

Project ECHO – Enhancing Palliative Care

SESSION NINE – 12TH APRIL 2023

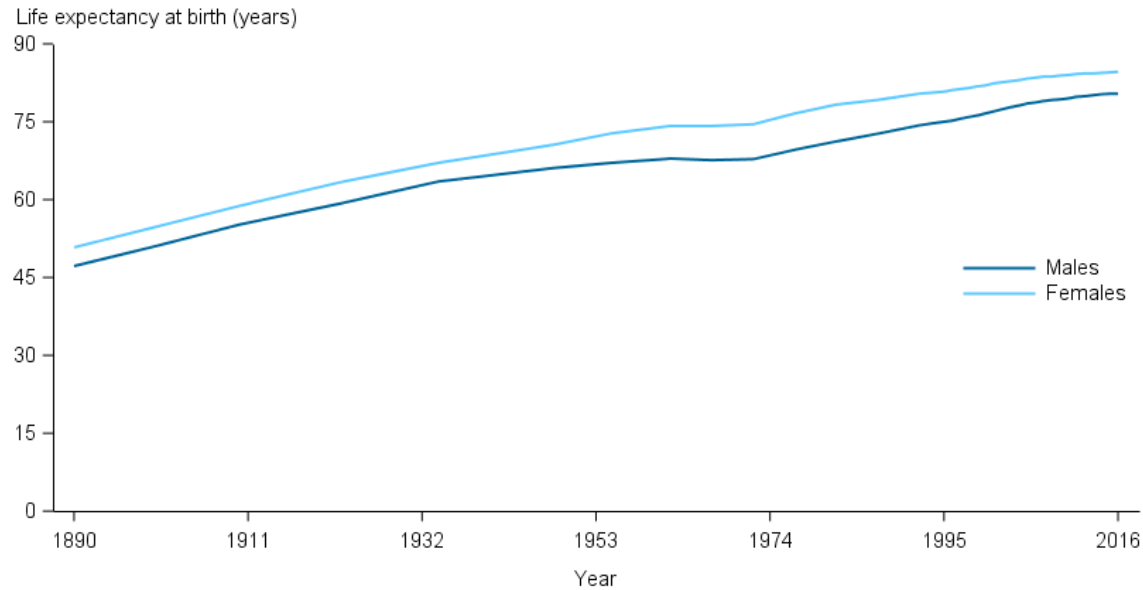


Ageing, Palliative Care and End of Life: Evidence and Resources

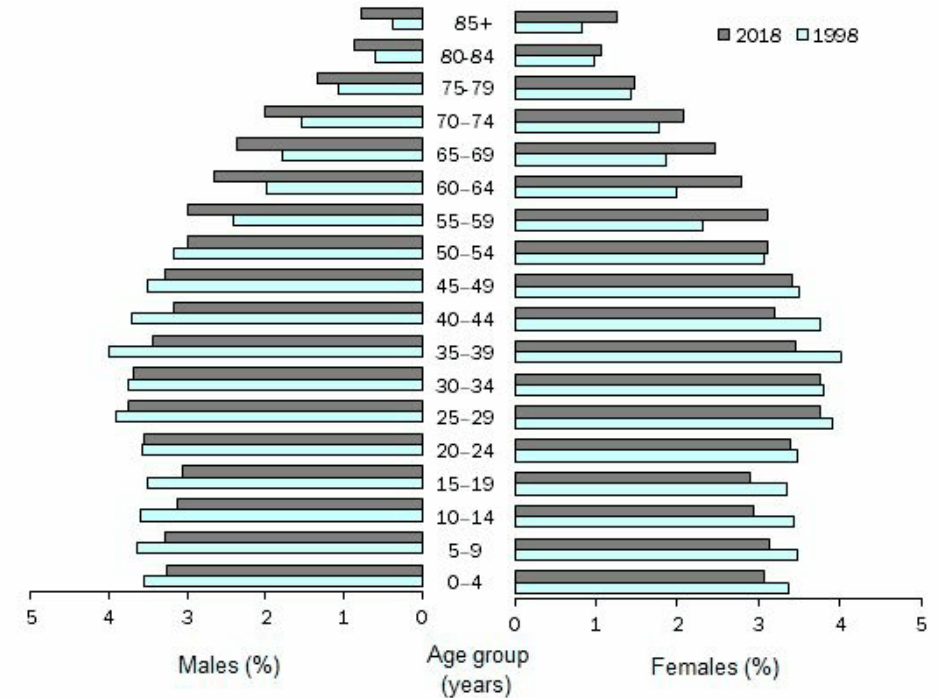


- Ageing demography
- Caring for older Australians and care needs at the end of life
- Managing care needs in your practice
- CareSearch (GP Hub), palliAGED (palliAGEDgp), ACPA, Advance, Caring safely at home (palliMeds), CarerHelp, ELDAC PEPA, Silverbook
- What do you need?

We're living longer!



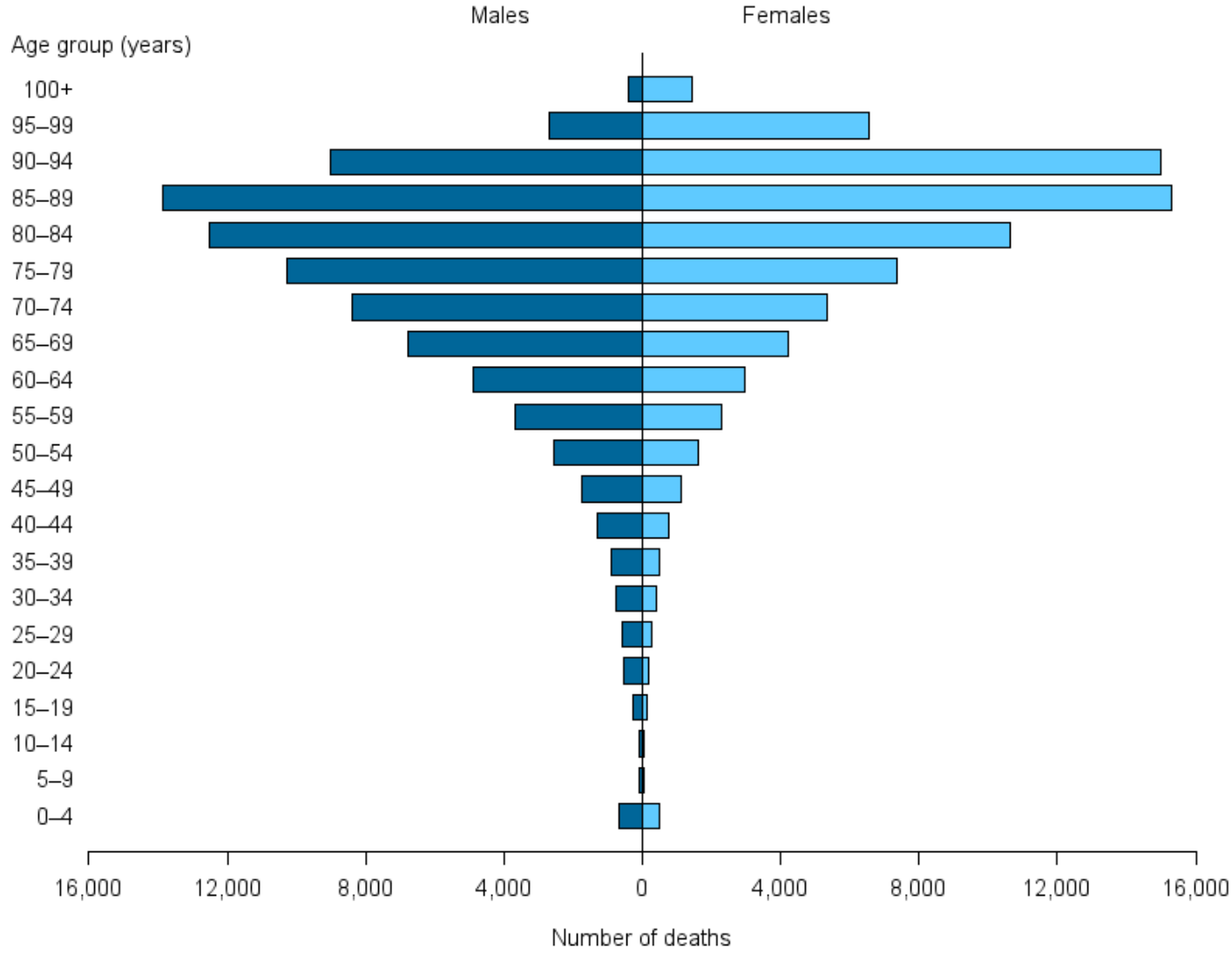
AIHW Deaths in Australia Life Expectancy Available from
<https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/life-expectancy>



3101.0 - Australian Demographic Statistics, Jun 2018

<https://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument>

And we're dying older!



