April 2010

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Deborah Parker

cebparac Comprehensive Evidence Based Palliative Approach in Residential Aged Care

The Comprehensive Evidence Based Palliative Approach in Residential Aged Care Project is funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care (EBPRAC) program.

Message from Associate Professor Deborah Parker

Welcome to the April 2010 edition of the cebparac newsletter.

We have had a busy start to 2010 working with facilities to implement the palliative approach with their residents. Each facility has been asked to nominate 10 residents who they believe would benefit from involvement in the project. Some of these residents and family have already participated in a palliative care case conference. The conferences are held with facility staff and a specialist palliative care nurse and/or GP. A major focus in these meetings is to achieve a shared understanding between medical staff, residents and families. The case conferences have been well-received, with all parties appreciating the opportunity to clarify the residents' wishes and respond to any questions or concerns.

Heartfelt thanks to the families and residents participating in our program.

We were recently able to share our successes, at the National Encouraging Best Practice in Residential Aged Care (EBPRAC) Program Workshop in February. The workshop brought together project staff and facility representatives from all 8 EBPRAC-funded programs to share their experiences and preliminary findings. It was very useful to have so many clinicians together to share ideas, address potential barriers, and generate solutions.

Best wishes-Deb



cebparac project staff and facility representatives at the EBPRAC workshop in Sydney

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Judith Dodds



Dot Golubic



Heather Bass

Meet 3 of our facility champions!

Judith Dodds

(The Oaks, Brightwater WA)

Judith always knew that she wanted to be a nurse. She qualified in Harrogate, North Yorkshire (UK) in 1982.

Initially Judith worked in a Rheumatology Hospital then she transferred to a night duty position. This included a 4 month internal rotation (medical, surgical, orthopaedics, accident and emergency and intensive therapy unit) in the acute setting. Judith saw these patients either nursed at home or at the local hospice. This was the beginning of her interest in Palliative Care.

In June 1989 Judith emigrated to Perth, Western Australia. Judith has worked in Aged Care since 1990, where she has developed a keen interest in Palliative Care. She hopes that this project will help improve her knowledge and expertise in this area.

Dot Golubic

(Boandik Lodge, SA)

For the past 11 years, **Dot** has worked as a Clinical Nurse at Boandik Lodge Residential Care Facility in Mount Gambier, South Australia.

Previously she worked in the acute care sector where her interest and passion for working with the elderly developed.

Being part of a team caring for the elderly has allowed Dot to foster a keen interest in developing quality, person -centred palliative care.

Dot is also involved in the 'Palliative Approach Team' at Boandik Lodge. This group of staff provide support and education to residents, staff and volunteers relating to best practice in palliative care.

Heather Bass

(Redland Residential Care, Qld)

Hi, I'm **Heather** Bass, registered nurse. I always wanted to be a nurse, commencing my nursing career in New South Wales in 1972. Early on, I enjoyed the challenge of working in the burns unit at Concord Hospital. I worked in the unit for three years.

My family moved to Queensland in 1988, the year of Expo. I have a husband of 39 years, two grown-up children and a dog. My hobbies include listening to music, sleeping, singing in the shower and walking the dog on the doggie beach at the spit on the Gold Coast.

Currently I work in aged care within Queensland Health. I firmly support quality Palliative Care so our residents can experience a peaceful and dignified death.

"Family meetings can be a useful way to assist (residents) and family members to clarify the goals of care"

(Centre for Palliative Care Education & Research, St Vincent's & The University of Melbourne, 2009)

A note to GPs: Medicare changes and case conferences

GPs can be reimbursed for participation in a palliative care case conference. A case conference team needs to include a medical practitioner and at least two other members, each of who provide a different kind of care or service.

Multi-disciplinary case conference MBS item numbers will change on 1 May 2010.

Eighteen items (734-779) will be combined into six new items (735, 739, 743, 747, 750 and 758) based on the duration of the service and on whether the medical practitioner is coordinating or participating in the case conference. The old numbers will be deleted. There will no longer be separate items according to the location of the service. For details of the new fees, see: http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-changes-to-medicare-primary-care-items-for-gps



Pain in residential aged care

Chronic pain is a very common problem for older people in residential aged care that is sometimes underestimated or overlooked.

Because pain is common in older age, it is sometimes dismissed as something to be expected and thus not important enough to report.

Older people can be reluctant to report unrelieved pain. Whether due to stoicism (waiting until it becomes severe) or not wishing to bother busy staff, this can lead to a resident not having an injury or illness investigated. Ultimately this can significantly reduce their quality of life.

It is vitally important that residents are asked the right questions about pain. Many older people will say they don't have "pain" as they equate this term with severe discomfort. Asking again using a different word (ache, soreness, discomfort etc) may get a different response.

Not being able to understand questions about pain or communicate the answers doesn't mean that pain isn't present. Assessment just becomes more focused on observing any changes in the resident's facial expression, vocalisation, body language, behaviour or other physical signs. **Family members are encouraged to report any changes they might observe.**

Becoming involved in this important area can help residents achieve the best level of comfort that they expect and deserve.

Our project is working with facilities to promote best practice in pain assessment and management. Pain management has been a significant focus of facility education and training.

