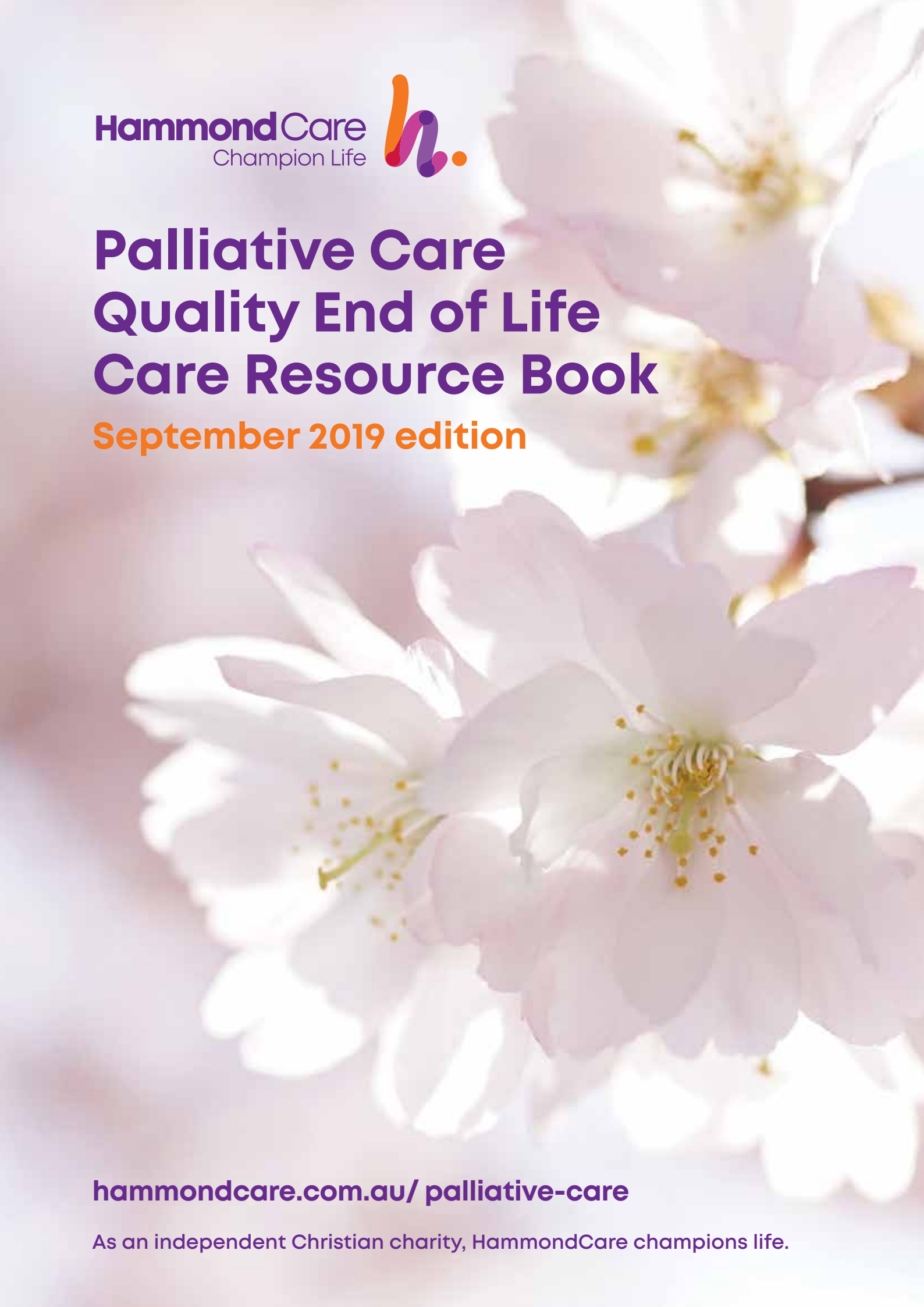


HammondCare
Champion Life

Palliative Care Quality End of Life Care Resource Book

September 2019 edition

hammondcare.com.au/ palliative-care

As an independent Christian charity, HammondCare champions life.

HammondCare Palliative Care

End of life care resource book

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

Identify

Manage

Care

Resources

Palliative Care Needs Round Checklist

Add patient sticky label

Ask "The Surprise Question"

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

If you are unsure about the surprise question refer to the SPICT tools.

Palliative Care Needs Round Checklist

Triggers to discuss resident at needs rounds

One or more of:

1. You would not be surprised if the resident died in the next six months
2. Physical or cognitive decline or exacerbation of symptoms in the last month
3. No plans in place for last six months of life/no advance care plan
4. Conflict within the family around treatment and care options
5. Transferred to our facility for end of life care

Actions

- ☐ Change in medications, ie route, or cease any non-essentials. Chart anticipatory medications
- ☐ Organise a substitute decision maker
- ☐ Develop and document an advance care plan in consultation with family
- ☐ Organise a case conference involving family
- ☐ External referrals (e.g. pastoral care, Dementia Support Australia, volunteer, AART team). Refer to the Quick Links, Page 12: Northern Sydney Services
- ☐ Refer to specialist palliative care referral form https://www.hammond.com.au/how-to-refer/palliative-and-supportive-care-referral-form/file found on page 4

Date of assessment _____

Comments _____

_____

_____

SPICT Tool

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS SCOTLAND

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.
- Progressive weight loss; remains underweight; low muscle mass.
- 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 2019

SPICT Tool 4ALL

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

Does this person have signs of poor or worsening health?

- Unplanned (emergency) admission(s) to hospital.
- General health is poor or getting worse; the person never quite recovers from being more unwell. (This can mean the person is less able to manage and often stays in bed or in a chair for more than half the day)
- Needs help from others for care due to increasing physical and/ or mental health problems.
- The person's carer needs more help and support.
- Has lost a noticeable amount of weight over the last few months; or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Does this person have any of these health problems?

Cancer

Less able to manage usual activities and getting worse.

Not well enough for cancer treatment or treatment is to help with symptoms.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Has lost control of bladder and bowel.

Not able to communicate by speaking; not responding much to other people.

Frequent falls; fractured hip.

Frequent infections; pneumonia.

Nervous system problems

(eg Parkinson's, MS, stroke, motor neurone disease)

Physical and mental health are getting worse.

More problems with speaking and communicating; swallowing is getting worse.

Chest infections or pneumonia; breathing problems.

Severe stroke with loss of movement and ongoing disability.

Heart or circulation problems

Heart failure or has bad attacks of chest pain. Short of breath when resting, moving or walking a few steps.

Very poor circulation in the legs; surgery is not possible.

