



Eastern Metropolitan Region Palliative Care Consortium

ANNUAL REPORT

2016 - 2017

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Message from the Chair



On behalf of the members of the Eastern Metropolitan Region Palliative Care Consortium (EMRPCC), I am pleased to present the 2016-17 annual report.

End of life (EOL) care is truly becoming ‘everybody’s business’ and the role of palliative care has been very much in the public domain attracting attention from many quarters. Discussions highlight the fact that people are still confused about what palliative care is and does, both in the general public and amongst our non - palliative care health colleagues. The

palliative care sector has, for decades, tried to send the message that palliative care is not just about dying, but has a strong focus on quality of life and living for people diagnosed with a life threatening illness. All Eastern Metropolitan Region (EMR) consortium services are committed to these principles and to the five priority areas described in the DHHS End of Life and Palliative Care Framework.

The Consortium has indeed been blessed with the amazing and innovative work that Consortium manager Karen Conte has undertaken this year. Never one to wait around for opportunities to come to her, Karen has been able to use her clinical, management and relationship skills to provide a smorgasbord of activities described further in this report. From the hilarious ‘Frock up’ Event to hosting communication workshops and setting up education scholarships, Karen has been a joy to work with and conducts herself with a sense of fun as well as practical efficiency, and has been an enormous asset to the consortium.

This report also reflects the collaborative nature of the three major funded services in the Eastern Metropolitan Region. From the after hour’s phone service hosted by St Vincent’s Health to the benefit of all clients of the region, to the signing of the Memorandum of Agreement between Eastern Health and Eastern Palliative Care, the Consortium has enjoyed a shared vision in a spirit of cooperation and mutual respect.

There are challenges ahead of course. These include the increased demand for services, potential legislative changes, an ageing workforce, an under skilled and under resourced aged care sector just to name a few. Additional challenges to meet community expectations to support death in place of choice, especially in younger patients with complex and resource intensive needs often with high carer burden requires an ongoing commitment to provide ‘best’ palliative care.

Dr. Margaret Bird

Chair

CONSORTIUM MANAGERS REPORT

Consortium Managers Report



Now having been in this role for just over twelve months, I can say that I have been very privileged to work with the EMRPCC. The members of our consortium are extremely dedicated and committed to providing best practice and high quality palliative care to all people residing in the Eastern Metropolitan Region.

I would like to thank the Chair of the Consortium, Dr Margaret Bird, for her support and enthusiasm for the Consortium and the role of the Consortium Manager. My gratitude extends equally to our other Executive members; Jeanette Moody (CEO, Eastern Palliative Care) and Lesa Stewart (Group Manager, Cancer & Palliative Care, St Vincent's Hospital Melbourne) for their

ongoing support and confidence in me to undertake a number of activities over the past year with limited resources.

The past year has been spent building links with many stakeholders across the eastern region, including Community Aged Care Service Networks, Local councils, Eastern Melbourne PHN, Aboriginal Controlled Health Organisations and Primary Care Partnerships, just to name a few. I have built firm friendships and strong business relationships across the region and I am thankful for the warm reception that has been extended by all sectors. It is apparent to me that all the health, aged care and disability service providers that I have had the pleasure of encountering have a good appreciation of the importance of palliative care within their own context.

A lot has happened in the palliative care sector over the last twelve months with the release of Victoria's end of life and palliative care framework, the Enquiry into EOL choices, Ministerial advisory panel for the Voluntary Assisted Dying Bill and the passing of the Medical Treatment and Decisions Act which will commence in March 2018.

There is much to be achieved in the future to ensure that palliative care is everyone's responsibility as stated in the end of life and palliative care framework and the Consortium is well placed to assist with the implementation of the framework as it connects specialist palliative care with the wider health, aged care and disability sectors.

Karen Conte

Consortium Manager

ABOUT US

About Us

The Eastern Metropolitan Region Palliative Care Consortium is an alliance of all funded palliative care services in the region as well as a number of associate members with a specific interest in collaboration to ensure the provision of quality palliative care.

Our partnering services are:



Our Vision:

The Consortium's aspiration is that residents of the Eastern Metropolitan Region with a life limiting condition, their families and carers have access to a high quality palliative care system that fosters innovation and provides coordinated care and support that is responsive to their needs.

GOVERNANCE

Governance

The EMRPCC consists of funded palliative care providers (voting members):

- Eastern Health (EH)
- Eastern Palliative Care Assoc. Inc. (EPC)
- St Vincent's Hospital Melbourne (SVHM)

And Associate Members:

- Eastern Melbourne Primary Health Network (EMPHN)
- Fernlea House
- North Eastern Melbourne Integrated Cancer Service (NEMICS)
- Royal District Nursing Service (RDNS)

The EMRPCC is one of eight regional palliative care consortiums and is hosted by EPC. The three funded specialist palliative care services make up the Consortium Executive and oversee the implementation of the palliative care policy direction of the Department of Health and Human Services.

The Consortium has worked towards implementing Victoria's end of life and palliative care framework: a guide for high-quality end of life care for all Victorians on a regional level.

Policy priorities:

1. Person-centred services
2. Engaging communities, embracing diversity
3. People receive services that are coordinated and integrated
4. Quality end of life and palliative care is everyone's responsibility
5. Specialist palliative care is strengthened

The role of the palliative care consortia is to:

- Undertake regional planning in line with departmental directions
- Coordinate palliative care service provision in each region
- Advise the department about regional priorities for future service development and funding
- In conjunction with the Palliative Care Clinical Network, implement the service delivery framework and undertake communication, capacity building and clinical service improvement initiatives

GOVERNANCE

The EMRPCC met on eight occasions during 2016 -2017. All meetings were held at EPC.

The number of scheduled meetings held during the year ended 30 June 2016 and the number of meetings attended by each of the member agencies is set out in the table below:

Table 1 Member attendance at consortium meeting

Member Agency	Representative	EMRPCC	Executive
St Vincent's Health	L Stewart	7/8	2/2
	M Boughey	3/8	
Eastern Health	K Marshall	3/8	
	M Bird (Chair)	8/8	2/2
Eastern Palliative Care	J Moody	7/8	2/2
	K Draper	7/8	
Fernlea House	M Carr S McGivor	3/8	
RDNS – EMR	T Easte	5/8	
North Eastern Melbourne Integrated Cancer	K Simons	7/8	
Eastern Melbourne Primary Health Network	G Poynter L Paulin	6/8	
Department of Health & Human Services- Box Hill office (ex-officio)	W Molesworth	3/8	
EMRPCC – Manager	K Conte (ex officio)	8/8	2/2
Total meetings		8	2

GOVERNANCE

PALLIATIVE CARE CLINICAL NETWORK (PCCN)

The PCCN was incorporated into the newly formed Safer Care Victoria (SCV) as of January 1, 2017. *Targeting zero: Review of hospital quality and safety assurance in Victoria*¹ and the *Clinician engagement scoping paper*² make a compelling case for building, refocusing and re-energising the clinical networks.

Clinical networks play an important and increasing role in the Victorian health system. In our devolved governance model, clinical networks allow us to connect people, coordinate and develop services, and share resources in common clinical areas. They also provide a way to better engage with and care for consumers across the state. Our clinical networks are not “communities of practice”. That will not change with the introduction of the new framework. Indeed, the networks will continue to be connectors, provide quality and safety leadership, and be champions for change but with a stronger mandate, greater role clarity relating to reducing variation, and better engagement with consumers and the Department of Health and Human Services.

The Consortium representative on the PCCN is the Consortium Manager - Karen Conte.

The EMR also has senior clinicians represented on the PCCN including:

- Assoc. Professor M Boughey (Clinical Lead of the PCCN)
- Ms K Draper (EPC)
- Dr P Poon (Monash Health & EPC)

¹ State of Victoria, 2016. *Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*. Duckett S, Cuddihy M, and Newnham H (Review panel).

²Jorm 2016. *Clinician engagement scoping paper*.

THE EASTERN METROPOLITAN REGION

The Eastern Metropolitan Region

DIVERSITY

The municipalities of Manningham, Monash and Whitehorse have the greatest ethnic diversity when compared to the other 4 Local Government Areas (LGAs).

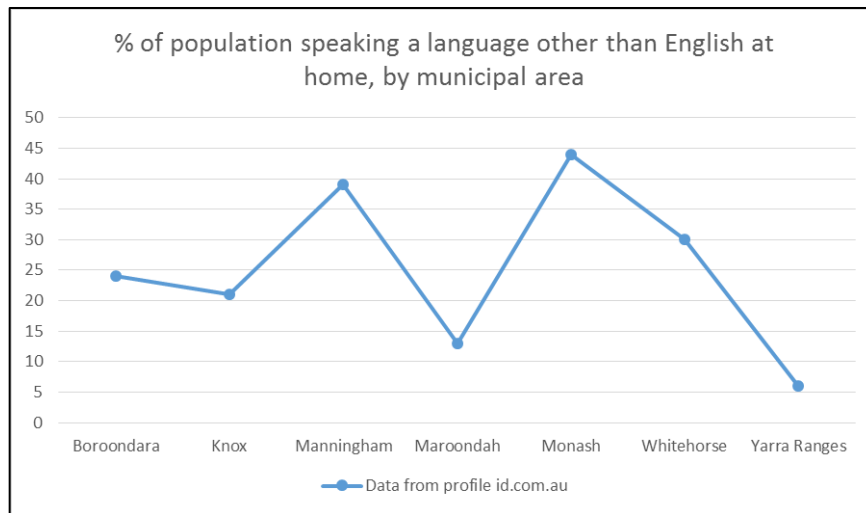
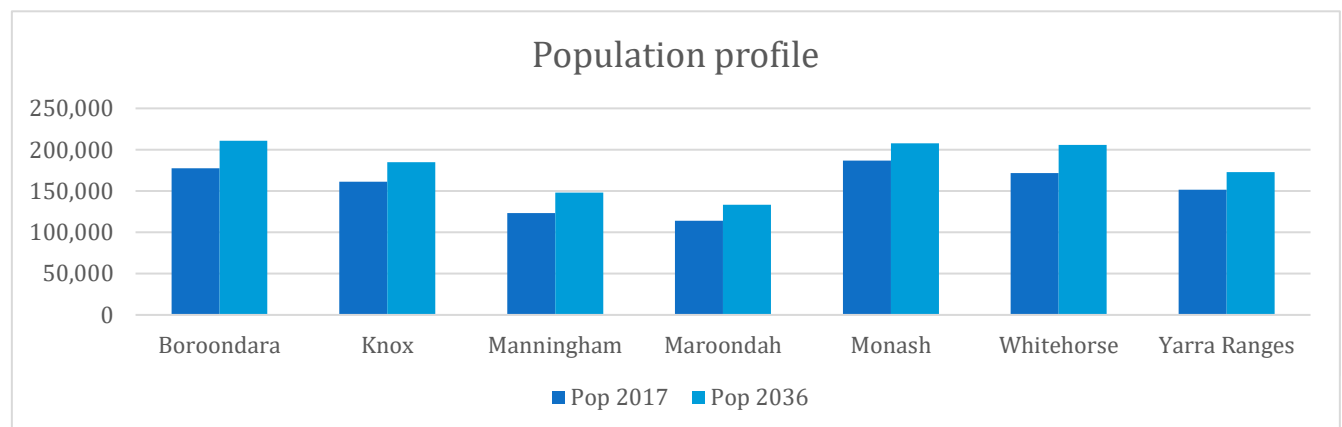


Table 2

As the region extends from inner city suburbs to outer rural areas, the demographics vary across communities

POPULATION GROWTH

Table 3: The current estimated population total is 1,086,201. This is expected to increase by 177,874 people over the next 19 years (2036) to 1,264,075 people.

