. If the patient needs ongoing services further arrangements can be made.
    - N.B., *Patients with immediate palliative need can receive more substantial packages of care.*
    - Home Care Providers include Vision West, Healthcare NZ, Access, Enliven, and Disabilities Resources Centre Trust (DRCT).
    - The Māori Health providers include Whaioranga Trust, Pirirakau Hauora, Ngati Ranginui, and Te Puna Ora o Mataatua (TPOOM).
- Kaupapa Māori services and nursing: Ngā ratonga Community & Hospital Services BOPDHB. Includes Pou Kōkiri and Emergency Whānau Accommodation.
- Falls Prevention programme referrals – Strength & Balance community classes/home programmes. Led by allied health Body in Motion team.
- ACC wound care (as appropriate)
- Community geriatric assessments (see more below)

For clients with complex needs in the community, particularly those with frailty, polypharmacy etc – a geriatric service team comprising two Nurse Practitioners, a Geriatrician, several Nurse specialists, and various allied health members are available to call or visit patients for short term supportive input/assess a deterioration.

Community Geriatric Service. Offers short-term acute interventions for at-risk older adults (≥65 years or Māori >55 years), with view to prevent hospital admission and maximise safety and quality of life. Patients are visited at home (unless phone/video consult is adequate) and team will liaise and feedback to the patient's GP. Patient needs may include:

- Increasing frailty
- Geriatric risk factors such as:
    - Depression
    - Cognitive impairment impacting on health outcomes
    - Polypharmacy
    - Falls
    - Nutrition/hydration issues
    - Isolation/lack of caregiver support
    - Recent decline in function
- Current inpatient transitioning from hospital or recently discharged from Tauranga Hospital
- Risk of readmission to hospital or multiple hospitalisations during last 3 months
- Complex multi-morbid patients who require consolidation and rationalisation of their health care plan

Aged Residential Care patients excluded unless referral comes from GP /clinical team for acute decline in function requiring specialist assessment and care planning input.

Exclusions:

- At moderate-high risk of hospitalization because of severe mental illness
- Last days of life/already on palliative care pathway or known to Hospice

Hours of Service:

Monday to Friday, 08:00-16:30, with an aim to respond to referrals within 3 working days.

Service provides short term intervention (ideally not longer than 4 weeks). Refer via CCC.

Support Net is the Needs Assessment and Service Coordination Service (NASC) for long term support services for people with physical, intellectual or sensory impairments, those with very high support needs associated with a chronic health condition or older people with age related loss of independent function.

Support Net aim to support those people who are eligible for assessment to access formal and informal services to be able to live as independently as possible in the community setting for as long as possible.

The needs assessments carried out by Support Net are relevant to the age and needs of the person and identify functional, cognitive and social areas where support is required. Co-ordinated care planning with the person and their carers may result in access to DHB funded services that include support with personal care, medication management, household management (for those with a current community services card), respite and carer support, day activity programmes, supported independent living and long-term residential care when required.

N.B. If a patient's prognosis is less than 3 months, referral requests for home-based support can be directed to CCC, where a funded package can be arranged without the need for a Support Net assessment.

Other Kaupapa Māori Supports - Whaioranga Trust and Te Puna Ora o Mataatua (also mentioned above) provide more than just home care. Whaioranga Trust for example offer whānau support and kaumātua days and Te Puna Ora o Mataatua provide Dementia Support Services for kaumātua & whānau. Huria Trust have kaiāwhina available to sit with patients and their whānau to discuss their health issues and assist in creating a 'whānau plan' or a 'healthcare plan'.

