# THE ESTABLISHMENT OF A NEW SPECIALIST COMMUNITY PALLIATIVE CARE SERVICE

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## KEYWORDS

- Community, Palliative, Establishing, Multidisciplinary

## EXECUTIVE SUMMARY

- The establishment of a new Community Palliative Care Team within a large metropolitan teaching hospital in Sydney has involved both significant challenges and notable successes. From securing sustainable funding and recruiting a skilled multidisciplinary workforce, to navigating the complexities of separating from an existing service, each stage required careful planning and strong leadership. This case study outlines the process of building the service from inception and charts its development and growth over a two-year period. It describes key lessons learned, service innovations, and highlights the patient journey to maintain high-quality, patient-centred palliative care.

## INTRODUCTION

This case study describes the establishment of a new specialist Community Palliative Care Team (CPCT), aligned to a palliative care consultative service at a Sydney major tertiary hospital. Prior to the CPCT commencement, care for palliative patients in the community was provided by two different hospitals in the same local health district, and catchment area for all community services. Establishing our own CPCT ensured improved communication and overall patient management. We will describe how a patient, de-identified to maintain confidenitality, received specialist palliative care from a single service regardless of their location; both in the hospital and the community.

## YEAR CASE STUDY WAS IMPLEMENTED

September 2023 to September 2025

### CASE STUDY DETAIL

Prior to September 2023, specialist palliative care was provided to patients at home; the medical service from one hospital and the nursing and allied health from another. The reality of this meant that at time of discharge home, patients once in the community were cared for by two different services. This carried potential for delays in triage and subsequently delays in assessing patients at home. It also caused confusion and distress for patients, believing that they were being “deserted” by their treating hospital. This was particularly difficult for patients going home for terminal care. Establishment of our new CPCT ensured continuity of care, contemporaneous and appropriate communications, improved patient safety, and provided the patient and their family with consistent care, and a sense of familiarity.

Service establishment was coordinated and implemented by the consultative palliative care Clinical Nurse Consultant (CNC) alongside the Palliative Care Service Head of Department and the Nursing Co-Director. These members of staff simultaneously had a full clinical and nonclinical workload to maintain. Creating the service required generating a model of care, and establishment of 10.7 Full Time Equivalent (FTE), as benchmarked against other CPCTs to provide best practice service delivery. The workforce consists of a full multi-disciplinary team (MDT) including; nursing, medical, physiotherapy, social work, dietetics, speech patholgy and occupational therapy. Logistical and organisational items such as provision of fleet cars,

electronic devices, creation of databases and schedulers, alongside appropriate patient documentation was also required. The recruitment, and orientation of most new staff occurred before the CPCT had officially commenced, creating it's own difficulties. Further, supporting patient safety, regular meetings were maintained by the two hospitals until every patient had been fully transitioned to the new CPCT, continuing over an eighteen month period.

By September 2025, CPCT's second anniversary, the service had grown to 19.7 FTE across the MDT. 530 patients had been referred, with 33% of patients empowered to die within their own home. Referrals have increased by 31% compared to the first three months of the service, and 57% when compared to the busiest three month period. Occasions of service had also increased by 300%.

Multiple lessons have been learned, and we have recommendations for other services wishing to commence their own CPCT. The service commenced with 4.4 FTE of Registered Nurses (RN) with little or no specialist palliative care experience, and most with no community nursing experience. To assist in their learning and standardisation of care, we recommend ensuring systems and processes are in place, such as templates for documentation. Furthermore ensuring access to senior and experienced nurses such as a CNC and Clinical Nurse Educator (CNE). With limited funding a choice was made to employ a Nurse Unit Manager over a CNC. A lack of Palliative Care Unit (PCU) beds in the area, coupled with this junior workforce, has seen high rates of acute hospital admissions, with many patients not wishing to move to the designated PCU due to distance, unfamiliarity and leaving the hospital where they had received all their treatment.

