WHEN CRISIS MEETS COMPASSION: PALLIATIVE CARE- EMERGENCY SERVICES PARTNERSHIP IN AN UNPREDICTABLE CASE

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KEYWORDS

Emergency services in the community, Community Palliative Care, complex transfers

EXECUTIVE SUMMARY

This case examines a highly complex attempted transfer of a reluctant, bed-bound palliative patient to an acute facility for essential procedural care. Despite extensive advance planning by the community palliative care team, the transfer escalated to a six-hour, multi-agency response involving multiple ambulance crews and the fire brigade. Extreme physical complexity, pain, environmental constraints, and system limitations contributed to distress and delay. The case highlights critical gaps in current transfer pathways and underscores the need for earlier escalation, realistic contingency planning, interagency coordination, and transparent discussions with patients and families about the limits of community-based care.

INTRODUCTION

This case study examines an exceptionally complex transfer of a patient from home to an acute hospital, requiring extensive interagency collaboration between NSW Ambulance paramedics, Fire and Rescue NSW, and the Community Palliative Care Team. The transfer involved more than 20 professionals and extended over six hours, highlighting the clinical, logistical and system challenges inherent in managing high-risk patient transfers within the community setting.

YEAR CASE STUDY WAS IMPLEMENTED

2026 to 2026

CASE STUDY DETAIL

This case describes a 60-year-old woman with advanced right hip chondrosarcoma receiving community palliative care, highlighting the significant clinical and system challenges associated with managing complex procedural needs in a home setting.

The patient had previously undergone tumour resection with insertion of a 3D-printed hemipelvis. Over time, she developed severe complications, including extensive right lower-limb lymphoedema, with the limb estimated to weigh approximately 80 kg. She lived at home essentially bed-bound, having not left her bedroom for six months.

Following a fall, the limb was dislocated from the reconstructed pelvis and fixed in flexion, resulting in profound functional impairment. Despite the fall, she consistently declined transfer to hospital, expressing a strong preference to remain at home. Functionally, she was deteriorating and required increasing levels of physical and symptom support.

As the lymphoedema progressed, she developed urinary obstruction. Conservative measures were no longer sufficient; urinary catheterisation became clinically necessary. The Community Palliative Care Team (CPCT) made extensive efforts to explore insertion of an IDC at home. Continence Clinical Nurse Consultant and specialist skill paramedics were considered. IDC insertion was deemed technically unfeasible due to altered anatomy, fixed positioning, and severe pain with manipulation. Concerns were raised regarding the feasibility and burden of six-weekly IDC changes, which were anticipated to become increasingly difficult and distressing. A suprapubic catheter (SPC) was considered the most appropriate long-term management option.

Consultation with local urology services determined the case exceeded their capacity and referral was escalated to the tertiary centre familiar with the patient's oncological history. The tertiary service accepted her for elective admission for SPC insertion. This decision represented a significant shift, requiring the patient to leave her home for the first time in many months.

In the week leading to admission, CPCT nursing and medical staff undertook extensive preparation to support a safe and dignified transfer including repeated home visits, assessment of all possible exits, hallway measurements, and the patient's body dimensions, and anticipation of positioning challenges related to limb size and deformity. Subcutaneous medications, including hydromorphone and midazolam, were prescribed to support pain and anxiety management during transfer. Patient Transport Services were notified in advance and asked to attend the home to assess and plan the extraction.

The patient was involved in discussions throughout and agreed to admission, expressing trust in the CPCT and an understanding of the need for the procedure, while remaining anxious about pain and loss of control. Despite thorough multidisciplinary planning, the transfer did not proceed as intended. On the day of admission, unanticipated challenges arose related to equipment limitations, manual handling constraints, and the physical realities of transferring a patient with extreme limb weight and fixed deformity within a domestic environment. These challenges resulted in increased distress for the patient, her family, and staff, and highlighted the limitations of existing systems in managing rare but high-risk scenarios in the community.

The coordinated expertise of more than 20 professionals—paramedics, fire brigade and rescue services, and community palliative care nursing and medical staff—was ultimately required to safely extricate the patient through her bedroom window. The complexity of the extrication demanded extensive interagency coordination, iterative problem-solving, and real-time adaptation of approaches, all occurring in the context of a patient experiencing an escalating pain crisis.

Key learning points include the need for early, system-level escalation for anticipated procedural requirements, improved integration between services, and realistic discussions with patients and families about the limits of what can be safely achieved at home. It became apparent that pain management extended beyond a traditional palliative framework, with procedural sedation by paramedics becoming the only viable option to enable safe transfer. This highlighted the critical importance of advance communication with ambulance services, the emergency department, and intensive care services. Seamless collaboration between fire and rescue teams and paramedics was central to preparing for sedation and ensuring dignified, safe extrication.

This case underscores the complexity of balancing patient autonomy, symptom burden, and safety in community palliative care. It highlights the critical importance of continuity of care in building trust, enabling honest conversations about risk, and supporting complex decision-making. The case also exposes gaps at the interface between community services, transport providers, and tertiary procedural teams, demonstrating how fragmentation can occur despite proactive planning and communication.