Protocols for After Hours Service

Acknowledgement:

This palliative care protocol is based on the work of the Griffith Area Palliative Care Service

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List of abbreviations

ADL	Activities of Daily Living
GP	General Practitioner
RUG	Resource Utilisation Groups
SAS	Symptom Assessment Scale
VMO	visiting medical officer

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1. Introduction

1.1 What is Palliative Care?

Palliative care is the active total care of patients whose diseases are not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal for palliative care is achievement of the best quality of life for patients and their families. *World Health Organisation,1990*

1.2 How did the Eurobodalla Palliative Care Service begin?

The Eurobodalla Palliative Care Service is funded by the Australian Division of General Practice until December 2006 and is one of eight national Rural Palliative Care Projects. Patients and their carers are the focus of the service.

A review of Palliative Care Services in the Eurobodalla region in March 2001 found that there was a lack of:

- service coordination;
- inconsistent access to support, especially after hours;
- minimal access to ongoing loss and grief support to bereaved relatives and carers;
- limited training available for all health care providers; and
- no visiting specialist service.

1.3 What is the Eurobodalla Palliative Care Service?

The Eurobodalla Palliative Care Service is a program rather than a place like a hospice. Palliative care is understood to be *"care provided for a person with an active, progressive, advanced disease who has little or no prospect of cure, and for whom the primary treatment goal is quality of life."* This includes oncology patients, chronic and complex care patients and nursing home patients. The service is responsive to needs as the patients and the family perceive them.

The service consists of an Advisory Committee that includes representatives from all those involved in the care of patients and their families.

The anticipated benefits of the Eurobodalla Palliative Care Service are:

- after hour access to palliative care expertise in the region;
- an increased pool of skilled palliative care providers (both voluntary and paid);
- improved communication between providers and coordination of services to patients;
- improved quality of clinical care provided; and
- increased access to bereavement support.

As the funding is limited, the aim of the service is to establish these improvements into existing structures for long-term sustainability.

1.4 Principles

The principles of the Eurobodalla Palliative Care Service are to:

- provide relief from pain and other distressing symptoms;
- integrate the psychological, emotional and spiritual aspects of care;
- offer a support system to help patients/clients live as actively as possible until death;
- offer a support system to help the family cope during the patient's/client's illness and in their own bereavement;
- affirm life and regard dying as a normal process; and
- neither hasten or postpone death.

1.5 Services

The services in the Eurobodalla Palliative Care Service include:

- Inpatient services for short-term respite care, pain and symptom management and terminal care when nursing the client at home is no longer possible. Services are provided by Moruya and Batemans Bay Hospitals;
- The Oncology Clinic and Chemotherapy Administration at Moruya Hospital;
- Palliative Care Volunteers and Pastoral Care Workers who provide information & support to clients and carers;
- Primary health care services provided by Eurobodalla Community Health Nurses and private nursing agencies;
- Nursing homes providing respite and long term care;
- An after hours on call system for access to a palliative care expert for advice;
- Consultancy services from a Palliative Care Specialist;
- On-going training opportunities for health care professionals and volunteers; and
- Assistance in the coordination of care for each patient.

1.6 Palliative Care Volunteers

The Eurobodalla region has a palliative care volunteer support service that is coordinated by SAHS. Detailed training is provided to the volunteers who follow a set of standards and procedures.

The duties of the palliative care volunteers includes:

- Providing emotional support and companionship to both client and carers
- Assisting with transport when required for carers and clients
- Providing respite for carers
- Assisting clients with personal care
- Overnight stays to enable the carer a good nights sleep
- On-going support during hospital care
- Assisting families during the bereavement period.

2. Registering a Patient

2.1 Who should be referred?

Most patients will have advanced cancer, but other patients with advanced disease of poor prognosis in whom intensive treatment is proving futile should be considered for referral to the Eurobodalla Palliative Care Service. People with HIV infection, motor neurone disease, multiple sclerosis, parkinson's disease and chronic end stage respiratory, cardiac, renal and liver disease are included in this group.

2.2 What is the purpose of referral?

Referral should have a specific purpose such as:
- Advice on symptom control;
- Coordination of home and family support;
- Provision of special equipment;
- Family counselling;
- Recruitment of a volunteer;
- Consideration of a placement in an inpatient facility;
- Coordination of health care between health care providers.

2.3 How do you make a referral?

- The Project Officer for the Eurobodalla Palliative Care Service can be contacted on the **1300 795 440 Telephone Helpline** during work hours or on 4474 5100 for new referrals.
- An admission form (Attachment 1) can be completed by a GP, nurse or pharmacist and sent to the SE NSW Division of General Practice.
- Anyone can make a referral.

2.4 Informed Consent

A consent form needs to be completed for the client's health information to be shared between health professionals. The consent form can be completed by the health care provider and signed by the client or the Project Officer will visit the client to get their informed consent. See Attachment 2. If a patient does not sign a consent form they still have access to the service but their health information will not be shared between health care providers unless otherwise agreed.

2.5 Documentation

The following information is required for each patient:
- Client's diagnosis
- Treatments
- Date of birth, sex & country of birth
- Pension/repat number and expiry date
- Medicare number and expiry date
- Current medications (including doses/ strengths)
- Presence of family/carer
- Linkage to other service providers
- Follow-up appointments
- Past history

- Allergies
- Physical condition (ambulant etc)
- Mental state
- Dates and duration of visits
- Hospitalization dates and hospital name and location
- Medical record number for each hospital the patient attends
- Hospital inpatient, emergency department and outpatient information
- Patient consent indicator.

2.6 Patient-Held Records

Newly registered patients are encouraged to use the red book, “my health record” that is distributed by NSW Health Department to keep an update of their records. The Palliative Care Card can be inserted in the slip at the back of the book.

2.7 Palliative Care Stage of Illness Data Set

- Common assessment tools have been shown to facilitate a more objective discussion about patient well-being and help to track a patient’s progression.

- The key item in Tool 1.1 (attachment 3) is the Palliative Care Phase. This is the basic management unit being used in the evaluation.

- The RUG-ADL and Karnofsky Rating Scale both measure functional dependency and are complementary.
    - The Karnofsky Rating Scale is a broad brush measure of function that ranges from 100 (normal with no complaints or evidence of disease) to 0 (death).
    - The RUG-ADL (4 items) is more detailed than the Karnofsky score, especially those rated between 30 and 60.

- The Palliative Care Problem Severity Scale consists of 4 items that, together, capture the severity of the patient’s symptoms and the complexity of their care needs.

- Formal training in use of the Palliative Care Phases, Palliative Care Problem Severity Scale, Karnovsky Rating Scale and RUG-ADL is not required. The descriptions are self-explanatory and not dissimilar to the sort of information that would be collected in a clinical history and assessment.

2.8 New Patient Survey

All new patients are required to complete a *Palliative Care New Patient Survey* as part of the evaluation for the project. Another further *Palliative Care Patient Survey* has been designed to be completed after a few months of having registered with the service.