Lung problems

Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best.

Needs to use oxygen for most of the day and night.

Has needed treatment with a breathing machine in the hospital.

Kidney problems

Kidneys are failing and general health is getting poorer.

Stopping kidney dialysis or choosing supportive care instead of starting dialysis.

Liver problems

Worsening liver problems in the past year with complications like:

- fluid building up in the belly
- being confused at times
- kidneys not working well
- infections
- bleeding from the gullet

A liver transplant is not possible.

Other conditions

People who are less well and may die from other health problems or complications. There is no treatment available or it will not work well.

What we can do to help this person and their family.

- Start talking with the person and their family about why making plans for care is important.
- Ask for help and advice from a nurse, doctor or other professional who can assess the person and their family and help plan care.
- We can look at the person's medicines and other treatments to make sure we are giving them the best care or get advice from a specialist if problems are complicated or hard to manage.
- We need to plan early if the person might not be able to decide things in the future.
- We make a record of the care plan and share it with people who need to see it.

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

SPICT-4ALL™, June 2017

HammondCare Champion Life

Palliative Care Referral Form

Download this form from:
https://www.hammond.com.au/how-to-refer/palliative-and-supportive-care-referral-form/file

HammondCare Champion Life

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)

PCOC Inpatient Assessment Form

AKPS assessment criteria	Score
Normal; no complaints; no evidence of disease	100
Able to carry on normal activity; minor sign of symptoms of disease	90
Normal activity with effort; some signs or symptoms of disease	80
Cares for self; unable to carry on normal activity or to do active work	70
Able to care for most needs; but requires occasional assistance	60
Considerable assistance and frequent medical care required	50
In bed more than 50% of the time	40
Almost completely bedfast	30
Totally bedfast and requiring extensive nursing care by professionals and/or family	20
Comatose or barely rousable	10
Dead	0

How to organise a defibrillator to be turned off:

1. Ensure family are aware, understand and give consent.
2. Discuss with the GP and ensure that the GP has documented and authorised the defibrillator to be turned off in the patient's progress notes
3. Contact the person's cardiologist (you may need to ask family if you cannot find details in file)
4. Ask cardiologist which implantable defibrillator was used.
5. Contact the company and ask for the local area rep to request a visit to turn off the devise.

For more information: **https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/179990/ACI-Deactivate-ICDs.pdf**

Palliative Care Outcomes Collaboration

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
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.

Abbey Pain Scale

Appendix 5: Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

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

Name of resident: _____

Name and designation of person completing the scale: _____

Date: _____ Time: _____

Latest pain releif given was: _____ at _____ hours

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

Q2. Facial Expression
eg. looking tense, frowning, grimacing, looking frightened
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 **Q2** ☐

Q3. Change in Body Language
eg. fidgeting, rocking, guarding part of body, withdrawn
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 **Q3** ☐

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

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

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

- **Add scores for 1 - 6 and record here:** **Total pain score** ☐
- **Now tick the box that matches the Total**

☐ **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

Abbey Pain Scale

Modified Abbey Pain Scale (Follow on assessment form)

	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME
VOCALISATION eg. whipering, groaning, crying Absent - 0 Mild - 1 Moderate - 2 Severe - 3										
FACIAL EXPRESSION eg. looking tense, frowning, grimacing, looking frightened Absent - 0 Mild - 1 Moderate - 2 Severe - 3										
CHANGE IN BODY eg: fidgeting, rocking, guarding part of body, withdrawn Absent - 0 Mild - 1 Moderate - 2 Severe - 3										
BEHAVIOURAL CHANGE eg: increased confusion, refusing to eat, alteration in usual patternsg Absent - 0 Mild - 1 Moderate - 2 Severe - 3										
PHYSIOLOGICAL CHANGES eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor Absent - 0 Mild - 1 Moderate - 2 Severe - 3										
PHYSICAL CHANGES eg: skin tears, pressure areas, arthritis, contractures, previous injuries Absent - 0 Mild - 1 Moderate - 2 Severe - 3										
Total score =										
Signature of person										

The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs, for example, patients with dementia, cognition or communication issues. The scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

The Australian Pain Society recommends the pain scale should be used as a movement-based assessment. Therefore observe the patient while they are being moved, during pressure area care, while showering, etc. Complete the scale immediately following the procedure and record the results on the Abbey Pain tool chart.

A second evaluation should be conducted 1 hour after any intervention taken. If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Complete the scale hourly until the patient scores mild pain then 4 hourly for 24 hours treating pain if it recurs.

If the pain/distress persists, undertake a comprehensive assessment of all facets of the patients care and monitor closely over 24 hours including further intervention undertaken.

If there is no improvement in that time, then it is essential to notify the GP of ongoing pain scores and actions taken.

Modified from Hywel Dda University Health Board NHS 2013; Wales, UK

Pain Management Using Pain Recognition Technology

PainChek
Intelligent Pain Assessment

PainChek® is the world's first pain assessment tool that has regulatory clearance in Australia and Europe.

Using AI and facial recognition technology, PainChek® provides carers across multiple clinical areas with three important new clinical benefits: https://www.painchek.com/

1. The ability to identify the presence of pain, when pain isn't obvious
2. To quantify the severity level of pain, when pain is obvious, and;
3. To monitor the impact of treatment to optimise overall care

Funding is available from the Department of Health

Follow this link to access the expression of interest (EOI) campaign for residential aged care organisations to complete 12 month funded grants available:

http://painchek.com/painchek-grant/

ISBAR Tool to Assist with Effective Communication

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 AART Team Flip Chart for more information

Palliative Care Equipment Stock List

PRN or 4/24 subcutaneous medication administration

1	Puncture proof receptable - kidney dish		
2	Gloves		
3	BD saf-t-intima	24g 0.75in	Ref: 383313
4	Smart site needle free valve	Care fusion 11717232	Ref: 2000E
5	Normal saline or water for injection for flushing	10ml ampoules	
6	Alcohol wipes		
7	Permeable transparent dressing - IV3000, Tegaderm	6cm x 6cm	Ref: 9354HP
8	Drawing up needles	18g 1/2 12mm x 38mm	Ref: 300204
9	BD 1ml syringe		Ref: 309628
10	BD 3ml syringe		Ref: 302113
11	BD 5ml syringe		Ref: 302135

For Syringe Drivers

1	BD Plastipak 20mls (leur lock)		Ref: 300629
2	Extension set Microbore 150mm	Priming volume 12mls	Ref: 503.07
3	Alkaline 9V battery		
4	For Subcutaneous Use Only' Label		