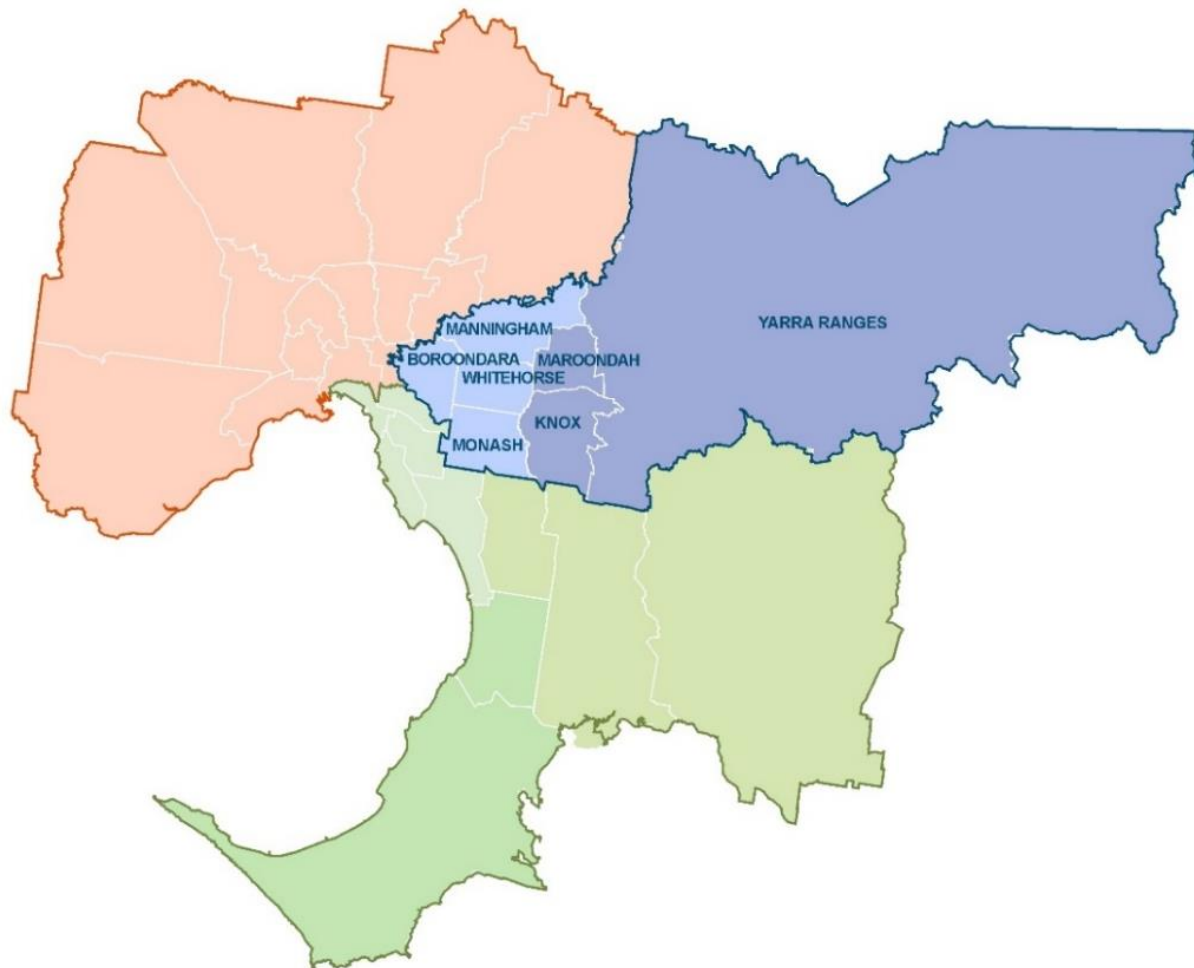


THE EASTERN METROPOLITAN REGION




REGIONAL PROFILE

The Eastern Metropolitan Region comprises seven Local Government Areas (LGAs):



Boroondara, Knox, Manningham, Maroondah, Monash, Whitehorse, Yarra Ranges



Metropolitan Regions

-  Eastern Metropolitan Region
-  Northern & Western Metropolitan Region
-  Southern Metropolitan Region

Eastern Metropolitan Planning Areas

-  Inner East Area
-  Outer East Area

THE EASTERN METROPOLITAN REGION

Motor Neurone Disease

The number of people diagnosed and living with MND in the EMR has remained stable, though the number of deaths dropped from last year by eight.

People Living With MND by DHHS Palliative Care Consortium Region in 2016/2017

	BARWON SOUTH WEST 16/17	EMR	GIPPSLAND	GRAMPIANS	HUME	LODDON	NWMR	SMR	VIC
Number of new MND diagnoses	21 (14)	29 (29)	9 (7)	9 (4)	10 (7)	13 (7)	52 (40)	51 (39)	194 (146)
No. of deaths from MND	12 (17)	29 (37)	4 (12)	8 (6)	10 (5)	8 (8)	44 (28)	38 (24)	153 (138)
No. of people registered with MNDV at 30/6/2017	42 (32)	76 (78)	20 (17)	13 (13)	19 (19)	30 (24)	105 (100)	94 (94)	399 (414)

Figures in brackets are comparative numbers from the previous financial year.

THE EASTERN METROPOLITAN REGION

TOTAL DEATHS IN AUSTRALIA

Deaths

As our population grows and ages, an increase in the number of deaths can be expected. However the crude death rate has remained relatively stable at 6.5 deaths per 1,000 population for the last decade. Life expectancy continues to make small increases, and reached 80.3 years for males and 84.4 years for females for those born in 2012-14.

At what age do people die?

It might sound obvious, but the majority of deaths in Australia are at the upper end of the age spectrum. In 2014, the median age at death was 81.8 years, meaning that half of deaths were under this age, and the other half over.

About one in ten deaths in Australia are persons aged 55 years and under, but by age 65 it's one in five, and around one-third of deaths are people aged about 73 years and under. The increases in life expectancy (at all ages) mean that many more people are reaching their 80s and 90s, but it also means a corresponding increase in the number of deaths at these older age groups. Almost half of all deaths in 2014 occurred between the ages of 80-94 years of age.

The cause of death does vary by age, but it's not until after the age of 45 that conditions such as heart disease and cancers (the leading causes of death overall) account for the most deaths in each age group. In other words, older persons are more likely to die from illness and other conditions, rather than deaths that are largely preventable.

THE EASTERN METROPOLITAN REGION

Leading Causes of Death

In 2015, there were 159,052 deaths in Australia (81,330 male and 77,722 female). The leading cause of death was Ischaemic heart disease with 19,777 deaths. People who died from Ischaemic heart diseases in 2015 had a median age at death of 85.1 years.

Dementia, including Alzheimer's disease, remained the second leading cause of death in 2015, with 12,625 deaths. Dementia has increased from 4.9% of all deaths in 2006 to 7.9% in 2015. Cerebrovascular diseases (6.8%), Cancer of the trachea, bronchus and lung (5.3%) and Chronic lower respiratory diseases (5.0%) complete the top five leading causes of death, and in total these causes accounted for more than one-third (37.6%) of all deaths registered in 2015.

Dementia deaths continue to rise as population ages

Heart disease has been Australia's leading cause of death since the early part of the 20th century, but that could be set to change as dementia death rates continue to rise, according to figures released in September 2016 by the Australian Bureau of Statistics (ABS).

Death rates from dementia have continued to increase, while those from heart disease and stroke have steadily declined. If these trends continue we can expect to see dementia become our leading cause of death within the next few years.

Cancers accounted for almost 30 per cent of Australian deaths in 2015. Lung cancer accounts for the most cancer deaths, making it the second leading cause of death for males and fourth leading cause overall.

THE EASTERN METROPOLITAN REGION

Leading Causes of Aboriginal and Torres Strait Islander Death

In 2015, the standardised death rate for Aboriginal and Torres Strait Islander persons was almost double that of non-Indigenous Australians (999.9 compared with 578.8 deaths per 100,000 people respectively). There were also significant differences in the leading causes of death. Causes including Intentional self-harm, Cirrhosis and other liver diseases and Land transport accidents feature prominently among leading causes of Aboriginal and Torres Strait Islander deaths. Diabetes is the second leading cause of death among Aboriginal and Torres Strait Islander people, but is ranked sixth for all Australians.

Causes of death in the Eastern Metropolitan Region

Overall, people living in the Eastern Metropolitan Region (EMR) enjoy a life expectancy slightly higher than that of any other region in Victoria.

The top ranking causes of death and disability in the EMR are:

- Ischaemic heart disease, diabetes, stroke, mental illness (depression, generalised anxiety disorder, suicide and dementia), cancer (lung, prostate, colon, rectum and breast) and chronic obstructive pulmonary disease (emphysema and chronic bronchitis)

Other main causes of death and disability include:

- Asthma, road and traffic accidents, dental caries, arthritis and other mental illnesses such as schizophrenia and borderline personality disorders

THE EASTERN METROPOLITAN REGION

Yarra Ranges has the lowest perceived health status within the EMR. It has the highest incidence of all causes of ill health and disability, communicable diseases and injuries in the EMR.

Maroondah has a relatively low health and wellbeing status and a high rate of accidents, injuries, suicide, poisonings, substance abuse and problem gambling.

Tobacco is the leading risk factor amongst males and obesity is the leading risk factor amongst females within the EMR.

Sources: ABS and profile.id.com.au

CONSORTIUM ACTIVITIES

Consortium Activities

AN EXPLORATION OF PATTERNS OF RESPITE INTO PALLIATIVE CARE UNITS IN THE EMR

Project Aim & Purpose

To explore patterns of inpatient respite usage within the EMR.

Quality Assurance project approval was sought and approved through St Vincent's Health, Eastern Health and Eastern Palliative Care to carry out this project.

Background

In Australia, palliative care is predominantly community based and relies on the availability of informal carers, including family, friends and volunteers, to provide the majority of care for terminally ill patients (Hileman et al, 1992; Farrell, 1998; Hudson, 1998; Aranda and Hayman-White, 2001). Despite the social and economic advantages of home-based palliative care, fewer people are able to die at home than wish to do so (Grande et al, 1998). This may be partly because of the inability of family carers to cope with the strain of caregiving, leading to early hospital admissions (Aranda and Hayman-White, 2001).

