Banksia Palliative Care Service

phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

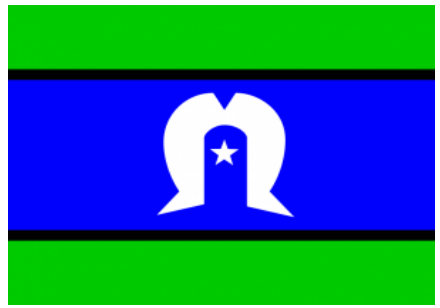
Understanding the role GPs play in community palliative care

Thursday 14 March 2024

The content in this session is valid at date of presentation

Acknowledgement of Country

- North Western Melbourne Primary Health Network and Banksia Palliative Care Service would like to acknowledge the Traditional Custodians of the land on which our work takes place.
- We recognise their continuing connection to land, waters and culture, and we pay our respects to Elders past, present and emerging.
- We also pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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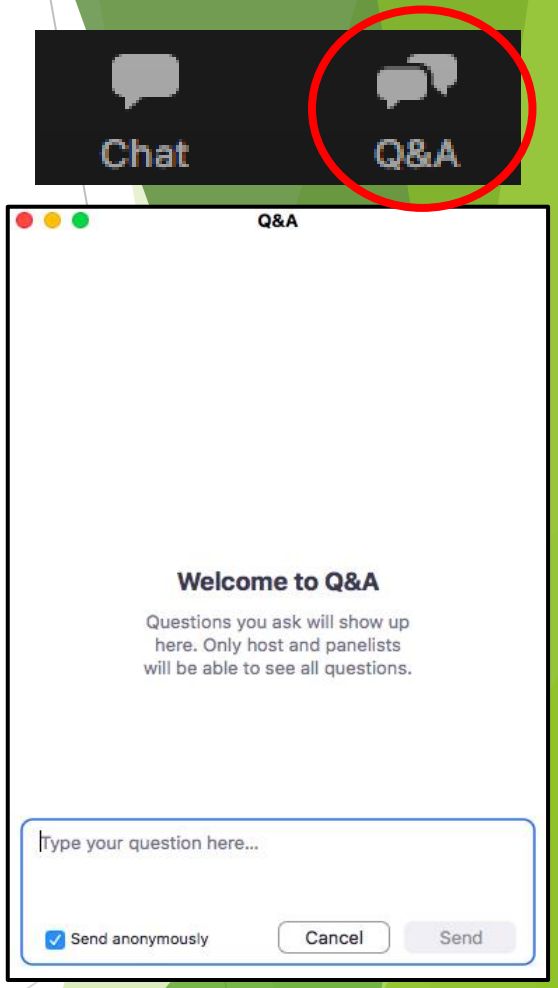
Q&A will be at the end of the presentation

This session is being recorded

Questions will be asked anonymously to protect your privacy



Housekeeping – Zoom Webinar

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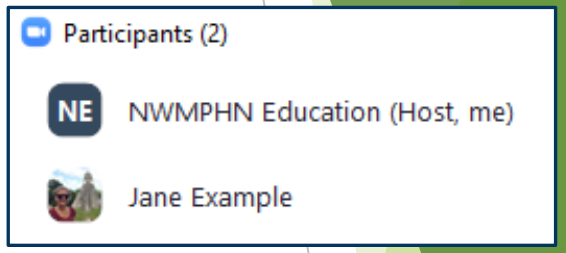

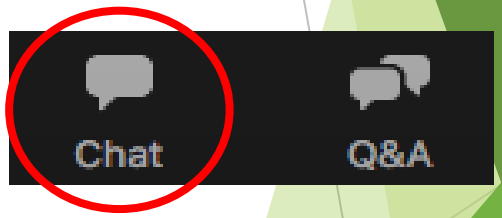

Welcome!

- CPD Webinar presented by Banksia's Palliative Care in conjunction with NWMPHN
- Today's presenters:
  - Dr Chien Lin – Palliative Medicine Specialist (weekdays), General Practitioner (Sat)
  - Amanda Petricola – Clinical Service Lead

Thank you for attending!

- Hopefully we can jointly improve the care we provide our common patients
- Community palliative care = joint care

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Understanding the role GPs play in community palliative care

Dr Chien-Che Lin
Specialist Palliative Medicine Consultant, Banksia Palliative Care

Amanda Petricola
Clinical Service Lead, Banksia Palliative Care

Firstly, who is Banksia?

- Banksia Palliative Care Service is the *only* not-for-profit Community Palliative Care Service in the north east suburbs of Melbourne, encompassing the 3 local government areas of Banyule, Nillumbik and Whittlesea.

- Banksia is a home visiting palliative care service which provides care and support to clients and their families 24/7.

- The Banksia Team work alongside other local health care services/providers to ensure all the needs of the client, their family and community are meet;
  - General Practitioners & Medical Specialists
  - Other services- Aged Care facilities, local councils, Bolton Clarke

Banksia Snap Shot 2022 in Numbers

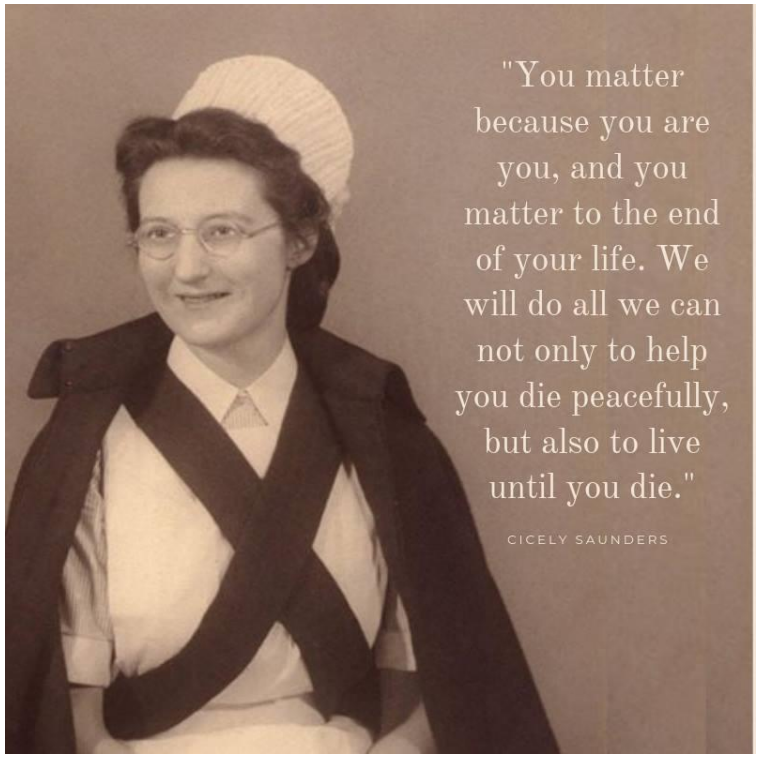
Banksia Palliative Care Service

- **Referrals Received 1051**
  - Self, relative, friend- 110
  - GP, other health specialist- 352
  - Aged Care, aged care related service- 181
  - Hospitals, inpatient acute & pall care services- 408
- **Admissions Completed 855 –** 196 people and/or their families did not receive the supports of Banksia
  - Non-Malignant 338
  - Malignant 517
- **Deaths 748**
  - Hospital Inpatient 308 (219 pall care unit, 89 acute service)
  - Home 440 (234 private residence, 206 residential aged care)

Overview of tonight's session

Banksia Palliative Care Service

- Who is Banksia?
- What is palliative care, and how is it delivered?
- The role of community palliative care (CPC)
- What supports can CPC provide?
- Case study
- Interventions, medications and practical supports to enable end-of-life care at home
- Bereavement support
- Verification and certification of death in the community



What is Palliative Care?

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Palliative Care Australia - Palliative care is person and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life. [1]

Key points

- *Life limiting illness*
- *Expected to die (usually 6-12 months)*
  - *Not always, involvement in potentially curative younger patients, complex symptoms*
- *Focus is QOL*

[1] Palliative Care Australia Website – 'What is Palliative Care' https://palliativecare.org.au/resource/what-is-palliative-care/

Palliative Care

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Does not equal no care!

Patients can receive palliative care together with other therapies that are intended to prolong life.

(WHO, 2018)

Palliative Care

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Palliative Care Service

- Aims to enhance quality of life and help patients live as actively as possible.
- Regards dying as a normal process.
- Provides relief from pain and other symptoms.
- Intends neither to hasten nor postpone death.
- Integrates the psychological and spiritual aspects of care.
- Uses a team approach to address the needs of patients and their families.
- Offers a support system to help the family cope during the patients illness and in bereavement.

(WHO, 2018)

Who can benefit from palliative care?

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- Anyone (adults & children) with a life limiting illness/condition

- Cancer
- Neurological Conditions eg: Motor Neurone Disease (MND)
- End stage organ disease:
  - Heart
  - Lung
  - Kidney
- Dementia
- Inherited metabolic disorders

Who provides palliative care?

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Palliative Care vs Specialist Palliative Care

- Palliative Care
  - Care required for people living with life limiting illnesses
  - Provided by
    - Nurses
    - PCAs
    - Family
    - GPs, oncologists, geriatricians…

- Specialist Palliative Care
  - Care provided by specialist palliative care services comprising multidisciplinary teams with specialised skills, competencies, experience and training for people with more complex needs

Palliative Care Service Development Guidelines, January 2018

Where is Palliative Care provided?

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- Palliative Care can be provided:
  - at home
  - at a specialist palliative care unit
  - in a hospital
  - in a residential aged care facility
  - anywhere a person identifies as being their home

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Now to focus on the community!!

Why focus on the Community?