Pressure Area Protection and use in Pressure Injury

1	Mepilex with safetac technology	10cm x 10cm Molnycke Health Care	Ref: 7310791103310
2	Mepilex border	7.5cm x 7.5cm	Ref: 1637361
3	Mepilex border	10cm x 10cm	Ref: 1637370

Palliative Care Essential Equipment

1. Bicarbonate impregnated mouth swabs
2. Lip balm
3. Oral balance gel
4. Aqua mouth spray
5. Sorbolene body lotion/cream
6. Sudocream
7. Dermalux soft towel lotion
8. Dry shampoo
9. Essential / aromatherapy oils
10. Ozone electric air diffuser
11. Oxygen ear protector
12. Nozoil nasal drops
13. Fess nasal spray
14. Zeoz105 Bag of Rocks (odour control rocks)
15. Lubricating eye drops such as polytears
16. Extra pillows
17. CD player and the person's favourite music
18. Desk or room fan
19. Pressure relieving mattress

Palliative Care End of Life Medications – Initial Suggested Doses

PAIN / SHORTNESS OF BREATH

a) If not on 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 (e.g. 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

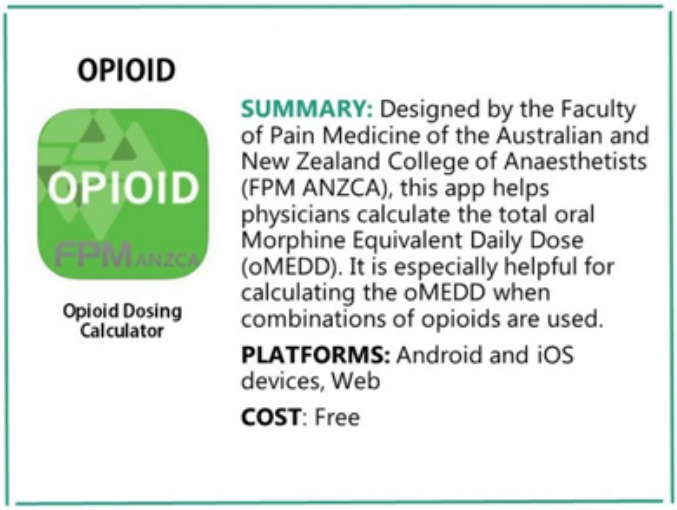
Converting from transdermal Buprenorphine and transdermal Fentanyl to Morphine

	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

Opioid Calculator – FPM ANZCA



Please download calculator here:
http://www.opioidcalculator.com.au/

GooglePlay:
https://play.google.com/store/apps/details?id=au.edu.anzca.opioidcalculatorapp

App Store:
https://itunes.apple.com/WebObjects/MZStore.woa/wa/iewSoftware?id=1039219870&mt=8

Breathlessness Action Plan to talk through with someone who is breathless

Name: _____

Action Plan

1. **Stop & get comfortable**

   Sit or lean against something.

2. **Breathe slowly**

   Coach the person to breath slowly 3 seconds in, 3 seconds out.

3. **Use a fan and direct it at the persons face**

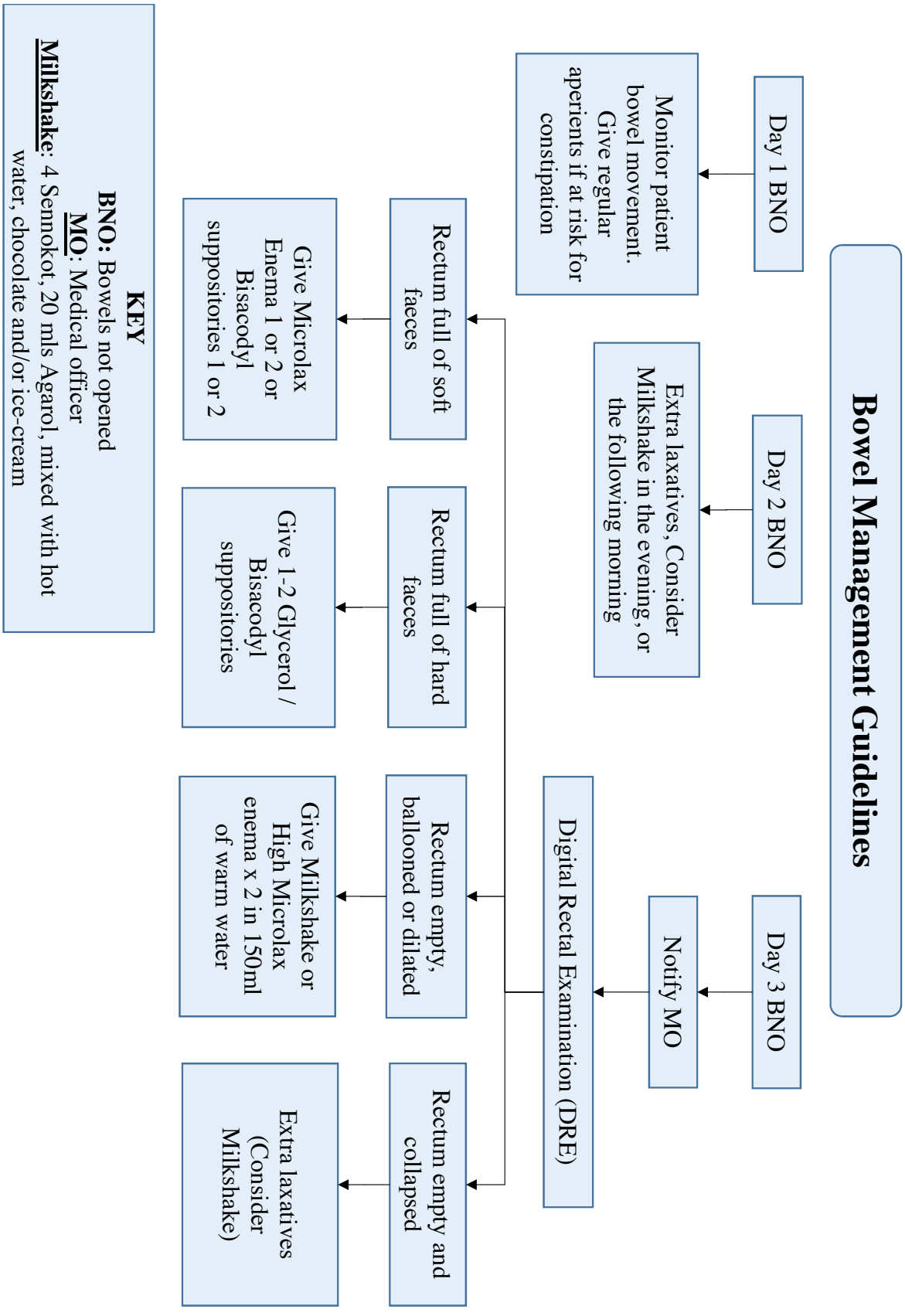
   This will stimulate the trigeminal nerve, which tricks the brain and helps with breathing.

