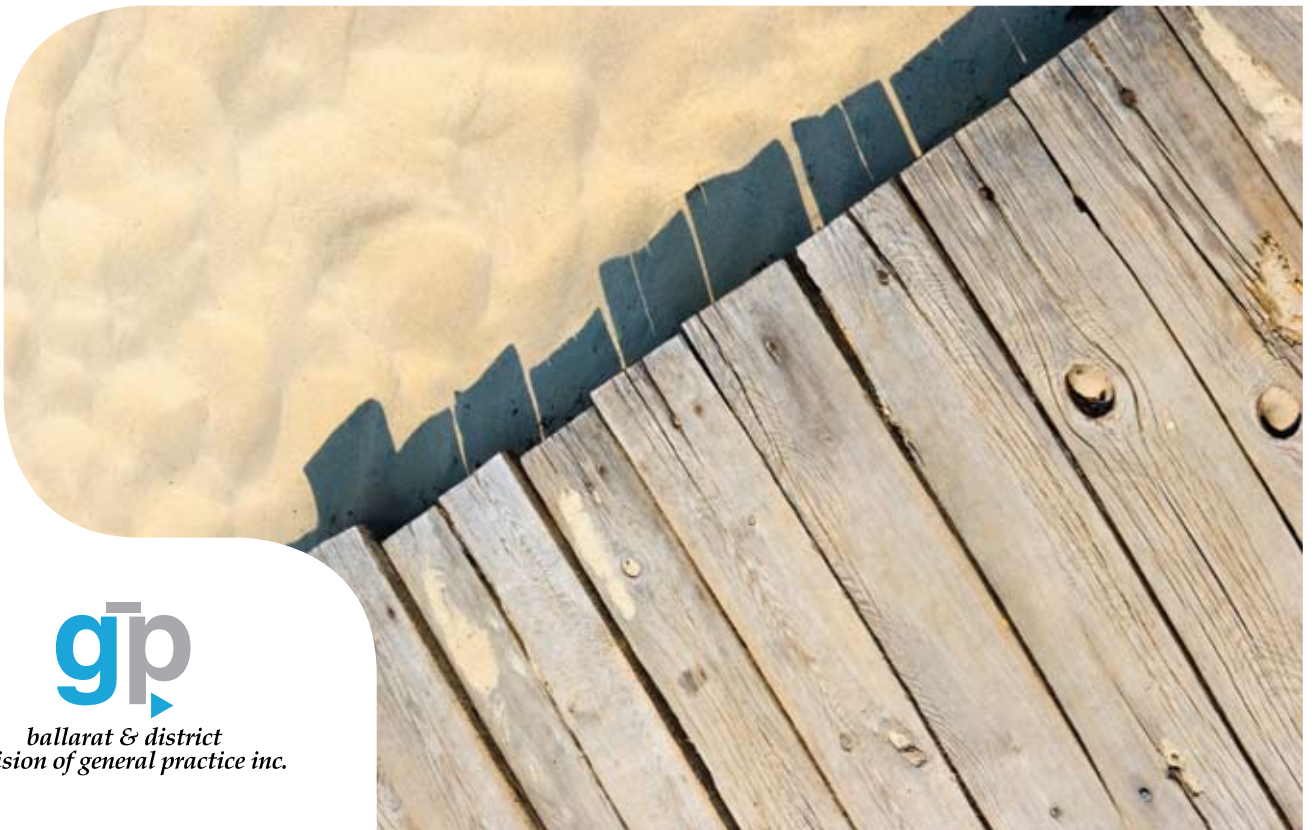


doctors
bag

PALLIATIVE CARE INFORMATION



*ballarat & district
division of general practice inc.*

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Introduction

Acknowledgements:

- Ballarat & District Division of General Practice
- Adelaide North East Division of General Practice
- Grampians Region Palliative Care Consortium
- Grampians Regional Palliative Care Team
- Palliative Care Victoria
- Care Search Website (www.caresearch.com.au)
- Therapeutic Guidelines Limited – Palliative Care
- End of Life/Palliative Education Resource Centre

What is Palliative Care?

Palliative Care Victoria describes Palliative Care as

“Any special needs of a person who has a life-threatening illness. The focus is not on curing them but on treating their symptoms by making them comfortable, by controlling their pain and by helping them to make changes that will make their life easier. Palliative Care aims to make the person feel in control of their treatment and their quality of life. It involves family and friends, recognising that they too may need help in coping with the illness of someone they love. Palliative Care will also be there to offer help and support during the grieving process.

Palliative Care can be provided in the person’s own home, at a specialist in-patient hospice unit, or at some other health facility, depending on where the person is living, and where they choose to die.”

‘Principles of a good death’, are:

- to have an idea of when death is coming and what can be expected
- to be able to retain reasonable control of what happens
- to be afforded dignity and privacy
- to have control of pain and other symptoms
- to have access to necessary information and expertise
- to have access to any spiritual or emotional support required
- to have access to ‘hospice style’ quality care in any location
- to have control over who is present and who shares the end
- to be able to issue advance directives to ensure one’s wishes are respected
- to have time to say goodbye and to arrange important things
- to be able to leave when it is time and not to have life prolonged pointlessly.