AIHW Deaths in Australia Age at Death Available from <https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/age-at-death>

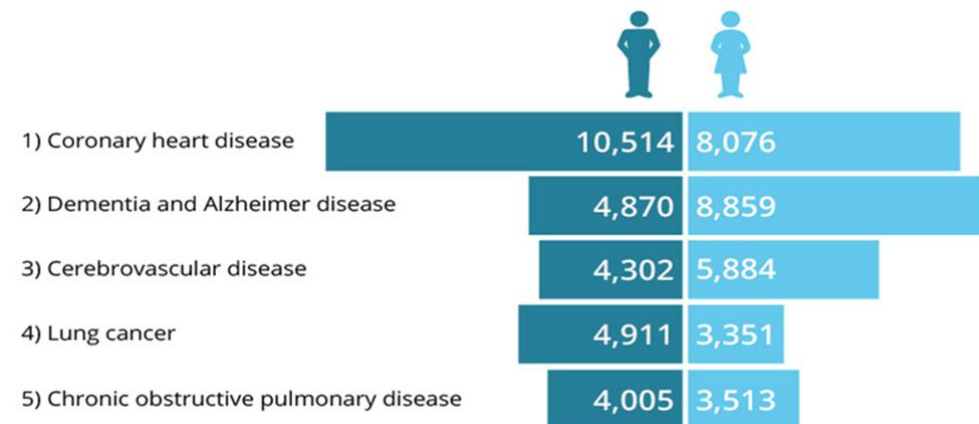


While we are living longer and dying later, there is still dying across the life course

SA has seen a 13% increase in number of deaths in 10 years to 2017 (12,345 in 2007 to 14,035 in 2017 but 19,113 deaths in 2018). Age specific death rates begin to increase from 40-44 years, then more rapidly from 50-54 years. By 65+ years, deaths are less cancer related and more ageing related particularly heart disease, dementia

As a society, our citizens have never lived as long as they are now living. Ageing is influencing dying, end of life and palliative care

Data source: ABS Census, AIHW



Hospital Use

1 in 2 deaths occur in hospital. Half of these are palliative care hospitalisations. Palliative care hospitalisations are increasing faster than all case hospitalisations.

1 in 2 of palliative care-related hospitalisations are for people 75+ years.

In SA in 2016-2017, there were 6,618 palliative care hospitalisations (76.6% in public hospitals). Increasing at around 10% annually in last 5 years. In SA, 45% of palliative care hospitalisations end in death, 38% return home.

Demand for care is increasing but end of life is not necessarily recognised and addressed within the system. Patients may not know that death is foreseeable. People intersect with many systems – primary, aged, acute community services

Source: AIHW Admitted in patient care

Our SA Community

1 in 5 of us are over 65

In South Australia, 51.8% of people had both parents born in Australia and 30.6% of people had both parents born overseas.

Aboriginal and/or Torres Strait Islander people made up 2.0% of the population.

In South Australia, 71.1% of people were born in Australia. Most common other countries of birth were England 5.8%, India 1.6%, China (excludes SARs and Taiwan) 1.5%, Italy 1.1% and Vietnam 0.9%. 4 in 5 speak English at home. Other languages spoken at home (Italian 1.7%, Mandarin 1.7%, Greek 1.4%, Vietnamese 1.1% and Cantonese 0.6%.)

Care in community

6% need assistance for core activities and 12.2% assisted family members or others due to a disability, long term illness or problems related to old age.

Communities are diverse and comprise individuals with different needs, different understanding and different points of intersect. A Human Rights approach is putting them at the centre of care.



Source ABS 2016 Census Data

Home and the Community

Dying is individual. But it affects more than the person. Families, friends, colleagues, neighbours are affected. Caring demands will affect families and communities.

Grief and loss is a personal, societal and professional issue.

Individuals live in a place and in a community. Geography, place and community vary.

People assume the system is there when they need it.

People say they would like to die at home. Regardless of where they die, most people dying an expected death will spend most of their last year at home.



Figure 1 – Placing the person at the centre of their care
National Palliative Care Strategy, 2018