4. **Request medication from staff.**

Bristol Stool Chart

HammondCare Champion Life **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

Bowel Management Guidelines



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 is 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 the person wears dentures, make sure they are clean, and not loose or rubbing which can cause pain and discomfort. Do the dentures need to be left out and the person's diet changed? Inform and reassure family that when deteriorating: gum size changes and avoid unnecessary dental intervention
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 or medication in mouth for long period of time, **Change** diet, request the GP reviews 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.

Trouble Shooting for Syringe Driver

Alarms Guide		
Intermittent audible ALARMS	**Possible causes**	**Action**
Screen display		
Occlusion Syringe Empty Check Line & Syringe	Infusion line clamped Tubing occluded Crystallisation of line and or cannula Driver has reached minimum travel position	Release clamp Clear occlusion Change cannula and line Turn driver off if finished Press YES to confirm
Syringe displaced Check Syringe	Syringe detectors not detecting syringe due to being displaced	Check syringe and reposition as required Press YES to confirm
Pump paused too long	When there is no key pad input after two minutes	Continue programming Start infusion Stop driver if not required
End program	Infusion completed	Turn driver off Prepare new infusion
Single audible beep ALERTS	Possible causes	Action
Screen display		
Near End	Nearing end of infusion (App 15 Minutes) prior to completion	Prepare to turn driver off
Low Battery	Battery is almost fully depleted	Prepare to change battery

Trouble Shooting for Syringe Driver

Troubleshooting Guide		
Fault	**Possible causes**	**Action**
Driver will not start	· No battery present · Battery incorrectly placed in pump or very low · Faulty driver	· Insert battery · Insert battery correctly and check available power · Replace driver & inform NUM to get Biomedics to check driver
Infusion finishing early or late	· Incorrect rate set · Wrong syringe brand confirmed at set up · Driver incorrectly calibrated	· Check display screen against prescribed medication order · Change program if necessary · Retrain staff if necessary · Replace driver and inform NUM to get Biomedics to check driver
Driver has stopped prior to syringe contents being totally infused	· Flat battery · Occluded infusion set	· Replace battery · Clear occlusion

NSW Ambulance Plan

NSW Ambulance Authorised Adult Palliative Care Plan

NSW Ambulance Authorised Palliative Care Plans (APCP) were developed to enable paramedics to provide individualised care to a patient, who has a life-limiting illness. The APCP will provide paramedics with the plan which has been developed by the medical practitioner in consultation with the patient and/or their person responsible. In order for the paramedic to follow the APCP it must be endorsed by NSW Ambulance. If the APCP is not endorsed, delay in the provision of the required treatment may result. Authorised Care Plans are only processed Mon - Fri (No Public Holidays)

Process for Endorsement

1. Form completed by the practitioner. If the form is being completed by both a medical and nurse practitioner, the medical practitioner must sign on page 2 and the nurse practitioner must complete the signature section on page 4. If the entire form is being completed by a medical practitioner one signature on page 4 will meet the medico-legal requirements. All fields must be completed and legible. Failure to complete the form legibly will result in the plans being returned to the author.
2. Completed form must be emailed to AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or faxed to (02) 9320 7380.
3. Completed form reviewed by NSW Ambulance and endorsed. If information is unclear or incomplete, clarification will be sought from the author and may result in processing delays.
4. Completed form with a covering letter will be mailed back to the address indicated on the form (this can take up to 10 days). If the patient/family agrees, the endorsed APCP can be emailed directly to the nominated email address in lieu of post. This will facilitate more timely access to the endorsed APCP.
5. A copy of the endorsed APCP will also be emailed or faxed to the medical practitioner.

N.B. please notify NSW Ambulance if the APCP is no longer required or if the patient dies.

APCPs remain valid for 12 months, after this time paramedics may not be able to follow the plan.

Paramedics carry a limited supply of routine medications (see list below). If the patient requires other medications to be administered to help manage symptoms, these medications must be available in the patient's residence.

Paramedics are not able to access medications that are in a locked medication safe in a RACF if the registered nurse is not available.

All Paramedics			
Adrenaline	Aspirin	Benzyl Penicillin	Clopidogrel
Compound sodium lactate	Droperidol	Enoxaparin Sodium	Fentanyl
Glucagon	Fexofenadine	Ibuprofen	Frusemide
Glucose Trinitrate	Ipratropium Bromide	Methoxyflurane	Metoclopramide
Midazolam	Morphine	Naloxone	Ondansetron
Oxygen	Paracetamol	Salbutamol	Tenecteplase
Intensive Care Paramedics Only			
Amiodarone	Atropine	Calcium Gluconate	Ketamine
Lignocaine	Sodium Bicarbonate		

NSW Ambulance Plan

NSW Ambulance Trim Number:	NSW Ambulance Document Number:

Patient's Details:	New APCP Patient ☐	Existing APCP Patient ☐
Surname:	Given Name:	Date of Birth: Sex: Male ☐ Female ☐ Other ☐
Street No. & Name		Home Ph: Mobile:
Suburb:		Postcode:
Safety Issues at home: Yes ☐ No ☐ (If yes, please provide details)		
Language:	Interpreter required: Y ☐ N ☐	Dialect:
If patient is a hospital inpatient	Hospital Name:	MRN:

THIS SECTION MUST BE COMPLETED AND SIGNED BY A MEDICAL PRACTITIONER

RESUSCITATION STATUS

In the event of cardiopulmonary arrest: CPR ☐ NO CPR ☐

Rationale for withholding CPR:

- Withholding CPR complies with the competent patient's verbally expressed wishes. ☐
- Withholding CPR complies with the patient's applicable Advance Care Directive. ☐
- The patient's Enduring Guardian agrees that withholding CPR is consistent with the patient's wishes. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

MEDICAL PRACTITIONER DETAILS

Name:	Contact Number:
Provider Number:	After-hours contact:
Organisation/Practice Name & Address:	
Email:	
As the medical practitioner, I support this care plan and by signing this form I request NSW Ambulance paramedics to implement the treatment options which have been discussed with the patient and is consistent with their treatment requirements	
Signature:	Date:

FOR COMPLETION BY A MEDICAL PRACTITIONER WHO ACCEPTS RESPONSIBILITY TO COMPLETE THE MCCD FOR EXPECTED HOME DEATH

Will you make yourself available at the time of the patient's death to view the body & complete the MCCD?