3. Moruya and Batemans Bay Hospital

3.1 Inpatient

- If a registered patient requires admission to hospital contact the VMO on call who will determine bed availability and make the necessary arrangments.

- The client's GP and the Eurobodalla Palliative Care Service Project Officer also need to be informed.

- Clients will have a card identifying them as registered clients of the service.

- A green sticker will also be applied to their hospital records to alert the Medical Officer that the patient is a client of the Eurobodalla Palliative Care Service.

- The Project Officer will attend the hospital weekly to update records of clients.

3.2 Emergency Department presentation

- If a registered patient presents to the Emergency Department the patient is treated by the on-call doctor.

- It is important that the nurses and doctor are alerted that the patient is registered with the Eurobodalla Palliative Care Service.

- The details of the presentation and the outcomes need to be reported to the GP and the Project Officer for the next case conference.

3.3 Discharge from Hospital

If the registered patient is ready for discharge contact the Eurobodalla Palliative Care Service Project Officer so that the relevant health professionals can be invited to the discharge planning meeting. It is important that the following occurs:

- If the patient requires a family conference, carry out
- If the patient requires further discharge planning, carry out
- Notify the family of impending discharge
- Inform relevant community based agencies to arrange follow up
- Arrange discharge medication.

4. After Hours On-Call Service

4.1 Purpose

The after hours on-call service is designed to provide a service to registered Eurobodalla Palliative Care Service patients who require after hours professional support. It is hoped that this will make the lives of those with a terminal illness and their carers more secure and comfortable in the setting of their choice. It is also envisaged that the coordination of palliative care services will improve with regularly up-dated health records available to health care providers and carers.

4.2 Principles

The on-call staff need to be aware of all registered clients history and current care need*s* and need to have a clear outline in regard to documenting relevant information to ensure good communication. On- call during the week begins at 5.00pm and ends at 9.00am unless organised with the Project Officer. Weekends and public holidays are also covered by the on-call staff.

4.3 Registering with the Service as a Provider

To register with the service as a provider you need to provide detailed information about your training and experience in palliative care. Two referees are also required who can confirm your experience and competence in this area. Although your application will go to the Program Officer, a small committee (consisting of a doctor, nurse and pharmacist) will meet on a regular basis to approve applicants.

4.4. The Roster Arrangements

The roster works with one person available for a week at a time if possible. There is no clear indication on how busy the line will be although the number of calls are expected to be low.

The 1300 number has been arranged with Southern Phone Company who divert the number to a roster provided on a monthly basis. Three mobile phones have been made available and it is possible to divert the calls to the a home phone number for those out of range.

Any changes to the roster made during the month will incur a $10 fee to the service. At least 24 hours notice is essential for changes to the roster.

4.5. Training

A short training session about the service and on data collection methods with the Program Officer is provided. Training will also be provided by a Palliative Care Specialist on a regular basis to assist with some of the clinical issues that may be encountered.

4.6. Arrangment for Allowance Payments

Allowance payments are made by either the South East NSW Division of General Practice or by Southern Area Health Service (for their employees only) or by other employers who sign an agreement with the Division.

Several issues need to be addressed for payments:

- A time sheet (attachment 4) needs to be completed and faxed or delivered to the Division office in Moruya. Address the timesheets to the Project Officer, Eurobodalla Palliative Care Service, Level 1, 73 Vulcan Street, Moruya, NSW 2537 or fax to 02 4474 5111 or email to sblogg@senswdgp.com.au.

For those not employed by SAHS or other employers with a signed agreement with the Division, details that are required for you to be paid include:

- ABN Number – you will be required to have an Australian Business Number as this is classified as contract work. Contact the Taxation Office for this to be arranged.

- If you do not have an ABN number and do not want to get one, then the Division is required to tax you 48.5% of your income from this service and your Tax File Number will be required.

- Registration for GST – As a contractor you will paid an additional 10% for GST that is then required to be paid by you as GST to the Taxation Office. You may need to discuss this with your accountant and you will need to register with the Taxation Office.

  If you do not register for GST, you are expected to earn less than $50,000 per year.

Other details that are required include:

- Tax File Number
- Banking details including Account Name, BSB Number, Account Number and your address. You can also be paid by cheque if you prefer.
- If you earn more than $450 per month from this service we will also have to meet superannuation requirements and will require details concerning your superannuation fund for payments.

4.7. Access to Client Information

There are strict ethical considerations that need to be adhered to with sharing client information.

- All clients need to register with the service and sign an agreement before sharing of their health information is possible.

- Some of the clients may not agree to have their information shared which means that they can still receive the service but the information about their condition will be limited.

- For those that have signed an agreement you will receive either a locked file or a palm pilot with a password with their health details. You need to be very careful with either of these and keep them in a safe secure place. Passwords will be provided by the Project Officer.

- For those with available client information, you should receive a medication chart, symptom assessment scales and other relevant charts and information.

4.8. Home Visits

- It is not necessary that people on call conduct home visits.
- As some distances will be quite large it is not a requirement or expectation of the service.
- Home visit will not take place if the client is in a stable phase.
- Registered clients will be visited by the Project Officer or the Volunteer Coordinator and a home visit environment checklist will be completed that will be available with other client information.

4.9. What to do if they are not a Registered Client

- If an unregistered person calls the after hours line it is required that information on their call is recorded on the form provided (attachment 5). Their details need to be sent to the Project Officer during working hours for completion of the registration process with their GP.
- It is expected that they receive helpful advice if possible.
- It may be appropriate to refer them to their GP or a local hospital.
- Home visits are not allowed for unregistered callers.

4.10. Knowing when to refer on

It is important that the person on call be prepared to refer the patient on to an appropriate health professional when relevant. The contact list for other services will be provided (attachment 6) and a list of VMOs roster will be provided for people requiring another opinion.

4.11. Patient Held Records

All registered patients will be provided with patient held records. It is important that the information in this record is updated.

4.12. PalCIS

- Training will be provided in how to use the palm pilot to access the PalCIS database.
- For those not comfortable using this devise or the database, paper based information will be made available.
- For those using a Palm Pilot the Project Officer will also arrange to collect this from you in a way that is convenient to both of you such as using a transport service or by personal delivery or pick up.

4.13. Weekly team meetings

There are planned multi-disciplinary meetings on a weekly basis for registered clients. Those on call may be invited to attend these meetings if they responded to a call from a client. For those that cannot attend, availability by phone or the provision of information for the other health professionals caring for the client would be required.

4.14 Procedure

- On call staff will be provided with patient information either in an on-call folder or a palm pilot.

- Document details of the call on the A*fter Hours Call Form* that will be provided.

- If the patient requires referral, document the details and refer to the appropriate service.

- If a home visit is required please ensure a *home visit environment checklist* is available and document outcomes.