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Where do people want to die? → At Home

- Worldwide - 2013 Gomes et al. Systematic Review
  - Worldwide data
  - 100,000 people, 200 studies
  - Results
    - **70% Home**
    - 19% Hospital
- Australia
  - South Australian Study
  - Population Survey (2500 respondents)
  - if dying of 'a terminal illness such as cancer or emphysema'
  - **70% of Australians want to die at home (South Australian Study)[2]**

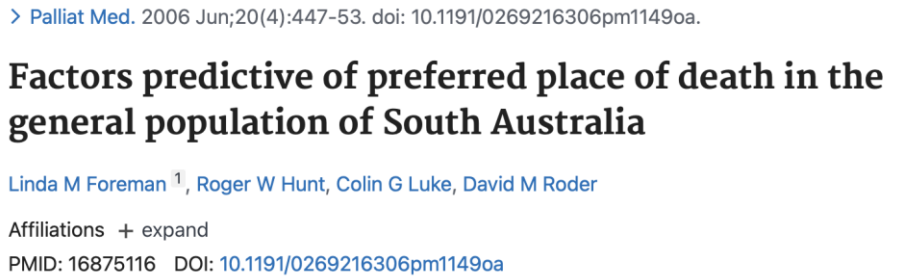
Gomes *et al. BMC Palliative Care* 2013, **12**:7
http://www.biomedcentral.com/1472-684X/12/7

BMC Palliative Care

RESEARCH ARTICLE Open Access

Heterogeneity and changes in preferences for dying at home: a systematic review

Barbara Gomes*, Natalia Calanzani, Marjolein Gysels, Sue Hall and Irene J Higginson



> Palliat Med. 2006 Jun;20(4):447-53. doi: 10.1191/0269216306pm1149oa.

Factors predictive of preferred place of death in the general population of South Australia

Linda M Foreman [1], Roger W Hunt, Colin G Luke, David M Roder

Affiliations + expand

PMID: 16875116 DOI: 10.1191/0269216306pm1149oa

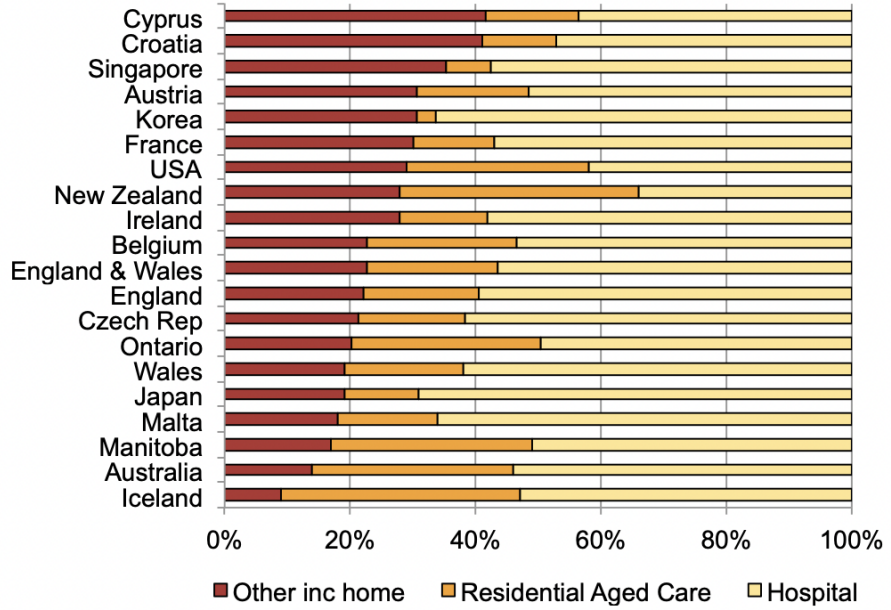
1 https://bmcpalliatcare.biomedcentral.com/track/pdf/10.1186/1472-684X-12-7.pdf
2 (Foreman 2006) https://pubmed.ncbi.nlm.nih.gov/16875116/

Why focus on the Community?

- Where do Australians die (2021 data)
  - 51.0% die in hospitals
  - 29.5% die in aged care
  - **14.8% at home**

In most cases → not at home

Figure 1: Few Australians aged over 65 die at home
Location of deaths in selected OECD countries; per cent of deaths



Source: (Broad et al., 2013 (2013))

1 Broad, Joanna B., et al. "Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential aged care settings in 45 populations, using published and available statistics." *International journal of public health* 58.2 (2013): 257-267.

So…

- 70% of Australians want to die at home
- Only 14% actually do

Thank you for your interest in CPC!

- Hopefully by attending today (and our coming seminars), together with us, you can help us improve this number and also the overall quality of life (and care) for our ‘shared’ patients

What supports can community palliative care provide?

DISCLAIMER – SOME VARIATIONS IN SERVICE WITH DIFFERENT PROVIDERS

Community Palliative Care (CPC) Team

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We are a specialised team of health professionals:

- Palliative Care Nurses;
- Social workers, Bereavement Counsellors;
- Occupational Therapist;
- Music, Massage Therapists;
- Client Support Volunteers;
- Palliative Care Physicians

What services do we (CPC) provide?

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- Access to support 24/7
- Trouble Shooting client and carer concerns
- Pain and other symptom relief
- Equipment to aid care at home
- Social work input for sensitive or complex issues
- Allied health input such as music therapy or massage therapy
- Respite and support
- In the community we are able to arrange direct admission to PCU. This reduces stress to client/carer but also assists in reducing the burden to the healthcare system by avoiding the need to present to ED

Case Study - Mark

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- Referred at 3pm Wednesday by Aged Care Case Manager – marked URGENT
- No medical information
- Intake phone call to home:
  - trouble getting out of bed
  - only eating and drinking small amounts
  - pain, SOB, cough, functional decline
  - multiple admissions to hospital
  - wanting to remain at home for end of life care
- Medical info request sent to GP clinic and local hospital

Case Study - Mark

Mark is a 76 y/o with end stage COPD

- Past medical Hx
  - chronic back pain
  - asthma
  - hyperlipidaemia
  - L) TKR 2015
  - chronic renal failure (Cr 166)
- 3 admissions to hospital past 6 months
- Significant functional decline over past 3 months
- Now essentially chair bound with mild SOB at rest
- Wife Sarah, 2 adult children, 4 grandchildren

CPCS assessment

Seen by CPCS RN at 10am Thursday

Issues:

- SOB++, moist cough
- Back pain
- Minimal oral intake – fluids only
- Dry mouth - tablets becoming more difficult
- No other GIT symptoms
- Functional decline
- Increase in care needs
- Wife distressed by deterioration
- GP works Mon-Wed – last seen face to face 4 months ago

Medications

Allergies – Morphine (severe nausea/vomiting)

- Targin 10/5mg BD PO
- Oxycodone IR 5mg QID PO prn
- Rosuvastatin 20mg nocte PO
- Panadol Osteo 2 tabs TDS PO
- Salbutamol inhaler 2 puffs 4/24 inh prn
- Spiriva inhaler 2 puffs daily inh
- Prednisolone 10mg daily PO

Considerations for dying at home

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- GP engagement including provision of Death Certificate
- Equipment needs
- Access to end of life/comfort care medications to manage symptoms
- Regular nursing visits
- Access to afterhours support
- Practical and emotional support for wife and family
- Bereavement support for family post *Mark's* death

CPCS follow up on day of assessment

- *Mark* clearly deteriorating likely entering terminal phase - wish to die at home
- RN contact with GP clinic

Symptom management:

- Fentanyl patch 12 microg/hr (cease Targin)
- Oxynorm liquid 5mg/5mL – pain/SOB
- Hydromorphone 2mg/mL x 5 amps
- Metoclopramide 10mg/2mL x 10 amps
- Clonazepam oral liquid 2.5mg/mL x one 10mL bottle
- Buscopan 20mg/mL x 5 amps

Safer Care Victoria – palliative care clinical guidance

Banksia Palliative Care Service

472 Lower Heidelberg Road,
Heidelberg Victoria 3084
Phone: (03) 9455 0822 Fax: (03) 9455 3199
Email: reception@banksiapalliative.com.au
www.banksiapalliative.com.au

To: Click or tap here to enter text.

From: The Clinical Team at Banksia Palliative Care Service

Fax Number: Click or tap here to enter text. **No. of Pages:** Click or tap here to enter text.

Telephone: Click or tap here to enter text. **Date:** Click or tap to enter a date.

Subject: Banksia Palliative Care Service – Escalation of Care Required

Dear Dr Click or tap here to enter text.,

Re: Click or tap here to enter text. **Date of birth:** Click or tap to enter a date.
MRN: Click or tap here to enter text.
Address: Click or tap here to enter text.

The Banksia Palliative Care Service (Banksia) clinical team completed a home visit with the person noted above on Click or tap to enter a date.**. We completed a detailed palliative assessment recognised that there has been deterioration, and that there are a number of palliative care symptoms/issues that require immediate action/planning. The details of the assessment are indicated below.**

Performance Status	Click or tap here to enter text.
Symptom/Issue	**Notes**
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

Dr Click or tap here to enter text.**, due to your patient's deterioration, we are anticipating that we will be undertaking more frequent face to face visits to maintain surveillance and management of their care needs and symptoms. To support Banksia to be responsive our shared patient, we recommend a small supply of emergency subcutaneous medications be available in the home, so that if there is a crisis or unexpectedly deterioration, we are able to provide medical support that may avert transfer to hospital. In addition, we may recommend medications to be used in a Syringe Driver (a small device that delivers a constant amount of subcutaneous medication over a 24hr period) to manage your patient's symptoms and to support them to remain at home for end of life care.**

The following is a table of suggested emergency medications to manage your patient at home, and an indication of the lowest dose. The recommended amounts have been calculated according to your patient's previous analgesia requirements, their needs now and any allergies they may have.