Yes ☐ No ☐ Comment:_____

Can you be contacted after hours? Yes ☐ No ☐

If No, are you prepared to provide a Medical Certificate of Cause of Death (MCCD) to the Funeral Director within 48 hours, if the death is not a reportable death under the Coroners Act 2009? Yes ☐ No ☐

Medical Practitioner Completing MCCD details:

A/H or Mobile (if available):_____Surgery Ph: _____

Print Full Name: _____ Signature:_____

Date:_____

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

NSW Ambulance Plan

NSW Ambulance Trim Number:	NSW Ambulance Document Number:
Patient Name:	Date of Birth:

This page can be completed by Medical or Nurse Practitioner

PATIENT'S CLINICAL HISTORY (Please print clearly – Attach additional pages if required)

Diagnosis:

History:

Goals of Care:

Is the patient known to a Palliative Care Service: Yes ☐ No ☐ (if yes, please specify)

Allergies:

PATIENT'S CURRENT MEDICATIONS

Drug Name	Strength	Frequency	Indication

As required medications to be administered to manage symptoms (if required please add extra list)

Medication	Strength	Frequency	Indication/s	Max 24 hour dose

Treatment Options

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

Respiratory Support: (Check box if appropriate)	Are other non-urgent interventions appropriate? Yes ☐ No ☐
Pharyngeal Suction ☐	If yes (please check the appropriate interventions):
Supplemental oxygen ☐	Vascular access ☐
Bag & Mask Ventilation ☐	IV Fluids ☐
Intubation ☐	IV Antibiotics ☐

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

NSW Ambulance Plan

Patient Name:	Date of Birth:

This page can be completed by Medical or Nurse Practitioner

To facilitate more timely return of Authorised Care Plan please provide an email address. (If no email address is provided the endorsed plan will be mailed to the person indicated below):

Email Address:

Name of Recipient:

Relationship of recipient to patient:

PERSON RESPONSIBLE (PLEASE PRINT CLEARLY)

Surname:	Given Name:

Relationship: Enduring Guardian ☐ Family Member ☐ Other ☐

Address:

Contact Number:

Language: Interpreter: Yes ☐ No ☐

Patient's & or Person Responsible's Acknowledgement of this Plan

Patient's Signature:	Date:
Person Responsible's Signature:	Date:

LOCATION OF CARE

In the event that care at home becomes too difficult, the choice for future care is at:

How to arrange admission to this location:

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

CONTACT LIST

Team	Name	Business Hours Contact	After hours contact
General Practitioner			
Palliative Care			
Primary Care Team			
Community Nurse			
Other Health Service			
Spiritual/Religious Supports			

MEDICAL OR NURSE PRACTITIONER DETAILS

Name:	Contact Number:
Provider Number:	After-hours contact:
Designation: (please circle) Medical Officer	Nurse Practitioner

Organisation/Practice Name & Address:

Email:

As the medical/nurse practitioner, I support this care plan and by signing this form I request NSW Ambulance paramedics to implement the treatment options which have been discussed with the patient and is consistent with their treatment requirements

Signature:	Date:

FOR OFFICE USE ONLY:	Date of Receipt:	Renewal Date:
Trim Number:	Document Number:	

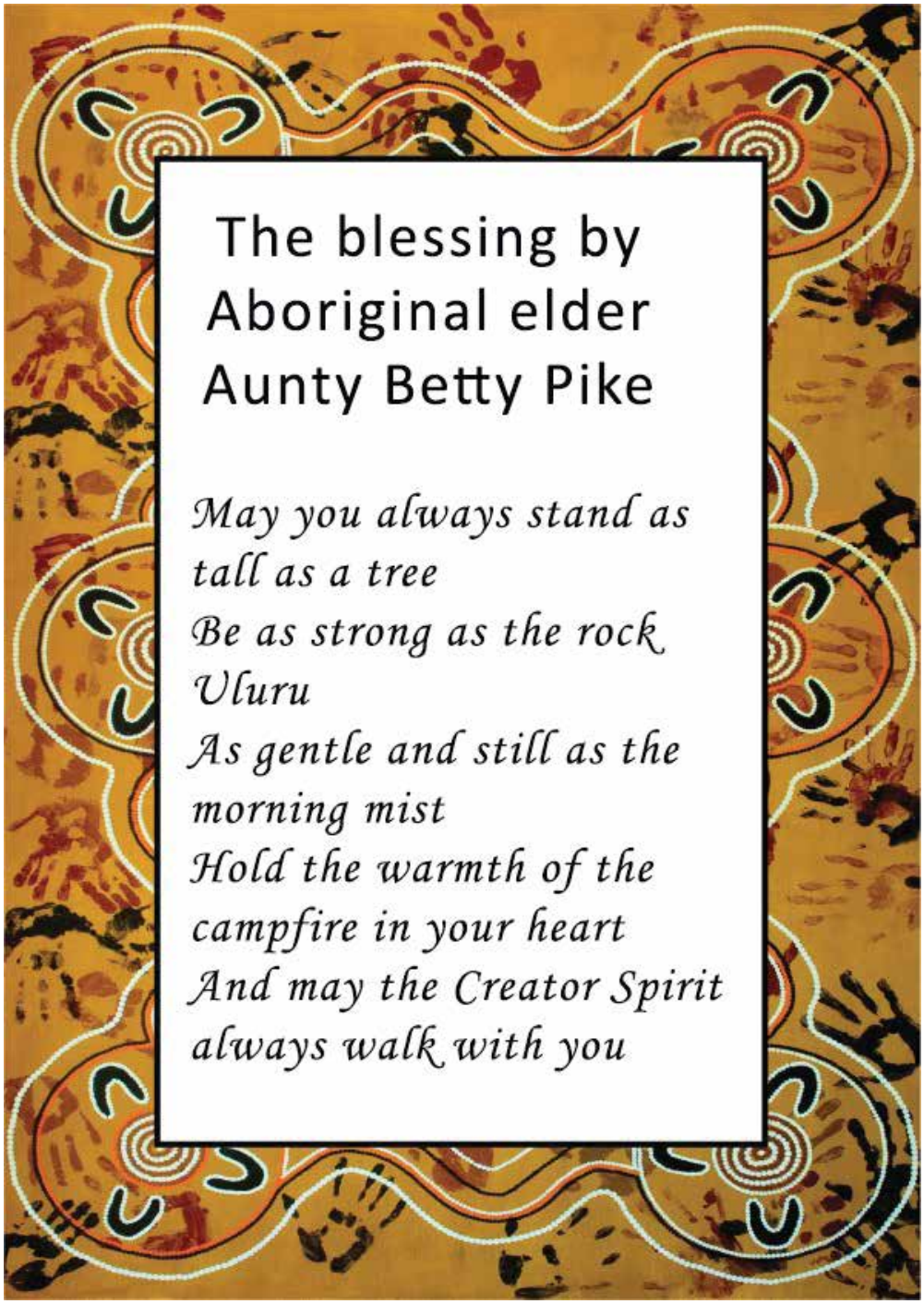
Endorsed By Name:	Date:

Signature:

Position:

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

Aboriginal Blessing



Namaste Care Program Guidelines

“To honour the spirit within”

Namaste Care is a structured program developed by Joyce Simard in the USA, integrating compassionate nursing care with individualised activities for people with advanced dementia, especially in the last stages. The purpose of Namaste Care is to give comfort and pleasure to people through the senses, touch, smell, hearing, sight and taste. Namaste Care increases the length of time that staff spend engaging and connecting with residents aiming to meet sensory and emotional needs enriching their quality of life.

Download and print off the Namaste Guide to implementation:
Namaste-Care-Programme-Toolkit

https://www.stchristophers.org.uk/wp-content/uploads/2016/03/Namaste-Care-Programme-Toolkit-06.04.2016.pdf

The core elements

- ‘Honouring the spirit within’
- The presence of others
- Comfort and pain management
- Sensory stimulation
- Meaningful activity
- Life story
- Food treats and hydration
- Care worker education
- Family meetings
- Care of the dying and after-death care
- After death reflection

Namaste Care Program Guidelines

Namaste Care Session

Creating the environment

- Gather supplies for the morning, including face cloths, basins, towels, beverages, pillows for positioning, individual resident supplies, etc.
- Tidy the room and dim the lighting
- Set up aromatherapy diffuser with lavender
- Play soft music & show nature videos

Welcome to Namaste

- Each person is touched as they come into the room
- Each person is placed in a comfortable lounge chair
- A quilt or blanket is tucked around them
- Extra pillows or towels can be used to help with positioning
- Each person is assessed for pain/discomfort

Morning activities

- Hands are washed and lotion applied to hands and arms
- Face is washed and face cream is applied
- Hair is brushed
- Take into account personal likes, e.g. lipstick, hair ornaments, etc.
- Hands are massaged
- Get to know the persons likes and dislikes and offer comforting items such as: Baby replacement therapy, a fiddle mat, PAT (pets as therapy). To order please contact Dementia Support Australia
- Large dogs, kittens, rabbits, etc.

Nutrition/Hydration

- Constantly offer drinks such as water/juices
- Offer ice cream, yoghurt, smoothies, fruits, chocolate – things you would like to eat!

As time permits

- Shaving the men
- Offering ice cream, puddings, etc.

Waking up for lunch (twenty minutes before lunch)

- Turn up the lights
- Change to lively music
- Fun activity such as blowing bubbles, tossing a ball/balloon, etc.
- Talk about the day
- Use bird sounds
- Take scents to each person to remind them of the weather, i.e. grass, flowers

Afternoon session

Activities

- Individual reminiscence with life stories, old pictures and items from the past
- Foot soaks + lotion feet and legs
- Range of motion to music (chair dancing)
- Fancy hair arrangements or nail care

Namaste closes

- Residents thanked for coming to Namaste
- Room tidied and prepared for the next day

Music Engagement

When language cognition and verbal communication decline, people who no longer speak or comprehend conversation can often still sing and even recall lyrics. Interestingly, music appreciation seems to outlast deterioration of any specific region of the brain.

We recognise that music provides a source of fun and relaxation as well as numerous benefits to wellbeing for people living with dementia in residential aged care. These include a greater sense of emotional safety, building rapport and trust with staff, and providing an opportunity for emotional expression.

Music also operates on many levels, family, grandchildren, staff, student visitors, and volunteers can listen to music and sit with an older person without being intimidated or wondering how to relate.

To make an individualised playlist:

1. Purchase online a specially designed headset called an eshuffle from: **https://shop.mbf.org.au/**

2. Purchase a google play gift card. Available at most grocery or department stores. ($20 card will buy approximately 10 songs)

Then:

3. Gain a list of favourite songs and artist from when the person was younger, aged approximately 15 to 25 years old.

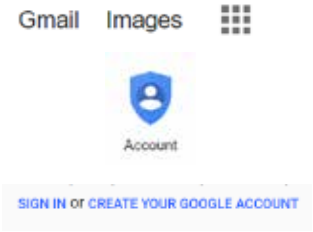
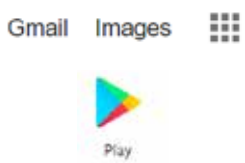
Music Engagement

How to load the eShuffle using Google Play

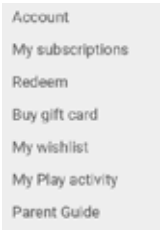
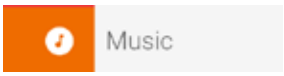
Quick guide

A. Create a Google account
B. Purchase music – create a music library
C. Download music
D. Load the downloaded music onto the eShuffle

Step by step guide

A. Create a Google account	
1. Open Google Chrome 2. Open the Google app launcher (9 dots at top right of page) 3. Select 'Account' 4. Select 'Create your Google account' 5. Complete all fields (first name, last name, email, & password), record the email & password, and click 'Next' 6. You may be asked to verify your mobile phone number 7. Enter your phone number, click 'Next' 8. Enter the validation code sent via SMS, click 'Verify' 9. Enter a recovery email address (optional), date of birth, and gender (optional), click 'Next' 10. On the 'Get more from your number' page, select 'Skip' 11. Read the 'Privacy and Terms' page, and if you agree, select 'I agree'	
B. Purchase music	
1. On the Google Account page, open the Google app launcher (9 dots at top right of page) 2. Select 'Play'	

Music Engagement

3. Select ‘Redeem’ (from the menu on the left of the page) 4. Enter the Google Play gift card code, click ‘Redeem’ 5. Select ‘Confirm’ 6. On the ‘Create account’ window, enter the postcode, click ‘Continue’ 7. On the ‘Congratulations!’ window, click ‘Shop’ 8. Select ‘Music’ (from the menu on the left of the page) 9. Use the ‘Search’ field to find favourite artists, songs, or albums Clicking on the artist’s name will give you their top songs. Consider either buying individual songs or a whole album. A ‘Best of…’ album can be a good option. Listen to the sound quality by clicking on the Play icon to the left of the song name. For older songs, remastered versions, can be best. Unless especially requested, avoid live versions of songs, as the audience responses can be intrusive to the listening experience. 10. When you find a song to buy, click the dollar amount to the right of the song title/album/time. Individual songs vary from $0.99, $1.69, & $2.19 11. Select ‘Buy’ 12. Enter the password and, click ‘Next’ 13. The song is now added to the library, select ‘Close’ to continue to purchase preferred music	  
C. Download music	
1. Select ‘My Music’ (from the menu on the left of the page) 2. Select ‘Music Library’ 3. Select ‘Albums’	

