HammondCare
An independent Christian charity

HammondCare Palliative Care

End of life resource booklet

www.hammondcare.com.au

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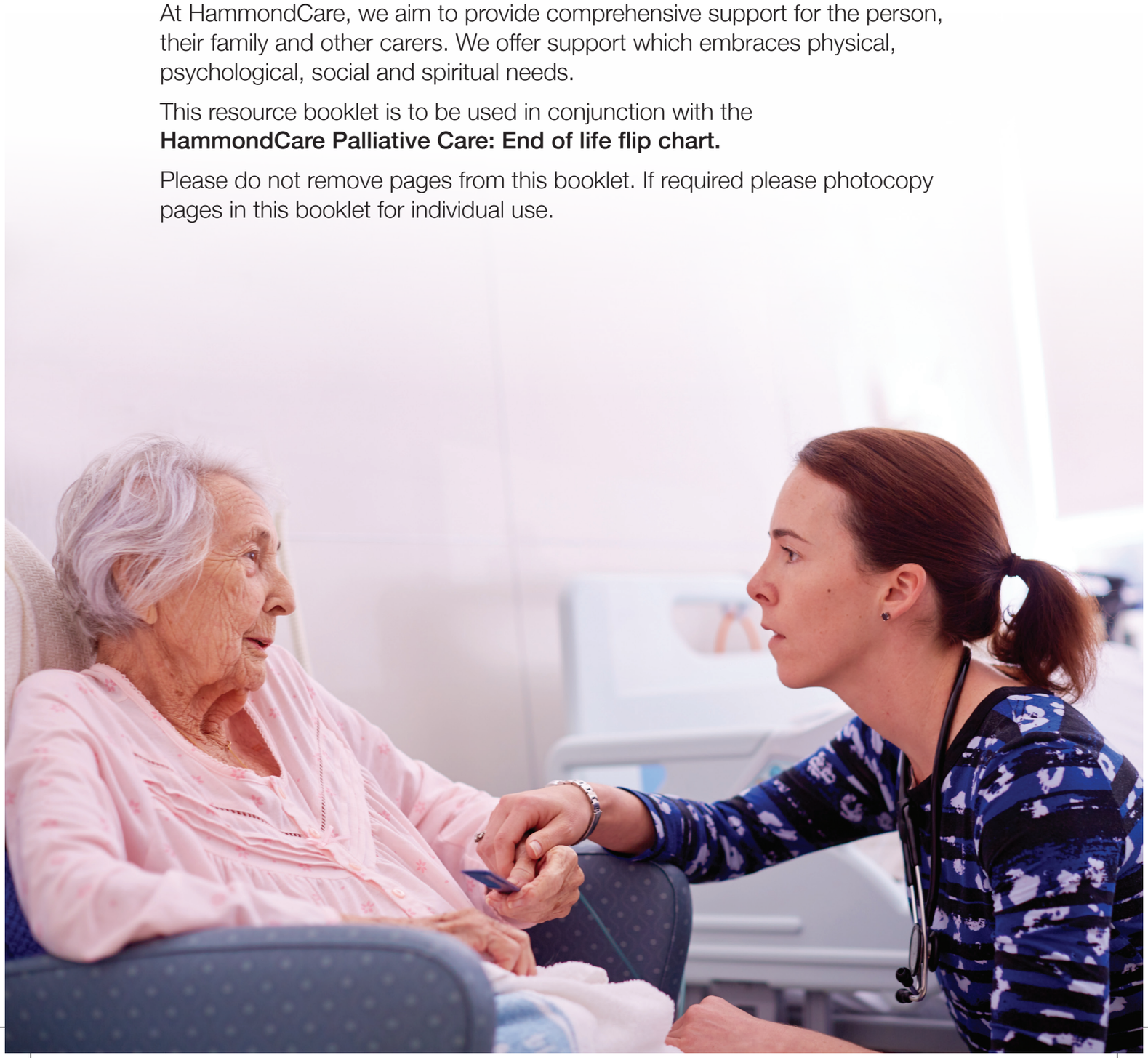
Palliative care aims to make people as comfortable and symptom-free as possible during the course of a progressive life-limiting illness.

At HammondCare, we aim to provide comprehensive support for the person, their family and other carers. We offer support which embraces physical, psychological, social and spiritual needs.

This resource booklet is to be used in conjunction with the **HammondCare Palliative Care: End of life flip chart.**

Please do not remove pages from this booklet. If required please photocopy pages in this booklet for individual use.



Contents

The Surprise Question

Ask yourself: Would you be surprised if the patient were to die in the next 6 months?

This question ‘has been used to identify patients at high risk of death who might benefit from palliative care services’

An intuitive question including co-morbidity, social and other factors.

What measures might be taken to improve their quality of life now and in preparation for the dying stage?

The Surprise Question can be applied as a trigger to ensure the appropriate actions enable the right thing to happen at the right time.

Fundamental Aspects of Palliative Care Nursing 2nd Edition: An Evidence ...
By Robert Becker

https://books.google.com.au/books?id=LkH0CgAAQBAJ&pg=PT61&lpg=PT61&dq=the+surprise+question+an+intuitive+question+integrating&source=bl&ots=ltptP-_Jun&sig=crJbkbuwv3Q_KxQBdYw0fmlXcPA&hl=en&sa=X&ved=0ahUKEwi9n4zb-unYAhULo5QKHe_YAXYQ6AEIPjAD#v=onepage&q=the%20surprise%20question%20an%20intuitive%20question%20integrating&f=false

SPICT Tool

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

- Functional ability deteriorating due to progressive cancer.
- Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

- Unable to dress, walk or eat without help.
- Eating and drinking less; difficulty with swallowing.
- Urinary and faecal incontinence.
- Not able to communicate by speaking; little social interaction.
- Frequent falls; fractured femur.
- Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.
- Recurrent aspiration pneumonia; breathless or respiratory failure.
- Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

- Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.
- Severe, inoperable peripheral vascular disease.

Respiratory disease

- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.
- Persistent hypoxia needing long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life limiting conditions or treatments.
- Stopping or not starting dialysis.

Liver disease

- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is not possible.

Other conditions

- Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2017

Palliative Care Referral Form

HammondCare

SPECIALIST PALLIATIVE & SUPPORTIVE CARE SERVICE
REFERRAL FORM NORTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
DOB	M.O
ADDRESS	
LOCATION/ WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Referral to : ☐ **PALLIATIVE CARE INPATIENT UNIT** ☐ **COMMUNITY PALLIATIVE CARE SERVICE**

ATTENTION: ☐ **Dr Bridget Johnson (Greenwich)** ☐ **Dr Sarah Thompson (Neringah)**
☐ **Dr Phil Macauley (Northern Beaches)**

Referrer`s Name : _____

Referrer's contact no: _____

Referral`s Facility: _____

On behalf of Dr: _____

Dr`s Provider no: _____

GP name (if not referring doctor): _____

Practice name: _____

GP Phone no: _____

Is GP aware of referral? ☐ Yes ☐ No

Patient location: _____

Consent to referral? ☐ Patient ☐ Family

Person responsible: _____

Relationship: _____ Phone no: _____

Name of palliative care consultant: _____

Medicare no: _____

Health fund name: _____ No: _____

Language: _____ Lives alone? ☐ Yes ☐ No

Interpreter needed? ☐ Yes ☐ No

Reason for referral (select one or more if appicable):
☐ Symptom control ☐ Terminal care ☐ Psychosocial support ☐ Supportive care

Diagnosis and treatment (previous & current):

Medical history:

NSW Health Resuscitation Plan completed? (Please attach to this form) ☐ Yes ☐ No

Relevant additional documents not available on eMR attached ☐ Yes ☐ No ☐ N/A

Infection status and location:

Special instructions (tracheostomy, wound care, CVADs, PEG, modified diet needs):

Falls risk / behavioural concerns:

☐ Functional status: ☐ Independent ☐ Partial assist ☐ Full assist

Skin integrity: Waterlow score:

Patient and family concerns: _____

Understanding of disease: _____

Goals of care: _____

Spiritual / cultural needs : _____

Referring doctor's signature:

Date:

PLEASE FAX COMPLETED REFERRAL TO:

Greenwich Hospital Inpatient Unit Ph: 9903 8227 Fax: 9903 8100

Neringah Hospital Inpatient Unit Ph: 9488 2200 Fax: 9487 1599

Palliative Care Community North : Ph: 1800 427 255 Fax: 9903 8265

(For urgent referrals please phone the relevant number above)

Rev: January 2018

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CR 11.1

Palliative Care Equipment Stock List

PRN or 4/24 S/C medication administration

1	Gloves		
2	BD Sat – T – intima	24GA 0.75in	Ref: 383313 .07x19mm
3	N/saline ampules 10 mls		
4	Water for injection ampules 10 mls		
5	Alco Wipes		
6	Tegaderm HP (3M Healthcare)	2 3/8 in x ¾ 6cm x 7cm	Ref: 9354HP
7	Normal saline 0.9% injection 10mls		
8	Drawing up needle (Without bevel)	18g ½ 12mm x 38mm	Ref: 300204
9	BD 5ml Syringe (Leur Lock)		Ref: 302135
10	BD 1ml Syringe (Leur Lock)		Ref: 309628
11	BD 3ml Syringe (Leur Lock Tip)		Ref: 302113

For Syringe Drivers

1	BD Plastipak 20 mls (Leur Lock)		Ref: 300629
2	Extension set Microbore 150 cm	MPriming Volume 12mls	Ref: 503.07
3	Smart site needle free valve	Care Fusion 11717232 Alaris Products	Ref: 2000E
4	'For Subcutaneous Use Only'	Red tablets	Labels for Syringe Drivers Information

Pressure area Protection and use in Pressure Injury

1	Mepilex with safetac technology	10 x 10cm 4x4 Molnycke Health Care	Ref: 73107911033107
2	Mepilex border	7.5cm x 7.5cm	Ref: 1637361
3	Mepilex border	10cm x 10cm	Ref: 1637370

Palliative Care Hygiene Stock List

1. Bicarbonate impregnated mouth swabs
2. Lip balm
3. Oral balance gel
4. Aqua mouth spray
5. Sorbolene cream
6. Sudocream
7. Dermalux soft towel lotion
8. Shampoo hair cap
9. Essential / aromatherapy oils
10. Ozone electric air diffuser
11. Oxygen ear protector
12. OT combine/bandages (to make ear protection)
13. Nozoil nasal drops
14. Fess nasal spray
15. Zeoz105 Bag of Rocks (odour control rocks)
16. Lubricating eye drops such as polytears
17. Extra pillows
18. CD player and the person's favourite music

Northern Sydney Services Available to Assist with Care in the Home

Quick links to Northern Sydney Services

Service	Phone
Acute Post-Acute Service (APAC)	**1300 732 503** (7days, 7am-10pm)
After Hours National Home Doctor Service	**137 425** (7days, 6pm-8am)
Community Palliative Care Service	**1800 427 255** (24hrs/7 days)
Dementia Support Australia (DSA)	**1800 699 799** (24hrs/7 days)
Mobile X-ray	**9998 0268** (Mon-Fri business hours)
Motor Neuron Disease Association CNC	**0408 803 789** (Mon-Fri business hours)
NSW Ambulance (Extended Care Paramedics)	**131 233** (24hrs/7 days)
Specialist Mental Health Services for Older People (SMHSOP)	**1800 011 511** (24hrs/7 days)

Aged Care Rapid Response Teams	
Service	**Phone**
GRACE Upper North Shore	**0434 183 549** (Mon-Fri 8am-10pm)
BRACE Northern Beaches	**0491 211 013** (Mon-Fri business hours)
Registrar's number	**0491 222 748** (Mon-Fri business hours)
AART Lower North Shore	**0408 546 907** (Mon-Fri business hours)
Ryde	**0409 460 419** (Mon-Fri business hours)
Registrar's number	**0434 329 970** (Mon-Fri business hours)

ISBAR Communication Tool

ISBAR Clinical Handover

Introduction

- Introduce yourself, your role and location
- Identify team leader
- Clearly identify patient and family and carer if present

Situation

- State the immediate clinical situation
- State particular issues, concerns or risks
- Identify risks – deteriorating patient, falls risk, allergies, limitations to resuscitation

Background

- Provide relevant clinical history referring to medical record and/or eMR

Assessment

- Work through A-G physical assessment
- Refer to observations, medication and other patient charts
- Summarise current risk management strategies
- Have observations breached CERS criteria?

Recommendation

- Recommendations for the shift
- Refer to medical record or eMR
- What further assessments and actions are required by who and when
- State expected frequency of observations
- Request that receiver read back important actions required

ISBAR Clinical Deterioration

Introduction

- Introduce yourself, your role and location
- Identify the patient

Situation

- State the immediate clinical situation

Background

- Provide relevant clinical history and background
- Presenting problems and clinical history

Assessment

- Work through A-G physical assessment
- What clinical observations are of particular concern?
- What do you think the problem is?
- Remember to have current observations and information ready!

Recommendation

- What do you want the person you have called to do?
- What have you done?
- Be clear about what you are requesting and the timeframe
- Repeat to confirm what you have heard

Please refer to the ARRT Team Flip Chart for more information

Abbey Pain Scale

Addressograph

Abbey Pain Scale
For measurement of pain in patients who cannot verbalise.

Name and designation of person completing the scale: ……..

Date: ……Time: ……

How to use scale: While observing the patient, score questions 1 to 6

Q1. Vocalisation **Q1**
eg. whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression **Q2**
eg: looking tense, frowning grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language **Q3**
eg: fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural Change **Q4**
eg: increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change **Q5**
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes **Q6**
eg: skin tears, pressure areas, arthritis, contractures, previous injuries.
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 - 6 and record here → **Total Pain Score**

Now tick the box that matches the Total Pain Score

0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe

Finally, tick the box which matches the type of pain

Chronic	Acute	Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002
(This document may be reproduced with this acknowledgement retained)

Palliative Care End of Life Medications – Initial Suggested Doses

PAIN / SHORTNESS OF BREATH

a) If not an opioid: Morphine 2.5mg s/c q4-6/24 regularly
plus Morphine 2.5mg s/c q 2/24 prn (Max 6 doses per 24hrs)

b) If on an opioid: Convert regular oral opioid to s/c morphine q4/24
plus 1/6th total daily dose s/c q 2/24 prn (Max 6 doses per 24hrs)
Please refer to the Drug Conversion Guide

(For impaired Renal Function: suggest charting S/C Hydromorphone 0.5mg instead of S/C Morphine 2.5mg PRN max 6 doses per 24hrs) Please refer to the Opioid Conversion Guide on page 10.