GPs and End of Life: Navigating Resources

Recognise last 12 months

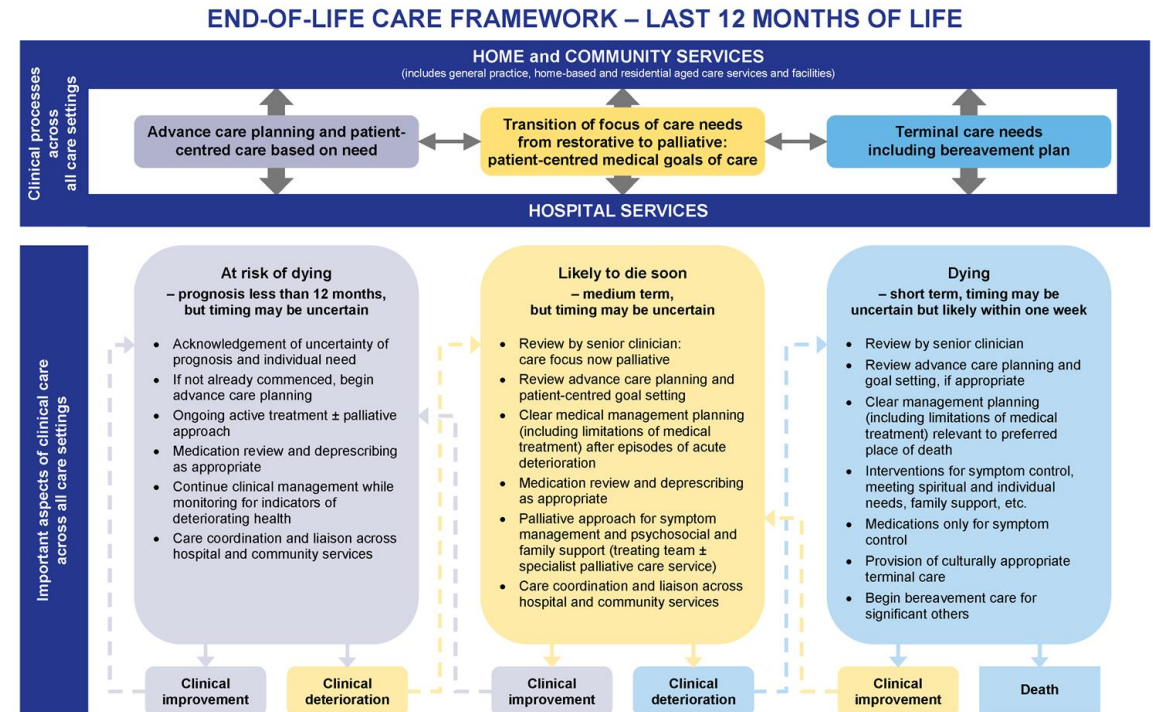
Advance care planning

Plan and coordinate care, plan, manage symptoms, cope with uncertainty

Terminal Care

Bereavement

Take care of yourself

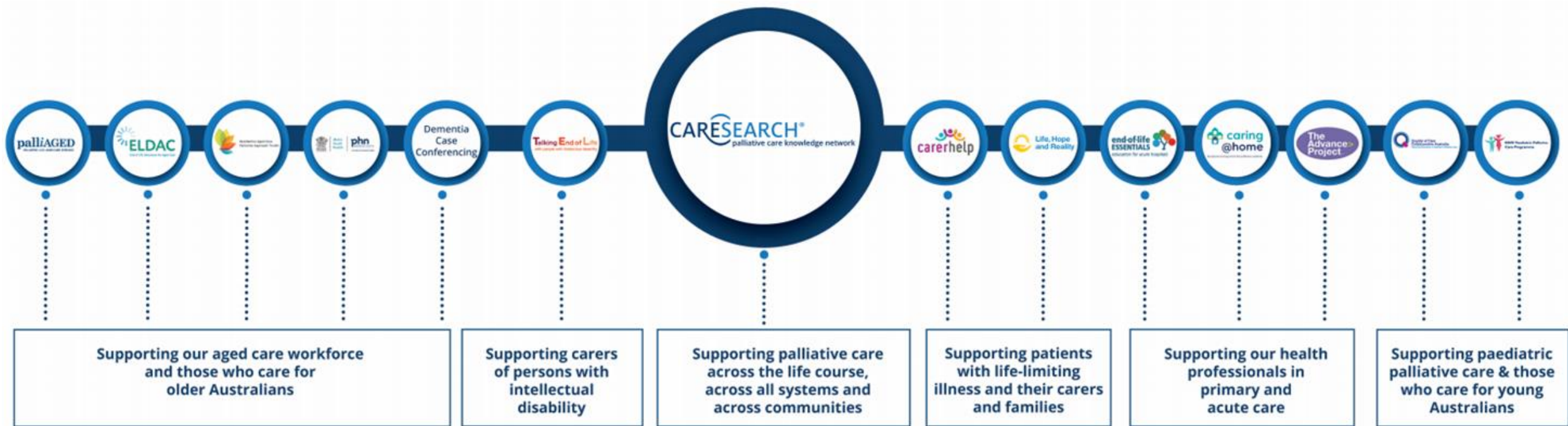


Adapted from: 1. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: essential elements for safe and high-quality end of life care. Sydney: ACSQHC, 2015
2. Alfred Health. Guideline End of Life Care Management. Alfred Health Prompt Doc No: AHG0001555 v1.0, February 2015
3. Raymond L et al. End-of-life care: Proactive clinical management of older Australians in the community. AFP 2016; 45(1-2)



© The State of Queensland (Metro South Health End-of-Life Care Steering Committee) 2016





CareSearch GP Hub

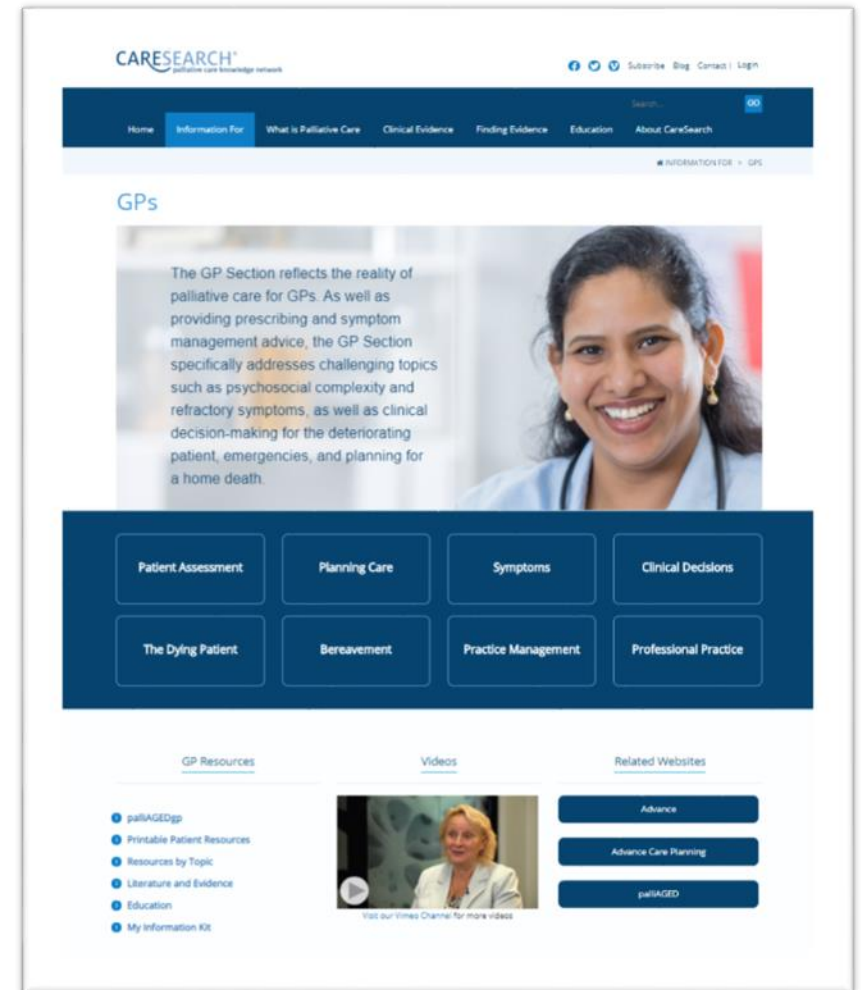
Provides a comprehensive set of information and resources for care and for practice management

Checklist for home death

Includes information on practice management (e.g. MBS items) and professional practice (e.g. self-care)

Resources by topic, printable resources and direct links into evidence and to patient, carer, family resources

Backed by CareSearch's quality processes



Assessing Prognosis

Key points

- Information about prognosis may affect patients' and families' decisions
- Patients' attitudes to treatment and interventions may shift as prognosis shortens
- Personal priorities and preferred place of care may change
- Prognosis may affect the sustainability of care arrangements in the community
- Performance state has prognostic significance, especially in advanced cancer
 - The performance state generally reflects the burden of disease. Rate of change is a global index of disease activity, and correlates to increasing constitutional symptoms such as anorexia, cachexia, fatigue
 - An Australasian-modified Karnofsky Performance Scale (AKPS) score of less than 40 or an Eastern Cooperative Oncology Group (ECOG) performance status score of 3 correlates to a median survival of around 3 months for patients with advanced cancer
 - A prognosis in terms of 'days', 'weeks' or 'months' can be reasonably predicted for many patients with cancer
- Specific prognostic guidance (SHCT) is available for a range of advanced non-malignant conditions
- Palliative care services cannot provide long-term malignant care, so
 - Families may sometimes need to consider residential aged care if the prognosis is months, and the need for good physical nursing is the main focus of the person's care
- It is important to identify the onset of the terminal phase in order to ensure appropriate care is provided.