4.15 Staff Safety Measures

- Every patient admitted to Eurobodalla Palliative Care Service and who requires a home visit is to have a Home Visit Environmental Check List to identify any potential or actual areas that may put the staff member at risk.

- Pay attention to instincts. On assessing a potential patient if the assessor does not feel safe, discuss with clinical co-ordinator and organise a joint visit to be conducted or arrange for the patient to attend the Hospital Emergency Department.

- Each worker who attends a home visit is expected to carry a switched on mobile phone at all times.

- Patients are to have the first home visit attended during the day by either a community nurse or the volunteer coordinator.

4.16 Documentation

Specific patient information will include:

- Home visit environmental checklist;
- Case conference proforma / multidisciplinary care plan;
- Previous after hours call forms;
- Medication Chart and other relevant charts;
- Symptom Assessment Scales (SAS.V.1.0) and Functional Assessment - Karnofsky and RUG-ADL chart and other relevant charts.

4.17 References

Griffith Area Palliative Care Service Policy and Procedures

Greater Murray Health Services Palliative Care Framework.
Standards for Palliative Care Provision. Palliative Care Australia. June 1998.

New South Wales Health. Draft Palliative Care Service Framework. May 2000.

Health Department Policies on Minimisation and Management of Aggression in the Workplace.

Sydney Home Nursing Service Policy Manual

5. Death At Home

5.1 Prior to Death

- In planning for a death to occur at home the family will need to make arrangements with their GP to be available to provide a death certificate (attachment 7) or alternatively make arrangements with the community nurse who can complete an Extinction of Life Form (attachment 8) or the Eurobodalla Palliative Care Service on-call team.

- Patients should think about making “Advanced Care Directives” so that their wishes are respected.

- Consider the need of some people for spiritual support such as a minister, priest or pastoral carer.

5.2 Death at Home

This table will assist the carers/family to obtain a death certificate thereby abiding by the requirements set out in NSW Births, Deaths and Marriages Registration Act 1995.

Situation	**Requirement**	**Follow Up**
Death has occurred at home	Obtain a death certificate from the attending Medical Officer	Then the Funeral Director can remove the body
The attending Medical Officer is unavailable	Another Medical Officer may provide an interim certificate or a Registered Nurse may complete a life extinct form	The Funeral Director can remove the body. The attending Medical Officer shall provide a death certificate within 24-48 hours
A Medical Officer has not seen the deceased within the last 3 months	An autopsy is required	This will become a Coroner’s case
The Medical Officer is not available after hours, but will visit during normal working hours	The deceased may remain in the house overnight	This is a personal choice
A Medical Officer is not available for any certificate	Call an ambulance, ambulance officers will notify the police	The deceased will be taken to the nearest hospital for certification of death

Assessment of the extinction of life is a clinical assessment process undertaken to establish that life is extinct. By evaluating cardiac output, neurological signs and respiratory status, using a standard regime of clinical assessment tools, a registered medical practitioner or a registered nurse can generally establish that life is extinct.

Certification of death is a process by which the issuer or the certificate (a medical practitioner) certifies the fact and circumstances of death, pursuant to legislative requirements in the Births, Deaths and Marriages Registration Act 1995.

5.3 Funeral Director

Be aware that Funeral Directors are required to place the deceased in a body bag and this can be distressing for the family.

Information about the deceased will be requested by the Funeral Director. Attachment 9 gives details required for death registration.

5.4 Documentation

Fully documented in medical record progress notes
Death Certificate
Life Extinct Certificate
Death Registration Form

5.5 References

Griffith Area Palliative Care Service Policy and Procedures

Hospital Policy

NSW Health Circular No 99/92 Issued 25 November 1999
Assessment of the Extinction of Life and the Certification of Death

6. Communicating

6.1 Communicating with Dying People

Allow all fears to be raised

People are often aware that they are nearing death. Except where cultural or religious beliefs forbid it, it is best to be open with them.

- “Am I dying?” – often fear is the emotion behind this question. Fear of the unknown, fear of the process of death, fear of being alone, and/or fear of judgement.
- Sometimes their worry is really “Has my life been worthwhile?”
- People may be fearful of the physical event itself – about the dying process – or about the emotional or spiritual aspects.
- Even the most devout religious believer may, when facing death, have doubts about long held beliefs.

Answer all questions honestly

- If they ask, “Do you believe in God or Heaven?” answer honestly, but tell them what is really important is what *they* believe.
- For people who have not expressed a religious faith, this may be the time to ask if they would like to speak to a chaplain or clergy, as they might not be able to ask outright.

Be supportive of their beliefs and concerns

- Some people are quite resigned to dying, believing they are going to a better place and will see loved ones again, or that their time is over and this is the end.
- Their beliefs should be supported and they should not be preached at.
- There might also be concerns about how loved ones left behind will cope.

Always treat people with dignity

- Respect the thoughts and opinions of dying people even if they are contradictory to your own.
- And always treat all dying people with dignity in how you speak to them, handle or assist them and in how you refer to them.

If you feel out of your depth, find someone else

- If you feel out of your depth, tell the resident that you don’t think that you are the right person for them to talk to and that you will find someone else.

6.2. Communicating with Families

Talk about the person who died

- Being uncertain of what to say to families and loved ones is a sign that your realise the depth of their loss.
- Whether or not you have had the chance to develop a close relationship with the family and loved ones, you may sometimes struggle with what to say, or even if it is your role to say anything.
- Invariably, both you and the family member will feel better if you do or say something to acknowledge their loss.

Express you feelings honestly

- When talking to relatives about the death it is best to be honest in expressing your feelings.
- It is all right to use common expressions like, “I am sorry”, “My condolences”, or “She’s at peace now”.

Acknowledge their grief

- If loved ones become emotional you can say, “It must be hard for you”, “It’s a difficult time”.

It’s OK to show your emotions

- Showing your emotions by, say, crying with the relatives, is perfectly all right.
- Remember: “No one ever complained that someone cried; but they have complained that no one seemed to care.”

Answer all questions honestly

- Answer all questions honestly. If you don’t have the information, say so, then find someone who does.

If their relative dies alone

- Sometimes people die when left alone. This can be distressing for the relatives, especially if they just stepped out for a coffee or for some other reason.
- While we don’t really know why, it has been suggested that some people may not wish their relatives to witness their death, or that the presence of loved ones somehow prolong a dying person’s life.
- Be sure to comfort the relatives with the knowledge that this is a fairly common event.

Being with the body

- If it is possible, offer relatives who wish to say good-bye, time alone with the body. Some relatives may even wish to be involved in the rituals of washing the body after death.
- Afterwards, offer a cup of tea and a quiet room with tissues; remain with them if they wish to talk. Try not to rush them. Don't be judgemental if they are in and out as fast as possible; no one truly understands anyone else's relationship with another person.