Admissions to inpatient palliative care units for 'respite' in the Eastern Metropolitan Region are frequent, however it was perceived that many of these respite admissions were actually due to deterioration of the patient and the inability of families to continue supporting care at home, due to carer fatigue or distress.

This project sought to explore the patterns of referral for respite to uncover the trajectories for these patients.

to support members of the health-care team who may be struggling to manage a complex care situation, rather than assisting the informal carer with the provision of respite care (Ingleton et al, 2003). It appears, therefore, that there is 'a basic problem of definition' (Johnson, 2005) of respite care in palliative care both nationally and internationally. As such, the development of a consensus definition of respite and the agreement of clear criteria for the purpose of respite services would be helpful (Payne et al, 2004).

CONSORTIUM ACTIVITIES

Methodology

An advisory group was established to guide decisions related to the carrying out of the respite project and consisted of staff from Eastern Health, Eastern Palliative Care and St Vincent's Health. In addition there were three consumer representative members.

A 12 month retrospective (1/7/2015-30/6/2016) desk top audit was carried out collecting the following data from PCOC and medical files at two inpatient specialist palliative care units:

- Demographics-age, sex, country of birth, living arrangements
- Diagnosis
- Whether the respite was planned or unplanned
- Referral source
- Length of stay
- PCOC:
 - Phase on admission, phase on day 2, phase on separation
 - scores on admission
- Karnofsky score on admission and separation
- RUG-ADL on admission and separation
- ESAS on admission (limited to the sum of pain, fatigue, nausea, bowels and breathing only) and on separation
- Separation status

CONSORTIUM ACTIVITIES

Findings

The number of males and females admitted for respite was fairly even at 54% male and 46% female. The great majority of patients were born in Australia and aged in their 70s or 80s. The majority of patients (59%) lived with a partner and had a diagnosis of a malignant disease (80%). There were more unplanned respite admissions (66%) than planned (34%). A planned respite was defined as a pre-planned respite booked by the carer due to carer unavailability due to holidays, surgery, special events etc. The majority of unplanned respite admissions were urgent requests from the community due to carer fatigue or distress.

Most referrals (72%) came from a community palliative care service, with 15% coming from a public hospital. Some referrals (6%) also came from private hospitals. The length of stay (LOS) was mostly between 1-10days (80%).

CONSORTIUM ACTIVITIES

PCOC DATA

Table 6: Phase on Admission

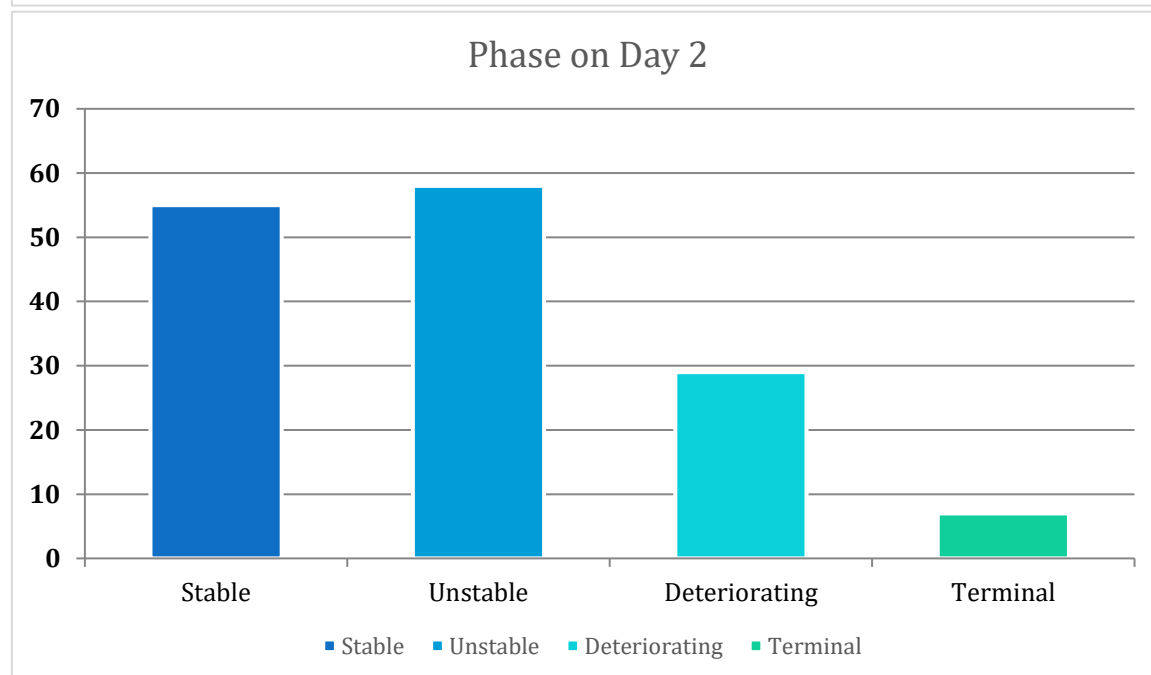
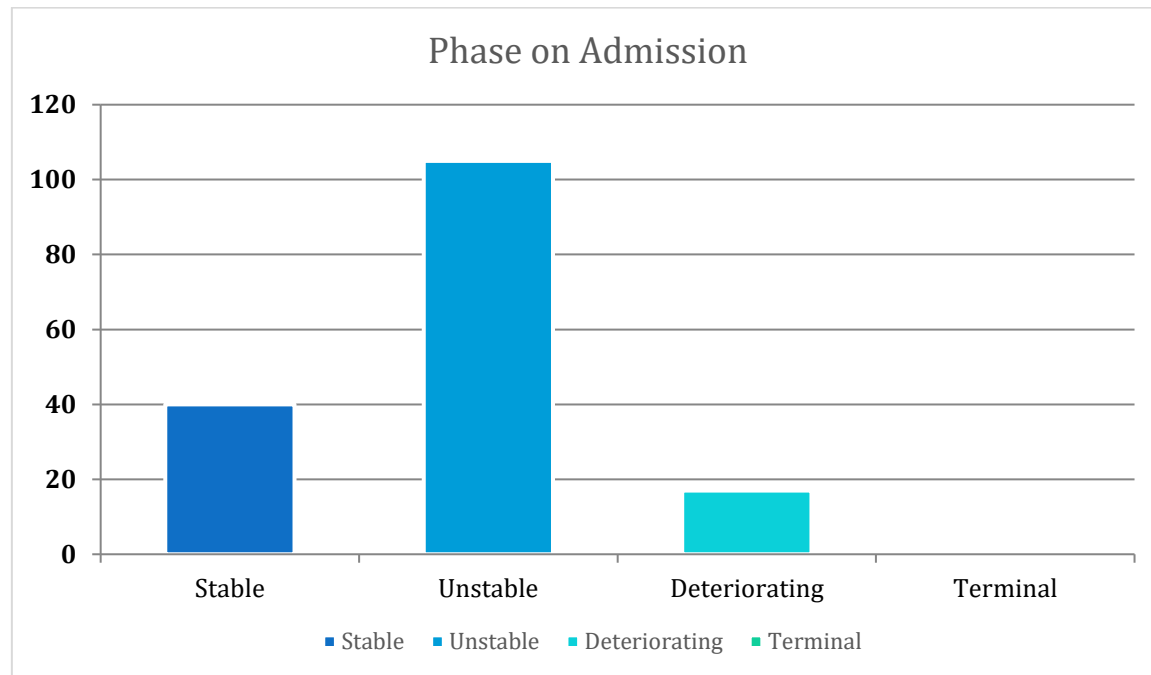
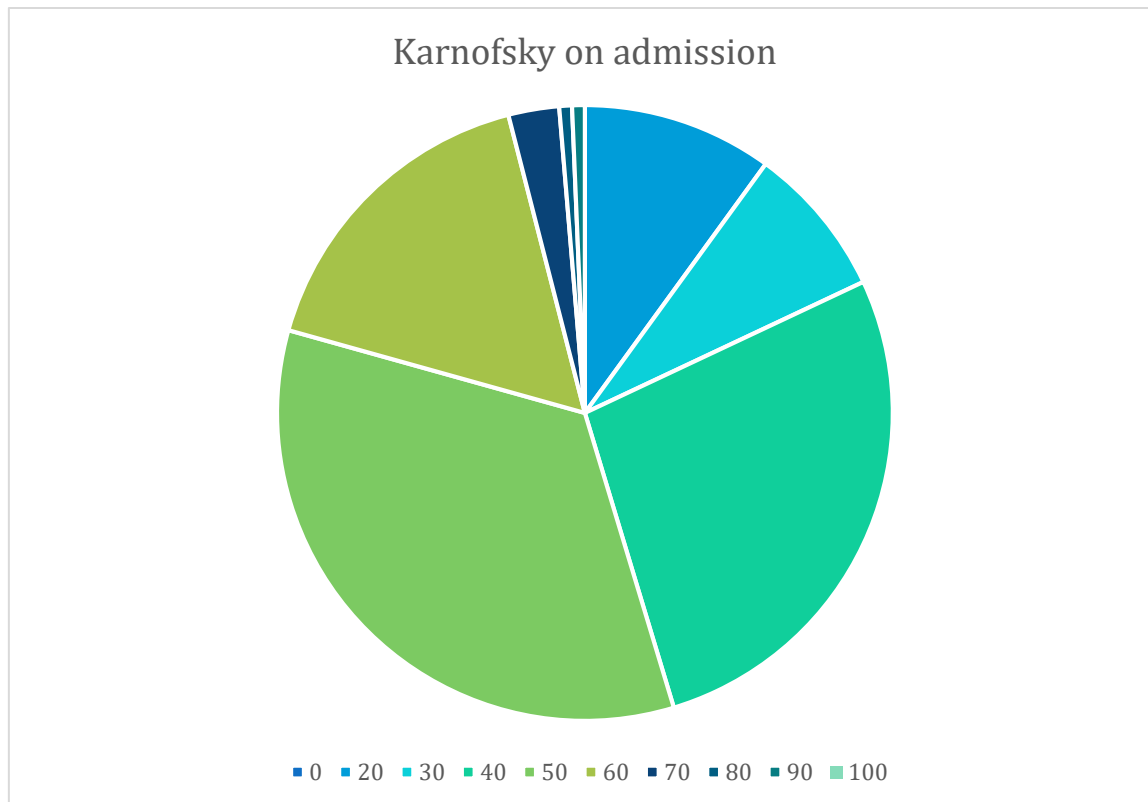
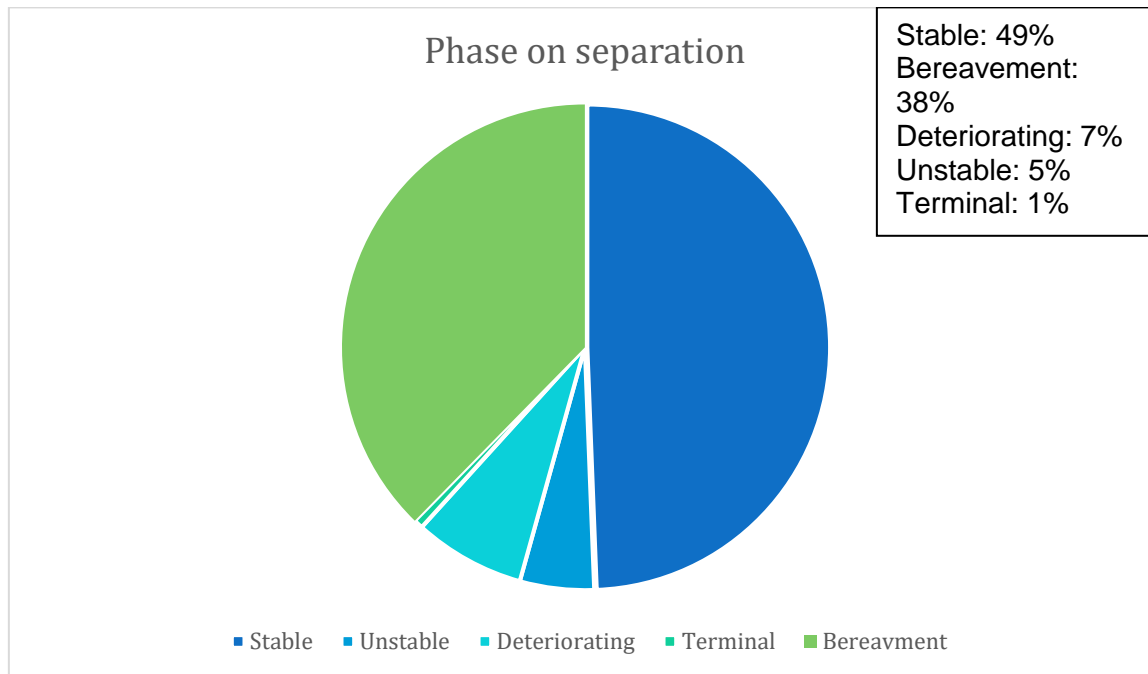


