Melbourne City Mission
Palliative Care

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Melbourne City Mission Palliative Care

- Established in 1981
- First community-based palliative care service in Victoria
- Interdisciplinary Team provide 24/7 care

- Service the local government areas of
  - Hume
  - Darebin
  - Moreland
  - Yarra
- Total population 552,222
- Area size 628km^2

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Special populations serviced

- Culturally and Linguistically Diverse (CALD)
- Clients with drug and alcohol misuse issues
- Clients experiencing homelessness
- Community-based asylum seekers
- Children/adolescents/young adults (24 clients <30 years in 2014)

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Model of Care

- Clients referred to MCM Palliative Care have access to:
  - Specialist palliative care nurses 7 days a week
    - Limited service on weekends
  - 24 hour paging service for acute symptom management with after hours RDNS support if visit needed
  - Specialist palliative care medical consultant (3 sessions)
  - Palliative Care Registrar (Monday – Friday 9 - 5)
  - Counselling and spiritual care
  - Bereavement preparation
  - Grief and loss counselling
  - Volunteer support

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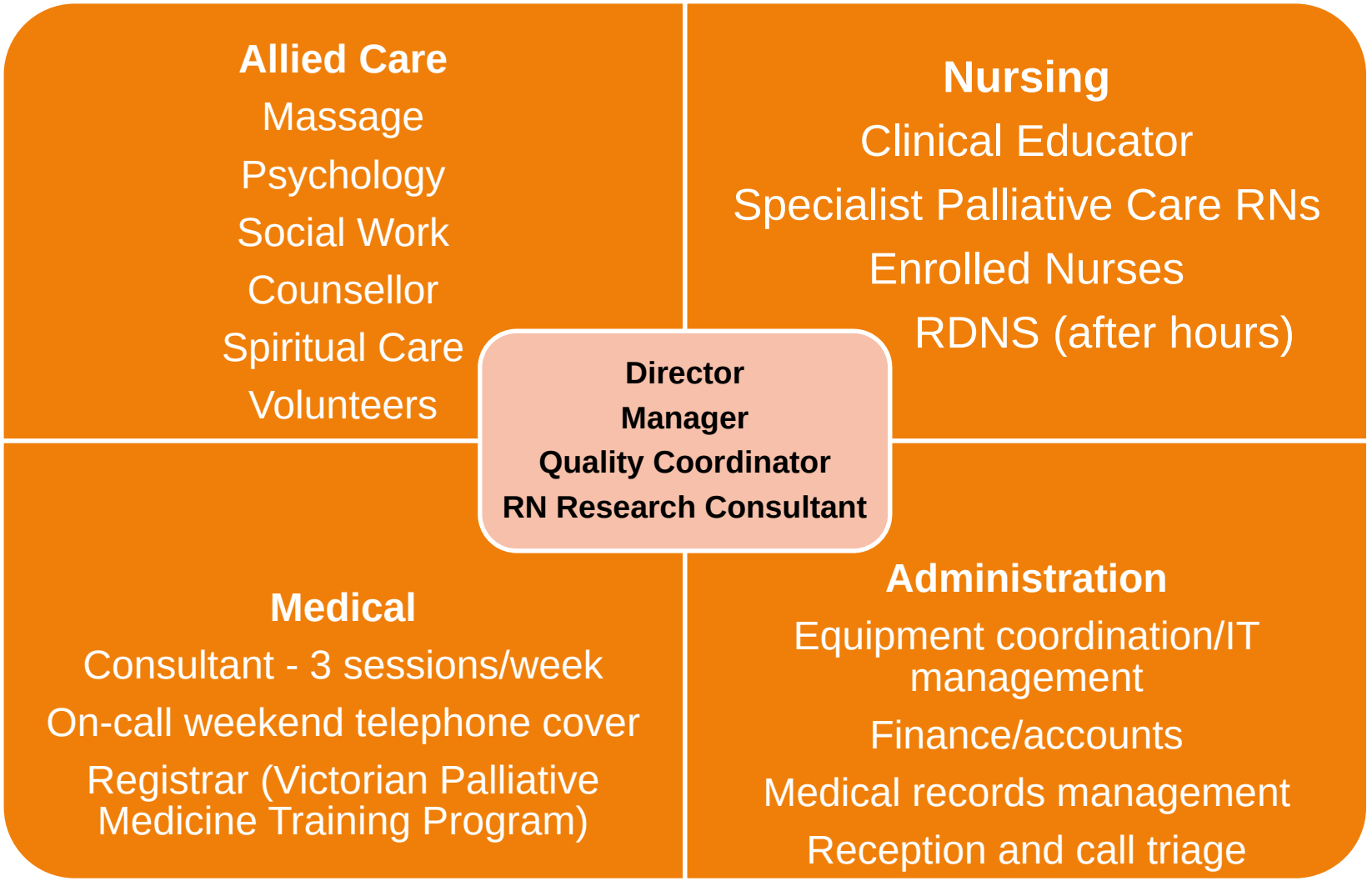
Interdisciplinary team



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Client pathway

Referral

- Triage – urgency/complexity/risk screening
- Arrange assessment visit with relevant staff (nursing +/- allied care/pastoral care, medical)

Assessment & 24/7 care

- Needs – physical/psychosocial, volunteers, end of life care planning
  - Carer/family assessment – support needs, risk of complex bereavement
  - Care coordination – referral to relevant community/acute services/volunteers

