Palliative Care Victoria Summit 2023

Reflect, Reconnect, Rest

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Living, dying & grieving well

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Welcome

Kelly Rogerson
Board Chair, Palliative Care Victoria

Palliative Care Victoria Summit 2023
Reflect, Re-connect, Reset

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Acknowledgement of Country

Kelly Rogerson

Board Chair, Palliative Care Victoria

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Palliative care – next steps

Palliative Care Victoria Summit Feb 2023

Jen Bliss

Executive Director Health Services & Aged Care Policy, Improvement and Engagement

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VICTORIA State Government | Department of Health

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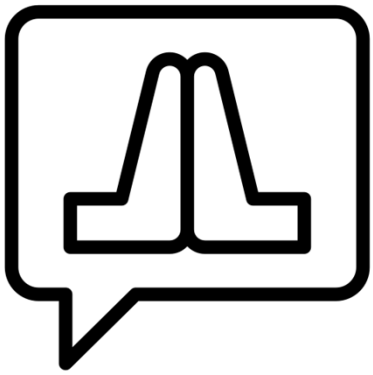
Here we are in 2023…



The Department of Health, our Government colleagues and our communities thank you for your unwavering efforts, ingenuity and resilience throughout the COVID-19 pandemic

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Changes within the department…

All Victorians and their families receive the best possible end of life care that places them at the centre where preferences, values, dignity and comfort are respected and quality of life matters most

Advance care planning

- Victorians have the opportunity to articulate their goals of care, preferences.
- We have the systems in place to support Victorians to articulate what matters most to them about their end of life care choices and care.
- Our clinicians and services are enabled to act on people's preferences.

Palliative care

- Victorians can have equitable access to palliative care services across Victoria.
- Models of care are effective and efficient.
- Specialist palliative care is accessible locally - this may take a variety of forms (direct care, consultancy etc).
- Workforce models are efficient and sustainable.
- System capacity and capability are key components of sustainability.

Voluntary assisted dying

- Victorians have a right to choose voluntary assisted dying as an end of life choice.
- Our health system and providers need to support people who elect this choice.
- Those who elect this choice should not be treated any differently from other patients receiving end of life care across our service system.

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The Department of Health 's strategic outlook and reform agenda provides insight to where the system is heading…

Planning for COVID normal and future direction of palliative care:
Minister for Health
"palliative care is a model under a process of adaptation and change …there's a role for hospital-based services but increasingly Victorians look to the wider palliative care services being home-based and community-based support…."

- Multiple providers, shared care – integration across service systems
- Care as close to home – or in the home when safe and appropriate
- New practices learnt during COVID-19

We have common objectives across the healthcare system (govt/community/providers):

- Improved population health
- Increased equity
- Quality patient outcomes, with reduced unwarranted variation
- Quality patient and provider experiences
- Affordable for the community

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What does this look like when we apply our lens to palliative care?

Manage upstream

Better hospital & primary care integration to prevent delays, reduce preventable admissions and manage illness

What are the issues?

- New players with similar focus – HIP, HITH, Better at Home, Resi-In-Reach, Hospital consultancy community in-reach – what's the opportunity for palliative care?
- Best health care is preventative (early intervention) – how can we do this in a resource constrained environment experiencing high demand?
- Most effective with strong integration between systems
- Integration constrained by funding models

More care outside of hospital

Deliver safer, more effective care for patients, closer to home

What are the issues?

- Limited 'planned' uptake of home-based care despite evidence patients achieve better outcomes at home
- Rapid growth in response to system-level crisis/emergency - need to focus on sustainability
- Shared models of care between 'like/competing' providers – how do we do this?
- Expansion of telehealth/digital health – what's the best use/value for patients and carers?

Better, safer care

Purposeful, systematic improvements in patient outcomes and experience

What is the issue?

- Variation in outcomes / experience
- Equitable and accessible care – is there equity?
- Data availability challenges
- Unsustainable cost increases
- What's the best way to cess for driving systemic improvement

Collaborate to solve system challenges

Working better as a system to respond to crises and plan for the future

What is the issue?

- Lack of incentives and structures for cooperation makes it harder to respond to crises
- How can we be better at surge response
- Future planning – workforce models/reform

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What's on the horizon in the immediate future Jan 2023 – June 2024 …?

Review & update capability framework

Articulate what Victoria's palliative care service system looks, including roles and responsibilities.

What are the issues?
- Last updated 2009-11
- Needs to incorporate landscape/system changes
- Roles & expectations need to be clearly articulated to enable greater clarity, support system development and help services move from one level to another.
- Balance existing and future needs.

What's required?
- Evidence base for change
- Engagement from all stakeholders
- Vision, commitment and patience (may require a phased approach)

Data is key to our sustainability

Data integrity, visibility and timeliness to inform improvement at every level of the system.

What are the issues?
- Limited coverage of data across all of Victoria's palliative care 'settings/streams' means we have a limited picture of the system's effectiveness as a whole.
- Need to better understand key drivers of activity to inform system improvements – not clear from existing data in some areas.
- Significant gaps in some parts of the system that are critical to sustainability (cost/workforce/outcomes).

What's required?
- Reduce the gaps, improve quality and present data that informs change.

Better, safer care for aged care residents

Purposeful, systematic improvements in patient outcomes and experience.

What is the issue?
- Variation in outcomes / experience
- Equitable and accessible care – is their equity?
- Workforce availability, variation in roles and expectations
- Commonwealth / state/ provider – who is responsible for what ?

What's required?
- Engagement with both sectors (aged care & palliative care) to understand gaps & build capacity across the 'combined system' to support better resident outcomes
- *Comprehensive Palliative Care in Aged Care initiative*

Collaborate to solve system challenges

Working better as a system to respond to crises and plan for the future.

What is the issue?
- Engagement with services has been limited throughout the COVID-19 pandemic.
- We've lost ground in building the necessary foundational work required to progress the desired outcomes of our policy framework.

What's required?
- Reconvene to deliver the foundational work (capability framework , data gaps to inform funding etc.).
- Engage and consult with the sector to understand where the immediate pressures are, system gaps and opportunities.

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Longer term….

Review our progress against our policy framework/strategy:

- Policy goals are aspirational – are they still relevant,
- Throughout the last 5 years the landscape has changed significantly - what have we learnt, what's the evidence tell us …are we heading in the right direction?
- Care as close to home – or in the home when safe and appropriate – is that realistic and achievable? If not what needs to change for this to occur?
- New practices learnt during COVID-19 – are they sustainable?

What targets should we be setting to drive change in the future?
- We expect the 'system' to be more integrated – what does that look like in terms of outcomes?

Where to from here?
- Work towards resetting our strategic outlook/vision for the next generation.

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Barwon South Western Region Palliative Care Consortium

Myra McRae - Barwon South Western Palliative Care Consortium Manager

Barwon South Western Region Palliative Care

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Pal at Home

Enhancing Palliative Care Services

Myra McRae - Barwon South Western Palliative Care Consortium Manager

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Program Goals

- Enhance the care delivery options for palliative care patients, enabling more patients to receive care, and die in their place of choice.
- Improve the patient and carer experience aligning with the Victorian Department of Health End of Life and Palliative Care framework.

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Model

- Bed substitution – subacute NWAU
- 6 virtual beds
- 24 hours care over 3 shifts
- Nursing and Medical

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Objectives

- Rapid response
- Care provision similar to inpatient setting
- Intensive nursing care
- Reduce emergency admissions
- Support the choice to remain at home

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Patients

- Barwon Health Palliative Care Patients
- Patients' who wish to receive care at home
- Identified needs
  - End of life
  - High symptom burden that would normally require admission
  - Carer support to facilitate a patient to remain at home

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Data

December 2019 to September 2022

358 patients

Average length of stay 10.7 days

Median length of stay 7 days

Phase type	Pal at Home Average	Australian Inpatient Average
Stable	5.6	6.5
Unstable	2.4	1.9
Deteriorating	4.7	5.0
Terminal	2.4	2.0

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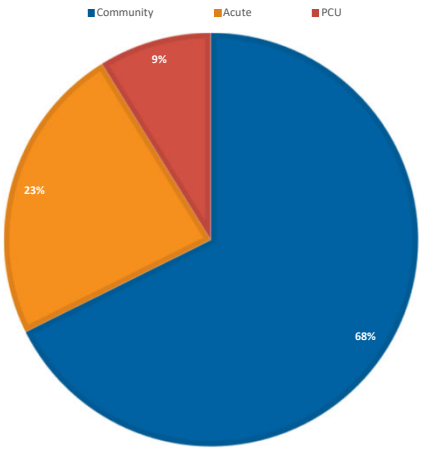
Admission Source



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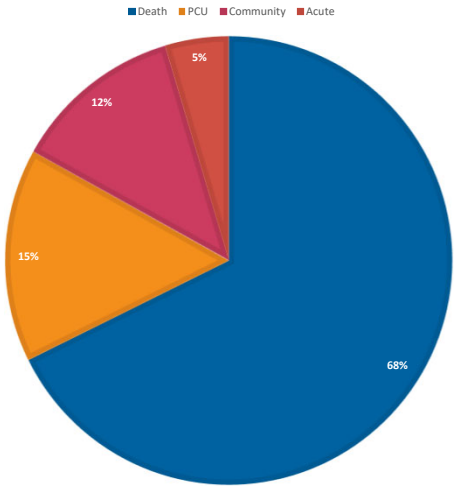
Discharge Destination



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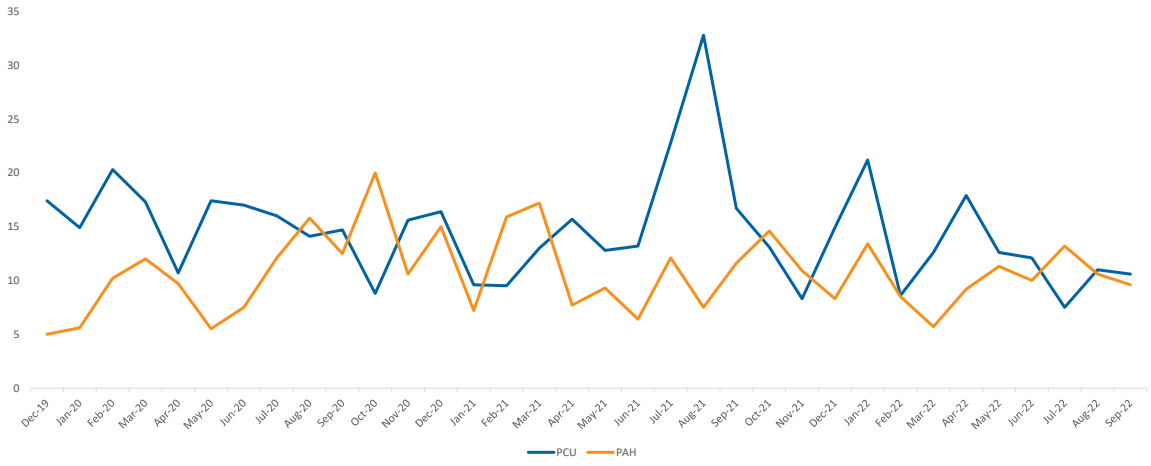
Average Length of Stay Comparison