Table 7: Phase on Day 2

CONSORTIUM ACTIVITIES



CONSORTIUM ACTIVITIES

Discussion

There may be a number of reasons for the high proportion of unplanned respite (66%) and the percentage of patients who died during a respite admission (38%). It may be that the patient's condition was deteriorating at home which increased carer burden and fatigue leading to an admission for carer respite when in fact the admission was precipitated by deterioration which led to death in 38 % of cases.

Phase on admission and phase on day 2 of the admission were both collected as it can take up to 24 hours for a full assessment by the multidisciplinary team which can lead to a better defined phase by Day 2. Only 37% of patients were in a stable phase on admission – perhaps these were the true planned respite admissions as planned respite was 34%. This leaves 63% of respite admissions being either unstable, deteriorating or terminal.

Only 45% of these people admitted for respite made it home again. 38% of patients died, 9% were placed in an aged care facility, 5% and were transferred to an acute ward/hospital.

Recommendations for further research

Many questions arose from the collection of this data: Are many of these respite admissions really admissions for terminal care but this conversation has not been had in the community? Is this an indication that greater resources are required to support carers in the home during the deteriorating phase leading to the terminal phase? Is this discussion taking place in the home that this may be the patient's final admission and they may not get home again? Is their choice for place of death being discussed at this point?

Do services need to have an agreed definition of respite being respite that is planned in advance, with other 'respite' admissions being reported more correctly as symptom management, high care needs due to deterioration without adequate resources to manage at home or a terminal care admission?

Further analysis of this data is beyond the resources of the consortium, however this data may receive further scrutiny and research through the palliative care research committee at Eastern Health.

CONSORTIUM ACTIVITIES

SAF-T-INTIMA GUIDELINES FOR RACF

A request came to the consortium from one of our external stakeholders, Dr Andrea Bee, Eastern Health In-Reach team, to develop a one page guideline for Residential Aged Care Facility (RACF) staff to assist them with managing subcutaneous (s/c) Saf-T-Intimas when administering s/c medications to residents for symptom management.

Research was undertaken across the state to ascertain current policies and procedures and evidence. These were then synthesized into a one page (back to back) guideline. The guideline was reviewed and feedback sought from a number of palliative care specialists within Eastern Health and Eastern Palliative Care, including Fiona McLeod, nurse practitioner HARP Eastern Health, Lee-Anne Henley, Palliative care support nurse, aged care/disability team Eastern Palliative Care and Kathryn Bennett, nurse practitioner Priority Assessment Team Eastern Palliative Care. Following amendments from this expert feedback, the guideline was user tested with the assistance of Lee-Anne Henley, by six RACFs in the EMR. This feedback led to further amendments and a final document which was approved by the appropriate committee within Eastern Health.

Sponsorship was sought from the manufacturer of the product, BD, who kindly printed and laminated 145 x A3 and A4 posters. These were delivered to facilities by Lee-Anne Henley or the In-Reach team whenever they visited, they were also given out to Facility Managers at an event held by Eastern Palliative Care during National Palliative Care Week which was specifically for the aged care sector. A large number were also posted out.

The feedback from facilities has been overwhelmingly positive and the delivery of these guidelines has prompted a number of facilities to make contact regarding further education for facility staff. The guidelines have also been uploaded onto the consortium's website to enable wider distribution.

See– [BD Safe-T-Intima Guidelines for RACFs](#)

CONSORTIUM ACTIVITIES

COMMUNICATION SKILLS TRAINING

Communication Skills training for staff of any discipline caring for palliative care patients was offered across the EMR utilizing the Victorian Cancer Clinicians Communication Program developed by Cancer Council Victoria.

Eliciting and Responding to Emotional Cues Workshops

	Date	Venue	Number of participants	Disciplines attending	Organisations represented
Workshop 1	October 3, 2016	Wantirna Health	Nine	Registered nurses x6 Family Support Worker x1 Advanced trainee doctors x2	Caritas Christi x2 EPC x 4 Wantirna Health x 3
Workshop 2	December 12, 2016	Caritas Christi	Eight	Registered nurses x 4 Family Support Worker x1 OT x1 Doctor x1 Planned Activity Coordinator x1	EPC x2 Eastern Epworth x 1 Caritas Christi x 2 Caritas Christi Day Centre x1 Eastern Health x2

Comments from participants:

What was the most useful part of the workshop?

‘The realistic scenarios and the immediate feedback from not only the participants of the workshop but the actor/patient directly’

‘The role plays-invaluable’

CONSORTIUM ACTIVITIES

PALLIATIVE CARE FORUM

A Palliative Care Forum targeted at health professionals working across all sectors including health, aged care and disability was held on June 7 at Eastern Palliative Care. The forum was kindly sponsored by PEPA and Menarini Australia Pty Ltd. Three wonderful volunteers from Eastern Palliative Care supported the Consortium Manager on the day of the forum – assisting with registrations, afternoon tea and packing up. A very big thankyou to these volunteers; Laura Chandler, Veronica Earney and Ann Craigie and to the fabulous speakers listed below who gave up their time to prepare and present at the forum. It was a great opportunity to showcase our talented staff and spread some important messages about palliative care to our colleagues from many different sectors.

Palliative Care in Chronic Disease Forum – Speakers & Topics

Sam Brean

Advance Care Planning Program Lead,
Eastern Health

**Starting Advance Care Planning
conversations with people living with
progressive chronic disease - An update
on the new Advance Care Planning
legislation**

Fiona McLeod

Nurse Practitioner-Palliative Care, HARP,
Eastern Health

**Principles of good palliative care and
symptom management in cardiac and
respiratory failure**

Tom Whelan

Nurse Practitioner-Palliative Care, St
Vincent's Health

**Principles of good palliative care and
symptom management in cardiac and
respiratory failure**

Kathryn Bennett

Nurse Practitioner-Palliative Care, Eastern
Palliative Care

**Recognising Dying - Community
Palliative Care-what's available, when &
how to refer**

Carol Pyke

Victorian Manager, PEPA
PEPA clinical placements

CONSORTIUM ACTIVITIES

Evaluation:

There were 80 registrations for the forum with 77 attending on the day.

An evaluation survey was developed and distributed via Survey Monkey with a 53% response rate.

All sessions were rated very highly and 97.44% of respondents said they would recommend future forums to their colleagues.

Participants were asked for their three **take home messages** from attending this forum:

'With the increase in the number of people dying in the community all health professionals need to be aware of palliative care and watching for when active treatment has greater risk than benefit. Specialist community palliative care is not required by all people dying in the community. Dementia is a terminal illness'

'Learnings related to 1) recognising dying, 2) supports available and 3) advanced care planning'

'More practical understanding of advanced care planning. 2. Hand held fan to help with breathlessness. 3. The surprise question'

'Referral process, Keep working on Advanced Care Plans, trying to increase GP's involvement. Education for staff'

'The difference between Palliative care approach and specialist palliative care, starting the conversation. The need for Doctors and consultant to have the conversation with families that Dementia is a terminal illness'.

CONSORTIUM ACTIVITIES

Who attended the forum? 34 attendees answered this question:

Nurses	17
Client Advisor	1
Social Worker	2
Aged Care Worker	1
Occupational Therapist	3
Home Support Assessor	1
Caregiver	2
HIV/Art therapist	1
Service Manager	2
Dietician	1
Case Manager	2
Medical Educator	1

DEATH & DYING-LIFTING THE LID ON IT



In February, the EMRPCC held an extravaganza night called [Death & Dying Lifting the Lid on It](#). This evening event was targeted at the general public in an attempt to increase death literacy.

The event was modelled on the highly successful work previously undertaken by [Frock Up](#). Frock Up is the brainchild of two innovative and creative oncology nurses from Gippsland using humour to help lubricate difficult topics. [Shelly O'Dwyer](#) and [Anny Byrne](#) have held these events at various locations around Victoria, but this was the first one to be held in a metropolitan region.

CONSORTIUM ACTIVITIES

We wondered how it would go in metro Melbourne but it was a sell out and a huge success.

The MCs for the night were the *Frock Up Promotions girls* who kicked the evening off with lots of laughs, music and glitter. Then it was down to business for some serious presentations:

- **Healthy End of Life Program** presented by *Andrea Grindrod* from La Trobe University's Palliative Care Unit. This program is based on the concept of Compassionate Communities and Andrea talked about the ability of communities to complement professional services by providing practical and social support to people who are being cared for at home at the end of their lives.
- **Death, dying and legal decisions** was presented by a lawyer from Hutchinson's Legal in Ringwood – *Madelaine Pelser*. Madelaine covered topics such making wills, probate, enduring powers of attorney and the impending change to legislation around medical decision making and advance care plans.
- **Natural Death Advocacy Network (NDAN)** – was presented by *Libby Maloney*. NDAN is as much about advocacy as it is about creating networks. Libby talked about what can and can't be done in terms of funerals, burials and cremations and the growing popularity of natural burials using shrouds rather than coffins.
- **Donate Life** speaker Pat Mills, spoke briefly about the importance of thinking and talking about organ donation.
- The hypothetical panel was held after the supper break and was moderated by a GP – Dr Chris Fogarty. The theme of the hypothetical was advance care planning using a humorous case study. The panel consisted of palliative care doctor - Peter Sherwin (SVHM), lawyer - Madelaine Pelser, psychologist – Julie Chichovski and GP registrar – Billy Stoupis.

