GP LINK Lunches | Rachael Williams

Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.

Rachael Williams

Dr Ken McCroary

Ken McCroary - Welcome everybody to a further edition of GP Link Lunches. As our GP members of Sydney South West GP Link and the wider primary health community are completely aware the local community here in South Western Sydney like the rest of the population is ageing and developing more chronic and complex health related issues.

Our region is growing at a rapid rate though the growth is not lineal throughout the population we have pockets of, or spikes in, different communities and illnesses throughout the South West.

One of the biggest challenges for us coming is the incredible increase in residents in South Western Sydney that will be living with dementia and other neurodegenerative conditions associated with ageing. It's forecast within the 2030s that parts of our region will have the highest incidence of dementia per head of population.

With this comes associated challenges and significant requirements for planning particularly with our workforce moving forward. With age also inevitably comes death and I thought it might be a good idea to discuss this with one of our region's CNCs in palliative care that Link has been working with and the PHN through aged and community working groups and committees.

I am therefore pleased to welcome Rachael Williams to join me today to discuss palliative care particularly in the aged and residential aged care.

Rachael Williams is the newly funded clinical nurse consultant-palliative care (residential aged care). Rachael brings a wealth of nursing experience extending from ICU, end of life research and as the advanced care planning project officer for South Western Sydney Local Health District. Rachael is supporting residential aged care facilities to enable the delivery of best practice palliative care. She has a keen interest in working with projects that transform the delivery of care for those with life limiting illnesses and end of life care needs across all settings aiming to support patient awareness and choice.

Ken McCroary - Thanks for joining us today Rachael. So you have just started this new role with in south west Sydney region about palliative care with aged care and facilities can you just tell a bit about that new role please?

Rachael Williams - Yes sure, so this role started and the end of last year very timely around after the Royal Commission we noticed one of the identified areas was around palliative care and then these roles were created looking at the delivery of palliative care within residential aged care facilities. So my new role is a district palliative care role for South Western Sydney Local Health District looking at the delivery of care and supporting the delivery of palliative care within residential aged care facilities.

Ken McCroary - So the South West certainly has a fair number of aged care facilities as you well and truly know the numbers are exponentially increasing with our aged population and our prevalence with dementia and all of that sort of stuff so I think you are going to have your work cut out for you going forward.

Rachael Williams - Yes so I think we have got over 60 facilities in the district and we have certainly seen an increase in referrals for palliative care, admission for palliative care and I know that the palliative care community teams are obviously looking after a lot of patients in the community as well so certainly within residential aged care as people are continuing to be alive for considerably more time a lot more chronic disease but also we are doing a really good job of treating them so people are able to manage well for longer periods and then it is the provision of making sure that people are at their best for as long as they can be so that is what we are aiming to do within the facilities in South Western Sydney.

Ken McCroary - So, you mentioned referrals where abouts are most of your referrals coming from?

Rachael Williams - We have been taking referrals since probably the middle of January and we have definitely moved over 100 in that time and they have come from a fairly wide source actually. We are looking at discharges from the acute facilities, so the hospitals can refer when patients are discharged to residential aged care facilities. We are getting referrals from out of area when people are transferred as an example from St George, we have had people from Westmead being transferred to facilities in South Western Sydney and then obviously we get referrals from the general practitioners and from the residential aged are facilities directly as well. And then often if those referrals will go through South West Sydney and then they now come to me and I contact the facilities and we get in touch through telehealth the majority of the time.

Ken McCroary - Great, you mentioned the palliative care community teams as well I gather you guys are working relatively closely in this new project?

Rachael Williams - Yes so originally all of the referrals in the past would have gone through the community teams but obviously as the work load has expanded, and COVID played a role in that as well where we saw the community teams like everybody under extreme duress during COVID it was an opportune moment where I was able to actually take those residential aged care facility referrals from the community teams and manage them under a model for the facilities directly so it has enabled the facilities to actually have a model that is directed just at them so all of the facility referrals now come to me rather than the community team and they can focus on the patients that are actually in the community.