Tools and Resources

- AKPS - Assesses performance status
- ECOG - Assesses performance status
- SHCT - Prognostic guidance for cancer, organ failure and dementia
- Palliative Care Network of Wisconsin Fact Facts - Additional resources related to prognostication

AKPS - Assesses performance status

The AKPS is a measure of the patient's overall performance status or ability to perform their activities of daily living. It is a single score between 10 and 100 assigned to a clinician based on observations of a patient's ability to perform common tasks relating to activity, work and self-care. A score of 100 signifies normal physical abilities with no evidence of disease. Decreasing numbers indicate a reduced performance status.

| AKPS ASSESSMENT CRITERIA | SCORE |
|---|-------|
| Normal: no complaints; no evidence of disease | 100 |
| Able to carry on normal activity; minor signs 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 |

Palliative Care Support for Patients, Carers and Families

CareSearch provides trustworthy information about palliative care for patients, carers, and families as well as for health professionals



- Bereavement
- Practice Management
- Professional Practice
- Resources
- Aboriginal and Torres Strait Islander Care
- Allied Health
- Nurses
- Residential Aged Care
- Researchers

Tools and Resources (GPs)

- Checklist - Planning for an expected home death
- Free full text article - Home-based support for palliative care families: challenges and recommendations

Checklist - Planning for an expected home death

Helping Patients and Families Plan for an Expected Home Death - GPs Checklist

1. Clarify expectations and support

What has the patient said about their wish to stay at home to die?

- Has the plan been discussed within the family?
- Consider - young children, others with care needs in the household

Are there enough people to share the care?

- Consider their practical, hands on availability for round the clock care
- Encourage a roster, with time out

Is it possible to determine the patient's prognosis, in order to help the family plan ahead and marshal their resources? Eg. is care likely to be needed for:

- Weeks or
- days or
- hours

For more: Assessing the Dying Patient

What is the back up plan if either the patient or the family find it difficult?

- Clearly document the plan and ensure that it is realistic, and understood by all involved
- Consider whether there are specific services that can support families caring for someone who is dying at home, for instance night nursing services or volunteers - the local palliative care service can advise
- Provide a letter (or Ambulance Plan) describing the palliative goals of care in case of a triple zero call, clearly stating that the patient is dying and that cardiopulmonary resuscitation is not appropriate

For more: Information needed for shared care

2. Assess the home situation

Will the patient be able to be cared for safely and comfortably in the home?

- Refer to home nursing or palliative care nursing services, and ask them to teach the family about how to provide care safely
- How much nursing support is available? Specifically, how many visits can the patient have?
- Are there complex nursing needs that will be difficult to manage at home eg. difficult wounds, fistulas, spinal analgesia, etc.
- Consider equipment that may be needed to nurse a bed-bound patient: eg. hospital bed, mobility aids, commodes and other personal care equipment, wheelchair, pressure mattresses, and so on
- Consider a palliative care referral for an occupational therapy and/or physiotherapy assessment to advise on and organise equipment
- Discuss the option of an 'in-dwelling' gatherer to reduce the burden on both patient and family in the terminal phase
- Encourage the family to think about any practical arrangements that might make caring easier or safer: eg. moving a patient's bed to a different room or perhaps relocating the patient and carers to a different family member's home - remembering however that a move into a different area may disrupt their eligibility for services, so plan ahead with this

3. Plan for symptom management

Review long-term medications - cease any that no longer contribute to the patient's comfort

Discuss with the family how the patient's symptoms will be reviewed and managed, eg:

- Whether home nurses will report to the GP
- How often GP visits will occur
- What the palliative care service will do
- Arrangements for providing prescriptions

Plan for predictable, common symptoms that occur at the end of life:

Reimbursement

Key points

- Palliative care patients include not just those who are very close to the end-of-life, but others with advanced disease
- A range of item numbers associated with the Chronic Disease Management program are appropriate in the care of palliative care patients
- Multidisciplinary care and case conferences are an important strategy in this population

Billing - Medicare items for palliative care

ACPA has provided a summary sheet (183kb pdf) on how Medicare Benefits Schedule (MBS) item numbers may be used by GPs for advance care planning where clinically appropriate

Medicare item numbers are subject to change. Please also refer to MBS Online for any updates.

- Standard GP assistance at a hospital, institution or home 24, 27, 27
- After hours care 803, 803, 804, 804, 804
- Aboriginal and Torres Strait Islander Health 715, 10987
- General practitioner management plans 721, 732
- Team care arrangement 733, 733
- Multidisciplinary care plan 728, 731
- Medication management review 803, 800
- Case conferencing - community setting 735, 747, 739, 750, 743, 758
- Mental healthcare items 2700, 2701, 2712, 2713, 2715, 2717, 2721, 2725
- Consultation at a residential aged care facility 20, 35, 43, 51

From: Medicare Benefits Schedule (MBS)

Last updated 30 July 2019

Finding and Using Evidence

An evidence-based approach is one which uses the best available evidence to answer clinical and service-related questions. CareSearch is committed to providing access to latest evidence in palliative care and provides the tools to help you find and use evidence for yourself



Why is Evidence Important?

Searching for Evidence

Using Evidence In Practice

PubMed Searches

Search Grey Literature

Systematic Review Collection

palliAGED

palliAGED is palliative care evidence base for aged care. Replaces APRAC and COMPAC guidelines

Evidence and Practice resources for the aged care sector

palliAGEDgp app

Resources for families of older Australians

The screenshot shows the palliAGED website homepage. At the top, there is a navigation bar with links for Home, Australian Context, Evidence Centre, Practice Centre, For the Community, and News. A search icon is also present. Below the navigation bar, a welcome message states: "Welcome to palliAGED. palliAGED is the palliative care evidence and practice resource for aged care. An Evidence Centre and a Practice Centre mean that aged care staff and health professionals can find the evidence easily and know how to use it in providing care. Older Australians, their families and friends are also welcome to use these trustworthy resources." To the right, a section titled "Getting Started with palliAGED" includes a video thumbnail and the text: "Watch a brief introduction to find out more about palliAGED and the support it provides." Below this, there are four main content boxes: "Find Guidance in Evidence" (Evidence on 35+ topics to support best practice), "Practice Centre Resources" (Practical guidance, tools and resources for quality care), "Go to GP Pages" (Resources for clinical decision-making and care management), and "Go to Newsroom" (Latest palliAGED updates, sector news, evidence, blogs and more). At the bottom, there is a "Follow palliAGED" section with social media icons for Facebook, Twitter, YouTube, and LinkedIn. A small icon in the bottom right corner indicates that the site complies with the Australian standard for trustworthy health information.

The screenshot shows the "Symptoms and Medicines" page on the palliAGED website. The page title is "Symptoms and Medicines" and it includes a sub-header "These pages are a resource to guide evidence-based practice in the care of older people in the last days of their life (terminal phase). On these pages many links direct you to the palliAGEDgp app. Once you have accepted the Terms and Conditions you will have access to all app content." Below this, there is a section for "Principles" which states: "Identification of the terminal phase requires the clinician to recognise when a person is actively dying. Signs of active dying include: bed-bound, unable to swallow, poor responsiveness with limited responses to verbal or physical stimuli, reduced or no urine output, changes in breathing pattern and signs of peripheral shutdown. Clinicians need to consider the needs of the person and the inappropriateness of ongoing investigations. When a person has been diagnosed as dying, the goals of care have changed to the management of the terminal phase. This diagnosis is the opportunity to support shared decision-making and to design care through conversations with the person, their family and carers. It can help the avoidance of unnecessary and futile orders of care, including hospital transfers and resuscitation, if a person dies peacefully without needless suffering, the family and carers have the best opportunity to see the death as a good death and have fewer difficulties as they grieve." The page also lists "The clinical priorities of terminal care are:" and includes a list of priorities: "relieving the person, the family and carers", "managing symptoms", "ensuring medicines are available for symptom management", "withdrawing non-essential medicines", and "adding other health professionals involved in the person's care." At the bottom, there are several buttons for different symptoms: Anxiety, Dyspnoea, Nausea and Vomiting, Pain, Respiratory Secretions, and Terminal Restlessness.