NAUSEA & VOMITING

Metoclopramide 10 mg s/c QID regularly
(if nausea present) or prn (if no nausea)

Or

Haloperidol 0.5-1.0 mg s/c prn tds

TERMINAL DEIRIUM / RESTLESSNESS / AGITITATION

Haloperidol 1mg s/c q2/24 prn
(Max 10 mg per 24hrs)

And/or

Midazolam 2.5mg s/c q2/24 prn
(more sedating – max 15mg per 24hrs)

ANXIETY

Lorazepam 0.5 mg sublingual tds prn

Or

Clonazepam sublingual drops 0.25-0.5mg bd prn

CONSTIPATION

High Enema daily

TERMINAL SECRETATIONS

Reposition patient to help drain secretions

MOUTHCARE

Regular q4/24 Sodium Bicarbonate mouth swabs, Oral Balance gel and lip balm

DRY EYES

Lubricating eye drops BD

CRISIS ORDERS

a) Seizure prophylaxis
Clonazepam 1 mg s/c or sublingual bd

b) Acute Seizure
Midazolam 5 mg s/c repeated at 5 min. intervals if seizure persists

c) Risk major airway obstruction or major bleed
Write order as CRISIS ORDER for severe respiratory distress or major bleeding

Midazolam 10 mg s/c stat prn
Plus
Morphine 10 mg s/c stat prn
} Can repeat every 10 mins

Or

If already on opioid, double q4/24 s/c morphine dose

From draft Northern Sydney End of Life Care Pathway – Guidelines for Symptom Management

Other useful refs: Woodruff, Roger: Cancer pain 4th Ed 2007: Symptom Control in Advanced Cancer 2nd Ed 2002

http://www.pbs.gov.au/browse/palliative-care

Therapeutic Guidelines – Palliative Care

Opioid Conversion Chart

Conversion factors are a guide only. Patients should be treated individually.
Patients on opioids require regular laxatives (eg Coloxyl with Senna)

Converting from Morphine to other Opioids and vice versa			
Drug	**Oral**	**Subcut**	**Equi-analgesic conversion to oral Morphine**
Morphine	10mg	5mg	
Hydromorphone	2mg	1mg	Multiply by 5
Codeine	100mg	Avoid	Divide by 10
NOTE: 1 tablet Panadeine Forte = 30mg + Codeine + 500mg Paracetamol 1 tablet Panadeine = 8mg Codeine + 500mg Paracetamol Doses of Codeine over 60mg every 4-6 hours are not recommended			
Oxycodone	7mg	3.5mg	Multiply by 1.5
Tramadol	100mg	Avoid	Divide by 10
Methadone	Variable		Discuss with consultant

Converting from transdermal Buprenorphine and transdermal Fentanyl to Morphine			
	Patch size	**Hourly rate**	**Conservative conversion to oral Morphine**
Buprenorphine (Norspan) change weekly	5mg	5 mcg/hr	12mg/day
	10mg	10 mcg/hr	24mg/day
	20mg	20 mcg/hr	48 mg/day
Fentanyl (Durogesic) change every 72 hrs	2.1mg	12mcg/hr	30mg/day
	4.2mg	25 mcg/hr	60mg/day
	8.4mg	50mcg/hr	120mg/day
	12.6mg	75 mcg/hr	180mg/day
	16.8mg	100 mcg/hr	240mg/day

Due to the possibility of poor transdermal absorption in palliative care patients, conversion from transdermal Buprenorphine (Norspan) or Fentanyl (Durogesic) to Morphine should be **very conservative**

HammondCare Palliative & Supportive Care Service Opioid Conversion Card
Revised January 2018

Pain Rating Scale

Wong-Baker FACES Pain Rating Scale

Please refer to http://wongbakerfaces.org/

http://wongbakerfaces.org/licensing-dashboard/licensing-web-form/

Instructions for Usage

Explain to the person that each face represents a person who has no pain (hurt), or some, or a lot of pain.

Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have the worst pain.

Ask the person to choose the face that best depicts the pain they are experiencing.

Breathlessness Action Plan

Information for Inpatients

Name: _____

Action Plan

1. **Stop & get comfortable**
   – sit or lean against something.

2. **Breathe slowly**
   3 seconds in, 3 seconds out.

3. **Use a fan on your face.**

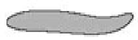
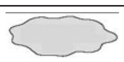
4. **Request medication from staff.**

Bristol Stool Chart

HammondCare

BOWEL CHART

TITLE	FAMILY NAME		
GIVEN NAME		DOB	SEX
ADDRESS			
TEL:		MOB:	

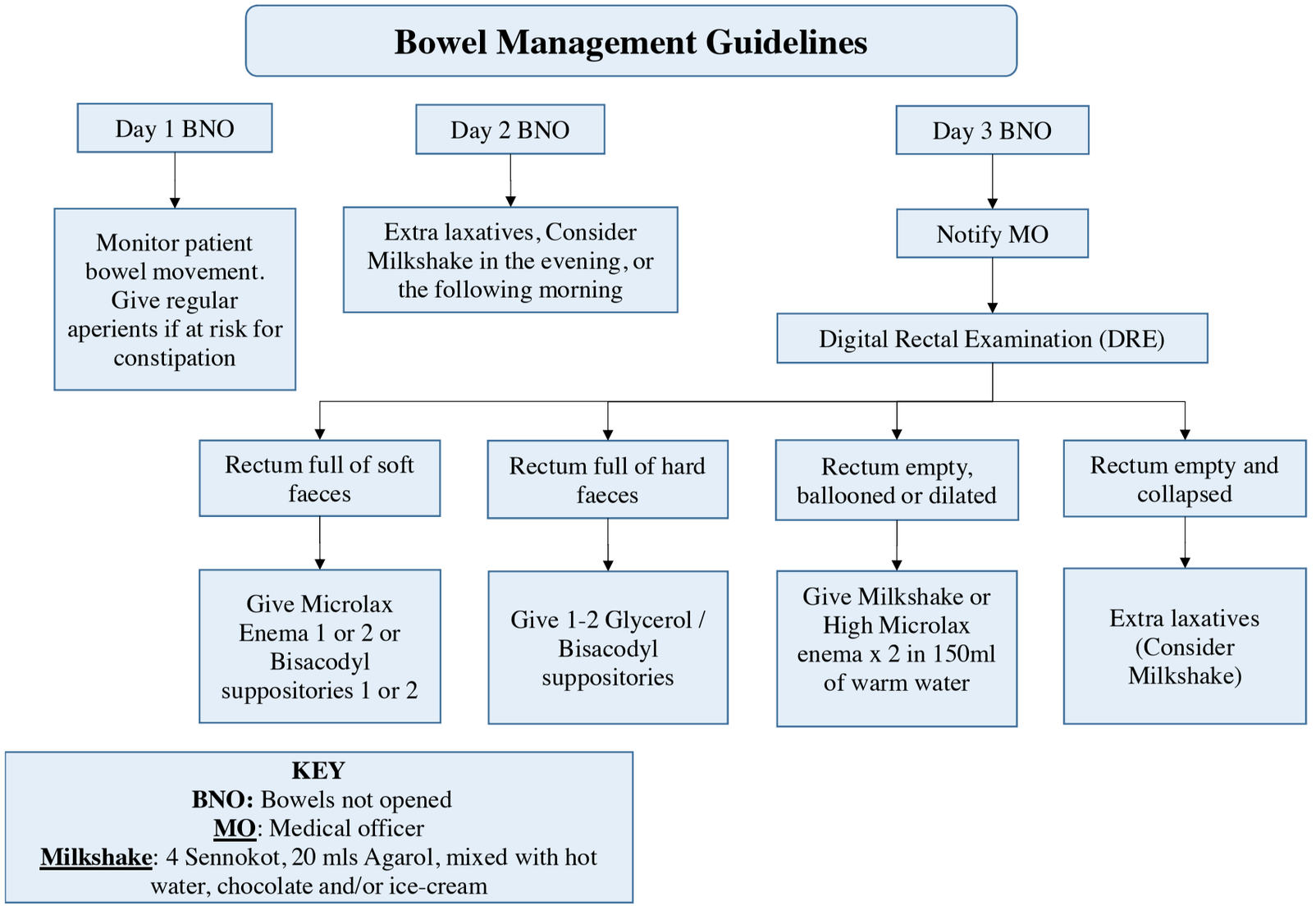
Type 1		Separate hard lumps. Like nuts (hard to pass)	**Rectal Examination**		**Interventions**	
Type 2		Sausage-Shaped but lumpy	EC	Empty collapsed	BS	Bisacodyl Suppository
Type 3		Like a sausage but with cracks on its surface	ED	Empty dilated	GS	Glycerol Suppository
Type 4		Like a sausage or snake, smooth and soft	FDS	Full dilated soft	H Micro	High Microlax enema
Type 5		Soft blobs with clear cut edges (passed easily)	FDH	Full dilated hard	Micro	Microlax enema
Type 6		Fluffy pieces with ragged edges, a mushy stool	**Specify** (S) Small (M) Medium (L) Large		MS	Milk Shake
Type 7		Watery – no solid pieces, entirely liquid			Oth	Other (specify)
Date bowels last opened:					OOE	Olive Oil Enema