Ken McCroary - You were mentioning the palliative care teams and your team and you did mention GPs at one time, how is that interactive liaison role going with the GPs in that transition to facilities and once they are in the facility?

Rachael Williams - Because my role is working primarily with the facility and the governance of medical care for all of those facilities sits with the general practitioners, we obviously have a large area and now being able to work with the facilities, the GPs at the facilities are always involved in the process, so whenever a referral comes to me whether it is from the facility or from the hospital, the GPs are involved in the process. So anytime I review a patient, the general practitioner will always be included in the report I generate from there, any recommendations that come through will also be sent to the GP because they are the medical governance for those residents, so basically it is side-by-side but we are actually just looking as a consultive service and the GP then makes a decision about what they feel is the appropriate care moving forward. We try and walk together, you know I have done a couple of family conferences where I have had discussions with the family the GP have then had discussions with the family so we are trying to walk alongside each other to try and increase the availability and support for the GPs within the residential aged care sector.

Ken McCroary - So, when you are in the facility talking specifics, what sort of things are you seeing yourself doing in terms of advising the nursing staff that are already in the facility? What sort of main things are they calling you about and what are the majority of things you are doing more frequently in there?

Rachael Williams - So generally, what happens is I will initiate a phone assessment so whenever I receive a referral, which has been obviously really useful during COVID as well, and obviously when it started so it has worked quite well. I will call and do sort of like a triage over the phone and just go through and do a phone assessment of what the residents' needs are, what are the major areas of concern for the residents at the facility whether it has been identified by the GP by the facility or somebody else has made the referral. We will go through and just look at what the facility and the GP feel are the major issues for that patient, and then I will go through and look at it from a nursing perspective, looking at all of those nursing related issues and being very mindful of keeping it at the palliative care complex so looking at symptom management, symptom control and what those major symptom issues are for that resident, and then different ways we can look at approaching it and then any recommendations or things we are seeing.

I will then provide that to the residents aged care facility and the GP and they will then decide if they feel that that is appropriate. And then if the GPs ask for a medical referral which is what will often happen, the referrals will still come to me directly and then I will liaise with the community palliative care medical team and then we can go out and do a joint visit together which we do reasonably regularly. I have just been on one today to a facility in Campbelltown and then the medical doctor will then make a whole lot of recommendations. Often they will speak to the GPs directly and have a look at those patients they will then do a medical management plan for those residents. But the initial phone call with me is to have a look at what are the identified palliative care needs and sometimes they are not, sometimes we are looking at what are the different needs of the residents, often I may then refer if I think it is a geriatric problem we will then refer to geriatric outreach and then obviously if it is a palliative care issue then we move forward with the usual pathway.

Ken McCroary - So, in the past if the GP required some assistance with the palliative care issue and they wanted to talk to the palliative care team or physicians is that still something that we should be doing or should we be more frequently going through you as our first stop?

Rachael Williams - What has been happening in the last sort of eight months is any of the GP referral letters will go either via Triple I, a lot of the facilities are now knowing that I am around obviously I am part of the residential aged care huddle that meets every week so a lot of the facility managers now know I am here and a lot of the facilities I have dealt with so a lot of the time they will contact me but in other ways then the GPs can also just send a generalised referral letter to Triple I and then that will just be answered through the same processes but at the same time as that medical letter going through they will refer to me at the same time and I will then initiate that process that we spoke about we just found that way if I am touching base first it just gives us that really good assessment process of what the main issues are and it is a triage process as well to have a look at what is the severity and what is the need and then I can consult with the medical team and we will just move forward from there.

Ken McCroary - You spoke about facility needs, do you guys have the capacity to be able to provide in-service or upskilling training for the staff at the facility? Do you think that is a possibility?