A key resource we recommend for clinicians are the guidelines from the Australian Pain Society: Pain in Residential Aged Care Facilities: Management Strategies (2005). These guidelines can be downloaded at: www.apsoc.org.au The guidelines and copies of the PMG Kit for Aged Care can also be ordered directly from National Mail and Marketing: email nmm@nationalmailing.com.au



"Pain should not be underestimated or overlooked"

(Australian Pain Society, 2005)

Medications and myths

There are many myths related to strong pain medications (such as morphine). Here are the facts:

Morphine and other opioid medicines are for improving life—not hastening death: Some people fear that being prescribed opioid medicines means that they're closer to the end. However, relieving your pain changes your quality of your life—not its length.

All medicines can have side effects. The side effects of opioid medicines are manageable: Sometimes people worry that the side effects of their opioid medicines will be worse than their pain. However, not everybody experiences side effects, and most of the side effects are temporary or manageable.

Possible side effects of opioid medicines include:

- Constipation—can be relieved by taking laxatives regularly
- Nausea and vomiting—is often only temporary or can be alleviated with medicines
- Drowsiness or confusion—may occur for only a short time after starting treatment or increasing the dose
- Dry mouth—may improve with time
- Itchy skin—may improve with time.

Opioid medications are not addictive when used for pain: When a doctor chooses the right dose of opioids for your pain, you will not become addicted. Addiction only occurs when people have no pain and they abuse opioid medicines.

If your pain medicines are not working as well as they used to, they can be adjusted to give you good pain relief again: People often worry that their pain medicines will become less effective. Over time, your body may become used to an opioid medicine. This is called 'tolerance'. If the pain medicine is not working as well as it used to, the doctor may:

- Increase the dose
- Prescribe a different medicine
- Choose a different mode of administration
- Prescribe a combination of medicines

If residents or family members have worries about medications, please discuss your concerns with your GP or facility nursing staff.

(Adapted and reproduced from: "Facts about morphine and other opioid medicines in palliative care" Palliative Care Australia: www.palliativecare.org.au)



2010 timelines: 2nd quarter

May

Intervention continues: case conferences, monthly reviews

Post-intervention staff surveys

Project liaison interviews

Final recruitment of residents

June

Intervention continues: monthly reviews

July

Intervention continues

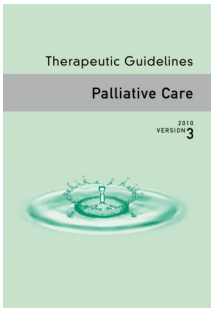
We're on the web!

www.caresearch.com.au/caresearch/CEBPARAC.aspx

****BREAKING NEWS****

Therapeutic Guidelines Ltd is pleased to announce a new version of the popular *Palliative Care* title for clinicians.

For more information or to purchase, contact Therapeutic Guidelines on www.tg.org.au or freecall 1800 061 260.



Dementia and multicultural issues

People from culturally and linguistically diverse (CALD) backgrounds face numerous barriers when it comes to assessing services. These include difficulties with language and a lack of knowledge of the service systems. The lack of culturally and linguistically appropriate services and culturally appropriate assessment is a major impediment to the accurate diagnosis and treatment for dementia.

Brain changes associated with dementia present unique challenges to people from non-English speaking backgrounds, often causing them to revert to their primary language and past experiences. Such changes not only have a significant impact on family relationships but also cause difficulties in service provision. Furthermore, there seems to be a lack of understanding of dementia by many people in some CALD communities. Alzheimer's Australia Victoria received funding to develop a resource kit outlining dementia perceptions in Arabic, Chinese, Croatian, Greek, Italian, Macedonian, Polish, Russian, Serbian, Spanish, Turkish and Vietnamese communities. The resource assists organisations working with CALD clients to better understand the background of consumers they are supporting and develop appropriate support strategies. It can be downloaded at the address below:

(Reproduced from "Perceptions of dementia in ethic communities" Alzheimer's Australia Vic: http://www.alzheimers.org.au/upload/CALDPerceptionsOct08.pdf)

"Currently, one in eight Australians with dementia do not speak English at home"

(Alzheimer's Australia Vic, 2008)

Focus on CareSearch:

Multicultural resources

CareSearch (www.caresearch.com.au) has a number of multicultural resources to assist families and health professionals.

CareSearch DVD's have been translated into 3 languages (Greek, Cantonese and Italian) and include titles: about palliative care; how to care; and bereavement, grief and loss.

The 'Patients and Families' section contains information for consumers from other cultures. Within 'Specific Groups' the Multicultural page provides CareSearch information that has been translated into 6 languages, as well as links to translator services and resources. The resources section includes access to other websites with translated palliative care information, including a book "Multicultural Palliative Care Guidelines".

Within the 'Clinical Practice' section, information is available under 'Specific Populations' on Multicultural /Cultural and linguistic diversity issues (non-English speaking background). This includes issues specific to those from a different culture, including family and community support, finding information in different languages and states services and resources. The GP section includes multicultural resources.

There is also a Multicultural PubMed Topic Search and a Multicultural CareSearch Review Collection in the 'Finding Evidence' section.

CareSearch is an online resource funded by the Department of Health and Ageing to help clinicians and consumers find relevant evidence about palliative care.

CARESEARCH palliative care knowledge network