

## **Connecting lines: Multidisciplinary client centered model of care**

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### Introduction

A review of the bereavement services at St Vincent's Brisbane lead by the Director of Palliative Care identified a lack of psychosocial and spiritual assessment and support for patients, families and children during the patient's illness.

As a result a new model of care was developed and a Patient and Family Support Team (PFST) was formed.

### Objectives

In the new model of care, the PFST (counsellors, social-worker, pastoral care worker) works collaboratively with doctors and nurses in the joint effort of offering an innovative and high quality care for St Vincent's palliative care patients and their carers.

### Discussion

Doctors and nurses identify and assess the patient and his/her caregiver/s' needs. New intakes are discussed in a weekly multidisciplinary team meeting, in which a plan of action is developed and patients and/or carers are referred to the appropriate member of the Team. Prognosis, end of life issues and advanced care planning are discussed with the patient and the carer individually and during Family meetings. The patient and the carer are followed up by the team at home and in the inpatient unit during the trajectory of the illness.

After the patient death, the multidisciplinary team discusses the case in a bereavement meeting. Actions are taken according to the psychological assessment of the carer/s.

### Results

Results from a satisfaction survey conducted in 2013 reveal a high level of satisfaction in terms of patient and carer support. In addition a carer study has been approved and will start late 2013.

### Conclusion

This model acknowledges the uniqueness of each person by tailoring therapeutic interventions to the individual and providing the same quality of service to all. It allows the team to respond to need in a timely fashion with sensitivity and understanding and to follow up patients and carers in a holistic way.

## Is there a place for BIS (Bispectral) monitoring in end-of-life care?

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### INTRODUCTION

Delivery of care to unconscious patients at the end of life is challenging, and many of the critical treatment decisions are subjective, relying almost exclusively on clinical acumen and experience. The outcome of these decisions is crucial to patient comfort, and can have a lasting effect on family and carers. By providing a continuous objective measure of comfort and sedation, Bispectral Index (BIS) monitoring may assist clinicians with many of the difficult decisions, particularly those relating to palliative sedation. BIS monitoring may also furnish information on the subjective experience of unconscious patients, affording a more informed framework for constructive dialogue on the care of the dying.

The palliative care service at Port Kembla Hospital is currently trialing the BIS monitor. A total of 50 consenting patients will be monitored from the time of unconsciousness until the moment of death. The degree of correlation between the following will be determined from the accumulated data:

- Clinical markers of patient comfort and BIS scores
- Clinical markers of patient distress and BIS scores
- Clinical response to breakthrough medication and BIS scores
- Sensory stimulation by means of sound or touch and BIS scores

This poster presentation will include

1. Background information on the BIS monitor and its application in various clinical settings
2. Potential difficulties inherent with its use in the palliative care situation
3. Interim results from the current research
4. Results of other relevant research

## **The development of safe people handling resources: For carers in the home setting**

**Geoff Bell**, Eastern Palliative Care Association Incorporated

During our annual “No Lift - Train the Trainer” day photographs were taken of several “Safe People Handling Procedures” initially to form a booklet to assist staff with care of clients in the home. From this, laminated posters were developed as a tool to meet the needs of families and carers in the home assisting them with on and off bed tasks.

### **Methods**

Eastern Palliative Care Association Incorporated Trainers are trained in the O’Shea No Lift Method. Each year the trainers are taken through re-accreditation and during this training, each “Safe People Handling Procedure” was photographed at key points and directions written to go with each photograph. Directions were kept simple so that all families and carers of clients could follow the instructions step by step.

Posters were developed and distributed to families and carers as identified by staff where safe people handling is required for on and off bed tasks.

### **Results**

The data received from a carer survey will be evaluated in August 2013 to determine the effectiveness of the posters in providing adequate instructions for carers in how to safely transfer clients with on and off bed tasks.

### **Conclusion**

Results from the evaluation in August 2013 will determine whether;

1. The posters are effective and the needs of the families and carers of safe people handling are met.
2. Posters will then be produced in different languages to meet the diverse client base we deal with.

### **References**

Acknowledgement to O’Shea & Associates

## Withdrawing from dialysis

Berquier, I.R. Royal Brisbane and Women's Hospital, Herston, QLD

### INTRODUCTION

Up until the early 1980's only the young and fit were offered renal replacement therapies (RRT)<sup>i</sup>. The number of people receiving RRT within Australia is rising each year with 48% of people currently on dialysis over the age of 65<sup>ii</sup>. Older people dependent on dialysis often experience significant burden from co-morbid disease and a variable quality of life. Withdrawal of therapy is discussed with the dialysis recipient when the treatment is not improving or maintaining a person physically or psychologically.

### DISCUSSION

The cessation of RRT leads to imminent death. The decision to cease must be one where shared conversation occurs between the person, their family, the nephrology and palliative care teams. It is important that the person considering withdrawal from dialysis continues to be seen by the renal team as to not to feel abandoned. A palliative renal shared care model is seen as gold standard<sup>iii</sup>. It is imperative that the person considering palliation is empowered with information regarding a realistic prognosis and can plan accordingly. The person must be reassured that both the palliative and renal teams will provide assistance with psychological, physical, social and spiritual aspects of dialysis withdrawal<sup>iv</sup>.

### CONCLUSION

Palliative care must be offered early to the person contemplating withdrawal from dialysis. Integrating care from both the palliative care and nephrology teams will ensure that holistic management is provided and that a peaceful and dignified death is anticipated<sup>v</sup>.

<sup>1</sup> Fetherstonhaugh D. Dialysis: A paradigm case of rationing medical treatment. *Renal Society of Australasia Journal* 2009; **5**: 88-94.

<sup>1</sup> McDonald S, Excell L, Dent H. Chapter 2. *New patients commencing Treatment in 2008*. ANZDATA Registry report 2009. Adelaide, Australia: Australian and New Zealand Dialysis and Transplant Registry, 2009.

<sup>1</sup> Davison S. Integrating Palliative Care for Patients with Advanced Chronic Kidney Disease: Recent advances, remaining challenges. *Journal of Palliative Care* 2011; **27**: 53-61.

<sup>1</sup> Renal Physicians Association of the USA. Clinical Practice Guidelines on Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis. *Executive Summary of Guidelines* 2010 (Extract).

<sup>1</sup> Germain M. Renal Supportive Care: why now? *Progress in Palliative Care* 2009; **17**: 163-164.

## **Masonettes making a difference**

**Carina Boehm** Clinical Practice Consultant, Paediatric Palliative Care Service  
Women's and Children's Health Network

In 2011 an opportunity presented itself to the Paediatric Palliative Care Service of South Australia to effect a difference to the families we care for and the *Masonettes Project* was born. A bereaved family were the impetus behind this innovative project taking shape and wanted to make a difference for other children and their families. The concept was a result of prior international conference knowledge. The combined knowledge and an opportunity resulted in improved service provision and a positive expression of a family's grief and loss. A mobile cupboard was designed to be equipped with home comforts and amenities not normally available in a hospital environment and the provision of distraction therapy for siblings. This cupboard on wheels can be transported to a hospital room, adapt the hospital room to a more amenable environment and remain with the family during their admission. This presentation will discuss the project development, the impact on children and families, as well as that of the ward staff. The budget, maintenance, and challenges will be considered. The feedback received and the progression of this ongoing project will also be examined.

## Patients with severe resistant terminal restlessness - a retrospective case series

**Laura Booth** Eastern Health

**Michael Franco** Southern Health

**Noam Winter** Eastern Health

**Nicole Stepanov** University of Queensland

**Sonia Fullerton** Eastern Health

### Objectives

There is paucity of information in the literature about terminal restlessness, and valid diagnostic criteria defining this condition is lacking. Severe terminal restlessness (STR) is seen in patients resistant to conventional first line treatment with benzodiazepines. The main objectives of this study were to identify clinical predictors and risk factors in this patient cohort

### Methods

A retrospective case notes analysis was carried out in two Palliative inpatient units Melbourne Victoria. Phenobarbitone was used as a surrogate to identify patients with severe terminal restlessness. Electronic patient notes were analysed for patients between 2008-2012. The control group used in this study comprised of all patient deaths in 2012.

### Results

47 patients met inclusion criteria; of these 44 patients had cancer and 3 had a non-malignant diagnosis as a cause of death. 62% of patients were male, compared with 53% in the control group. The mean age of patients with STR was 60.3 years compared with 75.7 years in the control group. Lung cancer was the most common cause of death and twice more prevalent than in the control group. Not surprisingly both primary and secondary cerebral tumours were three times more prevalent in the patient group compared with controls

### Conclusions

Severe Terminal Restlessness is a complex heterogeneous condition that needs to be identified promptly and managed effectively. This study has identified patients that may be predisposed to develop this. Pre-empting this condition whilst at the same time identifying reversible causes of delirium will allow for seamless management of this distressing symptom.

## **A study to explore the breadth of physical symptoms experienced by constipated palliative care patients**

**Naomi Byfieldt** End of Life Care Project Officer & Clinical Trial Coordinator  
Department of Palliative Care, Calvary Mater Newcastle

Constipation is common in palliative care with few data outlining the breadth of people's symptom experiences. This study aims to investigate this by administering the 11-item Patient Assessment of Constipation Symptom scale (PAC-SYM) together with the 28-item Patient Assessment of Constipation Quality of Life scale (PAC-QOL).

Of the 50 people who completed the PAC-SYM, only one person failed to report any physical symptoms despite a constipation diagnosis. The mean global PAC-SYM score was 1.14 (SD  $\pm$  0.76; range 0-4), reflecting a moderate symptom burden. Problems most commonly reported were either abdominal or difficulty passing bowel actions. This compares with rectal symptoms where nearly half of the group did not describe problems at all.

Similarly, only one of 50 did not perceive constipation to be associated with impaired quality of life with the mean PAC-QOL score being 1.32 (SD  $\pm$  0.62, range 0-4).

No relationship between PAC-SYM and other variables (age, gender, performance status, whether or not people experienced bowel actions less than three times per week) was identified. The only relationship identified was between PAC-QOL and PAC-SYM ( $r^2$  0.29;  $p=$  0.001).

Based on these results, it seems that people experience numerous physical symptoms secondary to constipation. However, rarely would the number of problems listed in the PAC-SYM be explored in clinical practise. Furthermore, this data suggests a relationship between poor constipation symptom control and impaired quality of life. A more definitive approach to assessing and managing the symptoms of constipation is needed.

## **An evaluation of staff attitudes and competencies when caring for dying patients in acute care wards**

**Naomi Byfieldt** End of Life Care Project Officer & Clinical Trial Coordinator  
Department of Palliative Care, Calvary Mater Newcastle

### **Introduction**

Although Australians die in acute hospitals, reports continue to identify that the care provided to such people at this stage of life may be less than ideal (Bloomer et al<sup>1</sup>). A need to undertake quality projects to improve this are needed. A recent project to implement and assess an evidence-based observation chart for the dying has been commenced. Part of the assessment is to consideration of how such an approach to caring for the dying impacts on staff's attitudes and sense of competency when caring for dying people in acute medical wards.

### **Methods**

Prior to the implementation of the Observation Chart for the Dying, staff will undergo a structured education session around caring for people diagnosed as dying. Before the education sessions, staff will be asked to complete the Thanatophobia Scale and Self-efficacy in Palliative Care Scale questionnaires.

### **Tools**

Changes in attitudes towards caring for dying people on acute medical wards will be assessed before the education and 4 months later using the Thanatophobia Scale, we will also assess efficacy in communication and patient management using the Self-efficacy in Palliative Care Scale.

### **Analysis plan**

The mean subscale scores of the questionnaires will be compared. Additional questions will be asked where staff will be asked to consider whether they feel care of the dying is improved by education and integration of the chart and their overall impression of the chart.

### **Results**

The results of the baseline questionnaires will be presented, allowing an exploration of the views of staff in acute hospitals who are caring for dying people on a regular basis. Given the fact that many more people die in acute hospitals than either aged care facilities or palliative care units, this work has the potential to positively affect a significant proportion of the Australian population.

### **References**

1. Bloomer M, Endacott R, O'Connor M & Cross W. The 'dis-ease' of dying: Challenges in nursing care of the dying in the acute hospital setting. A qualitative observational study. *Palliative Med* 2013 Feb 26.



## **Patient participation in the symptom assessment scale: Why is this still a challenge in 2013?**

**Chruszcz, J.** Sacred Heart Health Service

**CHRUSZCZ Janelle**

**CABLE Emma**

**WEYMAN Kate**

**WALKER Stephanie**

**HEHIR Lauren**

**FRANCIS Sally**

**WHITBY Adam**

**VERMA Manpreet**

### **INTRODUCTION:**

The Symptom Assessment Scale (SAS) informs clinical practice by screening for symptoms that are of concern to the patient and require further investigation. Proxy assessment by nurse or carer is a poor surrogate for patient reported outcomes, especially for patients who are able to report on distress of symptoms (To, et al., 2012). Yet, all too frequently proxy SAS are collected in specialist palliative care units.

### **METHODS:**

The project aims to increase participation of SAS rating by palliative care patients who are conscious, willing and able. Clinical Practice Improvement (CPI) provided a framework to examine the practice of engaging palliative care patients in assessing and scoring their symptom distress. The results of the diagnostic phase of this CPI project will be presented and involved; brainstorming; multi-voting; audits; and process mapping.

### **RESULTS:**

Chart audits identified that 60% of SAS were completed by nurses. Process mapping revealed the complexity and challenges for the team in engaging palliative care patient's in reporting SAS. Braining storming and multi-voting revealed accountability and reliability of information contributed to the use of proxy assessment by nurses.

### **CONCLUSION:**

Proxy SAS provides an inaccurate rating of the patient's experience related to the distress of their symptoms and is perceived to occur due to entrenched practices. Addressing the barriers related to patient's completing SAS in the specialist palliative care inpatient setting demands a system improvement approach.

### **REFERENCES:**

Clinical Excellence Commission 2011, *Clinical Practice Improvement Training Program*, <http://www.cec.health.nsw.gov.au/programs/clinical-practice>.

To, THM, Ong WY, Rawlings, D, Greene, A, & Currow, DC, 2012, The disparity between patient and nurse symptom rating in a hospice population, *Journal of Palliative Medicine*, vol. 15, no. 5.

## **Operation Medsafe: A QI initiative to reduce palliative care S4/S8 medication administration errors**

**Cable, E.** Sacred Heart Health Service

**CABLE Emma**  
**CHRUSZCZ Janelle**  
**COUGHLAN Julie**  
**COOPER Janet**  
**FRANCIS Sally**  
**VERMA Manpreet**

### **INTRODUCTION**

S4/S8 medications are used for palliative symptom management. Interruptions in the process of medication administration in the inpatient setting can lead to medication error (Westbrook et al., 2010). This study examined specialist palliative care nurses S4/S8 medication administration practices.

### **METHODS**

Clinical Practice Improvement (CPI) methodology was used to develop and implement strategies to reduce interruptions during S4/S8 medication administrations in a specialist palliative care unit. Baseline medication incident rates data was examined, before a cause and effect diagram was developed and a survey undertaken. These data informed the interventions developed and tested during the project's plan-do-study-act (PDSA) cycles, which included: equipment preparation, rescheduling medication administration times, and introduction of a disposable alert bib for nurses administering S4/S8 medications. After a two week trial the impact of each intervention was monitored for a week using observational audits.

### **RESULTS**

There was a decrease in the mean incidence of S4/S8 medication errors from 3 per month to 0.7 per month, which has been sustained over time. CPI methodology promoted positive teamwork by raising awareness and supporting cultural change.

### **CONCLUSIONS**

Adopting CPI methodology to address a common clinical problem decreased the incidence of interruptions during the medication administration process in this specialist palliative care setting. Importantly, the methodology impacted positively on patient outcomes by fostering a harm prevention culture committed to medication safety issues and changing entrenched practice within the unit.

### **REFERENCES**

Westbrook, J., Woods, A., Rob, M., Dunsmuir, W. & Day, R. 2010, 'Association of interruptions with an increased risk and severity of medication administration errors', *American Medical Association*, vol. 170, no.18, pp. 683-690.

## Peer review for palliative care nurses throughout the Hunter

**Lynette Campbell**

**Ludmilla Sneesby**

A Peer Review meeting is one in which health care professionals seek to improve their treatment and care of patients, and to maintain the currency of their practice by focussing on recent events and outcomes of the group forming the meeting (Raia, 2011). Unfortunately, Palliative Care nurses working in isolation or autonomously throughout the HNELHD had little or no opportunity to participate in a formal peer review activity.