Rachael Williams - Yes education is part of my role, so providing education to the residential aged care facilities, but obviously having to be realistic about the fact there is only one of me and as we spoke about, more than 60 residential aged care facilities so we have been looking at different ways we can provide education and opportunities to update that are already available so programs such as the ELDAC educational program we have a look at the PCOC palliative care outcomes and we did through the residential aged care facility huddle. I organised those two organisations plus first care planning Australia to come and speak to the residential aged care managers who attend about the different educational options that are available. So that is one of the steps that was made.

I have been approached by the facilities to ask me to do individual but I do have to be mindful that what I offer to one I have to be able to offer to all and you know we do have more plans to look at different educational models moving forward as well and obviously with palliative care as a district palliative care obviously works with the Primary Health Network as well and I know there are some GP education sessions being booked with the PHN looking at end of life palliative care and opioid use in palliative care which I believe the PHN have organised with district palliative care so there are some opportunities there for GP sessions as well which I think is really good and really good for the facilities too.

Ken McCroary - Yes, they need support from everyone to help with their education and their management of a very neglected and very under serviced and underfunded part of our health network, isn't it?

Rachael Williams - Yes and I think there is so many more complexities now. You know I think people are, and patients are, and certainly in the 12 years I have been in South Western Sydney, you see that the patients are more complex and they have more complex needs and I think that certainly transfers to residential aged care facilities where in the past those patients may have just been frail and may have been at end of life but now they actually can have some really complex needs and they have to be worked into the same model that they would have been worked into previously and I think that is where we are seeing some of the shortfalls, where these patients can have complex pain needs, they can have complex care needs and that has to be established in a different model.

I think the difference in the delivery of care is something I even have had to get my head around as well as primary care, residential aged care, and then acute care. We're all working in very different environments and I think sometimes we don't always understand the differences that those environments bring to the work we do and I have only learnt that through my own experiences of doing some projects within general practice where we went and did some advanced care planning projects in the Southern Highlands in general practice and I learned so many things about how primary health worked in that three-month period that I would never had learned being in intensive care for all the years that I was.

I don't think we often understand the different models and the way we all have to work and I think when you were talking about silos I think sometimes it is certainly not an intentional silo I think it is just if you don't do it and aren't a part of it then it is impossible to know how someone else's workload. So going into residential aged care has been again another opportunity for me to say ok we need to look at a slightly different model and how can we quicken the model that they have, the resources that they have, the staffing that they have all of those things have to be considered when we look at how we can deliver the best possible palliative care to the residents.

Ken McCroary - I think you have done a really good job there of actually summing up a lot of the fragmentation we have between the different groups of care, particularly with our patients becoming more complex, more complicated and unfortunately that being a sign of the inability to have primary care function as well as we should. A lot of the complexity a lot of this chronic complex stuff is related to degenerative conditions both musculoskeletal neuro degenerative conditions and a lot of them are preventable if we have got a better understanding of what primary care can do and if we got that through to those making decisions and funding choices for that part of the community hey?

Rachael Williams - Yes and I think the other really important part of that and it has certainly been for my role is around that whole coordination and continuity of care, we have really noticed how important continuity of care is when you're dealing with these complex patients. If we are not all communicating well and making sure that continuity happens, then there is no opportunity to get on top of these things early and have a particular plan of care.

So that has been a big part of the initiation of this role has really been about continuity of care, ensuring I get to work obviously with the acute care side of it and make sure it is delivered into the residential aged care facilities and therefore the GPs who have the medical governance there so looking at those processes has been really, really interesting. And certainly part of the work moving forward is looking at the way we refer and the way we discharge this complex patient, particularly our palliative care patients, to residential aged care facility. I think the usual processes of discharge and continuity don't really always work for this sort of group of patients. One of the projects we are focusing on this year is around discharges to residential aged care facility where that whole idea of making sure those really complex discussions and those really complex decision making processes are being communicated between the acute care and then the primary care and the residential aged care. So that is one of the projects I am working on for this year as well so it is really interesting to see how all of that works and doesn't work.

Ken McCroary - Yes, we have got a lot of work to do yet with that communication because it is such a effective and cost efficient way as well getting the groups discussing and communicating and working together, collaborating through primary care is definitely the most cost effective way of managing these patients moving forward isn't it?