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24hr Syringe Driver orders

Medication	Indication	Dose Range	Route	Frequency	Amount
Morphine (10mg/ml) *	Pain Dyspnoea	Click or tap here to enter text.	Subcutaneous	24 hours	10 vials
Midazolam	Agitation	Click or tap here to enter text.	Subcutaneous	24 hours	10 vials
Metoclopramide (10mg/2ml)	Nausea	Click or tap here to enter text.	Subcutaneous	24 hours	10 vials
Diluent	Click or tap here to enter text.				

Breakthrough medication orders

Medication	Indication	Dose Range	Route	Frequency	Amount
Morphine (10mg/ml vials) *	Pain Dyspnoea	2.5-5mg	Subcutaneous	Hourly PRN	5 vials
Haloperidol (5mg/ml vials)	Confusion Nausea	0.5-1mg	Subcutaneous	Hourly PRN (max 5mg/24 hours)	10 vials
Metoclopramide (10mg/2ml vials)	Nausea	10mg	Subcutaneous	Hourly PRN (max 30mg/ 24 hours)	10 vials
Hyoscine Butylbromide (Buscopan) (20mg/ml)	Antisecretory and antispasmodic properties	20mg	Subcutaneous	Hourly PRN (max 120mg /24 hours)	10 vials
Clonazepam (2.5mg/ml oral drops)	Agitation	2-5 drops (0.2-0.5mg)	Sublingual	Hourly PRN	1 bottle (10 l)

***If client has known Renal Impairment, please consider hydromorphone 0.5-1.0mg – if concerned, please contact the Banksia Palliative Care Physician**

For us to arrange to have these medications available for use (when needed) in the home, please see following:

1. Complete a medication order on Banksia's SOS Medication Chart (attached below). Our staff will follow these orders when administering the medications.
2. Please fax the completed SOS medications orders to Banksia **(03 9455 3199)** so it can be added to the client file and be available if and when needed.
3. Provide a prescription to the patient/carer for the medication. This can be faxed directly to the Pharmacy or collected by the patient/family from your surgery (please arrange directly with the patient/family).

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Syringe Driver and SOS Medication Orders

THIS SECTION COMPLETED BY BANKSIA NURSE	As per our telephone discussion could you please provide support and breakthrough medication orders below for: **Patient Name:** Click or tap here to enter text. **Address:** Click or tap here to enter text. **DOB:** Click or tap here to enter text.
	Name of Banksia Palliative Care Nurse requesting medication orders: Click or tap here to enter text.
	KNOWN ALLERGIES: Click or tap here to enter text.

THIS SECTION COMPLETED YB TREATING DOCOTR/ or NURSE PRACTITIONER

SYRINGE DRIVER (CSCI) MEDICATION ORDERS- SUBCUTANEOUS IFUSION

DATE	DRUG	24 hour Dose Range (for titration purposes)	PRESCRIBER'S SIGNATURE	Print DR/NP name
	Diluent-			

BREAKTHROUGH MEDICATION ORDERS

DATE	DRUG	DOSE	ROUTE	FREQUENCY	PRESCRIBER'S SIGNATURE	Print DR/NP name

Please PRINT orders to ensure each order can be clearly read then please fax: 9455 3199

Banksia Palliative Care Service

472 Lower Heidelberg Road,
Heidelberg Victoria 3084
Phone: (03) 9455 0822 Fax: (03) 9455 3199
Email: reception@banksiapalliative.com.au
www.banksiapalliative.com.au

Common medications used at end of life

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- Medications play an integral part in the managing symptoms of life limiting diseases and optimising comfort. Injectable medications may be required when a person can no longer tolerate oral medications.
- Common medications used during the end of life phase include:

- **Pain**; Morphine, Hydromorphone, Fentanyl
- **Nausea**; Metoclopramide, Haloperidol, Cyclizine
- **Agitation**; Clonazepam, Midazolam, Haloperidol
- **Secretions/ Noisy breathing**; Glycopyrrolate, Atropine, Hyoscine butylbromide

CPCS follow up on day of assessment

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- Education provided to carers re medication changes – Action plans
- Verbal and written information provided
- Practical information given - slide sheets, pressure area, mouth care
- Carer needs, bereavement risk, funeral plans
- Urgent equipment request by SW
- Referral made to Carer Gateway

CPCS follow up

- Handover to BPCS team
- Update faxed to GP clinic
- Regular nursing visits planned Mon/Wed/Fri
- SW providing ongoing support

Afterhours page Sunday evening, deteriorating swallow, worsening chest secretions, restlessness

- Hydromorphone 0.5-1mg subcut PRN - pain/SOB
- Buscopan 20mg subcut 4/24 PRN
- Clonazepam 3-5 drops subling/buccal PRN

CPCS Ongoing follow up

- Terminal phase
- Contact with GP on Monday
- Ongoing issues with SOB, secretions, restlessness
- Syringe driver commenced on Tuesday
  - Hydromorphone 3mg, Buscopan 80mg, Midazolam 10mg - 24 hours
- In terminal phase – daily nursing visits
- ENs also provided assistance with personal care
- *Mark* died comfortably on Friday night at 11pm
- BPCS nurse visited to provide verification
- Notification of Death faxed to GP
- Bereavement support for family

Mark - take home messages

- GP availability and ongoing support.
- Prompt access to injectable medications.
- Provision of equipment.
- Increased carer supports.
- Regular palliative care nursing support.
- Ongoing social work support for family.
- Verification of death & provision of death certificate.

Mark - reflections

- His case is one of ‘late’ referral.
- Ideally, may have been referred earlier to our service.

- Many patients with us for many months, some for up to 2+ years.
- If stable, we may discharge patients, then re-admit if deteriorating again.

Common interventions, medications and practical supports to enable end-of-life care at home

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- Interventions
  - Regular visits from experienced RNs to assess symptoms, trajectory of patients;
  - Emergency provision of equipment to assist care in context of functional deterioration / end of life scenario – BPCS will fund 6/52;
  - Support from SW / FSW / grief counsellors to provide emotional and social support to patients and their carers; and
  - Allied health input such as music therapy or massage therapy.

Common interventions, medications and practical supports to enable end-of-life care at home

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- Medications
  - RNs and Senior Nurses will provide specialist advice around symptom management medications.
  - GP remains main treating doctor.
  - We will often ask for anticipatory medications:
    - If GOPC are for comfort measures in event of deterioration, having EOLC medications in home prevents unnecessary hospitalization / suffering.
  - Palliative Care Physicians available for specialist support, advice around complex cases*.

Common interventions, medications and practical supports to enable end-of-life care at home

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- Practical Supports
  - Access to 24/7 phone number with visiting service to provide specialist advice on symptom management and end of life issues.
  - ENs provide training for family in providing personal care:
    - In some cases* may also assist in providing hands on personal care for patient in terminal phase.
  - RNs provide counseling to family about what to expect at time of death, and can attend home to verify death.

MCCD (Medical Certification of Cause of Death) Purpose

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- Legal Purpose
  - For validity of a will or life insurance payment
- Statistical and Public Health Purpose
  - Coded by Australian Bureau of Statistics for evaluation and development of measures to improve health of Australians
- For Family Members
  - To know what caused the death and to be aware of conditions that may occur in other family members
- Safeguard Purpose
  - To prevent disposal of bodies without professional scrutiny in relation to suspicious deaths

Verification of death

- Banksia will continue to support and visit the client and their support network every day until which time the client dies.

- **Banksia Palliative Care Nurse will attend the patient's home, complete a Verification of Death**, and provide the family with written documentation of the same. Banksia complies with the Victorian Department of Health's Verification of Death Guidelines.

- The clients care will be transferred to the deceased clients and carers preferred funeral service.
- The clients nominated GP/primary health provider will be informed of the death, and asked to complete the clients Medical Certification of Cause of Death (MCCD) online (www.avant.org.au/Resources/Public/20160411-death-certificates).

Eligibility to complete MCCD

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"A doctor who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, must, within 48 hours after the death, notify the Registrar of the death and of the cause of the death in a form and manner approved by the Registrar and specifying any prescribed particulars."

Births, Deaths and Marriages Registration Act 1996

Cause of death

- “the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury”
  - Information Paper: Cause of Death Certification Australia (2008); ICD; WHO

Completion of MCCD when someone dies under Banksia Palliative Care

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- In most cases, our nurses will request that the **GP complete the MCCD as the primary treating practitioner**
- In some cases, we may ask hospital doctors to complete MCCD
- In some cases, Banksia PCPs may complete*

- If no one is able to complete MCCD – Case is passed to the office of the coroner

Grief & Bereavement

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- Community Palliative Care Services offer support
  - Counselling for individuals and families
  - Information and education on grief, loss and bereavement
  - Remembrance Services
  - Walking Groups

- Australian Centre for Grief and Bereavement
  https://www.grief.org.au/

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Prescribing opioids in palliative care: the role of the GP

Dr Chien-Che Lin
Specialist Palliative Medicine Consultant, Banksia Palliative Care

Amanda Petricola
Clinical Service Lead, Banksia Palliative Care

Goals

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Opioid prescribing /community palliative care /GP

- General understanding of commonly encountered opioids in palliative care.
- Discussing opioid prescribing requests by community palliative care nurses.
- Discussing the PBS requirements for opioid prescribing in palliative care.

We will NOT be

- Covering molecular and pharmacodynamics detail.
- Talking about opioids in chronic non-malignant pain.

Opioid prescribing for community palliative care patients

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- **The GP continues to be the primary prescriber even though community palliative care is involved.**

- Situations
  1) acute symptom management.
  2) anticipatory medication.
  3) end of life care support.
  4) ongoing prescribing of patient's regular opioids.