This project facilitates the building of the workforce as well as enables collaboration and team work. The group encompasses palliative care nurses in remote and rural settings thus improving primary health care in the community. The objectives are:

- To critically analyse the circumstances that surrounded the outcomes of care provided by a multidisciplinary team. These outcomes include deaths, serious morbidity and significant aspects of regular clinical practice
- To make recommendations for improving the processes of care given to this group of patients
- To initiate action on these recommendations and to oversee the progress of these actions

An online survey was conducted in January 2013 inviting nurses to evaluate the peer review teleconference process. With a 98% response rate (n=11), 100% stated they found the activity very valuable in connecting and networking with other nurses. Comments were made such as highly relevant and most definitely valuable both individually and as a team. Another comment stated that the peer review process indicates all areas are working together in providing good outcomes for the patient and family.

All participants found that the review initiated reflection on practice and was informative.

### References

Raia, L. (2011). Peer Reviews, Taking on New Meanings. *Nursing administration quarterly*. Vol.35,,No 2,p.p. 174-177.

## **The dying patient: Your call! An end of life education program for GP's, locum GP's and practice nurses**

**Lyndsay Cassidy**

### **Introduction**

Within Australia, General Practitioners and locum services are often responsible for providing after hours medical care to people approaching end of life. However, it is known that GP's can be reluctant to prescribe appropriate medication and are also hesitant to diagnosis dying. This can result in transfer to hospital for patients with a life limiting illness at end of life, instead of being cared for in their existing care setting. This is both burdensome for the patient and costly in terms of health care provision.

The Centre for Palliative Care was invited to develop, deliver and evaluate an education program for afterhours GP's and Practice Nurses.

### **Objectives**

The aim of the education program is to improve GPs and Practice Nurses knowledge and confidence in caring for people at the end of their life. The program examines issues including Advance Care Planning, resuscitation, symptom control and accessing relevant community support and online resources.

### **Methods**

The program was developed by Palliative Care Specialists with input from GPs. A total of 17 programs will be delivered, and they are designed to be interactive and provided attendees with appropriate resources. Pre and post evaluation questionnaires will be completed by participants. The pre-questionnaire will be emailed to participants two weeks prior to the session with the aim of collecting some demographic data as well as survey the participant's knowledge and confidence in relation to caring for dying patients. The post questionnaire will be emailed to participants one month after attending the education session. Data from the questionnaires will be collated on an excel spread sheet to allow for statistical analysis.

Results will be available and presented at time of presentation.

## **Specialist Palliative Care Service responsibility to support Primary Care providers in palliative care planning and end of life care: a review.**

**M. Cole<sup>1,2</sup>.**

<sup>1</sup>*Community Palliative Care Service, Castlemaine Health, Victoria, Australia*

<sup>2</sup>*Loddon Mallee Regional Palliative Care Consultancy Service, Bendigo Health, Victoria, Australia.*

**Background:** Following a gradual but consistent increase in requests from within Castlemaine Health, a review of service provision by the Community Palliative Care Service (CPCS) was undertaken to determine a sustainable level of support to Primary Care Services.

**Aim:** Although this is a small rural service, the CPCS should provide some support to primary care services during an episode of a person's care. This includes promotion of a palliative approach across all care settings and to the community in general.

**Methods:** Data for the previous two years was reviewed to identify episodes of shared care or consultation to primary care providers; Key stakeholders interviewed and responses grouped into themes of need / support; Education provided and evaluated; Stakeholder review to determine perceived benefit.

**Results:** The number of shared care or 'consultation' episodes was not reflected in the data due to limited reporting fields and inconsistency of data entry. Stakeholders agreed that palliative care occurs across all settings but recognition by primary care staff continues to be low. There was a perceived need to increase staff confidence in abilities, recognizing transition of care (phases) and reviewing Advance Care Plans. Two education programs were provided with 47 staff attending. On 10 point scale there was a shift of +2 / +2.2 respectively in knowledge of after education.

**Discussion:** Access to Palliative Care Staff on a regular basis increases staff confidence within Primary Care Services.

**Conclusion:** Increased support and direct promotion of the Palliative Care Service is beneficial for general palliative assessment and care planning across Primary Care Services.

## Death at home associated with palliative care for patients with primary malignant glioma

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### Objectives

The supportive and palliative care needs of patients with primary malignant glioma (PMG) are not well described despite patients having a high burden of symptoms, psychosocial distress and care. This study examined symptom burden and current patterns of hospital utilisation, thereby providing a base to plan appropriate care.

### Methods

Retrospective cohort study of patients in Victoria admitted to hospital between January 2003 and June 2009 with an incident diagnosis of PMG, using linked hospital, emergency department and death data. Analysis was restricted to people surviving at least 4 months from diagnosis. Variables were analysed using descriptive statistics and multivariate regression analysis. The outcomes of interest were factors associated with receiving palliative care, and place of death.

### Results

2011 patients were identified, and 1190 (59%) died during the follow-up period. Of these, 512 (43%) died within 4 months from diagnosis, whereas 678 (57%) survived longer than 4 months. For the longer surviving cohort, palliative care utilisation steadily increased from diagnosis to the death admission (palliative care consultation from 5% to 63%; use of a hospice bed from 2% to 49%). Just one quarter (26%) of patients died outside of hospital.

In the 120 days before death: 1) Receipt of palliative care was associated with paraplegia (adjOR 3.51; 95% CI 2.21-5.57), poor physical function (adjOR 2.99; 95% CI 1.60-5.58), incontinence (adjOR 2.68; 95% CI 1.46-4.91) and vomiting (adjOR 2.30; 95% CI 1.12-4.74). 2) Patients who receive palliative care are more likely to die at home in comparison to an acute care, hospital bed (OR 1.72; 95% CI 1.05-2.81).

### Conclusions

Palliative care referral earlier in the illness trajectory enabled patients to be cared for and die at home. Linked data sets across hospitals in Victoria give valuable insights into the service use of patients with PMG to inform the development of relevant and responsive models of care.

**Tracking pathways to improve health services for patients with advanced cancer:  
Associations between service-related variables and quality of life at baseline.**

- **Patsy Yates (QUT) (Project Principal)**
- Geoff Mitchell (UQ)
- ***Shirley Connell (QUT – Presenting Author)***
- Helen Skerman (QUT)
- Andrew Wilson (QUT)
- Shoni Colquist (Qld Health: Qld Cancer Control Analysis Team [QCCAT])
- Carol Douglas (Qld Health)
- Frederick Burge (Dalhousie University)
- Louisa Gordon (Griffith University)
- James Stevenson (Qld Health)
- Louise Welsh (Qld Health)
- David Wyld (Qld Health)
- Brett Hughes (Qld Health)

**Objectives:**

The overall aim of this study is to quantify the health and support needs of patients with progressive advanced cancer and their primary informal carers over the 6 month period prior to death. The objective of this paper is to describe associations between service-related variables and quality of life (QOL).

**Methods:**

This is a prospective, longitudinal study. Patients were recruited from two major Queensland public hospitals. For a 6 month period, or until the patient's death, data relating to patients' symptom experience, QOL, experiences with care, and supportive care needs are collected at regular intervals using interviewer administered surveys. Information about the patient's health service utilisation is collected from patient-held diaries and from clinical and administrative health records. The data reported in this paper are from the baseline survey only.

**Results:**

The study sample comprises n=47 patients and n=24 carers. Using Spearman's rho, the service related variables (CANHELP) that has a significant positive correlation with patients' QOL (FACIT-Pal Total Score) included the patients' satisfaction of communication with health professionals ( $\rho = .51$ ;  $p < .01$ ) and their satisfaction with how health services manage their illness ( $\rho = .36$ ;  $p < .05$ ). However, satisfaction with their involvement in decision making was not significantly correlated with QOL.

**Conclusion:**

Health professionals' interactions with palliative patients may influence their quality of life. Study findings will inform the development of a large, population based, multisite study from which outcomes will inform planning benchmarks or baselines for palliative care utilisation at a population level.

## **Calvary Bereavement Walking Group**

**Simone Connell** Calvary Bereavement Counselling Service

This project report describes one of the new initiatives of Calvary Bereavement counselling Service (CBCS)- a bereavement walking group.

Reasons for running a group of this nature will be described eg. Throughout a caring role, carer's physical and emotional health can be compromised. Bereavement can be a time of great sadness but also relief and an opportunity for a former carer to begin to address their own previously unmet needs ie support of physical health through walking. Both a caring role and bereavement can bring about feelings of isolation practically and emotionally.

The project report will draw from the CBCS research study in 2005, *Bereaved Carer's Needs Analysis* investigating the experiences of carers in bereavement and what additional services they may like. This will begin to address the quality improvement process that has underpinned this project.

The partnership with the Heart Foundation will be highlighted in the report when defining the service model and setting of care. It will also articulate the formal health provider role within this partnership.

The governance aspects of the partnership including administrative and promotional components will be explored. The structure of the walking group and the intentional therapeutic dimension of the walking group will be discussed so that other interested bereavement services may begin to imagine if this model of service delivery may be desirable within their current service.

Findings from the pilot walking group will be shared and how they have been incorporated into the ongoing walking group will be used to further explore the quality improvement process.



**Dying Well in Residential Aged Care Facilities (RACF) – affirming the role of RACF and changing community perceptions. Report from a COAG funded Palliative Medical Consultative Service into RACF in Sydney Southwest LHD.**

**Elsbeth Correy** Staff Specialist, Braeside Hospital (HammondCare) and Liverpool Hospital, Sydney Southwest LHD. Conjoint Senior Lecturer University New South Wales

**Lourdes Tilde** Career Medical Officer, Liverpool Hospital

**Objectives:**

- Enhance RACF capacity to provide end of life care
- Reduce inappropriate presentations of palliative phase residents to Emergency Departments ( ED)
- Improve community understanding of the increasing role of RACF in End of Life ( EOL) care

**Method:**

2012/13 COAG funding enhanced Palliative Medical consultation into RACF. These doctors also had experience working in an innovative 9 bed RACF Palliative Care Suite.

Consultations included engagement with residents, family, facility staff and GP's on

- Affirming RACF provision of person centred care, personhood of the resident and family/ carer as advocate
- Benefits to residents in palliative phase of remaining within RACF for EOL care and ED avoidance.
- Palliative Care plan
- Affirming capacity of RACF to care for most EOL needs.

**Results:**

Improved understanding in Consultative team of personhood and comfort as Quality of Life concepts in RACF, not primarily functioning.

Improved understanding of the educational goals evidenced by

- Low representations to ED. Satisfaction with EOL care within RACF.
- Changed perceptions about the role of Hospital and RACF in EOL care.
- Increased interest in Advance Care Planning

High Level Care facilities managed well with mild symptom burden. Moderate and complex symptoms were usually manageable with Specialist Medical support. Stand alone Low Level Care facilities had most difficulty with complex, moderate or severe symptoms. Residents with uncontrolled symptoms were offered transfer to Palliative Care Unit or acute hospital.

**Conclusion:**

Involvement of a Palliative Medical Consultative Service with RACF experience led to enhanced EOL care, and influenced community perceptions regarding the increasing role of RACF in EOL care.

**An Australian model for dedicated palliative care beds in RAC –a successful joint venture between Hammond Care’s Bond House RAC and Braeside Palliative Care Service: the first 18months.**

**Elsbeth Correy** Palliative Medicine Staff Specialist, BraesideHospital,( HammondCare) and Liverpool Hospital, SWSLHD. Conjoint Senior Lecturer University of New South Wales

**Gwyn Perrin** Manager, Bond House RACF, Hammondville.( HammondCare )

**Robyn Walton** Assistant Manager, Bond House RACF, Hammondville. (HammondCare )

**Melanie Simpson** Project Officer, Evaluation of Lavender Suite. (HammondCare)

**Meera Agar** Director of Palliative Care, Braeside Hospital (HammondCare). Conjoint Associate Professor, University of New South Wales. Senior Lecturer Flinders University.

**Objectives:**

- Develop a sustainable and transferrable model of dedicated Palliative Care beds within a Residential Aged Care Facility (RACF).
- Develop and maintain skilled, dedicated facility staff, GP’s and Specialist Palliative Medical support
- Maintain patient satisfaction with care provided in previous care setting
- Ongoing evaluation of the service to improve care and address issues raised

**Method:**

- Formal partnership between Bond House RACF, Hammondville and South Western Sydney Palliative Care Service (PCS) including Braeside Hospital PCS.
- RACF Suite with 9 single rooms. Admitting GP and after hours medical service. Dedicated increased ratio nursing staff. Admission criteria including Specialist Palliative Care approval. Estimated prognosis < 8weeks.
- Palliative Medical consultative model of care including resident reviews, weekly Multidisciplinary Case conferencing and 24/7 phone advice.
- Evaluation including ‘weekly alerts’ and formal evaluation by employed project officer

**Results:** Demographics 11/2011- 05/2013: including age, diagnosis, and length of stay of residents. (63 residents to 30/03/2013)

Patient/resident/ carer satisfaction evident through maintenance of symptom management and satisfaction with care following transfer from acute hospital/ Palliative Care Unit. Low levels of ongoing resident/ family/carers psychosocial distress.

Staff satisfaction evident in their passion about the Palliative Care Suite, the “home-like” environment, their pride in the care residents received and their willingness to accommodate residents’ individual needs and wants. Mostly effective medical management model.

Formal evaluation partially completed. Parameters including financial sustainability still require evaluation. Awaiting further funding. Problems identified during evaluation continually addressed.

– case study

**Conclusion:** The Palliative Care Suite in Bond House RACF has provided a clinically sustainable model of care. Patient/ resident / carer satisfaction has been maintained. Staff satisfaction is high. Awaiting completion of evaluation including financial sustainability.

**Anticipatory prescribing of injectable medications in Victorian community palliative care services: a review of current practice.****Penelope Cotton****Aim:**

To review the current practices and policies of Victorian community palliative care services regarding the anticipatory prescribing of injectable medications.

The inability to control symptoms at home is a frequent reason for unplanned admissions to hospital in the last days of life. Anticipatory prescribing of medication for common symptoms at the end of life has been shown to avert symptom crises, increase the amount of time a patient can be cared for at home and improve the likelihood of dying at home. There is however no consensus approach or policy around the anticipatory prescription of injectable medications for community palliative care patients including; which patients require these medications, how they are acquired, stored and monitored. Accessing these medications for patients can be a source of frustration between community palliative care services and generalist practitioners such as treating specialists and general practitioners. This project describes the current practices and policies of Victorian Community Palliative Care services regarding anticipatory prescribing of injectable medications. It is hoped that this information gathering will assist in the development of guidelines to support access to vital medications for community palliative care patients. Data is obtained through survey of Victorian Community Palliative Care services.

## Audit versus actual recruitment in palliative care clinical trials

N Cutri<sup>1</sup>, Fazekas B<sup>1</sup>, Currow DC<sup>1</sup>.

<sup>1</sup>Discipline, Palliative and Supportive Services, Flinders University, Bedford Park, Australia.

**Aim:** The development of appropriate inclusion and exclusion criteria is necessary for recruiting patients who are suitable for a study and are likely to complete participation. Researchers commonly report difficulties with recruitment in any randomised controlled clinical trial and therefore it is important to assess the reasons which lead to study ineligibility<sup>1</sup>. The Palliative Care Clinical Studies Collaborative (PaCCSC) undertakes randomised clinical control trials, which assess a number of symptoms commonly associated with a life-limiting illness.

**Method:** The current recruitment numbers for risperidone (delirium study), megestrol (appetite study), octreotide (bowel obstruction) and Ketamine<sup>2</sup> (pain study) will be compared to previous audit findings<sup>3</sup>, based around inclusion and exclusion criteria obtained retrospectively from multiple palliative care services. The audit was conducted prior to the commencement of each study to determine the frequency of symptoms and the likely proportion of people who would meet general and study-specific eligibility criteria. Using the current data, did the audit accurately predict future recruitment?

**Results:** An audit can predict expected recruitment and dropout rate, by estimating the likely proportion of people who would meet the general and specific eligibility criteria, and then comparing the initial estimate with actual reasons for study exclusion. Frequency analyses have been performed to assess any statistical differences between the groups.

**Conclusion:** Performing an audit prior to a palliative care study appears to predict the actual rate of recruitment. Once a study commences, tracking the reasons for ineligibility is important for improving recruitment, especially in palliative care populations where there are challenges.

<sup>1</sup> Designing Research With Hospice and Palliative Care Populations, Ashley M, Wohleber DS, Davis McKittrick, Davis SE. *AM J Hosp Palliat Care*, 2011, 29: 335.

<sup>2</sup> Randomized, Double-Blind, Placebo-Controlled Study to Assess the Efficacy and Toxicity of Subcutaneous Ketamine in the Management of Cancer Pain. Quinn S, Fazekas B, Plummer J, Eckermann S, Agar M, Spruyt O, Rowett D and Currow DC. *Journal of Clinical Oncology* Oct 10, 2012:3611-3617.

<sup>3</sup> Planning phase III multi-site clinical trials in palliative care: the role of consecutive cohort audits to identify potential participants populations, Currow DC, Shelby-James TM, Agar M, Plummer J, Rowett, Glare P, Spruyt O, Hardy J. *Support Care Cancer* 2010, 18: 1571-1579.