CONSORTIUM ACTIVITIES

The EMRPCC needed to run this as a cost neutral event by selling tickets to the event, attracting sponsors and selling raffle tickets. We did it! We also made a small profit of \$3,330 which allowed us to develop a scholarship fund to educate health professionals about palliative care who do not work within the specialty.



Special guest comedian Jean Kittson performed to finish off the night. Jean was chosen because of her close ties and knowledge of palliative care.

CONSORTIUM ACTIVITIES



Some quotes from the audience:

"To learn that there is a lot going on in the death and dying space now. It was great to know that this is an area of growth in knowledge and ideas. I would like to see a time where death becomes talked about at dinner tables like we talked about birth and marriage".

"It clarified a number of misconceptions that I had around Advance Care Plans and end of life instructions"

What the audience learnt from the evening:

"We have more choices than what we imagine regarding end of life. Involving community during and after end of life.

Getting your house in order in regard to powers of attorney, wills etc."

"The importance of written instructions as to my wishes and verbal instructions to close family. It doesn't have to be a morbid discussion".

"I can make requests around my advanced care plan and end of life requirements. Making the next 30 years the best they can be"

The night would not have been possible without our generous sponsors and helpers:

A very big thank you to our sponsors:

- ❖ Ashton's manufacturing
- ❖ Cairnmillar Institute
- ❖ Elite Geriatric Care
- ❖ Greater Metropolitan Cemeteries Trust
- ❖ Heritage & Heritage Funerals
- ❖ Home Instead Senior Care

An extra special thank you to the staff from Home Instead Senior Care who not only supported the night, but also arranged all the raffle items and prizes.

Other helpers on the night included:

Mardie MacDonald, Patrick Conte and Marian Roberts

Whitehorse Council donated the venue and staff for the night. The venue was perfect and the staff couldn't do more to help on our big night!

CONSORTIUM ACTIVITIES

DYING TO KNOW DAY

The EMRPCC hosted a Dying to Know Day event in the foyer of Wantirna Health. The event was kindly hosted by Heritage & Heritage Funerals which allowed us to offer a free coffee from the café to visitors who came to our information stalls to chat about death & dying. We were also able to purchase resources for the day from The Groundswell Project who instigated these events.

It was a very successful day with over 50 visitors to our stall. They were able to collect resources and talk to experts in advance care planning, palliative care, funeral planning and grief and bereavement.



CONSORTIUM ACTIVITIES

The consortium had a number of helpers on the day who included:

<i>Name</i>	<i>Role</i>	<i>Organisation</i>
<i>Angela Reidy</i>	Volunteer	EPC
<i>Fiona McLeod</i>	HARP NP	Eastern Health
<i>Janet Heritage</i>	Funeral Director	Heritage & Heritage Funerals
<i>Dean Richards</i>	Funeral Director	Heritage & Heritage Funerals
<i>Laura Chandler</i>	Volunteer	EPC
<i>Sam Brean</i>	ACP clinical lead	Eastern Health
<i>Mardie MacDonald</i>	Admissions Coordinator	Caritas Christi Hospice
<i>Marisa Carr</i>	Registered Nurse	Fernlea House
<i>Marion Robertson</i>	Enrolled nurse	Fernlea House
<i>Leonie</i>	Volunteer Coordinator	Fernlea House
<i>Suzanne McLoughlin</i>	Director	Home Instead Senior Care
<i>Annalise James</i>	Director	Home Instead Senior Care
<i>Karen Philippzig</i>	Coordinator	Compassionate Friends Victoria
<i>Pat Burns</i>	Volunteer	Compassionate Friends Victoria
<i>Sonia Abel</i>	Volunteer	Compassionate Friends Victoria
<i>Sue Brown</i>	Volunteer	Compassionate Friends Victoria
<i>Jan Harrison</i>	Volunteer	Compassionate Friends Victoria
<i>Julie Watts</i>	Volunteer	Compassionate Friends Victoria
<i>Jim Strongman</i>	Volunteer	Wantirna Health
<i>Vicki Rizzo</i>	Volunteer	Wantirna Health
<i>Mary McFarlane</i>	Volunteer	Wantirna Health
<i>Gayle Slessar</i>	Volunteer	Wantirna Health

CONSORTIUM ACTIVITIES

PALLIATIVE CARE EDUCATION SCHOLARSHIP PROGRAM

The Eastern Metropolitan Region Palliative Care Consortium (EMRPCC) was pleased to offer scholarships for attendance at a palliative care course or study day for non-specialist palliative care health workers across the Eastern Metropolitan Region (EMR).

If staff worked in any health related field within the EMR, they were eligible to apply. They could apply to attend courses available within the region or a relevant course being held anywhere in Victoria.

There were six scholarships available each valued at up to \$500.

We know that many people require a palliative approach to their care and may not necessarily need to be referred to a specialist palliative service. These scholarships aimed to encourage health workers working outside the specialty of palliative care to increase their knowledge and skills to take back to their workplace.

The participants needed to commit to the following scholarship components:

- If being considered for acceptance of a scholarship, the participant was required to successfully complete the free online training: '[Palliative Care: Getting Started](#)' or similar depending on their discipline. The certificate of completion was submitted to the Consortium Manager prior to final scholarship approval.
- The participant then attended the approved course and provided their certificate of attendance to the Consortium Manager.
- The participant then needed to commit to arranging a clinical placement via PEPA. This placement into a palliative care service within the EMR was included to consolidate their learning and provide vital connections with specialist staff in the EMR.

CONSORTIUM ACTIVITIES

PEPA

In December 2016 a new contract was established for delivery of the Commonwealth funded Program of Experience in the Palliative Approach (PEPA) program in Victoria for 2015-2017. The Department elected to not continue as the contract managers for PEPA in Victoria and the Centre for Palliative Care (CPC) took on this role.

The Department of Health & Human Services had delivered the PEPA program in Victoria since its inception in 2003. Over that time they arranged more than 650 placements. PEPA has also supported the delivery of 166 workshops on the palliative approach to the health, aged and disability sector. More than 3,600 people had attended these workshops.

Carol Pyke, the current PEPA manager, agreed to join the CPC for 18 months to help establish the PEPA program under the CPC banner. Carol returned to her substantive role at the Department of Health & Human Services at the end of June 2017.

The following PEPA workshops were completed in the EMR during the 2016/17 year:

- 9 November 2016 Understand issues facing Aboriginal or Torres Strait Islander people with their Journey into the dreaming (15 attendees)
- 16 November 2016 Palliative approach for the aged care sector (25 attendees)
- February –Palliative approach in acute health care at eastern Health (28 attendees)
- 16 March 2017 Contemporary Issues in Palliative Care (20 attendees)

The following PEPA placements occurred across the EMR during 2016/17 year:

The total number of placements for the year was 16, which consisted of the following disciplines:

- Registered Nurses: 9
- Enrolled Nurses: 4
- Personal Care Attendant: 2
- Physio assistant: 1

Palliative care services in the EMR provided placements for 10 participants.

CONSORTIUM ACTIVITIES

Data indicates that the greatest percentage of deaths in Victoria occur in hospitals, especially those based in metropolitan Melbourne. To try and build capacity and focus on end of life care and dying in hospitals, it has been agreed in consultation with the Centre for Palliative Care, who auspice the PEPA program, that work should be done to try and improve the understanding of the palliative approach at our major acute hospitals.

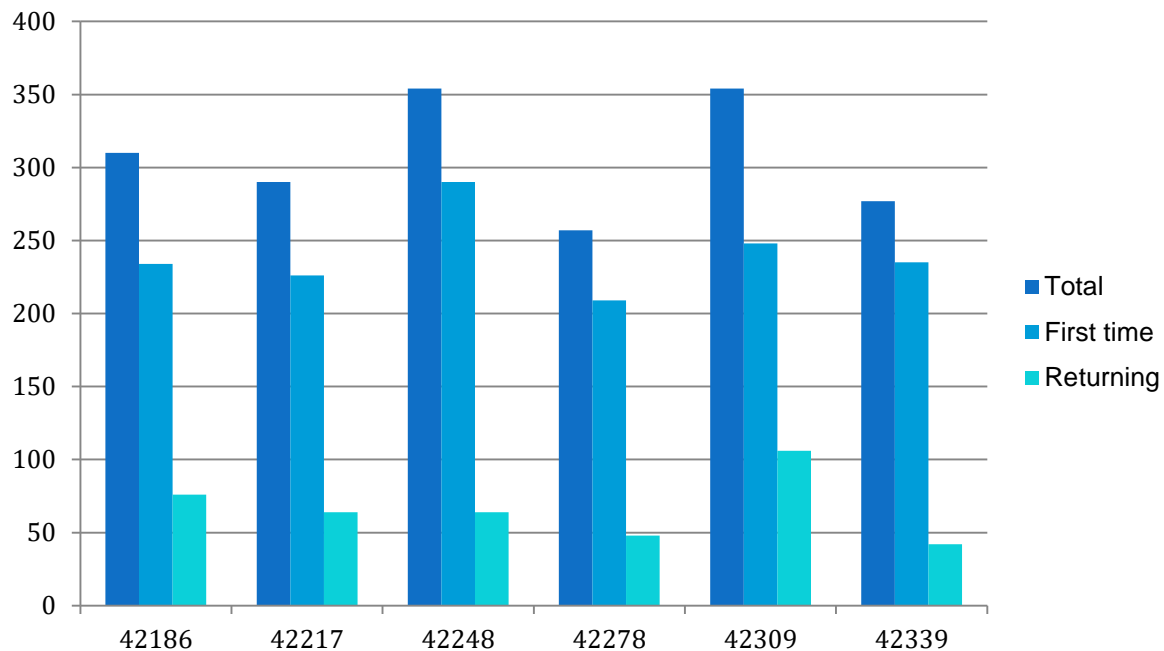


CONSORTIUM ACTIVITIES

EMRPCC WEBSITE ACTIVITY 2016/2017

The website contains relevant and up to date information for specialist palliative care and non-specialist services and service users. As can be seen by the comparisons in the tables below, there has been a significant increase in visits to the EMRPCC website compared to the previous financial year.