6.3 Reference

Managing Loss and Grief in the Aged-Care Industry. Workcover NSW August 2000

6.4 Communication between health care providers

Multidisciplinary team meetings can take place between the health care providers at several locations and times, depending on the carers involved. Regular meetings that can provide an adequate arrangement include the following:

- Batemans Bay Community Nurses Meetings – Thursdays at 2.30pm

- Batemans Bay Hospital Discharge Meetings – Tuesdays at 1.00pm

- Moruya Hospital Discharge Meetings (Quiet Room) – Wednesdays at 3.00pm

- Narooma to be advised

Attachment 1: Admission Form

Eurobodalla Palliative Care Service Admission Form

Surname:…………………………….. U.R.N. …………….
Given Names:………………………… D.O.B……………………
Gender…………. Country of Birth……………………
Address…………………………………………………………………………….
Next of Kin……………………..
Date of referral……………………… Source of Referral:……………………………..

Ethnic/cultural background:		Religion:
Home Tel:	Mobile Tel:	Work Tel:
Marital status:	Current Doctor:	Ambulance Fund: Y/N
Pension No:		Expiry Date:
Medicare No:		Expiry Date:
Veteran's Affairs No:		DVA Card Colour:
DVA Approval No:		
Carer Availability: Always available Limited Not available		Accom Status: Lives in residential care facility Lives with another Lives alone
Date of first diagnosis:	Doctor:	
Principal Palliative Care Diagnosis:		
Other Significant Diagnosis:		
Metastases:		
PC Phase at this time: Stable	Unstable	Deteriorating
Other service providers:		
Preferred Place of Terminal Care: Home	Hospital	
Reasons for Referral:		
Symptom Control:	Terminal Care:	Rehabilitation:
Home Care:	Opinion/Information:	Respite:
Other:		
History of this illness:		
Past Medical History:		
Medication on admission:		Allergies:
Patient's/Family Insight:		Primary Care Giver:
Pharmacy:		
Hospital Names and MRNs:		
Patient/Family Wishes Regarding Further Treatment:		

Attachment 2: Consent Form

NATIONAL RURAL PALLIATIVE CARE PROGRAM

PATIENT INFORMATION SHEET

The National Rural Palliative Care Program

A number of service providers in your area have formed a network to ensure that people with a life threatening illness get the range of services they need. The names and contact details of the services involved in your local service network are attached [specified in Attachment 1]. They have formed a palliative care team to bring together people with different training backgrounds who share the aim of improving the quality of life of patients and their carers.

The agencies in your local care network will be using common methods for collecting information from people requiring services. These common processes will enable agencies to share information more easily when you require more than one service. This will save you having to repeat your details with each service.

The services participating in this new way of coordinating the provision of care, have been funded for three years by the Australian Department of Health and Ageing under a funding program called the National Rural Palliative Care Program. This program is testing models of care that are appropriate for rural communities. The program, including your local palliative care service, is being independently evaluated by researchers from the Centre for Health Service Development at the University of Wollongong.

Who will take part in the Evaluation Project?

People requesting a service from one of the network services for the first time, or people currently receiving a service will be asked to participate in the project. They (and their carers) will be invited to provide feedback by completing a short confidential questionnaire about their experiences. This is likely to take about 15-20 minutes. An envelope will be provided for the return of the completed questionnaire to the Centre for Health Service Development. They will also be asked if the researchers may collect information about their use of medical services, which will help with the evaluation of the National Palliative Care Program. This information will contain personal details as explained below.

Your Right to Privacy and Confidentiality

The network of services involved in the project in your area will respect your rights to privacy and confidentiality. They are legally obliged to do so. The services will require some information about you to be able to assess your needs. However, they require your consent to collect, store and share information about you. Any information asked of you must relate to the services that you are seeking.

What will happen to the information about me that is collected during the project?

If you agree to take part in the project, one of the services in the local network will ask your consent:

- To collect information about you that will be treated with the strictest confidence and stored in a secure, protected environment to which only the services in the project network have access
- To share information only where it is relevant to services that can meet your needs (for example, with a specialist service or hospital that is not part of the local service network)
- To allow information that does not identify you personally, to be used to evaluate the services you receive
- To allow information that does identify you personally to be used to evaluate the services you receive (for example, the researchers will obtain information from hospitals about any hospital services you use)

- To allow information on medical services and medicines that are prescribed for you to be included in the assessment of the service. This means that your details would need to be given to the Health Insurance Commission to allow all the information to be provided.

Your further consent will be requested if your information is required for any other purpose. If there is something in particular you do not wish to share with other health care providers, please let your care provider know this.

No information which identifies you personally will be disclosed to anyone outside the project or the health authorities.

What happens if I do not give consent to participate in the evaluation?

If you do not give consent for your information to be used in the evaluation of the palliative care service, you will receive exactly the same services as if you had consented. The only difference will be that information about you and your experiences will not be used in the evaluation of the palliative care service that provides your care.

Do I have access to the information that is collected about me?

You are entitled to gain access to your personal information that has been collected by the agency, or agencies. There is no fee for this access. You also have the right to request corrections to your information, if necessary.

Am I free to withdraw consent?

You have the right to withdraw your consent at any time for your information to be used for any of the purposes, outlined above. Any withdrawal of permission should be made in writing and forwarded to the clinician providing services to you. If you would find this difficult to do for any reason, you could ask a carer or service provider to help.

Any other questions or concerns?

If you have any other questions or concerns about what happens to your information, or if you wish to access your information, please talk to one of the key contacts specified in the attached list. If you prefer to speak to someone outside of your local service network or the University of Wollongong, the **NSW Privacy Commissioner** on **02 9268 5588** may be of assistance.

If you have any questions or concerns about the research to evaluate the service, please contact Dr Natasha Posner on 02 4221 4190 (Coordinator, National Rural Palliative Care Program Evaluation, Centre for Health Service Development, University of Wollongong).

If you have any concerns or complaints about the way the research is being conducted, you may wish to contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong on (02) 4221 4457.

Participant ID:

PATIENT CONSENT FORM
FOR PARTICIPATION IN THE
NATIONAL RURAL PALLIATIVE CARE EVALUATION PROJECT

I / patient's representative understand:

- The contents of the Patient Information Sheet titled *National Rural Palliative Care Program Evaluation Project – Patient Information Sheet,*
- That if I do not give consent, my eligibility for services will not be affected in any way, and
- That I can withdraw or change this consent at any time.

Patient name: …………………………………………………………………………………...
Address:………………………………………………………………………………………
…………………………………………………………………………………………………

I consent to:	**Yes**	**No**
Information collection and sharing: information about me being stored in the local Rural Palliative Care Program information system and shared with other relevant health and community care agencies to meet my service needs.	☐	☐
Evaluation Project: information, excluding any information that identifies me personally, being used to evaluate the Palliative Care Program.	☐	☐
Evaluation Project: information, including information that identifies me personally, being used to evaluate the Palliative Care Program. I consent to researchers from the Centre for Health Service Development (University of Wollongong) obtaining information from local hospitals about any hospital services I use.	☐	☐
Evaluation Project: information, including information that identifies me personally, being used to evaluate the Palliative Care Program. I consent to researchers from the Centre for Health Service Development (University of Wollongong) obtaining information from the Health Insurance Commission (HIC) about the medical and diagnostic services I receive and the medicines that are prescribed for me. *Please fill in the attached HIC form with your details.*	☐	☐

The above options have been explained to me and I understand them.