Date:	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						
Date	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						
Date:	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						
Date:	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						
Date:	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						
Date:	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						
Date:	**No of days BNO**	**Rectal Examination**	**Intervention**	**Results**	**Comments**	**Urine**
Morning						
Evening						
Night						

BOWEL CHART

Version 2: September 2016

CR 154


Bowel Management Guidelines
Day 1 BNO
Monitor patient bowel movement. Give regular aperients if at risk for constipation
Day 2 BNO
Extra laxatives, Consider Milkshake in the evening, or the following morning
Day 3 BNO
Notify MO
Digital Rectal Examination (DRE)
Rectum full of soft faeces
Give Microlax Enema 1 or 2 or Bisacodyl suppositories 1 or 2
Rectum full of hard faeces
Give 1-2 Glycerol / Bisacodyl suppositories
Rectum empty, ballooned or dilated
Give Milkshake or High Microlax enema x 2 in 150ml of warm water
Rectum empty and collapsed
Extra laxatives (Consider Milkshake)
KEY
BNO: Bowels not opened
MO: Medical officer
Milkshake: 4 Sennokot, 20 mls Agarol, mixed with hot water, chocolate and/or ice-cream

Difficulties Swallowing

How to check if someone has an impaired swallowing reflex and signs of problems swallowing

Difficulties swallowing is a common symptom of Advanced Disease, Advanced Dementia and End of Life.

All people experience problems swallowing at the end of life which is called: **Dysphagia.**

It is important to **ALWAYS** check if the person you are caring for is swallowing safely.

Problems swallowing can cause: **Aspiration Pneumonia** which means the food or fluid goes "down the wrong way" and enters the lungs, not the stomach.

How to check if someone is swallowing safely:

1. Make sure the person is: alert, upright and having no problems breathing.
2. Never do this check lying down.
3. Check the person's mouth: if it is dry and dirty then eating will be very difficult and the chance of aspirating is increased.
4. If the person wears dentures: holding food or tablets in their mouth, ensure they have an appropriate diet ordered: soft, minced, pureed, soups, small meals. And appropriate fluids: thin or thickened.
5. If resident wears dentures, make sure they are clean, and not lose or rubbing which can cause pain and discomfort. Do the dentures need to be left out and the person's diet changed?
6. If required please request a speech pathology review.

Problems you may find:

1. Coughing even if the person coughs slightly while or soon after drinking or eating: **Stop** and try again later. Explain to the person and family what is happening and the risks associated.
2. Retains food in mouth for long period of time, **Change** diet, GP to review oral tablets.
3. Not attempting to swallow food: **Stop** and try again later. If needed **change** diet.
4. Spitting out lumps of food or chews for an extended period of time. **Change** diet.
5. Moist breathing sounding chesty or gurgled. **Stop** and explain to the family that this could mean that the person has possibly aspirated.

Make sure you are aware which tablets are designed to be slowly released and can never be crushed.

Make sure regular mouth care is charted and attended.

PCOC Inpatient Assessment Form

HammondCare

PCOC palliative care outcomes collaboration

PALLIATIVE CARE ASSESSMENT FORM

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
DOB	M.O
ADDRESS	
LOCATION/ WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Palliative Care Phase of Illness Abbreviated Definition

Clinician rated assessment

1. **Stable** Symptoms are adequately controlled by established management
2. **Unstable** Development of a new problem or a rapid increase in the severity of existing problems
3. **Deteriorating** Gradual functional decline and worsening of existing symptoms or the development of new but expected problems
4. **Terminal** Death likely in a matter of days

Complete Phase Definitions available on the PCOC website www.pcoc.org.au

Resource Utilisation Group – Activities of Daily Living Abbreviated Definition

Clinician rated assessment of dependency over 24hr period

For Bed Mobility, Toileting & Transfers	For Eating
1. Independent or supervision only	1. Independent or supervision only
3. Limited physical assistance	2. Limited assistance
4. Other than two person physical assist	3. Extensive assistance / total dependence / tube fed
5. Two or more person physical assist	

Complete RUG - ADL definitions available on the PCOC website www.pcoc.or.au

Problem Severity Score Complete Definition

Clinician rated assessment of problems over a 24hr period

Global assessment of four palliative care domains to summarise palliative care needs and plan care.
The severity of problems are rated and responded to following using the scale:

0 = Absent; 1 = Mild; 2 = Moderate; 3 = Severe

Pain: overall severity of pain problems for the patient

Other Symptoms: overall severity of problems relating to one or more symptoms other than pain

Psychological / Spiritual: severity of problems relating to the patient's psychological or spiritual wellbeing. May be one or more issues.

Family / Carer: problems associated with a patient's condition or palliative care needs. Family / Carer do not need to be present to asses needs as written, verbal or observational information may be used.

Australia-modified Karnofsky Performance Status Complete Definition

Clinician rated assessment of performance relating to work, activity and self-care over a 24hr period

100. Normal, no complaints or evidence of disease
90. Able to carry on normal activity, minor signs or symptoms of disease
80. Normal activity with effort, some signs or symptoms of disease
70. Care for self, unable to carry on normal activity or to do active work
60. Occasional assistance but is able to care for most needs
50. Requires considerable assistance and frequent medical care
40. In bed more that 50% of the time
30. Almost completely bedfast
20. Totally bedfast & requiring nursing care by professionals and/or family
10. Comatose or barely rousable

Symptom Assessment Scale Complete Definition

Patient Rated distress relating to symptoms over a 24hr period

The Symptom Assessment Scale describes the patient's level of distress relating to individual physical symptoms. The symptoms and problems in the scale are the seven most common.

Usage:

1. Best practice is for the patient to rate distress either independent or with the assistance of a clinician or family/carer using a visual of the scale such as the *Symptom Assessment Scale Form for Patients*.
2. Symptom distress may be rated by proxy. This only occurs when the patient is unable to participate in conversation relating to symptom distress i.e. Terminal phase.

Proxy: a family / carer or clinician who rates symptom distress on behalf of the patient though observational assessment.

Instructions: patient to consider their experience of the individual symptom or problem over the last 24 hours and rate distress according to

A score of 0: means the symptom or problem is absent

A score of 1: means the symptom or problem is causing minimal distress.

A score of 10: means the symptom or problem is causing the worst possible distress.

SAS translations available on the PCOC website www.pcoc.org.au

PCOC Phase Definitions

The palliative care phase identifies a clinically meaningful period in a patient's condition. The palliative care phase is determined by a holistic clinical assessment which considers the needs of the patients and their family and carers.	
START	**END**
Stable	
Patient problems and symptoms are adequately controlled by established plan of care **and** ▪ Further interventions to maintain symptom control and quality of life have been planned **and** ▪ Family/carer situation is relatively stable and no new issues are apparent.	The needs of the patient and / or family/carer increase, requiring changes to the existing plan of care.
Unstable	
An urgent change in the plan of care or emergency treatment is required **because** ▪ Patient experiences a new problem that was not anticipated in the existing plan of care, **and/or** ▪ Patient experiences a rapid increase in the severity of a current problem; **and/or** ▪ Family/ carers circumstances change suddenly impacting on patient care.	▪ The new plan of care is in place, it has been reviewed and no further changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis and plan of care (i.e. patient is stable or deteriorating) **and/or** ▪ Death is likely within days (i.e. patient is now terminal).
Deteriorating	
The care plan is addressing anticipated needs but requires periodic review **because** ▪ Patients overall functional status is declining **and** ▪ Patient experiences a gradual worsening of existing problem **and/or** ▪ Patient experiences a new but anticipated problem **and/or** ▪ Family/carers experience gradual worsening distress that impacts on the patient care.	▪ Patient condition plateaus (i.e. patient is now stable) **or** ▪ An urgent change in the care plan or emergency treatment **and/or** ▪ Family/ carers experience a sudden change in their situation that impacts on patient care, and urgent intervention is required (i.e. patient is now unstable) **or** ▪ Death is likely within days (i.e. patient is now terminal).
Terminal	
Death is likely within days.	▪ Patient dies **or** ▪ Patient condition changes and death is no longer likely within days (i.e. patient is now stable or deteriorating).
Bereavement – post death support	
▪ The patient has died ▪ Bereavement support provided to family/carers is documented in the deceased patient's clinical record.	▪ Case closure Note: If counselling is provided to a family member or carer, they become a client in their own right.