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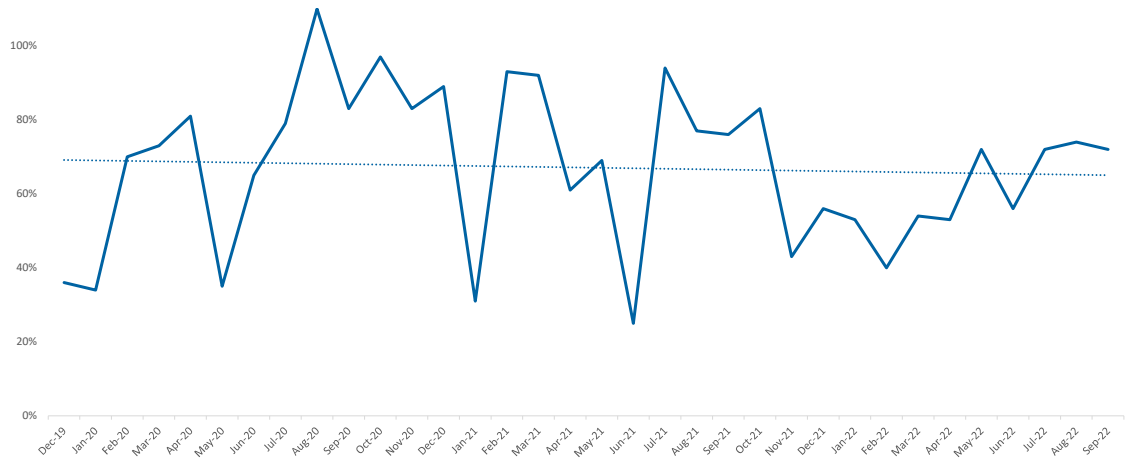
Occupancy



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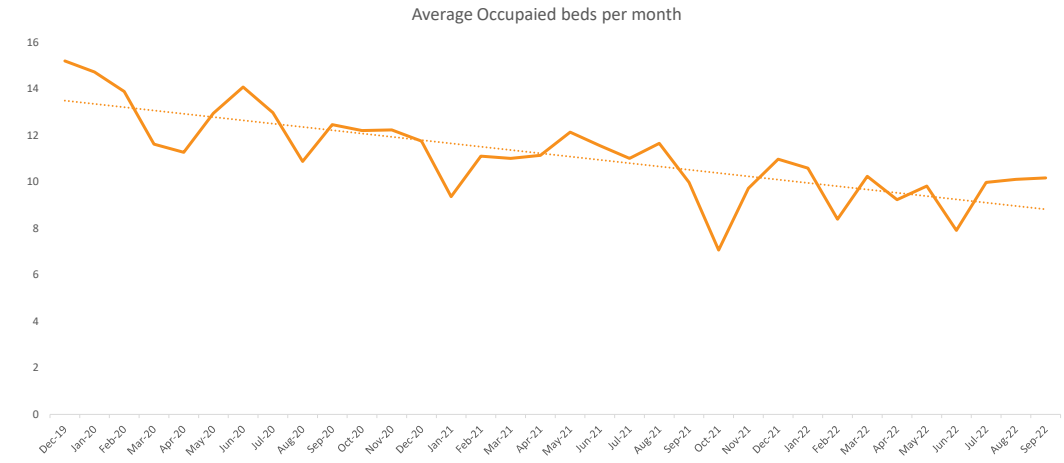
Inpatient Demand Reduction



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Staff Satisfaction 97%

"I was able to provide an excellent service to my patients"	• Always - 67% • Most of the time - 33%
"I had access to everything that I needed to do my job to the highest possible standard"	• Always - 50% • Most of the time - 50%
"I was supported by my leaders to do my job to the highest possible standard"	• Always - 100%
" I was encouraged to come up with better ways of meeting patient and family needs"	• Always - 100%
"There was great teamwork in this service"	• Always - 100%

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Patient and Carer Satisfaction

'They kept in constant touch with us and arrived to assist every time we called them. No matter what the time, morning, night, or the early hours of the morning'.

'They looked after dad's physical needs, washing, changing, etc. so that my wife and I could focus on his emotional and spiritual needs'.

'They have made a really difficult few days as easy as it possibly could have been'.

"It was very responsive to my mother's needs. They were caring and compassionate to the whole family. They were available at the end of a phone when required. They attended promptly. Allowed my mother to die with dignity where she wanted at home.

"The fact that I knew he was happy being looked after at home and receiving the care he needed, and that I could be with him constantly".

"My father wished to remain at home and not in hospital and this service allowed his wishes to be met, and took pressure off his family."

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Value

- Basic care needs of patients
  - Hygiene
  - Pressure Injury prevention
- Most helpful
  - Respite hours
  - Rapid response for assistance
  - Medical visits

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Enhancement

- Care for people who live alone
- Substitute carer
- Support where there is no afterhours care
- Avoid restrictive environment
- Post death support

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Objectives Met

- Rapid response
  - 100% of patient were admitted same day as requested
  - Within 4 hours of request
  - Call for assistance, visit response only subject to travel time
- Care provision similar to inpatient setting
  - Procedures and medications requiring frequent monitoring are able to be delivered at home
  - Round the clock visiting similar to ward rounding
  - 2 nurses available to provide manual handling and safe medication administration
- Intensive nursing care
  - Complex or technical nursing tasks
  - Patients receive a minimum of 3 visits per day
  - Respite overnight
- Reduce emergency admissions
  - Pal at Home admission in response to rapid deterioration in the community
- Support the choice to remain at home
  - 97% of patients who wish to remain at home stayed at home

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Morning Break

Next Session:

11.25am

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Eastern Metropolitan Region Palliative Care Consortium

Sarah Kleinitz - Eastern Metropolitan Region Palliative Care Consortium Manager

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Improving Access to Care

Sarah Kleinitz - Eastern Metropolitan Region Palliative Care Consortium

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Bridging the Gaps

Improving Access to Palliative Care in the Eastern Metropolitan Region

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EMRPCC Partners

Eastern Health

Eastern Palliative Care Association Inc. (EPC)

St Vincent's Hospital Melbourne (SVHM)

Bolton Clarke

Eastern Melbourne Primary Health Network (EMPHN)

North Eastern Melbourne Integrated Cancer Service (NEMICS)

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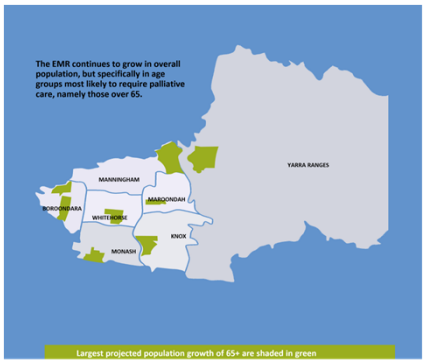
EMRPCC Catchment

- DHHS regions: inner east and outer east
- Area of 2025 km²
- Population = 1.15 million (census 2021)
- 18% of Victorian pop'n
- 24% of those living in Greater Melbourne
- 2036: 19% pop'n will be aged over 65
- Inner east pop'n has Victoria's highest life expectancy

Adapted from Eastern Palliative Care Association Inc. *Strategic Directions 2022*



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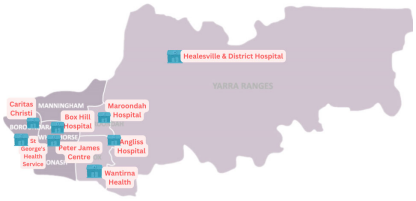
Service profiles

- Hospitals and health services
  - Ambulatory and inpatient care
  - No outpatient specialist palliative care service = no early involvement in care
  - Largest specialist palliative care consult service in Australia
  - 2 dedicated inpatient palliative care services with full capacity of 48 designated palliative care beds



- General Practice
  - 316 General Practices located across the Eastern Melbourne PHN catchment
- Community Palliative Care
  - EPC is only public-funded community palliative care service in EMR and largest single community palliative care provider in state

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COVID-19 in the EMR

- Low COVID-19 prevalence
- Wide-ranging public health orders and social restriction measures
- High patient, caregiver & staff distress
- Unprecedented demand for specialist community palliative care
- Flexible approach to balance public health protocols with compassion
- Later referrals presenting with more complex issues & dying more quickly
- More deaths at home

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Improving Access to Care

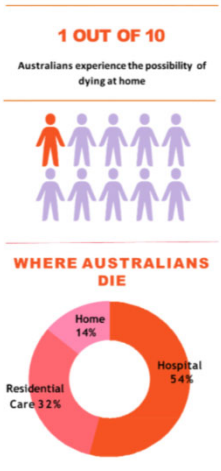
The COVID-19 pandemic accentuated existing issues with referral processes and access to specialist palliative care

Important to increase:

- Knowledge and capacity of palliative care workforce
- Awareness and knowledge of palliative care by GPs, pharmacists & aged care staff
- Knowledge of cultural diversity
- Connections between sectors and services

Medical and community attitudes plus a lack of funds for formal, home-based care mean that Australians die at home at half the rate that people do in New Zealand, the United States, Ireland and France.

~ Dying Well by Hal Swerissen, Stephen Duckett, Grattan Institute 2014



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What is planned for 2023

- Key focus areas will be:
- Preparing GPs, hospital palliative care generalists and aged care facilities to better deal with end of life care
- Assisting hospital services to make timely referrals to community services and ensure these meet the service's delivery of care models
- Collaborating across care settings to manage the demand for specialist palliative care in the region.
- Collaboration on generalist and specialist palliative care needs analysis
  - Current availability of generalist and specialist palliative care service provision and gaps in current provision with projections for future service requirements and the workforce available to provide these.

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Thank you

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0413 264214

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Gippsland Region Palliative Care Consortium

Anny Byrne – Gippsland Region Palliative Care Consortium Manager

Carol Barbeler – Palliative Aged Care and Disability Resource Nurse & MND Shared Care Worker, Gippsland Region Palliative Care Consortium

Gippsland Region Palliative Care Consortium

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Region Overview

Anny Byrne - Gippsland Region Palliative Care Consortium Manager

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Partnerships in Action

Workforce Development

- PD SMaRT – Skills Matrix
- Transition to Specialty Palliative Care Practice (TSP)
- Communications Skills Training
- Deceased Resident File Audit

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About Gippsland

- 41,375 sq. km (18.3% of Victoria), 300, 000 people (4.6% of Vic population)
- 8 specialist community palliative care services
- 11 designated palliative care inpatient beds
- Health Services, Community Health, Private Hospitals
- Regional Palliative Care Consultancy Service
- 53 RACFs

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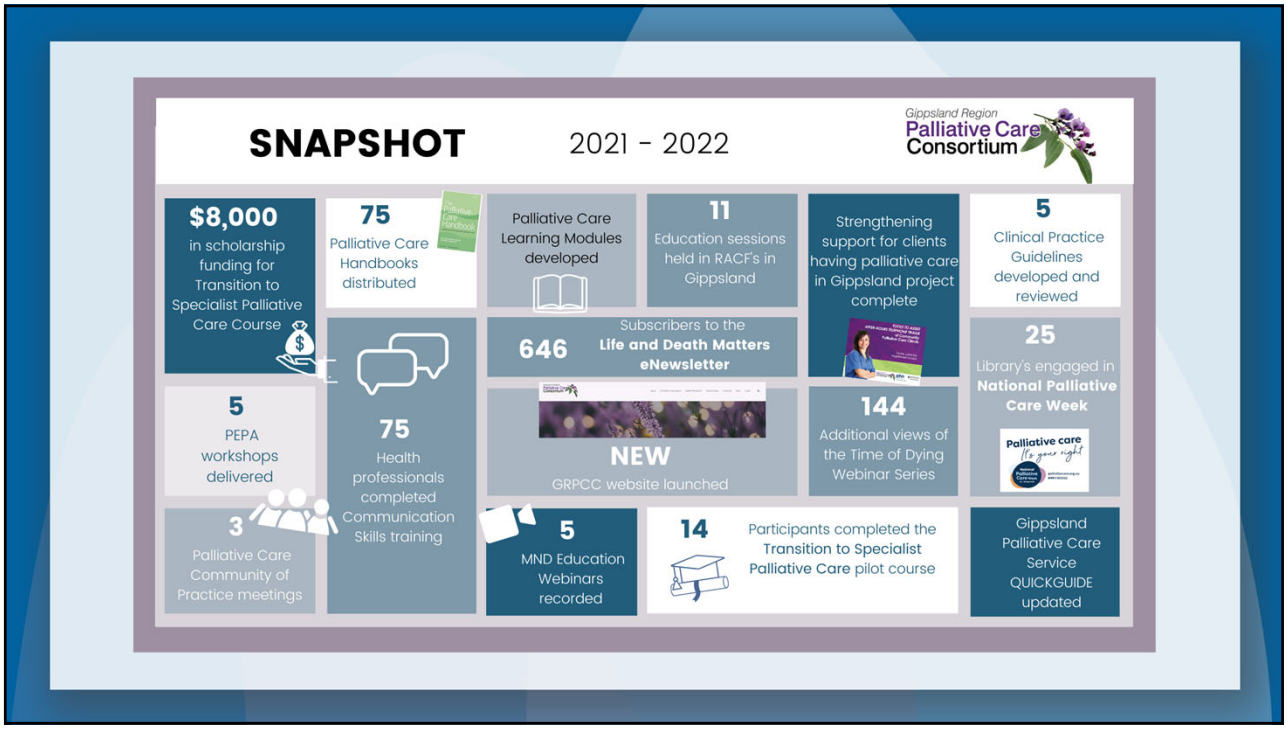