## **“Are you being served” Improving care for our patients in palliative Care**

**Trish Dagleish** Nursing Unit Manager Palliative Care Unit Mt Druitt Hospital

### Problem/Background:

From May 2011 – May 2012, the Palliative Care Unit (PCU) had a total of 35 “reported” falls, that's 8.75 falls per quarter.

This data was taken from the Incident Information Management System (IIMS) and the WSLHD dashboard.

A small team came together and used clinical practice methodology to identify why our patients fall. We knew that we couldn't prevent all falls but we could try to reduce the risks and severity associated with them.

### Aim:

To Decrease falls in the palliative population by 20% at the PCU at Mt Druitt Hospital.

### Problem identified:

After completing an affinity diagram and a pareto chart identifying the 3 main causes why our patients fell, our team then constructed a PDSA cycle and went from there. Two of my team members got a book and rounded the patients in the unit on a hourly basis.

### What changes were made?

This was a cost neutral project, the unit did not require extra staff, we had to change the way we worked.

The staff rounded the patients hourly making sure that the patients were comfortable, their nurse call buzzer was within reach and the environment around the patient's bed area was clear of any obstructions.

It is now core business of the PCU that hourly rounding is done on all patients on all shifts

### Measurement/ process measures

This allowed the staff more interactions with the patients and the carers and vice versa

The nurse call buzzers were decreased,

Falls dropped by 36.6% (we aimed for 20%)

There were fewer complaints by the relatives and patients and more compliments

Patients' needs were being met more frequently,

Staff injuries decreased due to fewer patients falling (manual handling risks)

Improved staff satisfaction

### Benefits to the organisation

Decreased cost

Decreased cost = decreased length of stay

Rounding equals decreased falls

Good change is sustainable change

### Benefits to the patient & carers

Improved patient/carer journey

Patients' needs are met in a more timely fashion

### Plans to sustain or spread change.

It is now core business to round hourly on the PCU; new staff is explained the benefits and current staff are encouraged to hourly round.

It is brought up at each ward meeting about hourly rounding and the expectations of rounding.

## **Knowing what to say after recognition of deathbed visions: A systematic review**

**Devery K** Flinders University

**Tieman JJ** Flinders University

**Damarell R** Flinders University

**Rawlings D** Flinders University

### **Introduction**

Many nurses, doctors and allied health care professionals who work with people who are facing the end of their lives have heard stories or accounts of deathbed visions and hard to explain phenomena. Such patient phenomena and accounts take on many forms:

- patients hearing the voices or seeing relatives who had died sometime before,
- being aware of the time and day of their own death,
- having a dream that is quite significant
- seeing angels or religious identities

### **Aims**

The aim of this Systematic Review is to answer the following question: *What are the clinical opportunities and responses to reported deathbed phenomena of patients who are 'palliative'?*

### **Discussion**

At the heart of compassionate health care is an elemental requirement to truly listen to the patient and carer. Rather than dismiss deathbed visions as drug induced or physiological effects of dying, these significant events can bring comfort to patients and carers. Disclosure of deathbed visions can be a point at which health care professionals can begin to discuss more spiritual and existential concerns of patients and carers, which have the potential to offer hope, meaning and connection. This talk will inform clinicians on the practical steps that can be taken in response to reports of deathbed phenomena.

### **Conclusion**

All clinicians who work with people at the end of life can know what to say when challenged by the report of a deathbed vision or phenomena.

**My Learning: staying well informed**

**Devery K** Flinders University

**Tieman JJ** Flinders University

**Introduction**

Learning through case based narratives is a powerful method. Online learning has been found to be effective and well received for ongoing education for nurses [1]. CareSearch is an online evidence based resource for palliative care, and online learning modules have recently been added to the website.

**Aims**

My Learning helps users stay well informed. My Learning is a series of interactive learning modules designed to help guide users in how to use 6 of the core website resources to provide better clinical care, or answer service related questions.

**Approach**

A factsheet designed to help answer clinical questions has been a well evaluated tool available to support evidence based practice (EBP). This process has been utilised as a framework in the development of online learning modules.

An experienced educator has developed the modules based on experience and on the literature related to online learning. Case studies are used, a format that is well received by nurses as a learning tool.

**Outcomes**

The learning package includes a quiz and a demonstration of website resources. The modules are free to use, easy to access and a certificate is available for professional records.

**Discussion/Implications for practice**

CareSearch has developed online learning modules within an EBP framework to help find relevant evidence to answer clinical questions. Online learning modules can also fulfil the need for ongoing professional development and lifelong learning.

**References:**

[1] Karaman S. Nurses' perceptions of online continuing education. *BMC Medical Education* 2011, 11:86 doi:10.1186/1472-6920-11-86

## Palliative care database

**G. Dixon** Clinical Nurse Consultant & Coordinator of Community Palliative & Supportive Care Services, HammondCare Health & Hospitals

**K. Gill** Service Development Manager, Palliative Care, Northern Sydney Local Health District

The ability for health professionals to access patient information that reflects a multidisciplinary approach to care which involves family and carers is a core component for the provision of holistic care. Transfer of information between the community setting and the acute services that articulates the expressed wishes and choices of individuals and provides a summary of the clinical assessment of the patient enhances a coordinated and collaborative approach to care.

To promote this approach in palliative care, a Northern Sydney Local Health District (NSLHD) Working Group was established with the aim to develop a Palliative Care Database within the current NSW eMR. Enhanced care would be achieved through improved communication between clinicians due to easy access to patient information that is current and available regardless of location.

This work aligns with priority 4 of the Palliative Care Strategic Framework 2010-2013), improving palliative care data, and is informed by the National Standards for Providing Palliative Care for all Australians. The Palliative Care Outcomes Collaboration (PCOC) dataset is incorporated to the database for service evaluation and benchmarking.

Palliative care is provided across many settings and clinical services and therefore, is an integral component of the health system. This Palliative Care Database has been approved for inclusion as a NSW state-based build, facilitating its use by other services.

The poster presentation will illustrate the steps the group took to arrive at the implementation of the pilot phase of the project, its evaluation and the future opportunities for its use and further development.



**Palliative care outreach end of episode/ reactivation of episode of care****Lisa Dunford****OBJECTIVE**

This is a continuous quality improvement initiative developed for the Palliative Care Outreach service to maximise the efficient use of its available resources so that we can continue to provide a quality service to a rapidly expanding community based need.

**METHOD**

This method of patient support enables the Palliative care Outreach patient to have their Episode of Care end if they are stable and managing well from Initial contact and throughout their time on the service. The issues affecting a patient and their carer's are variable and are considered before ending a patient's episode of care. A patient may have an End of Episode in place with Palliative care Outreach and still be supported by the Allied health team. The patient/carer are educated at initial contact so that they clearly understand the process and how to reactivate contact with the service when requiring support in the future. The patients General Practitioner is always faxed to inform them of their patients current level of contact with the team.

**RESULTS**

Patients could possibly have an End of Episode of Care and Reactivation of Care many times as their condition changes while on the a service. This method ensures that New referrals, Unstable and Deteriorating patients are prioritized. It has significantly reduced the number of phone calls and support visits by the Outreach team successfully enabling the team to efficiently managing the growing demand for palliative care support in the community.

## Simple strategies to improve patient safety and prevent medication errors

**Karen Eaton** Nursing Unit Manager

**Julie Farmer** CNE

**Alice Lau** RN.

Palliative Care Unit, Greenwich Hospital, Sydney NSW.

### Introduction

The palliative care unit at Greenwich hospital, Sydney Australia administers on average between 250 to 400 doses of Schedule 8 and 4d drugs to patients a day. In an effort to improve efficiency and decrease the incidence of S8 and s4d drug errors the unit embarked on a medication systems redesign project.

Staff identified distractions, lack of focus, poor communication, and failure to follow standard operating procedures during medication administration as factors contributing to inefficiencies and medication error.

A number of strategies were introduced such as the introduction of a team leader, the wearing of a 'Do not disturb bib' during drug rounds, minimizing two nurses at any one time at the drug safe, rationalization of S8 drug cupboards, introduction of an electronic key finder and implementation of a S8 drug communication tool.

### Method

Drug error incident data was audited 6 months prior to and 6 months post introduction of the interventions.

The number of times nurses were interrupted during S8 and S4d drug rounds was recorded over a 14 day period utilizing a tick box questionnaire prior to interventions and measured again for another 14 days post interventions.

### Results and Discussions

In the 14 days prior to the interventions staff recorded an average of 4.3 interruptions and post an average of 1.8 interruptions per drug round. A 90% reduction in the occurrence of S8 and S4d medication errors has been achieved and the drug rounds have become streamlined improving the provision of patient care and safety.

## **"Caring for Pasifika families" living in Auckland - A Pasifika perspective.**

### **Luisa Falanitule**

This presentation we will look at how do we support Pasifika fanau (families) living in Auckland to ensure they are receiving appropriate end of life care through a holistic approach of physical, psychological, emotional, spiritual care.

For many in the Pasifika community, hospice is an unknown concept. For many it is considered a 'palagi' (Pakeha / European) concept and a service providing care that is different from the preferred family model of care that is widely accepted. The Pasifika community within the Auckland region is a large, ethnically and linguistically diverse group.

The Pasifika community represents approximately 12% of the population, nearly 51,890 people (Auckland District Health Board website). This number includes those who identify as Samoan, Tongan, Cook Island, Niuean, Fijian, Tokelauan and Tuvaluan. Focus groups held as part of the Cultural Care Project within Mercy Hospice Auckland (MHA), with Tongan and Niuean people, reveals that very little is known about hospice and the services it can offer.

It is important to provide a service to Pasifika communities, which is accessible. Community engagement and building stronger relationships is necessary to ensure that there is better understanding of hospice services, and for hospice to better understand the care needs of this community for end-of-life-care.

The recent development of Pasifika Palliative care resources "Caring for Pasifika families" (translated into four different Pacific Ethnic groups Tongan, Samoan, Niuean and Cook Island) will be highlighted in this report including Pasifika community engagement and working with Pasifika families.

## **Monitoring clinical trials – improving quality**

**B Fazekas** Flinders University

**N Cutri** Flinders University

**L Devilee** Flinders University

**C Litster** Flinders University

**D Currow** Flinders University

### Aim:

PaCCSC undertakes an innovative and complete monitoring process for the quality of data. The review of files is targeted at specific data elements and has involved both study monitors and study staff from recruiting sites. Does this process result in an improvement in data quality over time?

### Method:

The monitoring outcomes of three studies have been examined; ketamine (to manage cancer pain), octreotide (for control of vomiting in bowel obstruction) and risperidone (for the management of delirium) to see if the monitoring process improves the quality of subsequent recruitment. The review considered the different training procedures implemented across 4 years.

### Results:

Monitoring of two studies is now complete and specifically used site staff to monitor other sites; the third study is still recruiting but can similar strategies bring about similar changes?

Improvements are evident for each site in response to direct feedback from monitoring.

### Discussion:

Monitoring has ensured that the data quality can be enhanced and has resulted in exclusions of some participants that were not eligible. The use of different monitoring strategies is integral to the process of improving quality.

### Conclusion:

Monitoring as part of clinical trials can improve the quality of the documentation and ultimate study outcomes. The challenge is how to use the process of monitoring to bring about sustained improvement over time.

## **Palliative care experience, education and education needs of aged residential care clinical staff**

**Rosemary Frey<sup>1</sup>, Merryn Gott<sup>1</sup>, Michal Boyd,<sup>1,2</sup> Jackie Robinson<sup>1,3</sup>**

<sup>1</sup> Faculty of Medical and Health Sciences, University of Auckland, New Zealand

<sup>2</sup> Waitemata District Health Board, New Zealand

<sup>3</sup> Auckland District Health Board, New Zealand

### **INTRODUCTION**

The New Zealand Palliative Care Strategy has identified a: “scanty provision of palliative care in institutional settings for the care of older people and those with degenerative conditions” (MOH, 2002). Interviews with hospital clinical staff conducted for a Health Research Council/Auckland District Health Board partnership project, pinpointed a lack of formal palliative care training among ARC staff as a potential contributor to inappropriate hospital admissions of residents from ARC facilities.

The objectives of the present study are to examine the palliative care related: experience, education and education needs of clinical staff working within the aged residential care setting.

### **METHODS**

A purposive sample of clinical staff members (392) across 52 ARC facilities in one district health board were surveyed regarding their palliative care experience and education.

### **RESULTS**

Early results (n = 164) indicate that on average the clinical staff rated the quality of care provided to people who die in their facility as either “very good” (36%) or “excellent” (29%). The majority of participants reported that between 1-25% of the residents that they cared for would have been eligible for end-of-life care. However, slightly over half (46%) of respondents reported formal palliative care training. In contrast, the majority (80%) of respondents answered that they would like formal training.

### **CONCLUSION**

Although preliminary, the findings indicate both the need and desire for formal palliative care education among ARC clinical staff. The results of the study should be utilised to inform the design and delivery of future palliative care education programmes within ARC to successfully meet the needs of all clinical staff.

### **REFERENCE**

Ministry of Health. *Health of older people strategy*. (2002) Retrieved April 16, 2012, from <http://www.moh.govt.nz>.

## The role of clinical hypnotherapy for cancer patients in the palliative care setting

**Jenny Gilchrist RN, BNurs, Grad Cert (Cancer Nursing)**

Clinical Nurse Consultant, Metastatic Breast Cancer, Westmead Hospital, Sydney.

In Australia, two out of three cancer patients use at least one form of complementary therapy during or after their treatment<sup>1</sup>. Cancer patients receiving palliative care commonly investigate the use of complementary and alternative medicine (CAM) as an adjunct to conventional medicine for a variety of reasons, including the desire for a therapeutic response, maintaining control and hope<sup>2</sup>. Patients often use CAM for the management of side effects related to either their disease or treatment<sup>3</sup>, and as a result are able to maintain their own physical, emotional and psychological well-being. In the palliative setting, where the goals of care are symptom management and improvement of quality of life, some complementary therapies have the potential to play a vital role.

Regardless of what health professionals believe about CAM, it is apparent that cancer patients are using and are going to continue to use these therapies in addition to conventional medicine. It is therefore important that healthcare professionals are informed and able to provide appropriate information to patients regarding these treatments. Education of healthcare professionals also facilitates the integration of scientifically proven complementary therapies into mainstream healthcare, and consequently fosters a more holistic model of care, the preference for many cancer patients<sup>4</sup>.

This poster will discuss the role of hypnotherapy in cancer patients receiving palliative care. There is some evidence to suggest that hypnotherapy, a non-invasive modality of treatment has beneficial effects on pain, nausea, dyspnoea, anxiety and fatigue, the most common and distressing symptoms in terminally ill patients<sup>5</sup>. Despite this however, research to date is limited, and there is scope for further research before clinical hypnotherapy can be more integrated into the mainstream palliative care of cancer patients.

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## **Death in the midst of life – A vignette of doctor's role in community paediatric palliative care**

**Aisling Griffin**

Daily in palliative care we listen to peoples' stories. There are many occasions where the patients and families we are honoured to care for have a profound effect on us and our view of life. These tend to occur even more, when the stories we hear have parallels with our own lives.

Reflective writing has become a more accepted form of professional medical self-assessment over the last few years and now is included in continuing medical education evaluation. However, more than this, it helps us maintain a level of insight into our daily practice, cultivate our observational skills and become a more critical observer of our own response to the patient's illness, treatment and the context of care.

The clinical vignette I would like to relate tells the story of one such case that affected me deeply, being that of a young mother and child, far away from their homeland. It looks at aspects of community and paediatric care, care of the dying, doctor-patient communication, spirituality, and multiculturalism.

**Caring is a lonely and isolating experience: Immigrant Chinese women's experience in caring for a terminally ill relative at home in New South Wales, Australia.**

Mary T Heidenreich<sup>1,2</sup>  
Kate White<sup>2</sup>  
Fung Kuen Koo<sup>2</sup>

<sup>1</sup> Calvary Health Care Sydney

<sup>2</sup> University of Sydney

Limited research considers the impact of migration on the palliative caregiving experience for home-based immigrant Chinese females.

The Chinese community, whilst highly visible and the fastest growing non-English speaking community group, remains mostly hidden and underrepresented in palliative care service delivery and health research.

Saliently, research demonstrates the immigration experience entails major upheaval and adjustment to the new socio-cultural, language and employment environment resulting in high rates of psychological distress, particularly for women (Aroian, 2001; Chung, 2010; Spitzer et al, 2003).

This poster presents findings of a study examining the experience of Immigrant Chinese female carers in palliative care

**Objectives:** To explore the impact of migration on female immigrant Chinese carers in the community palliative care population; To identify potential barriers to palliative care in immigrant Chinese carers; To identify the support needs of the female Chinese carers of palliative care patients.

