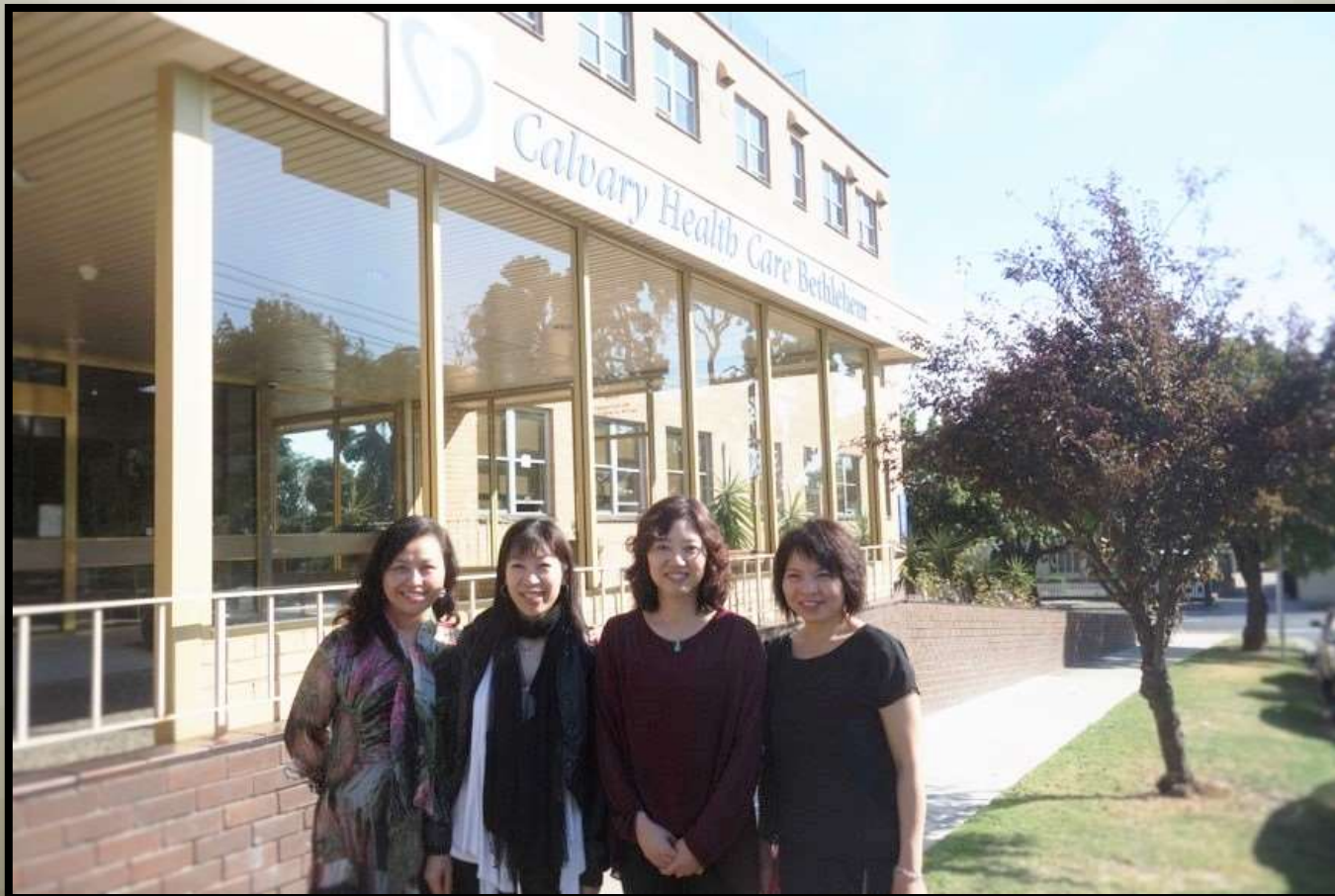


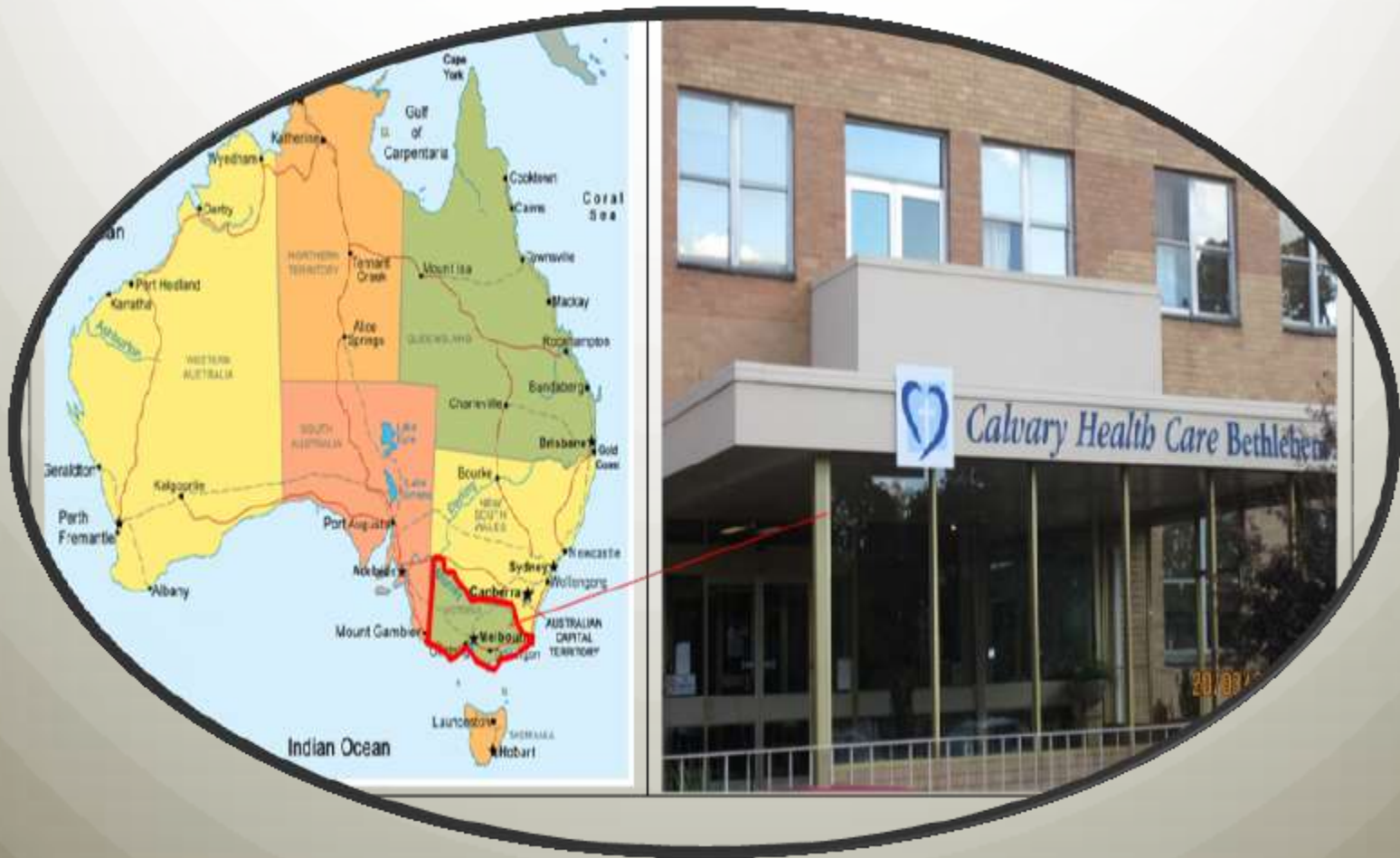
**Hospital Authority
Overseas Corporate Scholarship Training Program
Palliative Care
Melbourne, Australia**

18 March 2013 – 12 April 2013



Calvary Health Care Bethlehem

A leading Victorian hospital that has served the community for over 85 year in caring for those patients with malignant disease and progressive neurological illness.