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Community of practice

Partnerships in Action

A forum for clinicians to connect, discuss challenges and opportunities, develop quality initiatives in response to workable priorities

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The Professional Development & Skills Matrix Resource and Tools for Palliative Care Nurses (PD SMaRT)

Anny Byrne- Gippsland Region Palliative Care Consortium Manager

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PD SMaRT

The Professional Development Skills Matrix and Resource Tool was developed by:

- GRPCC Community of Practice (COP)
- Monash University School of Rural Health

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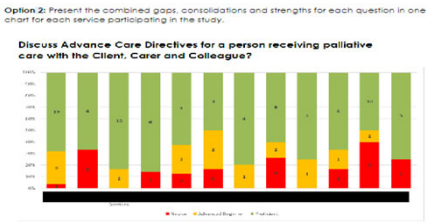
PD SMaRT

The aim of the 'Skills Matrix' is for nurses to self-rate their capability, knowledge, and skills in identified domains for the delivery of end of life and palliative care.

The program provides:

- Individual assessment for PD
- Organisational view of capacity
- Regional view and data to support education and project initiatives



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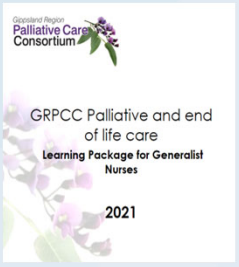
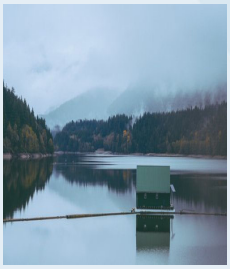
From the Skills Matrix project ....





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Transition to Specialty Practice (TSP)

Carol Barbeler – Palliative Aged Care and Disability Resource Nurse & MND Shared Care Worker, Gippsland Region Palliative Care Consortium

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The Transition to Specialty Practice

Partnerships in Action

The Transition to Specialty Palliative Care Practice Course (TSP) was developed by :

- GRPCC
- Palliative Care South East
- Australian College of Nursing

TRANSITION TO SPECIALTY PALLATIVE CARE PRACTICE

Expressions of Interest 2023

Applications now open

Transition to Specialty Palliative Care Practice (TSP) - 2023

The TSP course is a partnership between Gippsland Region Palliative Care Consortium (GRPCC) Palliative Care South East (PCSE) and the Australian College of Nursing (ACN).

This TSP course is for registered nurses and is a combination of two online and four face to face workshops, as well as the online learning component and assessment, provided by ACN.

Participants with successful completion of all components of the course and assessments will be awarded of one unit, the 'Principles of Palliative Care', towards a Graduate Certificate in Palliative Care at ACN or other universities.

Date: February through to August 2023

Requirements: Nurses will need to allow personal study time of approximately 5 hours per week, plus study days to attend the workshops

Locations: Yarra Warren or Shepparton (nurses enrol for one site only)

Cost: $2750, payable before commencement of course

Applications: Available on the GRPCC and Palliative Care South East websites, or click here to download

Applications close: January 25th, 2023.

For further details of the course, please contact Carol Barbeler (carol.barbeler@wahs.com.au) or Anny Byrne (anny.byrne@wahs.com.au) at the GRPCC, or Kelly Rogerson (kelly.rogerson@palliativecare.org.au) at PCSE.

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Transition to Specialist Palliative Care Practice Course (TSP)

The idea came in response to the ongoing challenges in recruiting and retaining specialist trained palliative care clinicians, from the skills matrix, and the desire to create a pathway of education in Gippsland, beyond professional development

- Pilot course in 2021 (yes….)
- 14 nurses from across Gippsland and Southern Metro region
- Heavily subsidised and supported by consortia (GRPCC and SMRPCC)
- 19 nurses in 2022

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Communication Skills Training

Transition to Palliative Care

Carol Barbeler – Palliative Aged Care and Disability Resource Nurse & MND Shared Care Worker, Gippsland Region Palliative Care Consortium

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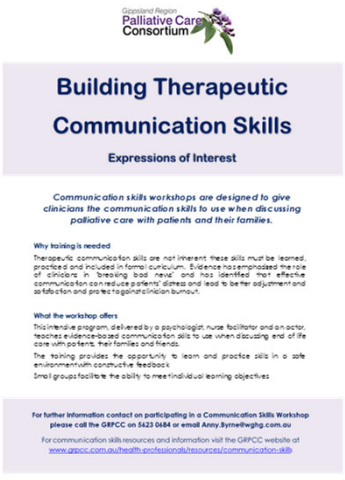
Communication Skills Training


Gippsland Region Palliative Care Consortium

Building Therapeutic Communication Skills

Expressions of Interest

Communication skills workshops are designed to give clinicians the communication skills to use when discussing palliative care with patients and their families.

Why training is needed

Therapeutic communication skills are not inherent these skills must be learned, practiced and included in formal curriculum. Evidence has emphasised the role of clinicians in 'breaking bad news' and has identified that effective communication can reduce patients' distress and lead to better adjustment and satisfaction and protect against clinician burnout.

What the workshop offers

This intensive program, delivered by a psychologist, nurse facilitator and an actor, teaches evidence-based communication skills to use when discussing end of life care with patients, their families and friends.

The training provides the opportunity to learn and practice skills in a safe environment with constructive feedback

Small groups facilitate the ability to meet individual learning objectives

For further information contact on participating in a Communication Skills Workshop please call the GRPCC on 5623 0684 or email Anny.Byrne@wghg.com.au

For communication skills resources and information visit the GRPCC website at www.grpcc.com.au/health-professionals/resources/communication-skills

Partnerships in Action

A team of a Clinical Psychologist, a Registered Nurse, and a simulated patient/actor

Partnerships with:

- Gippsland Primary Health Network
- PEPA
- Monash School of Rural Health
- GRICS

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Experiential Learning

Therapeutic communication is critical to identify patients' goals of care, particularly in the cancer and palliative care setting. The process of communication is central to effective, safe, patient-centred and compassionate care. Effective communication has the potential to improve quality of life, access to key services, and relationships between patients, families, and clinicians.

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Deceased Resident File Audits

Carol Barbeler – Palliative Aged Care and Disability Resource Nurse & MND Shared Care Worker, Gippsland Region Palliative Care Consortium

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Deceased Resident File Audits

Partnerships in Action:

Developed with a past aged care project worker, and based on project from the original Palliative Approach Toolkit

Partners with:

- RACF

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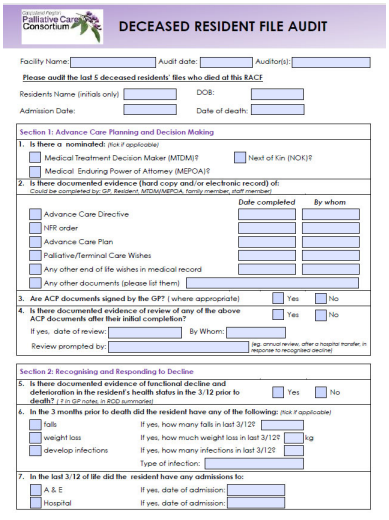
A baseline of palliative care practice

The Deceased Resident File Audit Program enables RACF to strategically target opportunities for quality improvement based on their practice evidence, to target clinical education and to evaluate the impact of change or improvements in clinical and organisational practice.



DECEASED RESIDENT FILE AUDIT

Facility Name: Audit date: Auditor(s):

Please audit the last 5 deceased residents' files who died at this RACF

Residents Name (initials only) DOB:

Admission Date: Date of death:

Section 1: Advance Care Planning and Decision Making

1. Is there a nominated: (Not if applicable)
   - Medical Treatment Decision Maker (MTDM)? Next of Kin (NOK)?
   - Medical Enduring Power of Attorney (MEPOA)?
2. Is there documented evidence (hard copy and/or electronic record) of:
   Could be completed by: GP, Resident, MTDM/MEPOA, family member, staff member)

	Date completed	By whom
Advance Care Directive		
NFR order		
Advance Care Plan		
Palliative/Terminal Care Wishes		
Any other end of life wishes in medical record		
Any other documents (please list them)		

3. Are ACP documents signed by the GP? (where appropriate) Yes No
4. Is there documented evidence of review of any of the above ACP documents after their initial completion? Yes No

   If yes, date of review: By Whom:

   Review prompted by: (eg. annual review, after a hospital transfer, in response to recognised decline)

Section 2: Recognising and Responding to Decline

5. Is there documented evidence of functional decline and deterioration in the resident's health status in the 3/12 prior to death? (if in GP notes, in ROD summaries) Yes No
6. In the 3 months prior to death did the resident have any of the following: (Not if applicable)
   - falls — If yes, how many falls in last 3/12?
   - weight loss — If yes, how much weight loss in last 3/12? kg
   - develop infections — If yes, how many infections in last 3/12?

     Type of infection:
7. In the last 3/12 of life did the resident have any admissions to:
   - A & E — If yes, date of admission:
   - Hospital — If yes, date of admission:

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Thank you… please ask us for further information

About Us

The Gippsland Region Palliative Care Consortium (GRPCC) is an alliance of 14 member agencies that provide inpatient and/or community palliative care for the residents of Gippsland. The GRPCC is one of eight regional consortia established as part of the Victorian Government's palliative care policy released in 2004. The Consortium's role is to help deliver and facilitate the Victorian Government's current policy, 'end of life care and palliative care

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Grampians Region Palliative Care Consortium

Diane Nimmo – Project and Research Coordinator, Ballarat Hospice Inc. & Project Lead, Grampians Region Palliative Care Consortium

Anna Gray– Grampians Region Palliative Care Consortium Manager

Grampians Region Palliative Care Consortium

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Rapid Discharge Research Project

A collaboration between Ballarat Hospice Care and Grampians Health

Funded by the Victorian Department of Health and Human Services, 2019 Palliative Care Service Innovation and Development Grant

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Rapid Discharge

- Objective:
  - → To support the timely, smooth, safe and sustainable return of palliative care patients from acute hospital to home
  - → Avoid re-presentation to the ED and re-admission to acute hospital

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Rapid Discharge

- Empirical approach to ensure evidence-based outcomes
  - → Capturing the perspectives of healthcare workers, and patients and their carers
  - → Understanding of events pre, during and post admission
  - → Expert and consumer consultation
  - → Governance review

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Rapid Discharge

- Re-framing of care provision:
  - → Care as a continuum
  - → Transfer of care between services
  - → Patient and information handover from one care team to another

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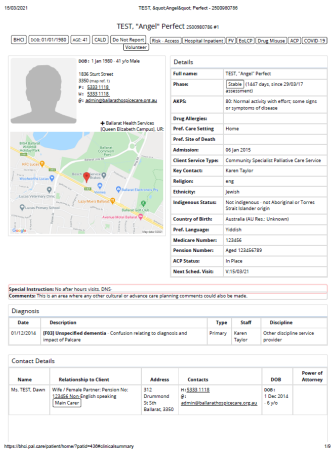
Rapid Discharge

- Patient-centred care: Enabling and facilitating rapid understanding of
  - → a patient's medical history
  - → recent health events
  - → medication
  - → involvement of healthcare providers
  - → and patient preferences

through real-time communication.