M. Masso, S. Frederic. Allingham, M. Banfield, C. Elizabeth. Johnson, T. Pidgeon, P. Yates & K. Eagar, "Palliative care phase: inter-rater reliability and acceptability in a national study", Palliative Medicine 29 1 (2014) 22-30.

Advance Care Directive

NSW Health Advance Care Directive (ACD)

NSW GOVERNMENT Health

SECTION 1 YOUR DETAILS AND YOUR PERSON RESPONSIBLE

Family name: _____

Given names: _____

Date of birth: _____

Address: _____

_____

I have legally appointed one or more people as my Enduring Guardian and they are aware of this Advance Care Directive:

	ENDURING GUARDIAN 1	ENDURING GUARDIAN 2
Name:		
Home phone number:		
Mobile phone number:		
Email address:		

I have not appointed an Enduring Guardian.

If, because of my medical condition, I am not able to understand and make decisions about my treatment or can't tell the doctors or my family, my Person Responsible is:

	PERSON 1	PERSON 2
Name:		
Relationship:		
Home phone number:		
Mobile phone number:		

www.health.nsw.gov.au

Advance Care Directive

SECTION 2 PERSONAL VALUES ABOUT DYING

Information about your values is important as it is not possible for this document to cover all medical situations. Information about what is important to you may help the person who is making decisions on your behalf when they are speaking to the doctors about your care and treatment.

In this section you can include:

- things that are important to you at the end of life (your beliefs and values)
- issues that worry you, and
- personal, religious or spiritual care you would like to receive when you are dying.

If I am unable to communicate and not expected to get better:

- I would like my pain and comfort managed; and
- when deciding what treatments to give to me or not to give me, I would like the person/people making health decisions for me to understand how the following would make me feel (initial the box that is your choice):

VALUES	Acceptable	Unbearable (I would like treatment discontinued and to be allowed to die a natural death)	Unsure
1. If I can no longer recognise my family and loved ones, I would find life...	☐	☐	☐
2. If I no longer have control my bladder and bowels, I would find life...	☐	☐	☐
3. If I cannot feed, wash or dress myself I would find life...	☐	☐	☐
4. If I cannot move myself around in or out of bed and rely on other people to reposition (shift or move) me, I would find life...	☐	☐	☐
5. If I can no longer eat or drink and need to have food given to me through a tube in my stomach, but can still communicate, I would find life...	☐	☐	☐
6. If I am not able to communicate by talking, reading or writing, I would find life...	☐	☐	☐
7. If I can never have a conversation with others because I do not understand what people are saying, I would find life...	☐	☐	☐

Advance Care Directive

SECTION 2 PERSONAL VALUES ABOUT DYING

At the end of my life when my time comes for natural dying, I would like to be cared for (initial the box of your choice)

At home or in a home like environment ☐

In a hospital or hospital like environment ☐

Other location (please provide details) _____ ☐

I do not know. I am happy for my family / Person Responsible to decide. ☐

When my Person Responsible is making decisions about care at the end of my life, I would like them to consider the statements below.

If you need extra space please attach an additional page.

I do not want to complete Section 2:

_____

(Signature)

www.health.nsw.gov.au

Advance Care Directive

SECTION 3 DIRECTIONS ABOUT MEDICAL CARE

This section applies to when you are unable to make or communicate decisions about your health care and medical treatment, including CPR.
If you are able to communicate you will be included in decisions about your care.

Cardio Pulmonary Resuscitation (CPR)

CPR refers to medical procedures that may be used to try to start your heart and breathing if your heart or breathing stops. It may involve mouth to mouth resuscitation, very strong pumping on your chest, electric shocks to your heart, medications being injected into your veins and/or a breathing tube being put into your throat.

If I am ill or injured and not expected to get better, or if my quality of life is unbearable as indicated in the table on page 3, if my heart stops and CPR is an option (please initial one box only):

Please try to restart my heart or breathing (**Attempt CPR**) ☐

OR

Please allow me to die a natural death. Do not try to restart my heart or breathing (**No CPR**) ☐

OTHER MEDICAL TREATMENTS

If I am ill or injured and not expected to get better, or if my quality of life is unbearable as indicated in the table on page 3, I DO NOT WANT TO HAVE the following medical treatments (initial the box/boxes that are your choice):

Artificial ventilation (also called life support, breathing machine) ☐

Artificial feeding ☐

Renal dialysis ☐

OTHER: Please list below

Even if I am expected to get better I would never want the following medical treatments:

I do not want to complete Section 3:

_____

(Signature)

www.health.nsw.gov.au

Advance Care Directive

SECTION 4 SPECIFIC REQUESTS FOR ORGAN AND TISSUE DONATION

My wishes about organ and tissue donation for transplantation following my death are (initial your choice for each statement):

	Yes	No
I would like to donate my organs and tissues for transplantation following my death.	☐	☐
I have discussed my organ and tissue donation wishes with my family and friends and they are aware of my decision.	☐	☐
I have registered my wishes on the Australian Organ Donor Register.	☐	☐

Antemortem treatment for organ donation (treatment/s immediately before my death only for the purpose of organ donation)

	Yes	No
It is my wish to donate my organs for transplantation after my death. If I am dying, I consent to the doctors providing treatments before my death (including artificial ventilation, insertion of intravenous lines and administration of medications) intended only for the purpose of enabling me to donate my organs and tissue for transplantation.	☐	☐

I do not want to complete Section 4:

_____

(Signature)

Advance Care Directive

SECTION 5 AUTHORISATION

PERSONAL DETAILS

By signing this document, I confirm that:

- I have read the accompanying information booklet, or had the details explained to me
- I understand the facts and choices involved, and the consequences of my decisions
- I am aware that this Advance Care Directive will be used in the event that I cannot make or communicate my own health care decisions. If I am able to communicate, I will be included in decisions about my care.
- I have completed this Advance Care Directive of my own free will.

_____ ____/____/____

(Signature) (Date)

DETAILS OF WITNESS*

I can confirm that _____ signed this document on ____/____/____

Signed: _____ Name (please print): _____

Address: _____ Phone: _____

TREATING HEALTH PROFESSIONAL*

Name: _____ Phone: _____

Address: _____

Email: _____

I confirm that _____ had capacity and was aware of the implications of the information in this Advance Care Directive.

_____ ____/____/____

(Signature) (Date)

*While not legally required, it is strongly recommended that a health professional co-signs this Advance Care Directive and/or a person witnesses you sign this form.

NSW Ambulance Plan

NSW Ambulance excellence in care

INSTRUCTION SHEET

Authorised Adult Palliative Care Plan

NSW Ambulance Authorised Care Plans encompass Adult Palliative Care Plans, Paediatric Palliative Care Plans and Authorised Care Plans. It is the responsibility of the treating clinician to ensure all fields are completed prior to submission

SUBMISSION OF AN AUTHORISED CARE PLAN

- The document may be completed electronically and saved utilising a PDF viewer e.g. ADOBE reader.
- Completed forms may be submitted electronically via email: protocolp1@ambulance.nsw.gov.au or fax: (02) 9320 7380
- All fields are to be completed. If handwritten, all fields must be clear and legible.
- Address fields must be complete including post codes.
- Patients with an existing NSW Authorised Care Plan must have 'Existing Patient' checked in the patient details section of the plan.

