Melbourne City Mission
Palliative Care
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 628km²
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)
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
Interdisciplinary team

**Allied Care**
- Massage
- Psychology
- Social Work
- Counsellor
- Spiritual Care
- Volunteers

**Nursing**
- Clinical Educator
- Specialist Palliative Care RNs
- Enrolled Nurses
- RDNS (after hours)

**Medical**
- Consultant - 3 sessions/week
- On-call weekend telephone cover
- Registrar (Victorian Palliative Medicine Training Program)

**Administration**
- Equipment coordination/IT management
- Finance/accounts
- Medical records management
- Reception and call triage

**Director**
- Manager
- Quality Coordinator
- RN Research Consultant
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
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 NWMRPC Operating Environment diagram
Top 5 referral sources 2014

- Melbourne Health: 220
- Austin Health: 164
- St Vincent’s Health: 101
- Peter MacCallum Cancer Centre: 89
- Northern Health: 85

Other referral sources 2014

- General practice: 61
- Private Hospital: 54
- Aged Care: 37
- Family/significant other: 5
## Client data

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

Gender 2014
Referral trends

Number of referrals 2010 - 2014

- 2010: 970
- 2011: 868
- 2012: 946
- 2013: 917
- 2014: 1015
Top 10 diagnoses 2014

- Lung: 145
- Other Gastrointestinal: 82
- Colorectal: 76
- Breast: 57
- Haematological: 56
- Pancreas: 42
- Head and Neck: 41
- Respiratory Failure: 41
- Gynaecological: 40
- Cardiovascular: 36

Malignant/Non-Malignant

- Malignant diagnoses: 688
- Non-malignant diagnoses: 183
Birth and language

- 34% born outside Australia
- 43% prefer to speak a language other than English
CALD Admissions and Interpreters 2015

No. CALD admissions

No. Interpreters
Main reason for after hours calls
(1 month snapshot audit)
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.
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
Challenges

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