Network Supports - there are various network support organisations available in the community for patients with palliative conditions and other co-morbidities. Support Net promote these and the DHB partially contributes to the funding. They can be contacted directly also. Examples include:
Cancer Society – provides information on every kind of cancer, offers a cancer helpline, one-on-one support, videos, counselling, transport, accommodation, support crew, connecting patients with others, relaxation & mindfulness
Parkinson's NZ– social and support groups, information, advice, advocacy, referrals education, Parkinson's nurse home visits, exercise sessions, interdisciplinary care service offering physiotherapy, hydrotherapy, art and music therapy
Motor Neurone Disease NZ – information and support

Asthma & Respiratory Foundation information on various lung diseases and healthy homes
Kidney Foundation – information on kidney/renal diseases
Heart Foundation information on heart failure and other heart diseases
Pulmonary Fibrosis Foundation – education on PF and oxygen therapy
Multiple Sclerosis Society – information on MS

Age Concern – promote dignity of older people through social connections, health promotion, elder abuse and neglect prevention, advocacy, policy and submissions, research, communication
Stroke Foundation – Kaupapa Māori resources, provides community stroke advisors, return to work support, blood pressure check vans, stroke prevention campaigns, the FAST tool
Also Diabetes NZ, Epilepsy NZ, Arthritis NZ, Blind and Low Vision Society, Halberg Foundation (supports physical activity for physically disabled)
Various Facebook Support Groups are also available for life-limiting conditions

Dementia Support options
Alzheimers NZ – Information about dementia (including in Te Reo Māori), Getting support, Advocacy
Dementia New Zealand – Information, Support, Involvement
Enliven Plus A programme for people with dementia, their care partners and families. Currently needs to be paid for privately.
Dementia Support Services for kaumātua & whānau through Te Puna Ora o Mataatua

24/7 Homecare and Sleepovers (privately funded)
Miranda Smith Homecare – private homebased palliative and end-of-life care, dementia care
Care on call – private Dementia Care, Palliative care, Homecare, Respite and Personal Care
Golden Years Homecare – companion-based services including supports for people living with dementia and cognitive decline

Carer Support – Carer support is a subsidy that allows full-time carers to be reimbursed for some of the costs of using a support person or service to care and support the dependent person while the carer takes a break. A carer is only eligible for this if the person has been assessed for long term support needs by Support Net (NASC) and it has been included in the co-ordinated service package.

Counselling
Grief Support Services offer counselling and regular bereavement support groups which are free to access and are delivered in various locations. Located 147 Chadwick Road, Greerton, Ph: 075784480.
St Peters House offers free or low-cost counselling services free or low-cost counselling services to people in the WBOP. Located 136 Spring Street, Tauranga. Ph: 075715916.
Whaioranga Trust provide whānau counselling support in the WBOP. Located 531 Welcome Bay Road, RD5 Tauranga. Ph: 075449981.
Work and Income can also assist with the costs of counselling (see WINZ disability allowance below).
Community chaplains may be available through churches and religious venues.

MedWise (Pharmacist support services). MedWise provides a clinical pharmacist support service in the Bay of Plenty that includes medicines optimisation, support for people on discharge from hospital and medicines education for consumers and healthcare professionals info here. In relation to a patient with an unstable long-term condition (or palliative need) this may include:


Medwise Clinical Pharmacist Service
PO Box 6164
TAURANGA
Phone: 07 218 6337
Fax: 07 579 4222
pharmacist@medwise.co.nz

MEDWISE REFERRAL: Clinical Medication Review

Patient Details
Name: Patient Name | NHI No: Patient NHI
Residential Address: Patient address
Phone: Patient phone number
Date of Birth: Date | Ethnicity: Ethnicity
Reason for review request: Please describe main concerns and reason for Medwise referral
Consent* (patient consent will be obtained separately by Medwise): Has the patient agreed to the referral? Yes/No
Usual GP: GP: | GP Ph: | GP phone:
Referrer's NAME: (please print) Your name | Phone: Your ph # | Referrer Regn #:
Organisation & Role: Referrer Organisation/Role | Regn No:
Signature: | DATE: Click here to enter a date

- A medication review
- Medication adherence
- Deprescribing
- Pain management

How can patients be referred?