Effective Palliative Care can ensure these principles are maintained and followed.



Symptom Control

G

Symptom Control

Evaluation

Evaluate the symptom

What are the likely causes (remembering a symptom may be due to disease progression, to treatment and medications or to intercurrent illness)? Accept the patient's description of the symptom. What options are there to modify and are there any other factors impacting on the severity of the symptom?

Evaluate the patient

How far has the disease progressed? Is there a temporary relapse, which may be reversible or the terminal stage? What is the patient's understanding of and response to the symptom?

Explanation

Informing the patient about the likely cause of the symptom can reduce their level of anxiety. A new symptom does not necessarily mean the disease is worse, but if it does, it may provide an opportunity to discuss the implications and prognosis, and prompt review of the patient's life goals and priorities.

Discussion

Discuss the treatment options and the likely outcomes with the patient. The following questions should be addressed:

- What is the best outcome with the proposed treatment?
- What is the possibility of no change or deterioration with the proposed treatment?
- What will be required? (eg tests, hospitalisation, more tablets)
- What if nothing is done about this symptom?

Individualised Treatment

Individualising treatment depends on:

- The available options (eg radiotherapy, chemotherapy)
- Weighing benefits against burdens for each patient
- The wishes of the patient and family
- Optimal symptom control requires a multidisciplinary approach.

Attention to Detail

Even small improvements in symptom control may be worthwhile. Thoroughness and fine tuning are important.

Monitoring of Progress

An important facet of care is a proactive approach to symptom control. Review the patient, their symptoms and their therapy frequently, as the situation of a patient with a terminal illness may change quickly. New symptoms can emerge and old symptoms recede.

Rapid Dose Escalation

There is a need to recognise extreme situations of distress in a dying patient. In these situations, an urgent response is required, with rapid dose titration and dose escalation over a short period of time if necessary.





Gastro-intestinal Symptoms



Gastro-intestinal Symptoms



Oral Symptoms

Oral problems can compromise the quality of life of a patient with a terminal illness. Simple symptomatic improvements can dramatically benefit the patient, with improved appetite, easier eating and an improved sense of wellbeing.

Management of oral symptoms includes meticulous mouth care:

- Frequent mouth washes – mouth swabs and water is usually sufficient
- Moistening the oral cavity – small sips of fluids
- Gentle teeth brushing
- Induce saliva flow via sugar-free chewing gum, frozen lemon slices, frozen tonic water etc
- Applying lanoline-based preparations or lip balms
- Using choline salicylate mouth gel or toothpaste

Symptomatic treatment:

<i>Benzydamine+chlorhexidine solution</i>	10 to 15 mL	Rinse and spit – 4 hourly
<i>Lignocaine viscous 2%</i>	10 to 15 mL	Rinse and spit – 4 hourly
<i>Aspirin or paracetamol gargles</i>		4 hourly
<i>Choline salicylate gel</i>		Applied 4 to 6 hours.

Anorexia

Anorexia and weight loss in advanced disease are among the most recognised and troubling symptoms for patients and caregivers. The loss of weight is seen as a sign of advancing disease and a cause of death and 'death by starvation' is a common misconception. The reason that the person is not eating is often because they are dying.

Management includes avoiding measuring weight in advanced disease. Patients know already they are losing weight and it is unnecessary to focus on this. Explaining the distinction between dehydration and thirst, and malnutrition and anorexia is important. Identify any causes and treat them accordingly ie nausea and vomiting etc.

Pharmacological treatment of anorexia include:

<i>Metoclopramide</i>	10 mg	Orally, 3 times daily before food
<i>Domperidone</i>	10mg	Orally, 3 times daily before meals

Nausea and Vomiting

Nausea may be intermittent or persistent either with or without vomiting. Nausea and vomiting can arise from all parts of the gastrointestinal tract. Assessment of the cause of nausea and management of the cause are essential.

General management can include:

- Review the patient's medication and consider stopping drugs that can induce nausea
- Nausea arising from anxiety may be reduced with discussions and behavioural therapies.
- Patients with nausea and vomiting from external pressure on the stomach or a delay in emptying can benefit from consuming small amounts of food and drink regularly. Pureed foods may also be of benefit if the patient cannot tolerate solid food.

Common antiemetics used:

<i>Haloperidol</i>	Dopamine antagonist, works at chemoreceptor trigger zone	Nausea due to drugs, metabolic disorders, sepsis, bowel obstructions	0.5-5.0 mg/day (oral or SC)
<i>Metoclopramide</i>	Prokinetic but also dopamine antagonist	Opioids, gastric irritation, gastric stasis, partial bowel obstruction, constipation	10 mg 4 hourly (oral/SC) or 50mg up to 4 times per day (oral/SC)
<i>Cyclizine</i>	Works at vomiting centre	Vestibular component, small bowel obstruction	50 mg twice per day (oral/SC), max 200 mg/day
<i>Ondansetron</i>	Chemoreceptor trigger zone and the gut	Chemotherapy and radiotherapy	4-8 mg twice per day (oral/SC)

Constipation

In Palliative patients, aetiology is usually multifactorial and laxatives need to be used early, in sufficient doses and often in combination.