Acute symptom management

- Pain – cancer pain.
- Dyspnoea (cancer/ COPD).

- Opioids Cook's Tour.

Opioids

- Opioids medication act on opioid receptors in the brain and spinal cord.
- Strong opioids – Morphine, Hydromorphone, Fentanyl, Methadone.
- ‘Weak’ opioids – Tapentadol, Codeine, Buprenorphine.

Principles of opioids in managing cancer pain

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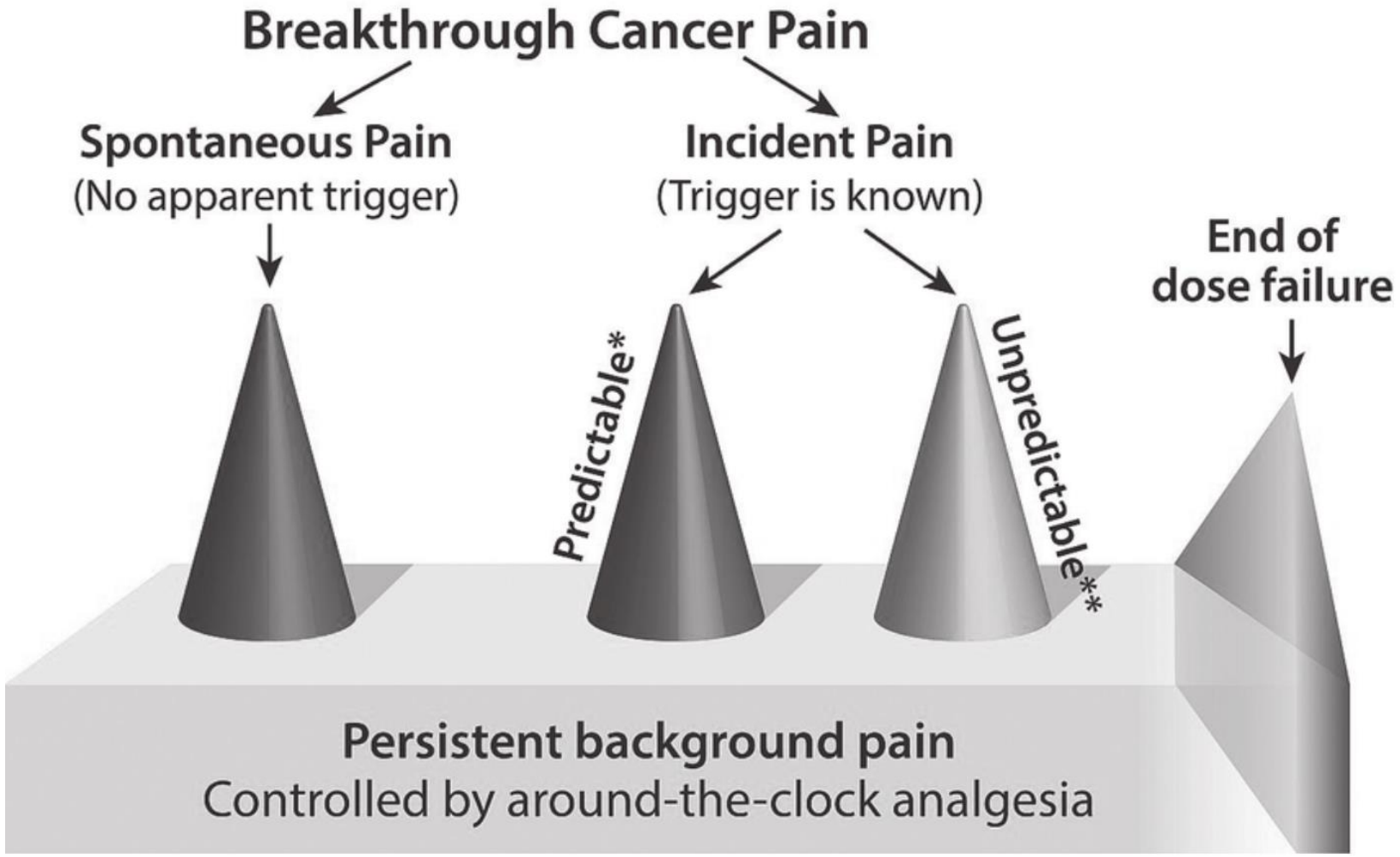
- Strong opioids in small doses rather than weak opioids.
- Concept of a background dose and BT doses.
- Background dose
  - long acting formulation (bd, daily, patch).
- BT doses
  - usually 1/6-1/12 of total daily dose (IR formulation).
- Same molecule where possible.
- Prescribe aperients.

Background v Breakthrough Analgesia



From Daeninck P 2016

Opioids work in cancer pain

- People with moderate to severe pain from cancer.
  - opioids can reduce pain to mild or no pain in 19/20 people within 14 days if they can tolerate the side effects.
- Most people will have side effects.
- Most common side effects were constipation, and nausea and vomiting.
- 1-2/10 will require a change in treatment because of side effects.

Opioids for cancer pain – an overview of Cochrane reviews. Wiffen et al. *Cochrane Database of Systematic Reviews* 2017, 7

Side effects of opioids

- Common initial - worth warning patients about
  - Drowsiness, nausea/vomiting.
  - Usually transient.
  - Allergy vs expected side effect.
- Common ongoing
  - Constipation.
- Others
  - Dry mouth, urinary retention, itch, hyperalgesia, confusion, hallucinations, vivid dreams, sedation, myoclonus, respiratory depression (risk is low if used appropriately/not titrated too quickly), physiological dependence.

Opioids in cancer pain

Banksia Palliative Care Service

- Can start with IR PRN (Sevredol 10mg PRN , Endone 5 mg PRN).
- If regular BT use introduce a background dose.
- Then uptitrate slowly based on BT use and tolerability.

- There is no upper limit
  - Very variable depending on person.
  - Dose decided by dose limiting toxicities
    - Drowsiness, hallucinations.

- Up to x3 BT doses are ok if comfortable most of the time.

Strong opioids commonly encountered in cancer pain management

Banksia Palliative Care Service

- Morphine.
- Oxycodone.
- Hydromorphone.

- Fentanyl.
- Methadone.

	Immediate release *(15-30 minutes onset, 4 hours duration)*	Sustained release
Morphine • Natural opioid • Parent drug and metabolites excreted by kidneys • Metabolised in liver • Active metabolites M3G, M6G	*•Oral liquid – Ordine 2mg/ml, 5mg/ml, 10mg/ml, other brands* *•Oral tablets - Sevredol 10mg, 20mg, Anamorph 30mg* *•Morphine injections*	• *Oral tablets- MS Contin* *12hours* • *Oral capsule- Kapanol* *16~24hours*
Oxycodone • Semi-synthetic opioid • 1.5x potency of morphine • Metabolised in liver • less active metabolites	• Oral tablets - Endone 5mg • Oral capsules – Oxynorm 5mg, 10mg, 15mg, 20mg • Oral liquid – Oxynorm liquid 1mg/ml • Oxynorm injections – non PBS	• Oxycontin tablets - 10mg, 15mg, 20mg, 30mg, 40mg, 80mg • Targin tablets - 2.5/1.25mg, 5/2.5mg, 10/5mg, 15/7.5mg, 20/10mg, 30/15mg, 40/20mg, 60/30mg, 80/40mg *12hours*
Hydromorphone • Semi-synthetic opioid • 5 times potency of morphine • Metabolised in liver • Even less active metabolites	• *Oral tablets – Dilaudid 2mg, 4mg, 8mg* • *Oral liquid – 1mg/ml x 473mL(!)* • *Hydromorphone injections – Dilaudid -2mg/ml, 10mg/ml*	• *Oral tablets – Jurnista withdrawn from pbs* • *Awaiting replacement but no updates as yet*

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	Immediate release	Sustained release
Fentanyl • Synthetic opioid • No active metabolites • Less constipating	Oral transmucosal fentanyl citrate – Abstral lozenges Sublingual tablets – Abstral Orally disintegrating tablets – Fentora Multiple strengths for each Onset of action – 10-15mins* Duration of action – 1-2 hrs	Transdermal patches – Durogesic and others Min dose 12mcg/hr = roughly equiv to morphine 30mg PO/24hrs Onset of action – 12-24hrs Duration of action – approx 72hrs

Methadone

- **Strong mu and delta agonist**
- **NMDA antagonist**
- **Role especially in incident pain and neuropathic pain**
- **Can be used as background opioid or adjuvant**
- **Relatively safe in renal failure**
- **TRICKY PHARMACOLOGY – non linear pharmacokinetics**

- **Need for slow titration and careful monitoring – greater risk of sedation and respiratory depression**
  Suggest using only in conjunction with specialist palliative care/pain service

Oral tablets – Physeptone **10mg**	**Injectable methadone – 10mg/ml** **PO methadone : SC methadone** **2:1**

Targin v Oxycontin

- Targin (oxycodone + naloxone)
- **THEORY**
  - *Naloxone is an opioid receptor antagonist.*
  - *Co-administration with oxycodone is meant to reverse opioid effects in the gut.*
  - *Removed by first pass metabolism in liver, so should not enter systemic circulation.*
- **PRACTICE**
  - *When liver impairment is present, naloxone may escape first pass metabolism → increased systemic levels → reduced analgesic effect.*
  - *Avoid in any liver impairment / liver mets if possible.*
  - *If targin not working can switch to oxycontin same dose as a start (weary of narcotization)*
    - *10mg of oxycontin vs 10mg oxycontin / 5 mg naloxone.*

Weak opioids

- Prefer to avoid.
- In selected patients getting intolerable side effects with strong opioids can trial
  - Buprenorphine
  - Tapentadol