- Medwise referral form here
- E-Referral: via Medtech or via Bay Navigator
- Email: pharmacist@medwise.co.nz
- Phone: 07 218 6337 (MedWise office Monday to Friday) or Fax: 07 579 4222

Aged Residential Care (ARC) facilities (Rest homes and residential villages)

Residential villages - Palliative clients may live in their own villa, home or apartment within a retirement village. If eligible, they can receive DHB funded home-based support services – including support workers for personal cares. Some support workers will have undertaken palliative care training. The clients cannot access DHB funded (registered) nursing care and this would need to be

privately funded. Some retirement village residents may be able to access some support from adjoining residential care services privately and informal supports such as meals from the residential care kitchen.

Rest home beds and Hospital level care beds. There are four levels of care provided in an ARC service – rest home, hospital, secure dementia and psycho-geriatric care. Each of these can provide palliative and end-of-life care to older people who have been assessed by Support Net as needing long term permanent residential care. Paying for Residential care is privately-funded, unless the person meets the Residential Care Subsidy criteria to access government funded care. Many facilities will charge a premium rate. The person and family are encouraged to choose the facility. Full details and availability of options can be found on www.eldernet.co.nz/.

Aged residential care residents are required to have access to General Practitioners and/or Nurse Practitioners and can retain their own GP or the facility contracted primary care services. Many facilities in the Western Bay contract the clinical care of residents to aged care GP providers Cicada Health Ltd (ph: 0223595886) or Third Age Health (ph: 09 390 005). Out-of-hours access to acute medical support is limited and dependent on the contracted GPs and after-hours services. Palliative care clients in short term residential care would be expected to continue to have access to their own general practitioner and their after-hours service. GP practices can counter this out-of-hours gap through documenting Shared Goals of Care, Ceiling of Intervention and Just in Case plans with anticipatory prescribing. This can allow a right care approach reflective of the patient's wishes to be followed when a deterioration occurs. Considering that the average length of stay in a rest home bed just 18 months to 2 years, pre-emptive planning around end-of-life care needs is widely recommended.

Residential care facilities with 24/7 Registered Nurse cover (not rest home or secure dementia units) are likely to have access to syringe drivers. Both medical and ARC nursing teams can access 24/7 telephone advice from Waipuna Hospice for specialist palliative care advice – if their patients are known to hospice services.

Funded Palliative ARC beds. There are DHB funded beds reserved for end-stage high-level care for cancer and renal failure related patients with a prognosis of less than 3 months. Hospital in-patients are assessed for this through hospital social workers. Community hospice patients are assessed by the hospice social workers, who liaise with the patients GP, and then refer to the Tauranga Hospital Social Work Team Leader to seek Palliative Community Bed funding approval. The Waipuna Social Workers assist the patient and family to find a suitable placement.

Many ARC facilities charge additional costs to the funded amount for premium rooms. The average length of stay in a palliative funded bed is 1 month. If the patient is approaching the maximum funded stay of 92 days, the facility can apply either for a short extension or refer back to Support Net for long-term care. Long term placements go through the standard means-tested process. The individual can apply for a WINZ residential care subsidy or loan or pay privately.

N.B. For people living at home and requiring short term residential care at the end of life, access to DHB funded care is limited to specific diseases – cancer and some chronic medical conditions. This is a recognised service gap with families needing to consider privately funding respite care if needed.

St John Ambulance are the main frontline ambulance in New Zealand. The government cover approximately 80% of their funding. The remainder is made up from ambulance part-charges/ membership scheme, third-party contracts and fundraising. Where ambulance costs are a barrier, WINZ may be able to cover the yearly membership and/or a St John alarm. There are also easier

payment options available. Those with hearing and speech difficulties can register with the emergency 111 TXT service .

Palliative and end-of life care are both outlined in the scope of ambulance personnel clinical guidelines. Skill levels vary from Emergency Medical Technician (EMT), to Paramedic, to Intensive Care Paramedic (ICP) which relate to the interventions, medications and decision-making these personnel may undertake. A crew member may call for the back-up of someone more senior as needed. Where appropriate and it is provided, they will call a patient's GP to discuss patient care management. Oversight can also take place with hospice or through their national clinical desk in Auckland.