Rachael Williams - Yes, it is definitely also in our best interest of the patient you know we could actually incorporate everybody's role and then make sure the family are aware of what everybody's role is, and the patient is aware of what everybody's role is, it just makes that transition that much easier and I am sure from your perspective getting a really good discharge summary with really good information or a discussion around a patient is so much more effective if it is done really well and you have gotten all of the information you require compared to one that isn't and vice versa Being able to make sure all of that information that is really important as an example of when residents come into hospital when that transition is done really well again we know that that is going to make a much better care for that resident or that person that is coming into hospital so I think there is lots of work we can do both ways and that makes me really hopeful. I think there are so many opportunities and even just beginning the discussions I have over the last few months with the residential aged care facilities and the managers and having conversations with some of the GPs in the facilities, it has really enabled a much better process we are able to actually discuss when things are coming up or there is an issue it is all fairly open that line of communication that wouldn't have been there before this role so I think there is lots of availability in options for improvement which is really, really good.

Ken McCroary - Absolutely, thinking of before this role, you have mentioned your previous work within the life care and advanced care directives, again, I can think of another neglected part of aged care what can you tell us about advanced care directives and end of life care?

Rachael Williams - Well mine all started some time ago when I was an intensive care nurse really working with Professor Ken Hillman who obviously is very large in the end of life space and is doing a lot of work at the ACI sort of level. We did some research projects around end of life goals of care having those challenging discussions and I think having spent as many years as I did in critical care I realised how important those discussions can be particularly in those life threatening moments, so it completely changed the trajectory of my career and that is when I then went into the advanced care planning role and started realising how important these discussions were for everybody. For patients, for families, and for the clinicians both primary and acute that were caring for them we all know they are very challenging we all know they are not the most enjoyable things for people to do

but certainly the evidence is there that is does make a difference and certainly from my own experience I have seen that it really does help. I have really found it to be an important part of this role probably I wasn't so much expecting. It could just be because of my background but I have found myself being involved in quite a number of when the referrals come through there has often been some fairly very big advance care discussions being had with families and the patients and residents in the facilities just to ensure everybody is on the same page and it never fails to amaze me how important these conversations can be and what a difference it makes in the delivery of care for those people. So you know I think just having those conversations I think can be such an important part of care in all levels and when those patients the residents I have been involved with and we have had those discussions when they come into the acute care those discussions are well and truly documented and available so it means that because I have seen them and I have been able to document what the advanced care discussions have been I always ask the facilities to ensure any documents are sent which they do the majority of the time if they have them anyway and it just makes such a difference for what the delivery of that care for that person is going to look like. I know it is really challenging and this just supports the challenge and the complexity around it certainly in my experience it has been just so critical and crucial for the patients the families and for all of the clinicians that are involved in the care.

Ken McCroary - Yes, and it is better outcomes for families, patients and us certainly make it worthwhile moving forward. You also initially touched on the Royal Commission and how that was one of the triggers for this new role. Have you got anything else to add about the outcomes of the Royal Commission?

Rachael Williams - Not really I think it is just one of those things we have all been aware of issues within care whether that be residential aged care or general care. The one thing I will say is I think the commission has in some ways obviously highlighted areas that need improvement and that is a great thing. I think it has also added a level of pressure to residential aged care which sometimes is not necessarily a good or bad thing it is just what it is. But I have hope the commission will enable some changes that will be beneficial not only for residential aged care but for the residents as well.

So obviously my focus has been around palliative care provision which was a big part of the Royal Commission but I think as we move forward and we start to see the new standards. There is obviously the new funding model which is just in the process of making its way out and I think all of those things will work towards bridging some of those gaps within residential aged care and supporting residential aged care which I think is obviously what the district of South Western Sydney has been attempting to do as well. We have got my role, we have geriatric outreach which have been doing the most wonderful job and obviously during COVID have just been so critical, then crucial ,and all of these roles are there to support those identified areas. So you know I think working together we can certainly see some changes and I think the facilities will be supported by the new standards the new funding model and hopefully we will start to see some really good positive change.