Table 10 July-December 2015



CONSORTIUM ACTIVITIES

Table 11 July-December 2016

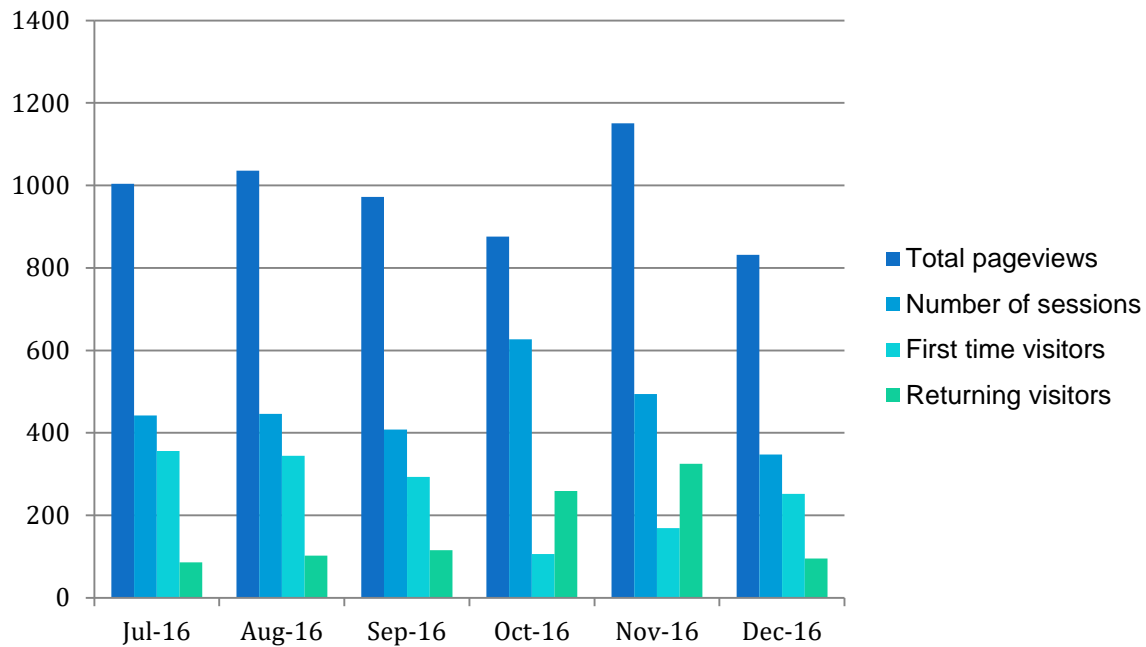
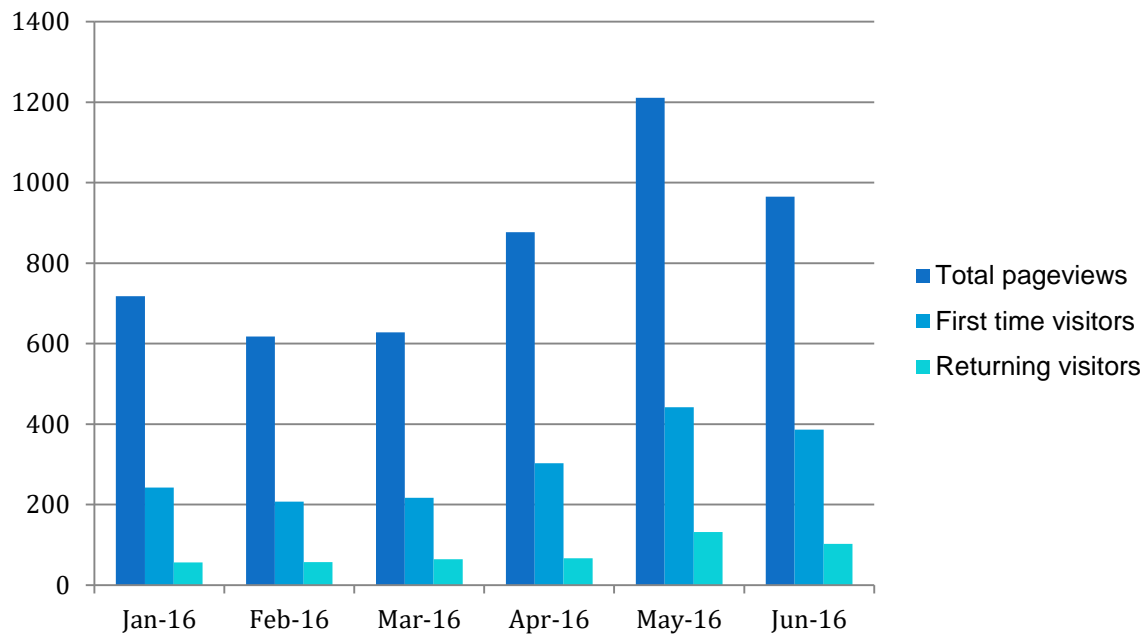
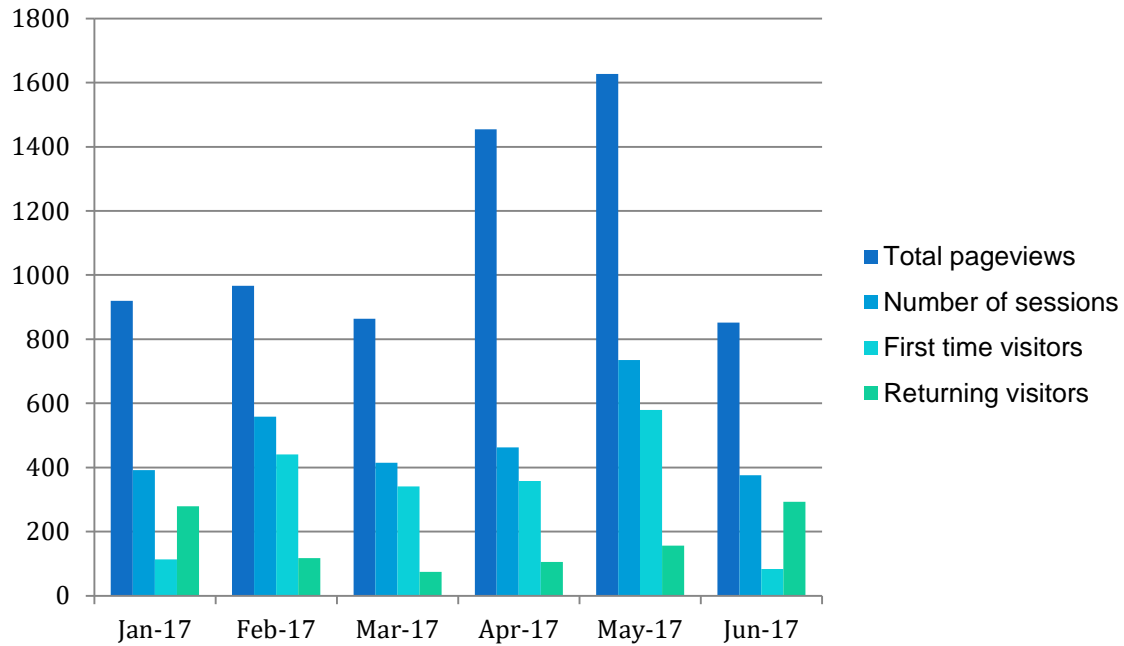


Table 12 January-June 2016



CONSORTIUM ACTIVITIES

Table 13 January-June 2017



CONSORTIUM MEMBER ACTIVITIES

Consortium Member Activities

EASTERN HEALTH

Eastern Health Supportive and Palliative Care Service

The Wantirna Health Supportive and Palliative Care Unit (SPCU) provided care for 819 patients in 2016/2017 and the Hospital Based Palliative Care Consultancy Service received 2181 referrals.

The SPCU completed a yearlong redesign which saw significant improvements in patient outcomes reflected in PCOC benchmarks. The SPCU reintroduced music therapy and now also has the services of a qualified massage therapist. A significant change involved the signing of a Memorandum of Understanding between Eastern Health and Eastern Palliative Care as partners in service provision to shared clients. This MOU opened the way for clinical information sharing and seamless transition of care between the hospital and community services.

Eastern Health was also delighted to announce the recruitment to the Vivian Bullwinkel Chair in Palliative Care Nursing - with Professor Claire Johnson taking up this appointment on 3 July 2017. This joint appointment with Monash University will champion research into palliative and end of life care. Research at Eastern Health has included a study into the referral patterns for patients with Stage 4 lung cancer demonstrating a significant need for earlier involvement of palliative care in patients with advanced cancer.

The Eastern Health End of Life Care Expert Advisory Committee also developed and endorsed a service wide End of Life Care Standard based on the principles of the National Consensus Statement and the Victorian End of Life and Palliative Care Framework.

CONSORTIUM MEMBER ACTIVITIES

EASTERN PALLIATIVE CARE

Palliative Support Nurse Report

During 2016, the Palliative Support Nurse (PSN) role broadened its focus in order to provide increased individual clinical support to clients in Residential Aged Care Facilities (RACF). This involved numerous nursing assessments and family meetings. During these assessments, additional informal education and provision of palliative resources to staff also occurred. Included in this client support has been in excess of 700 follow up phone calls to assist staff to provide excellent palliative care and discuss conditions, symptoms, medications and possible end of life issues with family members.

Nursing assessments included family members with a senior staff member of the aged care facility being present. This has led to improved relationships between family members and facility staff through open conversations. These assessments also provide an opportunity to mentor staff in pain assessment, physical examination and having conversations with families around end of life issues.

Intake referrals involving clients from RACF, Disability homes and Supported Residential Services (SRS) have been managed by the PSN (when available) and have involved over 300 new clients.

Additionally there have been 46 formal education sessions given to RACF staff by the PSN and a further 30 site visits for engagement with Managers around improving palliative care and providing resources. An additional 512 phone calls and emails have provided RACF staff with information when needed, and provided an accessible service that staff can feel free to ask for generic information around end of life situations, medication, and symptom management, advance care planning and difficult conversations with families.

In May 2017 the Palliative Support Nurse roles were enhanced with additional hours and the employment of an Aged Care Family Support Worker 5 days per fortnight. This Team now undertakes first assessment of client in aged care and disability homes and provides education and resources to the sector as required.

CONSORTIUM MEMBER ACTIVITIES

Disability Services

Disability group homes have been provided with 19 sessions of education to staff and a further 28 site visits to explain the role of Eastern Palliative Care (EPC). There have been 193 phone calls and emails to staff in-group homes. Typical support given includes assistance in managing the palliative care of clients, contact with the Coroner's Court, staff education, and the development of new palliative care policies for service.

National Palliative Care Week activities

In May 2017, EPC held a session entitled "Pain Management in Palliative Care'. Two speakers, Kathryn Bennet, Nurse Practitioner and Lee-Anne Henley, Palliative Support Nurse took the audience through the essential element in pain assessment and guidelines for effective pain relief.

The session was very well attended with a number of subsequent referrals of clients and also requests for further pain education at facilities.



CONSORTIUM MEMBER ACTIVITIES

SVHM PALLIATIVE CARE SERVICES

Palliative Care Services at SVHM provides inpatient beds at Caritas Christi Hospice (CCH) Kew and Fitzroy to patients in the terminal phase of care, requiring symptom control or respite. Coupled with this is the palliative care consultancy which provides service across all of SVHM and St Vincent's Private, palliative care clinics at Fitzroy; two day a week day respite program at CCH, after hours telephone triage service to community palliative care clients, and VMO clinics and telephone support to the Hume Region.

SVHM also provided the 24 hour specialist palliative care telephone support line for Decision Assist up until the 30th of June 2017.