Signed: ………………………………………….. [patient/representative] *(please delete one)*
Date: …../…../……..
Signature of witness: ………………………………………….. (service representative)
Name of witness & agency:…………………………………………………………………….

Where written consent cannot be given and consent/non-consent is verbal:

I verify that the above consent/non-consent was given verbally

Signature:……………………………… Name (Print): ……………………………………
Organisation/Position:…………………………………………………………………….
Date: …../…../……..

Participant ID:

PATIENT CONSENT FORM (HIC)
Consent for release of Medicare and/or Pharmaceutical Benefits Scheme information for the Purposes of the National Rural Palliative Care Program Evaluation Project

Please complete this form in BLOCK LETTERS. All details in the first section MUST be completed.

Full Name of Participant:…………………………………………………………………………..
Address: ……………………………………………………………………………………….
Contact Phone Number: …………………………………… Gender: Male ☐ Female ☐
Medicare Card Number: ………………………………………. Date of Birth: …../…../……..
Consent valid from: ………………………. **to:** …………………………

Specified Medicare/PBS information required for this study:

Medical and diagnostic services and prescribed medicines

Participant's Signature: ……………………………… Date: …../…../……..

<u>Participant is unable to sign*:</u>

Signature of Witness: ………………………………………………………Date: …../…../……..

Full Name of Witness: ……………………………………………………

Reason Participant is unable to sign:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Relationship to Participant:……………………………………………………

Please attach supporting documentation/evidence of reason Participant is unable to sign.

By signing this form, you are acknowledging that you have read, and agree to all details on page 5 headed 'Important information…' of this form.

* *Authorised Person who can sign for the Participant.* If you are a guardian or you have a power of attorney that extends to the right to make decisions about the person's health care, you can sign the consent form on behalf of that person. HIC requires confirmation of this authority, so a photocopy of authorising document must be attached to this form.
If there is no power of attorney as above (for instance, a spouse caring for a mentally or physically incapacitated partner), you can consent to participate in the Project on that person's behalf, provided that the following two statements are attached to this form:

- A letter from the prospective Participant's usual medical practitioner advising that the individual concerned does not have the mental or physical capacity to consent on his or her own behalf and that participation in the Project is not contrary to the individual's best interests; and,
- A statement from you (eg. the carer) attesting to the fact that you ordinarily make health decisions on behalf of the incapacitated individual.

Alternative forms of signature. Where the Participant or person who is consenting on behalf of the Participant is unable to sign due to illiteracy or physical impairment, the signature on the consent form may be in the form of the written name of the person who can give consent on behalf of the Participant, or a mark made by that person, if they are unable to sign. The mark on the consent form must be notated as his or her signature by a witness who is known to that person and be accompanied by information as to why they are unable to sign on their own behalf.

Important information: To be read by the participant or their parent/legal guardian.
Please refer to page 4 regarding signature requirements.

1. I agree to be a Participant in the **National Rural Palliative Care Program Evaluation Project.**

2. I have been provided with information about this Project including how this Project will access, store, use and disclose information about me. I have been given an opportunity to ask questions and have been fully informed about this Project. I understand that my participation is entirely voluntary and that my participation will not have any affect on my personal dealings with my health care providers, the Centre for Health Service Development, the University of Wollongong or the Health Insurance Commission (HIC).

3. My participation in this Project will be from the commencement date to the end date specified on this form, or to the end of this Project. I can elect to withdraw from this Project at any time (refer to points 6 and 11 for more information).

4. I understand that this Project is/may be ongoing, unless I am otherwise notified. In the event that this Project exceeds the five year maximum period of consent, this Project will be required to obtain a new consent form signed by me.

5. I understand that I can, at any time, withdraw my consent to participate in this Project .

6. In the event that I withdraw my consent, I understand that the effective date of this notification will be the date on which my withdrawal notice is received either by this Project, or HIC, and that information about me collected prior to this date will continue to be used and form part of this Project.

7. I understand that specified information about me collected for the purposes of this Project could be stored for a period of five years after the conclusion of this Project, or until the completion of the evaluation of this Project, whichever date occurs last. At the end of this period, this information will be destroyed.

8. I understand that my details on this consent form will be provided to HIC if I indicate that I agree to this. I will be agreeing to the release by HIC of the specified Medicare and/or Pharmaceutical Benefits (PBS) claims information about me to the Centre for Health Service Development (University of Wollongong).

9. I understand that the specified information from HIC will be collected, stored and analysed only for the purposes of this Project.

10. I understand that any information about me collected by this project including the specified Medicare and/or PBS claims information will not be published in a manner that could identify me as an individual, during or after the conclusion of this Project.

11. I understand that I can, at any time, withdraw my consent to the further release of my Medicare and/or PBS claims information. Should I wish to withdraw this consent, I can do so by:

    - telephoning HIC on 1800 101 099; or
    - writing to the Client Liaison Unit, Information Services Branch,
      PO Box 1001, Tuggeranong, ACT 2901.

KEY SERVICE CONTACTS

Name of Project: ____

Key Contacts:

Key Contact	**Address**	**Phone Number**

Network of Local Service Providers:

Agency Name	**Address**	**Phone Number**

Attachment 3: Palliative Care Stage of Illness Data Set (Tool 1.1)

Evaluation Guide 2: Protocol for use of Tool 1.1 (Palliative Care Stage of Illness Data Set)

Introduction

The original rural palliative care model was implemented in Griffith, NSW, and was shown to be successful in that environment with a small number of GPs working together with the local hospital and community health services. Extension of the model to the area around Griffith demonstrated that such a service can be successfully implemented in smaller towns, if they can be supported by the services of a larger area.

The Griffith project adopted several measures of health status including the Karnofsky scale, a measure of symptom severity, and the Resource Utilisation Groups/Activities of Daily Living (RUG-ADL) that provided functional, psychosocial and symptom severity information relating to each phase of illness. These clinical assessment tools were found to be helpful for both the project and for the evaluation. Clinicians in the Griffith project found that the use of common assessment tools helped them to develop a common language that facilitated a more objective discussion about patient well-being and helped to track a patient's progression.

The clinical information collected by these measures was used in the evaluation to describe the mix of patients seen by the project and to track the relationship between the patient's clinical profile and their use of various services. The clinical assessment tools used in the Griffith project have been included in Tool 1.1 and are the core clinical collection being used by rural palliative care projects.