**Methods:** Methods: Qualitative Design: an explorative, descriptive qualitative framework. Data collection: Semi-structured face-to-face interviews with five Chinese women carers in the homes of the carers.

**Participants:** Five immigrant Chinese women home-based carers of a palliative care patient.

**Languages:** Cantonese (3), Mandarin (2), English (5).

**Countries of origin:** China, Hong Kong and Indonesia.

**Results:** Being a female Immigrant Chinese carer was an isolating and lonely experience. Sources of isolation and loneliness included social isolation experienced as a solitary carer without meaningful family and social relationships; loss of familiar cultural understandings and family values; and emotional isolators expressed in response to the physical and emotional role commitment and other constraints.

**Conclusions:** Profound adjustment challenges amidst the absence and loss of cultural connections experienced by Immigrant Chinese female carers highlights the need for increased education and support services to ensure effective and culturally appropriate palliative care services are available to this group



## **The primary caregiver: A vulnerable role**

### **Amanda Henderson**

Seven of the “Standards for Providing Quality Palliative Care for all Australians” supported by Palliative Care Australia directly reference caregivers. The fifth standard specifically states that: “The primary caregiver/s is provided with information, support and guidance about their role according to their needs and wishes” (Palliative Care Australia, May 2005, p. 6). While the standards confirm the expectations for care delivery, it is acknowledged that everyday practice gaps exist. A consumer perspective supports that potential caregivers need to be fully informed in order to correctly understand or frame their role.

This study theoretically explores the vulnerabilities of experience that may impair the informed acceptance by caregivers of their role. To do this it will ask: “In what ways is a potential caregiver vulnerable to misinterpreting the requirements and commitments associated with undertaking the actual role?”

The application of Alfred Schutz’s phenomenological writings provide insight into how the role of the “caregiver” may differ from what was originally expected. The application of 14 vulnerabilities of experience, adapted from Erving Goffman’s social theory, describes how this role may be easily misinterpreted or misframed.

Failure to address these inherent vulnerabilities risks unsatisfactory caregiving situations, as the caregiver may not always be fully aware of what is expected of them. This theoretical review highlights how current practices pertaining to initial discussions of the caregiver’s role and expectations can be improved.

## Establishing a clinical trials centre

### Alison Hession

HammondCare is an independent Christian charity specialising in dementia care, palliative care, rehabilitation and older age mental health. HammondCare has established two Clinical Training Centres (CTC) – Hammondville specialising in Rehabilitation and Restorative Care, and, Greenwich focussing on Palliative Care and Pain Medicine- the aims of which are to provide a community-based hub where academic teaching and learning are integrated with specialist clinical practice and innovative, translational research. One of the aims of the CTC research program at Greenwich has been to establish a Clinical Trials Centre. With the appointment of a Clinical Trials Nurse, supported by the academic unit, the site investigators and clinical leadership team, and, with practical support provided by PaCCSC (Palliative Care Clinical Studies Collaborative), we have been able to implement clinical trial processes according to Good Clinical Practice (GCP) guidelines, ensuring patient safety and data integrity. The presence of a network of clinical trials nurses who share information, in addition to the support and training provided by PaCCSC has been invaluable in establishing recruitment strategies not only for in-patients but also for patients being cared for in the community. As a result of this support we are currently recruiting to five clinical trials and for example, have been successful in recruiting patients to the PaCCSC Constipation study at a rate similar to that of a much larger clinical trials unit. With the increasing need to build research capacity within Palliative care, we believe our experience should be an encouragement to others contemplating participating in clinical trials.

## **Can the Australian-modified Karnofsky Performance Status scale be used as a trigger for referral to community Palliative Care physiotherapy services?**

**Bronwen Hewitt, Erin Bugden and Sarah Ambrose: St Vincent's Hospital**

### Introduction

Knowing when it is appropriate to refer a palliative care patient to physiotherapy can be a challenge. Physiotherapy services can assist in this process by providing referrers with a range of criteria to prompt a referral. However, there is a suggestion that even with these prompts, patients are not being referred to physiotherapy services in a timely manner. This project aims to explore whether the use of the Australian-modified Karnofsky Performance Status scale (AKPS), in conjunction with existing referral criteria, is effective in facilitating the referral of patients to our community physiotherapy service.

### Methods

In the first part of this project, 50 new patients referred to the physiotherapy service will have their AKPS score determined on their initial consultation by the community physiotherapist. At the conclusion of this period, AKPS scores will be collated and any trends identified. It is anticipated that this part of the project will identify a distinct range of AKPS scores, within in which the majority of patients fall. Subsequent parts of the project will concentrate on introducing routine use of the AKPS with our referrers and examining what effect this has on referrals to our service.

### Results

In the first three months of the project, 39 new patients have been referred to our physiotherapy service. 38 of these have had their AKPS score determined. Initial review of these scores has revealed that the majority (90%) of patients' AKPS scores fall between 50 and 70. Of interest is that the remainder of patient scores falls equally above and below this range. The lowest score recorded has been 30 whereas the highest has been 90.

### Conclusion

This project aims to establish whether use of the AKPS can facilitate appropriate referral to community physiotherapy service. Preliminary results from the first part of the project indicate that it will be possible to identify a band of AKPS scores to assist referrers in their referral to community physiotherapy services.

## The survey of antiemetic therapy to CINV using MAT

Takuya Hiromasa Hakodate National Hospital, Japan

### Purpose

The need of the palliative care is said from an early stage, and the increase of a case receiving both chemotherapy and palliative care is expected.

CINV (Chemotherapy Induced Nausea and Vomiting) is one of the hard side effects.

In Japan, the first antiemetic therapy guideline was published in 2010. In the guideline, the antiemetic therapy according to the emetic risk of the anticancer drug was indicated.

However, the evaluation of the clinical antiemetic therapy is insufficient, and here is little references about evaluation of an antiemetic therapy. I investigate the effectiveness of the antiemetic therapy in our hospital.

### Method

MASCC Antiemetic Tool (MAT) is a tool to evaluate CINV. Recently, Japanese edition of MAT was released. Using this, I performed a questionnaire survey on 107 patients from August 2012 to April 2013.

### Result

1. Vomiting was reported by 4.67% of patients (1.87% acute, 3.74% delayed) and nausea by 30.84% (14.02% acute, 28.97% delayed).
2. When nausea of the acute occurred, 86.67% of patients have symptoms in the delayed
3. 29.4% of patients who have become CINV were treated for breakthrough

### Conclusion

More detailed CINV were evaluated. It was shown clearly that the present antiemetic therapy about controlling of delayed nausea is insufficient still. In this case, some options are shown in the domestic guidelines. It will be necessary to develop better antiemetic therapy to maintain the QOL of the patients in the future.

## Palliative care in a small rural multi-purpose service – Three case reviews

Linda Ireland

Katherine Power

### Aim

Despite the dissemination, expansion and significant advancement of palliative care services and the advent of the Multi-Purpose Service Program in rural Australia since 1991, little is written about the complex nature of the chronic diseases, disabilities and illnesses experienced by MPS residents and the way in which this presents a “palliative care” challenge for nurses working in these small and often remote rural settings. This paper/poster presents three detailed case studies selected from the medical records of the twelve permanent aged care residents at Eugowra Memorial Multi-Purpose Service (MPS), a facility that services a town with a population of only 914 (2011 Census) and is 40 minutes to one hour away from a major hospital.

### Purpose

The purpose of this paper/poster is to highlight the palliative care complexities and challenges facing health care workers employed within the context of the small rural Multi-Purpose Service.

### Background

The term ‘palliative care’ refers to the holistic care that is provided to people at the end of life. In Australia, ‘palliative care services’ have evolved significantly during the last thirty years and they continue to adapt to meet the changing needs of the palliative care patient over time (Palliative Care Australia 2005). In this era of advanced technology, people are living longer, both in terms of life span and in terms of living longer with chronic disease, disability and illness. Consequently, people are also dying with more complex, complicated and advanced disease states. Although there is a vast amount of literature concerning the subject of palliative care for cancer patients, there remains a dearth of literature on the subject of palliative care in residential aged care. This is supported by Allen, Chapman, O’Connor and Francis, who assert that “care of the dying has largely been ignored in residential aged care facilities where death is common place” (2008, p. 170). Further to this, the development of small rural and remote Multi-Purpose Services, which provide a combination of emergency health care, long-term residential care for the elderly, palliative care for the terminally-ill and respite services for the community and their carers, added a new dimension to the care of the dying patient and the way in which palliative care services are provided. The Multi-Purpose Service (MPS) Program is a quality Australian Government Department of Health and Ageing initiative that was first conceived in 1991 with the aim of meeting the aged care needs of small rural populations (Australian Government Department of Health and Ageing 2013). In subsequent years, since the program’s conception, more than 130 Multi-Purpose Services have commenced operation in those rural communities that were considered to be too small to support the individual services of a hospital, residential aged care facility and other services, such as a community centre, medical practice, palliative care services, physiotherapy rooms and so on. Eugowra Memorial MPS constitutes one of these 130 flexible centres for health care, servicing a rural community of 914 and providing one emergency department bed, 12 permanent residential aged care beds, one respite bed and one palliative care bed.

### Method

A systematic review of the three selected medical records was undertaken and the data obtained is to be presented in case study format. Permission was obtained from the study participants prior to data collection. Medical records were also reviewed for evidence of utilisation of a palliative care approach to patient management and for effectiveness of symptom control in the study group.

### Findings

The three study subjects selected were all permanent residents aged over 80 years of age, with multiple co-morbidities and non-malignant disease at this time. Between the three residents, they amassed a total of thirty-seven different diagnoses and were prescribed a total of thirty-two pharmacological treatments for their varying illnesses and symptoms. All three residents received regular analgesia, ranging from TDS Panadol Osteo to BD Oxycotin 5 mg to 25 mg Fentanyl Patches, though none of the three reported or were assessed to have achieved an adequate level of pain relief at the time of this study. Two of the three residents were receiving current medication for depression and the third resident, who is no longer verbalising or cognisant of her surroundings, had received antidepressant therapy in the past but not at the time of the study.

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## **The usefulness of prognostic tools in community palliative care**

**Kathy Isaacs** – RN Gr 3, Eastern Palliative Care

**Kathryn Bennett** – Nurse Practitioner Candidate, Eastern Palliative Care

**Kylie Draper** – Manager Nursing and Medical Services, Eastern Palliative Care

### **Introduction:**

Eastern Palliative Care Association Inc is the largest provider of community-based palliative care in Victoria, receiving over 2000 referrals annually. Referrals are processed by a central Intake team; prioritising according to the client's acuity.

Assessment priority is based on the client's individual situation, expected prognosis and symptom burden but a more evidence-based approach to this prioritisation process would assist in appropriate service provision.

Prognostic tools have been used in palliative care since the early 1990s. The Palliative Prognostic Score (PaP) and the Palliative Prognostic Index (PPI) were identified as satisfying the criteria of having been validated in other settings and being broad enough to cover both malignant and non-malignant diagnoses.

### **Methods:**

This study was conducted between 1<sup>st</sup> July and 31<sup>st</sup> December 2012. When clients were accepted for admission for the program, data for both the PaP and PPI was collected by Intake RNs and scored according to each tool's criteria. Some information was difficult to collect due to incomplete information provided at initial referral. PPI data collection was generally more complete, as it can be based on assessment questions asked by Intake RNs of client or carer at time of referral.

The clients were then followed on an ongoing basis, and the date of death, if applicable, was noted on the tool at regular intervals during the data collection period.

### **Analysis:**

Data analysis is underway to determine and compare the usefulness of each of these tools in the community palliative care setting, and results from this will inform practice.

## **Use of the palliative care outcomes collaboration assessment tools for clinical communication and transferring care**

**Claire Johnson** - The University of Western Australia (UWA)

**Tanya Pidgeon** - The University of Western Australia

**Maree Banfield** – The University of Wollongong

**Kathy Eagar** - The University of Wollongong

**Objectives:** Safe and effective clinical handover has been highlighted as an important aspect of care in the National Safety and Quality Health Service Standards. This presentation will describe how the use of the Palliative Care Outcomes Collaboration (PCOC) assessment tools enhances clinical communication and transfer of care.

**Methods:** PCOC has compiled a suite of five clinical assessment tools and embedded them into routine practice in 105 palliative care services (PCSs) nationally. PCSs submit patient assessment data to the PCOC office every six months. Data is then synthesised into a report of outcomes against benchmarks for quality improvement activities.

**Results:** PCOC provides standardised training of the clinical assessment tools to services ensuring all patients receiving end of life care are assessed consistently and accurately, thereby providing a holistic clinical picture of the individual patient, their symptoms and concerns. Furthermore, use of the tools drives care planning and provides a common and standardised language for health professionals to communicate and document the patient's and family's condition and care - contributing to the seamless delivery of care between settings. Families and patients also learn the language of the tools and are engaged in the assessment of their own needs—thus improving communication between consumers and health professionals. Assessment across domains can trigger referral to relevant services or specialists.

**Conclusion:** Standardisation and consistency in assessment of patients and the language used to describe and document patient outcomes contributes to successful communication about patient's symptoms and concerns within and between palliative care jurisdictions.

**What should health care professionals consider when planning your end of life care?****Nikki Johnston,<sup>1</sup> Dennis S. Pacl,<sup>1,2</sup> Sue Quayle,<sup>1</sup> Sharon Bale<sup>1</sup>**

<sup>1</sup> Palliative and Supportive Care Service Capital Region Cancer Service, Canberra Hospital and Health Services

<sup>2</sup> Clare Holland House, Calvary Health Care ACT

**Aim:** To provoke consideration regarding the important elements of end of life care (EOLC) from a consumer perspective as compared to a medical perspective.

**Method:** Our primary research will utilise a qualitative mixed methodology and thematic analysis. Following a short instructional video (3 minutes).

We asked consumer volunteers to use the tool in response to the question “What are the important elements health care professionals should consider when planning your end of life care?”

We asked health professional volunteers to use the tool in response to the question “What are important elements to consider when planning end-of-life care for your patients?”

The responses would be analysed by thematic analysis with the results serving in end-of-life care training and education efforts for healthcare professionals.

**Tool:** A Messaging tool intended to help achieve culture change around understanding patient and family goals of care in the context of life-limiting illness. A blank board with only the word ‘CONSIDER’ as the starting point for making crosswords, would be distributed to groups of consumers and healthcare professionals, who will then be asked to enter 3-5 words to describe what they feel is important in end-of-life care plans.

**Results:** The investigators will first engage in data familiarisation. The messaging tool readily translates into single word responses that will be coded and the subsequent frequency will establish themes to be analysed using thematic analysis. The frequency of responses will then be compared between the two groups.

**Conclusion:** The results of our thematic analysis provided an opportunity for the communication of the perspectives of consumers in promoting culture change within practice improvement initiatives around care of the dying, which are underway at the Canberra Hospital.



**‘Talking about sexuality and intimacy – ‘everyone’s business’: Health professional communication in the context of cancer and palliative care’.**

**Lauren Kadwell**

Palliative care recipients report that sexuality, and in particular the emotional connection expressed through intimacy, are important aspects contributing to their quality of life (QOL). Nonetheless, palliative care recipients experience significant disruptions to their sexuality and intimacy which diminish their overall QOL. Palliative care recipients have reported a desire for health professionals to raise and provide opportunity to discuss issues of sexuality and intimacy, and health professionals have also recognised that these are important issues that need to be discussed as part of their professional role. However, health professionals often report difficulties in discussing issues of sexuality and intimacy, and consequently, these issues are rarely talked about and have become an area of unmet need for palliative care recipients. This presentation will report the preliminary results of my PhD research which has examined how health professionals understand and communicate about issues of sexuality and intimacy in the context of cancer and palliative care. The results, drawn from interviews with thirty health professionals (physicians, nurses, psychologists/counsellors, and social workers) indicate that although palliative care health professionals recognise and have a deep and holistic understanding of the sexual and intimate needs of palliative oncology patients, they often experience barriers to raising and discussing sexuality and intimacy. Many of these identified barriers stem from wider socio-cultural constructions of illness, dying, aging and sexuality which, for example, can lead to health professionals making assumptions that people with cancer are “too ill” or “too old” to be interested in or engage in sexual practices.

## **Development of a policy compliance procedure for administration of breakthrough opiate medications in the community**

**Noeline Karlson**, Calvary Mater Newcastle,  
**Katherine Clark**, Calvary Mater Newcastle  
**Stacey Diana**, Calvary Mater Newcastle  
**Jessica Cain**, Calvary Mater Newcastle

### **Introduction:**

Australian Therapeutic Guidelines Palliative Care advises that, for severe breakthrough pain, it may be appropriate to give up to three consecutive doses of breakthrough opiate medication as frequently as 30 minutes apart. Once the person has received three consecutive doses, a review of pain management is recommended<sup>1</sup>.

Recommendations on breakthrough dosing are frequently made by community palliative care Registered Nurses but we queried whether this is operating outside their scope of practice.