Music Engagement

4. Select the 'More options' menu on the album (hint: hover the mouse over the album and look for 3 vertical dots) 5. Select 'Download album' 6. Click on 'download directly' 7. Select 'Download now' 8. Click 'Done' 9. Continue for each album in the Music Library	
D. Load the downloaded music onto the eShuffle	
1. Plug the USB jack into the eShuffle 2. Turn the eShuffle on (hint: use the slide control to the right of the USB connector plug) o A blue light will appear on the right ear cup 3. Plug the USB into the USB port on your computer o The USB Drive (D:) folder will open 4. From your Downloads folder, select all relevant songs (they will be in .mp3 format) 5. Drag the selections into the USB Drive (D:) 6. Check that all the relevant songs are in the USB Drive o Note that Albums in the download folder which are zipped will need to be extracted prior to being copied into the USB Drive. 7. Once all songs are in the USB drive, close the folder, eject the USB drive, and unplug the eShuffle	 01 - Ain't Misbehavin'

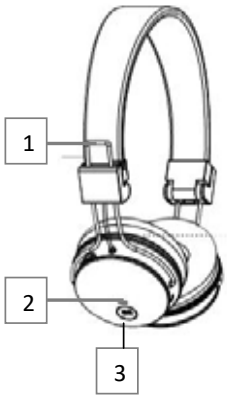
You are now ready to enjoy listening to your music!

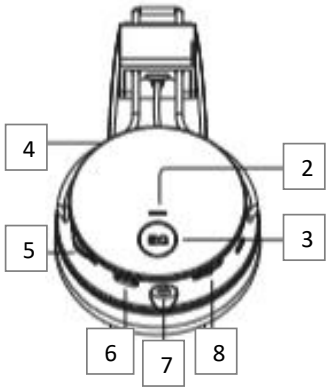
Note: The eShuffle can also be loaded from iTunes. Songs must be converted to MP3 format to load onto the eShuffle.

Disclaimer: This document is a technical guide to loading music only and does not represent a product or services endorsement. Respect copyright laws and comply with the music provider's Terms and Conditions at all times.

Music Engagement

eShuffle User Guide





1. Adjustable Band
2. Mode Indicator Light (Playlist/Radio/Charging)
3. Random Play/Radio Tuning Button
4. Micro SDHC/TF Memory Card slot
5. Mode Selection & Volume Control
6. Micro USB Cable Port
7. Audio in/out (Music Share)
8. Slide Power ON/Power OFF

To Charge: Plug the small end of the black USB cable into the eShuffle USB Cable Port (6) then connect the large end of the same cable into a 5V wall charger. Turn on power at power point. A flashing red light (2) indicates that device is charging. A solid light (2) indicates when device is fully charged.

When charged, turn off the power at the power point and disconnect the device from the charging cable.

NOTE: The eShuffle can also be charged by plugging the large end of the black USB cable into a computer instead of a wall charger.

To Turn Device On/Off: Slide the rectangular On/Off button (8) to turn the device on/off.

Mode Status and Selection:

Flashing **Red** Light	=	Device is charging
Solid **Red** Light	=	Device is fully charged
Blue Light	=	Music playlist
Flashing **Green** Light	=	Device is tuning in local FM stations
Solid **Green** Light	=	FM radio successfully tuned

Selection is made by gently pushing the Mode Selection (5) button in and then releasing same

Default Mode:

Once there is a playlist on the eShuffle, the indicator light will be blue at start up and the playlist will automatically start playing. If there is no playlist on device, or if the supplied memory card (4) has been removed, the indicator light (2) will be green at start up and radio (if tuned) will automatically play.

Loading Music to Playlist:

The correct file format is mp3. For assistance, please refer to Online Tutorial Notes as relevant to your particular platform (Mac or Windows)

Repeat Tracks & Random Play

With the playlist blue light displaying, press and hold Random Play (3) button once to Repeat Track (Green solid light displays). Press and hold for a second time for Random Play (Green light flashes). Press and hold for a third time to return to the default sequential play.

Tuning FM radio:

Gently press and release the Mode Selection (5) button until the green light (2) displays. Press the Radio tuning button (3) until green light flashes and release. The light will continue to flash whilst device tunes in to available stations in your area. When the green light stops flashing, the FM radio is tuned and ready for use.

Track / Station Selection:

PLAYLIST … Gently flick the Mode Selection (5) button forward or backwards to change tracks

FM RADIO … Gently flick the Mode Selection (5) button forward or backwards to change stations

Adjusting Volume Control:

PLAYLIST … Gently roll the Mode Selection (5) button forward and hold to turn volume up … Release when volume level is ok

Gently roll the Mode Selection (5) button backwards and hold to turn volume down. Release when volume level is ok,

FM RADIO … Gently roll the Mode Selection (5) button forward and hold to turn volume up … Release when volume level is ok

Gently roll the Mode Selection (5) button backwards and hold to turn volume down. Release when volume level is ok,

Music/ Radio/Talking Book Sharing With Another: No splitter is required to share a playlist, talking book or radio with another person. A second set of headphones/earphones with a 3.5 jack can be plugged directly into the Music Sharing Port (7) so that two people can listen at once.

Music Broadcasting: Plug one end of the supplied white Audio Cable into the Music Sharing Port (7) and the other end into the 3.5 microphone jack of a larger amplifier or CD player to broadcast direct from the eShuffle through an amplifier or CD player.

Traditional Headphone Use: Slide the On/Off button (8) to OFF. Plug one end of the supplied Audio Cable into the Music Sharing Port (7) and the other end into a 3.5 speaker jack of a mobile phone, tablet device, CD player etc to listen to eBooks or music from your mobile phone or other players.