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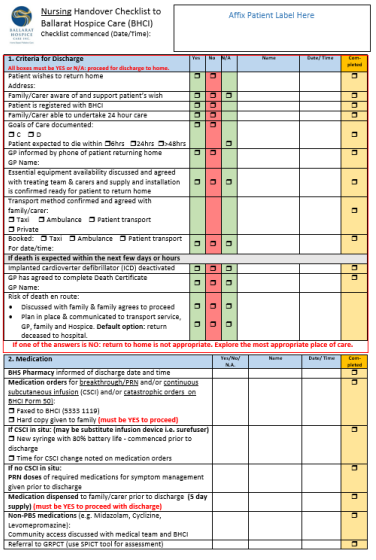
Key output

- **Framework** of shared acute hospital and community palliative and End-of-Life care
  - → **Context-specific principles** of patient-centred care
  - → **Model of shared care**
  - → **Pathways**
  - → **Processes** for transfer of care
  - → **Tools** for patient and information handover



Nursing Handover Checklist to Ballarat Hospice Care (BHCI)
Checklist commenced (Date/Time):

Affix Patient Label Here

1. Criteria for Discharge All boxes must be YES or N/A: proceed for discharge to home.	Yes	No	N/A	Name	Date/ Time	Com-pleted
Patient wishes to return home Address:	❒	❒				❒
Family/Carer aware of and support patient's wish	❒	❒	❒			❒
Patient is registered with BHCI	❒	❒				❒
Family/Carer able to undertake 24 hour care	❒	❒				❒
Goals of Care documented: ❒ C ❒ D Patient expected to die within ❒8hrs ❒24hrs ❒>48hrs	❒	❒	❒			❒
GP informed by phone of patient returning home GP Name:	❒	❒				❒
Essential equipment availability discussed and agreed with treating team & carers and supply and installation is confirmed ready for patient to return home	❒	❒	❒			❒
Transport method confirmed and agreed with family/carer: ❒ Taxi ❒ Ambulance ❒ Patient transport ❒ Private						❒
Booked: ❒ Taxi ❒ Ambulance ❒ Patient transport For date/time:	❒	❒	❒			❒
If death is expected within the next few days or hours						
Implanted cardioverter defibrillator (ICD) deactivated	❒	❒	❒			❒
GP has agreed to complete Death Certificate GP Name:	❒	❒	❒			❒
Risk of death en route: • Discussed with family & family agrees to proceed • Plan in place & communicated to transport service, GP, family and Hospice. **Default option:** return deceased to hospital.	❒	❒	❒			
If one of the answers is NO: return to home is not appropriate. Explore the most appropriate place of care.						

2. Medication	Yes/No/ N.A.	Name	Date/ Time	Com-pleted
BHS Pharmacy informed of discharge date and time				❒
Medication orders for breakthrough/PRN and/or continuous subcutaneous infusion (CSCI) and/or catastrophic orders on BHCI Form 90: ❒ Faxed to BHCI (5333 1119) ❒ Hard copy given to family **(must be YES to proceed)**				❒
If CSCI in situ: (may be substitute infusion device i.e. surefuser) ❒ New syringe with 80% battery life - commenced prior to discharge ❒ Time for CSCI change noted on medication orders				❒
If no CSCI in situ: **PRN doses** of required medications for symptom management given prior to discharge				❒
Medication dispensed to family/carer prior to discharge **(5 day supply) (must be YES to proceed with discharge)**				❒
Non-PBS medications (e.g. Midazolam, Cyclizine, Levomepromazine): Community access discussed with medical team and BHCI				❒
Referral to GRPCT (use SPICT tool for assessment)				❒

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Afterhours Medical Emergency Support via Telehealth – Pilot Project

An initiative of the Grampians Region Palliative Care Consortium

Funded by the Western Victoria Primary Health Network, After Hours Research and Development Models

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Afterhours Medical Emergency Support via Telehealth – Pilot Project

- **Objective**: To strengthen afterhours emergency medical Telehealth support throughout the Grampians Region to support
  - → local SPCNs on call in the afterhours
  - → patients to remain at home if this is their preference

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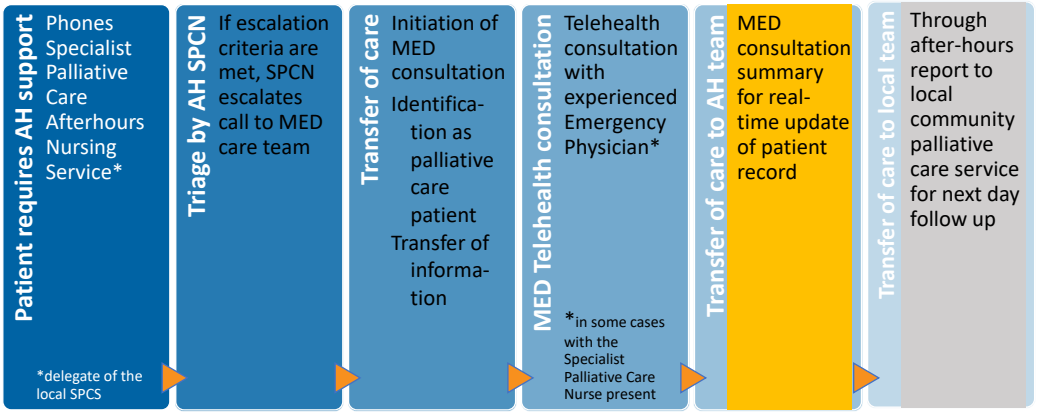
Afterhours Medical Emergency Support via Telehealth – Pilot Project

Model of integrated shared afterhours nursing and medical care:



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'Starting the conversation' Psychology support in Residential Aged Care – Pilot Project

An initiative of the Grampians Region Palliative Care Consortium in collaboration with One Red Tree resource Centre

Seed-funded by the Grampians Region Palliative Care Consortium

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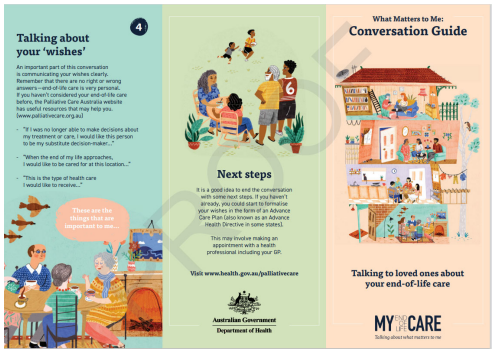
‘Starting the conversation’ – Pilot Project

- Objectives:
  - → Early intervention in initiating End-of-Life conversations with aged care residents to improve person-centred services and End-of-Life experience
  - → Improve access to local specialised palliative care support
  - → Decrease work related stress and improve support for staff, resulting in strengthened workforce sustainability.



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‘Starting the conversation’ – Pilot Project

- Key activity:

  Face-to-face support by qualified Psychologist for participating residential aged care facility to
  - → Initiate conversations with residents
  - → Initiate conversation with carers/families of deteriorating residents
  - → Provide peer-support to staff

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‘I did it my way’ – Voluntary Assisted Dying for Palliative Care Patients

An initiative of Bacchus Marsh Community Palliative Care Service – Western Health

Co-funded by the Grampians Region Palliative Care Consortium and local donations

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‘I did it my way’ - Voluntary Assisted Dying for Palliative Care Patients

- Objective:
  - → To ease the burden for other patients and families who may be considering End-of-Life options
  - → To assist clinicians to better understand Voluntary Assisted Dying.

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'I did it my way' - Voluntary Assisted Dying for Palliative Care Patients

- Outcomes:
  - → A video has been produced an is available on YouTube
  - → It has been embraced by Andrew Denton's 'Go gentle Australia' charity
  - → Over 11,000 views to date

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Home Vigils

An initiative of the Grampians Region Palliative Care Team

Funded by the Grampians Region Palliative Care Consortium

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Home Vigils

- **Objective**: To support end of life care choices for patients in the Grampians region by providing access to cooling blankets

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Home Vigils

- **Benefits:** Increasing the time that the deceased can remain at home to
  - → Provide choice in after death care
  - → Support culturally appropriate after death care
  - → Allow families time to say farewell, access assistance i.e. funeral services, verification of death.

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'Where the wild things are – At the fringes of Palliative Care'

Virtual Conference

An initiative of the Grampians Region Palliative Care Team

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'Where the wild things are – At the fringes of Palliative Care'

- Acknowledging the challenges faced by marginalised communities in accessing palliative care services
- Exploring emerging treatments and their role in managing symptom distress at end of life.
- Topics:
  - → Magic mushrooms and death anxiety
  - → Homelessness
  - → End of life care in prisons
  - → Hope, Heart and Healing in health care
  - → Immunotherapy in advanced cancer
  - → Organ donation and the palliative care interface and much more.

Virtual Conference 2021
Where the wild things are.

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National Palliative Agreement

Comprehensive Palliative Care in Aged Care

Violet Platt – Chief Executive Officer, Palliative Care Victoria

Theresa Williamson – Manager, Victorian Department of Health

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Comprehensive Palliative Care in Aged Care - CPCiAC

- Joint project with Commonwealth and State/Territory government's to improve palliative and end of life care coordination for older Australians living in residential aged care

- 5 Victorian project streams:
  - Capacity building to improve access to palliative and end of life care for aged care residents
  - Enhance aged care staff's assessment, recognition of functional decline, deterioration
  - Enhancing RAC models re: palliative care engagement, referrals, coordination between providers/services
  - Goals of care for residents without decision making capacity
  - Resident Elders – promoting culturally safe palliative and end of life care

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Department of Health

- Project 1 Improving access to palliative and end of life care.
  - Building on the work done by our palliative care services with RACF for early identification of residents who may benefit from palliative care, referral pathways, aged care mentoring programs (in various forms)
  - A key focus on capacity building
- Project 2 Enhance aged care staff assessment
  - Better understanding of assessment processes in RACF, recognition of functional decline and deterioration, PACOP assessment tools and outcome data
- Project 3 Enhance models of care
  - Explore models to strengthen integration across multiple service streams/providers
  - Could we explore 'rounding' 'pop-up clinics' using the project funds to test models and then consider how best to incorporate them within existing structures
  - Explore ways to maximise the benefits to residents of collaboration/coordination across palliative care community/consultancy services and residential-in-reach teams

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When, how and who?

- Dept project team
- Aged care, palliative care, community providers, education providers
- Sector consultation
- Expression of Interest - project funding
- Community of Practice

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Palliative Care Victoria

- Project 4 – Goals of care for residents without decision making capacity
- Project 5 – Resident Elders, promoting culturally safe Aboriginal and Torres Strait Islander palliative and end of life care for elders

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PCV Activity

- Introducing the project team
- Engaging with lead Aboriginal agencies
- Engaging with CALD agencies
- Engaging with RACF's

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PCV Activity 2

- Community consultation
- Collating existing activity
- Determining key project activities

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How you can help?