The clinical assessment instruments in Tool 1.1

The key item in Tool 1.1 is Palliative Care Phase. This is the basic measurement unit being used in the evaluation. The evaluation team will be analysing all other Level 1 impacts in the evaluation framework in terms of the phase of the patient.

The RUG-ADL and Karnofsky Rating Scale both measure functional dependency and are complementary. The Karnofsky Rating Scale is a broad brush measure of function that ranges from 100 (normal with no complaints or evidence of disease) to 0 (death). The RUG-ADL captures what are called 'late loss activities of daily living'. These are self-care functions that are lost late in a person's life. The RUG-ADL (4 items) is more detailed than the Karnofsky (1 item) and is being collected because it discriminates between patients with the same Karnofsky score, especially those rated between 30 and 60. In contrast, the Karnofsky scale distinguishes between patients who are rated 4 (no problems) on the RUG-ADL.

The Palliative Care Problem Severity Scale consists of 4 items that, together, capture the severity of the patient's symptoms and the complexity of their care needs.

Formal training in use of the Palliative Care Phases, Palliative Care Problem Severity Scale, Karnovsky Rating Scale and RUG-ADL is not required. The descriptions are quite self-explanatory and not dissimilar to the sort of information that would be collected in a clinical history and assessment.

Data collection protocol

Please note: Palliative care phase should be reviewed at each visit. The Palliative Care Problem Severity Scale, Karnovsky Rating Scale and RUG-ADL should be administered each time there is a change in palliative care phase.

When palliative care patients are treated in either the emergency department of local hospitals or admitted to a ward it is desirable that the measures included in Tool 1.1 continue to be collected. However it is recognised that this may not be practical in all circumstances. Accordingly, the collection of Tool 1.1 in the hospital setting is not an essential requirement for evaluation purposes. Each project will need to determine whether it will be possible to capture this information either by linking to the information routinely collected by hospitals, or by organising a way to collect it separately. If this is possible, the evaluation team will include the data in the evaluation findings, and this will be useful for reflecting on ways of improving continuity of care across settings.

Palliative Care Phase

The Palliative Care Phase instrument categorises a person into one of five 'phases of illness' – stable, unstable, deteriorating, terminal and bereaved. As shown in the definitions on page 2 of Tool 1.1, phases are defined based on an overall assessment of patient and family/carers characteristics. Definitions of each phase and a Phase Change Validation flowchart are provided on page 2 of Tool 1.1. The concept of illness phases has been useful in a number of ways:

- As a common language amongst clinicians to describe patients' conditions.
- As triggers for more detailed clinical assessment.
- As an indicator that specialist expertise may be required.

Previous work has found that the five phases are good indicators of the level of resources required by patients. Palliative care phases will also provide the framework for summarising and analysing data for the evaluation.

Each patient registered in the project should be classified according to the correct phase at his or her first clinical assessment. The first phase and the date need to be recorded in the first row in Tool 1.1 (Initial Phase). The Palliative Care Problem Severity Scale, Karnovsky Rating Scale and RUG-ADL for the first phase are also recorded in this row.

Tool 1.1 has provision for the patient to have up to 10 phases. Each row is used to record information about each phase. These rows are only completed if there is a phase change. If there are more than 9 phase changes, append an additional form. Note that patients do not proceed through each phase in a linear fashion (ie, start at 1, then to 2 and so on). A patient may move backward and forward between phases as their condition changes. If a patient goes through more than one phase in a day, record the predominant phase for that day.

Problem Severity Scale

The 4 items in the Problem Severity Scale are completed at the first clinical assessment and at each subsequent phase change. The score for each item should be based on the overall degree of symptoms or problems during the home visit. For patients admitted overnight to hospital the score should be based on the degree of overall symptoms or problems within the first 24 hours of admission. Further details of how to use the Problem Severity Scale are to be found on Tool 1.1.

RUG-ADL

The 4 items in the RUG-ADL are also completed at the first clinical assessment and at each subsequent phase change.

The RUG-ADL is based on what the person is capable of doing, not what they actually do. **This is best done by asking or assessing "Can you…?" rather than "Do you…?" The**

rationale for this is that some people may not undertake the activity themselves and yet be quite capable of doing so. For example, a spouse or carer may routinely assist a patient transfer from a bed to a chair even though the patient is quite capable of doing so without assistance. The RUG-ADL is designed to measure the functional ability of the patient, not the support they have. If the patient's capability varies, record the poorest performance during the assessment period.

Please note that there is no score of 2 for bed mobility, toileting and transfers. This is quite deliberate. The tool was derived as a measure of resource use, with a score of 2 indicating twice the use of resources of a score of 1, a score of 3 indicating three times the use of resources of a score of 1 etc. For bed mobility, toileting and transfers the change from independent/supervision to limited assistance was found to equate to a three-fold increase in resources. For eating, the same change equated to a two-fold increase in use of resources.

The RUG-ADL describes the level of independence for four activities – bed mobility, toileting, transfers and eating – according to the following definitions:

Bed Mobility

Ability to move in bed after transfer into bed has been completed.

1	Independent/Supervision	Is able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands on assistance required. May be independent with the use of a device.
3	Limited assistance	Is able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.
4	Other than 2 person	Requires the use of a hoist or other assistive device to readjust position in bed and requires physical assistance with pressure relief. Still requires only the assistance of one person for task.
5	2 person physical assist	Requires two assistants to readjust position in bed, and perform pressure area relief.

Toileting

Ability to mobilise to the toilet, adjust clothing before and after toileting and maintain perineal hygiene without the incidence of incontinence or soiling of clothes. If levels of assistance differ between voiding and bowel movement, record the lower performance (which is a higher score).

1	Independent/Supervision	Is able to mobilise to the toilet, adjust clothing clean self, and have no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands on assistance required. May be independent with the use of a device.
3	Limited assistance	Requires hands on assistance of one person for one or more of the toileting tasks.
4	Other than 2 person physical assist	Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/suppository. Requires the assistance of one person for the management of the device.
5	2 person physical assist	Requires two assistants to perform any step of the task.

Please note: If the person cares for a catheter or other device independently, and is independent in all other tasks, then score 1.

Transfers

Ability to transfer in and out of bed, from bed to chair, in and out of shower/tub. **Record the poorest performance of the day/night.**

1	Independent/Supervision	Is able to perform all transfers independently or with prompting from carer. No hands on assistance required. May be independent with the use of a device.
3	Limited assistance	Requires hands on assistance of one person to perform any transfer.
4	Other than 2 person physical assist	Requires the use of a device for any of the transfers. Requires only one person plus a device to perform the task.
5	2 person physical assist	Requires two assistants to perform any transfer.

Eating

Ability to cut food, bring food to the mouth and the chewing and swallowing of food. Does not include food preparation.