The primary aim of this Policy Compliance Procedure (PCP) is to enable palliative care Registered Nurses to recommend up to 3 additional breakthrough doses of opioids as close as 30 minutes apart (when the patient has severe breakthrough pain).

### **Methods:**

After consultation with NSW Health and Hunter New England Health Quality Use of Medicines (QUM) Committee a PCP, which included an authorisation form signed by the treating GP or specialist, was devised and subsequently approved by the QUM committee in Feb 2013.

### **Results:**

The PCP with attached authorisation form will be presented together with details of the education being provided to local GPs and progress of the rollout within Hunter New England Health.

### **Conclusion:**

Community palliative care RNs can now confidently provide appropriate advice to their patients who develop severe breakthrough pain. This process enables patients to remain at home for longer and potentially avoids unnecessary visits to the Emergency Department.

### **Reference:**

1. Therapeutic Guidelines Palliative Care Version 3, Melbourne 2010

## **'The Discordant Composition' Complicated Grief - A Case Study**

### **Maralyn Karpathiou**

This case study underscores disenfranchised complicated grief and demonstrates issues that arise when loss leaves the bereaved with unfulfilled needs. In this case, death delivered an assaultive narcissistic injury beyond what may be experienced after the loss of a loved one. The extreme dependency characterised by an overreliance upon the deceased to feel secure, achieve gratification, make decisions and manage life was evident. Due to the bereaved presenting as overly dependent, this translated as something 'special' and 'irreplaceable'. The effect of such a loss generated a sense of enmeshment. This resulted in feelings so overwhelming it compromised her ability to cope with loss and its consequences.

**The objective** was to provide interventions to increase appropriate autonomy and independence through grief and loss work. This involved offering support in order to build trust, creating a safe environment where feelings can surface, be expressed, so healing can occur, while discouraging the tendency to cling to the role of mourner. Identify and work through problems created by the loss of the dependent relationship, building upon her self-esteem, decreasing anxiety and helplessness whilst increasing assertiveness and appropriate skill development.

### **Methods**

Reflective listening

Encourage research into external social links

Involvement in activities that increased independence and sense of self

Identify supports that are available to her

Use of the creative arts

A ritual- with her taking ownership- preparing symbols to give personal meaning.

### **Conclusion**

The mourner moved adaptively into a new world, integrating the 'old' with the 'new', enfranchising her relationship and acknowledging the loss.

### **Simple ways to increase PCOC Benchmarks**

**Roslyn Holloway, Sharon Ferrar, Jane McEniery** - Ipswich Hospice

The team of Ipswich Hospice believe that the care quality of care provided was very good. However, we were consistently not meeting some of the benchmarks in the Patient Outcomes in Palliative Care (PCOC) reports. Simple changes were made to our every day practice, education was provided to the nursing staff & the result has been a significant increase in the results in the PCOC reports.

This project report will outline what changes were implemented & the evidence to support the improvements that have been made. The aim of this project paper is to share information, in a practical way, to assist other organisations currently reporting to PCOC.

**Clinical assessment skills: is this still a nursing skill?****Kendall, R., Odgers, J.**

The Grampians Regional Palliative Care team developed a series of Clinical Skill study days to assist nurses in developing and maintaining their clinical skills and clinical knowledge in the palliative care setting. The study days attracted one hundred and ten nurses, and addressed the fundamental principles of clinical assessment in Palliative Care. The day focused on four areas of clinical assessment: respiratory, abdominal, neurological and cognitive.

A clinical research project was undertaken to assess skill retention of nurses working in palliative care. A questionnaire was developed to reflect the content of the lectures, and was completed by participants at commencement of the study day, at the conclusion of the day and six weeks post study day.

Questionnaire results indicated that nurses had limited knowledge of clinical assessment skills prior to the study day. Post audit study demonstrated an increase in knowledge and confidence of nurses undertaking clinical assessment of patients. Overall nurses who returned the questionnaire at six weeks demonstrated a high level of knowledge and assessment skills. It is hoped that improving clinical assessment skills in nurses working in palliative care will improve patient outcomes.

**Development and implementation of a regional palliative care training plan – the it way!**

**Jade Odgers & Regina Kendall** - Grampians Regional Palliative Care Team, Ballarat Health Services.

The Grampians Regional Palliative Care Team was established over ten years ago. In its original capacity the role had 12 nursing hours per week, and one person was responsible for consultation, coordination and education throughout the Grampians region. Education was on a needs only basis, and was reactive and ad hoc. In 2006 the hours were increased to 16 hours, and in order to facilitate education the Highway model was developed. The Palliative care nurse would travel throughout the region delivering one hour sessions regardless of distance. The one hour rule occurred as a result of time constraints on health facilities, and they were only interested in Topics of Nausea and vomiting, pain, and terminal restlessness.

In 2006 the Grampians Regional Palliative Care Team (GRPCT) developed a regional palliative care training plan. The purpose of the training plan was to utilise the current EFT to its greatest capacity and minimise duplication of education across the region.

Since the development of annual regional training plan more than 3000 participants have attended our training. Ongoing evaluation and training needs analysis ensure that training needs of the region are met. Both quality and access are the key principals of our training. Equity of access is achieved through the ongoing use of video conferencing facilities and the recording and development of pod casts.

The aim of this presentation is demonstrate the viability of IT options to deliver high quality education across a region.

## Anticipatory medications in a community palliative care service

**Scott King, Angie Dredge**

*Calvary Health Care Bethlehem, Melbourne, Australia*

It is an established practice in our community palliative care service (CPCS) to have subcutaneous medications supplied to our patients, kept in their homes, for use by our nursing staff if called out for unstable symptoms. These have been termed “emergency medications” and are frequently requested at admission to the service using a standard medication list.

A search of current literature revealed the importance of the availability of subcutaneous medications in the community for palliative care professionals, to reduce the need for patient hospitalization (1,2).

A prospective audit undertaken of the aforementioned practice revealed that it was time consuming, orders were at times difficult to obtain, and a high rate of inappropriate orders were discovered.

A working group was subsequently formed to review the recommendations made from the audit.

Key outcomes of the working group include:

1. Use and definition of the term “Anticipatory Medication” instead of emergency medication.
2. Development of criteria and policy to guide the prescribing and provision of anticipatory medication
3. Development of a new process for the supply of anticipatory medication after hours when GP not available.
4. New documentation recording medication use, dispensing and communication to the GP.

This presentation will include findings and recommendations from the audit as well as details of the outcomes of the working group.

1. Thomas K. Out of hours palliative care in the community: Continuing care for the dying at home. Macmillan Cancer Relief. 2001
2. Carney J, Analysis of “Just in Case” Anticipatory Prescribing Pilot. June 2008

## The day after tomorrow: reducing time of referral to first meaningful contact

**Peter Kozaczynski**

### Background:

After attending the PCOC reports session in 2012, it was noted that many community palliative care services do not meet **Outcome measure 1: Time of referral to first contact**. Which states "90% of patients are contacted by a member of the clinical team (either face to face or by phone) within two days of referral (including weekends).

### Objectives:

To reduce the time from referral of new patients to first meaningful contact with the Palliative Care Outreach Service at the Calvary Mater Hospital.

### Methods:

In February 2013 we moved the initial nursing phone call from after the initial medical consult, to before the first medical consult. During this call the outreach nurse completes a safety checklist, SAS scores, Karnofsky scale, RUG score and PHASE. This assists the medical staff to prioritise the urgency for each visit, and any safety concerns. The outreach nurse also starts appropriate interventions, or makes referrals highlighted from this initial over-the-phone assessment.

### Results:

Before February 2013 the average contact time for our service was seven days from first referral, as measured from date of referral to initial medical consult. With this small change in our practice we have reduced the average contact time and are achieving the PCOC benchmark. A preliminary analysis using a random audit of 10 medical records since February 2103 indicated all patients were contacted within two days. The results of the first three months of data is being analysed and will be presented.

### Conclusions:

This project will not only reduce the time of referral to first meaningful contact, but also improve the quality of the service by addressing patient and carer needs prior to being visited by the service.



## **'Too many to even think about' Christmas tree of remembrance in a multicultural community**

**Shirley Lee**

Mercy Palliative Care, Sunshine, is located in one of the most culturally diverse municipalities in Australia with over 150 different languages spoken.

Volunteers and staff set up a Christmas Tree of Remembrance in Sunshine Library in the week before Christmas.

The simple ritual of hanging Christmas cards on the Tree recognises the ongoing bond with those who have died. It also better equips the community to care for those experiencing the loss associated with death and dying.

Explanatory posters were translated by volunteers into 6 of the 13 languages offered by the library. Volunteers mingled with library patrons handing out cards and giving explanations in simple English.

Nearly 100 cards were hung from the Tree in 3½ days.

20% of the cards were written in languages other than English. Others were written in both English and another language and some by people of Muslim faith.

The feedback from volunteers and staff was overwhelming positive. As hoped, many people openly talked about the loss of loved ones, especially their heightened feelings of grief at Christmas.

Some simply stood before the Tree in tears. A teenager, recently arrived in Australia, wrote a message in his own language, but declined to add names saying simply, 'Too many to even think about.'

As well as assisting the community, volunteers felt they learned a great deal especially about the multiple losses suffered by new arrivals in Australia.

All felt they had reached a section of the community we are otherwise unable to assist.

## Palliative approach – The life care way

### Raelene Madden

Life Care is a *not for profit organisation* providing independent living accommodation, residential and respite care, and community aged care packages across Adelaide.

The organisation has recently adopted a fully integrated and holistic approach in their provision of care for residents, clients and their families during the time of palliation.

The project, which commenced in March 2012, has resulted in consistent processes to palliative care within the organisation. Multi discipline case conferencing involving residents (clients) and their families is a pivotal innovation which ensures the resident and their family's needs and expectations are met. In addition, *Palliative Liaison Staff* are appointed at each site to assist staff, families and residents during the end of life phase.

Information booklets have been produced to assist with greater understanding of the palliative process and an *End of Life Pathway* has been developed to ensure uniformity of care for residents requiring palliation.

Following a resident's death, memorial services and booklets have been introduced to celebrate the life of the resident and to provide support for fellow residents and families during their time of loss.

To ensure successful implementation of the *Palliative Care Approach*, training of staff from all facets of the organisation commenced in February 2013. This included clinical and personal care, hotel services and lifestyle staff. The training focussed on resident needs, empathy and best practice to support a *good death*.

Early evaluation of the *Palliative Care Approach* at Life Care has revealed that staff have embraced this initiative and are eager to gain greater understanding of what constitutes "good palliative care".

## **Ms. L's Story: An Aboriginal and Torres Strait Islander (ATSI) woman's end of life journey in a Residential Aged Care (RAC) Facility**

**Larissa B McIntyre FACN**

Baptist Community Services - NSW & ACT (BCS) BCS Orana Centre

### AIM

To present the how the culturally specific palliative care needs of Ms. L were met in a RAC environment using available resources including *The Resource Kit: providing culturally appropriate palliative care to Aboriginal and Torres Strait Islander peoples (2004a)* and *Practice Principles: providing culturally appropriate palliative care to Aboriginal and Torres Strait Islander people (2004b)* as a guide to our care delivery during Ms. L's end of life.

**BACKGROUND** Ms. L was a 69 – year lady living in RAC facility who identified as an ATSI woman and had end stage renal failure (ESRF) and was undergoing haemodialysis thrice weekly. Ms. L's last estimated glomerular filtration rate (eGFR) was 7mL/minute (>59mL/min). Other co-morbidities were Parkinson's disease, insulin dependent diabetes mellitus (IDDM), ischemic heart disease (IHD), peripheral vascular disease (PVD) and hypertension (HT).

Ms. L was a loner with few external supports, she had no children, and her closest friend lived locally but was without transport and could not afford the taxi charges to visit. Ms. L had a half-sister whom she had located a few years ago; she was travelling at the time but they had been communicating via letters or the occasional telephone call.

Ms. L's presence in a RAC was somewhat unusual as ATSI people either do not live long enough to enter aged care or their poorer health status means they if they do come into aged care it will be at a younger age than non - ATSI people (McMurray & Clendon, 2010). At the time of her stay with us Ms. L was the only ATSI person in the facility.

### OUTCOME

The decision to cease life maintaining treatment is not an easy one and this was the case for Ms. L. This decision had been made after extensive consultation with the multidisciplinary team at the local hospital where Ms. L received her treatments and with her close friend. Ms. L made a decision to withdraw from haemodialysis knowing full well the consequences and made the decision to die at the facility. Ms. L died three days after making this decision. At the time of her death Ms. L was treated in a culturally sensitive and safe manner; with the principles of palliation and ATSI specific areas identified and applied. Ms. L died in a manner in which enabled her to complete her "story".

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## Case conferencing: how to incorporate holistic person-centred care

**McVey, P.** <sup>(1)</sup> & **Dixon, G.** <sup>(2)</sup>

Greenwich Palliative care Service, HammondCare

Palliative care is holistic person-centred care which aims to address the physical as well as the spiritual, emotional, social and cultural needs of the person and their family/carer(s). In 2011, HammondCare community palliative care services participated in the National Standards Assessment Program (NSAP) - Care Assessment and Planning Collaborative project. The project team developed and implemented a one-page comprehensive holistic on-going assessment and care planning tool for use within three interdisciplinary community services. The successes of this tool led to the development of a SPECS (Spiritual, physical, emotional, cultural and social) case conference form which incorporates holistic person-centred care. A person-centred approach is based on consultation, patient/client autonomy, choice, individual care and patient involvement in decision-making (McCormack & McCance, 2010). The methodology for this quality project used the Plan-Do-Study-Act (PDSA) cycles. Several validated symptom rating tools were incorporated from the Palliative Care Outcome Collaborative (PCOC) datasets - the Symptom Assessment Scores, Australian Karnofsky Performance Scale and the Activities of Daily Living Scale (RUG-ADL). Case conferences for all new referrals occur on a weekly basis involving all members of the community interdisciplinary team. The key results of this project have revealed that the form is a feasible tool that assists in summarising the individual's current health status, values and goals of care. In addition, the format of the form creates a structured process for conducting case conferencing and assists in identifying further referral pathways.

This presentation will outline the interventions/changes implemented to achieve a user-friendly holistic person-centred case conference form.

**Council of heirs international missions (CHI missions) work on palliative care for HIV/AIDS infected and affected victims in Cameroon****Bernard Pierre Messing, Heirs International Missions (CHI Missions)**

I am Bernard Pierre Messing a trained cross cultural and global missions. In 2006, I founded an inter denominational Missions organization(officially registered in 2010) for the purpose of making the great commission the priority of the church but also as a response to some social issues such as HIV/ AIDS, Cancer, Non Contagious and contagious tropical diseases.

Living with HIV/AIDS in Cameroon is very difficult because you are stigmatized, rejected even by your family like Elizabeth. She found out about her status at her husband's burial. She sort support from wrong people, places which worsened her situation especially when the entire city found out about her health condition. Stigmatization set in and rejection became worse, it is important to know that she was dying not because of this disease but because of psychological trauma. Since Elizabeth's family knew that this disease is contagious, they rejected her causing her to suffer even more. She almost gave up on herself but was rescued by CHI Missions volunteer team who sensitized her on her disease and how to live with the disease. The volunteer team spoke to her about God and built her up spiritually, psychologically and physically. The team supports her financially as well and today with the help of CHI Missions volunteer team, she lives in another city communicating with her family and has embraced her situation with courage, hope and Faith. For the Glory of God.

## **The feasibility of using the distress thermometer and problem list screening tool in community palliative care populations: A pilot study**

**Helen Moore, Trish Sutton, Matra Robertson, Anne Morris, Trish McKinnon, Adam Finch, Bradley King, Richard Chye** - St Vincent's Hospital, Sydney

### **Introduction**

A terminal diagnosis is frequently associated with increased psychological distress for patients and caregivers.<sup>1</sup> Early identification of distress and appropriate intervention is essential to improving quality of life and providing cost-effective healthcare<sup>2</sup>. The Distress Thermometer and Problem List screening tool has been developed to identify patient distress.<sup>3</sup> This pilot study aims to test feasibility of using this screening tool to ensure timely identification and referral of patients with self-reported distress to pertinent members of our community based interdisciplinary team.

### **Method**

This pilot prospective cross sectional questionnaire study is being undertaken within one specialist community palliative care service over 12 weeks. New referrals whom are able to express their responses through verbal/written communication with/without the assistance of a carer were eligible to participate. Patients indicating high levels of distress as determined by the questionnaire were invited to participate in a consultation with pertinent member(s) of the interdisciplinary team. Statistical inferences using multivariate analysis will be made after achieving the appropriate sample size (n=33).

### **Results**

Interim data analysis reveals that out of 33 new referrals 13 patients were ineligible and 3 of 13 questionnaires were returned. Seven of the 33 new referrals are awaiting initial review by medical/nursing staff. Three of 3 returned questionnaires indicate high level of distress ( $\geq 7/10$ ). Two patients were referred to interdisciplinary team members and one patient was admitted to hospital.