- Avoid
  - Codeine (constipating)
  - Tramadol (delirium in the elderly)

Buprenorphine

- **Partial agonist at mu receptors and antagonist at kappa receptors → used for treatment of opioid misuse**
- **Antagonist effect not significant in doses used in palliative care**
- **Minimal renal excretion → safe in renal failure**
- **Less constipating than some other opioids**

IR	MR
Sublingual tablets – Temgesic 200mcg, 400mcg **Not PBS listed for analgesia** Onset of action – 1-2hrs Duration of Action – 6-8hrs	Transdermal patches – Norspan 5, 10, 15, 20, 30, 40mcg/hr **Buprenorphine 5mcg/hr is roughly equivalent to morphine 10mg PO/24hrs** Onset of action – 1-2 days Duration of action – 7 days

Tapentadol

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Renally excreted	
IR **Oral tablets – Palexia** **50mg, 100mg** **Not PBS listed** **Onset of action – 30mins** **Duration of action – 4hrs**	**MR** **Oral tablets – Palexia MR** **50mg, 100mg, 200mg, 250mg** **Max dose Tapentadol MR 250mg BD** **PO Tapentadol : PO Morphine=** **500mg : 160 mg = 3 : 1** **Onset of action – 4hrs** **Duration of action – 12hrs**

Opioids in dyspnoea

- Majority of evidence for opioids in breathlessness is with morphine
  - No evidence for fentanyl.
- Current evidence shows some reduction of overall breathlessness on PO sustained release morphine up to 40mg daily.
- In contrast to pain you don't keep increasing dose.
- Kapanol is PBS listed for management of breathlessness.
- However, from practical perspective
  - if someone is already on another opioid, suggest using that opioid for breathlessness as well.
  - If SOB is predictable (eg with shower), try IR opioid about 30 mins prior.
  - Episodes of SOB may still occur with background MR opioid – may still need IR doses.

Barriers to appropriate opioid use

Banksia Palliative Care Service

- Clinician related
  - Fixed prescribing patterns.
  - Fear of prescribing.
  - Lack of time.
  - Rules and regulations.
- Patient related
  - Reluctance to report pain – “I don’t want to complain”; “there are others sicker than me”; “but what does it mean if my pain is increasing?”
  - Cultural.
  - Fear of opioids.

Fear of opioids

Banksia Palliative Care Service

- "You're talking about morphine - are you telling me my time is short?"

no, opioids can be used at different stages of disease.

- "If you start mum on morphine, she'll die more quickly"

no, opioids do not hasten death when used appropriately.

- "I don't want to become an addict" " I don't want to take drugs"

risk of psychological addiction in pall care patients is very low.

- "If I take strong painkillers now, there'll be nothing for me when I get closer to death or when the pain gets worse"

tolerance unlikely, different opioid options available.

- *" My mother told me not to smoke or take drugs".*

Opioid conversion table

OPIOID CONVERSION
QUICK REFERENCE GUIDE

epc
Palliative care. Living well every day.

Banksia
Palliative Care Service

Adapted from Safe Care Victoria Opioid Conversion Ratio Guideline version February 2021

ORAL MORPHINE TO OTHER ORAL OPIOIDS			
From ORAL	**To ORAL**	**Ratio**	**Example**
Morphine	Hydromorphone	5 : 1	Oral morphine 5mg = Oral hydromorphone 1mg
Morphine	Oxycodone	1.5 : 1	Oral morphine 15mg = Oral oxycodone 10mg
Morphine	Tapentadol	1 : 3	Oral morphine 100mg = Oral tapentadol 300mg
Morphine	Tramadol	1 : 5 to 1 : 10	Oral morphine 10mg = Oral tramadol 50-100mg

ORAL TO SUBCUT OF SAME DRUG			
From ORAL	**To SUBCUT**	**Ratio**	**Example**
Morphine	Morphine	2 : 1 to 3 : 1	Oral morphine 30mg = Subcut morphine 10-15mg
Oxycodone	Oxycodone	1.5 : 1 to 2 : 1	Oral oxycodone 30mg = Subcut oxycodone 15-20mg
Hydromorphone	Hydromorphone	2 : 1 to 3 : 1	Oral hydromorphone 24mg = Subcut hydromorphone 8-12mg

SUBCUT MORPHINE TO OTHER SUBCUT OPIOIDS			
From SUBCUT	**To SUBCUT**	**Ratio**	**Example**
Morphine	Hydromorphone	5 : 1	Subcut morphine 10mg = Subcut hydromorphone 2mg
Morphine	Oxycodone	1 : 1	Subcut morphine 10mg = Subcut oxycodone 10mg
Morphine	Fentanyl	75 : 1	Subcut morphine 7.5mg = Subcut morphine 7500mcg = Subcut fentanyl 100mcg

Patches

- Fentanyl patches – 3 days
- Buprenorphine patches – 7 days

- Smallest fentanyl patch = ? Oral morphine

- Good for stable pain.
- Difficult to titrate.
- Some people have trouble with adhesive.
- Need fat to absorb.
- If absorption / adherence is a problem.

Patches

Banksia Palliative Care Service

FENTANYL TRANSDERMAL PATCH TO MORPHINE (CONSERVATIVE CONVERSION RATIO)		
Fentanyl (mcg/hr) patch	**Oral morphine equivalent (mg/24hr)**	**Oral morphine breakthrough (mg) (using 1 : 6 ratio)**
12	30	5
25	60	10
37	90	15
50	120	20
75	180	30
100	240	40

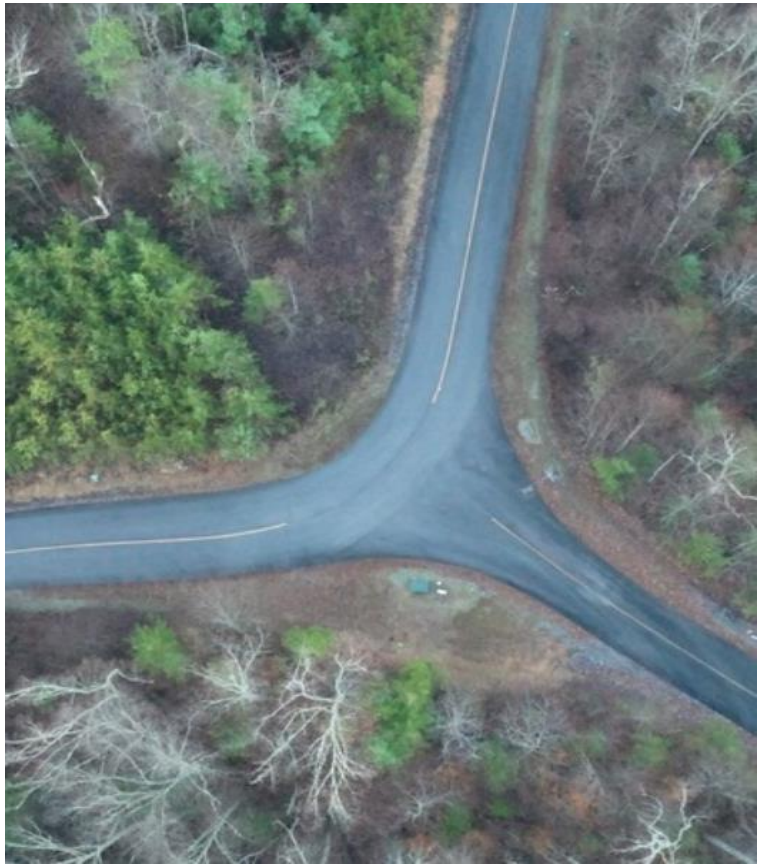
BUPRENORPHINE TRANSDERMAL PATCH TO MORPHINE		
Buprenorphine (mcg/hr) patch	**Oral morphine (mg/24hr) (Ratio 1 : 75 – 1 : 100)**	**Subcut morphine (mg/24hr)**
5	9-12	3-5
10	18-24	5-8
15	27-36	See note*
20	36-48	12-16
25	45-60	See note*
30	54-72	See note*
40	72-96	See note*

Opioid prescribing for community palliative care patients

Banksia Palliative Care Service

- The GP continues to be the primary prescriber (thank you)

- Situations
  1. Acute symptom management.
  2. Anticipatory medication.
  3. End of life care support.
  4. Ongoing prescribing of patient's regular opioids.



How to choose appropriate anticipatory medication

Banksia Palliative Care Service

- The need for anticipatory medication.
- Timing , s/c, easily available drug.
- How it is used practically (nurses draw up etc).
- How to choose an appropriate dose.
- Usually opioid / antiemetic / anxiolytic /antipsychotic
  - David on 30mg bd of MS contin.
  - Sarah on 24 mg of Jurnista daily.
- Reasonable question to ask a palliative care specialist.

How to prescribe a syringe driver for end of life care

Banksia Palliative Care Service

- Can't swallow.
- Better drug delivery.
- Easy for family.
- Bypass gut / liver.
- Multiple drugs at once.

- Eve on 60mg bd of MS contin daily.
- John on 36 mcg fentanyl patch.

- Range to facilitate titration.
- A reasonable reason to call a palliative care specialist.

Opioid prescribing for community palliative care patients

Banksia Palliative Care Service

- The GP continues to be the primary prescriber (thank you)

- Situations
  1. Acute symptom management.
  2. Anticipatory medication.
  3. End of life care support.
  4. Ongoing prescribing of patient's regular opioids.

Ongoing prescribing

Banksia Palliative Care Service

- GP is the primary prescriber.
- You **DO NOT NEED A PERMIT** to prescribe opioids for any patient receiving palliative care.
- Current PBS rules allow one months supply of medication with a call to the PBS number or authority via PRODA.

ie:

OxyContin 10mg bd Endone 5 mg PRN (taking 3 Endone daily).