Death

- Bereavement follow up 13 months
  - Card, telephone calls
  - Individual counselling, group work

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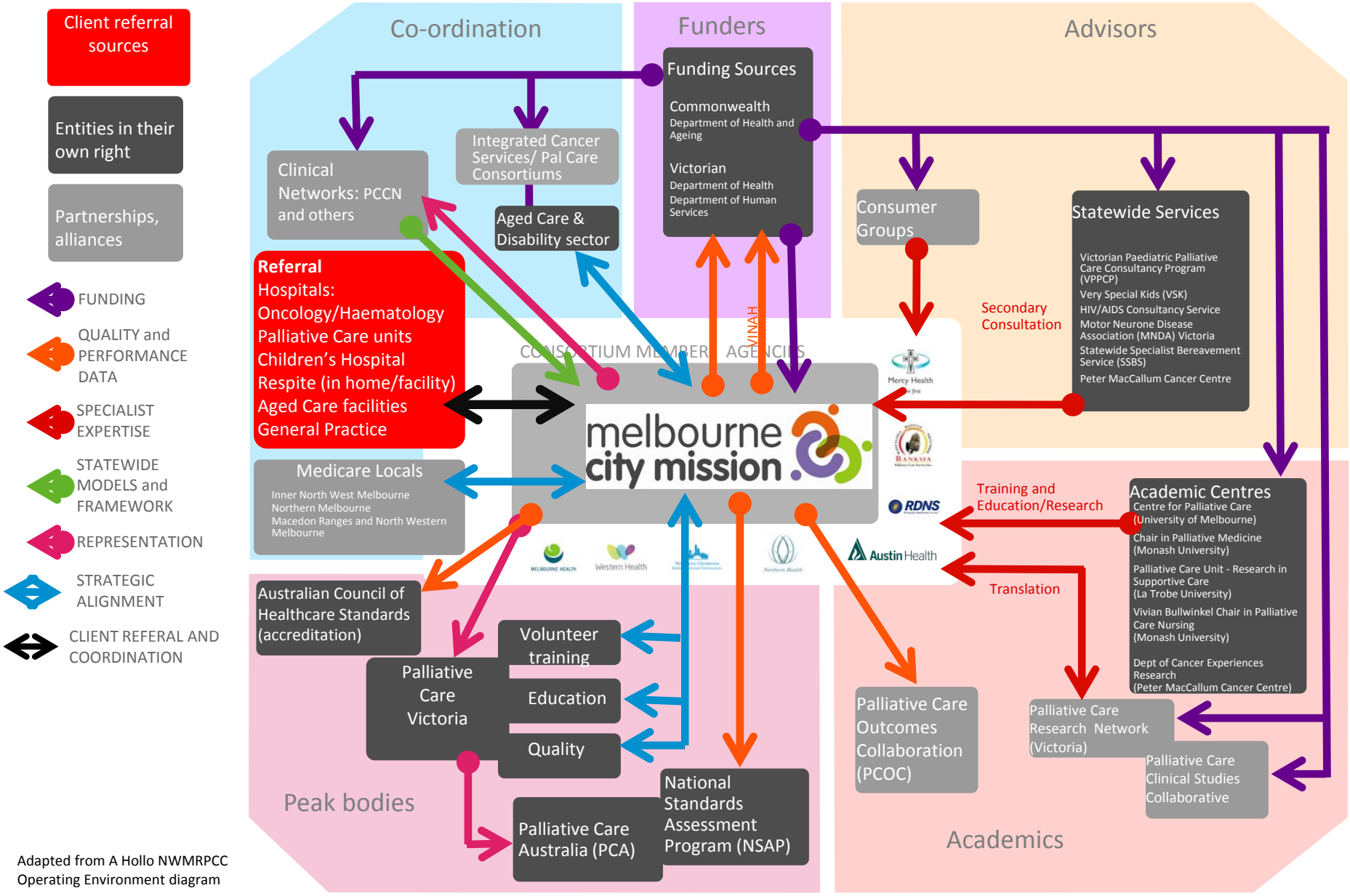
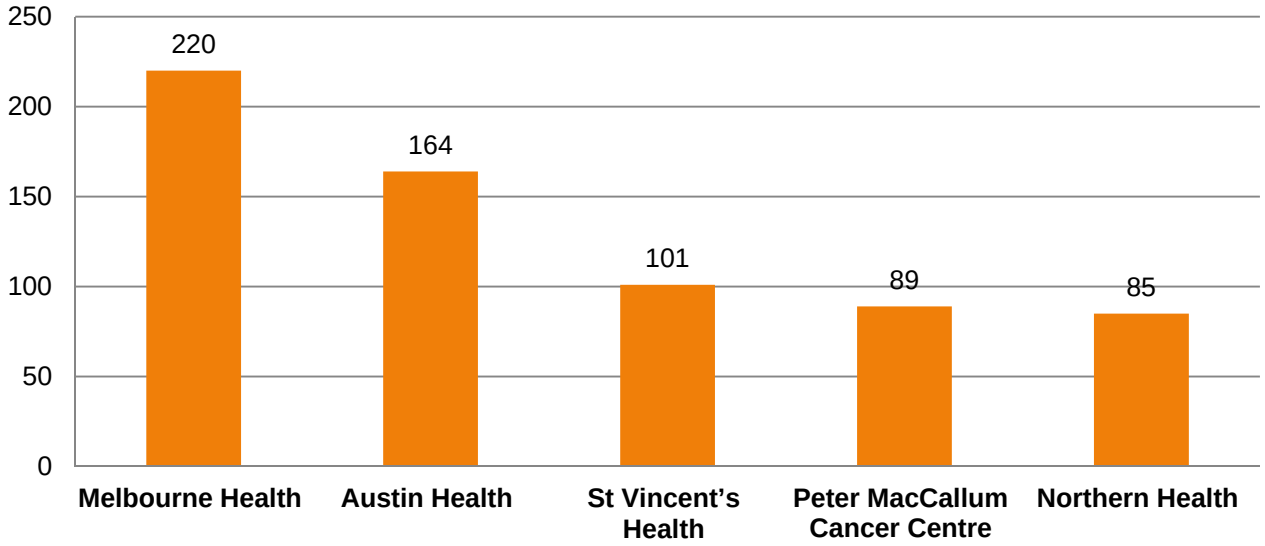
Operating environment