1	Independent/Supervision	Is able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands on assistance required. If individual relies on parenteral or gastrostomy feeding which he/she administers him/herself then score 1.
2	Limited assistance	Requires hands on assistance of one person to set-up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).
3	Extensive assistance/total dependence/tube fed	Person needs to be fed meal by assistant, or if the individual does not eat or drink full meals by mouth but relies on parenteral/gastrostomy feeding and does not administer feeds by him/herself.

Karnofsky Rating Scale

The Karnofsky Rating Scale is a measure of the patients’ overall function or ability to manage their own activities of daily living. It is a single score between 0 and 100 assigned by a clinician based on observations of a patient's ability to perform common tasks. Thus, a score of 100 signifies normal physical abilities with no evidence of disease. Decreasing numbers indicate a reduced ability to perform activities of daily living.

How to collect the data

Although the scales and their items are standardised, there are various ways, and combinations of ways, to collect the data in Tool 1.1, and each project will need to develop their own system based on locally agreed arrangements:

- Small projects can use their regular case conference to assess whether a patient has had a change of phase and, if so, to complete the required information either on a paper-based record or the computerised database used by the project.

- Some projects may elect to include Tool 1.1 in the patient-held record. Anyone visiting the patient could use the form to record phase changes, together with the other components of Tool 1.1.

  Please note: The information contained in Tool 1.1 could be distressing for some patients and carers. Projects considering this option might like to consider using a simplified version of Tool

1.1 that does not include all the ratings and instructions. In this case, the definitions and instruments would be provided to participating clinicians on a separate page, perhaps as a laminated sheet.

- A key worker such as a community nurse is appointed for each patient in a project. The key worker is responsible for completing Tool 1.1 on behalf of the whole team. Any health care provider observing a phase change is responsible for providing that information, and the other information prompted by the change, to the key worker.

- Every health care provider involved in the project carries a set of Tool 1.1 forms to record any information and at the end of the month sends the forms to the project office for data entry.

- Palm pilots loaded with the PalCIS software can be used to enter the information during a patient visit with subsequent downloading to a central computer.

There may be other ways of collecting the information for Tool 1.1 and any project that has developed such a system is encouraged to share it with the evaluation team and the other projects.

Your diligence in collecting this information is much appreciated and will greatly assist the palliative care service in following the course of each patient's illness, in understanding the continuity of their care and in prompting timely interventions.

RPC Evaluation Tool 1.1
Patient/client palliative care stage of illness data set

Patient Id:……………………………………..

	Date of Phase or Phase Change	PC Phase	Reason for phase change	PC Pain Score	PC Other Symptom Score	PC Psych/ Spiritual Score	PC Family/ Carer Score	RUG ADL Score at start of Phase				Karnofsky Score
								Bed Mobility	Toilet	Transfer	Eating	
Initial Phase												
1st Phase change												
2nd Phase change												
3rd Phase change												
4th Phase change												
5th Phase change												
6th Phase change												
7th Phase change												
8th Phase change												
9th Phase change												

PALLIATIVE CARE (PC) PHASES

1 - Stable Phase
2 - Unstable Phase
3 - Deteriorating Phase
4 - Terminal Care Phase
5 - Bereaved Phase

Reason for Phase Change

1 - Phase change 2 - Discharge/case closure 3 - Died 4 - Bereavement phase end

PALLIATIVE CARE (PC) PROBLEM SEVERITY SCORE

PC Pain
The degree of overall pain symptoms.

PC Other Symptom
Record the degree of overall other symptoms. The following list may be used as a guide:
Nausea/vomiting, anorexia, itch/irritation, constipation/diarrhoea, wound/ulcer, dysphagia, incontinence, weakness/fatigue, oedema, dyspnoea, confusion/delirium.

PC Psychological/Spiritual
Record the score for overall degree of psychological/spiritual problems of the patient. The following list may be used as a guide:
Anxiety/fear, anger, unrealistic goals, agitation, request to die, depression/sadness, confusion.

PC Family/Carer
Record score for the overall degree of family/carer problems. The following list may be used as a guide:
Denial, care giver fatigue, unrealistic goals, anger, difficult communication - non-English speaking-sensory impairment, financial, family/carer conflict, legal, family/carer anxiety, accommodation, cultural.

FOR ALL (PC) PROBLEM SEVERITY ITEMS SCORE: 0-absent 1-mild 2-moderate 3-severe

RUG-ADL SCORE

For bed mobility, toileting & transfers:

1	Independent or supervision only
3	Limited physical assistance
4	Other than 2 person physical assist
5	2 person physical assist

For eating:

1	Independent or supervision only
2	Limited assistance
3	Extensive assistance/total dependence/ tube fed

Karnofsky Rating Scale

100	Normal with no complaints or evidence of disease.
90	Able to carry on normal activity but with minor signs of illness present.
80	Normal activity but requiring effort. Signs and symptoms of disease more prominent.
70	Able to care for self, but unable to work or carry on other normal activities.
60	Able to care for most needs, but requires occasional assistance.
50	Considerable assistance and frequent medical care required; some self-care possible.
40	Disabled, requiring special care and assistance.
30	Severely disabled; hospitalisation required but death not imminent.
20	Extremely ill; supportive treatment and/or hospitalisation required.
10	Imminent Death.
0	Death.

Definitions of Palliative Care Phases

(1) Stable Phase

All clients not classified as unstable, deteriorating, or terminal.

- The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.
- The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