- Check Newsflash for latest activities
- Share your expertise and experience
- Join round tables and consultations
- Introduce yourself to the project team
- Join the special interest group

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Lunch Break

Next Session:

1.50pm

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Hume Region Palliative Care Consortium

Elizabeth Jenkins - Hume Region Palliative Care Consortium Manager

Kate Stratton – Northeast Health Wangaratta

Samantha Moorhouse – Lower Hume Palliative Care Service, Seymour health

HUME REGION Palliative Care Consortium

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Hume Region Overview

- Albury Wodonga Health
- Benella Health
- Department of Health, Hume Region
- Goulburn Valley Health
- Goulburn Valley Hospice Care Service
- NCN Health – Numurkah Campus
- Northeast Health Wangaratta
- Seymour Health

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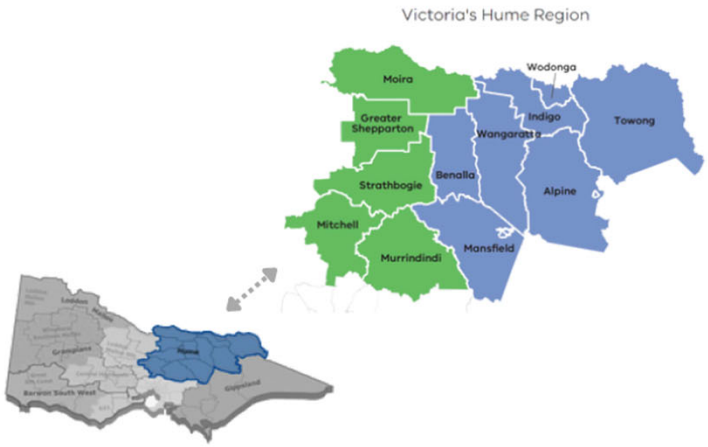
Hume Region



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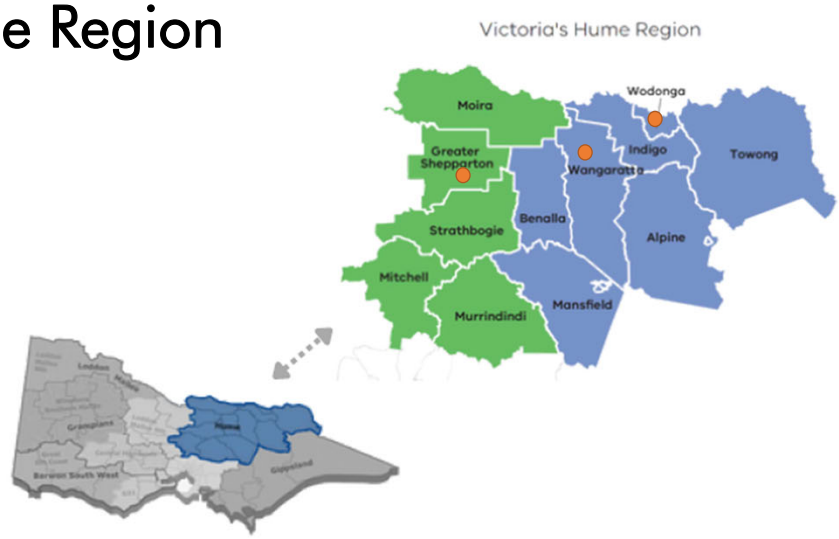
Hume Region



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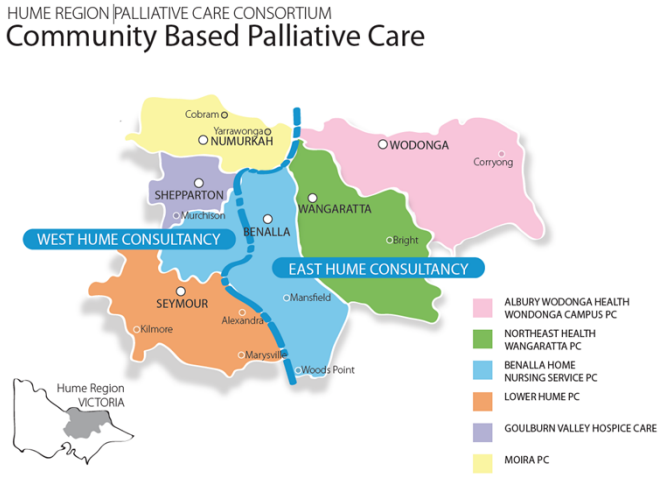
Hume Region



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Overview of Hume Region Innovation Projects

Elizabeth Jenkins – Hume Region Palliative Care Consortium Manager

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Innovation Projects Overview

- From 2019 – 2022, 9 service innovation and development projects were completed in the Hume Region.
- Inc. a Consortium joint project across 5 Community Palliative Care Teams - the Regional dedicated palliative care system integration project.

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Innovation Projects Overview

- Hospital to Home for End of Life Care
- Palliative Care Liaison Project
- Palliative Care Patient Flow Project
- Early Referral Clinics (2)
- Multidisciplinary Service Models (2)
- Palliative Care Digital Health Implementation
- Regional dedicated palliative care system integration

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Acute Palliative Care Liaison Nurse Role

Kate Stratton – Northeast Health Wangaratta

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PROJECT BACKGROUND

- The aim of the Acute Palliative Care Liaison Service was to support a palliative model of care that focused on consumer outcomes including appropriate symptom management and advocacy for preferred site of death. The position supported a continuum of care across the acute and community divisions.

- A Palliative Care Service Innovation and Development Grant from the Victorian Department of Health and Human Services in 2019 enabled Northeast Health Wangaratta (NHW) to employ a project officer for 6 months and 1.0FTE of Specialist Palliative Care Nurse Consultants for 12 months to establish a Palliative Care Liaison Service and collect data to support an ongoing funding model.

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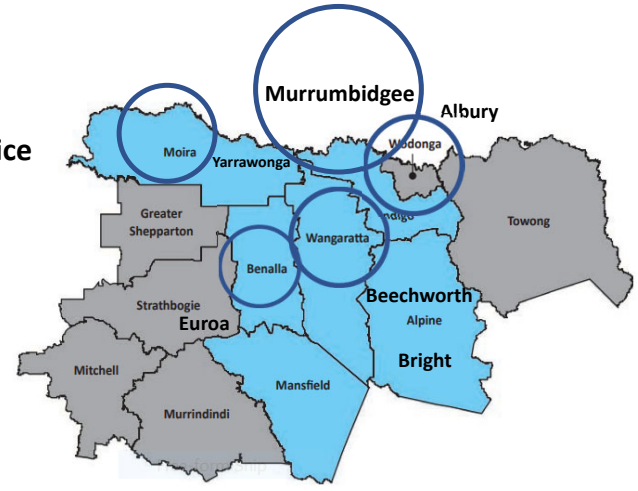
Northeast Health Wangaratta (NHW)
NHW Acute Palliative Care Liaison Service

Community Palliative Care Services
Moira
NHW
Benalla
Wodonga
Murrumbidgee



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Focus areas & key performance indicators

ADVOCACY	• Improved outcomes for provision of care/dying in site of choice
SUPPORT	• Education and support to patients and families • Education and support to acute medical, nursing and allied health
LIAISON	• Referral to appropriate agency for ongoing care (minimise re-admissions) • Improved engagement and collaboration with East Hume Regional Palliative Consultancy service
EXPERTISE	• Comprehensive holistic palliative care > symptom assessment and implementation of care
ACCREDITATION	• Develop evidence-based policies and guidelines for acute setting • Lead the strategic direction for Care of the Dying Committee

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Outcomes & Lessons Learnt

1. Significant clinical demand for specialist palliative care in acute setting at regional hospital
2. Palliative Liaison Nurses highly valued by acute staff across multiple disciplines
3. Evaluation:
   - better patient outcomes (positive feedback, nil complaints)
   - improved site of care/death
   - inpatient deaths decreased by 1/3
   - Increased utilization of palliative bed funding
   - Regular and ongoing engagement with local palliative care consultancy service
   - 1/3 of patients reviewed in hospital referred to CPC
   - NHW have committed 0.5 FTE towards ongoing role
4. Project Lessons:
   - *Be aware of the importance of project structure and data collection. Don't start too quickly, maintain focus on your project objective*
   - *Clear Governance and commitment is essential before progressing temporary grant projects. Find an Executive Champion.*
   - *Ensure an early focus on evaluation to support project goals.*

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The Early Referral Clinic for Supportive and Symptom Care Project

Samantha Moorhouse – Lower Hume
Palliative Care Service, Seymour Health

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Expected outcomes of the Early Referral Clinic

- Advanced care planning
- Better symptom management
- Earlier awareness of support services available
- Reduced carer stress
- Preferred place of care and death met

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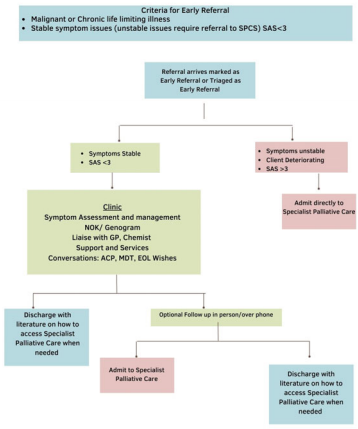
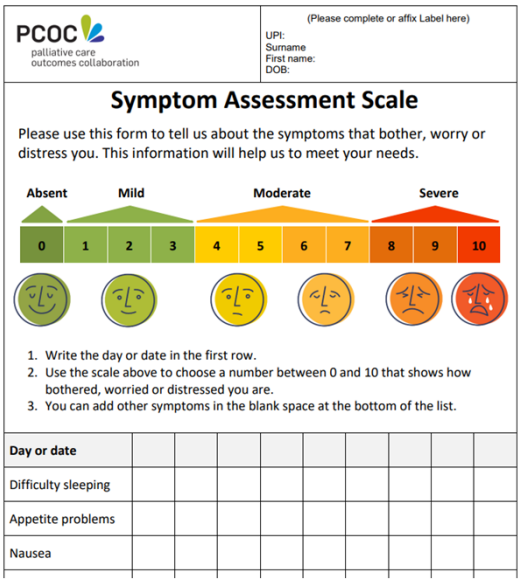
Early Referral Clinic Pathway





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What a Client can expect from the appointment

- Symptom Assessment and management advice
- Social review including Next of Kin Details and Genogram
- Advice on local services
- A Report back to the GP and/or Specialist with a summary of the consult.
- A Chance to discuss Advanced Care Planning

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Clinic Outcomes

- 29 Referrals Received over 2 years
- Client location and Referral Source was evenly distributed
- Client Diagnosis leaned largely towards Malignancy and Chronic Respiratory Disease
- Just over half of the clients had a completed Advance Care Plan on discharge from the service and a further 30% had begun Advance Care Planning Conversations
- 31% of clients went on to be referred to the local Specialist Palliative Care Service

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What worked well

- Early Referral picked up some under-represented demographics of timely access to palliative care, most notably clients with chronic Respiratory disease
- Specialist Palliative Care reported time factors saved when Early Referral clients were rereferred (or self-re-referred) back to Palliative care
- Improved outcomes were demonstrated in client symptom management and also the uptake of Advance Care Planning

Lessons Learned

- This model works better in home in regional areas.
- Opening Criteria up to clients with both Malignant or Chronic Disease improved client outcomes and nurtured a multidisciplinary approach with the local HARP team
- Engagement with Referring services needs to be ongoing for continues awareness
- Young adults were a demographic identified for late referral to palliative care

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Future considerations

- The implementation of a systemic early referral and consultation process in Specialist Palliative Care
- The early referral and consultation process should allow for a client to have access to a Palliative Care specialist for one to two home appointments
- The client could then be provided with information on how to re-refer into palliative care when needed.