Illustrating the relationships between Melbourne City Mission Palliative Care, NWMRPC Consortium, key coordinating, funding, advisory, academic and peak body stakeholders.

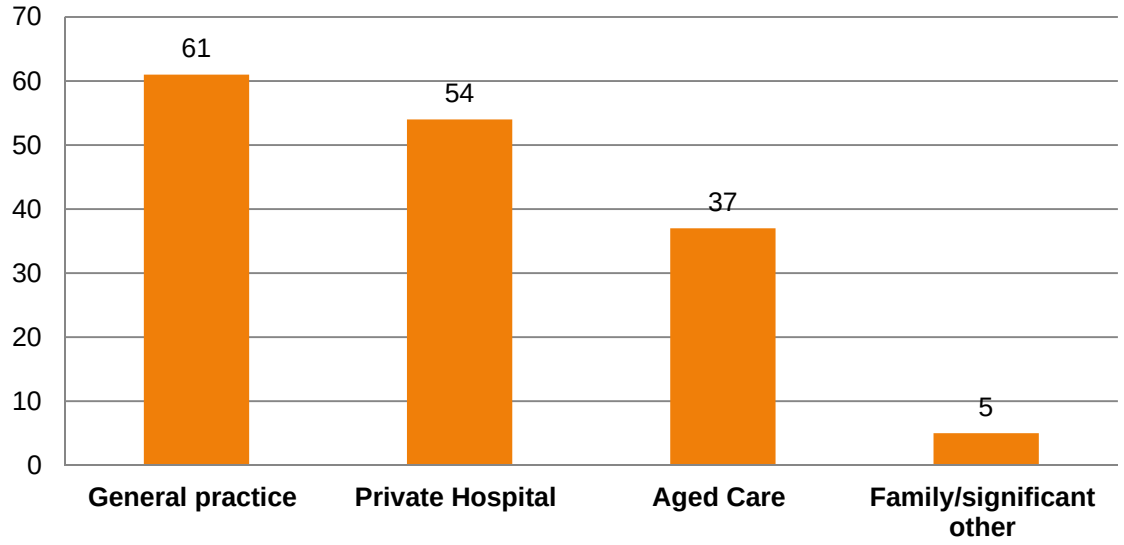


Adapted from A Hollo NWMRPCC Operating Environment diagram

Top 5 referral sources 2014



Other referral sources 2014



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Client data

	2015 YTD	2014
Current active clients	197	
Number of referrals	716 (80/month)	1015 (85/month)
Number of deaths	421 (47/month)	559 (46/month)
At home	107 (25%)	140 (25%)
Hospital or Palliative Care Unit	292 (69%)	377 (67%)
Aged Care	17 (4%)	39 (7%)
Median length of stay	123 days (2 – 742)	140 days (2 – 294)