St John promote a right care approach in the triaging and dispatching of ambulances. St John frequently attend to palliative care patients in the BOP, and endeavour to support the wishes of the patient and their whanau, which are often to remain at home. However, the lack of information and planning around the management of these patients needs means that many are transported acutely to hospital. Just in Case plans can be developed in general practice or in hospital to enable St John to be informed clinicians of the patients care. This can be particularly helpful OOH since there is little other support for these patients and their whanau during these periods.

St John in the WBOP have received training on the Just in Case plans and the administration of subcutaneous medications for end-of-life. They can administer any (anticipatory) medication that has been prescribed for a patient's exacerbation management or end-of-life symptom management. All St John vehicles in the WBOP have been provided with haloperidol and hyoscine butylbromide. They have existing access to fentanyl and midazolam.

There is an Extended Care Paramedic (ECP) scope which has been rolled-out in other areas of New Zealand and is pending the approval of funding in the Western Bay of Plenty. The scope of an extended care paramedic includes the setting up of palliative syringe drivers. Their role covers support to residential care facilities as well as to individual homes.

Products and equipment

Private funding:

The Mobility Centre offers an extensive range of products and services that can be purchased in person or online. The store is at 160 Devonport Road, Tauranga 3110, Ph: 07 571 6351. Their products include seating and bedroom equipment, mobility/transferring aids, toileting and bathroom supplies and safety equipment. Their incontinence range includes disposable and reusable options.

Medical consumables can also be purchased in bulk from Capes. Examples include wound care, incontinence products, gloves and daily living aids.

Large equipment such as hospital beds and hoists can be hired privately on a weekly basis through Mobility Equipment Services based at Tauriko in Tauranga, Ph 0800 141 764.

Funded:

Funded Allied health equipment can be accessed through Community Allied Health. Refer via CCC as above.

For funded incontinence products patients can be referred by a health professional or self-refer to the DHB continence nurse. There is also a community continence service through district nursing, through whom funded products could be provided (refer via CCC).

Hiring a hospital-type bed for a patient at home (at no cost to the patient) can be arranged through Waipuna Hospice for patients known to them.

WINZ disability allowance

Disability Allowance is a weekly payment for people who have regular, ongoing costs because of a disability, such as visits to the doctor or hospital, medicines, extra clothing or travel. Other examples of costs the allowance can assist with are Medical Alarms, Medical alert bracelets, Counselling, Phones, Power/gas/heating or other costs. It is NOT exclusive to those on the disability benefit.

Service Guide for Older People

Tauranga service guide for people aged 65+ by Tauranga Council
A guide containing info on:

- Civil matters – advice, advocacy and information
- Health, independence and well-being
- Nutrition and exercise
- Transport
- Digital and phone support
- Financial support
- Phone numbers

Transport

Some transport options are outlined below. There are known service gaps here.

However, there are limited options available when mobility deteriorates in relation to palliative changes and last days of life. This is when home-visits would benefit patients. It is worth considering:

- Advising patients/their whānau to contact general practice early in a concerning change. This may help primary care to manage these home visiting needs.
- Completing Just in Case plans with ambulance plans.

Total Mobility BOP Regional Council - The Total Mobility scheme helps people with serious mobility constraints access subsidised door-to-door transport through approved transport providers based in Tauranga (and Rotorua and Whakatāne). Assessment and membership details for Total Mobility are on the website (link above). Contact number 0800 884 881 (0600-1800). The following are the approved transport providers – and can be booked privately also.