Ken McCroary - Fingers crossed and not too soon. As you may be aware GP Link represents GPs in the wider GP team and primary care space in South Western Sydney now it is a very interesting area and particularly health wise. Have you noticed any special needs or more significant challenges in South Western Sydney?

Rachael Williams - Yes I have been working in South Western Sydney for over 12 years now and I certainly think there are particular challenges to our area and I think we have, firstly we have a large geographical area you know covering Fairfield, Bankstown all the way to the Southern Highlands so it is a fairly large area. I think as well as part of that geographical area we have had a massive growth and continue to have massive growth so there is obviously challenges from a healthcare perspective both primary and each year to see the numbers of people that are living within South Western Sydney and I certainly don't think that is stopping anytime soon. When we look at all of the development happening so I think that in itself we have a really large multicultural community which again has a different lot of challenges, particularly in that end of life space. There are a lot of cultural issues we need to be aware of and to be identified and supported so I think there is that side of it. And we have a wide ranging socioeconomic status as well so it is not like some of the other areas in Sydney were we see that sort of different levels ours is quite wide and quite wide ranging and we have that socioeconomic status makes it challenging for people and challenging for health service you know because we have got to look at both ends of the spectrum at all times and so I think South Western Sydney does have all of those things and I think we can see that everyone is doing all of the work they can to try and bridge all of those things and bring them all together so I think we are all working towards it as best we can.

Ken McCroary - Yes, we certainly do always have to look every end of each spectrum in every determinate, don't we?

Rachael Williams - Yes.

Ken McCroary - It is certainly a varied and vibrant region. Now you also touched on COVID, what were the main impacts of COVID in the past and present and what you think in the future relating to aged care, palliative care, and aged care facilities?

Rachael Williams - I think COVID has been particularly challenging within residential aged care facilities. I have only been in this role since December so really only one wave of COVID, before this particular role but I was working in the emergency operation centre for south west Sydney during that peak time prior to that and so I think residential aged care facilities particularly and therefore the GPs servicing them have really seen a lot of pivoting. There has been a lot of support required and they have all had to work really, really hard because they obviously hold the most you know their residents are the ones that are at greatest risk. I just think everyone has just done the most amazing job of trying to work together and seeing the residential aged care facility huddle South Western Sydney runs has been a really great example of how everyone just comes together to try and come up with the best possible outcome.

I think there has been many challenges for palliative care and during COVID particularly from that perspective of visitation being able to have people come into the hospital who are dying and not being able to have their loved ones with them and then try to support those people who are trying to get people home again and again those community teams and the GPs involved have to then pivot as well

so I think there has just been so many requirements for everybody to pivot on the spot and just keeping the patient at the centre of everything we are trying to do and therefore the families. So I just think the challenges have been really far reaching and have certainly you could see the impact particularly in facilities having to have their residents almost kind of locked up for such an extended period of time, not being able to have people come in and visit other than when they are at end of life and having to have exemptions, and then I think moving forward the facilities have gotten really good at managing COVID as has everybody through nothing but need and I am just hopeful moving forward I think we have got everything in place to support everybody as best we can. I am seeing so many of my residents now who we do go and see who have had COVID and I mean obviously they have got palliative care needs and they have done just a good job of managing them and it has been really heartening to see actually.

Ken McCroary - You mentioned patient-centred, I like that term, how moving forward do we work better together to improve our patient-centred outcomes?

Rachael Williams - Well that is a good question. I think at the end of the day it is about remembering that the patient is at the centre of everything we do whether it is that difficult conversation, whether it is picking up the phone to the GP or vice versa, whether it is making that referral even if we are just not quite sure, you know opening lines of communication. Examples being the huddle, my position. the Primary Health Network have been amazing at opening all of these lines of communication and I really feel that, that honestly is the key is actually opening the line of communication between all sectors of health care so we can keep the patient at the centre of everything we do because if we don't all communicate and look at the way we are communicating with each other, it is very difficult to provide care that centres the person and therefore their families where as I think all of these steps we are taking, the care that has been provided on all levels is only being improved through those conversations and therefore keep the patient at the centre of everything that we do.