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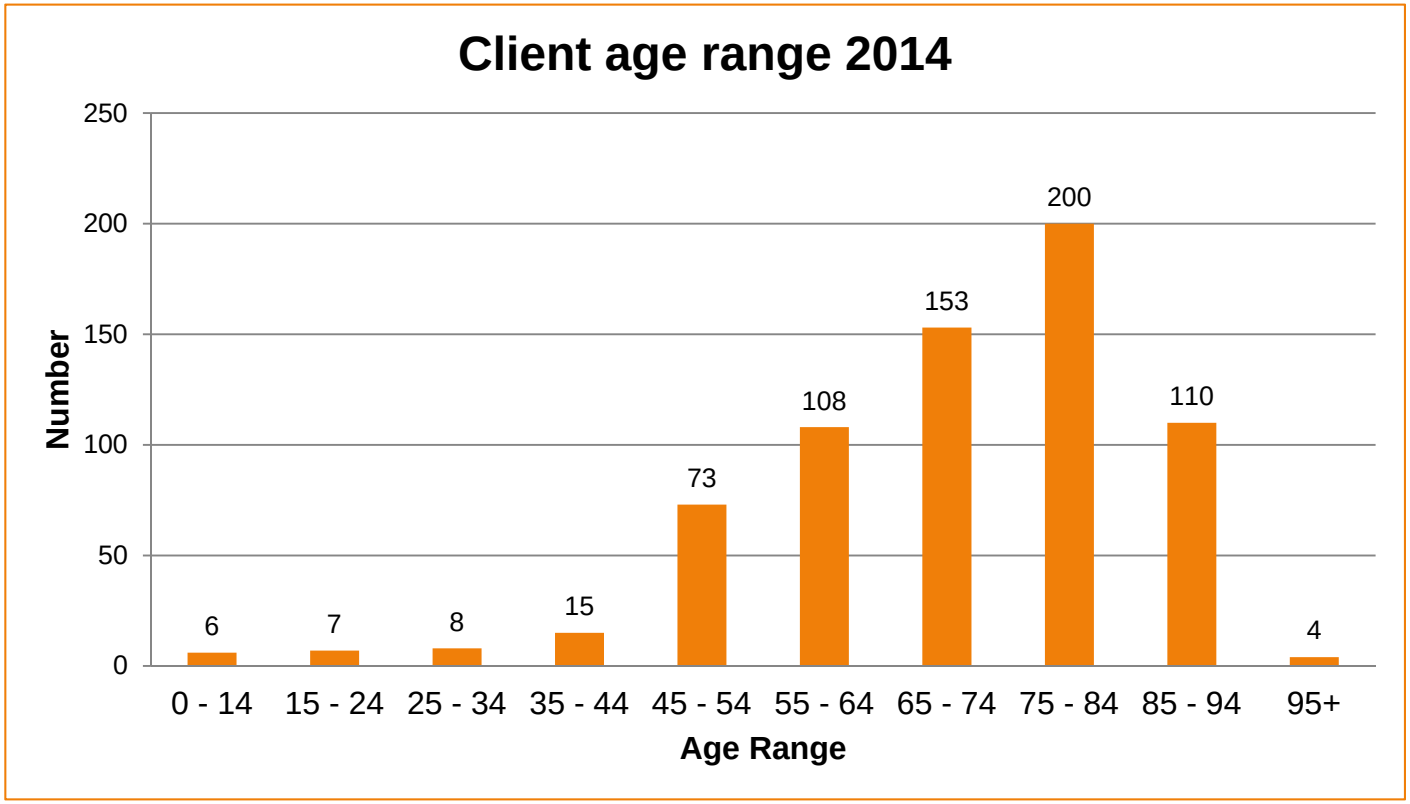
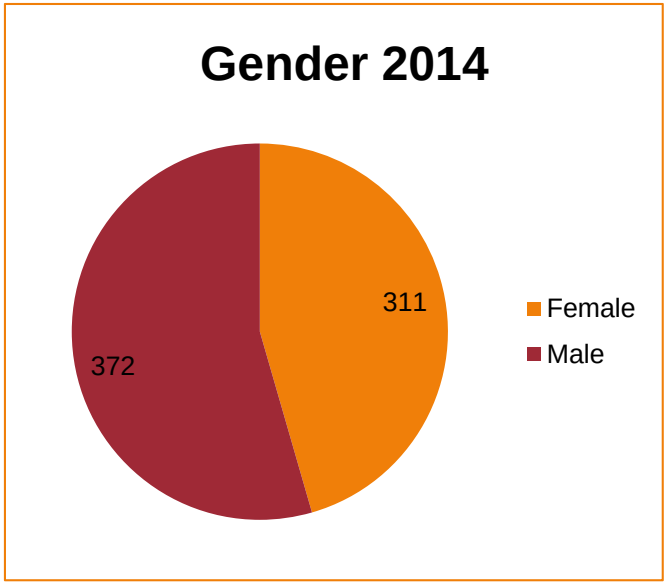
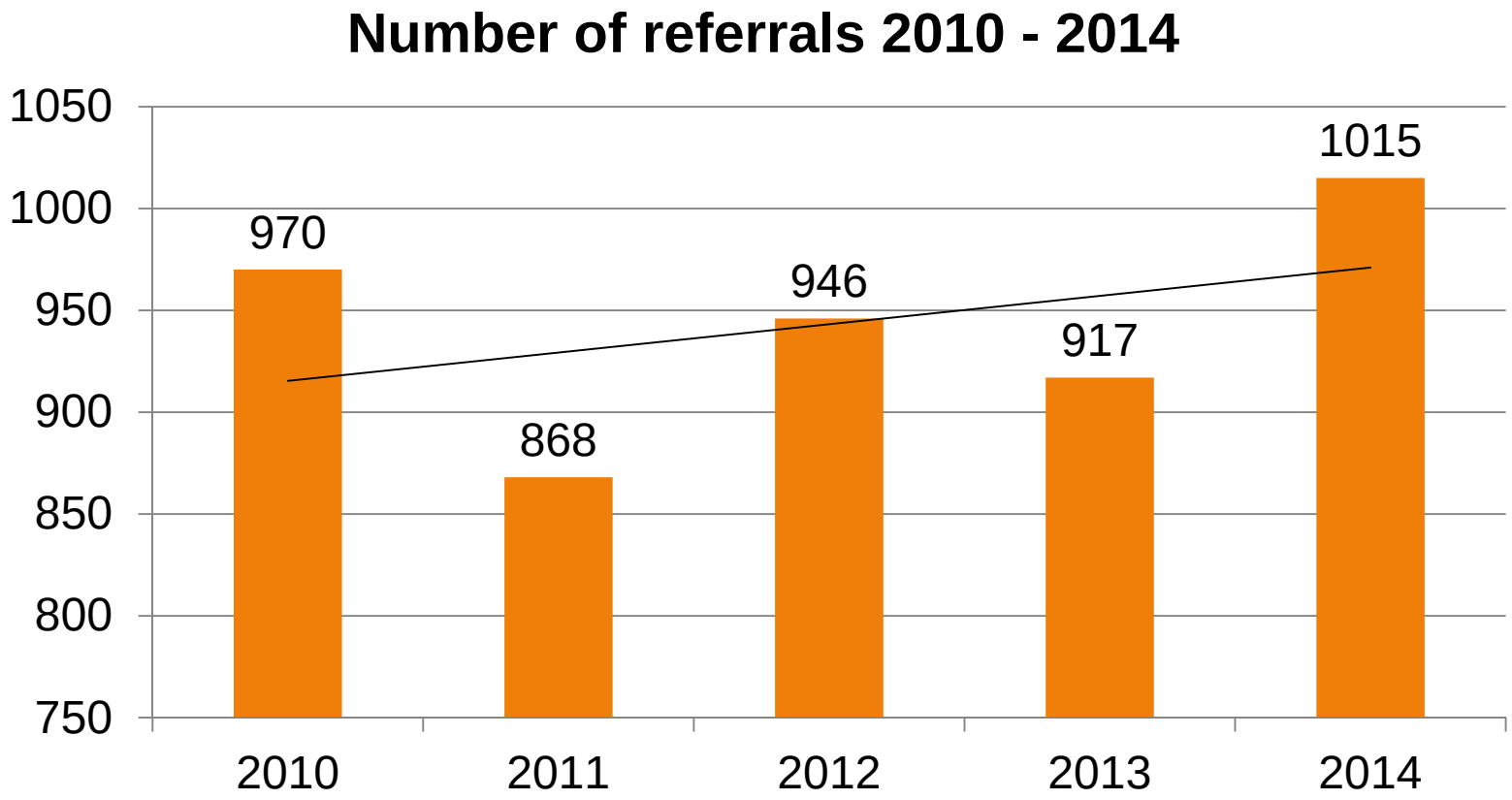