Trading name	Contact details	Hoist vehicle
Tauranga Taxis	0800 829 477 or 07 578 6086 www.taurangataxis.co.nz/ bookings@taurangataxis.co.nz	Yes
NZ Cabs	0800 482 947 or 07 577 9797 nzcabs.com	Yes
Kubat Taxis	0800 698 294 www.kubat.co.nz bookings@kubat.co.nz	
Driving Miss Daisy BOP	0800 363 000 or 027 607 7354 www.drivingmissdaisybop.co.nz info@drivingmissdaisybop.co.nz	Yes
Freedom Drivers Tauranga South	07 575 6324 or 027 489 7621 freedomdrivers.co.nz taurangasouth@freedomdrivers.co.nz	No
SuperCare4u.com Bay of Plenty	07 343 7220 or 027 6889957 Please book a day in advance where possible. supercare4u.com information@superare4u.com	Yes

St John Health Shuttles - a service that is staffed by trained St John volunteers. It helps people get to their GP, dentist, specialist, or day surgery appointments. Some shuttle vehicles are fitted with hoists to help passengers who have restricted mobility. Booking office for Tauranga, Mt Maunganui, Papamoa: 0800 824 325 (Monday – Friday). Call at least the day before.
Voluntary koha (contribution) from clients.

NZ Red Cross Hospital Transport Service - This service covers the Papamoa, Mt Maunganui & Tauranga area. The Red Cross Transport Service can be contacted by phoning 578 6987 or call free 0800 733 276 or email us westernbay@redcross.org.nz

The National Travel Assistance Scheme (NTA) was set up to help people who travel a long way to *specialist appointments* get some of their travel expenses back.

Enduring Power of Attorney and **Advance Directives**

An EPOA for personal care and welfare is a legal document that gives someone the patient trusts the power to make decisions about their health and welfare if they're unable to. An EPOA comes into effect if they become 'mentally incapable', i.e., deterioration of illness (or an accident) affecting cognition. The person given the decision-making power to is called the patient's attorney. They're often a family member or a trusted friend.

If a patient does not have one set up and they are not able to manage anymore, their family would need to apply to the Family Court to have someone appointed as a welfare guardian. This can be expensive and time-consuming, and the Court may not appoint the person the patient would have chosen. The appointment of a welfare guardian also needs to be renewed every few years.

N.B., If the patient needs CPR the attorney cannot refuse permission. If the patient decides that, in some cases, they do not want to be resuscitated, they need to make an advance directive — sometimes known as a 'living will' — before you become mentally incapable.

If the patient cannot afford a lawyer legal aid may be available see here.

SPECIALIST CARE

Community Specialist Palliative Care/Hospice. The Waipuna Hospice eligibility criteria is based on a national framework which has been regionalised into the Midland framework. See summary box to the right.

REFERRAL CRITERIA link - Individuals should meet all of the below:
- advanced, progressive disease which cannot be cured, or the patient has refused treatment if competent to do so
- complex problems including symptom control, psychological, social or spiritual issues important to the patient
- **the needs of the patient exceed the capacity of the primary provider alone and are best supported by a specialist hospice service**
- the patient agrees to referral if competent to choose
- the patient is registered with a local primary healthcare provider and has New Zealand residency or reciprocal rights
- if the patient is under 18 years old, they are appropriately supported by specialist paediatric services
- if the patient has non-malignant disease, supportive evidence of end-stage disease is provided

Referrals

- Non-urgent referrals can be made as e-Referrals via MedTech or MyPractice. An alternative is to call the Referral Team on 07 552 4380.
- Urgent referrals requiring a response within two working days should involve a call to the clinical nurse specialist in the referral team on 07 552 4380 (Mon - Fri, 8.00am-4.30pm). Urgent referrals requiring a response outside working hours, the on-call medical officer should be called by the referring health professional on 07 552 4380. An Online Referral Form should be completed following this contact link here.

Waipuna Hospice employ a Kaiwhakamaru who works across the service to enhance and support service delivery for Māori. Waipuna Hospice facilitate cultural training and other education both internally and externally (primary care, home-based support workers and aged residential care).

Waipuna Hospice and ARRC facilities are currently the only providers who set up and manage syringe drivers in the Western BOP community setting.

Waipuna Hospice provide equipment for their own clients only.