Staff Changes

In February 2017, Jenny Philip the former Deputy Director of Palliative Care Services and Co Director Centre of Palliative Care was appointed as the Chair in Palliative Care Medicine for the University of Melbourne and the VCCC partners, coupled with a co appointment at SVHM for a palliative care clinical session. This new Chair position is located at SVHM Fitzroy campus.

Jenny Weil was appointed the new Deputy Director of Palliative Care Services and Co Director of Centre of Palliative Care and commenced her role in May 2017.

CONSORTIUM MEMBER ACTIVITIES

End of Life Care

The End of Life Care (EoLC) working group at SVHM has developed a framework for End of Life Care across the organisation. The group is currently focused on improving the care of the imminently dying. The first part of the work plan involves developing interventions to improve recognition of dying by clinical staff, and specifically empowering staff to ask "Could this be dying?" The second part involves implementing the Care Plan of the Dying Person, Victoria (CPDP-Vic), an evidence based document developed by the Victorian End of Life Care Coordinating Program (VEC) and endorsed by the International Collaborative for Best Care for the Dying Person. The CPDP-Vic will support high quality and consistent care of the dying across SVHM and align our practice with:

- National Safety and Quality Health Service Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health care
- Australian Commission on Safety and Quality in Healthcare's Essential Elements for Safe and High-Quality End-of-Life care (Consensus Statement)
- Australian Council on Healthcare Standards EQulP 5; and
- National Palliative Care Strategy 2010, Supporting Australians to Live Well at the End of Life

CONSORTIUM MEMBER ACTIVITIES

THE ROYAL DISTRICT NURSING SERVICE

This year, RSL Care + RDNS united under a new name, Bolton Clarke.

Since coming together they have expanded their service offerings and their footprint, providing more services for more people in more places. Now they are taking the next step in bringing together their combined experience and services.

Their new name gives them a new identity that builds on the heritage, legacy and long held values they share and supports their growth, innovation and expansion for the benefit of those they serve.

It honours two key community leaders from their organisation's past whose values continue to drive their purpose today.

- **Lady Janet Clarke** (1851-1909), a well-known philanthropist, became president of the Melbourne District Nursing Society (later RDNS) in 1889 and remained a driving force for more than 20 years of dedicated service and commitment.
- **Lieutenant Colonel William Kinsey Bolton** (1860-1941) was a returned serviceman and Gallipoli veteran who in 1916 became the first president of the Returned Sailors' and Soldiers' League (forerunner of the RSL), an organisation that has been actively caring ever since.

CONSORTIUM MEMBER ACTIVITIES

As Bolton Clarke – an organisation built on more than 200 years of shared experience helping people live enriched and fulfilled lives – they are one of Australia’s most experienced providers of independent living services, including specialist nursing services and palliative care, that meet the changing needs of their diverse client base at home and in their retirement living and residential communities.

Table 8: Shows the number of palliative care clients seen by RDNS by LGA.

LGA	No. of clients	No. of clients	No. of episodes	No. of episodes	No. of visits	No. of visits	Visit duration hours	Visit duration hours
Boroondara	28	22	30	24	670	403	510	197
Knox	24	45	27	52	797	1,439	580	746
Manningham	31	30	34	33	744	656	405	401
Maroondah	18	22	18	23	587	618	311	346
Monash	34	42	36	46	1,331	1,203	1322	573
Whitehorse	22	26	22	28	537	476	444	250
Yarra Ranges	24	33	28	37	707	763	376	374
TOTAL	181	220	195	243	5373	5558	3948	2887

N.B. Grey columns show the data from the previous year 2015-2016 and Gold columns show the data from this reporting period 2016-2017.

CONSORTIUM MEMBER ACTIVITIES

After Hours Support

2016-2017 After Hours Report

Eastern Palliative Care Association Incorporated (EPC) and Caritas Christi Hospice (CCH), Kew, developed a specialist After Hours Triage support model in the 1990's. Through continuous refinement, review and development this is now a very supportive and well run model with excellent client/carer satisfaction. The service now covers 4 regions of Victoria encompassing rural, regional and metropolitan services.

The service run out of CCH now covers four regions of Victoria encompassing rural, regional and metropolitan services. A new web based data system was developed and implemented from the 1st of July 2016, replacing the outdated CCHPalAssist. The new PalAssist program is more user friendly, robust, with increased reporting capabilities, which has resulted in increased efficiencies and timely dissemination of KPI report to services.

EPC clients and carers are provided with an After Hours phone number which connects them to Caritas Christi inpatient palliative care unit. The senior nurses (Triage Nurses) at Caritas Christi receive and respond to calls backed up by access to the client's electronic medical record. The Triage Nurse adds to the record when phone calls are received providing integrated support to the client and carer. The Triage Nurses at Caritas Christi are very experienced in supporting clients and carers on the phone and have available a number of agreed protocols and procedures to follow. They also have access to telephone interpreters when required.

In the Eastern Region this is backed up with on call specialist palliative care nurses employed by EPC who will visit clients in their homes, out of hours, if the issue cannot be resolved over the phone. In the past 12 months 2608 calls were received by the Triage Service for clients on the Eastern Palliative Care program of which 28.5% of calls required a nurse to visit. All calls to the Triage Nurse are followed up next day by Eastern Palliative Care nurses.

CONSORTIUM MEMBER ACTIVITIES

Generally, there are multiple issues when clients and families ring the Triage Nurse. Most times there will be a combination of advice given, medication instruction/advice, education or a request for specific follow up the next day. Where symptoms are complicated the Triage Nurse may ring the EPC Nurse who will in turn contact either the GP or the EPC Doctor on call. Contact with medical practitioners usually occurs while the nurse is in the home supporting the client.

Triage Impacts

The purpose of the Triage Nurses and On Call Nurses are:

- To provide a 24-hour response to clients and carers
- To answer questions that arise outside business hours for clients of EPC
- To explain medications, particularly when medications have changed or symptoms have changed
- To support clients and their carers as symptoms progress/change or there is general deterioration
- To advise on unexpected medical issues that arise

The Triage Service is designed to prevent clients and carers from calling an ambulance or attending a hospital emergency department where they may or may not be known. It also provides education and support.

Data analysis

A total of 1508 calls were received by the After Hours Triage Service for EPC clients from the 1st of July 2016 to the 30th June 2017, out of which 94% of calls were answered within 15 minutes (*Table 9*). There may be multiple phone calls required to be made to resolve the initiating call which resulted in 2608 calls being made over the year, (*Table 9*) equaling 27740 minutes. The median duration of a call was 19 minutes (*Table 9*).

A total of 20% of calls required a nurse to visit (*Table 9*).

CONSORTIUM MEMBER ACTIVITIES

The majority of calls were related to uncontrolled symptoms, followed by death of a client.

Further to this, a small proportion of clients 7% are required to attend the **Emergency Department** (*Table 9*). The main reasons for an emergency department attendance were symptoms not able to be managed in the home and family /client preference.

Table 9: Data Analysis

1 July 2016 to 30 June 2017	Year to date
% calls answered within 15 mins	94%
Total no phone calls to complete episodes	2608
Mean length of episodes	19 mins
% of episodes with ambulance+/- ED recommendation	7%
% of AH nurse call outs	20 %

Seventy-five percent of calls occurred between the hours of 5 PM and midnight. This is up from 73% in the previous year. Most calls come from a son/daughter (37%) closely followed by the partner (31%).

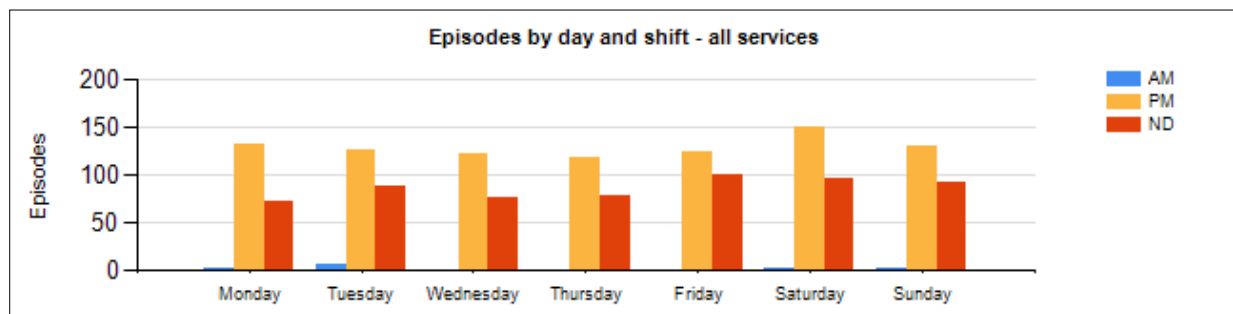
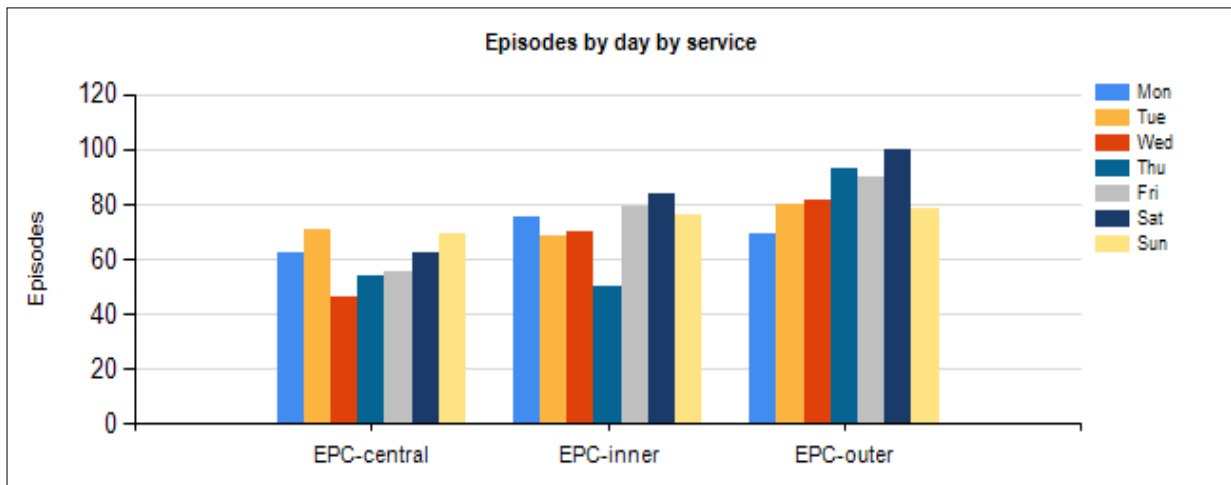
The average number of calls per month was 217 up from 202 in the previous year June had the lowest number of calls at 155 while November had the highest number of calls at 269.

The average number of call outs was 28.5 with the lowest month being 19 in December and the highest 36 in March.