Client age range 2014
250
200
150
100
50
0
Number
6
7
8
15
73
108
153
200
110
4
0 - 14
15 - 24
25 - 34
35 - 44
45 - 54
55 - 64
65 - 74
75 - 84
85 - 94
95+
Age Range


Gender 2014
311
372
Female
Male

Referral trends



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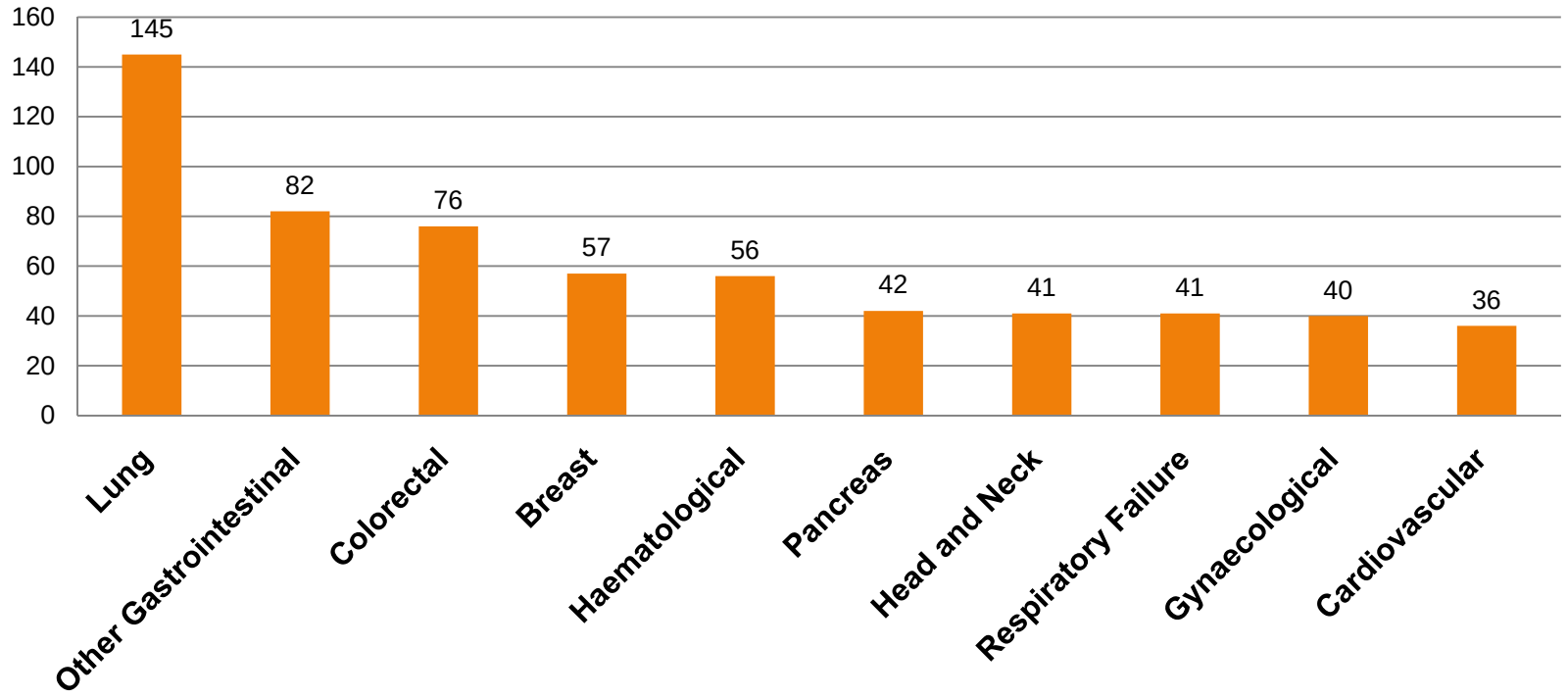
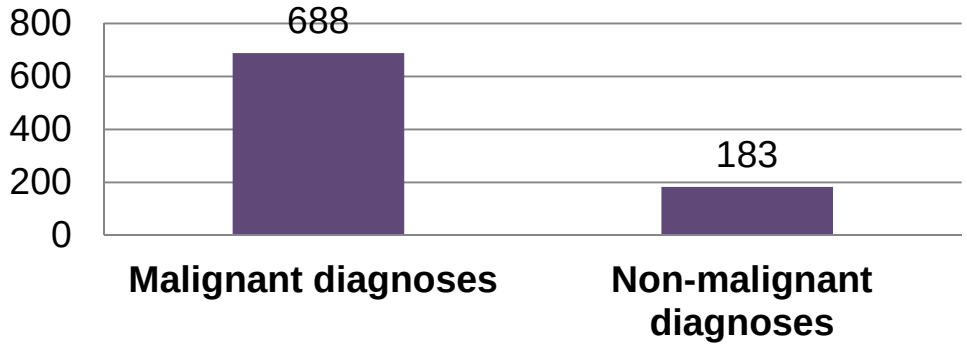
Top 10 diagnoses 2014