ENDORSEMENT OF AUTHORISED CARE PLANS

- The treating clinician must approve all authorised care plans by signing the 'Clinician Details' section on page one.
- Adult Palliative Care Plans require authorisation from the patient, where appropriate, in the relevant section on page two
- Adult Palliative Care Plans require endorsement from the patient's family and/or enduring guardian.

ENDORSEMENT BY NSW AMBULANCE

- NSW Ambulance will review and endorse each completed application upon receipt.
- Patients will receive via post a copy of the completed endorsed plan and a covering letter. Please allow up to five business days for receipt. Adult Palliative Care Plans may be sent to either the patient or the family/enduring guardian as nominated in the relevant section of page two. Where no selection is made, the plan will be sent directly to the patient.
- A copy of the completed endorsed plan will be forwarded to the treating clinician via fax or emailed in PDF format where a valid email address has been supplied.
- Incomplete forms may result in processing delays.

MEDICATION ADMINISTRATION

- NSW Ambulance paramedics may administer medications within their specific clinical scope of practice without additional authorisation. Note: not all clinical levels can administer the entire suite of pharmacology.
- Medications outside of the NSW Ambulance clinical pharmacological scope of practice must be available with the patient at all times to enable administration by NSW Ambulance paramedics in accordance with the instructions detailed on the patient's plan.
- The current list of medications available under the NSW Ambulance Clinical Pharmacology (as of July 2015) include: Adrenaline, Amiodarone*, Aspirin, Atropine*, Benzyl Penicillin, Calcium Gluconate*, Clopidogrel, Compound Sodium Lactate, Droperidol, Enoxaparin Sodium, Fentanyl, Fexofenadine, Frusemide, Glucagon, Glucose 10%, Glucose Gel, Glyceryl Trinitrate, Ibuprofen, Ipratropium Bromide, Ketamine*, Lignocaine*, Methoxyflurane, Metoclopramide, Midazolam, Morphine, Naloxone, Ondansetron, Oxygen, Paracetamol, Salbutamol, Sodium Bicarbonate*, Tenecteplase (*intensive care paramedics only).
- Unless specified otherwise, paramedics will administer medications in accordance with NSW Ambulance pharmacology.

ENDORSED CARE PLAN EXPIRATION

- All endorsed Authorised Care Plans will remain in effect for a period of 12 months from the date of endorsement unless a reduced review date is requested by the treating clinician.
- It is the responsibility of the treating clinician to review the plan and submit a new plan prior to the 12 month review date.
- In the event the endorsed plan is no longer required, a cancellation notification including the reason for the cancellation should be forwarded to NSW Ambulance via email: protocolP1@ambulance.nsw.gov.au.

NSW Ambulance Plan

Date of Application: Review Date:

Trim number: Document number:

Patient Name:	New patient	Existing patient
Surname:	Date of Birth:	
Given Names:	Male	Female
Address:		
Interpreter Required: No Yes Language	Contact Number	

CARDIAC ARREST TREATMENT DECISION

If the patient is in cardiac arrest (select one) PERFORM CPR WITHOLD CPR

Please check the statements which are applicable (may be more than one):

If withholding CPR, the patient, family and/or enduring guardian and I, as treating clinician, have considered the care options and a decision to withhold resuscitation has been made based on the discussion between the patient, family and/or enduring guardian.

The patient's current medical diagnosis and prognosis is such that if CPR is successful it is likely to be followed by a length and quality of life which is not in the wishes of the patient.

Initiation of CPR is not in accordance with the orally expressed and/or documented wishes of the patient who is/was mentally competent at the time of making the decision.

If initiation of CPR is not in conjunction with an Authorised Care Directive (ACD).

Note: If concerns arise about the validity of the documents or the safety of the environment, NSW Ambulance protocol will be followed.

TREATMENT AND MEDICATION OPTIONS

In cases where the patient is not in cardiac arrest, the following treatment and medication options have been considered appropriate through consultation with the patient and/or family and/or enduring guardian:

Airway Management	Administer	Withhold
Oxygen	Administer	Withhold
Nasopharyngeal suctioning	Administer	Withhold
IV access	Administer	Withhold

The following medications are to be administered by NSW Ambulance paramedics as directed. Please note: medications outside of the NSW Ambulance clinical scope of practice are required to be with the patient at all times.

Medication	**Dose/Route**	**Repeat times and intervals**

CLINICIAN DETAILS (PLEASE PRINT CLEARLY)

Name:	Contact number:
Provider number:	Fax:
Organisation/Practice Name and Address:	
Email:	
As the treating clinician, I authorise this Care Plan and by signing this form I authorise NSW Ambulance paramedics to implement the treatment options specified which have been discussed with the patient and consistent with their treatment requirements.	
Signature:	Date:

Please fax completed form to: (02) 9320 7380 or scan/email to: protocolp1@ambulance.nsw.gov.au 2 of 4

NSW Ambulance Plan

Trim number: Document number:

Patient Name:	Date of Birth:

PATIENT CLINICAL HISTORY (PLEASE PRINT CLEARLY)
Diagnosis:
History:
Co-morbidities:
Current Medications:
Allergies:

FAMILY/ENDURING GUARDIAN (PLEASE PRINT CLEARLY)			
Surname:			
Given Names:			
Relationship	Family Member	Enduring Guardian	Other:
Address:			
Contact Number:		Interpreter Required: Yes No (If yes, language):	
All correspondence will be sent to the person identified in this section			

PATIENT/FAMILY/ENDURING GUARDIAN AUTHORISATION	
Patient's Signature:	Date:
Family/Enduring Guardian Signature:	Date:

Please fax completed form to: (02) 9320 7380 or scan/email to: protocolp1@ambulance.nsw.gov.au 3 of 4

NSW Ambulance Plan

Trim number: Document number:

Patient Name:	Date of Birth:

LOCATION OF CARE

While every effort will be made to accommodate the patient's wishes, NSW Ambulance will review the location of care at the time of attending the patient, distances and travelling times will be factored into the destination decision.

In the event that care at home becomes too difficult, the choice for end of life care is at:

Should death occur during transport, treatment will be in accordance with the patient's wishes detailed on page 2 of this plan.
In the event of death during transport the patient should be transported to:

POST DEATH MANAGEMENT PLAN:

If the patient dies, the management of the patient is the responsibility of the clinician/palliative care team. Paramedics should contact the patient's:

General Practitioner (GP): Name: Phone:

or Palliative Care Team: Name:

Phone (BH): (AH):

CONTACT LISTS

Team	Name	Contact Number (BH)	Contact Number (BH)
General Practitioner			
Palliative Care Team			
Primary Care Team			
Community Nurse			
Other Health Services			
Spiritual/Religious Supports			

NSW AMBULANCE USE ONLY

Endorsed by:	:
Signature	Date

Please fax completed form to: (02) 9320 7380 or scan/email to: protocolp1@ambulance.nsw.gov.au 4 of 4

Bereavement Referral Form

HammondCare

B E REAVEMENT SERVICE REFERRAL FORM

TITLE	FAMILY NAME	MRN
GIVEN NAME	AMO	
ADDRESS	SUBURB	POST CODE
DOB	SEX	ADMISSION DATE

Referring Service

☐GWH PCU ☐GWH Community ☐Northern Beaches Community

☐Neringah PCU ☐Neringah Community ☐Royal North Shore

☐GP ☐ Self -Referral ☐Other

Person To Be Contacted

Name :