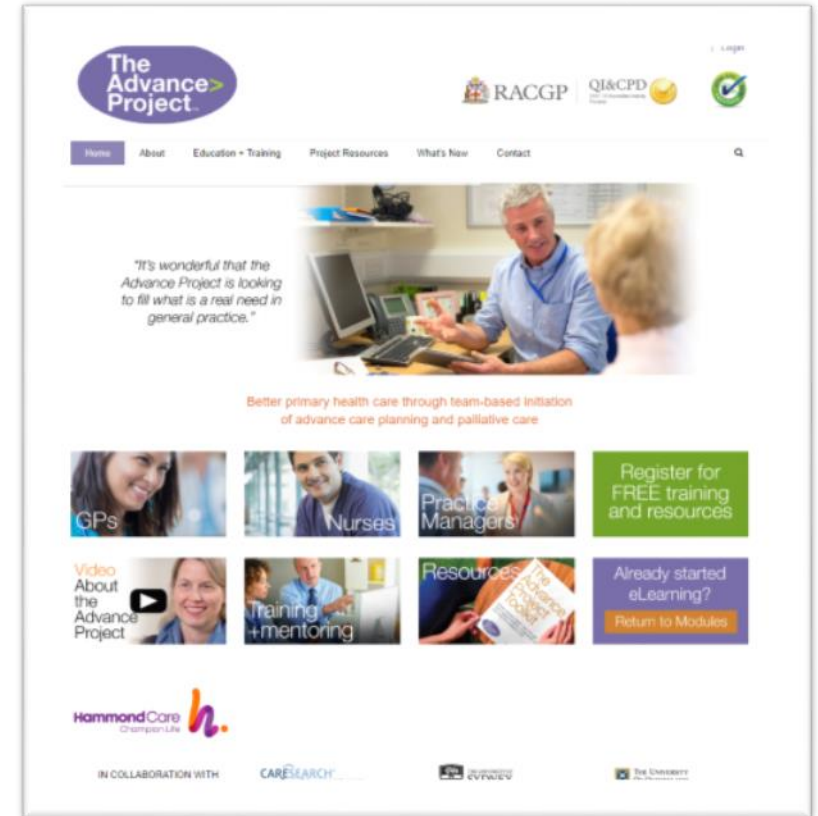
Advance Project

Implement a team-based approach to initiating advance care planning (ACP) and palliative care into everyday clinical practice.

Modules for GPs, GPNs, GPMs

Toolkits including assessment tools and patient, carer sheets

Videos to support care approaches



Advance Care Planning Australia

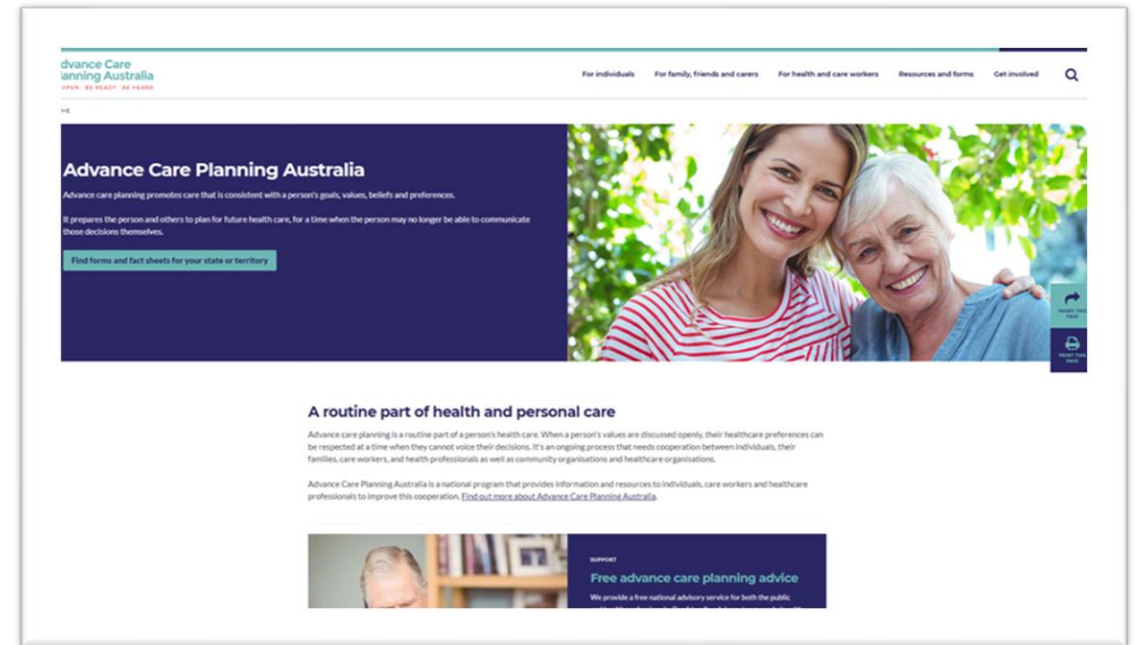
ACPA is centre of ACP related resources and training.

Provides links to all state and territory legislation and forms

Addresses legalities of ACP

Available in multiple languages

Resources aged care



CarerHelp

Recognises that family carers enable patients to remain at home

Information, carer videos and interactive forms

Five pathways:

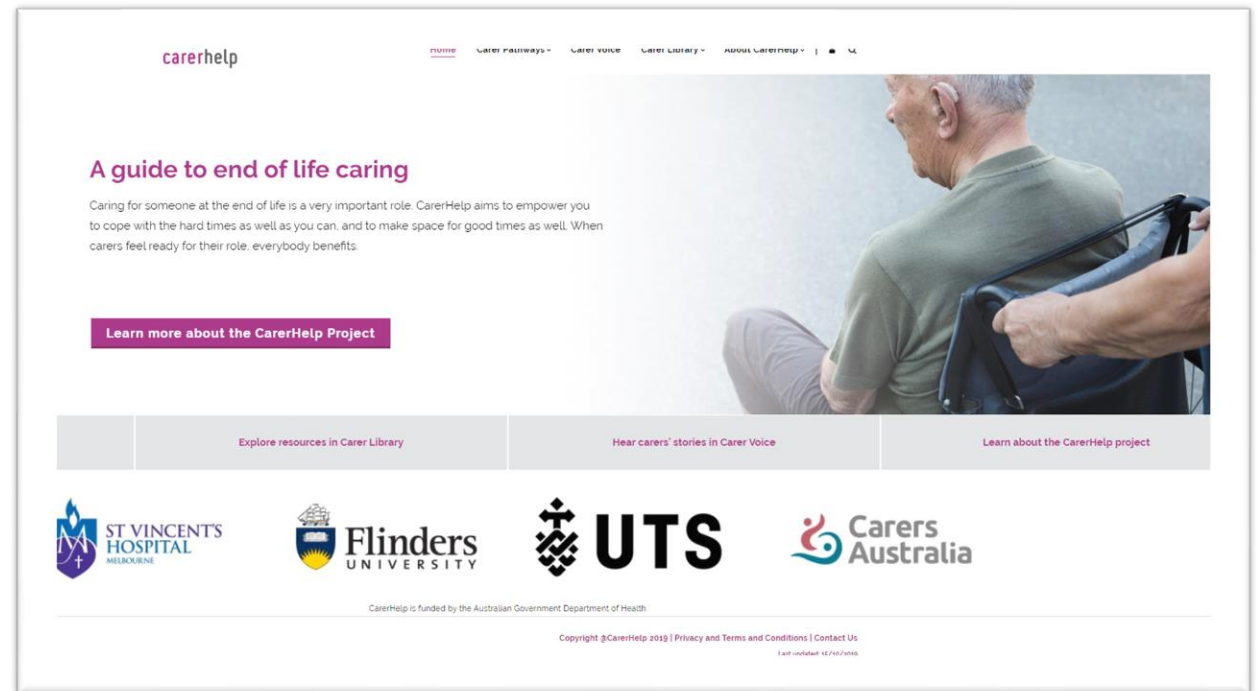
When someone needs care

Caring when death is a possibility

Preparing for dying

When the person is dying

After caring

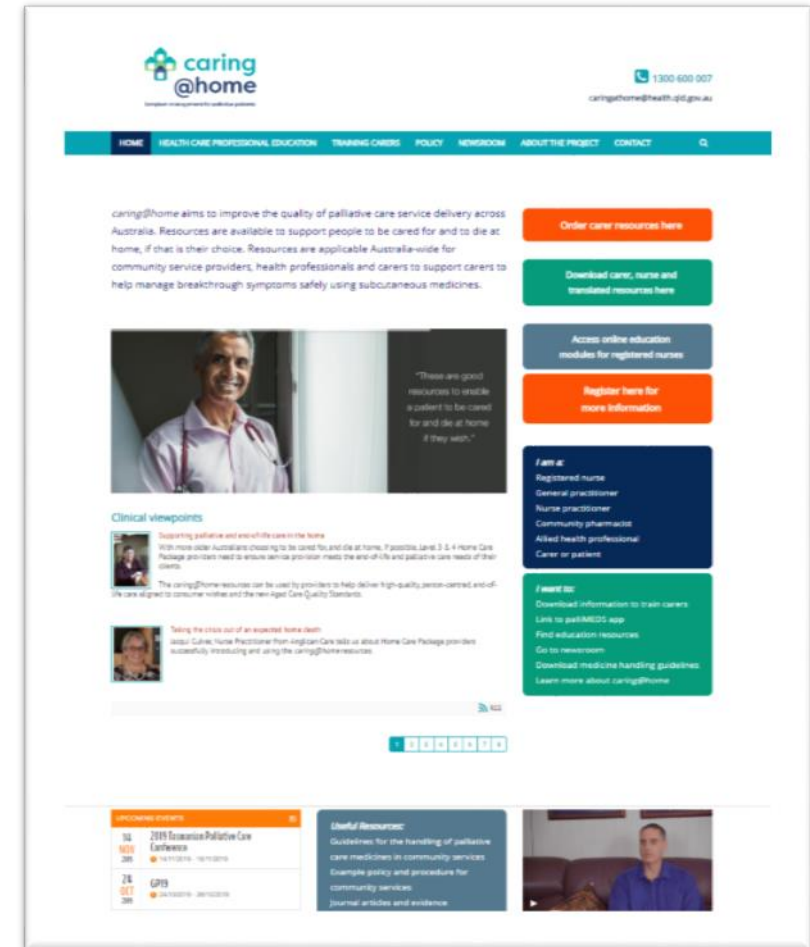


Caring Safely at Home

Evidence-based, best practice resources to support services to teach carers to help manage breakthrough symptoms safely, using subcutaneous medicines, if that is something they want to do.

Guidelines for the handling of palliative care medicines in community services, developed by NPS MedicineWise

Online education modules for registered nurses
palliMEDs App



ELDAC

End of Life Directions for Aged Care

Five toolkits including a primary care toolkit

Legal toolkit on common legal concerns

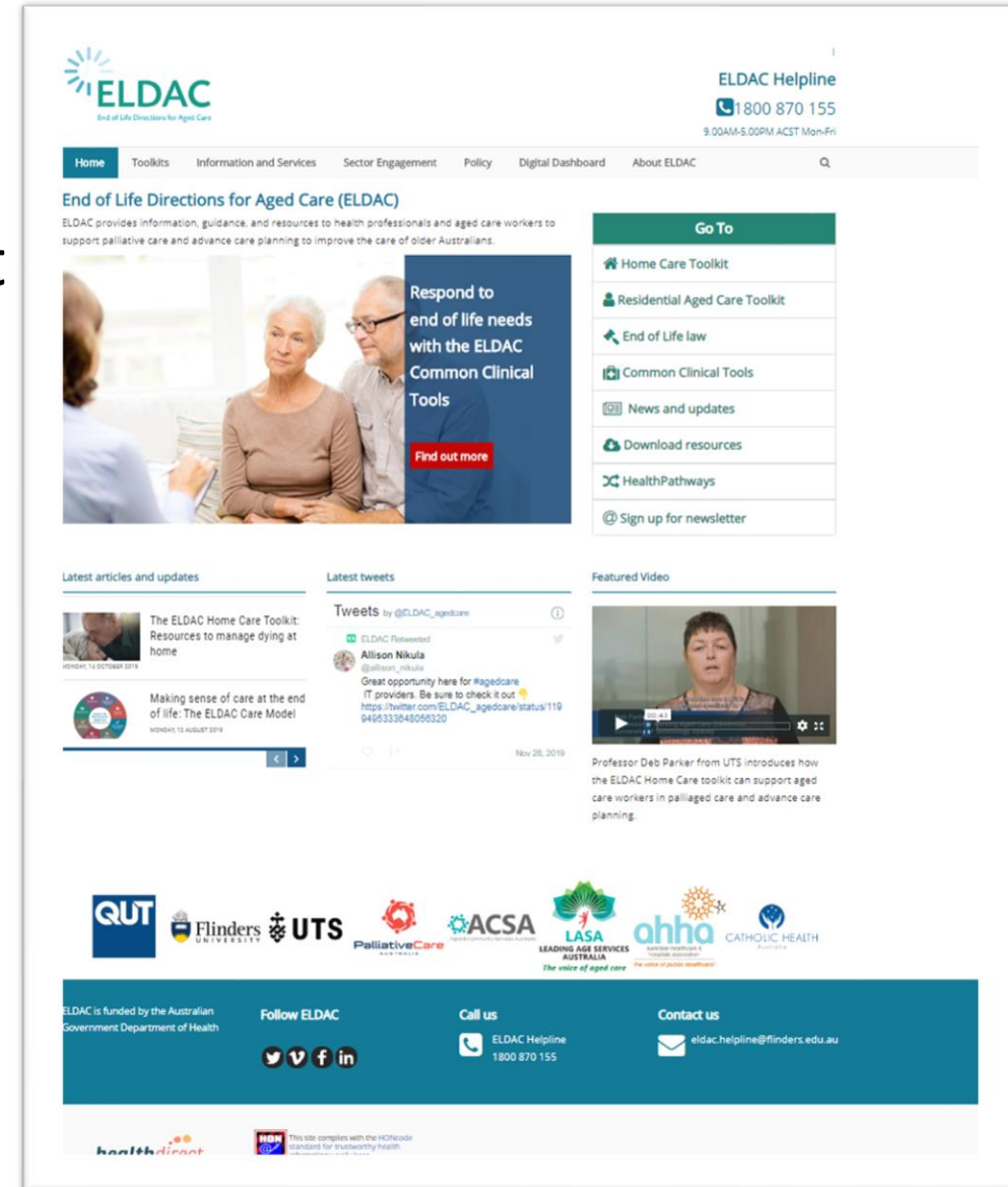
Common clinical tools

Health pathways

Facilitator enabled sector engagement

Digital dashboard and other digital innovations

Policy support



- > Home Care
- > Primary Care
 - > Clinical Action
 - > Team Action
 - > Quality Improvement
 - > Collaboration and Partnering
 - > Practice Management
 - > My Health Record
 - > Health Care Homes
 - > Greater Choice for At Home for Palliative Care
 - > HealthPathways
- > Residential Aged Care
- > Legal
- > Working Together

Practice Management

Palliative care practice in primary care is supported through the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme. There are no specific palliative care MBS items. Instead other MBS items are used to reimburse the delivery of palliative care.