Malignant/Non-Malignant



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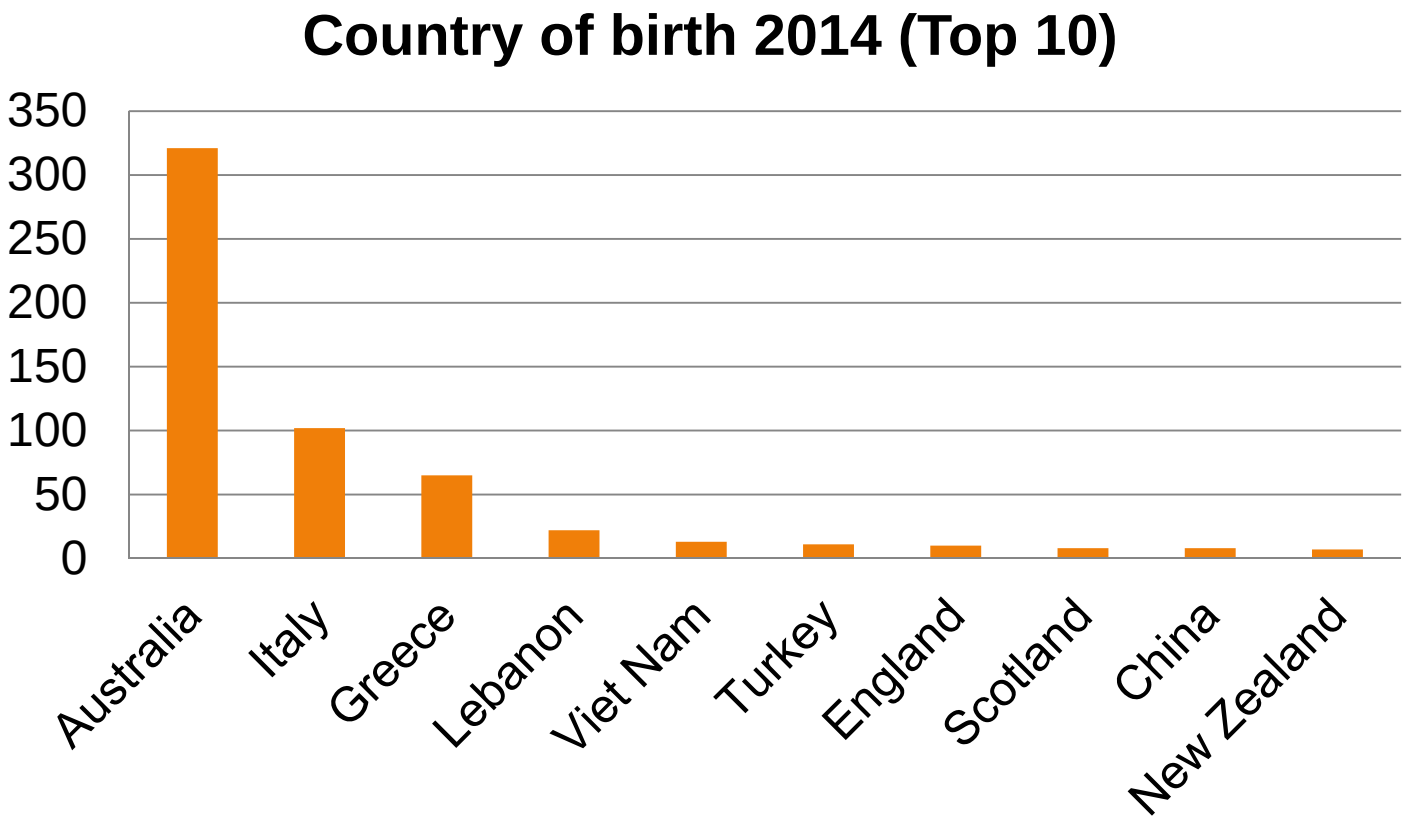
Birth and language