Specialist Palliative care in the home

- Most patient care and whānau support is provided in the home by an interdisciplinary team that comprises community nurses, CNS, NP, OT, Physio, Counsellors, Chaplin and Social workers. Service provision covers the WBOP area between Waihi Beach and Pukehina Beach. Importantly, Waipuna's IDT teams work alongside a person's GP, hospital specialist, residential care facility staff and/or other health professionals involved.
- Regular IDT meetings are held within the Hospice to discuss the needs of the person and their family/whānau various needs.
- Out-of-hours patient support is available - but at a reduced level. There is an evening community nurse (covering a broad area).
- GPs remain the primary provider of the patient's primary palliative care (and decision-making), even when the patient is registered with the hospice service.
- Hospice may offer additional supports such as family support services and day programmes.

Hospice Phone Support is available to patients and whānau (and health professionals) 24 hours a day, 7 days a week. Access is through the Hospice switchboard during the day and the IPU nurse overnight - 07 552 4380. If the nurse cannot answer immediately, it is best to leave a name and number as they have a call-back system to return calls on. The enquiry can be put through to a hospice doctor at any time if necessary.

In-patient Hospice admissions can occur between 0800-1630 hours Monday-Sunday and require a doctor or nurse practitioner assessment prior to this decision being made. Waipuna hospice IPU beds are limited to a total of 5 (one is used for respite).

Waipuna Hospice has a short stay inpatient unit (IPU). Most people under the care of Waipuna Hospice will not require an inpatient hospice admission, but in some cases, patients may be referred by their GP, specialist doctor or hospice nurse for a short stay for pain and complex symptoms control, rehabilitation, or respite care. Their team of nurses, doctors, social workers and family support will spend time identifying specific needs, and work closely with patients and their whānau, to ensure treatment is aligned to patient need and wishes. The Inpatient Unit has access to all Waipuna Hospice's support services such as counselling, massage therapy and chaplaincy.

A person's length of stay in the IPU will be determined by their identified needs, but generally, most stays are between seven and ten days.

For some patients it may be identified that a hospital-level ARC facility is deemed as more beneficial than transferring back to the home from the Inpatient Unit (DHB funded palliative beds outlined above).

Hospital Specialist Palliative Care – BOPDHB Palliative Care Team in Tauranga Hospital

The Palliative Care Specialist team comprises a Senior Medical Officer, Nurse Practitioner, Specialty Clinical Nurse and a Registrar (on rotation). The SMO supports Whakatane hospital with phone advice on selected days also. The palliative care team is available to all Tauranga hospital wards and departments and compliments the care provided by the hospital staff. They do not see every palliative admission; only where inpatient teams request their input. They operate as an in-person and phone advice consultative service that:

- Provides assessment of patients and their palliative care needs
- Works alongside and in collaboration with the patient's primary team
- Advises on treatment aimed at maximising quality of life for patients and whanau through the active
- Management of symptoms in all domains of life – physical, social, emotional and spiritual
- Supports clinical staff in all aspects of palliative care
- Provides support to patients and whanau
- Promotes a continuum of care across multiple sites for the person and their whanau
- Advises on discharge planning
- Assists with referrals to other community services within and outside the BOPDHB
- Provides education in palliative care to all staff both on the wards and through in-service education

CRITERIA FOR REFERRAL

- Any person, in the hospital, who has a diagnosis of life-limiting illness, cancer or non-cancer can be referred to the palliative care service at any phase of their illness.
- Patient must be aware of and agree to a palliative care referral.
- Clinical teams can also access 'advice only' from the palliative care hospital service.
- The hospital palliative care team is available Monday to Friday 0800 – 1600.

SPECIFIC TRIGGERS

Referral to the service should always follow in these circumstances:

- A patient experiencing physical symptoms or psychological distress caused by a life-limiting illness, cancer or non-cancer
- A patient dying in the hospital and the clinical team require advice regarding end-of-life care of the patient
- The patient and whanau and/or treating team are facing changes in the goals of care, prognosis or treatment and require support/advice.

