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Grampians Regional Palliative Care Team

PILOT OF A PALLIATIVE CARE ORIENTATION PROGRAM FOR OVERSEAS TRAINED NURSES IN THE WIMMERA

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There have been an increasing number of overseas trained nurses migrating to the rural region of the Wimmera in western Victoria. These nurses working in Aged and Acute Care had no or minimal experience in palliative care and were not familiar with symptom management or opioids.

In 2012, Wimmera Hospice Care received a Rural Health Continuing Education Stream 2 (RHCE 2) program grant from National Rural Health Alliance (funded by the Department of Health and Ageing) to deliver a palliative care orientation program for overseas trained nurses.

There were three key learning objectives:

1. Cultural awareness of death and dying in Australia and the Wimmera;
2. Palliative Care Symptom management; and
3. Supports available to deliver palliative care in the Region

There were two parts:

1. A self-directed learning package and orientation manual which included Palliative Care Victoria podcasts.
2. Participation in the Cancer Council of Victoria Workshop 'Responding to Emotional Cues' (Conducted by the Grampians Regional Palliative Care Team).

Participants came from 3 Health Services (5 campuses) and were Registered Nurses working in Aged Care and Acute Care. 35 participants received a self-directed learning package. Of these, 29 attended a workshop.

Participants were surveyed pre and post completion of the program. The surveys also included a validated tool[1] to assess attitudes towards the end of life and confidence in palliative care knowledge and skills. Overall, there was a positive response and an increase in confidence.

Some of the participant's comments included; "The program was really great. Wonderful acting and the role play really improved one's perception" "I would like to attend more programs like this" and "I gained more practical knowledge about dealing with palliative care patients. I was able to get rid of some of my misconceptions in Australian Nursing practice."

This program has improved cultural awareness of death and dying in Australia for overseas trained nurses. Nurses, their Clinical Educators and Managers reported this program was extremely/highly relevant and useful for their practice. Ongoing delivery and expansion of the program with other palliative care services is currently being investigated.

Further Acknowledgements: Jennifer Noonan, Bronwen Clayton and Sharyn Meyer (Wimmera Hospice Care Registered Nurses), Jade Odgers and Regina Kendall (Grampians Regional Palliative Care Team), National Rural Health Alliance, Department of Health and Ageing, Wimmera Health Care Group, West Wimmera Health Services, Rural North West Health.

[1] Bradley, EH, Cicchetti et al (2000) 'Attitudes about care at the end of life among clinicians: A Quick, Reliable, and Valid Assessment Instrument' in *Journal of Palliative Care 1*6(1);

MEDICATIONS – EASY TO START, HARD TO STOP

In a recent letter to the Medical Journal of Australia, Dr Ross Cruickshank explains a recent study he and others made of the drug sheets of patients over the age of 65 who were admitted to and died in the palliative care unit at Redcliffe Hospital in Brisbane[i]. Twenty-one of fifty consecutive patients were taking more than nine medications on admission. These patients lived a median time of just seven days after admission to the unit.

This letter struck me as important, because it is also my experience that patients with advanced disease suffer from tablet overload, that this is wasteful and potentially a cause of many problems in itself. As doctors we are good at starting drugs, and bad at stopping them. Could this represent an unwillingness to accept the reality of dying, or it is just that we're a bit lazy in our management of these details of care?

My impression is that there are a few frequent flier drug therapies that are not stopped when they should be. Anti-cholesterol drugs for example. A moment's reflection is enough to realize that for the cachectic person with little food intake and weeks to live, continuing to take these drugs is plain silly, and perhaps toxic if there is significant liver impairment. I also often see people admitted with dehydration caused by poor fluid intake and still taking their diuretic every morning!

What to do? Dr Cruickshank suggests vigilance and the need for one doctor to be responsible. These are both sensible suggestions, but given the level of waste and the likelihood of patient injury, I think it is necessary to take some further steps and make medication review a part of routine palliative care practice. In some situations it already is - for example the Liverpool Care Pathway requires such review – but some more research and assessment of the morbidities associated with this problem is in order.

Thanks, Ross, for bringing this to the notice of the wider medical community.

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SEP/OCT 2013

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[i] Cruickshank RP, Stafford B, Jones L Med J Aust 2013; 199 (1) 29