### **Conclusion**

This feasibility study will determine if the questionnaire identifies early and more frequent detection of distress plus impacts on referral rates to other interdisciplinary team members.

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**Prospective multicenter comparative study of syringe driver practices within palliative care service providers in New South Wales, Australia**

**Helen Moore** - Sacred Heart Health Service, St Vincent's Hospital, Sydney

**Richard Chye** - Palliative Care - South East Sydney LHD & St Vincent's & Mater Health, Sydney

**Introduction**

Syringe drivers are a convenient and commonly used method of drug delivery at the end of life. Single/multiple drugs can be continuously infused, usually over 24 hours, into the subcutaneous tissue of the arm, chest, abdomen and thigh. There are many indications for the use of syringe drivers, including dysphagia and pain control. Syringe drivers are considered a safe route for drug delivery with few complications, the commonest complication being site reaction.

The aim of this survey is to compare current syringe driver practices across five hospitals within New South Wales, Australia with the overall aim of improving patient safety and efficacy in syringe driver practice.

**Method**

A prospective cross sectional survey involving five hospitals will be administered to participants over 12 weeks. Registered nurses will be invited to complete daily non-identifiable questionnaires pertaining to each palliative care in-patient's syringe driver prescription between the study dates (April-June 2013). Statistical inferences of incidence and causes of complications during/post administration of the medication via the syringe driver will be made using multivariate analysis after achieving the appropriate patient sample size (n=83).

**Results**

Preliminary data from across all sites reveal 21 patients receiving medication via a syringe driver with a total number of 128 questionnaires pertaining to these patients being completed.

**Conclusion**

This study will specifically appraise syringe driver practices within each of the five hospital settings and determine incidence and causes of complications arising during/immediately following the use of the syringe driver with the overall goal of improving safety.

## **Patient-Centered palliative care: Fact or fiction?**

**Anne Morris**

The aim of this poster is firstly to challenge our thinking on patient-centered palliative care, by exploring the complexities that arise when a variety of sometimes conflicting viewpoints seek to determine the best outcome for the patient. Secondly, this poster seeks to encourage reflective thinking on our current clinical practice and consider solutions to these issues as they arise.

What do we mean by patient-centered palliative care? Although there are many definitions in the literature, patient-centered palliative care is broadly understood to describe treatment and care provided by health services that empowers the patient to be at the centre of their own care, and operates collaboratively with both the patient and their carers to ensure the best outcomes for the patient.

Evidence in the literature has shown that patient-centered palliative care is beneficial for all involved, as it allows all parties to actively participate in the decision-making and facilitates improved outcomes and patient satisfaction. In this way palliative care is indeed “everyone’s business”, and encouraging a collaborative and respectful partnership between all involved will make a positive difference to patient health outcomes. However this collaborative involvement, although beneficial, brings with it new challenges, as treatment teams, patients and carers must negotiate sometimes competing interests and perspectives on what they believe to be the best interests of the patient, with the risk of overlooking the actual needs of the patient themselves.



## **Palliative care – A non-malignant perspective**

**Jane O'Donnell**

Neringah Hospital provides a specialist palliative care service including a 19 bed inpatient unit, a community service and a consultative inreach service to Hornsby Ku-ring-gai Hospital (HKH).

This poster will explore the beneficial link between the inreach and inpatient services for patients with non-malignant issues.

The inreach service receives referrals from HKH which are frequently nurse driven. The nurses at HKH are very proactive in initiating appropriate referrals. The referrals are predominantly for patients with end stage chronic illness as HKH does not have an inpatient oncology unit.

Mrs S was an 86 year old woman with a background of chronic obstructive pulmonary disease( COPD). Prior to admission to HKH, she lived alone and was facing increasing challenges managing independently. The staff on the acute medical ward were experiencing difficulty in managing her worsening dyspnoea and deteriorating condition.

The nursing staff prompted the medical staff to refer the patient to the palliative care service for symptom management and transfer to Neringah Hospital. At the initial consultation, it was clearly evident that Mrs S was approaching the last days of her life. She was significantly compromised by her symptoms and both she and her daughter were welcoming of the palliative care team's advice and recommendations. She was transferred to Neringah Hospital the following day where she died peacefully and comfortably five days later. Her daughter was present when she died.

This poster demonstrates the valuable link between the inreach service and the acute hospital setting in the delivery of supportive palliative care.

## Dying to get it right

Dennis Pacl<sup>1,3</sup>, Nikki Johnston<sup>1</sup>, Carmel Jekabsons<sup>3</sup>, Sonia Hogan<sup>2</sup>

<sup>1</sup>Palliative and Supportive Care, Capital Region Cancer Service, Canberra Hospital and health services, <sup>2</sup>Quality and Safety Unit Canberra Hospital and Health Services, <sup>3</sup>Clare Holland House, Calvary Health Care ACT

**Purpose:** The key improvement to be discussed in this Quality Improvement project report is the result of a pilot, care pathway for systematic change of care of the dying in three adult wards at Canberra Hospital.

**Background:** Nationally the Palliative Care Strategy (2010) *Supporting Australians to live well at the end of life*, outline's goals to improve the appropriateness and effectiveness of end of life care. Identified measures of success include 'An Australia-wide roll out of: end of life care pathways and palliative care referral pathways.

**Method:** A retrospective baseline audit using a data abstraction tool designed by the investigators was used to collect data from the charts for 100 consecutive hospital deaths from the pilot wards in the hospital. A new audit tool – the "Audit Angel" was used to enter the data. A care of the dying pathway was implemented in a pilot quality improvement project on three medical wards. On completion of the pilot project a second audit examined the charts of those patients who died on those wards following the implementation of the pathway.

**Conclusions:** Within a quality improvement framework this project defined a minimum standard for supportive care of patients who died while in the hospital. Staff felt more confident in the provision of appropriate care for dying patients.

## **Palliative care case conference (PCCC) in residential aged care (RAC): Views of general practitioners**

**Deborah Parker<sup>1</sup>, Anthony Tuckett<sup>1</sup>, Karen Clifton<sup>1</sup>, Liz Reymond<sup>2</sup>, Fiona Israel<sup>2</sup>, Kris McAnnally<sup>2</sup>, Kim Greeve<sup>3</sup>, Karen Glaetzer<sup>5</sup>, Peter Jenkin<sup>4</sup>, Teresa Prior<sup>3</sup>, Helen Walker<sup>3</sup>**

1 University of Queensland/Blue Care Research & Practice Development Centre

2 Brisbane South Palliative Care Collaborative

3 WA Cancer & Palliative Care Network

4 Resthaven

5 Southern Adelaide Palliative Services

### **Aim**

To examine the views of General Practitioners (GPs) on providing a palliative approach in residential aged care in particular their experiences with the palliative care case conference.

### **Background**

The national Comprehensive Evidence-Based Palliative Approach in Residential Aged-Care (CEBPARAC) project, funded by the Commonwealth Department of Health and Ageing, sought to implement and evaluate an evidence-based palliative approach in residential aged-care.

### **Methods**

A purposive sample of eleven GPs across Western Australia (2), South Australia (6) and Queensland (3) participated in face-to face, semi-structured interviews. Qualitative content analysis was used to generate the core categories.

### **Findings**

The overall evaluation by the General Practitioners (GPs) of the palliative care case conference (PCCC) in residential aged care (RAC) is understood through three core themes: people, performance and place. The GPs identified elements important for policy makers and health administrators seeking ways to translate into practice the PCCC in RAC. GPs identify what best serves to make the PCCC work well and also provided insights into what the PCCC actually looks like in aged care.

## **Learning after a child's death**

### **Lee-Anne Pedersen**

The paediatric palliative care service (PPCS) has now been caring for both oncology and non oncology patients under 18 years of age, for more than 3 years- totalling more than 300 patients with over 100 deaths reviewed. There is a clinical death review process documented by the PPCS within one month of the child's death. This presentation will examine the use of a death review process which is utilised to improve clinical care provided to children and families. The review process is based on the 13 Standards of Palliative Care Australia, as well as 22 clinical indicators developed by the Australia and New Zealand Paediatric Palliative Care reference Group. The process looks at the contributions of the PPCS to a child's care, symptom burden, and clinical management challenges including: areas for improvement, family goals, bereavement care and feedback from the family. Data to be presented will include patient demographics and clinical issues that arose. Key parts of the PPCS which were evaluated include the influence of a nurse practitioner and the presence of a 24 hour toll telephone service. It was found that the death review process can improve the quality of care and also serve as a forum for reflection on the care provided by the team.

## **Specialist palliative care nurses pain assessment capabilities: results from a baseline survey**

**Phillips, J.L., Shaw, Tim., Heneka, Nicole., Hickman, Louise and Lam, Lawrence** - The University of Notre Dame, Australia

### **INTRODUCTION**

Specialist palliative care nurses are ideally placed to undertake routine screening, regular assessment and on-going monitoring of palliative patient's pain given they are the discipline that spends the most time at the bedside. Yet, little is known about specialist palliative care nurses' pain management capabilities.

### **METHODS**

This paper reports on the results of a baseline survey undertaken to appraise specialist palliative care nurses' pain assessment capabilities. Nurses employed within two specialist palliative care services participated in the 'Cancer and Palliative Care Nurses Pain Assessment Knowledge' survey in early 2012. Data was analyzed using descriptive and inferential statistics.

### **RESULTS**

The 74 participants, who completed the survey, were: predominately female (96%), registered nurses (84%) with a mean age of 45.3 years ( $\bar{X}$ ). Participants had moderately high levels of general pain assessment knowledge ( $\bar{X}$  7.32, SD + 1.6) and high levels of pain assessment confidence ( $\bar{X}$  7.55, SD + 1.48), but limited knowledge about validated comprehensive pain assessment tools ( $\bar{X}$  3.31, SD + 3.02). Participants who had completed a post-graduate specialist palliative care course had higher levels of pain assessment knowledge and confidence and knowledge of pain assessment tools compared to participants who had not completed a post-graduate palliative care course.

### **CONCLUSIONS**

Registered nurses who had completed a post-graduate specialist palliative care had the highest levels of pain assessment capabilities. These results reinforce the importance of post-graduate tertiary education in advancing nurses palliative care clinical capabilities to meet palliative patients complex care needs.

**Can a novel, online learning module increase specialist palliative care nurses' pain assessment knowledge and practices?**

**Jane Phillips**, The University of Notre Dame, NSW

Audience will be engaged through five short vignettes which depict five individual palliative journeys, and how through a person centred approach the psychosocial and emotional needs of five individuals were met.

The stories will include backward and forward conversations between carer and client, along with actions.

The five stories will elicit a number of different audience responses.

The audience will also have the opportunity to hear of how the above stories have been used in a Registered Training organisation for students studying their certificates 111 and 1V in Aged Care.

The workshop will improve skills and knowledge in palliative care in a number of different areas.

It will revolve around the "stepping into the moment" concept of care.

It will demonstrate that each and every patient/client has individual psychosocial/emotional requirements that need to be met on a person centred basis if a dignified palliative journey is to be contemplated.

It will secondly demonstrate the importance that Aged Care students need to attach to the individual journeys of those whom they care for.

## **Palliative care volunteer support across a wide range of settings**

**Jill Pierce**, Palliative Care ACT

As the Host State for the APCC 2013 we are pleased and proud to submit for a poster presentation on the Palliative Care ACT Volunteer Program. PC ACT is unique in that as a founding peak body and member of PCA, we also have an operational aspect in our remit: PC ACT implements the only palliative care volunteer service in the ACT.

Our poster fits comfortably in all the four streams patient, families and carers, health providers and community.

**Aim:** To inform the audience about the Palliative Care ACT Volunteer Program.

The Volunteer program is unique in that it is an independent, not for profit, community based organisation that offers support to families across a wide range of settings including the ACT Hospice (Clare Holland House); people living at home, or being cared for in Residential Aged Care Facilities. An innovative Day Hospice is also supported by dedicated palliative care volunteers.

**Objectives :** To increase knowledge, understanding and appreciation about a comprehensive and broad ranging model of palliative care volunteering . The areas covered will include:

- The core training and ongoing training opportunities
- The range of settings for supporting families receiving palliative care.
- Ongoing support for volunteer work force-including an annual retreat, now in its 13<sup>th</sup> year
- The relationship between volunteers and other members of palliative care service delivery

### **Delirium in advanced cancer: Incidence within an inpatient hospice setting**

- Dr Suzanne Rainsford
- Dr Andrew Skeels, Medical Director, Palliative Care ACT
- Dr John Rosenberg, Director/ Senior Research Fellow, Calvary Centre for Palliative Care Research
- Dr Tracey Bullen, Research Associate, Calvary Centre for Palliative Care Research

#### **INTRODUCTION AND OBJECTIVES:**

Delirium is a common but often under diagnosed condition in patients with advanced cancer. It can cause significant distress for the patient, their family and care providers, therefore making it everyone's business.

The actual incidence of delirium in patients with advanced cancer is unknown with estimates ranging from 25% to 88%. Studies have suggested that delirium is missed 20-23% of the time. At present there is no standardised assessment tool, and 24 different scales are available.

This study aimed to determine the incidence of delirium in patients with advanced cancer admitted to the ACT inpatient hospice applying a validated screening tool (DRS-R-98). This tool, on a 0-46 scale was chosen as it assesses both the presence *and severity* of delirium.

#### **METHOD:**

A retrospective audit of medical records for cancer patients admitted to the ACT Hospice was performed to determine the baseline incidence of delirium diagnosed using clinical judgement alone. Subsequently, patients with a primary diagnosis of advanced cancer were recruited and screened for delirium within 72 hours of admission. Incidence and severity of delirium were determined using the DRS-R-98 total and severity scores utilising the recommended cut off score of 15.25 indicating the presence of delirium and the score range of 8 -15 to indicate subclinical delirium. Demographic data and ADL performance scores were also collected.

#### **RESULTS:**

The retrospective audit demonstrated a baseline incidence of delirium of 31%. Preliminary analysis of this study indicates an incidence of subclinical and clinical delirium cases at 25% and 5% respectively. Results were analysed using frequency and exploratory cluster analysis to determine the symptom profile of delirium within a sample of 100 consecutive patients admitted to the ACT hospice. Completed analysis will further compare characteristics of patients with and without delirium symptoms.

#### **CONCLUSION**

It is predicted that utilising this screening tool to assess presence and severity of delirium will improve diagnosis of clinical and subclinical delirium in advanced cancer patients.



## **Translating the evidence: An allied health hub in caresearch**

**Rawlings D and Tieman JJ**

Palliative & Supportive Services, Flinders University, Adelaide, South Australia

### **Introduction**

Palliative care in the community can be complex with different disciplines contributing individually or as part of a multidisciplinary team to meet the needs of an individual patient. These health professionals may be private providers and palliative care maybe only part of their practice. CareSearch has developed 'hubs' of information and resources that consolidate the knowledge base and practice issues<sup>1</sup> for specific professional groups. This paper describes the development of an Allied Health Hub.

### **Methods**

Following a Special Interest Group (SIG) meeting at the 2011 PCA Conference, the National Advisory Group endorsed the development of an Allied Health Hub. Representatives from the SIG and from the Allied Health Professions Association completed an initial scoping activity. Representatives from six Allied Health professions were then invited to form a working group to support the page author in developing content (including webpages, resources and links) and to assist with the design, organisation and promotion of the hub.

A project newsletter has been widely disseminated.

### **Results**

The Hub comprises a targeted set of palliative care information to support Allied Health professionals. There has been increasing interest in the Hub, with substantial feedback on proposed content and resources from the sector. The Allied Health Hub will be launched at the Palliative Care Australia Conference in 2013.

### **Conclusion**

The Allied Health Hub recognises the involvement Dietetics, Occupational Therapy, Physiotherapy, Psychology, Speech Pathology and Social Work to palliative care provision in Australia.

CareSearch is funded by the Australian Government Department of Health and Ageing.

### **References**

Tieman JJ (2012) Filters and hubs: shortening the distance to palliative care evidence. *Australian Journal of Primary Health*, 2012, 18, 268–273

## **Patient and cancer information: Can they read and understand it?**

**Rawlings D and Tieman JJ**

Palliative & Supportive Services, Flinders University, Adelaide, South Australia

### **Introduction**

Palliative care will affect most people at some stage whether as a patient, carer, family member, neighbour or friend. Different information may be needed over time and it is important to know how to write for these circumstances. While it is important to provide good quality information, it is also important that the content can be easily understood<sup>1</sup>. Almost half of the Australian adult population have literacy levels not sufficient to cope in today's modern society<sup>2</sup>. Health literacy is therefore an important issue for the sector. This paper highlights issues that need to be considered in communicating effectively with patients and carers.

