

PALLIATIVE CARE AUSTRALIA: Generalist Supplement CONSULTATION DRAFT

Overall comments

Thank you for the opportunity to comment on this document and for the work and effort that has gone into its development.

The main comments relate to the intention of the standards, in particular, are they aspirational or do they intend to set standards, guidance and potentially benchmarks. Currently, the standards and the background reads as a comprehensive description of high quality palliative care, and indeed appears to be more describing the scope and activities of specialist palliative care.

Therefore, as written it seems more aspirational. I have pasted in the boxes some areas where this seems to stand out - for example the use of evidence informed clinical assessment tools or validated bereavement assessment tools seems unlikely in routine general practice. Similarly ensure access to 24 – 7 appropriate care, access to respite seems unlikely at least in a number of states in Australia.

There is a gap in the lack of emphasis of anticipation of problems and having potential responses in place prior to a crisis. This seems like a key component/principle of palliative care delivery which I think is not sufficiently highlighted.

A minor comment - throughout the document the word service is used, yet in many instances it will be an individual practitioner eg. a GP.

Finally, it feels like it would be helpful to have some indication of when generalists should be alert to, recognise and act upon the need to engage specialist palliative care services if they are available.

Again, thanks for the opportunity to comment on this. It is an important piece of work.

Standard	Comments (eg noting any gaps, oversights, how integration and comprehensive care might be better supported, etc)
1. Initial and ongoing assessment incorporates the person’s physical, psychological, cultural, social and spiritual experiences and needs.	1.2 Systems include clinical assessment tools, informed by the best available evidence.
2. The person, their family and carers work in partnership with the team to communicate, plan, set goals of care and support informed decisions about the comprehensive care plan.	
3. The needs and preferences of the person’s family and carers are assessed, and	appropriate care available 24 hours a day, 7 days a week, allowing access to the person's

directly inform provision of appropriate support and guidance about their role.	records and advance care plan, and to informed decisions about changes to care, and to certify death; <input type="checkbox"/> an out-of-hours palliative care advice line; <input type="checkbox"/> community support and respite care; and <input type="checkbox"/> a 24-hours a day, 7 days a week access to medicines for symptom management in people approaching the end of their life.
4. The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan.	
5. Care is integrated across the person's experience to ensure seamless transitions within and between services.	
6. Families and carers have access to bereavement support services and are provided with information about loss and grief.	The service uses validated tools to assess for signs and symptoms of persistent and intense distress in grieving or bereaved persons.
7. The service has a philosophy, strategy, values, culture, structure, and environment that supports the delivery of person-centred palliative care.	
8. Services are engaged in quality improvement and research to improve service provision and development.	
9. Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.	
Any other comments	