For Further Support: call Music and The Brain Foundation on 0417 216 187 or email info@mbf.org.au

Frequently Used Websites

Informative websites

- **Hammondcare**. Providing palliative Care in Northern Sydney. At home, in hospital, in residential aged care. To refer to the palliative care service: the referral form is found at: **www.hammond.com.au**
- **Palliative Care NSW**. State peak body and leading voice in NSW promoting quality palliative care for all. **www.palliativecarensw.org.au**
- **Palliative Care Australia**. National peak body for palliative care. **www.palliativecare.org.au**

Education and Professional Development

- **The Palliative Care Bridge**: free innovative educational videos and resources on palliative care by respected experts and specialists in the field. Go to caring tips and information to download the Palliative Care Flip Chart and Palliative Care Resource Booklet **www.palliativecarebridge.com.au**
- **CareSearch**: Online resource providing evidence-based palliative care information for health professionals. **https://www.caresearch.com.au/caresearch/tabid/80/Default.aspx**
- **ELDAC (End of Life Directions for Aged Care)**: provides information, guidance, and resources to health professionals and aged care workers to support palliative care and advance care planning to improve the care of older Australians. **www.eldac.com.au**
- **PEPA (Program of Experience in the Palliative Approach)** Provides an opportunity for primary health care providers to develop skills in the palliative approach by undertaking a supervised observational clinical placement. To apply for this free program, go to: **www.pepaeducation.com**
- **palliAGED**: information regarding palliative care evidence and practical resources (Practice tip sheets) for aged care. **www.palliaged.com.au**
- **AHHA** – Palliative Care Online Training **https://www.caresearch.com.au/caresearch/tabid/3659/Default.aspx**

National Standards

- **Aged Care Quality Standards**: **https://www.agedcarequality.gov.au/providers/standards**
- **National Palliative Care Standards** **https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/11/PalliativeCare-National-Standards-2018_Nov-web.pdf**
- **ELDAC Funding & Standards** – ELDAC has developed resources to help aged care staff and organisations meet the eight standards. **https://www.eldac.com.au/tabid/5034/Default.aspx**

Frequently Used Websites

Resources

- **CareSearch** – Palliative care print resources for patients, carers and families.
  https://www.caresearch.com.au/caresearch/tabid/1262/Default.aspx
- **PalliAged Tip Sheets**. A series of practical tip sheets focusing on commonly encountered issues by Nurses and personal careworkers provide to support them in caring for older people approaching the end of life.
  https://www.palliaged.com.au/tabid/5544/Default.aspx
- **SPICT Tool**. A tool which can be used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs, and plan care.
  www.spict.org.uk
- **ELDAC After Death Audit**: This audit provides more detail on care provided to individual residents and families. It is recommended that a baseline audit be completed for either the most recent five to ten resident deaths or for a time period (e.g. all deaths that occurred over the previous 3 month period). Download the ELDAC After Death Audit (744kb):
  https://www.eldac.com.au/Portals/12/Forms/Toolkits/ELDAC_After%20Death%20Audit_HC.pdf
- **Music engagement**:
  https://www.musicandthebrain.org.au/
- **Namaste Program toolkit**:
  https://www.stchristophers.org.uk/wp-content/uploads/2016/03/Namaste-Care-Programme-Toolkit-06.04.2016.pdf

Advance Care Planning Information

- **The Advance Project**: free online training and resources, ie Preparing for an Advance Care Planning conversation.
  www.theadvanceproject.com.au
- **Advance Care Planning Australia**: provides free information, online training and resources to health professionals, individuals, care workers and substitute decision-makers.
  www.advancecareplanning.org.au
- **NSW Government Planning Ahead**:
  https://planningaheadtools.com.au/faqs-and-more-info/
- **NSW Ministry of Health Advance Care Directive**:
  https://www.health.nsw.gov.au/patients/acp/Pages/acd-form-info-book.aspx
- **NSW Ambulance Authorised Palliative Care Plan Adult**
  http://www.ambulance.nsw.gov.au/Community-Info/NSW-Ambulance-Authorised-Care-Plans.html

Resources for Patients, Families and Carers

Palliative Care Support for Patients, Carers and Families

To order FREE information booklets to give to families go to: caresearch@flinders.edu.au

https://www.caresearch.com.au/caresearch/tabid/1262/Default.aspx

Supported Decision-Making: A guide for people living with dementia, family members and carers

https://cdpc.sydney.edu.au/wp-content/uploads/2019/06/SDM_Handbook_Online_Consumers-ReducedSize.pdf

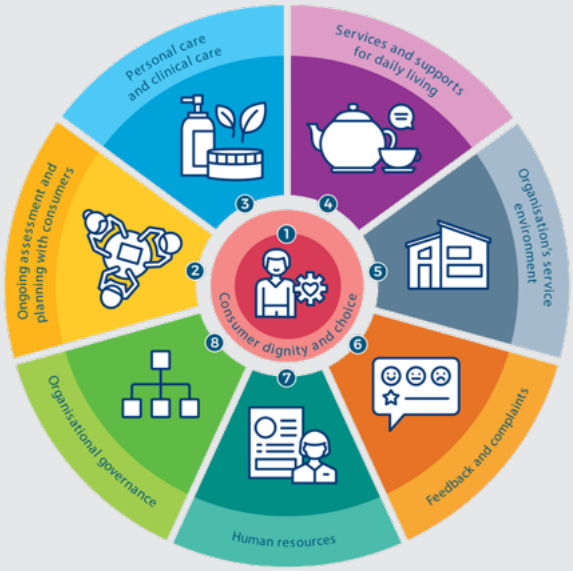
Standards and Funding

The End of Life Direction for Aged Care (ELDAC) Residential Aged Care provide guidance understanding aged care accreditation standards and funding arrangements that support palliative care and advance care planning.

Aged Care Quality Standards

The Aged Care Quality and Safety Commission expects that organisations providing aged care services in Australia will comply with the Aged Care Quality Standards (Standards), which include end of life care and advance care planning. For more information on the Standards, see the Guidance and Resources for Providers webpages.

Source : Aged Care Quality and Safety Commission website www.agedcarequality.gov.au



ELDAC has developed resources to help aged care staff and organisations meet the eight Standards **https://www.eldac.com.au/tabid/5034/Default.aspx**

National Palliative Care Standards

Palliative Care Australia have released the 5th edition of the National Palliative Care Standards (371kb pdf). These standards are useful to refer to when reviewing palliative care and advance care planning in your organisation.

ACFI Funding Instrument

Funding for residential aged care is provided through completion of the Aged Care Funding Instrument (ACFI). ACFI Section 12 (Complex Health Care) Question 14 allows a service to claim funding for a palliative care program involving end-of-life care where ongoing care will involve very intensive clinical nursing and/or complex pain management in the residential aged care. **See the ACFI tool (467kb pdf) for funding requirements.**

Northern Sydney Complimentary 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** (Mon–Fri 6pm–8am, Sat 12pm–8am, Sunday/PH All day)
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 (Please ask for 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–Sun 8am–8pm)
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)

Notes

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Champion Life

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Phone 1300 426 666 **hammondcare.com.au**

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