- This patient can have 56 tablets of OxyContin and 60 tablets of Endone prescribed each month.

Ongoing prescribing

Banksia Palliative Care Service

- Patients worry about ongoing supply of medication
  - being perceived as drug seeking.
  - medication running out.
  - Most patients when they reach the community palliative care involvement stage have limited mobility and can't get to the doctor (telehealth/home visits)
  - We ask patients to make a 3 weekly appointments with GP to have medications prescribed for the following month.
  - GP's are busy
- Limitations from GP perspective
  - Time
  - Remuneration
  - Others

Opioid prescribing

- Safescript – can check safescript to get a record of opioids dispensed to patient.
- If terminal best to do one week and repeats so that families don't end up with lots of medication.
- The palliative care section on PBS has streamlined authorities for increased quantities of some drugs
  - Oral IR: morphine liquid, hydromorphone liquid.
  - Injectable: morphine, hydromorphone.
  - PBS screen share.

Mark

Banksia Palliative Care Service

Mark is a 78year old man with lung cancer, who is known to have bone and liver metastases. His wife, Sharon, calls for a telehealth appointment as he has developed moderate lower back pain. It is localized to the spine with no radiation; his motor and sphincter function is intact. Renal function (from last bloods) is within normal limits; imaging shows uncomplicated bone metastases.

- He has been taking paracetamol for the last 4 days with little effect.
- He has been taking Endone 5mg he had left over in the home –he finds this works but the pain comes back quickly.
- He had to take 3 tablets yesterday.
- He doesn't want to go into hospital
- What are you going to do?

Which slow release would you choose?

Banksia Palliative Care Service

1. Start Oxycodone MR (Targin) 5/2.5mg BD.
2. Start a Fentanyl patch 12mcg/hr.
3. Start MS Contin 15mg BD.
4. Other?

ORAL MORPHINE TO OTHER ORAL OPIOIDS			
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75	180	30
100	240	40

Mark’s breakthrough dose

Banksia Palliative Care Service

Mark was commenced on Targin 5/2.5mg BD by his GP.

- What breakthrough opioid do you think we would suggest?

1. Endone 2.5mg PO TDS PRN.
2. Sevredol 5 mg oral PRN.
3. Endone 5-10mg PO 1/24 PRN.
4. Endone 2.5-5mg PO PRN.

Mark

Over the next weeks, Mark's Targin dose is increased to 30/15 bd

- What is an appropriate oral BT dose?
- What is an appropriate SC anticipatory dose?
- Nurse thinks Mark has deteriorated and wants a syringe driver prescribed in case this is needed over the weekend.

Mark

Over the next weeks, Mark's Targin dose is increased to 30/15 bd.

- What is an appropriate oral BT dose?
  - 60mg OxyContin , 1/6, 10mg Endone.
- What is an appropriate SC anticipatory dose?
  - 10mg Endone, 15 mg morpine, 5 mg s/c PRN.
- Nurse thinks Mark has deteriorated and wants a syringe driver prescribed in case this is needed over the weekend.
  - 60mg oral OxyContin, 90mg oral morphine.
  - 30mg s/c morphine over 24 hours (90/3).
  - 30-50 mg over 24 hours.

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Palliative Care Service

Conducting essential conversations with palliative patients and their carers

Dr Chien-Che Lin
Specialist Palliative Medicine Consultant, Banksia Palliative Care

Amanda Petricola
Clinical Service Lead, Banksia Palliative Care

Topics to Cover

Banksia Palliative Care Service

- Disease Trajectory and Care (Limitation of Medical Treatments)
- Informed Consent in Palliative Care
- Palliative Care and Human Rights
- Terminal Phase Changes
- Advance Care Planning
- Wish to Hasten Death

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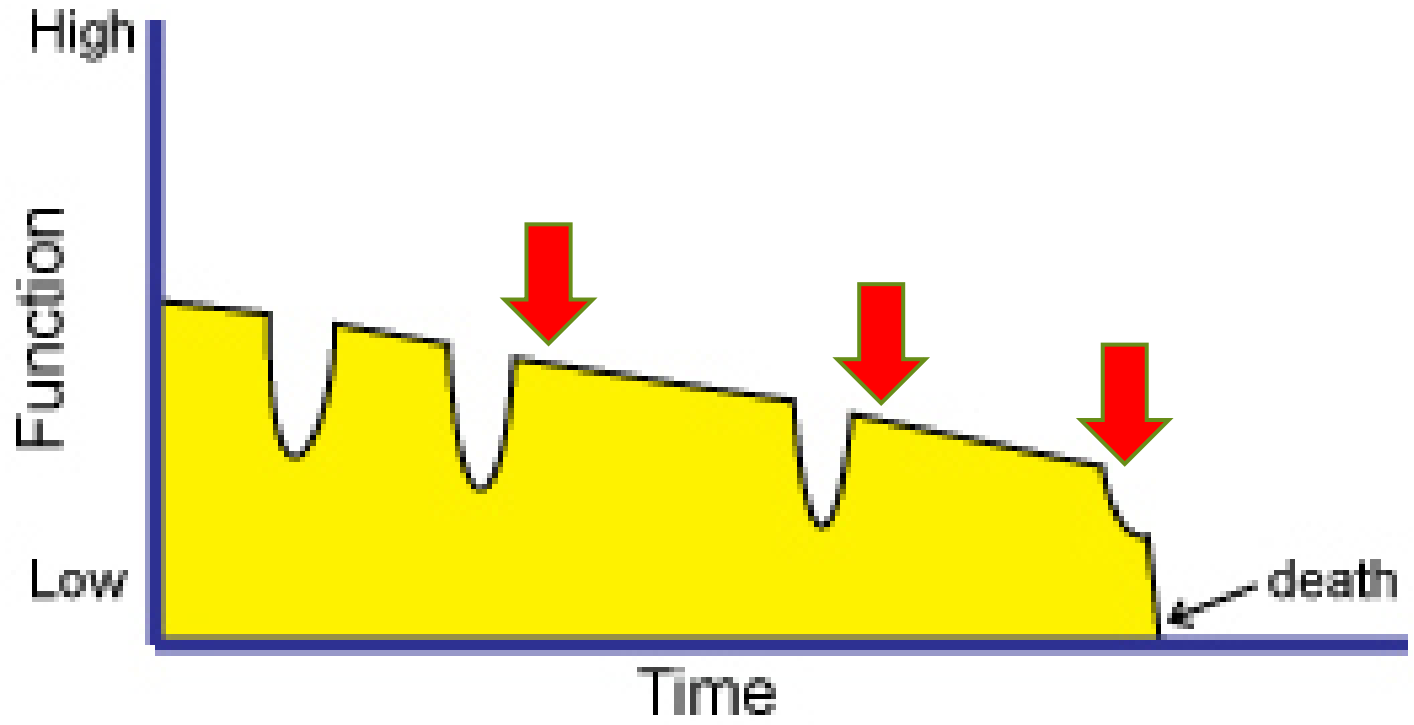
Palliative Care Service

"Cardio-Pulmonary Resuscitation is a treatment for cardiac and respiratory arrest, not a treatment for dying"

-Neurologist's comment

Disease Trajectory and Care

Banksia Palliative Care Service



Disease Trajectory and Care

Banksia Palliative Care Service

- Limitation of Medical Treatment
  - People living with frailty and/or significant comorbidity have an increasing risk that treatments will not achieve the **desired outcome**:
    - Some **won't work**,
    - Some are **unacceptably burdensome** to the person and,
    - Some **won't enable** recovery to an **acceptable lifestyle** to the person.

Disease Trajectory and Care

Banksia Palliative Care Service

- Limitation of Medical Treatment
  - Health professionals should **not** offer or continue treatment(s) that's **non-beneficial** to the patient
  - Health professionals should always do everything to ensure people's **symptoms** are managed and **care needs** are met
  - Limitation of non-beneficial medical treatments allows treating teams to focus on **right care**, at the **right time**, in the **right place** for the person