Referral Process: relevant health professional to complete the electronic referral form - Palliative Care Tauranga Hospital Consult Liaison Service (from One Place)
Urgent: if review is needed same day, call the palliative care team also – via hospital operator
Non-urgent: contact will be made within one working day

The hospital palliative care team has regular meetings with the teams from their counterpart disciplines at Waipuna Hospice. Referrals to Waipuna Hospice is not part of the hospital service and requires a separate referral form, which can be found on One Place. More information can be found on PALLIATIVE CARE intranet page on One Place.

HOSPITAL-BASED SERVICES

Emergency Department

Tauranga ED provide generalist acute care and deal with palliative emergencies and admissions. For many palliative presentations, ED will often default to active care and admission to hospital because of the uncertainty of wishes and access to safe community support. Good documentation of wishes such as Shared Goals of Care or a Just in Case plan may help to prevent admissions where appropriate. If a health professional (e.g., GP, NP, district nurse) has reviewed a patient prior to ED presentation, a call to the ED consultant via the operator is appropriate.

Medical and Surgical Wards

Generalist palliative care is provided on the hospital wards of Tauranga hospital, and involvement from the palliative specialist team will be requested as appropriate. There is a Last Days of Life pathway bundle to direct the approach with best practice guidelines. Unless patients show signs of last days/weeks of life, a palliative approach is not consistently discussed or offered. Palliative patients who do not have sufficient carer support to return home may have funded palliative rest home beds arranged (cancer and end-stage renal failure related, outlined in ARC section). Other patients, who may have a palliative need (but not explicitly identified as palliative) may remain in an acute hospital bed until a rest home bed becomes available.

Hospital clinicians can develop Just in Case plans as a way of facilitating safer discharges and preventing the avoidable readmissions of palliative patients.

Canopy Cancer Centre

A range of oncologists, haematologists, nursing, pharmacy and support staff offering a range of cancer treatments and care, with emphasis on treatment and recovery. Treatments may include chemotherapy, immunotherapy, antibody therapy, hormone therapy and more targeted therapies, in addition to holistic health and wellbeing.

The Cancer Psychological Support Services (CPSSS) Team includes a social worker and psychologist who work with patients until the point of no active treatment.

The specialists will refer to the GP (+/- hospice) when patients fail to respond to treatment and the approach changes to have a palliative focus.

Faster Cancer Treatment Clinical Nurse Specialist Team - there is one Kaihautū Cancer Hauora Navigator Nurse in Tauranga hospital (and one in Whakatane). These navigator nurses support cancer patients and their whānau/family through their care journey, aiming to improve the experience and outcomes for all, particularly for Māori.

Kathleen Kilgour Centre

Offers a range of radiation therapies, both for active cancer treatment and palliative radiation when appropriate. Most radiation treatments are publicly funded, others must be privately funded (such as for Dupuytren's). See the online referral process here.

Chaplain Services

The BOPDHB chaplaincy service offers pastoral care and spiritual guidance to patients and families in the hospital. The chaplains strive to be culturally sensitive and affirm the culture of each person. A chapel for prayer, meditation or quiet reflection is located on the ground floor. Chaplains can be accessed via ward or clinic reception staff, or via the hospital operator.

Hospital chaplains:

- offer spiritual care to all who seek it, regardless of religious or cultural backgrounds
- connect you with a member of your own denomination or faith if you wish (N.B., Jehovah's witness chaplain can be contacted 24/7 though operator)
- provide spiritual support and comfort, prayer, scripture readings and other religious services on request, including Holy Communion

Kaupapa Māori cultural needs

Te Pare o Toi services are available to support inpatient Māori cultural needs Ngā ratonga Community & Hospital Services BOPDHB. Request Pou Kōkiri services on extension 8560 or via the operator.

Shared Goal of Care

Shared goals of care (*Ngā whāinga tauwhiro*) are when clinicians, patients and whānau explore patients' values, the care and treatment options available and agree the goal of care for the current admission and if the patient deteriorates. When shared goals provide the basis for clinical treatment plans, there is less risk of a patient receiving unwanted or unwarranted treatments which is especially important if their condition deteriorates.

This document is about to replace the resuscitation document in Tauranga Hospital.