### **Methods**

CareSearch has developed quality processes to guide the development of content for different audiences. Strategies that are used to improve communication include:

- Training page authors in web writing
- Readability assessment processes and scores for content pages
- Input and feedback from intended page users
- Formal peer review
- Style templates for online presentation
- Usability testing, as appropriate.

These processes are currently being applied in the review of the For Patients and Carers page within the CareSearch website.

### **Results**

The updated consumer pages will be released for National Carers Week, October 2013. Quality processes are improving the presentation and usability of these pages.

### **Conclusion**

Online palliative care information can help support patients and families at the end of life. Having trustworthy information can help encourage involvement in decision making. Processes need to be in place to ensure that information is current, reliable and easy to understand.

CareSearch is funded by the Australian Government Department of Health and Ageing.

### **References**

<sup>1</sup>Walsh T and Volsko T (2008) Readability Assessment of Internet-Based Consumer Health Information *Respiratory Care* 53 (10) :1310 -1315

<sup>2</sup>ABS Australian Social trends 42102.0 June 2009

## Caresearch, NSAP, PCOC: Evaluation of the working together change framework workshops

Rawlings D<sup>1</sup>, Tieman J<sup>1</sup>, Adams A<sup>1</sup>, Mills S<sup>2</sup>, Vaz H<sup>2</sup>, Banfield M<sup>3</sup>

<sup>1</sup>Palliative & Supportive Services, Flinders University, Adelaide, South Australia

<sup>2</sup>Palliative Care Australia, Canberra, ACT

<sup>3</sup>Australian Health Services Research Institute, University of Wollongong, NSW

### Introduction

The Australian Palliative Care Knowledge Network Project (CareSearch), the National Standards Assessment Program (NSAP) and the Palliative Care Outcomes Collaboration (PCOC) work together to enhance practice in palliative care and improve care for patients and their families. A series of workshops were held to address the possibility of integrating evidence, standards and outcomes and address quality improvement.

### Methods

A model was developed and presented at 3 hour workshops, held in Adelaide, Perth, Melbourne, Launceston and Dubbo. An evaluation survey was provided on the day, emails were sent out at 3 weeks and six weeks with further resources, and a final survey was sent at 8 weeks to see how services used the information to make changes in their service.

### Results

The workshop surveys (n=77) had a 70% (n=54) response rate. 89.2% agreed or strongly agreed that the workshop met their needs and 81.1% agreed or strongly agreed that they were more confident in applying an evidence based approach to problem solving.

The survey at eight weeks (N=72), had a 19% (n = 15) response rate. Findings include: 79% (n=11) had considered the role of evidence in change activities. 57% (n=8) were more confident about QI activities and 57% had identified areas that they wanted to change.

It is proposed that the reality of time, staffing and workload constraints impinge on the ability to plan and manage change.

### Conclusion

A collaborative approach has been taken to address how to support palliative care services in addressing change, quality improvement and knowledge uptake.

## **Embarking on the nurse practitioner pathway**

### **Raelene Rees**

It is acknowledged that health care services are under pressure and are continuously adapting to ongoing advancements and change. Palliative Care Nurse Practitioner (PCNP) roles are developing as many Service Providers identify areas of need which the PCNP role can address. The successful implementation of PCNP roles is complex and is influenced by multiple factors, related to both the Health Service Provider and to the PCNP candidate themselves.

The candidate who embarks on this career path commits to a journey that is frequently more difficult and demanding than they had anticipated. Candidates commonly have many years of experience in palliative care and are often being recognised as experts, however during candidacy they find that they unexpectedly return to novice status. The journey to endorsement can be challenging and personality characteristics and traits can contribute to success; other elements such as a support network from colleagues and family, are also critical.

Health Service Management has a responsibility when considering the implementation of a PCNP role, to understand what this role entails, and to have identified a significant gap which the role can address. It is crucial they establish a comprehensive candidacy program, ensuring that they develop a supportive network, including specialist mentors and a broad based detailed training program. Candidates are more likely to withdraw when the correct framework has not been designed and assembled. Management also need to acknowledge that achieving endorsement and role establishment will take significant time, and that each candidate can be at different starting points along this path.

**Sexuality and palliative care**

**Robyn Reid**, MND SCW Southern Region, SMRPPC

This workshop explores the issues around sexuality and palliative care, with particular reference to Motor Neurone Disease, and provides a model to discuss this with clients using strategies and at a comfortable level for Health Care Professionals. Points of change in the client's condition provide opportunities for Health Care Professionals to raise the subject of changes to relationships and intimacy and allow the client to have permission to talk about this very important area of their lives. Health professionals who work in the field of MND and palliative care are working with two taboos-sex and death. Palliative care work can create an intimate and deeply personal interaction with clients that can be challenging and very rewarding. Health professionals need to be able to talk to clients about all the issues that are of concern to them in order to provide care that is truly holistic and takes into account the very important issues of intimacy and sexuality and the relationships that are impacted upon by their symptoms and management.

## **A national survey of palliative care service managers' advance care planning practices and policies**

W. Silvester<sup>1</sup>, M. Sellars<sup>1</sup>, M. Masso<sup>2</sup>, C. Johnson<sup>3</sup>, R. Sjanta<sup>1</sup>

<sup>1</sup>*Respecting Patient Choices, Austin Health, Melbourne*

<sup>2</sup>*Palliative Care Outcomes Collaboration, Australian Health Services Research Institute, University of Wollongong*

<sup>3</sup>*Cancer and Palliative Care Research and Evaluation Unit, University of Western Australia*

**Background:** Past research has shown that advance care planning (ACP) programs can improve end-of-life outcomes for palliative care patients and can successfully be embedded into palliative care services. The current state of ACP policy and practice within Australian palliative care services is unknown.

**Aim:** To distribute a national online survey investigating current ACP policies and practices to palliative care service managers involved with the Palliative Care Outcome Collaboration (n=105).

**Results:** Of 59 palliative care service managers who completed the survey, 95% believed their service had a role in ACP, but only 60% of services offer ACP to half or more of their patients. 76% reported that their service formally record patient's ACP wishes, 45% report that ACP documents were always followed and only 35% of managers believed ACP was done well within their service. 90% report that they discuss the patient's end-of-life wishes, but only 57% of services had written policies and guidelines about ACP and 24% do not check for pre-existing ACP documents. 95% of services believe GPs have a role in ACP, yet only 35% of services routinely transfer completed ACP documents to GPs.

**Discussion:** Although palliative care service managers see a role for ACP, the majority believe that ACP could be improved within their service. Palliative care services are not currently equipped to provide a consistent approach to ACP across services nationally, due to a lack of written policy, documentation and communication with GPs.

## Exploring the interface between palliative care and legalised assisted death

**Dr Linda Sheahan (FRACP, M. Bioethics)**

St George Hospital Cancer Care Centre

### **Background and Objectives:**

The literature surrounding this issue demonstrates overwhelming community support for PAS/VE at the community level (in Australia 60-65%). In response to this community mindset, a number of countries around the world have legalized or decriminalized assisted death, and some have formally introduced PAS/VE into their health systems and legal structures. These include the Netherlands, Belgium, Luxembourg, Switzerland, and the US states of Oregon, Portland and Montana.

Palliative care specialists have largely opposed the legalization of euthanasia, or deliberately distanced themselves from the issue in attempt to stay clearly differentiated from any practices that deliberately shorten life. While I understand the motivations behind this approach, I feel that the level of debate surrounding this issue has been patchy, sometimes ill informed, and arguably fear based in many respects.

As caregivers we deal daily with terminal illness, and are thus often confronted with questions regarding physician assisted death. It has been my experience that palliative care specialists vary widely in how they confront or avoid this question, and are often uncomfortable in discussing this issue with patients and colleagues. The question is why, and how ought we be addressing this question, both in our clinical practice and on a policy level?

My exploration of this issue thus consists of two parts:

1. To identify current attitudes and practices among palliative care specialists in Australasia regarding PAS/VE
2. Churchill Fellowship to visit institutions where PAS/VE is practiced or legalized, and engage with key palliative care and assisted death stakeholders regarding how these practices affect communities and healthcare at the end of life. My expectation is that this fellowship will broaden and deepen our understanding of how legalization may effect end of life care in Australia, and what concerns have actually been validated by the overseas experience.

### **Methods:**

In order to explore part 1, I have constructed a survey for Australasian specialists in palliative care in order to gather some simple baseline cross sectional data regarding their experiences and opinions surrounding physician assisted suicide and voluntary euthanasia. The survey is an anonymous, online survey with 18 questions, distributed by email through ANZSPM (Australian and New Zealand Society of Palliative Medicine). Pending ethics approval (due April 23<sup>rd</sup> 2013), it will be distributed during May, with responses closing end of July.

Key questions:

1. General demographic information
2. Frequency of requests for assisted death, and what type of response is generally given
3. Understanding of the term 'voluntary euthanasia.'
4. Opinion regarding legalisation of physician assisted suicide and/or voluntary euthanasia in an Australasian context
5. Identify the most important and relevant values that inform this opinion, which has been compiled from the literature around these questions
6. Potential impact legalization of PAS/VE would have on palliative care practice and services in Australasia.

Part 2 involves the details of my Churchill Fellowship report consequent to my visits to jurisdictions where PAS/VE have been legalized.

I would like the opportunity to present my preliminary findings.

**Recognise my dying - A creative end of life model for end stage liver disease**

**Caroline Short**, Hunter New England Local Health District

**Tracey Jones NP**, Hunter New England local Health District

**Kathryn Bensley**, Calvary Mater Newcastle

**Robert Gibson**, John Hunter Hospital. Hunter New England local Health District

**Carla Silva**, John Hunter Hospital. Hunter New England local Health District

It is the year 2013. Developed countries are technologically advanced yet remain challenged in the provision of end of life care for people with non-malignant chronic diseases, specifically in recognising dying and offering appropriate care.

End Stage Liver Disease (ESLD) is on the increase in Australia and has specific complications requiring specific recognition and management. In addition to the difficulty of recognising dying there are ethical, economical, medical, legal, social and geographical challenges in accessing appropriate care. There are a number of generic and specific prognostic tools available to assist in determining stage of illness such as the Prognostic Indicator Guide (PIG), the Model for End Stage Liver Disease (MELD), and the Palliative Care Outcomes Collaborative (PCOC) Assessment tools as well as experts from fields not so afar from palliative care.

This presentation is designed to challenge all health professionals including specialist palliative care to consider what constitutes appropriate end of life care for people with ESLD, and to consider that management of ESLD requires awareness and expertise from a wide variety of health professionals. Thus willingness for collaboration between and within health professionals is essential for mutual exchange of knowledge and skills to support the care of people with ESLD.

This presentation will represent 'Jack' and his family in challenging health professionals to examine their models of care delivery and appropriate partnership development in the provision of care for people with ESLD in any care setting, be it home, hospital or aged care facility.



## **Shifting attitudes and knowledge of Haemodialysis nurses: Impact of integrating renal and palliative care in rural satellite services**

**Vicky Smith<sup>1</sup>, Carita Potts<sup>1</sup>, Wendy Penney<sup>2</sup>, Sally Wellard<sup>2</sup>.**

<sup>1</sup>Ballarat Hospice Care Incorporated

<sup>2</sup>University of Ballarat

### **Background**

Haemodialysis nurses are challenged in delivering quality end of life (EOL) care for the growing population of older, sicker patients with end stage kidney disease (ESKD) receiving dialysis.

To improve outcomes for patients and families at EOL an innovative collaboration between a regional Victorian haemodialysis unit (1<sup>st</sup> Intervention site) and a community palliative care service has established an integrated renal palliative care framework. This framework addresses the continuum of care from pre-dialysis with an integrated palliative approach whilst patients are still actively dialysing to a post dialysis setting and EOL care.

### **Objectives**

To measure the impact of integrated renal palliative care education on nurses caring for haemodialysis patients and families at EOL. The nurses are located in five rural haemodialysis satellite services in regional Victoria.

### **Methods/Results**

A mixed method design approach was used. A focus group was conducted at the first intervention site to develop a questionnaire and targeted palliative care education program. A pre-test and post-test survey at three months following the one day targeted education program was conducted with nurses from five rural satellite haemodialysis services. A report on these findings is currently being analysed, and will be presented.

### **Conclusion**

The expected outcome is integrating renal and palliative care will “shift the attitudes and knowledge” of haemodialysis nurses to improve outcomes for haemodialysis patients and families at EOL.

This study may generate further exploration of the impact of nurses caring for haemodialysis patients at EOL in Australia to inform nursing practice and guidelines, which is currently lacking.

**Mentoring of carers integral to supporting a better end of life experience for those dying, their families and community, and to building sustainable communities able to care for their own**

**Katriona Smith**, LifeCircle

**Averil Biddulph**, LifeCircle

**Lucy Baker**, LifeCircle

88% of Australians say that they would like to die at home if they had proper support, and only 17% do so. LifeCircle provides support for carers and families to help this happen. LifeCircle will explore with participants how, by supporting carer resilience, bringing together family networks and linking families to palliative care and other health and community services, people in Australia can be cared for longer at home and given the opportunity to die where they chose.

LifeCircle's mentoring of carers empowers people to participate in the care of those who are dying, increasing knowledge, skill and confidence in caring at end of life, and contributes to greater understanding of dying and death. LifeCircle's mentors are trained volunteers with personal experience of caring at end of life, bringing lived-experience to their role. The support provided by the mentor has immediate outcomes for the carer and the dying person, reducing anxiety and carer burn-out and creating greater confidence in caring, higher uptake of palliative care and end of life services, and improved quality of life for people dying.

LifeCircle engages family members, friends and community in supporting people in Australia to live well and die well. LifeCircle's volunteers promote resilience and connectivity among family members and friends who are involved in the caring journey, helping people to flourish through the later stages. This creates a virtual circle in which each person's life is enriched, the person ill or in later stages of life, their families, peers and younger generations.

## **What is happening to the children? Exploring a cancer centre's readiness to address the needs of children facing grief and loss**

**Odette Spruyt<sup>1</sup>, Clare O'Callaghan<sup>1</sup>, Helen McLennan<sup>1</sup>, Alison Hocking<sup>2</sup>**

1. Department of Pain and Palliative Care
2. Department of Social Work

Although psychosocial care of adults with cancer is accepted as an essential aspect of comprehensive cancer care, few services are directed toward supporting children who are facing the death of a parent.

### **Objectives**

This study draws from the organisational change literature to explore the discrepancy between current service provision and need, and also examines adult cancer centre staff attitudes, knowledge and skills appropriate to working with children, and organisational support for the development of additional services.

### **Methods**

An organisational readiness framework was applied. Organisational factors were assessed through interviews with key leaders, and documentation of current services and resources directed toward children. Individual factors were assessed through interviews with key service providers and an on-line staff survey. The external context was assessed through interviews, internet and literature searches.

### **Results**

The psychosocial care of children was seen as consistent with the organisation's core vision. There was evident discrepancy between existing services and perceived need with 80% of surveyed staff supporting service development. Current provision consists of ad hoc identification, assessment and support. Staffs lack confidence and training in child counselling. Forty-nine percent of survey respondents favoured provision of services for both adults and their children, while 36% favoured focussing services toward parental guidance and support only. There was lack of knowledge about external service providers and request for better access to relevant information.

### **Conclusion**

Findings support the further exploration of child-directed services with comprehensive assessment of the unmet needs and consideration of a dedicated service for children facing grief and loss.

**Hope versus realism - the views of a sample of 700 readers of *Brain Tumour* magazine which is distributed in the international brain tumour community**

**Denis Strangman**

Brain tumours are a so-called "rare" or "less common" cancer but in 2010 there were 1,247 deaths in Australia from primary brain tumours. Brain tumour patients are also disproportionately represented in all palliative care hospitalisations. (See *Brain Tumour Facts 2013* [www.btaa.org.au](http://www.btaa.org.au)). The current prognosis for someone diagnosed with a primary malignant brain tumour is between 11 and 15 months.

*Brain Tumour* magazine is an annual free publication now distributed to 12,000 people in 109 countries by the International Brain Tumour Alliance (IBTA).

The editors of the magazine are conscious that its readership is very diverse and includes recently diagnosed patients who are sustained by hope that they will beat their prognosis and former carers who have seen their loved one pass away despite all efforts to extend their survival.

This poster is based on an analysis of the raw data from a survey in 2013 which was responded to by 700 readers who were asked whether or not the editors had achieved the right balance between realism and hope in the magazine content.

## **Facilitating education excellence: Inpatient and community specialist palliative care teams collaborating to achieve excellence in learning and patient care**

**SULLIVAN Sandra, WALKER Stephanie, CHRUSZCZ Janelle – Sacred Heart Service**

### **Introduction**

The project was initiated in response to assumptions the authors had about staff engagement with education. The aim was to ensure base line education programs facilitate excellence in learning and patient care by incorporating evidence based practice. It was anticipated this would be achieved by improving access to education and fostering a culture of knowledge sharing, learning and collaboration between the multidisciplinary inpatient and community teams.