General measures that can help avoid constipation:

- Encourage the patient to toilet regularly at the same time each day. Have the patient sit upright.
- Ensure adequate hydration and optimise the level of fibre in the diet.
- Encourage general activity by good control of other symptoms.
- Seek a remediable cause, such as lack of privacy, pain, poor mobility, dehydration and medications.

Laxatives for Constipation

Mode of action	Oral Agents	Dosage	Suppository/enema	Dosage
Predominant softening ▼ ▼ ▼	<i>Paraffin</i> <i>Fybogel</i> <i>Coloxyl</i> <i>Lactulose</i> <i>Epsom salts</i>	30 to 60 mL daily 3.5 g sachet daily 8 mg 4-6 daily 10-30 mL 2-3 daily 5-15 g daily	<i>Glycerol</i> <i>Coloxyl with Senna</i> <i>Glycerine/Microlax</i> <i>Sodium phosphate</i>	As required 10mg as required 5mL as required 5mL as required
Predominant stimulant	<i>Senokot</i> <i>Bisacodyl</i>	5.5 mg/g granules 5 mg tablets 2-4 daily	<i>Bisacodyl</i>	10mg as required



Respiratory Symptoms



Respiratory Symptoms

Respiratory Secretions

Problems related to respiratory secretions can be caused by infection or aspiration, or by pooling of normal oropharyngeal secretions in a patient who is weak or unable to swallow or cough effectively (for instance in motor neurone disease) or who has a reduced state of consciousness. The latter situation is common as death approaches ('death rattle'). Pulmonary oedema also causes increased respiratory secretions

Pharmacological treatment for respiratory secretions include:

<i>Hyoscine hydrobromide</i>	0.4mg	S/C 3 to 4 hourly prn
<i>Hyoscine butylbromide</i>	10-20mg	S/C 4 hourly prn
<i>Glycopyrronium</i>	0.2mg	S/C (max 1.2mg/24 hours)

General management can include:

- Repositioning the patient from side to side in a semi-upright position is recommended as a nursing strategy for patients with terminal secretions.
- Suctioning of the oropharynx is occasionally useful, but it often causes patient distress.
- Counselling of relatives and caregivers is important, and reassurance that the patient is not aware of the distress can usually be given.

Dyspnoea

Dyspnoea (shortness of breath) is described as 'an uncomfortable awareness of breathing'. It is a subjective symptom which may not correlate with measurable physical abnormalities such as hypoxia. Treating the dominant cause of breathlessness, including the contributing co-morbidities, is likely to be most effective, but is not always possible.

(Opioids in low doses)

<i>Morphine</i> , commencing at	2.5mg– titrate up to effect	Orally or S/C
---------------------------------	-----------------------------	---------------

(Patient may experience relief, however physically they may still look 'short of breath')

(Associated Anxiety)

<i>Diazepam</i>	2mg	Orally or rectally twice daily
<i>Clonazepam</i>	0.25-0.5mg	Orally or S/C twice daily
<i>Midazolam</i>	1-5mg	S/C as hourly boluses or by continuous infusion, starting dose 5mg (rarely sedating) to 20mg (usually sedating) per 24 hours



Cough

Cough in palliative care patients is often caused by infection, pleural effusion, or the direct effects of malignancy on the lung or airways. Co-morbidities such as Chronic Obstructive Pulmonary Disease (COPD) and cardiac failure may also contribute, and should be optimised. Antibiotic treatment of infection may sometimes give good palliation of infected secretions.

The investigation and management of cough may differ depending on the person's illness stage and wishes for treatment. Active treatment of malignancy as appropriate with surgery, chemotherapy or radiotherapy, or by drainage of pleural effusion, may effectively treat coughing in patients who are well enough.

Pharmacological treatment for coughing include:

(Dry, non-productive cough)

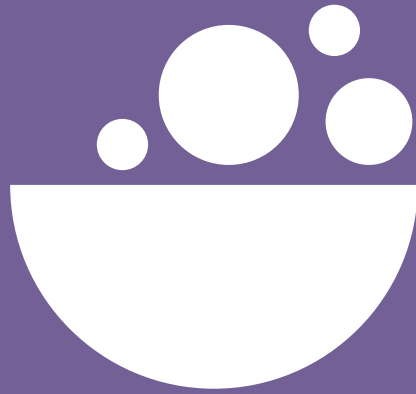
- Cough suppression with opioids or opioid analogues:
 - » Dextromethorphan syrup
 - » Pholcodine or codeine linctus
 - » Morphine 1-2.5mg orally, 1-2 hours prn

(Moist productive cough)

- Humidification: steam, inhalations (eg eucalyptus), nebulised saline
- Bronchodilators (eg: Salbutamol)
- Antibiotics – consider for symptom relief

Haemoptysis:

- Consider palliative radiotherapy for recurrent bleeding from tumours
- Catastrophic haemorrhage: Anxiolytic, Morphine
- Dark towels to conceal bleeding and to minimise visual impact for patient and family



Cognitive and Emotional



Cognitive and Emotional

Delirium and Terminal Restlessness

Delirium is defined as a condition of disturbed consciousness, with reduced ability to focus, sustain or shift attention.