- 34% born outside Australia
- 43% prefer to speak a language other than English



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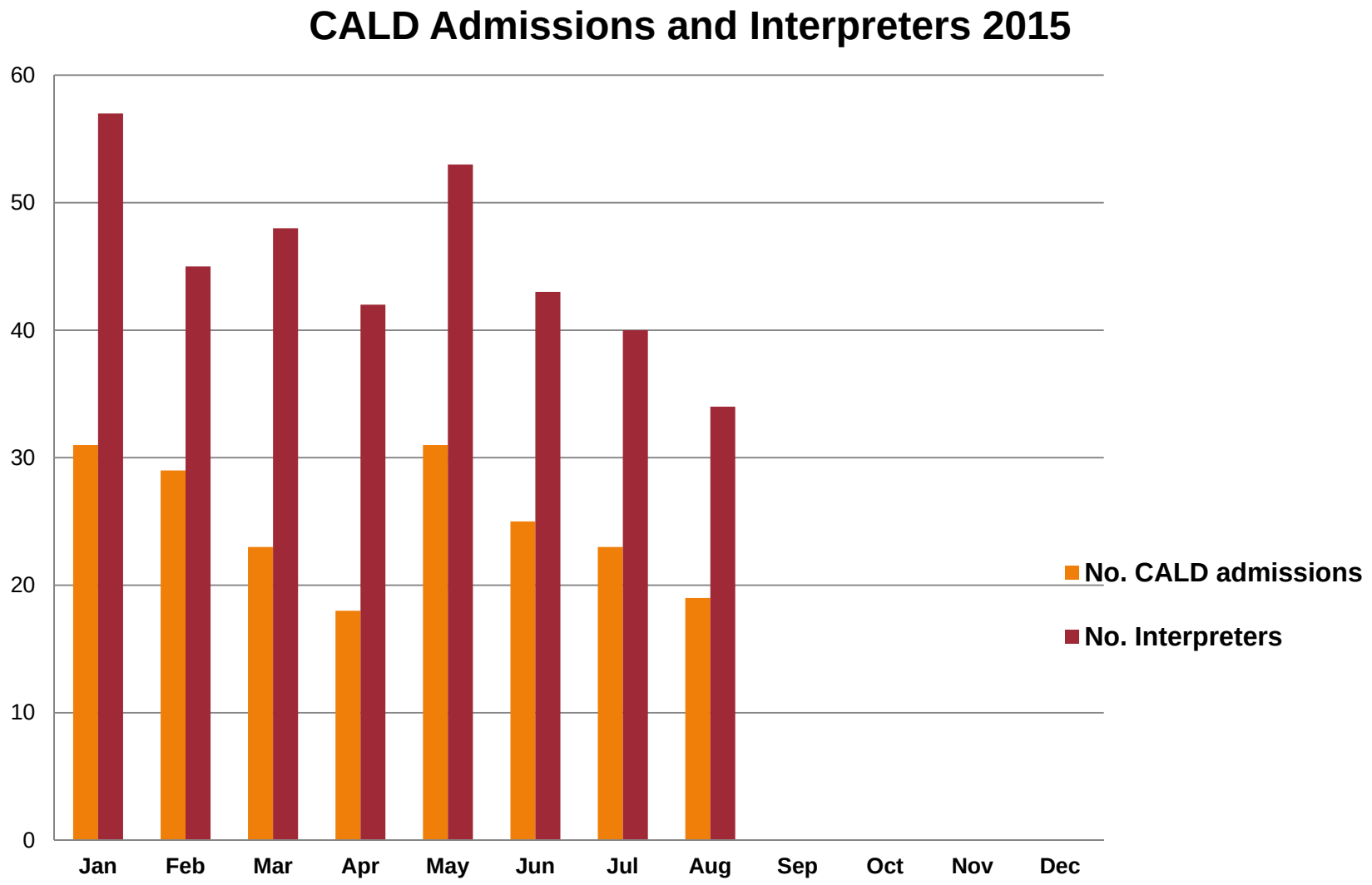
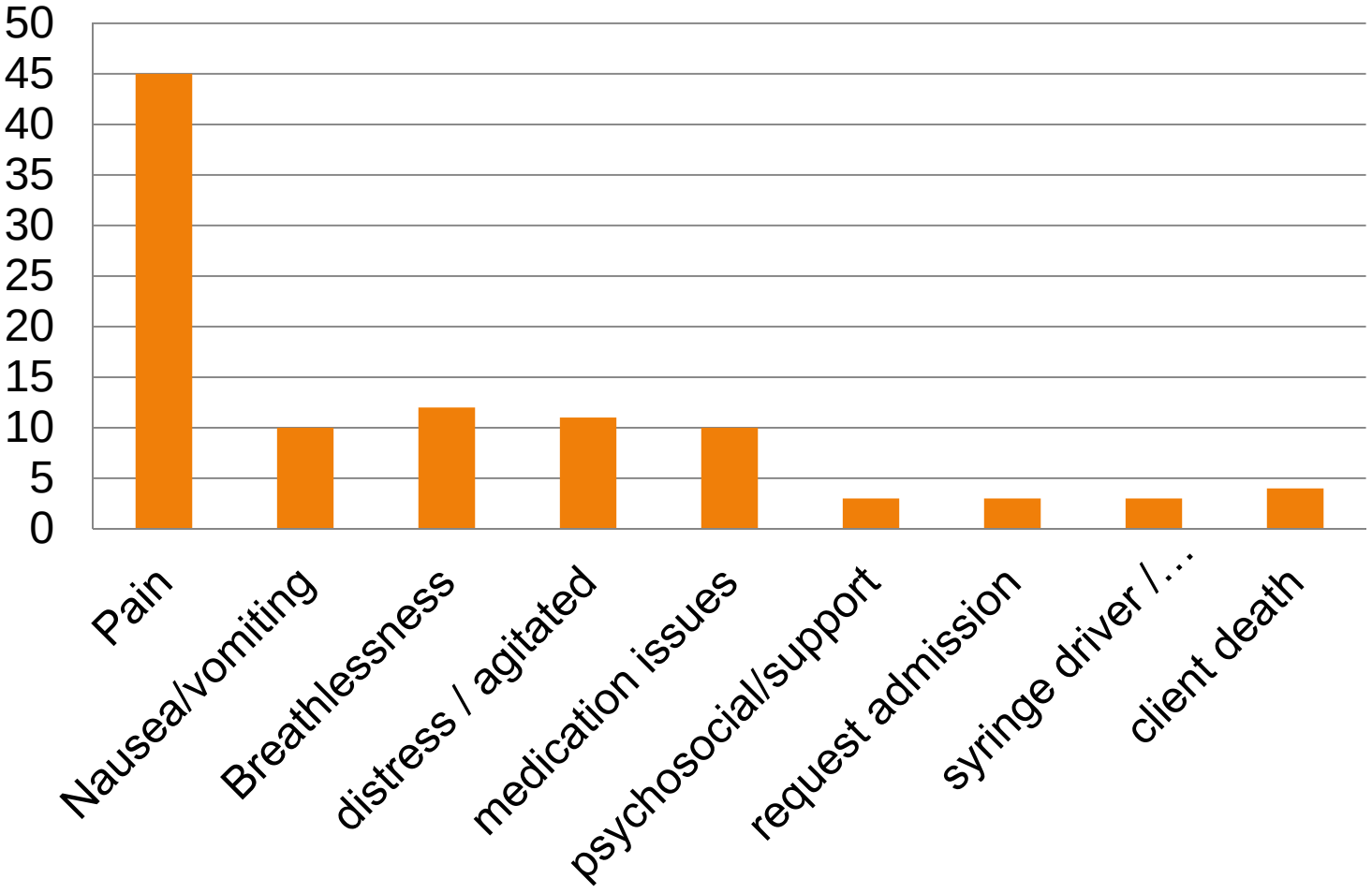