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Thank you

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Palliative Care
Consortium

Hume Region Palliative Care Consortium

www.humepalliativecare.org.au

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Loddon Mallee Regional Palliative Care Consortium

Adam Rutyna – Loddon Mallee Regional Palliative Care Consortium Manager

Dr Hossein Kasiri – Consultant Palliative Care Medicine, Geriatric, Rehabilitation and Palliative Care Medicine, Bendigo Health

Jo Amos – Palliative Care Coordinator, Echuca Regional Health

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Region Overview

Adam Rutyna – Loddon Mallee Region Palliative Care Consortium

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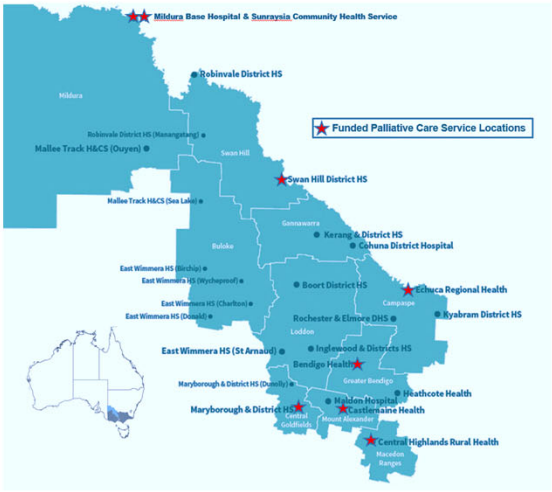

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regional palliative care consortium

Mildura Base Hospital

Sunraysia Community Health Service

Swan Hill District Heath service

Echuca Regional Health

Bendigo Health

Dhelkaya Health

Maryborough District Health Service

Central Highlands Rural Health (Kyneton)

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Consortium Priorities 2021-2023

- Access
- Capability
- Education & Specialist Training

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Access

Access to Specialist Palliative Services – Aged Care

- Low numbers – Why?
- Funding Model and National Standards
- Palliative Aged Care Resource Nurse program

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Palliative Aged Care Resource Nurse program

- Each participating RACF will determine how many QI and education activities that they will participate in.
- As a minimum – every RACF will be re-connected to their community palliative care service.
- Performance measured by death audit, organisational capability audit, participation & feedback in the program and referrals to regional specialist palliative care services (community & consultancy)

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Capability

Only 2 out of 8 services provide access to specialist palliative care afterhours. The other 6 services rely on the After-hours/Bed Coordinators from the local hospitals.

It is cost-prohibitive for smaller services, and a region-wide Grade 4 specialist palliative care nurse would cost $535K per year.

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Capability

Afterhours service

- Successful Project funding from Murray PHN
- Trial Caritas After hours service – with Swanhill
- Additional funding for clinical staffing afterhours

Swan Hill District Health
Grampians Region Palliative Care Consortium
phn MURRAY An Australian Government Initiative
SCHS
KYNETON DISTRICT HEALTH
palcare
castlemaine HEALTH
HUME REGION Palliative Care Consortium
ST VINCENT'S HOSPITAL MELBOURNE
Echuca Regional Health
BENDIGO HEALTH
Maryborough District Health Service

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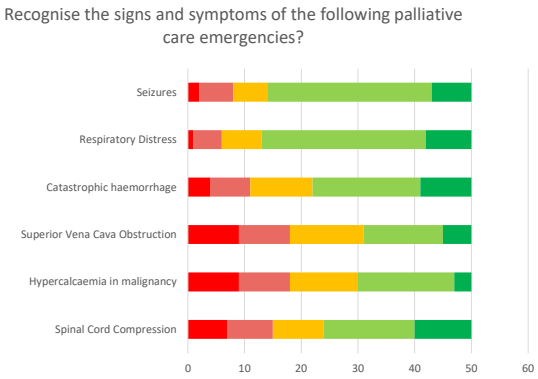
Education - Training Needs Analysis

- Survey provided detailed information about learning needs
- Participants received copies of their responses
- Service Managers were provided reports for their staff
- Regional-level data used to inform consortium decisions



Source: *The Loddon Mallee Region Palliative Care Knowledge and Skills Survey (PD Smart)*

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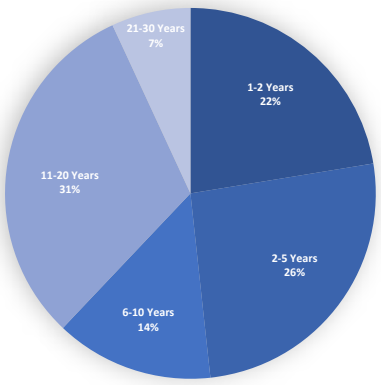
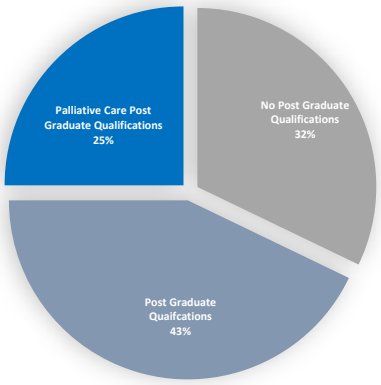
Education – Training Needs Analysis

Years of experience working in Palliative Care



Post Graduate Qualifications



Source: *The Loddon Mallee Region Palliative Care Knowledge and Skills Survey (PD Smart)*

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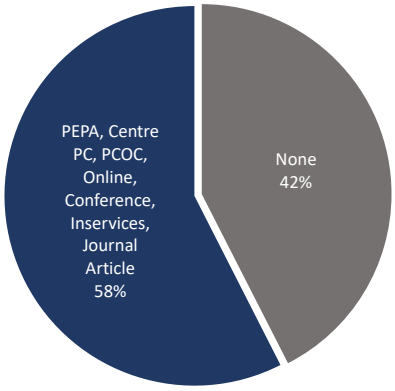
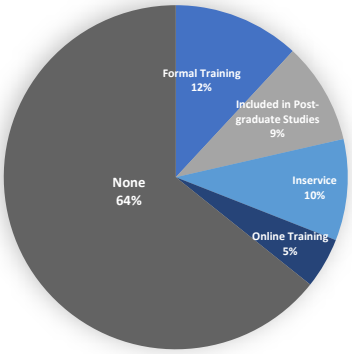
Education - Training Needs Analysis

What palliative care education you have attended/undertaken in the last two years?



Communication skills training attended in last 5 years



Source: *The Loddon Mallee Region Palliative Care Knowledge and Skills Survey (PD Smart)*

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Education

Consortium funded 23 Grants that were awarded for;

- Palliative Post-Graduate Studies (Flinders University, Australian College of Nursing)and;
- Palliative Care-related education (Banksia, Centre for Palliative Care, MND Australia)

Loddon Mallee Specialist Palliative Care Consultancy;

- Created online presentations for generalist clinicians
- Communication skills training for Palliative Care Clinicians
- Using TNA data to prioritise education opportunities for specialist palliative care clinicians.

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Loddon Mallee Palliative Clinicians Network

- Complex Clinical Review
- Mindfulness
- Group Clinical Supervision

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Re-designing a Palliative Model of Care in Regional Victoria

Jo Amos – Palliative Care Coordinator, Echuca Regional Health

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Echuca Regional Health Palliative care teams

- Small Community Palliative Care Team
- In patient palliative care Co- Ordinator
- 2 funded palliative care beds
- Loddon Mallee Regional Specialist Palliative Care Consultancy

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What was the objective?

128

An Over arching document for ERH and Region,

"Palliative Care- Specialized Care When You Need it the Most "

Incorporating general information on

- Palliative Care / Identification of palliative care patients and referral pathways both local and regional
- Advanced care planning
- End life care – Home, Hospital and Glanville
- Bereavement and Spiritual care

And to be the basis of the Palliative Care Dying Policy available on the inter and intranet

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Not with out some breakdowns

- Project funding occurred at same time as COVID- 19
- Community Palliative Care and Cancer Services transitioning to new IT software
- Unable to implement change with external stakeholders
- ERH HIS systems and multiple IT systems needing upgrade
- Assumptions i.e. how things work metro v rural
- Constant change in staff /junior staff
- Increase in work load
- Hospital transitioning from GP to Consultant lead system
- Cross border issues

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The Main road

- GAP analysis/ Service Mapping; current referral processes and barriers
  - Improved recognition of patients requiring specialised palliative care
  - Recognition and appropriate referral – to-from: chronic health/ Cancer /Palliative care and acute teams
  - Coordinated discharge from acute

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Completed parts of the journey Referral/ Access/Handover

ERH Quick Referral guide – flow chart

Community Palliative Care – Updated referral tool incorporating validated tools , PCOC and RUN-PC, as well as information specifically needed to both adequately triage, assess appropriateness and admit patients to service.

Inpatient Palliative Care Bed – updated Palliative Private admission flow chart with continue to aim for a standard admission process

ERH Clinical handover tool had been trialled as an inter- hospital transfer form, adapted to incorporate specific Palliative/ cancer /Chronic disease/ RACF language to be used for all handover for all services to be used both when on discharge and admission

Dying at home check list

Resource folders with above information

Overarching ERH palliative policy

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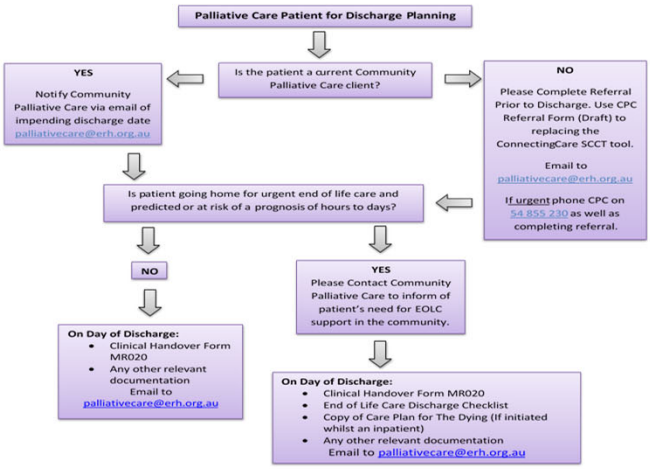

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Side roads

- End of Life Care Plan/ consistency of end of life care in acute
- PCOC extend current assessment and reporting
- Standardised bereavement follow-up
- Improved Advanced Care Planning
- Update and addition of policies and procedures
- Improved Culturally specific and spiritual care
- Non Malignant versus Malignant
- Education

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Aboriginal and Torres strait islander

- ERH ALO was involved in steering committee cultural appropriate resources and wording
- ERH – LMS compulsory education module
- Specific wording in "When someone dies " booklet as well as art work
- Butterfly symbol with local indigenous art work to identify rooms of loved ones dying
- Specific Advanced Care Planning documentation from Njernda as well as Palliative Care Australia
- Indigenous artwork through out hospital and new cancer wellness centre
- Memorial service – smoking ceremony

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The Bumpy Road Ahead

- Population growth
- GP shortage
- Floods
  - Resulted closure of Rochester Hospital and RACF more pressure on ERH beds
  - Increased percentage of homeless and displaced persons
- Increase in Palliative care patients and complexity as well as late diagnosis post COVID / GP shortage
- Burnout of staff
- Community Palliative Care- Still waiting for updated software programme…

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Thank you

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Items of interest

- Model of care overarching document
- When someone dies
- Butterfly
- Care plan for dying
- Quilt/ clothing/ bags

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Early Access, Symptom Management, and Education (EASE) Program

Dr Hossein Kasiri – Consultant Palliative Medicine, Geriatric, Rehabilitation and Palliative Care Medicine, Bendigo Health

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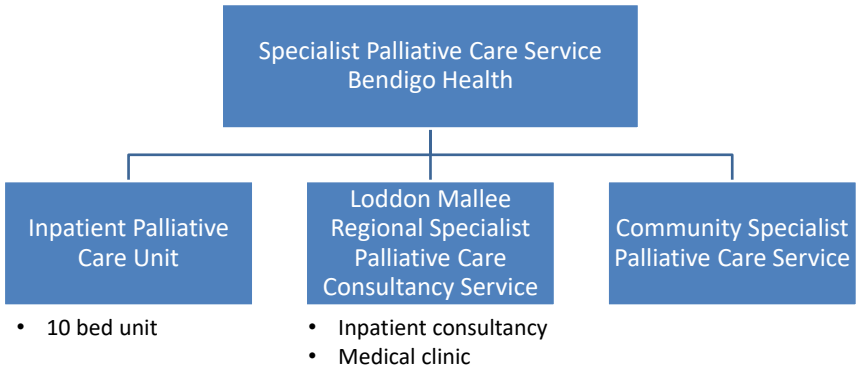
Overview of BHSPCS