Delirium may be:

- Hyperactive (presenting with agitation, hyperarousal, and restlessness), or
- Hypoactive (presenting with drowsiness, lethargy and reduced levels of arousal), or
- A mixed pattern in which the symptoms fluctuate between hyperactive and hypoactive.

Delirium is extremely common in palliative care patients. It becomes more frequent towards the end of life, and is associated with a worsening prognosis. The diagnosis is often missed, or may be confused with depression or dementia. Hypoactive delirium in particular is under-diagnosed.

Terminal restlessness is a cluster of symptoms; most often described as agitation and altered mental state, which occurs close to the end of life. There is no agreed definition of this condition.

Factors which should be considered as possible contributors to delirium/Terminal Restlessness in a palliative care patient, and treated as appropriate, include:

- Infection
- Metabolic and biochemical disorders (eg, renal failure, hypercalcaemia, hyponatraemia, dehydration, hypoxia, hypercapnia)
- Hepatic encephalopathy
- Structural cerebral disease (eg, primary or secondary cancer, leptomeningeal disease, radiotherapy to the brain)
- Medications (eg, psychoactive medications such as benzodiazepines, opioids, steroids, antidepressants, or medications with an anticholinergic effect)
- Drug withdrawal (eg, alcohol, benzodiazepine, nicotine)
- Environmental (hospital admission, uncorrected sensory deficits eg, vision and hearing).

Delirium is defined as a condition of disturbed consciousness, with reduced ability to focus, sustain or shift attention.

Pharmacological and nonpharmacological management, as well as the treatment of reversible causes, should be considered simultaneously.

Nonpharmacological measures include:

- A peaceful, familiar environment
- The presence of people well-known to the patient
- Appropriate music
- Avoidance of the dark and of bright lights
- Explanation, reassurance and regular reorientation
- Minimising sensory deficits (eg hearing, vision loss) by providing aids
- Explanation to and support of family is necessary so they may be reassured and also assist in patient care.

Pharmacological treatment for Delirium/Terminal Restlessness include:

Haloperidol	1.5-10mg	Orally daily in divided doses
Olanzapine	2.5-10mg	Orally daily
Diazepam	2.5-10mg	Orally or rectally twice daily
Clonazepam	0.25-0.5mg	Orally or S/C twice daily
Midazolam	2.5-5mg	S/C as hourly boluses or by continuous infusion, starting dose 5mg (rarely sedating) to 20mg (usually sedating) per 24 hours





Pain



Pain



Opioid Conversion Chart

		TO	Codeine		Morphine		Oxycodone		Hydromorphone		Fentanyl
			PO	mg/day	PO	SC	PO	SC	PO	SC	TD
FROM			mg/day	mg/day	mg/day	mg/day	mg/day	mg/day	mg/day	mg/day	mcg/hr
Codeine	PO mg/day			8	20	12	20	40	120	24	
Morphine	PO mg/day	8			2.5	1.5	2.5	5	15	3	
Morphine	SC mg/day	20	2.5			0.6	1	2	6	1.2	
Oxycodone	PO mg/day	12	1.5	0.6			1.67	3.33	10	2	
Oxycodone	SC mg/day	20	2.5	1	1.67			2	6	1.2	
Hydromorphone	PO mg/day	40	5	2	3.33	2			3	0.6	
Hydromorphone	SC mg/day	120	15	6	10	6	3			0.2	
Fentanyl	TD mcg/hour	24	3	1.2	2	1.2	0.6	0.2			

Multiply

Divide

Opioid Conversion Chart Instructions

1. Add current opioid doses to get total milligrams over 24 hrs (for Fentanyl note the total hourly rate in mcg)
2. Use conversion chart -
 1. Identify current opioid in column on far left
 2. Scan across the column corresponding to new opioid
 3. Note conversion factor and whether to be multiplied or divided
3. Multiply or divide current opioid total by conversion factor. This will give the dose of the new opioid in milligrams per 24 hours
4. Divide 24 hr dose by appropriate number ie 2 for BD dosing of 6 for q4H dosing or 100% breakthrough dose

When changing patients from one opioid to another, it is safer to initially give less than the calculated equivalent dosage and increase if needed.

NOTE: Conversion from morphine to fentanyl is more variable than the other conversions in this list. One reason is that morphine depends on renal excretions whereas fentanyl does not. For example, the prescribing information for fentanyl patches states that a 25mcg/hr patch is equivalent to a 30-120mg oral dose of morphine daily.

Obtain specialist advice if uncertain.