CALD Admissions and Interpreters 2015
60
50
40
30
20
10
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
No. CALD admissions
No. Interpreters

Main reason for after hours calls (1 month snapshot audit)



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Case study

Complex client/care coordination – client experiencing homelessness

People experiencing homelessness have complex and diverse end-of life care needs and the approach needs to be very individualized with multidisciplinary involvement, plus collaboration with other agencies. There is often a long history of alcohol and/or drug issues, abuse, trauma and fragmented relationships for this population, which adds to the complexity of their care.

Client:

- 49-year-old homeless gentleman with advanced liver cancer. English speaking of CALD background (Macedonian).
- Long history of homelessness.
- No contact with adult daughter, separated from his wife.
- Extensive history of heavy alcohol use (since 8 years of age). Aggressive when drinking
- Isolation and loneliness is constantly present, exacerbated when intoxicated.
- Legal issues: jail sentence for driving offences and previous restraining order.
- Financial Issues: very low income
- Mental Health issues: Diagnosed with antisocial personality disorder; chronic suicidal ideation - assessed as low risk to self and others.

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Complex client/care coordination

Issues

- Chronic suicidal ideation
- Housing – in boarding house
- Non-compliant with medication
- Pain symptoms due to non-compliance with medications
- Confusion
- Difficulty complying with institutional conditions

Strategy

- Allocated consistent, small team of staff – to build trust and rapport
- Inclusion of client with care planning/EOL care planning (in SVH PCU)
- Collaboration with GP, MCMPC Registrar, Oncologist, SVH Hospital in the Home
- Daily visits – ensure medication compliance and assessment of clinical condition
- Education regarding after hours service

Achievements

- Admission to De Paul House for alcohol detoxification and rehabilitation (successful)
- Good pain control
- End of life care delivered in client's place of choice

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Challenges

- Respite
- Hospital admissions for end of life care
- Access to specialist palliative care consultancy
- General practitioners and palliative care medications

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Respite

- Respite
  - Planned respite
    - > Carer burden relief
    - > End of life care support at home
- Provision of staff at terminal phase so client can die in place of choice
  - Limited resources
  - Limited funds (24 hours provided by Carer Links North)
- Impact on client/carer and acute health system when resources unable to be provided and carer no longer able to support client

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Hospital admissions for end of life care

- Majority of clients die in hospital
- Many clients require increased resources for the last few days of life
  - symptoms increase
  - need closer monitoring
- Carer burden increases correspondingly
- Limited capacity to increase resources to level required without compromising another area of service
- In 2014 MCMPC clients experienced between 1 and 10 inpatient admissions for symptom control and/or EOL care
- Of those specifically admitted for end of life care - 20 died within 2 days of admission
  - could they have been supported to die at home if resources available?

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Topical Issue:
Voluntary euthanasia/assisted suicide (EAS)

- Of approx 50,000 palliative care admissions less than 1% patients have a sustained desire for euthanasia/assisted suicide
- Where EAS supported the rate is less than 2.8% (Netherlands)

- Not a typical reaction of a dying individual.
- Often unaddressed psychosocial concerns behind request (depression, burden to others).
- Opportunity to explore what client is thinking about – fears, concerns, fear of uncontrolled symptoms
- A trigger for assessing whether there is potential for a crisis

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