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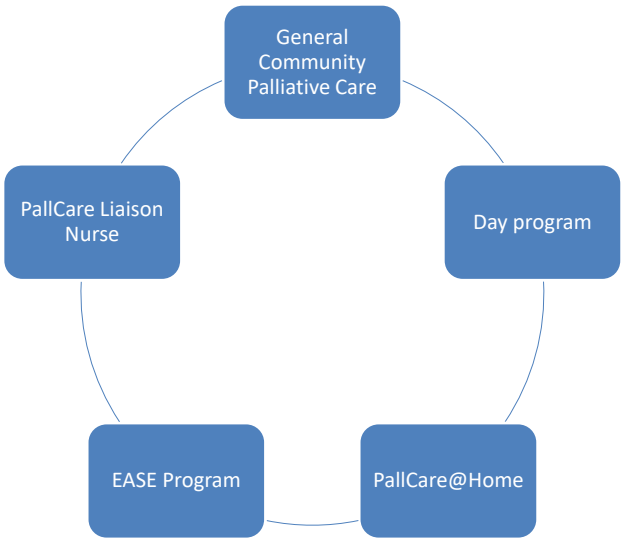
Community Specialist Palliative Care



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Background

Benefits of concurrent palliative and oncology care in advance cancer

- Better QOL & symptom management
- Less caregiver distress
- More accordance of care with patient wishes
- Survival advantage
- Reduce prolonged hospitalisation & ICU admissions near EOL
- Cost savings

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A Response to a Need

- Increasing early referral to palliative care
- Addressing population needs
- Allocation of resources and workforce
- Improve access and quality of service delivery

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Early Access, Symptom management & Evaluation (EASE)

- Stand-alone outpatient clinic
- Operates by Clinical Nurse Consultant (CNC)
- 12 week program
- Supported by OT, SW and physician

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EASE Program

Eligibility Criteria:	Documents:	Domains:
• Malignant condition • Non-urgent referral (RUN-PC) • RUG score ≥ 4 • AKPS ≥ 70 • Independently mobile	• Appointment letter • Map • The Carer Support Needs Assessment Tool (CSNAT) • Registration documents	• Symptom management • Coping mechanisms • Establishing illness understanding • Engaging family members • Caregiver education • Rapport building • Future planning • Advance Care Directives

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EASE Program

Safety Net:	Discharge Criteria:	Ongoing review:
• Access to 24hr advice line • Referral to general CPC or PC@H if situation changes	• Stable phase for 2 consecutive reviews over 2-4 weeks • Relevant SPC Domains addressed • MDT team discussion	• Demographics • Type of malignancy • Time from diagnosis to referral • PCOC/AKPS/RUG/SCNAT score on the initial visit • SPC domains discussed • staffing (SW/OT/physician) involvement • Number of ACP/MTDM completed • The outcome (discharge from EASE, or refer to CPC/PC@H)

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The reason why this model was selected

- Resources consideration
- Workforce allocation
- Improving access
- Improving quality of service delivery

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North & West Metropolitan Region Palliative Care Consortium

Kylie Johnson – Clinical Operations Manager, Banksia Palliative Care Service Inc.

Suzanne Peyton – COVID-19 Response Business Partner/Clinical Lead

NORTH AND WEST METROPOLITAN REGION PALLIATIVE CARE CONSORTIUM

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Banksia Rapid Assessment Team (BRAT)

Banksia Palliative Care Service

www.banksiapalliative.com.au

Kylie Johnson – Clinical Operations Manager, Banksia Palliative Care Service

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The *Banksia Rapid Assessment Team* (BRAT) Program:

The BRAT program provides specialist resources to address high-stress, acute situations that occur in client homes, such as rapid deterioration, acute exacerbation of symptoms, unexpected complications or carers stress and burden.

The model delivers face-to-face support and interventions in the home, within the shortest timeframe possible (maximum 1.5 hours from notification) to address the 'crisis' and implement measures to greatly reduce the need for ambulance attendance, presentation to acute health service emergency departments and unplanned in-patient admissions.

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Development of the BRAT:

- The pandemic exhausted health services and supports, including GP's, Acute Health Services, Private Hospitals.
- Accessible to services diminished, resulting in unavoidable and unacceptable experiences for palliative clients and their families.
- Hospital visiting restrictions significantly decreased client and carer preference for hospital admission.
- Willingness and capacity to address and manage crises in the home became an essential service demand.

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The focus of the BRAT:

- Provide immediate and effective supports to people in their homes at times of crises;
- Provide timely, expert management of symptoms, complications and emotional burden to clients and carers;
- Provide a high level of expertise in the home to ensure optimal outcomes, both immediate and long term;
- Alleviate burden to emergency and health services by preventing presentations to ED or calls to AV wherever possible, and
- To support clients and carers through acute episodes, with the goal of preventing disruption or alteration to preferred site-of-care and end of life wishes.

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Process for BRAT intervention:

- Senior staff with the clinical team are allocated as "BRAT" members for the day.
- Notification reached of increased tensions within the home, acute symptom exacerbation or sudden decline (etc), with carer distress being evident during the interaction. Notification may be via:
  - Phone call to office and conversation with Desk Nurse or clinical staff member;
  - Notification from a partner health provider, eg GP, visiting service, etc, or
  - Via Banksia staff member who may be in the home, and requiring additional expertise of colleagues, immediately.
- Situation escalated to BRAT nurse, who will notify other members of the team required, based on the situation, and arrange the visit to the home within the smallest possible timeframe – maximum of 1.5hrs.

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The BRAT members:

The members who attend will be determined after assessment of need for each situation. Team members may include any or all of the following:

- Palliative Care Physician.
- Senior Registered Nurse.
- Senior Social Worker.
- Enrolled Nurse.

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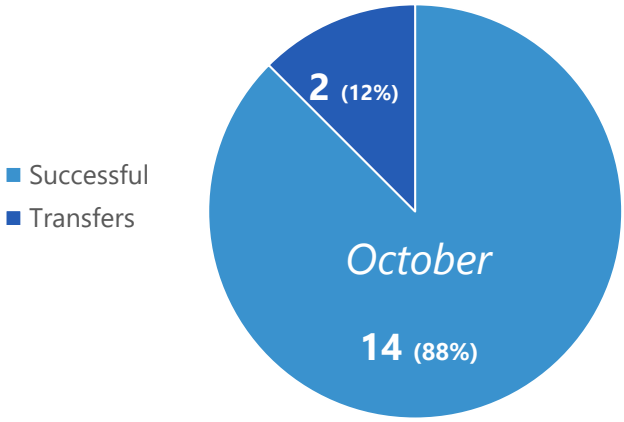
BRAT - The impact:



16 BRATS:

14 successful – situation addressed.

2 unsuccessful.

- N&V- worsening symptoms. ED presentation preferred.
- Aged Care- Resident deterioration. GP requested admission for EoLC.

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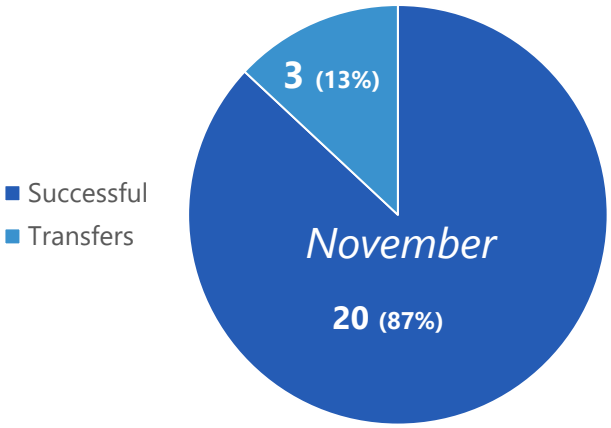
BRAT - The impact:



23 BRATS:

20 successful – situation addressed.

3 unsuccessful.

- Fall and functional decline. MRI – SCC.
- Pain crisis - presented to ED.
- Aged Care - client deteriorated. Transfer preferred.

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Thank you….

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Palliative Care Service

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Self-compassion Training in Palliative Care During COVID-19: A Pilot Study

Collaborative Research Team –

Melbourne City Mission Palliative Care & Monash University

Margaret O'Connor AM, Suzanne Peyton, Kaori Shimoinaba, Yaping Zhong

Suzanne Peyton – COVID-19 Response Business Partner/Clinical Lead, Melbourne City Mission Palliative Care

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Compassion v. Self-compassion

- **Compassion** – feeling of concern for the suffering of others, that is associated with the motivation to help.
- has assumed considerable significance with the dire impact of the COVID-19 pandemic on health care systems
- well-discussed as an essential skill in the specialty area of palliative/end-of-life care
- compassion - understanding and responding to the dying person and their family's physical, emotional, social and spiritual suffering and engaging in sensitive conversations about losses, grief, death and dying
- ***Self*-compassion** - a way of managing the difficulties experienced in working with others, offering protection and resilience against caregiver fatigue and burnout
- may assist in maintaining one's own health and wellbeing, provide a buffer against the constant stress in most healthcare settings AND it is a skill that can be learned and developed with practice.

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What is Self-Compassion?
(Neff, 2003)

Mindfulness

Becoming aware of and present with our negative internal experiences (Germer & Neff, 2019).

Allowing yourself to be aware of painful thoughts without over-identifying with or ruminating about them.

Self-Kindness

Being kind and understanding of yourself rather than judgmental or critical.

Actively comforting, protecting, or supporting ourselves (Germer & Neff, 2019).

Common Humanity

Viewing your circumstances, mistakes, suffering, or inadequacies within the context of a shared human experiences.

"Becoming our own first responders and providing kindness on arrival" (Black, 2018)

"Treating ourselves in the same way as we would a friend, during times of challenge" (Germer, 2002)

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Aim

- to replicate and test the 'Self-Compassion training for Healthcare Communities' (SCHC) program (Neff 2020)
- to support people in caring roles in palliative care settings
- using on-line rather than face-to-face delivery

Method

- convenience sampling from services in the Northern and Western Palliative Care Consortium
- electronic notification; those interested invited to contact the program coordinator
- once weekly gathering for 75 minutes in the evenings, for 6 weeks, delivered online
- ethical approval – Monash University
- three survey rounds with identical questions were conducted prior to, immediately after, and three months after the training.
- demographic and 6 tools used to measure affect of the program

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Skills learned and practiced over six weeks:

- yin – embodied practices to down-regulate ns – inner realm – safety, support, validation
- yang – strength – encouraging, motivating and protecting self – behaviours.
- cultivating kind and encouraging self-talk to counter self-criticism (inner ally)
- inclusive balancing meditation 'in situ' offering kindness to self and others in challenging encounters
- connecting to one's values and purpose at work
- participants encouraged to bring awareness to times they experienced stress or distress at work and apply the skills 'on the spot'
- reflection time built in during classes with small groups meeting in break-out rooms to discuss learning, challenges, discoveries. "What works for me?"

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Results

- low attrition
- convenience of on-line attendance
- self-compassion scores - moderate level at the commencement of the program and increased significantly following training (Data points 2 & 3)
- mindfulness scores also increased following training (Data points 2 & 3)
- compassion towards others' scores - altered little over the time from a high initial baseline
- participants' self-reported emotional state (depression, anxiety and stress levels) improved at end of program with further positive improvement three months post-training
  - may indicate program effectiveness, teaching regulation of one's inner state, and responses to others, by developing and practicing self-compassion skills.