Pain

Treat constant pain with regular analgesia. Different types of pain respond to different analgesics. Psycho-social factors like anxiety or depression, which may reduce tolerance to pain or be exacerbated by pain, must also be assessed and treated

A step-by-step guide to pain control

1. Mild pain of many causes will respond to paracetamol.
2. Identify if the type of pain can best be treated by a specific treatment:
 - pain from bone metastases → radiotherapy
 - smooth muscle colic → antimuscarinic
 - infection such as cellulitis → antibiotic
 - pathological fracture → radiotherapy or surgical fixation
 - raised intracranial pressure → corticosteroids
3. For moderate pain, consider an NSAID e.g. diclofenac 50mg t.d.s. if an inflammatory process is thought to be involved and there are no contraindications to an NSAID:
 - bone metastases
 - musculo-skeletal pain
4. For more severe pain start a strong opioid and titrate dose:
 - morphine PO or SC is the usual first-line opioid.
5. If this does not relieve the pain or the opioid dose has been escalated to the maximum tolerable side effects - consider:
 - adding an NSAID if not already tried
 - morphine-resistant pain
 - underlying depression or fear lowering the patient's tolerance to pain
 - if disseminated bone pain, consider hypercalcaemia which lowers pain threshold
 - a new pain may have developed
 - vomiting preventing drug absorption
 - poor compliance to medication

Common types of pain

Visceral pain

Tumour infiltration of the viscera causes a constant dull pain, poorly localised, that usually responds very well to opioids.

Liver pain may also be due to stretching of the liver capsule. Dexamethasone 4-6mg o.d. often helps the pain.

Raised intracranial pressure pain is due to stretching of the meninges and may respond well to dexamethasone.

Pancreatic malignancy may produce pain unrelieved by opioids, due to retroperitoneal nerve involvement. A coeliac plexus block has a high success rate.

Bone pain

Often described like 'toothache', bone pain is usually well localised, and local tenderness may be elicited.

Musculo-skeletal pains

Commonly occur due to general debility. **NSAIDs** are often successful but a strong opioid may be needed as well.

Soft tissue involvement

(e.g. chest wall involvement in breast or lung cancer) Dexamethasone may be more effective than a **NSAID** (usually in combination with an opioid). Consider radiotherapy referral.

Infection

Pain from cellulitis or deep pelvic infection is best treated with an antibiotic if appropriate. **NSAIDs** may also be helpful.

Smooth muscle colic

Opioids are often ineffective for intestinal colic, biliary colic and bladder spasms.

Nerve pain (Neuropathic pain)

Often but not always associated with sensory changes. Neuropathic pain is often at least partially responsive to opioids, which should be titrated first.

Odynophagia (painful dysphagia)

Causes include painful mouth, radiotherapy-induced oesophagitis, candidiasis, acid reflux and oesophageal spasm. Pain from oesophageal spasm may respond to nifedipine or glyceryl trinitrate.

Ischaemic pain

When surgery is inappropriate for ischaemic pain from a gangrenous foot, pain relief can be difficult. Spinal analgesia with an opioid and local anaesthetic is probably the treatment of choice. It may not always be possible. Alternatives to consider include liberal use of local anaesthetic (e.g. Emla cream) smothered over the affected part, or a local anaesthetic subcutaneous infusion. Ketamine and methadone (as described under Neuropathic pain) may be helpful.

Episodic pain

Pain that varies significantly with time may be:

- 'end-of-dose' pain requiring a review of analgesic dose or regimen
- pleuritic pain (**NSAID**, corticosteroid, antibiotic, intercostal nerve block, interpleural anaesthetic infusion)
- pain on movement from bone disease or nerve compression
- pain on movement may respond better to **NSAIDs** than opioids
- skin hypersensitisation - neuropathic or inflammatory
- pain related to dressing changes or procedures
- Entonox (nitrous oxide) may be helpful for predictable pain e.g. dressing changes or procedures



Living Well Discussions Advance Directives



Living Well Discussions Advance Directives

The Living Well Discussion:

Doctor-patient discussions about end of life treatment are often framed as a choice between “medical treatments vs. treatment withdrawal”. When framed in this manner, treatment withdrawal is a negative choice that often implies giving up, abandonment, not giving the doctor a chance to do his or her job and not caring; this option would seem to be no option at all.

The physician can reframe the doctor-patient dialogue about end of life treatment by starting a conversation with the patient focused on the question “How can we help you live well?” The goal of the living well interview is to elicit the patient’s perspective regarding how they want to spend their remaining time. Treatment decisions are then discussed within this broader context of patient goals and hopes. Treatments become tools for achieving patient goals.

When: Begin soon after the diagnosis of a life-limiting condition

Who: Physician and patient with support from others: family, carer, friends, nurse, chaplain, etc.

How: Begin by expressing a need and interest to understand the patient’s views. The physician’s initial goal is to develop a broad understanding of the patient’s hopes and goals.

What to say: Given that we now know about your medical condition....

- How can we help you live well? What makes you happy?
- Maintaining or fulfilling what activities or experiences are most important for you to feel your life has quality, or for you to live well?
- What fears and worries do you have about your illness or medical care?

- If you have to choose between living longer and quality of life, how would you approach this balance?
- What needs or services would you like to discuss?
- What do you hope for your family?
- Are there any special events or activities that you are looking forward to?
- What sustains you when you face serious challenges in your life?
- Do you have religious or spiritual beliefs that are important to you?
- In what way do you feel you could make this time especially meaningful for you?