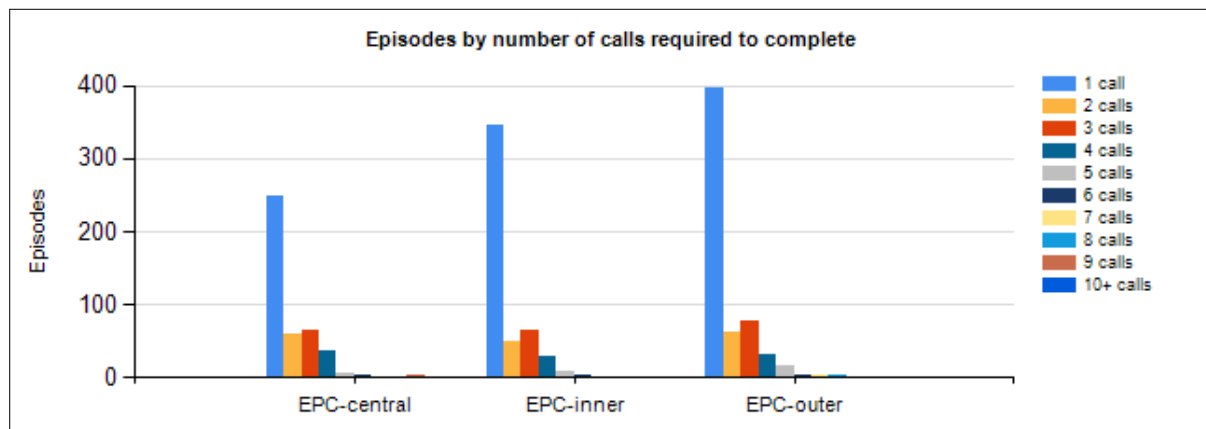
The main reasons for a **nursing visit** include:

- Client death, verification of the death and support for the family
- Uncontrolled symptoms: for example the client has taken several oral doses of “breakthrough” analgesic or anti-nausea medication with little relief of symptoms
- To administer an injection or commence a s/c device: for example, a syringe driver
- Client deterioration and family request a visit

CONSORTIUM MEMBER ACTIVITIES



Episodes by duration of episode



CONSORTIUM MEMBER ACTIVITIES

Number of episodes where outcome = ED recommendation or Ambulance recommendation

Team	Advised ED/Ambulance this service	Advised ED/Ambulance % of episodes	Advised ED/Ambulance all serv Avg	Comparison with all services Avg
EPC-central	25	6 %	7 %	<
EPC-inner	38	8 %	7 %	>
EPC-outer	43	7 %	7 %	=
TOTAL	106	7 %		

Reasons for ED or Ambulance recommendation (may be multiple per episode)

Symptoms not manageable at home	Alerts	Family or client preference	Medical or nurse advice	No PCU bed available	No support meds
31	1	26	8	2	7

Number of episodes where outcome = After hours nurse call out

Team	AH nurse call out this service	AH nurse call out % of episodes	AH nurse call out all serv Avg	Comparison with all services Avg
EPC-central	113	27 %	20 %	>
EPC-inner	81	16 %	20 %	<
EPC-outer	114	19 %	20 %	<
TOTAL	308	20 %		

CONSORTIUM MEMBER ACTIVITIES

Occupational Health and Safety

When on the road for EPC business out of hours, all nurses use an EPC vehicle and carry a mobile phone and a GPS enabled duress system. When leaving home and returning to home the Triage Nurse (at Caritas Christi) is notified and the time noted. If no return phone call is received in the given time the Triage Nurse rings the nurse on call. If no answer is received the EPC Manager- Nursing and Medical Services is notified.

Summary

The After Hours Service provided to clients and their carers is well used, understood and appreciated. Systems are in place to support clients with a nursing visit out of hours if issues cannot be resolved on the phone. All systems have functioned well in the past 12 months.

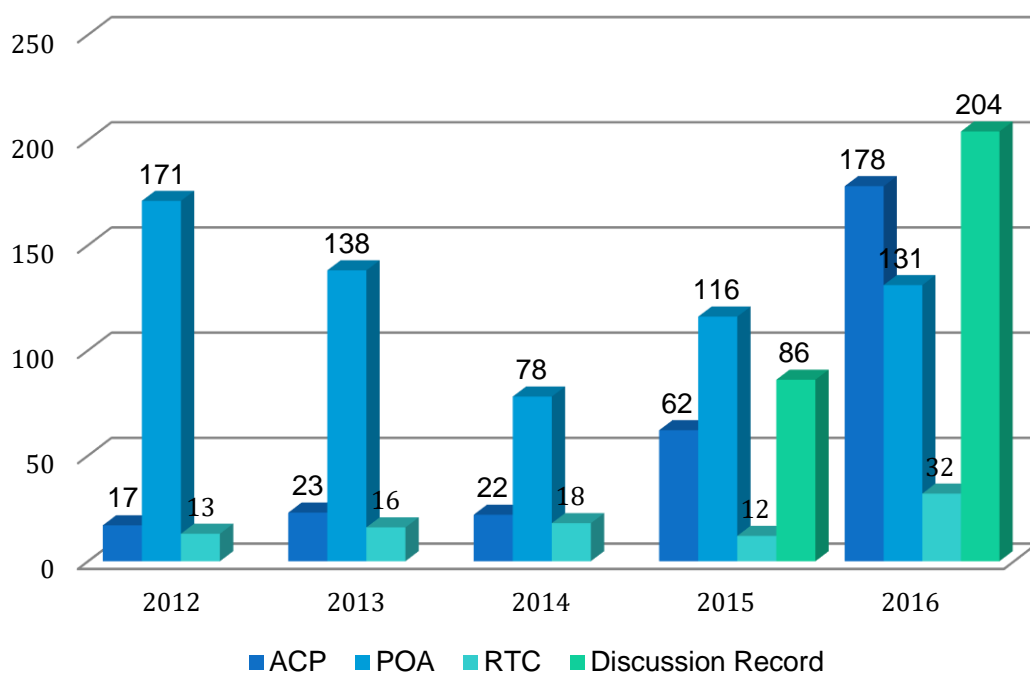
CONSORTIUM MEMBER ACTIVITIES

Advance Care Planning

bestCARE is St Vincent's Advance Care Planning program. *bestCARE* is across all SVHM sites and in line with the Victorian State Government policy. *bestCARE* is a process of planning for future health and is as easy as CARE:



Number of Documents by Year



Since the introduction of *bestCARE*, Advance Care Planning at SVHM, there has been an increase of 709% in documented Advance Care Plans (ACPs) in Medical Records Online (MRO) from 2014 (pre-implementation) to 2016 (second year of implementation). In 2015, which was the first year of implementation, ACPs almost tripled.

CONSORTIUM MEMBER ACTIVITIES

We acknowledge that developing one ACP can take time and involve multiple conversations, so the ACP discussion record was developed, which is an e-blog style form located in the legal tab of MRO. This allows patients to have their values recorded centrally – a one stop shop. This record of conversations and progression of conversations is a vital component. The ACP discussion record was only active for 6 months of 2015, however there were entries for 86 patients. 7 of these patients also had an ACP on file. 2016 showed marked increases again, the number of ACPs on file almost tripled again and the ACP discussion record continues to rise (300 entries for 204 patients in 2016).

Of the audited patients in 2016 with any type of ACP document, at the time of auditing 52 patients had died. 39 died at SVHM. Of these patients, 37 of the audited patients' wishes were respected. The remaining 13 patients died outside of SVHM so unable to determine if their wishes were respected.

The Advance Care Planning program continues to develop resources for staff and patients, the *bestCARE* brochure 'What matters to you' has been translated into other languages and an education video for staff has been produced.



FINANCIAL REPORT

Financial Report

ANNUAL FINANCIAL INDICATORS STATEMENT (FIS)

Organisation Name: Eastern Metropolitan Region Palliative Care Consortium
Organisation Ref No: 10797

Date From: 01 July 2016
Date To: 30 June 2017

Income Statement for period

Recurring revenues (eg. Government grants)	A	\$131,307.41
Non-recurring revenues (eg. Capital grants, asset sales)	DD	\$18,248.10
Employee benefits expense	B	\$95,935.09
Depreciation & amortization expenses	C	92.38
Lease expenses	D	\$0.00
Borrowing costs expense	E	\$0.00
Other expenses	F	\$43,637.19
Net Surplus/(deficit)	G	\$9,890.85

Balance Sheet as at

30 June 2017

Current Assets

Cash & cash equivalents		\$38,461.74
Receivables		\$34.51
Non-current assets classified as held for sale		
Other current assets		
Prepayments	T	
Inventories	H	
Deferred tax assets	Z	
Total Current Assets	I	\$38,496.254

Non-Current Assets

Receivables		
Other financial assets		
Available for sale financial assets		
Property, plant & equipment	J	
Investment properties		
Pension asset	X	
Intangibles		
Total Non-Current Assets	K	\$0.00
Total Assets	L	\$38,496.25

FINANCIAL REPORT

Current Liabilities

Payables
 Unearned income (including government grants in advance)
 Interest bearing liabilities
 Liabilities directly associated with non-current assets held for sale
 Short term provisions (eg.annual leave, sick leave, vested LSL)

Total Current Liabilities

	\$5,536.81
CC	\$15,700.00
M	
BB	
N	\$21,236.81

Non Current Liabilities

Payables
 Pension Liability
 Interest bearing liabilities
 Long-term provisions (eg. LSL)

Total Non-Current Liabilities

O	
EE	
	\$0.00

Total Liabilities

Net Assets

P	\$21,236.81
Q	\$17,259.44

Equity

Contributed equity
 Reserves
 Retained earnings/(losses)
 Total Equity

	\$7,368.59
	\$9,890.85
R	\$17,259.44

Other Required Information

Cash held for restricted purposes (including money held in trust) (1)
 Capital grants (*)
 Unapplied grant revenues (*)
 Cash backing for employee entitlements (eg. LSL, defined benefit plans)(2)
 Fair value gains/(losses) to income statement on defined benefit plans (*) (3)
 Fair value gains/(losses) to income statement on investments (*) (4)
 Method applied to account for defined benefit plan gains/(losses) (*) (5)

S	\$0.00
V	\$0.00
W	\$0.00
AA	\$0.00
	\$0.00
	\$0.00
	N/A

(*)Information not contained on the face of the financial statements

- (1) Where cash balance is included in total current assets
- (2) This is an estimate of how much the long service leave & defined benefit provisions shown in your Balance Sheet is backed by cash reserves
- (3) This reflects the quantum of non-cash fair value gains/(losses) on defined benefit plans recognized to the Income Statement in accordance with AASB 119
- (4) This is the quantum of non-cash fair value gains/(losses) on investments recognized to the Income Statement in accordance with AASB 139
- (5) Select from one of the following: Not applicable (if not used); Direct to Income Statement; Direct to Equity; or Corridor Approach

Future Directions

Victoria's end of life and palliative care framework was released in July 2016.

The framework established five priority areas:

- Priority 1: Person-centred care
- Priority 2: Engaging communities, embracing diversity
- Priority 3: People receive services that are coordinated and integrated
- Priority 4: Quality end of life and palliative care is everyone's responsibility
- Priority 5: Specialist palliative care is strengthened

The EMRPCC will undertake a strategic planning forum in September 2017 to plan for the delivery of improvements to palliative care provision over the next two years.