Medicare Benefits Schedule (MBS) Items >

Practice Incentives Program (PIP) General Practitioner Aged Care Access Incentive (ACAI) >

Training for Practice Managers

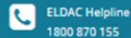
Page updated 25 March 2019

ELDAC is funded by the Australian Government Department of Health

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- > Home Care
- > Primary Care
- > Residential Aged Care
- > Legal
 - > Overview of end of life law in Australia
 - > Capacity and consent to medical treatment
 - > Advance Care Directives
 - > Substitute decision-making
 - > Withholding and withdrawing
 - > Medication for pain and symptom relief
 - > Futile or non-beneficial treatment
 - > Emergency medical treatment
 - > Managing disputes about medical treatment decision-making
 - > Assisted Dying
 - > Factsheet
 - > Resources
- > Working Together

Factsheet: Assisted Dying

Assisted dying is illegal in all Australian States and Territories except Victoria where Voluntary Assisted Dying (VAD) will be lawful from 19 June 2019. VAD will be available only in restricted circumstances to a person who has decision-making capacity and seeks assistance to die.

Clarifying the law

This factsheet explains:

- What assisted dying is
- The law on assisted dying in Australia
- The law on VAD in Victoria, including processes, safeguards and conscientious objection

Download Factsheet
(200 kb pdf)

What is assisted dying?

Assisted dying is the term used in Australia to refer to the assistance provided to a person to end their life. In Victoria, the assistance will be provided by a medical practitioner either by prescribing the medication to the person for self-administration or, in limited circumstances, through administration by a medical practitioner. Different terminology is used for assisted dying in different countries. For example, 'medical assistance in dying' is used in Canada, and 'physician-assisted suicide' is used in some parts of the United States. Both Belgium and The Netherlands use the term 'euthanasia'.

Is assisted dying legal in Australia?

Assisted dying is illegal in all Australian States and Territories. In those States and Territories where it remains illegal, a person (e.g. a doctor) who assists another person to die may be charged with murder, manslaughter or assisting suicide.

Though there have been many Bills introduced in other Australian State and Territory parliaments to legalise these practices, aside from the brief legalisation of euthanasia in the Northern Territory in 1996-1997, no other attempts have been successful.

Providing appropriate palliative medication with the intention of relieving a person's pain and suffering is not assisted dying. For further information on palliative medication, refer to the Legal Toolkit factsheet: Medication for pain and symptom relief for people with a life-limiting illness.

Learn more about the law on assisted dying and euthanasia in [End of Life Law in Australia](#)

An overview of VAD in Victoria

The Voluntary Assisted Dying Act 2017 (Vic) makes VAD legal in Victoria from 19 June 2019. VAD is only available to a person who is 'eligible'.

Eligibility criteria

A person will be eligible for VAD if he or she:

- > is aged 18 or over;
- > is an Australian citizen or permanent resident, ordinarily resident in Victoria, and, at the time of making a first request for VAD, has been resident in Victoria for at least 12 months;

The Legal Toolkit provides practical information about the law at end of life for the aged care sector. It contains useful resources on end of life legal issues commonly encountered in aged care to help you to know the law and to support your practice. To find out more, read our Legal factsheet (701 kb pdf).

Overview of End of Life Law in Australia

Capacity and Consent to Medical Treatment

Advance Care Directives

Substitute decision-making

Withholding and Withdrawing Life-Sustaining Medical Treatment

Medication for Pain and Symptom Relief

Futile or Non-Beneficial Treatment

Emergency Medical Treatment

Managing Disputes About Medical Treatment decision-making

Assisted Dying

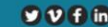


Hear more about the Legal Toolkit from Prof Lindy Willmott

Page updated 17 July 2019

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PEPA

PEPA provides Australia's only free placements in palliative care services for practicing health professionals (2-4 days) and free palliative approach workshops

Reverse PEPA placements entail a specialist palliative care staff member travelling to the applicant's place of employment to facilitate learning.

PEPA Program of Experience in the Palliative Approach
Funded by the Australian Government Department of Health

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PEPA Empowers
Health Professionals
To Deliver Quality End-of-life Care

PEPA Provides Australia's only free health placements in palliative care services for practicing health professionals (2-4 days duration) and free palliative approach workshops.

Workshops
PEPA workshops incorporate activities which are consistent with the aims of PEPA, and integrate contemporary, evidence-based educational strategies.
[Read More](#)

Placements
PEPA provides an opportunity for primary health care providers to develop skills in the palliative approach by undertaking a supervised clinical placement of up to four days within a palliative care specialist service (host site).
[Read More](#)

Support & Education
A key component of PEPA is activities designed to promote transfer of learning into the workplace. These Workplace Learning activities are designed to provide ongoing education and support to reinforce learning and
[Read More](#)

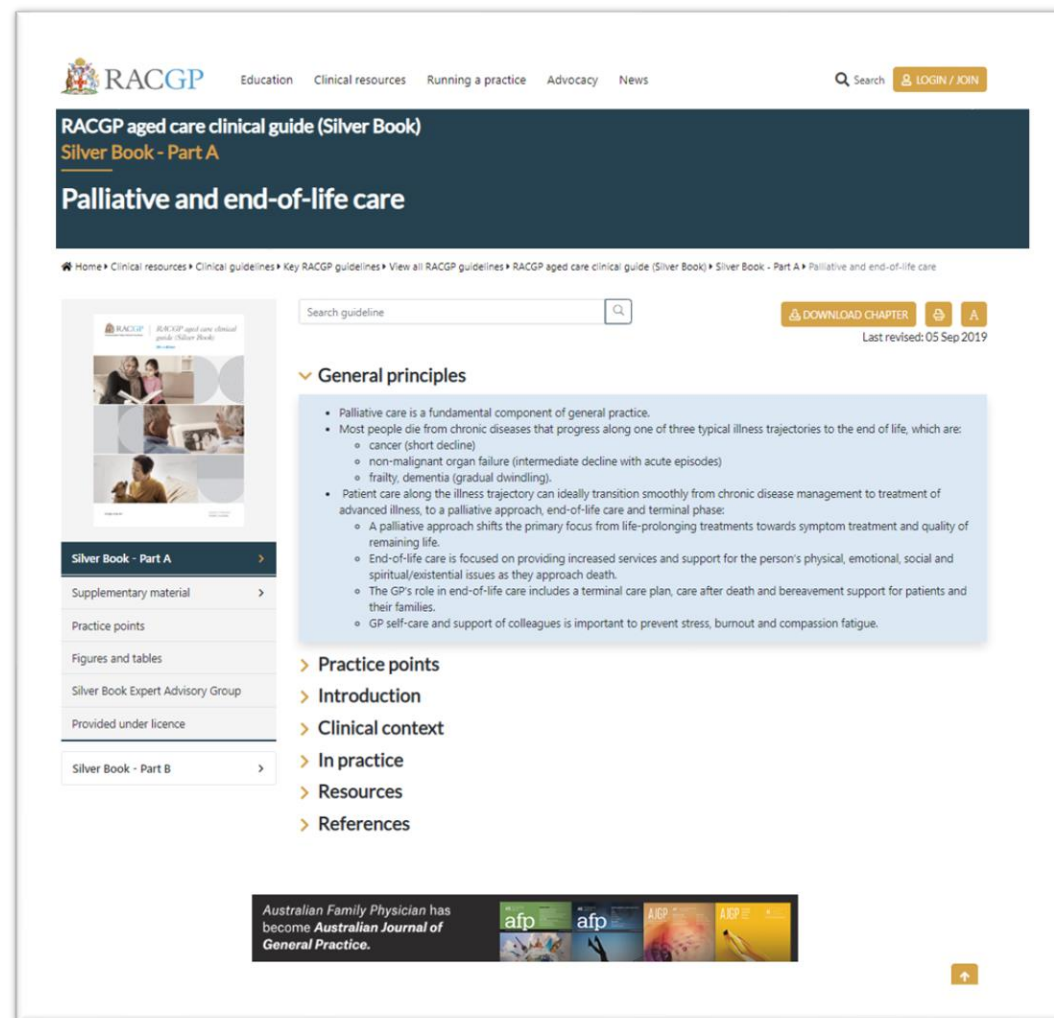
[Learn More About PEPA](#)



SilverBook (RACGP)

More than one in three general practice patient encounters are with older people aged 65 years and over, and general practitioners (GPs) are increasingly seeing more older people in their practice.