Advance Care Planning/Legal Considerations

Palliative care emphasises advance care planning. It helps patients and their families to:

- Consider the kind of care that fits with their values
- Make decisions about future care, and review possible scenarios in relation to their own situation and their values
- Identify a proxy decision maker, if one is available and appropriate
- Discuss organ donation, wills, funerals, and other matters related to the end of life.

Written information about a patient’s wishes may need to be available for emergencies, and for when a patient is transferred between different settings of care. Ensuring this happens is part of the advance care planning process.

TIP - Advance care planning simply involves discussing a person’s wishes and ensuring that the family or other proxy decision-maker is aware of these wishes. Make sure they are noted in the clinical record.

Legal considerations

Advance care planning processes can vary between states and territories. The relevant Acts for Victoria are the Medical Treatment Act 1988 and the Guardianship and Administration Act 1986.

General comments:

- A competent adult has the right to refuse medical treatment.
- A competent adult can sign a legally binding refusal of medical treatment but not palliative care under the Medical Treatment Act 1988 in Victoria.
- A competent adult has the right to appoint a substitute decision-maker, who can make decisions regarding their medical treatment should they become incapable of making these decisions themselves. In Victoria they can appoint:
 - » A Medical Enduring Power of Attorney (MEPOA also referred to as an agent);
 - » An Enduring Guardian or
 - » In writing, a “person responsible”
- If a person has not appointed an enduring power of attorney (medical treatment) or an Enduring Guardian (with the power to make medical decisions), the responsibility for medical treatment decisions falls to the “person responsible”.
- The “person responsible” cannot refuse medical treatment on a patient’s behalf in circumstances where the patient is dying and unconscious, and the patient considers the medical treatment unwarranted or considers that the treatment could cause unreasonable distress.

Appointing a Decision Maker:

- To appoint a MEPOA or agent the person must be over 18 years of age, able to understand the nature and effect of the power of attorney, capable of choosing an agent.
- A doctor can witness the appointment of a MEPOA by a competent individual.
- A person may also choose to nominate an alternate agent who will only make decisions if the agent is unavailable, or incapable of making decisions. The alternate agent can only make decisions for the person if they sign a statutory declaration stating that the agent is either dead, incompetent or cannot be contacted.

Once nominated, the agent and/or alternate agent has the power to:

- Refuse medical treatment on the person’s behalf if the treatment would cause the person unreasonable distress or if the agent believes on reasonable grounds that the person would consider the treatment to be unwarranted, agree to medical treatment on the person’s behalf.
- The agent does not have the power to make non-medical decisions, nor does he or she have the power to refuse palliative care.

Advance Directives

- A patient can plan and document their choices for future medical treatment by completing a Statement of Choices (or similar) document that captures their future medical treatment wishes and other requests for psycho-social spiritual care, document this in a letter, via discussions with their Medical Enduring Power of Attorney, family and/or health care professionals.
- Under schedule 1 of the Medical Treatment Act 1988, competent patients can also complete a Refusal of Treatment Certificate. This Certificate must be related to a current illness only but cannot refuse palliative care and is legally binding and cannot be overridden by family or doctors. This is a particularly useful tool if a person does not have a family or friend whom they could nominate as their MEPOA.
- Legally appointed MEPOAs can also refuse treatment on a person’s behalf and this must be documented on a Refusal of Treatment Certificate (Schedule 3). If a Schedule 1 or 3 is completed a copy needs to be placed in the patient’s Medical Record. If a patient or an agent wants to cancel a certificate, this must be stated to a doctor or another person and the certificate should then be destroyed.
- The Act protects medical practitioners who act in good faith and in accordance with the patients express wishes.

Information

For more information please contact Office of the Public Advocate on:

Phone: 1300 309 337
(24 hour Emergency Service)

Fax: 1300 787 510

www.publicadvocate.vic.gov.au





Resources



Resources

Useful references to use in conjunction with these guidelines are State and Commonwealth standards as well as:

- 1. Therapeutic Guidelines**
Palliative Care, Version 3
www.tg.org.au
- 2. CareSearch**
(Palliative Care Knowledge Network)
CareSearch is an online resource of palliative care information and evidence:
www.caresearch.com.au
- 3. Palliative Care Australia**
Palliative Care Australia is the peak national organisation representing the interests and aspirations of all who share the ideal of quality care at the end of life for all:
www.palliativecare.org.au
- 4. Palliative Care Victoria**
Palliative Care Victoria Inc (PCV) is the peak body representing palliative care providers, consumers and their families and those with an interest in palliative care in Victoria:
www.pallcarevic.asn.au
- 5. Grampians Region Palliative Care Consortium**
Grampians Region Palliative Care Consortium is an alliance between all the services in the Grampians Region that provide direct palliative care services:
www.grampianspalliativecare.com.au
- 6. Grampians Regional Palliative Care Team**
works closely with the Palliative Care Service Providers across the region to assist with ongoing development and delivery of effective palliative care services:
www.grampianspalliativecare.com.au
- 7. EPERC**
End of Life Palliative Education Resource Centre
The purpose of EPERC is to share educational resource material among the community of health professional educators involved in palliative care education:
www.eperc.mcw.edu