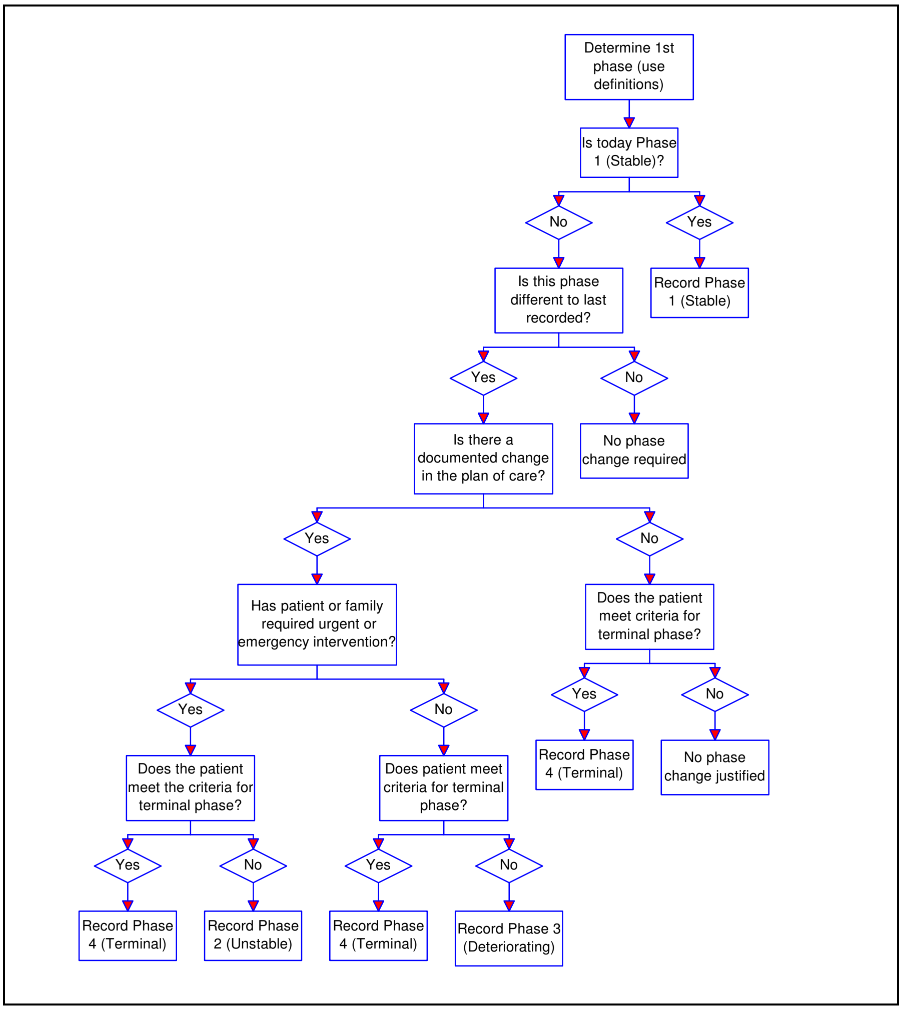
(2) Unstable Phase

The person experiences the development of a new problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment

- The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multi-disciplinary team.

(3) Deteriorating Phase

- The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.
- The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.



(4) Terminal Care Phase

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak
- Essentially bed bound
- Drowsy for extended periods
- Disoriented for time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication
- This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues.
- The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement

(5) Bereaved Phase

Death of the patient has occurred and the carers are grieving. A planned bereavement support program is available including counselling as necessary.

Attachment 4: Time Sheet for On-Call Service

SOUTH EAST NSW
DIVISION OF GENERAL PRACTICE LTD
ABN: 32 066 905 931

"GPs caring for South East NSW"

Weekly Time Record – Palliative Care On-Call Service

Name:	Week Ending Date:

Day	Date	Start	**Finish**	Total
Monday		5.00pm	9.00am	16
Tuesday		5.00pm	9.00am	16
Wednesday		5.00pm	9.00am	16
Thursday		5.00pm	9.00am	16
Friday		5.00pm	9.00am	16
Saturday		9.00am	9.00am	24
Sunday		9.00am	9.00am	24

Total Hours	48 hrs @ $4.41 = $211.68 80 hrs @ $2.21 = $176.80
Total Allowance	$388.48

Notes:

Signature:	Exec Officer Signature:

Send, Fax or Email to Program Officer, Eurobodalla Palliative Care Service
Fax: 4474 5111
Email: sblogg@senswdgp.com.au
Mail: Level 1, 73 Vulcan Street, Moruya NSW 2537

Attachment 5: After Hours Record of Calls

Record of Calls – After Hours Service

Name:…………………………………….
Location (Town): …………………………………………………..

Date	Time	*Client Id* (if registered) or *telephone no.*	Client name	Home visit?(Y/N)	Name of GP & if informed (Y/N)	Reason for call and outcomes, including any referrals

Attachment 6: Contact List for Other Services

Eurobodalla Palliative Care Resource Directory – 1300 795 440

Palliative Care Specialist	95533472
Oncology Unit	4474 1576
Palliative Care Volunteers	4474 1641
Pastoral Care Workers	44735407

General Practices

Batemans Bay	
Bayview Medical Centre	4472 4715
Batemans Bay Medical Centre	4472 4626
Batehaven Medical Centre	4472 4422
Surf Beach Surgery	4471 2199
Moruya	
Campbell Street Medical Centre	4474 2200
Queen Street Surgery	4 474 2222
Tuross	
Tuross Surgery	4473 6177
Narooma	
Lighthouse Surgery	4476 2999
Blue House Surgery	4476 1390
Dr Hunt	4476 2622
Dr Woodall	4476 2066
Bermagui	
Wapengo Street Surgery	6493 4233
Aboriginal Care	
Katungal	4476 2155
SAHS Batemans Bay	4472 4544
Aboriginal Hospital Liaison	0429 037 357

Community Health

Eurobodalla Community Health	4474 1561
Community Nurses	
Batemans Bay	4472 4544
Moruya	4474 1561
Narooma	4476 2344
Community services	
Hospital in the home	4474 2666
Oxygen and PADP	4823 7949
Home Care Services	4474 3569
Meals of Wheels	4474 4464
EuroTransport	4474 1040
Centrelink Carer Allowance	13 2717
Community Care Packages	4475 3355
Respite Services	4474 1300
Southern Highlands Respite Services (emergencies)	1800 059059
Dementia CNC	4474 1561
Narrama Multi Services Aboriginal Corp (Narooma)	4476 4133

Hospitals

Batemans Bay Hospital	4472 4504
Pharmacy Department	4472 0601
Moruya Hospital	4474 2666
Pharmacy Department	4474 1587

Private Nursing Agencies

Eurobodalla Nursing Service	4474 4499
ER Nursing & Transport Service	4472 3372
Nursing Group P/L 4476 5500 or	4423 2553

Aged Care

Managed Aged & Extended Care	4823 7902
Aged Care – CNC	0407 98697
Assessment team	4474 1561
Veterans Home Care	1300 550 450
Aged Care Package Workers	
Batemans Bay	4475 3638
Moruya	4474 0243
Narooma	4476 4355

Aged Care Facilities – Nursing Homes

Batemans Bay	
Edgewood Park	4472 8155
Maranatha Lodge	4472 8608
Crown Gardens	4475 3633
Broulee	
Banksia Village	4471 6031
Moruya and Dalmeny	
Illawarra Retirement Trust	4476 7611
Sir James at Dalmeny	4476 8744

Counselling Services

SAHS Social Worker	4474 1561
Centrelink social worker	13 2717
Division counsellors	GP referrals
Centacare (Moruya)	4474 4158
Carers NSW Inc	9280 4744
Grief Support Inc (24 Hrs)	9489 6644
Bereavement Care Centre	1300 654 556
Private Counselling Service	
T.L.C.'s	4472 9433
Peter Erskine & Kristel Dragisic	4471 5010

Organisations

Leukaemia Foundation	1800 620420
Cancer Help Line	131120
Look Good Feel Better	1800 650 960
Cancer Council Connect	1300 131 533
Telegroup Counselling	9334 1755
Community Carer Respite Centre	1800 242636
Carers Support	1800 242 636
Public Trustee	1300 364103
Guardianship Tribunal	1800 463928
Dementia Advisory Service	1800 639 331
National Assoc for Loss &Grief	9988 3376

Attachment 7: Death Certificate

Attachment 8: Live Extinct Form

Attachment 9: Death Registration Form