Palliative care specific section



The screenshot displays the RACGP SilverBook website interface. At the top, the RACGP logo is visible alongside navigation links for Education, Clinical resources, Running a practice, Advocacy, and News. A search bar and a LOGIN / JOIN button are also present. The main heading reads "RACGP aged care clinical guide (Silver Book) Silver Book - Part A Palliative and end-of-life care". Below this, a breadcrumb trail shows the path: Home > Clinical resources > Clinical guidelines > Key RACGP guidelines > View all RACGP guidelines > RACGP aged care clinical guide (Silver Book) > Silver Book - Part A > Palliative and end-of-life care. A search bar and a "DOWNLOAD CHAPTER" button are located on the right. The "General principles" section is expanded, showing a list of bullet points: Palliative care is a fundamental component of general practice; Most people die from chronic diseases that progress along one of three typical illness trajectories to the end of life, which are cancer (short decline), non-malignant organ failure (intermediate decline with acute episodes), and frailty, dementia (gradual dwindling); Patient care along the illness trajectory can ideally transition smoothly from chronic disease management to treatment of advanced illness, to a palliative approach, end-of-life care and terminal phase; A palliative approach shifts the primary focus from life-prolonging treatments towards symptom treatment and quality of remaining life; End-of-life care is focused on providing increased services and support for the person's physical, emotional, social and spiritual/existential issues as they approach death; The GP's role in end-of-life care includes a terminal care plan, care after death and bereavement support for patients and their families; and GP self-care and support of colleagues is important to prevent stress, burnout and compassion fatigue. A sidebar on the left lists "Silver Book - Part A" and "Silver Book - Part B" with expandable options for Supplementary material, Practice points, Figures and tables, Silver Book Expert Advisory Group, and Provided under licence. At the bottom, a banner for the Australian Family Physician becoming the Australian Journal of General Practice is shown, along with a small "up" arrow icon.



End of Life Law for Clinicians

<https://end-of-life.qut.edu.au/>

End of Life Law in Australia provides accurate and practical information to assist in navigating the challenging legal issues that can arise with end of life decision-making.

It is a broad introduction to end of life laws in each Australian State and Territory to help you know the law, and your rights and duties.

- Legal Overview
- Capacity and Consent to Medical Treatment
- Advance Care Directives
- Treatment Decisions
- Legal Protection for Providing Pain and Symptom Relief
- Organ Donation
- Voluntary Assisted Dying

End of Life Law for Clinicians training

Are you a doctor or medical student?
Want to know more about end of life law?
Complete our **online training** by registering below
or attend a **workshop** (program coming soon).

ELLC End of Life Law
for Clinicians

Register



ELLC End of Life Law
for Clinicians

Voluntary Assisted Dying in South Australia

The [Voluntary Assisted Dying Act 2021](#) (the Act) commenced 31 January 2023.

All South Australians are entitled to high-quality end of life and palliative care, regardless of their medical diagnosis, age, culture, background, beliefs or where they live.

Resources are available on the SA Health website:

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/primary+and+specialised+services/voluntary+assisted+dying/voluntary+assisted+dying+in+south+australia>

Health services information for voluntary assisted dying are also available via the SA Health website:

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/governance/policy+governance/policies/voluntary+assisted+dying+clinical+guideline+for+health+practitioners>



Specialist Palliative Care Services

Specialist palliative care teams work in a consultative way with general practitioners and other health care providers, when symptoms and/or concerns exceed the capacity, resources, knowledge or skills of the treating health professional/s.

Within metropolitan Adelaide, there are three regionalised, adult specialist palliative care services:

- Northern Adelaide Palliative Service (based at Modbury Hospital)
- Central Adelaide Palliative Care Service (based at The Queen Elizabeth Hospital)
- Southern Adelaide Palliative Services (based at Flinders Medical Centre)

SA Health - Website

<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+programs+and+practice+guidelines/end+of+life/end+of+life+care+resources>



Palliative Care Referral

Metropolitan Services

- Northern Adelaide Palliative Care
Phone: 8161 2499
Fax: 8161 2169
- Central Adelaide Palliative Care
Phone: 8222 6825
Fax: 8222 6055

- Southern Adelaide Palliative Care
Phone: 8404 2058
Fax: 8404 2119

Statewide Services

- Paediatric Palliative Care
Phone: 8161 7994
Fax: 8161 6631

Country Services

For metropolitan referrals to country, please direct to the **Country Referral Unit**.

For local referrals within country, please direct to the Country Referral Unit (preferred) or the relevant specialist palliative care service.

- Country Referral Unit
Phone: 1800 003 307
Fax: 1800 771 211
- Lower North Palliative Care (Clare)
Phone: 8842 6559 / 8842 6500
Fax: 8842 6590
- Riverland Palliative Care (Barmera)
Phone: 0408 805 966
Email: HealthCHSARCHSReferrals@sa.gov.au
Fax: 08 8580 2550
- Adelaide Hills Palliative Care (Mt Barker)
Phone: 8393 1833
Please direct to the Country Referral Unit
Fax: 1800 771 211
- Murray Mallee Palliative Care (Murray Bridge)
Phone: 8535 6800
Fax: 8535 6808
- South Coast Palliative Care (Victor Harbor)
Phone: 0413 835 509
Please direct to the Country Referral Unit
Fax: 1800 771 211
- Inner North Palliative Care (Barossa/Gawler)
Phone: 8521 2080
Please direct to the Country Referral Unit
Fax: 1800 771 211
- Naracoorte Palliative Care
Phone: 8762 8160
Fax: 8762 8164
- South East Palliative Care (Mt Gambier)
Phone: 8721 1460
Fax: 8721 1461
- Ceduna Palliative Care
Phone: 8626 2119
Fax: 8626 2190
- Port Augusta Palliative Care
Phone: 8668 7754
Fax: 8668 7801
- Whyalla Hospital Palliative Care
Phone: 8648 8327
Email: HealthCHSAWhyallaPalliativeCare@sa.gov.au
Fax: 8648 8479
- Kangaroo Island Palliative Care
Phone: 8553 4231
Fax: 8553 4227
- Port Lincoln Palliative Care
Mob: 0427 006 983
Fax: 8682 5831
- Yorke Peninsula Palliative Care (Wallaroo)
Phone: 8823 0289 / 8823 0270
Fax: 8823 2902
- Port Pirie Palliative Care
Phone: 8638 1100
Fax: 8115 5734

GPs and End of Life: Navigating Resources

Recognise last 12 months: CareSearch GP Hub, SilverBook, ELDAC

Advance care planning: ACPA, CareSearch GP Hub, palliAGED, ELDAC

Plan and coordinate care, plan, manage symptoms, cope with uncertainty: CareSearch GP Hub, Caring at Home, ELDAC, CarerHelp

Terminal Care: CareSearch GP Hub, palliAGEDgp, CarerHelp, SilverBook

Bereavement: CareSearch GP Hub, CarerHelp

Take care of yourself: CareSearch GP Hub

Your Practice: CareSearch GP Hub, ELDAC Primary Care Toolkit,

Education and Training: Advance, PEPA, CareSearch GP Hub

Aged: palliAGED, ELDAC, SilverBook



Take Home Points

Department of Health funds the National Palliative Care Program

National Strategy recognises increasing demand for palliative care

Impact of ageing is apparent

Many resources are available. (Can raise question of which one when!)

Good news is that there is coherence in approach, tools and resources.
So, no matter where you start you are likely to get similar information.

Two Questions?

Resources are available. How do we share effectively?

What would make resources more useful?

At the Heart of Palliative Care

It's more than you think