Drug List

DRUG NAME	MOST COMMON BRAND NAME
Benzydamine + Chlorhexidine solution	Difflam-C Anti inflammatory, antiseptic solution
Choline Salicylate Gel	Bonjela
Clonazepam	Rivotril, Paxam - 0.5mg, 2mg Tabs, Rivotril oral drops 2.5mg/ml
Codeine linctus	Actacode 5 mg/ml David Craig Codeine Linctus Gold Cross Codeine Linctus
Cyclizine	Marazine – not marketed in Aust
Dexamethasone	Dexamethsone - 0.5mg , 4 mg Tab
Dextromethorphan Single ingredient (Others have a combination of ingredients.)	3mg/ml mixtures Robitussin Dx Dry Cough Forte Benadryl for the family, Dry Forte 2mg/ml Bisolvon Dry oral liquid Strepsil cough relief lozenge 5 mg

DRUG NAME	MOST COMMON BRAND NAME
Diazepam	Valium, Antenex, Ducene 2 mg, 5mg Tab 5 mg/ml, 2ml Inj , Diazepam elixir 1mg/ml
Domperidone	Motilium – 10 mg Tab
Glyceryl trinitrate	Anginine - 600mcg Tab Nitrolingual spray - 400 mcg
Glycopyrrolate	Robinul – 0.2 mg/ml Inj.
Haloperidol	Serenace – 0.5, 1.5, 5mg Tabs 2mg/ml oral solution / 5mg/ml Amps
Hyoscine hydrobromide	Travacalm HO – 0.3mg Tabs, Kwells - 0.3mg Tabs
Hyoscine butylbromide	Buscopan – 10 mg Tab, 20mg/ml injection
Ketamine	Ketalar – 100mg/1ml Amp
Lignocaine viscous	Xylocaine – 2% viscous (oral liquid)
Metoclopramide	Maxolon – 10mg Tab, 10mg/2ml Amps
Methadone	Physeptone – 10 mg tab – 10 mg/mg injection, methadone oral syrup 5mg/ml 200ml
Midazolam	Hypnovel – 5 mg/5ml, 5mg/ml, 15mg/3ml, 50mg/10ml Injection
Morphine sulphate	Kapanol – long acting capsules – 10mg, 20mg, 50mg, 100mg MS Contin – short acting tabs 5,10,15,30,60, 100 & 200 mg Ordine, Mixture Oral – 1, 2,5,10 mg/ml Morphine Sulphate injection – 5, 10, 15, 30 mg/ml All used frequently dependent on situation
Nifedipine	Adalat , Adefin – 10mg , 20mg Tab Adalat Oros CR 20,30, 60mg Tab
NSAIDs	
Ibuprofen	Nurofen 200 mg *
	Brufen 400 mg *
Diclofenac	Voltaren / Fenac *
Indomethacin	Indocid / Arthrexin
Naproxen	Naprosyn / Inza Proxyn SR
Piroxicam	Feldene / Mobilis
Celecoxib	Celebrex *
Meloxicam	Mobic / Movalis
	* most common
Olanzapine	Zyprexa 2.5, 5, 7.5, 10mg Tab. 5, 10mg Wafer
Ondansetron	Zofran – 4 mg/8mg Tab
Pholcodine	3 mg/ml Duro-tuss Dry Cough Liquid Forte 1 mg/ml Duro-tuss Dry Linctus Tussinol Gold Cross Pholcodine Linctus

Please note: this is not a comprehensive list.



Grampians Region Palliative Care Consortium
Referral Pathway

Grampians Region Palliative Care Consortium

Referral Pathway



Grampians Region Palliative Care Consortium - Referral Pathway

Referral from Family, Friends, GP's, Community Health, DNS, RACF, Acute/Sub-Acute wards, Allied Health, Medical Specialists, Other Health providers ie MS Society, MND

Referrals received via a VSRF, SCTT or RIMS Referral Tool to appropriate Local Service Provider