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Conclusions

- a self-compassionate approach could mitigate against the stressors of caring roles
- for balance - promote an organisational culture of compassionate care of self and others - both are protective – “compassion literacy”.
- self-compassion / self-care & staff supports go hand in hand, wellbeing is a shared responsibility between the individual professional and workplace management/culture.
- training in skill development may enhance self awareness and self-regulation, individual wellbeing and reduce fatigue and/or burnout
- academic collaboration provides a structure to add to the evidence

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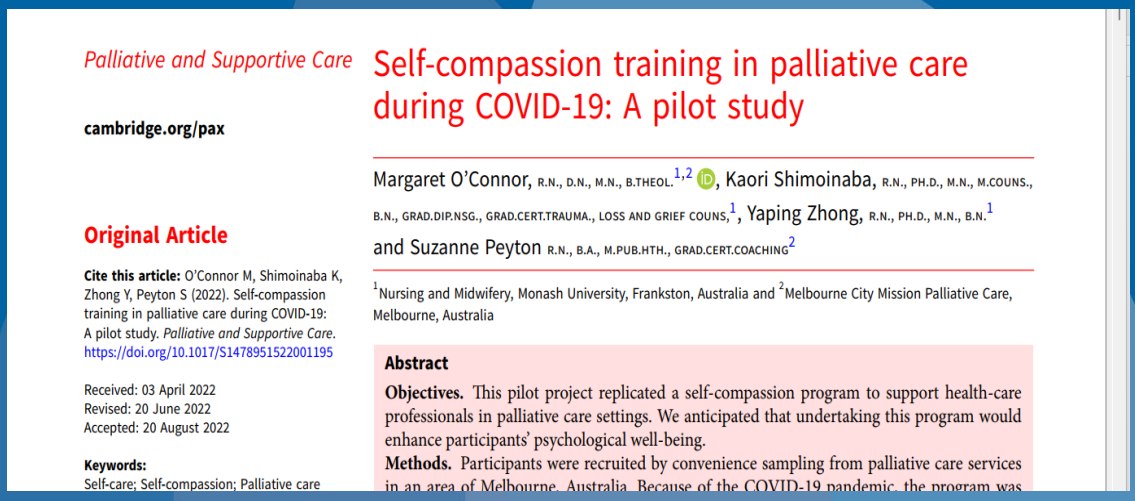

Palliative and Supportive Care

cambridge.org/pax

Original Article

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Self-care; Self-compassion; Palliative care

Self-compassion training in palliative care during COVID-19: A pilot study

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[1]Nursing and Midwifery, Monash University, Frankston, Australia and [2]Melbourne City Mission Palliative Care, Melbourne, Australia

Abstract

Objectives. This pilot project replicated a self-compassion program to support health-care professionals in palliative care settings. We anticipated that undertaking this program would enhance participants' psychological well-being.

Methods. Participants were recruited by convenience sampling from palliative care services in an area of Melbourne, Australia. Because of the COVID-19 pandemic, the program was

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melbourne city mission
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Southern Metropolitan Region Palliative Care Consortium

Tanja Bahro – Southern Metropolitan Region Palliative Care Consortium

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'Out of Complexity Find Simplicity' – Albert Einstein

Tanja Bahro – Southern Metropolitan Region
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The players

Consortium members and associated members
- Community, Inpatient, Consultancy, Private, ICS, PHN

Regional
- 160 aged care, Disability, community health, In-reach, advance care planning, local councils, PHN

Statewide
- Other consortia, PCV CPC, VACCHO, GCHCOP, Disability, PCAS, VSK, etc.
- CEH, CCDA, OPA, DoH, SCV, VAHI, MNDAV, LASA, ACSA

Federal
- PEPA, PCOG, PACOP, ELDAC, Caresearch, PCA

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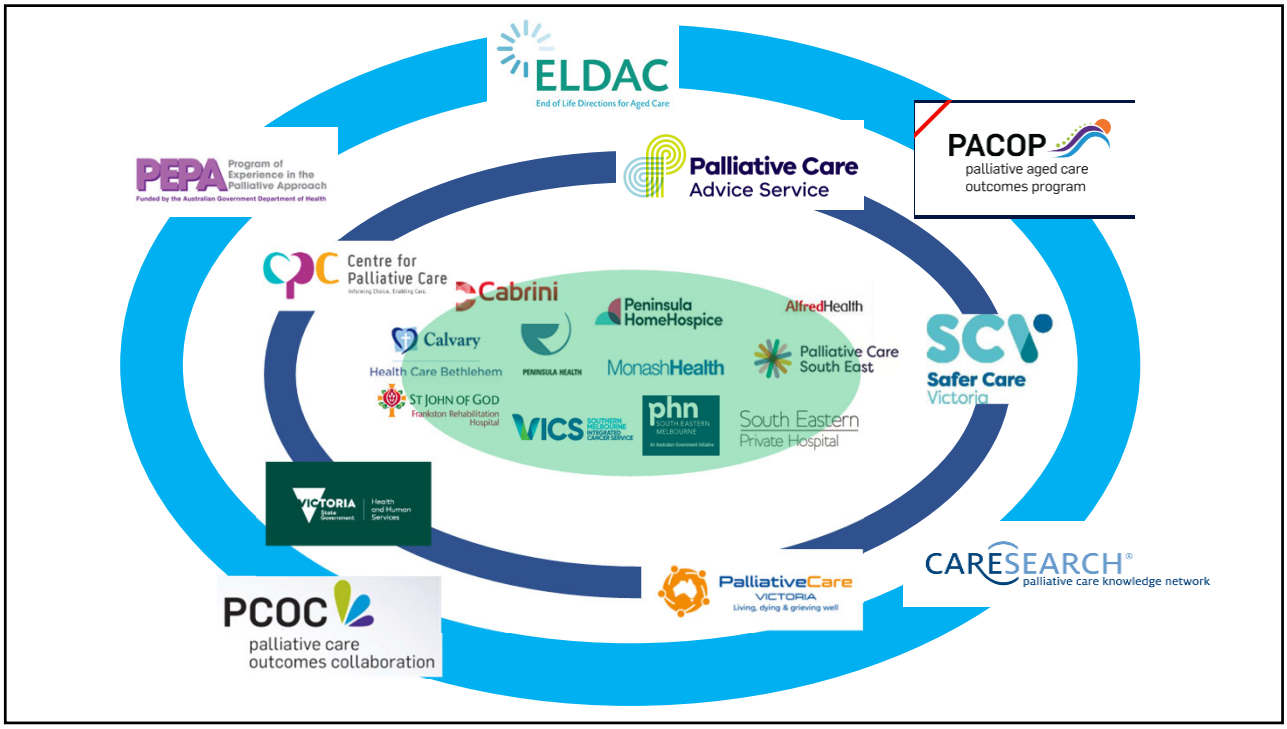

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Strategies for navigation

- Monthly email update with news and education opportunities
- Regular meetings with and connection of stakeholders
- Raising awareness for existing projects and resources
- Establishment of the Victorian Palliative Care Network (in progress)
- But when there are gaps, we dive in!

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Gap! PND and end of life

Identified by:

Consortium clinicians

Position statement of Progressive neurological diseases and end of life (PCA, MS Society, Huntington's, Fight Parkinson's)

What we have:

- Established and successful MND program
- Connection with specialist progressive Neuro and palliative service (Bethlehem)
- Internal capabilities in resource development, training and networking

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Just because something is impossible, doesn't mean we can't do it!

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How we are doing it:

- Data analysis
- WHICH PND? All? A less common one? A common one?
- Employ amazing clinician
- Stakeholder consultation
- Jim Howe (neurologist) volunteered to oversee the program

PARKINSON'S DISEASE!

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Issues for PD

- Referral to palliative care often not because of PD
- Potential of losing contact with neurologist
- Specific medication issues relating to PD
- Movement disorder clinics not clear about PC and when/how to refer
- PD patients often access RACFs before PC and lose contact with neurologist at that point

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Solutions

- Collaboration with external stakeholders (Fight Parkinson's, state-wide PND service at Bethlehem)
- Training for palliative care clinicians in the region
- Awareness raising for health professionals working with PD (in progress)
- Training regarding referral to Palliative care (existing train-the trainer resource)

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Solutions cont.

- Need for clinical guidelines identified, but no capacity or authority to develop them.

Next best thing!

- "Parkinson's Disease – Issues for the Palliative Care team"
- Resource developed by Lee-Anne Henley in conjunction with Jim Howe, Victor McConvey, Robert Wojnar
- "Parkinson's Disease – Issues for the Aged Care team" adapted by Jane Turton

- Distributed statewide, careseach, pallihub, article in palliverse, requests from interstate and overseas.

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Still to come

- More training for palliative care services in the region
- Meaningful links with movement disorder clinics and development of a red flags resource

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Similar Initiatives by the Consortium Have Included:

- Promoting Quality of Live – speakers kit
- Disability fact sheet series
- Palliative Care Conversations – train the trainer resource
- Consider the Carer
- MND Podcast series

All still relevant and available

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Thanks to the palliative care sector, especially clinicians and other consortia, which stand out for generosity, collaboration and sharing of ideas and resources.

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Palliative Care Victoria Summit 2023

Reflect, Reconnect, Rest

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Overview

Violet Platt- Chief Executive Officer, Palliative Care Victoria

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Culturally and Linguistically Diverse Community Engagement

- Community engagement projects with:
- Serbian Community Association of Australia
- United Spanish Latin American Welfare centre
- Australian Vietnamese Women's Association
- Springvale IndoChinese Mutual Assistance association
- ECCV Positive Ageing and Aged Care Policy Group
- More in the pipeline!!

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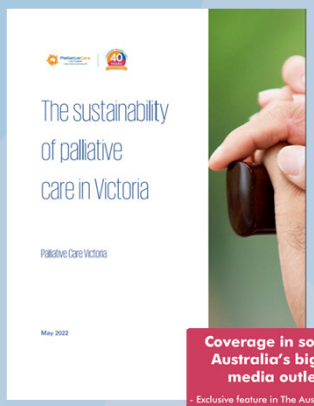
Advocacy



Coverage in some of Australia's biggest media outlets.

- Exclusive feature in The Australian to launch the campaign.
- ABC Radio Melbourne
- ABC News Radio
- Channel 9 News
- Herald Sun
- Plus many local news organisations

Political Contact

128 MPs contacted

Meaningful correspondence with 43 MPs

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Engagement

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Current Projects

Heike Fleischmann – Volunteer Engagement & Capacity Building Manager, Palliative Care Victoria

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Current projects

- Collaboration with VALID
- Promotion of Easy English booklets
- National Volunteering Conference
- Professional development for leaders of volunteers
- Visits to regional Victoria

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Collaboration with VALID

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Promotion of Easy English booklets

Our Choice Expo

Part of the
Having a Say Conference 2023

9.30am - 3.30pm

Mon. 20th & Tuesday 21st Feb. 2023

Deakin Uni, Waterfront campus, Geelong

Take the opportunity to browse around 100 exhibits and see what is available to support you to get the best out of the NDIS and be involved in your community. **Free entry** to the public.

VALID

More Information - www.valid.org.au
Christine Scott E: havingasay@valid.org.au
M: 0475 698 884

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National Volunteering Conference

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Professional Development for Leaders of Volunteers

Title

- 2 day Train the trainer workshop
- Designed for leaders of volunteers who are responsible for the induction of palliative care volunteers
- Facilitated by Heike Fleischmann from PCV

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Professional Development for Leaders of Volunteers

- Collaborative Leadership training
- Designed for leaders of volunteers who want to grow their practical confidence and competence in their leadership and management endeavours
- Facilitated by Nancy Nunez from Groupworks Centre

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Visits to regional Victoria

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Questions?

Thank you!

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Summit Finish

Thank you for attending the
Palliative Care Victoria Summit 2023

Be sure to fill out the Summit Feedback Form, from the QR code at your table.

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Afternoon Refreshments

Drinks and nibbles to be served

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