Other recommendations include rostering a RN to cover weekday late shifts, which we have found beneficial to the patients, and aim for two RNs at weekends to ensure staff safety, and ability to review new referrals. With an increase in nursing FTE we now routinely cover weekends and public holidays with at least two nurses, resulting in no delays to patient care.

We believe this implementation is fully scalable, and are actively building an efficient and high performing service. The CPCT, embedded within the wider specialist palliative care service, are now housed in our own joint office space; further improving communication and interpersonal relationships across the teams. Recent and imminent developments include CNE and CNC positions, and we recently gained accreditation for an advanced trainee in Palliative Medicine.

Having a CPCT with a consultative service aids in maintaining a genuinely positive workplace culture. We are proud of our achievements of providing a CPCT built from scratch.

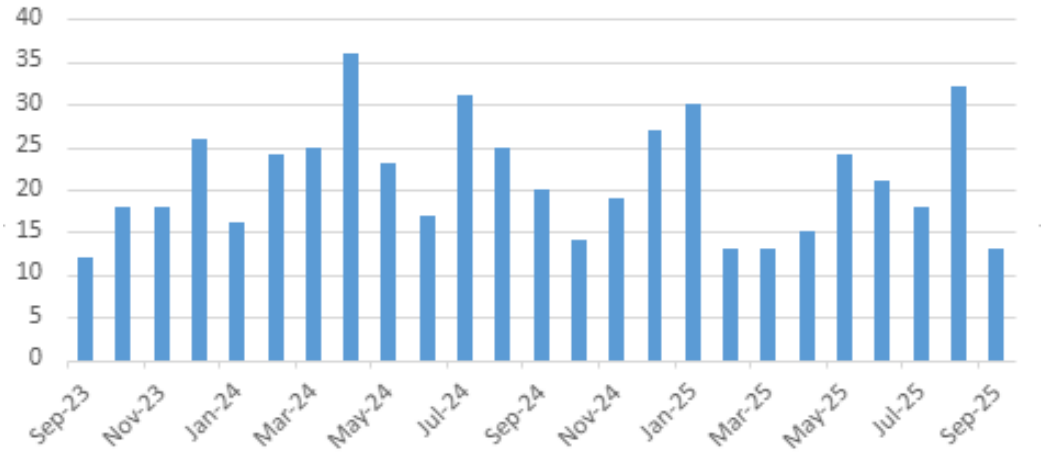


*Figure 1: Number of new referrals to CPCT*

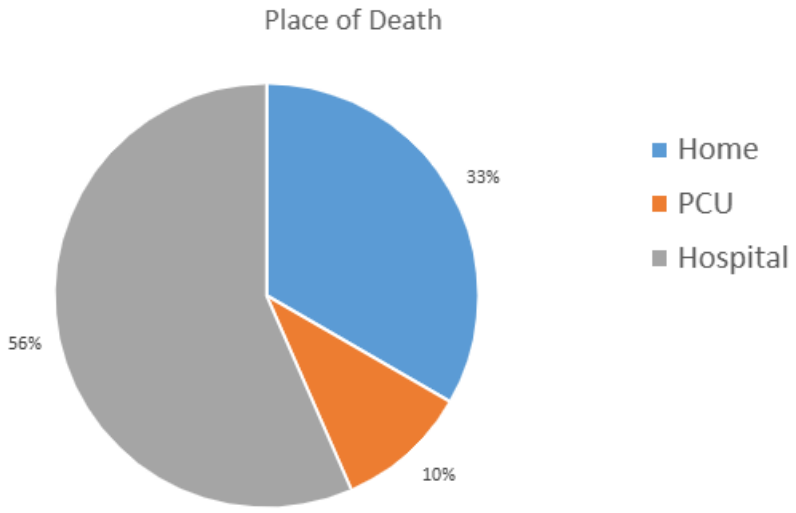


*Figure 2: Place of death for all CPCT patient who died within the first 2 years of the service. Demonstrated as a percentage of total deaths (n=318)*