Djerriwarrh Palliative Care

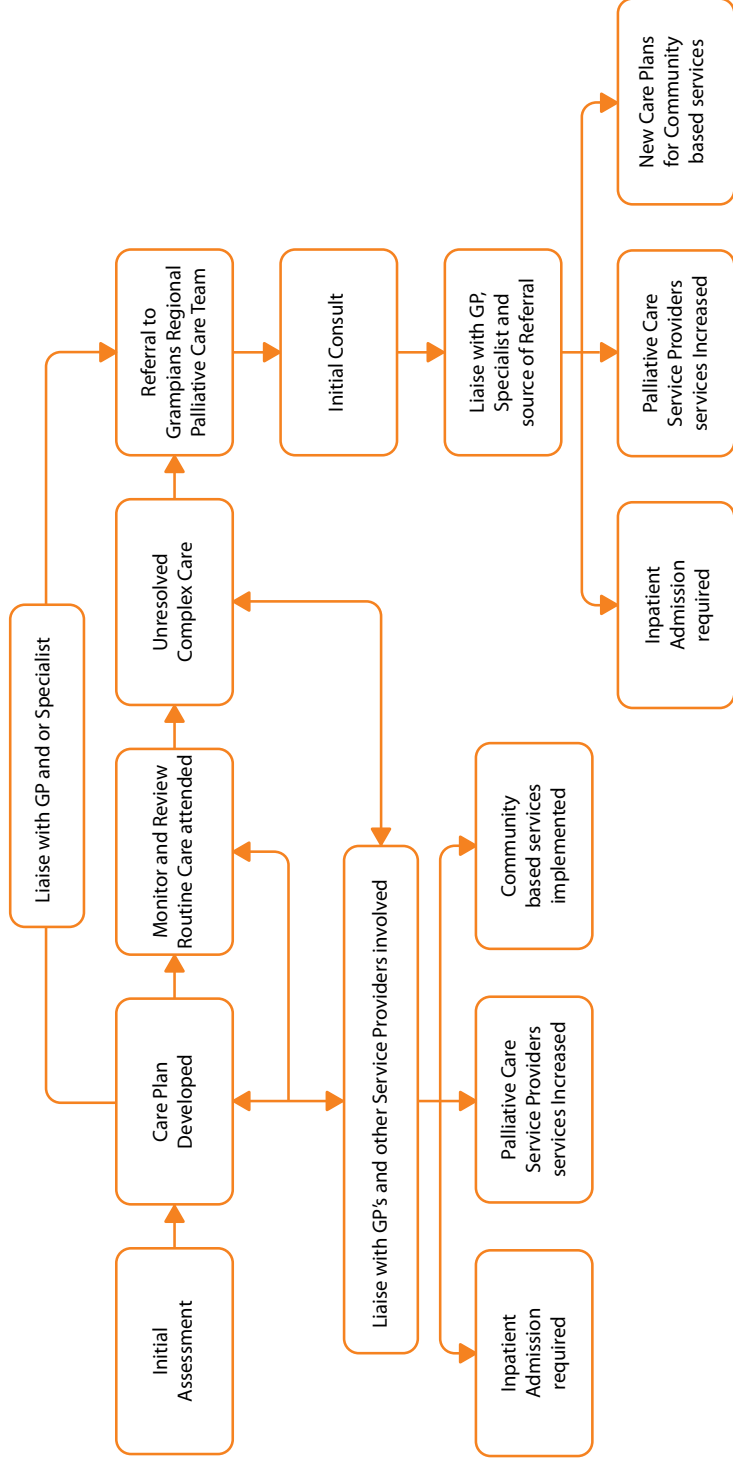
Ballarat Hospice Care Inc

Grampians Regional Palliative Care Team Ballarat Health Services

St John of God Hospital

Central Grampians Palliative Care

Wimmera Hospice Care



Palliative Care Information

Palliative Care Services located within Grampians Region:

Referrals to Community Services are required on RIMS/SCOTT/VSRF via electronic or fax. Referrals will only be processed during normal business hours.

Ballarat Hospice Care

312 Drummond Street South, Ballarat 3350
P O Box 96, Ballarat 3353
Ph: 03 5333 1118
Fx: 03 5333 1119
Em: eo@ballarathospice.com
Wb: www.ballarathospice.com

Central Grampians Palliative Care

Girdlestone Street, Ararat 3377
P O Box 155, Ararat 3377
Ph: 03 5352 9465
Fx: 03 5352 9319
Em: cgpc@eghs.net.au
Wb: www.eghs.net.au

Djerriwarrh Health Services and Palliative Care

Grant Street, Bacchus Marsh 3340
P O Box 330, Bacchus Marsh 3340
Ph: 03 5367 2000
Fx: 03 5367 9641
Em: pamr@djhs.org.au
Wb: www.meltonhealth.com.au

Gandarra Palliative Care Unit

Ballarat Health Services (Queen Elizabeth Centre)
102 Ascot Street South, Ballarat 3350
Ph: 03 5320 3895
Fx: 03 5320 3763
Wb: www.bhs.org.au

Grampians Regional Palliative Care Team

Palliative Care Physicians:

Dr David Brumley and Dr Greg Mewett
Ballarat Health Services (Queen Elizabeth Centre)
102 Ascot Street South, Ballarat 3350
Ph: 03 5320 3553
Fx: 03 5320 6493
Em: info@grampianspalliativecare.com.au
Wb: www.grampianspalliativecare.com.au

Grampians Region Palliative Care Consortium

The Grampians Region Palliative Care Consortium has a role in the strategic direction for palliative care within the region. It is made up of all the specialist palliative care services (inpatient and community) in the Grampians Region. The aim of the consortium is strategic planning in palliative care which includes advocacy, education, research, quality, special projects, clinical issues and improvement in practice.

Ph: 0428 737 330
Em: gpalcareconsort@gmail.com
Wb: www.grampianspalliativecare.com.au

St John of God Healthcare

101 Drummond Street North, Ballarat 3350
Ph: 03 5320 2130
Fx: 03 5320 2832
Em: joanne.howard@sjog.org.au
Wb: www.sjog.org.au

Wimmera Hospice Care

Baillie Street, Horsham 3400
Ph: 03 5381 9363
Fx: 03 5381 9170
Em: hospice@whcg.org.au
Wb: www.wimmerahealth.com