- **Multidisciplinary specialist model of care across inpatient and community services.**
- **A broad range of allied health services provide holistic care to patients and their families.**
- **The diversional program promotes patients' quality of life**
- **The person-centered care practice puts patients at the heart of care and respect their preferences, values, needs and autonomy in making their own choices.**



The CHCB Model of Specialist Palliative Care

CHCB Inpatient Interdisciplinary care

- 1) Pain and symptom management
- 2) Restorative care
- 3) Respite Care
- 4) End of life care

CHCB SPECIALIST PALLIATIVE CARE SERVICE

CHCB Community Interdisciplinary care

- CHCB Day Centre
- 24 hours support Service

Palliative Care Wards

St. Luke's & St. Joseph's - 18 beds in each ward



Neurology ward

St. Teresa's : 30 In-patient Beds



Ambulatory Services

- 1) Outpatient clinics
- 2) Day Centre
- 3) Home Setting and Residential care facilities



Role and Function of Clinical Nurse Consultant in Neurological Out-patient Clinic Service

- Triage new referral from GPs/other hospitals and arrange appointment
- Formulate the care plan
- Coordinate care and make appropriate referrals
- Follow up and review patient's disease progress
- Collaborate with local service providers



Community Palliative Care Services

Interdisciplinary team provides care coordination such as symptom management, practical assistance, psychosocial and spiritual support.

Community support system 1) 24 hours hotline 2) after hours nurse coordinator 3) on call physician and home care nurses



Role and Function of Nurse Practitioner in Community Service

1. Advanced clinical assessment
2. Clinical nursing practice
 - prescribing medications
 - initiating diagnostic imaging and laboratory testing
 - referring to specialists
 - admitting and discharging patients
3. Education
4. Counseling
5. Research
6. Quality improvement, administration and management.



Diversional Program

The purpose is not to kill time, but to **make time live**; not to keep patients occupied, but **to keep them refreshed**; not to offer an escape from life, but to provide **a discovery of life**.



Recreational activities promote self-esteem and personal fulfillment

Complementary Therapies

- At CHCB, a range of complementary therapies are offered in in-patient and outpatient settings.
- The complementary therapies are driven by patient demand.
- An evidence base is developing which provides support for the role of complementary therapies in improving the symptoms and quality of life of palliative care patients.



Palliative Care Day Centre

- Organized by diversional therapist
- Offer a variety of programs in small groups - 8 patients each time
- Every Wednesday and Friday from 9 a.m. to 3 p.m.



Wednesday	Friday
9.00 - 10.00am All welcome	9.00 - 10.00am All welcome
10.00 - 10.30am Meet, cup of tea/coffee	10.00 - 10.30 Meet, cup of tea/coffee
 Music Therapy	<i>Art Therapy</i> 
Poetry writing/ readings	<i>Pet therapy</i>
12.00 - 12.30 - lunch 1.00pm - 2.00pm Monthly armchair travel	12.00 - 12.30 - lunch 12.30 - 1.00pm Relaxation & Quiet discussion
2.00pm - 3.00pm Quiz, word games, craft, stories, jokes	1.00 - 3.00pm Matinee music

Music Therapy



Live music therapy sessions increase perceived quality of life for people with terminal illness

Art Therapy



Art therapy is a way of helping patients to express their emotions and cope with their illness.

Pet Therapy



Hospice pet visits offer a welcome distraction from illness and may help patient to reduce distress.

Other Program Activities



Games



Movie



Nail polish



Gardening



Shopping



Massage



Amotherapy



Armchair travel

Advance Care Planning Respecting Patient Choices (RPC) Program

Aim : Promotion of autonomy and dignity to help people understand their wishes about future treatment

Advance Care Planning (ACP) showed improvement of end-of-life care for the patient and reduce stress, anxiety and depression in surviving relatives. (Detering et al., 2000)

Respecting Patient Choices

If we know your choices for future health care, we can help you respect them.

Advance Care Planning Guide

The guide aims to assist you in thinking about your future healthcare choices. Making decisions about future healthcare is also known as advance care planning. Advance care planning can help those closest to you make healthcare decisions on your behalf should you be unable to make these decisions for yourself. The process may involve thinking and talking about complex and sensitive issues. You can use this guide to write down thoughts or responses that you may have about advance care planning.