Disease Trajectory and Care

Banksia Palliative Care Service

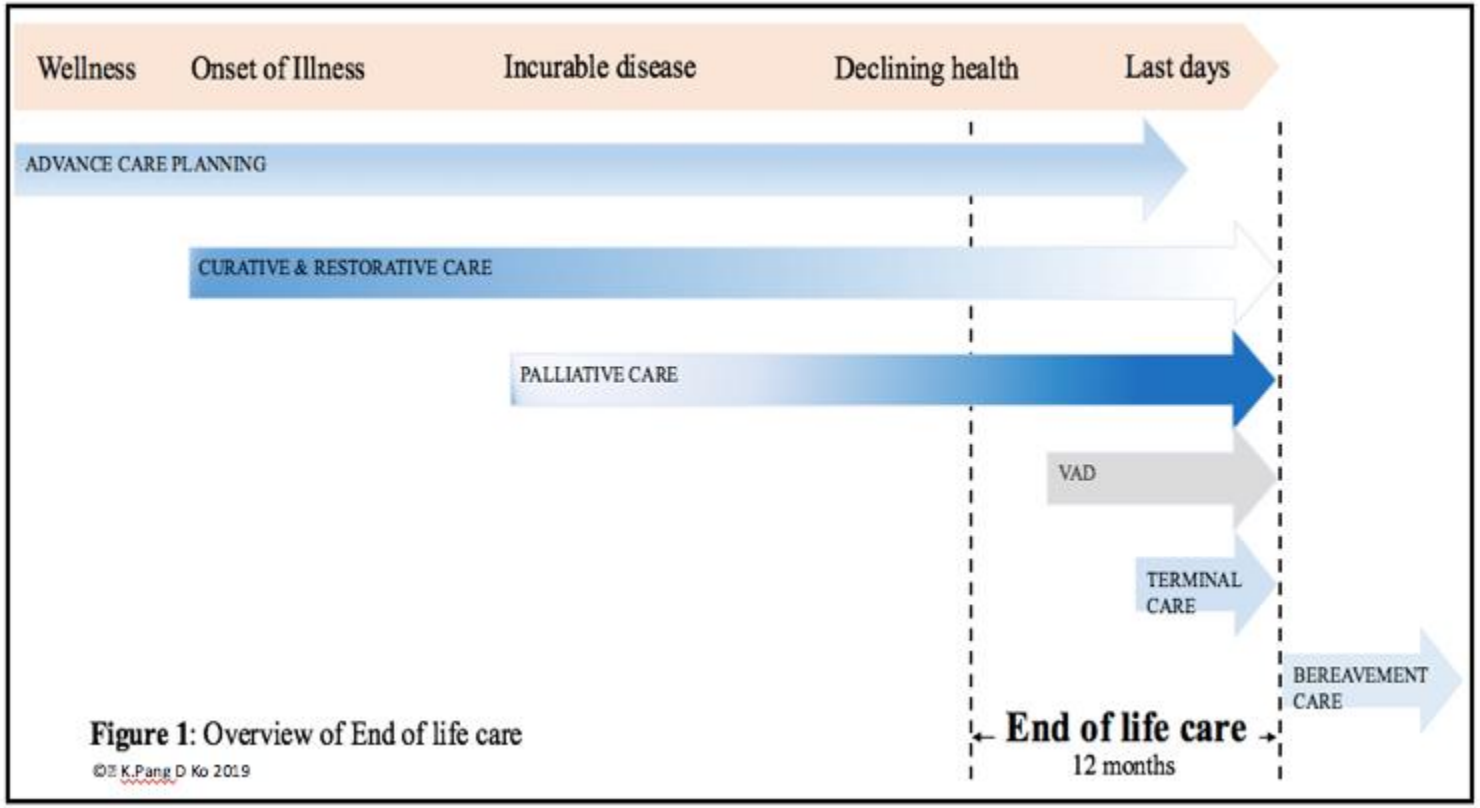


Figure 1: Overview of End of life care

Disease Trajectory and Care

Banksia Palliative Care Service

- “We want everything done!”
- “There must be more treatment that he can have.”
- “Should he not be in the hospital for antibiotics and IV drip?”
- “Can’t we at least give subcut fluids?”

Disease Trajectory and Care

Banksia Palliative Care Service

- Limitation of Medical Treatments
  - Not Starting
  - Stopping Preventive Treatments (of new diseases / complications)
  - Stopping Maintenance Treatments
  - Setting limits on Trials of Treatments – shared decision making re. treatment burden, direct efficacy and overall benefit / Goals of Care

- Better Health Channel (DHS Victoria)
  - You have the right to ask a doctor for a second opinion if you are unsure about your doctor's suggested medical treatment or a diagnosis

End of Life Care Conversations

Banksia Palliative Care Service

Encourage people to talk about their wishes for End of Life Care with family and loved ones.

Encourage people to document their choices of care and initiate a conversation with their health professional(s).

Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

Health providers need to initiate honest, timely and culturally-sensitive conversations with patients so they are a routine part of healthcare delivery.

(Bartel, 2016)

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How to discuss prognosis and end-of-life issues

Banksia Palliative Care Service

For communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers.

Josephine M Clayton, Karen M Hancock, Phyllis N Butow, Martin H N Tattersall and David C Currow., Med J Aust 2007; 186 (12): 77.

https://www.mja.com.au/journal/2007/186/12/clinical-practice-guidelines-communicating-prognosis-and-end-life-issues-adults

How to discuss prognosis and end-of-life issues.

End-of-Life Directions in Aged Care.

https://www.endoflifeessentials.com.au/Portals/14/document/resources/MJA-4-How-to-discuss-prognosis.pdf

Advance Care Planning

Banksia Palliative Care Service

- A 2017 Australian study assessed how many people aged 65 years or over had at least one advance directive on file
  - 48% in residential care
  - 16% in hospitals
  - 3% in general practices
- Less than 3% had a statutory advance directive outlining preferences for care

Advance Care Planning

Banksia Palliative Care Service

- Substitute Decision Maker
  - Medical Power of Attorney or Medical Treatment Decision Maker
  - Formalised or default appointment

- Advance Care Directive
  - Instructional Directive or Refusal of Medical Treatment Certificate
  - Values Directive
  - Informal wishes expressed to MPOA/MTDM

Advance Care Planning

Banksia Palliative Care Service

- A health practitioner is not permitted to administer medical treatment or a medical research procedure to a person… if the practitioner is aware that the person has refused the particular medical treatment or procedure, whether by way of an instructional directive or a legally valid and informed refusal of treatment by or under another form of informed consent

Informed Consent in Palliative Care

Banksia Palliative Care Service

- “Please don’t tell my dad that he has cancer.”
- “Don’t tell my mother you are from palliative care.”

Informed consent in Palliative Care

Banksia Palliative Care Service

DHS Victoria

- A person has the right to refuse medical treatment in most circumstances
- The medical practitioner must usually seek the person's consent prior to carrying out medical treatment
- A person's capacity to consent is assumed unless there are indications otherwise

Medical Treatment Planning and Decision Making Act 2016

- A health practitioner may administer palliative care to any person who does not have decision-making capacity for that care despite any decision of the person's medical treatment decision maker, but in making a decision to administer that care must:
  - A. have regard to any preferences and values of the person, whether expressed by ways of a values directive or otherwise
  - B. consult with the person's medical treatment decision makes (if any).

Palliative Care and Human Rights

- “You’re just starving / dehydrating him to death.”
- “You are killing him with morphine.”

Palliative Care and Human Rights

Banksia Palliative Care Service

- Palliative Care in context of Human Right
  - Palliative care is explicitly recognised under the human right to health (WHO)
  - …a standard of living adequate for the health and well-being… including food, clothing, housing and medical care and necessary social services (UN)
- Human right in Palliative Care context
  - Offer of food, water, clothing and shelter
  - Hygiene and skin care
  - Pain relief, other medications for distress

Palliative Care and Human Rights

Banksia Palliative Care Service

- Medical Treatment Planning and Decision Making Act 2016
  - A health practitioner may administer medical treatment… to a person without consent… if the practitioner believes on reasonable grounds that the medical treatment… is necessary, as a matter of urgency to –
    - (a) save the person's life
    - (b) prevent serious damage to the person's health
    - (c) prevent the person from suffering or continuing to suffer significant pain or distress

Terminal Phase Changes

- “S/he is drowning / choking / suffocating (in secretions)”
- “S/he keeps calling out and getting out of bed, s/he must be in so much pain”
- “Do we have to reposition her/him? Every time we do s/he calls out in pain… we’re giving too much morphine just so we can move her/him”

Terminal Phase Changes

Banksia Palliative Care Service

- Reassurance – everything is distressing for the grieving family
- Delirium is common, many can have agitation / hallucinations and sedatives are more effective and safer than opioids - pain is often restrictive or triggered by movement, agitation adds to restlessness
- Respiratory changes secondary to loss of consciousness are not distressing to the person – like snoring
- Cool peripheries is from reduced perfusion and not directly related to feeling cold
- Unconscious people loses the sense of time – it may seem long or short to bystanders but not to the person
- Skin care is important and pre-care analgesia / sedatives are important to enable comfortable care routine and prevent pressure injuries adding to distress

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"Why do you need doctors for palliative care? Don't you just give them more Mortein?"

-real patient remark

Wish to Hasten Death

- “This is not life. This is just suffering! You wouldn’t do this to a dog.””
- “Can’t you make this end sooner?”
- “I just want dad sleeping and not wake up.”
- “Can he have more morphine?”
- “You need to give more morphine. He needs morphine!”

Wish to Hasten Death

- Opioids and benzodiazepines are NOT reliable lethal agents
- Common
- Sporadic vs persistent
- European Association of Palliative Care
  - Wish to Hasten Death is a manifestation of Desire to Die (and not the same)
  - A reaction to suffering, in the context of a life-threatening condition, from which the patient can see no way out other than to accelerate his or her death
  - Must be distinguished from the acceptance of impending death or from a wish to die naturally, although preferably soon

Wish to Hasten Death

- WHO
  - (Palliative Care) intends neither to hasten nor postpone death

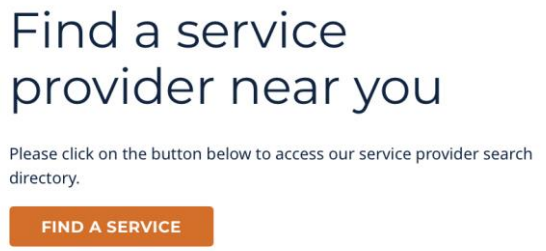
- Banksia Palliative Care Service Inc. (Banksia)
  - Banksia staff and volunteers will not participate in the access or administration of Voluntary Assisted Dying medications or treatments, and will maintain all boundaries as permitted and defined by law, the scope of their professional practise, organisational policies and this statement. Banksia will support all of our clients and continue to provide Palliative Care services until the care is no longer requested or required.

Community Palliative Care Services

- NWMPHN website

- Palliative Care Victoria service finder

→



Refer to community palliative care

Banksia Palliative Care Service

- **Banksia Palliative Care Service** is a not-for-profit Community Palliative Care Service in the north east suburbs of Melbourne, encompassing the 3 local government areas of Banyule, Nillumbik and Whittlesea.