Ken McCroary - Yes, the communication the GPs, the Nurses the rest of the primary health team and the aged care facility is important moving forward. Saying that, we have got about 1100 GPs locally now, not everyone is interested in palliative care, not everybody is experienced and competent in palliative care. How would you rate the engagement of the 1100 GPs locally in the palliative care team and if we could do better how could we improve our GP engagement in this really, really important part of health care?

Rachael Williams - it is a challenging question for me to answer because obviously I have only been in this role for a short period and I have only been working at the aged care residential facilities so I cant speak for how the community teams work and the engagement in that regard. But I think just opening that line of communication and obviously the Primary Health Network are part of that as well, is actually if we can get that engagement with the Primary Health Network to therefore collaborate with those of us in the acute sector I think that is a really good starting point which is obviously the whole point of what they do I think, utilising that ability to coordinate through the PHN through to the district and ensuring there is plenty of forums and opportunities for everybody to liaise and to have these discussions.

But I think that is probably the first place to start and in terms of the residential aged care I think that was a huge part of doing this today was so that the GPs that are working in aged care facilities know that palliative care are here and that we are working in South Western Sydney within the facilities because obviously it is a very wide area as we have discussed and not everybody understands these services are available and I don't always think that that is clear so I think it is about really opening those lines of communication so everybody knows where to go to get the information they require.

Ken McCroary - I think you have done a splendid job of explaining the communication lines and letting us know about the presence of your service so I am thinking of winding up soon so I thought one of the last questions I would ask you is and I know you have only been in this role for a short time but what are some of the rewards and the most positive experiences and outcomes so far, what drives you to be so passionate and interested in what you are doing?

Rachael Williams - I think to be honest I think I always knew from the beginning of being a nurse, from being a baby nurse that I had a big interest in aged care and obviously going into critical care really showed me and highlighted some of the areas seeing people at end of life who really didn't need to be where they were and then having the experience with my own grandmother going through end of life with her so we all have our own personal and professional reasons for doing what we do. I think just recognising the importance you know just really seeing the importance of open communication giving people the information that they need to make really good health decisions so I think that is why I have always pushed myself to do these things and I think that is just the important thing moving forward and keep everyone moving in the right direction.

Ken McCroary - Yes I really like that I always thought and I always tell my students and registrars providing a good antenatal care and a good six-week check is just as important as providing a good death as well, it is part of the journey in primary care that we have got this life-long partnership essentially and the better we can do with end of life and palliation and not like make it a good experience but the least bad we can make it for the individual patient and their family and the people around them at home or in the facilities that are caring and have obviously feelings and input as well is a really big thing and it is neglected and we don't talk about it enough so.

Rachael Williams - And it is an honour you know just like people talk about the honour of being involved in somebody's birth I think there is a huge honour in being involved in somebody's death as well, being any part of that role whether it be providing advice, being there as part of the death and those of us that are just providing advice as we go it is all about remembering that those people and their families are only going to have that experience once and if we can do anything to facilitate the inadverted comments could guess and we also know that it assists with the bereavement process as well so if we can facilitate the bereavement period for families afterwards as well so there is just so many important parts to allowing people to have plenty of information to know what they are going into with their eyes wide open and then supporting them through the process so I think we all get honoured to be a part of that.

Ken McCroary - I think that is a fantastic way to finish up. See there was no need to be stressed like you said you were at the beginning I think you have done tremendous job you have done very well and we are just glad to have you on board doing the role that you are doing with the palliative care and aged care and liaising with us out here in GP land as well so thank you so much and congratulations for what you are doing.

Rachael Williams - Thank you, thanks so much Ken.

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