This Advance Care Planning Guide is best used together with the Respecting Patient Choices® Advance Care Planning Information Booklet. You can also refer to the guide during discussions with your doctor, family and other health care providers about a Respecting Patient Choices® facilitator. Once you have completed this guide you may wish to speak with those people about completing an Advance Care Plan without requiring someone who will be able to make the health care choices that you would want to have made should you be unable to make them for yourself.

An Advance Care Planning Program for all Australians

Your past experiences of health...
Have you or anyone else you know had a positive or a difficult experience with health care?
You may have had an experience with a family member or friend who was faced with a serious illness or condition and the role of the doctor. This may have been a difficult experience for you and tell you to look further into regarding what kind of medical treatment you may or may not want in the future.

Your thoughts...
Have you or anyone else you know had a positive or a difficult experience with health care?
Are there things that you wish could have been done differently?
Are there any medical treatments that you're experienced or seen others experience that influence your view?

Your current health...
You may be healthy now, or you may be experiencing health problems. It is worth thinking about your health while helping to mind the things that you value, goals you may want to achieve and the place of spirituality in your life.

Your thoughts...
Thinking about your health may help you explore health problems that concern you.
How may the quality of your life and your values and your beliefs about religion or spirituality affect your choice of medical treatment?

Your future health...
You may have thought at the time of health problems that you'd never get to the future. The medical treatment that you should now also be based upon your values and goals.
If you are receiving medical treatment how might the doctor help or hinder you in accomplishing these goals?

Who should make decisions?
It is a good idea to think about who you would want to make decisions about your health if you are unable to make these decisions for yourself. They should either be those family members that you can talk with about what you think would best represent you. You may wish to legally nominate someone for this role (the form for this differs in each State and Territory).
The person that you choose needs to be:
- aged 18 or over
- a resident of the State and Territory that you live in
- willing to accept the responsibility
- available to take on the role if required
- able to make decisions in stressful situations.

How to make decisions?
It is best to plan for situations when you may:
- become unexpectedly incapable of making your own decisions.
- be that you will have difficulty in making it.
- The impact or loss of function is significant.
Such situations might arise because of an injury to the brain (such as a stroke), a stroke, or a slowly progressive disease like Alzheimer's disease.
To plan for this type of situation, some people choose "If I'm going to be a vegetable, let me go." Or "I don't want you to make an decision." Or "I want everything." While these comments are helpful, they need to be more specific to guide decision-making. Clearer comments such as "I do not want to live in a permanent state where I am unable to eat, talk or move." Your doctor can help you understand this, it is important to then discuss these choices with those closest to you.

Who would you want to make decisions regarding your medical treatment to be made if you could not make them for yourself?
Who would you want to have making these decisions?
Would you also like your family doctor or other members from your community (e.g. religious adviser) involved?
You have discussed
willing to accept the responsibility
available to take on the role if required
able to make decisions in stressful situations.

Your thoughts...
Write down the aspects of your life that you value. This may include your independence, activities you enjoy, communicating with your loved ones etc.

What next?
How do you make sure that your choices will be respected? First make sure that you talk about them with your doctor, family, friends and significant others. You can then put your choices in writing in the form of an Advance Care Plan or Advance Directive. Ask your doctor about this.
You can also find more information on advance care planning by contacting a Respecting Patient Choices® office or by going to the Respecting Patient Choices® website: www.respectingpatientchoices.org.au
For contact details of other Respecting Patient Choices® offices:
Austin Health
Respecting Patient Choices® Office:
143 Studley Place
Melbourne VIC, 3084
03 9495 5440
rpcoffice@austin.org.au

Reference

Detering, K. M., Hancock, A. D. Reade, M. C., Silvester, W. (2000). The impact of advance care planning on end of life care in elderly patients: randomized controlled trial. *British Medical Journal*, 340(7751), 847.

Support patient “die at home”

◆ Communication

Home Information Folder

- name list of interdisciplinary team and emergency phone contact

◆ Emergency kit

opioid, antiemetic, anxiolytic drugs



◆ Community support services

- 24 hours hotline and on call system
- After hours nurse coordinator and on-call home care nurse
- GP / Palliative care specialist certified death at home
- 24hr funeral director

Thank You

time for a little
question & answer
session