### **Methods**

Assumed barriers to attending education sessions were identified by the authors through brainstorming and included: inability of staff to attend due to work load, lack of coordination of education across individual units, competing priorities leading to a low value placed on education sessions and no strong culture of interdisciplinary education. Staff were engaged through facilitated workshops and electronic surveys to determine their experience of the current education program.

### **Results**

There was a 33% response rate to the electronic survey and 18 nurses attended facilitated feedback sessions. 72% of participating staff were moderately satisfied with the current program; however they identified 'room for improvement'. Access to education due to shifts, workload priorities and awareness of sessions were identified as the main barriers. The most frequently suggested topics were pharmacology and cultural diversity. There was 100% interest from allied health to present and attend education with workload the main barrier to attendance.

### **Conclusions**

As a result of consultation with staff, a streamlined system of education across the inpatient and community teams was developed. All staff now have access to an online calendar on a networked computer system. Education sessions are repeated at different venues and times and multidisciplinary participation is encouraged.

**Communicating my values, my wishes: Advance care planning in community palliative care**

*K.Tatlow, Eastern Palliative Care, VIC.*

**Background and Aim:**

All people have the right to receive high-quality care; to be offered Advance Care Planning (ACP) opportunities and to have a dignified death in line with their spiritual and psychosocial wishes.

With the recent dissemination of the National Framework for Advance Care Directives, it was timely that Eastern Palliative Care Association Incorporated (EPC) strengthen its ACP approach and develop a clearer process for it within its service.

**Method:**

A reference group was conducted that emphasised the need to produce something relevant to the needs of community palliative care clients. Staff expressed the desire for a 'kit' of resources that could be utilised according to client need.

Following extensive research and consultation with other services, a Resource Kit was designed.

**Results:**

The Kit contains a staff guide; information brochure; conversation tools; legal forms and Statement of Wishes form.

The conversation tools include the Coda Alliance 'GoWish cards' and EPC's 'My Values, My Wishes prompt booklet'. These tools can be a less intrusive way of facilitating sensitive conversations.

The Statement of Wishes form was designed to ensure clients' psychosocial and spiritual needs are included at the onset.

**Discussion and Conclusion:**

EPC's ACP Resource Kit is a unique and innovative step forward in facilitating ACP with palliative clients, by incorporating aspects of care that are most important to them. A recent staff evaluation after 12 months in use, indicated that the kit 'opened doors' in assisting client's to reflect on and communicate things that they previously were unable to do.

**Quality improvement in Australia: What the NSAP results tell us**

**Helen Vaz** , National Standards Assessment Program (NSAP) Quality Manager

**Shyla Mills**, NSAP Manager, Palliative Care Australia

**Mari Lo**, NSAP Assessment Coordinator, Palliative Care Australia

National Standards Assessment Program is funded by the Australian Government  
Department of Health and Ageing

**Objective**

The poster will present the key learning to date from the results provided through the National Standards Assessment Program (NSAP).

**Methods**

NSAP is a quality improvement program available for all specialist palliative care services across Australia. It is a resource that enables services to engage in continuous quality improvement through self assessment against the national palliative care standards<sup>1</sup>, action plan development and implementation, as well as peer mentorship. NSAP was formally launched in July 2009 and national participation in this voluntary program has grown significantly since that time.

**Results**

The NSAP cycles deliver meaningful, useful and actionable quality improvement information at a local service, state/territory and national level. This poster utilises all the self assessment results (including planned improvement actions) to describe national quality improvement priorities in relation to the national palliative care standards

**Conclusion**

This analysis of results up to June 30 2013 foreshadows a real opportunity to develop processes for working collaboratively across core areas for improvement based on an emerging understanding of the needs of the sector, in addition to supporting system level change to enable improvement in palliative care for patients and their families/ carers. The consistency of the results over the first 4 years suggests these provide a reliable baseline against which results from future cycles can be compared to infer progress in Service quality improvement.

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**Paediatric Palliative Care in Australia: What are the NSAP results from cycle 1 & 2?**

**Helen Vaz**, National Standards Assessment Program (NSAP) Quality Manager

**Shyla Mills**, NSAP Manager, Palliative Care Australia

**Mari Lo**, NSAP Assessment Coordinator, Palliative Care Australia

National Standards Assessment Program is funded by the Australian Government  
Department of Health and Ageing

**Objective**

The poster will present the National Standards Assessment Program (NSAP) results from both cycle 1 and cycle 2 describing the comparisons and what has happened between these cycles.

**Methods**

NSAP is a quality improvement program available for all specialist palliative care services across Australia. It is a resource that enables services to engage in continuous quality improvement through self assessment against the national palliative care standards<sup>2</sup>, action plan development and implementation, as well as peer mentorship. The paediatric palliative care services in Australia and New Zealand have participated in NSAP since 2010 and completed self assessment snapshots for 2 cycles.

**Results**

The NSAP cycles deliver meaningful, useful and actionable quality improvement information. This poster utilises all the self assessment results (including planned improvement actions) to describe the quality improvement priorities for the paediatric services from cycle 1 to cycle 2 in relation to the national palliative care standards

**Conclusion**

This analysis of results between cycle 1 and cycle 2 for the paediatric palliative care services can inform progress in quality improvements for this group over the last couple of years and an understanding of what the system level changes have occurred and the focus of the improvements for this cohort.

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## **Role modelling that palliative care is everyone's business for undergraduate nursing students**

**Claudia Viridun** – University of Technology, Sydney

**Michelle Kelly** - University of Technology, Sydney

**Danni Cheng** – University of Technology, Sydney

**Tamara Power** – University of Technology, Sydney

**Fiona Orr** - University of Technology, Sydney

**Angela Phillips** - University of Technology, Sydney

**Joanne Gray** –University of Technology, Sydney

**Josh Van Houten** – University of Technology, Sydney

**Carolyn Hayes** – University of Technology, Sydney

### **Introduction**

In an effort to enable student's to recognise that palliative care is everyone's business and develop skills to work within this area, a case study has been written to embed principles of the palliative care approach. An evaluation of this work from the perspective of the students is awaited and this data will form the basis of this presentation.

### **Methods**

A curriculum review was completed to elicit data about how and where subject objectives referred explicitly to palliative care. Meetings were held with the Palliative Care Curriculum for Undergraduates (PCC4U) Project Manager to assist mapping of this work throughout our undergraduate program. Agreed approaches to support teaching and learning across several subjects was discussed and planning for this is underway. A specific project is now underway to look at how the skills for end of life care / terminal care can be taught within a second year subject. This involved developing a case study that evolves across four subjects in second year, culminating in terminal care towards the end of semester. A hybrid model of learning has been used to engage students on multiple levels with the aim to enable deeper learning in this field inclusive of online learning, audio-visual materials, lectures and directed laboratory sessions. Online learning modules prepare students for principles of care and practical skills required. A lecture focuses on enhancing understanding of broader principles of palliative care. Finally, a laboratory session enables class discussion about key thinking points (linked with work from PCC4U), skill development for required nursing skills and communication practice with patients at the end of their life and their families / loved ones.

### **Results**

Evaluation data from students will be available after June 3, 2013.

### **Conclusion**

It is clear that to enable student nurses to understand that palliative care is everyone's business and feel confident in the care of people with life limiting illness, universities need to consider the mapping of such content throughout multiple subjects within the curriculum, innovative approaches to teaching and learning in this field and targeted clinical placements. This session will provide information and evaluation of one approach that is attempting to meet this need.

## **Audit of a palliative care service integrated in an Acute General Hospital**

**Waterfall M (1), Waugh J(1), Jackson B(1,2), Pang J(1,2), Farmer M(1,2)**

Monash Health Melbourne Victoria. (1)

Monash University Melbourne Victoria (2)

Casey Hospital is a new 243 bed acute community hospital. The palliative care unit comprises five protected beds adjacent to the general medical wards. It is staffed on a rotational basis by three Senior Physicians of the General Medical Service, a Palliative Care Nurse Consultant and a multidisciplinary support team.

We report an audit of 5 years data and the success of the model of service. From 2008 - 2012, 1987 patients were referred; of these 993 (50%) were inpatients at Casey Hospital, 460 (23%) inpatients at other hospitals and 534 (27%) from the community. 984 (49.5%) referrals were admitted to the palliative care unit, average length of stay was 8 days. The primary diagnoses were cancer (66%), end stage lung disease (6%), and end stage renal failure (3 %.)

The majority of patients were admitted for terminal care (82%), but patients were also admitted for symptom management or respite. The onsite palliative care ward eliminates the need for transfer of inpatients to an external facility, allows for patients to be easily and comfortably moved to the unit, and enables seamless handover from the caring teams. From the time of referral to admission, family and patients have continued support from the palliative care team.

The Victorian Palliative Care Satisfaction Survey shows scores for the unit are higher than the Victorian average, confirming this to be a well-accepted service.

Continuity of care, ease of transfer and a close relationship with the general medical wards and the community has enabled the palliative care service to flourish.

## **Walking through grief: The establishment and evaluation of a bereavement walking group in Western Sydney**

**Westman, K, Western Sydney LHD, NSW**

Bereavement support should be offered in various forms to family members to reflect diverse needs and coping styles (PCA, 2005, Silverman, 2004). The majority of bereaved people do not require formal counselling and there is clear evidence for offering a “continuum” of other forms of support according to the complexity of their needs (Silverman, 2004, Walsh, O’Connor and Winston, 2008). Inspired by bereavement walking groups run in Victoria and in consultation with the Heart Foundation, an inaugural bereavement walking group for bereaved partners was established in 2011 within the Palliative Care Service in Western Sydney. This approach to bereavement support recognises that some people with an accumulation of risk factors for complex grief may be less likely to engage with counselling or more traditional support group models. It acknowledges the value of group process and social connection in processing grief and the documented emotional and psychological benefits of group physical activity (Priest, 2007). The group was run as a closed group for six sessions, with one session per fortnight over 12 weeks in a nature reserve within the area. Members participated in a walk together for approximately 45 minutes and then spent time in discussion facilitated by the Bereavement Counsellor for approximately one hour. A semi-structured evaluation survey was distributed at the conclusion of the group which demonstrated a range of positive outcomes. This poster will explore the walking group as a case study and report on aspects of establishing and facilitating the group as well as evaluation findings.

**Living well dying well at Southern Cross Care (SA&NT)**

**A Larpent<sup>1</sup>, B. Davidson-Park<sup>1</sup>, S. McCallum<sup>1</sup>, K. Price<sup>2</sup>, D. Evans<sup>2</sup>, S. Ullrich<sup>2</sup>, P. Williamson<sup>2</sup>**

<sup>1</sup>*Southern Cross Care, South Australia, Australia*

<sup>2</sup>*University of South Australia, South Australia, Australia*

**Background:** The provision of person-centred, end of life care in a residential aged care facility (RACF) is influenced by many factors including the workforce. Older Australians rank palliative care and dying with dignity as major issues. This project addresses these through workforce reform and establishing an end of life care framework within RACF.

**Aim:** To build the aged care workforce capacity to skilfully and confidently deliver person-centred end of life care within a RACF by:

- implementing a targeted training program focusing on educating and up-skilling all staff
- creating better workforce balance by reconfiguring roles and encouraging all staff to practice at their highest capacity
- harnessing a cultural shift within the RACF to establish a multi-disciplinary, partnership approach
- building leadership for change and sustainability of the new workforce model.

**Discussion:** The establishment of a clear framework for end of life care which highlights the role and importance of all staff ensures residents and families are awarded the choice and dignity that is integral to living well and dying well in a RACF. Key factors include increasing skills and confidence of all staff to deliver palliative care, allowing staff to practice at their highest capacity and adopting a multi-disciplinary team approach with emphasis on effective communication. Southern Cross Care is taking a systematic and pragmatic approach to how its workforce provides end of life care and is translating this thinking about how to realise the desired outcomes into action. The project is possible due to funding by Health Workforce Australia.

## **The role of social work in palliative and end of life care**

**Julianne Whyte**, CEO Amaranth Foundation & PhD Candidate Charles Sturt University

In Palliative and End of Life Care, the unit of care encompasses the patient, the family and care giver. Dying is a very public and community event and has to be understood in the context of the person's environment. Because of this, the social work profession is ideally placed to provide effective assessment and support for people with terminal illnesses, inclusive of the needs of the person's family and care givers.

Social work practice occurs at the interface between the individual and the environment. Social work activity begins with the individual and extends to the context of the family, social networks, community and the broader community. In the journal *Progress in Palliative Care* (2010) the authors state that 'both palliative care and social work reflect philosophies of caring that consider individuals in the full context of their lives'. Social work sits at the interface of the patient, family system and the wider community or society and is concerned with the wider context of illness and care.

In 2012 the Australian Association of Social Workers awarded a research grant to enable the development of Australian Competencies for Social Workers in Palliative and End of Life Care thus ensuring that social workers continue to play a pivotal role in the delivery of quality, evidence based psychological, psychosocial and supportive care for individuals, families and care givers at the End of Life.

## **The development of a primary health care model of palliative and end of life care for rural communities**

**Julianne Whyte**, RN, BSW. AMHSW & PhD Candidate. CSU Wagga Wagga

A sustainable and effective model of primary health care suitable for people requiring end of life and palliative care in rural and remote communities needs to be flexible, multidimensional, multidisciplinary, incorporate both the biological and psychological care aspects, be sensitive to the specific needs and population trends of each community, be sustainable, be equitable and available to all people living with an eventually fatal (terminal) condition.

Applying a one size fits all approach to the provision of end of life and palliative care will only further alienate many rural and remote communities and their people. The model that needs to be developed has to be mindful of the larger client capture areas in rural areas, smaller populations, paucity of public transport, geographic isolation and larger distances to access health care services, poorer reported health, lower life expectancy, fewer specialist and primary health care professionals and a very complex community care system. These conditions can affect demand for infrastructure and services and employment, as seen in many mining and irrigation communities.

In 2009, the Commonwealth Government commissioned an action research project, through the Local Palliative Care Grants Program. This research has enabled the trial and development a new model of rural primary health care delivery that is affordable, enabled care to be delivered where people live and addressed many of the identified gaps and challenges in End of Life and Palliative Care in Rural and Regional Australia today.

**Case Report: Patient and family requested home-based care****Fumie Yamamura****[BACKGROUND]**

Although many patients wish to stay at home until death, many of them actually die at hospital due to issues regarding the care-giving ability of their families and disease conditions. We herein report our experience with a case in which an intervention of a palliative care team allowed a patient to receive home-based care until his death as he and his family preferred.

**[CASE REPORT]**

The case is a 70-year-old man with inoperable esophageal cancer. Because administration of chemotherapy was also difficult due to chronic renal failure, he was admitted for radiotherapy. He became bed-bound (performance status 4) due to leg pain, and his systemic conditions deteriorated. Thus, he was referred for palliative care. Because an interview with him for a few days revealed that he requested treatment, radiotherapy was initiated after adequate induction chemotherapy. After treatment initiation, complaints of pain decreased, and rehabilitation was initiated with a goal of staying at home overnight. At this time, the hospital served as a care facility, and staying at home overnight was the goal. However, because his family requested home-based care, he was discharged to home 5 months after admission.

**[CONCLUSION]**

In this case, it seems that we should have performed early interventions while identifying what the patient and his family preferred regarding a place of care. If needed, several options should have been provided. In the future, we want to provide information while we identify changing preferences of patients and their families.

## Early palliative care in advanced lung cancer: A qualitative study

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Early ambulatory palliative care (PC) is an emerging practice and its key elements have not been defined. We conducted a qualitative analysis of data from a randomized controlled trial which demonstrated improved quality of life, mood and survival in patients with advanced lung cancer who received early PC integrated with standard oncologic care versus standard oncologic care alone.

**Objectives:** 1) Identify and explore timing of key elements of early PC clinic visits; 2) compare content of PC and oncology visits at critical clinical time-points (clinical deterioration, radiographic disease progression).

**Methods:** We randomly selected 20 patients who received early PC who survived within 4 time-frames: <3 months, 3-6 months, 6-12 months and 12-24 months. Content analysis was performed on PC and oncology visit notes of these patients.

**Results:** Addressing symptoms and coping were the most prevalent components of the PC clinic visits. Initial visits focused on building relationships and rapport with patients and their families and illness understanding, including prognostic awareness and information preference. Goals of care and hospice discussions predominantly occurred during later visits. Comparing PC and oncology visits around critical time-points, both included discussions about symptoms, illness status and goals of care; however PC visits emphasized psychosocial elements (e.g. coping), while oncology visits focused on cancer treatment and medical complications.

**Conclusion:** Early PC clinic visits emphasize managing symptoms, strengthening coping, and cultivating illness understanding in a structured, responsive and time-sensitive model. Around critical clinical time-points PC and oncology visits have distinct features, suggesting a key role for PC involvement.

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