Address Street: Suburb : Postcode :

Contact no Home: Work: Mobile:

Email :

Interpreter Required : ☐ Yes ☐ No Language Spoken:

Has the person to be contacted provided verbal/written consent for this referral ? ☐Yes ☐No

Relationship to the deceased :

When should we make contact? Within: ☐1 - 2 weeks ☐4 - 8 weeks

Deceased Details

Name:

Date of Birth: Date of Death:

Place of Death: MRN:

Concerns

☐Extremely Close Relationship ☐Estranged Relationship ☐Family Conflict ☐Social Isolation

☐Bereaved Parent ☐Ber eaved Spouse with Dependent Chil dren ☐Multiple Bereavements

☐Unanticipated Rapid Deterioration ☐Traumatic Events Surrounding Death

☐Death Not In Desired Location ☐Not Present for Death When Wanted To Be

☐Low Acceptance of Impending Death ☐Other:

Additional Concerns and Information

WH S Issues? ☐ Yes ☐ No (e.g. violence, weapons, dogs, access issues)

Comments :

Referral By : Signat ure:

Date of Referral : Phone : Fax :

PLEASE EMAIL COMPLETED FORMS TO: bereavement@hammond.com.au

Version: February 2017

CR 96

Bereavement Referral Form

HammondCare B E REAVEMENT SERVICE REFERRAL FORM	TITLE	FAMILY NAME	MRN
	GIVEN NAME	AMO	
	ADDRESS	SUBURB	POST CODE
	DOB	SEX	ADMISSION DATE

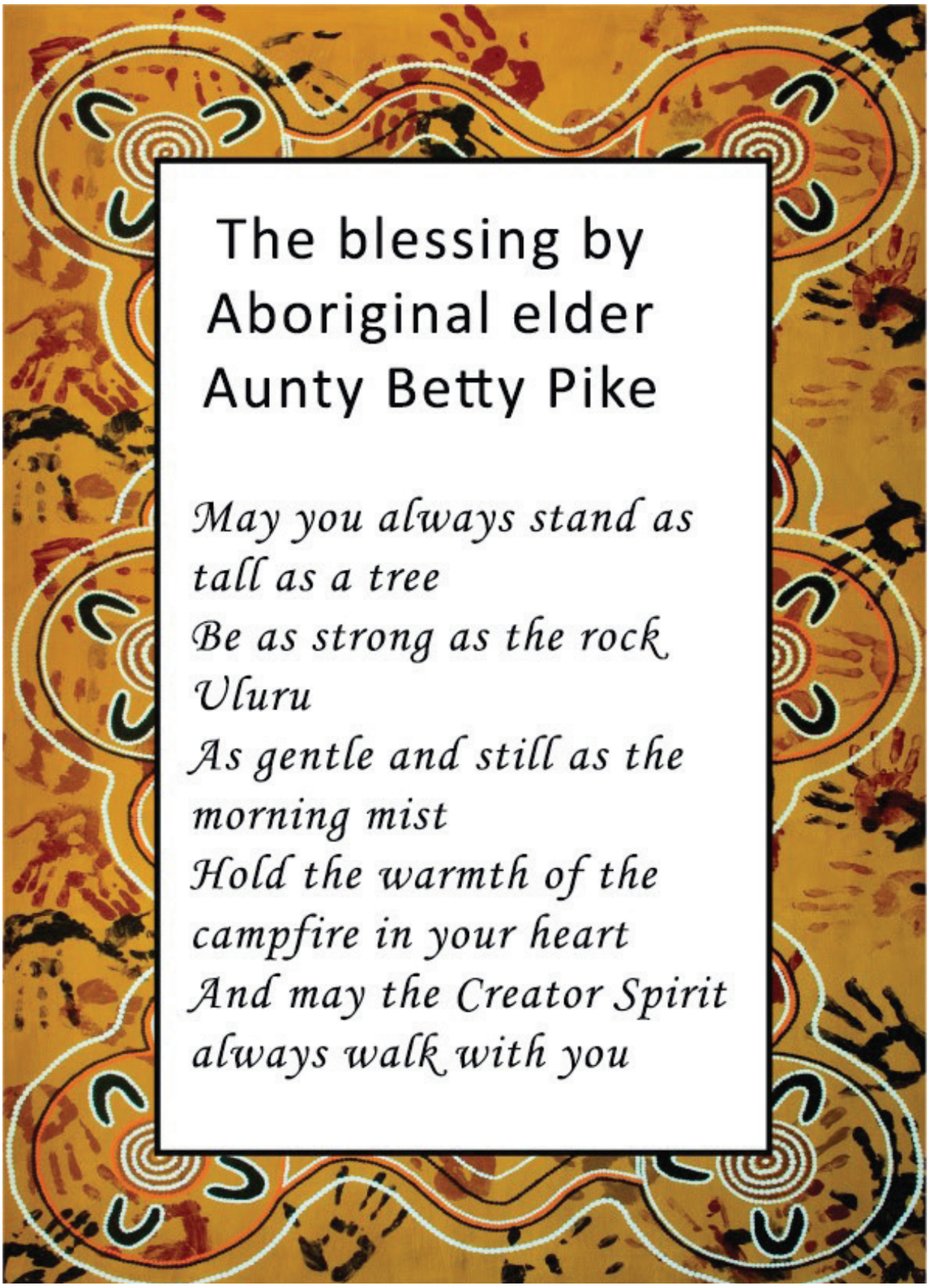
Name: Date:

PLEASE EMAIL COMPLETED FORMS TO: bereavement@hammond.com.au

Version: February *2017*

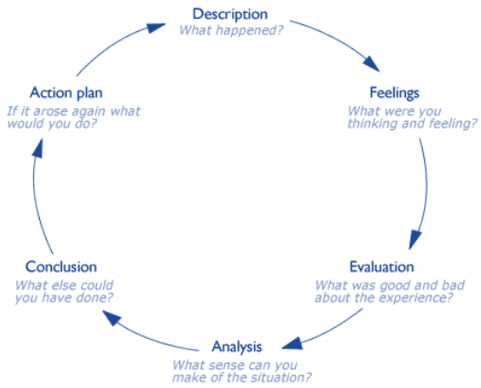
CR 96

Aboriginal Blessing



GIBBS Reflective Cycle

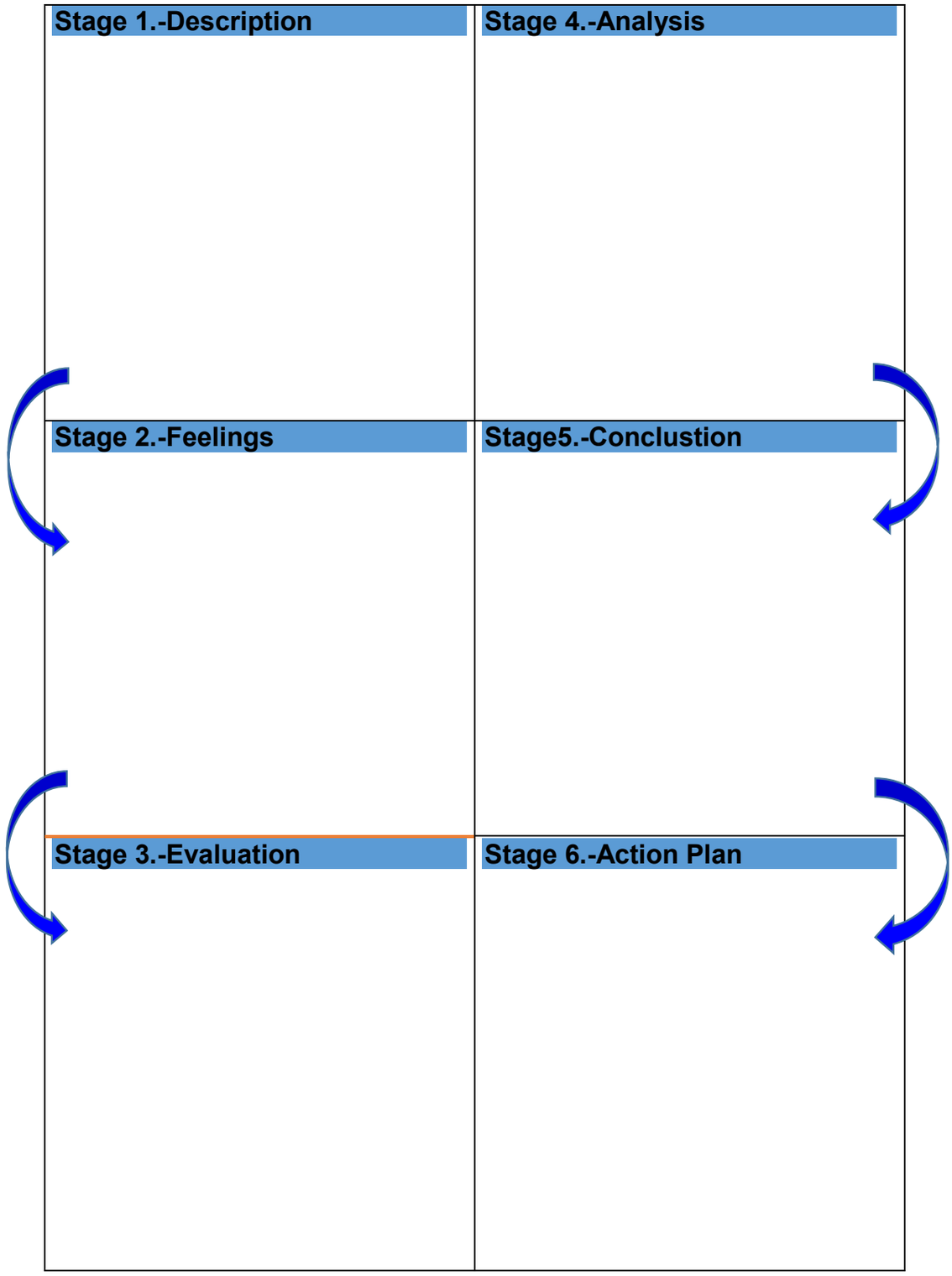
Gibbs' Reflective Cycle.



The reflective cycle (Gibbs 1988)

Stage 1.-Description	Stage 4.-Analysis
✓ Describe the event in detail ✓ Set the scene ✓ What happened? ✓ Who was involved? ✓ What was the result? ✓ The what , where and when	✓ What sense can you make of the experience? ✓ If things didn't go so well how did you or others contribute to this? ✓ What recent evidence is in the literature surrounding this situation? ✓ What is the impact of different perspectives e.g. the resident, colleagues and others?
Stage 2.-Feelings	**Stage 5.-Conclusion**
✓ Simply describe your feelings, thoughts and perceptions. ✓ What were your emotions? ✓ How did the event make you feel?	✓ Conclusions are drawn ✓ How could you have done this better? ✓ What would you have done differently" ✓ What have you learnt from this event?
Stage 3.-Evaluation	**Stage 6.-Action plan**
✓ What was good about the event ✓ What was bad about the event? ✓ What was difficult? ✓ What went well? ✓ What did not go well?	✓ With hindsight would you do something differently next time and why? ✓ How can you use these lessons learned from this event in the future? ✓ What has this taught you about your professional practice? ✓ How will you use this experience to further improve your practice in the future?

GIBBS Reflective Cycle



After Death Audit Tool

Aged Care Training : After Death Audit Tool

Facility Name:

.....

.....

..... Postcode .....

1. Facility assigned resident ID*

*(*Please enter the resident's unique identifier assigned by your facility.)*

.....

2. Resident's date of admission

☐☐ / ☐☐ / ☐☐☐☐ *(dd) / (mm) / (yyyy)*

3. Resident's date of birth

☐☐ / ☐☐ / ☐☐☐☐ *(dd) / (mm) / (yyyy)*

4. Resident's date of death

☐☐ / ☐☐ / ☐☐☐☐ *(dd) / (mm) / (yyyy)*

5. Was this a sudden, unexpected death?

☐ Yes ☐ No

6. Place of death

☐ Residential aged care facility
☐ Hospital
☐ Other, please specify .....

7. Was the resident transferred to hospital in the last week of their life?

☐ Yes ☐ No (*If no, skip to Question 11*)

8. Principal reason for hospitalisation

☐ Symptom management
☐ Sudden, unexpected deterioration or event
☐ Following a fall
☐ Other, please specify .....

9. Person requesting admission

☐ Request of resident
☐ Request of family
☐ Request of the general practitioner
☐ Request of the nursing staff

10. Length of hospital stay

☐ Not admitted
☐ 1 to 3 days
☐ Greater than 3 days

11. Were the resident's preferences for future health care wishes documented?

(N.B. Documentation of a funeral provider is not sufficient to check "yes" for this item.)

☐ Yes ☐ No (*If no, skip to Question 15*)

12. What is the name of the document that these wishes were recorded on? *Tick as many as applicable.*

☐ Progress notes
☐ Aged care specific Advance Care Directive/Plan
☐ Your facility Advance Care Directive/Plan
☐ Your state or territory's statutory Advance Care Directive/Plan
☐ Other, please specify .....

13. When were these wishes documented? *Tick as many as applicable.*

☐ Before admission to the residential aged care facility
☐ At time of admission to the residential aged care facility
☐ While living at the residential aged care facility
☐ Other, please specify .....

14. Were these wishes followed?

☐ Yes ☐ No
☐ Unsure

15. Was a palliative care case conference conducted within the last six months of the resident's life?**

*(**A palliative care case conference focuses on end of life issues. The resident and/or family should be in attendance.)*

☐ Yes ☐ No (*If no, skip to Question 20*)

16. Date of palliative care case conference

☐☐ / ☐☐ / ☐☐☐☐ *(dd) / (mm) / (yyyy)*

17. Was the palliative care case conference attended by a GP?

☐ Yes ☐ No

18. Was the palliative care case conference attended by a specialist palliative care nurse?

☐ Yes ☐ No

19. Was the palliative care case conference attended by a representative from your local palliative care service?

☐ Yes ☐ No
☐ No service available

20. Was the resident commenced on an end of life care pathway?

☐ Yes ☐ No (*If no, skip to Question 22*)

21. Date commenced end of life care pathway

☐☐ / ☐☐ / ☐☐☐☐ *(dd) / (mm) / (yyyy)*

22. Did the facility claim Complex Health Care Palliative Care through ACFI for this resident?

☐ Yes
☐ No, as already claiming maximum
☐ No

Frequently Used Websites

www.hammondcare.com.au

www.palliativebridge.com.au (This is where you will find great presentations on Palliative Care, including the filmed presentation from Northern Sydney Services available to assist with care in Residential Aged Care Homes)

www.palliativecarensw.org.au

www.palliatvecare.org.au

www.caresearch.com.au (This is where you will find great information and the Residential Aged Care Palliative Approach Toolkit. And the APP: Palliaged)

www.cancercouncil.com.au

www.myagedcare.gov.au

For Advanced Care Planning Information

www.health.nsw.gov.au/patients/acp/Publications/acd-form-info-book.pdf

www.advancecareplanning.org.au (Free online advance care planning modules)

For Loss & Bereavement in people with Dementia

www.alzheimers.org.uk/info/20046/help_with_dementia_care/411/grief_loss_and_bereavement

For further professional development and education

www.caresearch.com.au/dying2learn (Free online course: Dying2learn MOOC Flinders University)

https://mooc.utas.edu.au/courses (Free online course: Understanding Dementia MOOC University of Tasmania)

www.pepaeducation.com (To apply for a program of Experience in the Palliative Care Approach Placement - PEPA)