- Telephone: 03 9455 0822
- www.banksiapalliative.com.au

Refer to community palliative care

Banksia Palliative Care Service

mcm melbourne city mission
your future, your way

- **Melbourne City Mission** - MCM provides expert in-home palliative care services 7 days a week in the cities of Hume, Merri-bek, Darebin and Yarra.
- Telephone: 03 9977 0026
- https://www.mcm.org.au/services/palliative-care/i-need-palliative-care

Refer to community palliative care

Banksia Palliative Care Service

Mercy Health

- Mercy Palliative Care is a community-based palliative care service offering support in the North and West Metropolitan Region of Melbourne who cover seven municipalities including: Brimbank, Maribyrnong, Melbourne, Melton, Moonee Valley, Hobsons Bay and Wyndham.

- Telephone: 1300 369 019

- https://health-services.mercyhealth.com.au/our-health-services/mercy-palliative-care/?_gl=1*1co16q0*_ga*NTQ4NTE3OTkwLjE2OTE5OTIwMjE.*_ga_MC8HS4VLW9*MTY5MTk5MjAyMC4xLjAuMTY5MTk5MjAyMC42MC4wLjA.

HealthPathways – Palliative Care

Palliative Care Pathways, Resources and Referral pages

General Palliative Care guidance and assessment

Palliative Care Overview
New Palliative Care Patient
GP Palliative Care Resources
Palliative Care Advice
Acute Palliative Care Assessment (Same-day)
Caring for a Dying Patient at Home
Caring for a Dying Patient in a RACF
Carer Stress and Wellbeing

Local community palliative care provider

Specialist Palliative Care Services (SPCS)
Palliative Care Services Referrals
Home and Community Support for Older Adults
Carer Resources and Support Services

Palliative care medications

Pain Management in Palliative Care
Pain Medications in Palliative Care
Syringe Drivers
in Older Adults
Terminal Phase Management
Subcutaneous Fluid Administration in Palliative Care
Deprescribing and Dose Administration Aids
Medication Management and Polypharmacy

Essential conversations

Advance Care Planning (ACP)
ACP Advice and Assistance
ACP Documents and Forms
ACP Important Terms and Explanations
Terminal Phase Management
Caring for a Dying Patient at Home
Bereavement, Grief, and Loss
Bereavement, Grief and Loss Resources and Support Services
After Hours Services.

Palliative care Pathways, Resources and Referral pages

Symptom Control in Palliative Care

Anxiety, Distress, and Agitation in Palliative Care
Cachexia and Anorexia in Palliative Care
Constipation in Palliative Care
Corticosteroid Use in Palliative Care
Cough in Palliative Care
Diabetes in Palliative Care
Dyspnoea in Palliative Care
Excessive or Retained Airways Secretions
Hiccups in Palliative Care
Nausea and Vomiting in Palliative Care
Oral Care in Palliative Care
Pruritus (Itch) in Palliative Care
Sleep Disturbances in Palliative Care
Sweating in Palliative Care
Weakness and Fatigue in Palliative Care

Emergencies in Palliative Care

Bowel Obstruction in Palliative Care
Delirium and Terminal Restlessness in Palliative Care
Hypercalcaemia of Malignancy
Malignant Spinal Cord Compression
Raised Intracranial Pressure in Palliative Care
Seizure Management in Palliative Care
Superior Vena Cava Obstruction (SVCO) in Palliative Care
Terminal Haemorrhage in Palliative Care

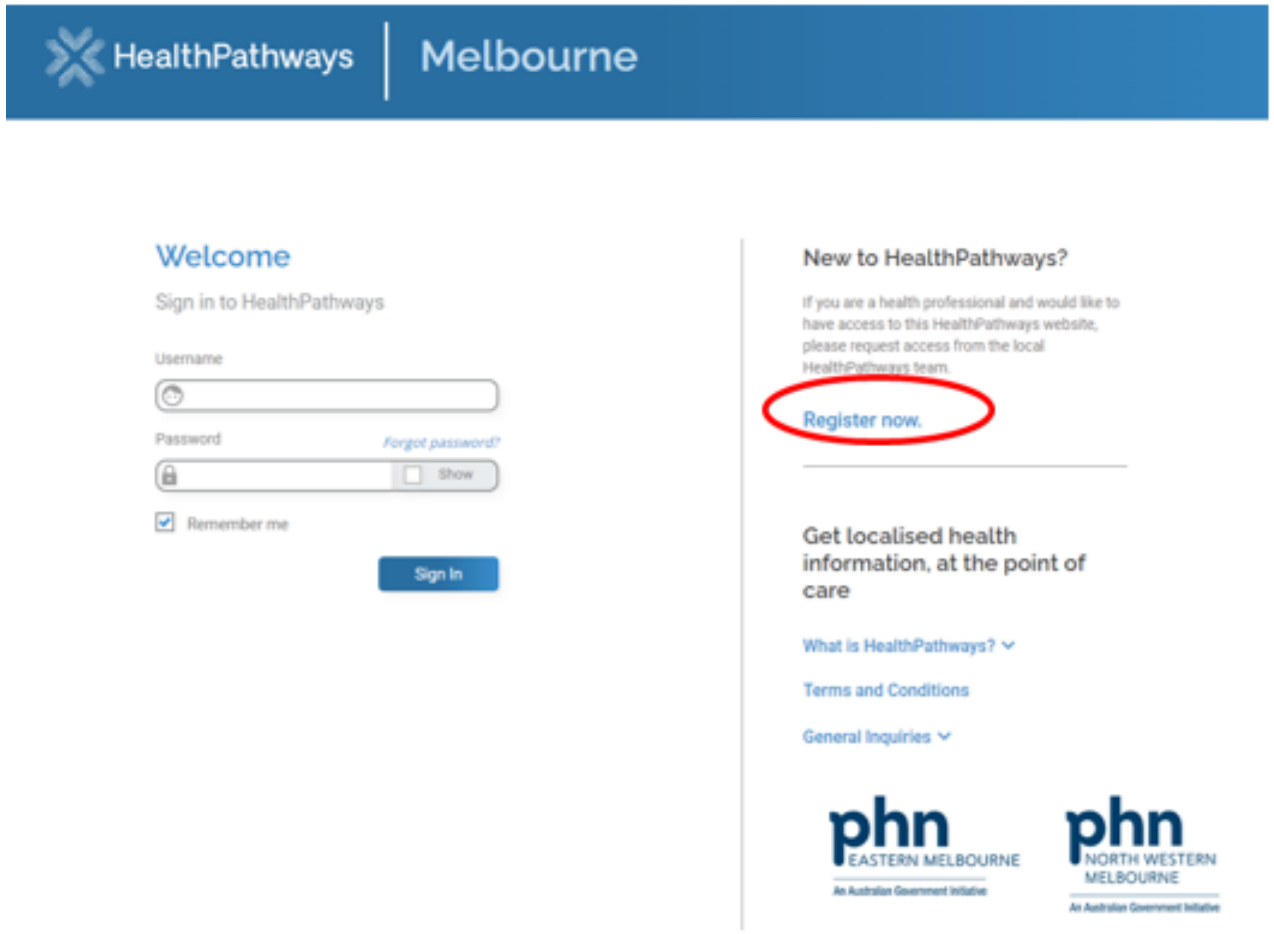
Palliative Care Services Referrals

Acute Palliative Care Assessment (Same-day)
Specialist Palliative Care Services (SPCS)
Palliative Care Advice

Resources:

GP Palliative Care Resources
Palliative Care Overview
Medicines Information and Resources
SafeScript

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



Register via QR code

info@healthpathwaysmelbourne.org.au

Any Questions?

Banksia
Palliative Care Service

Conclusion and resources

You will receive a post-session email, which will include slides and resources discussed during this session.

Attendance certificates will be sent in 4-6 weeks

RACGP CPD hours will be uploaded within 30 days

This session was recorded and will be ready to view within a week.

Visit nwmphn.org.au/resources-events/resources/

To register for Banksia Palliative Care's more in-depth GP webinar series, delivered in collaboration with Eastern Melbourne PHN, visit banksiapalliative.com.au/education-for-gps

We value your feedback! Please scan this QR code to complete the survey.

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References

- Bartel, R. (2016) Conversations: Creating Choice in End of Life Care. Melbourne: Australian Centre for Health Research. Retrieved from http://apo.org.au/sites/default/files/resource-files/2016/03/apo-nid62025-1226536.pdf

- Clayton, J.M., Hancock, K.M. Butow, P.N, Tattersall, M.H.N and Currow, D.C. (2007). Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers, Medical Journal Australia, 186 (12): 77.

- Grimm, K.T. (2013). The Conversation. Retrieved from http://www.palliativeinstitute.com/files/6314/0206/5542/The_Conversation_-_PCI.pdf

- https://www.reference.com/world-view/effective-communication-28822756433c3f67

References

- Lim, R. & Dunn, S. Chapter 2: Journeys to the Centre of Empathy: The Authentic Core of Communication Skills. In Kissaine, D.W., Bultz, B.D, Butow, P.N., Bylund, C.L., Noble, S. & Wilkinson, S (Eds), Oxford Textbook of Communication in Oncology and Palliative Care (pp.10-15).
- Roberts, A. (2017). Chapter 30: Communication in the Last Days or Hours of Life. In Kissaine, D.W., Bultz, B.D, Butow, P.N., Bylund, C.L., Noble, S. & Wilkinson, S (Eds), Oxford Textbook of Communication in Oncology and Palliative Care (pp.193-199).
- Therapeutic Guidelines Limited, Palliative Care Expert Group, Edition 4 2016
- Upchieve.org (2022) https://upchieve.org/blog/what-is-active-listening
- Vital Talk. (2018). Discussing Prognosis. https://www.vitaltalk.org/guides/discussing-prognosis/