



# WA Country Health Service Going Home to Country



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August 2024



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**ACKNOWLEDGEMENT TO COUNTRY**





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The following presentation is of sensitive topics and we may refer to people that have passed.

If you feel you need to leave anytime during the presentation, please do so.

If you would like to chat with staff, we are available after the presentation.

**DISCLAIMER**





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# Caring@home Resource



[caring@home website.](http://caring@home website)

HEALTHIER COUNTRY COMMUNITIES THROUGH PARTNERSHIPS AND INNOVATION  
COMMUNITY | COMPASSION | QUALITY | INTEGRITY | JUSTICE





# WHAT IS IPEPA?

- ⦿ IPEPA is a grassroots approach to breaking down the barriers to palliative care for Aboriginal and Torres Strait Islander peoples across Australia.
- ⦿ Informed by community, for community, the *Indigenous Program of Experience in the Palliative Approach* (IPEPA) is **embedding Australian Indigenous knowledges** across all PEPA resources and **facilitating two-way learning**



# Palliative Care

Palliative care helps people with any life-limiting or terminal illness to live their life as comfortably as possible.

Palliative care identifies and treats symptoms which may be physical, emotional, spiritual or social.

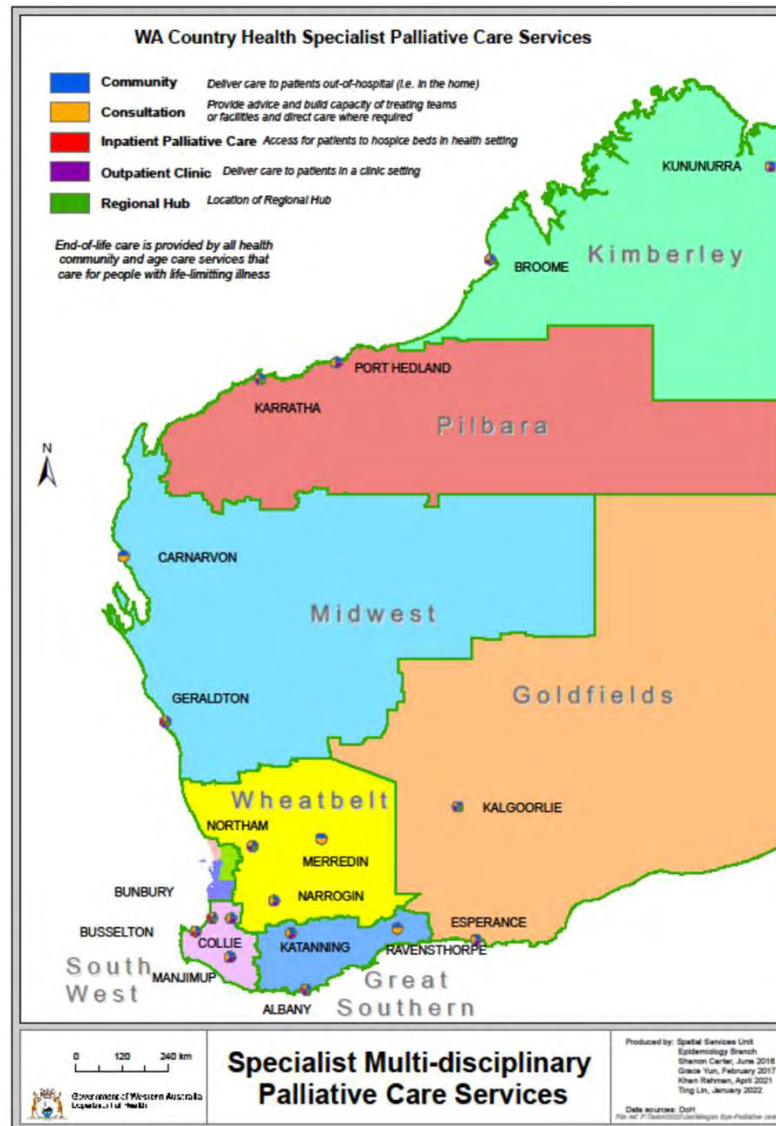
It also provides practical and emotional support to family and carers.





# WACHS Hubs

- Community Service
- Consultation
- Multidisciplinary
- PaICATS
- Packages





# Team Members

## Nurse Led Service

- The main team members are the patient and family
- Aboriginal Health Liaison Officer (AHLO)
- Nurses
- Doctors
- Social Worker
- Admin
- Pharmacist
- Allied Health
- Personal Care Assistant







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# South West Palliative Care



- Project Overview
- Consent
- Outreach



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# Limited Resource



Department of Health WA  
Department of Health

**Advance care planning**  
Planning for your health care

Here we are caring for a really sick one who can't be fixed or might be dying. This is for when the medical boss (maybe a doctor or a nurse) says, 'Oh, that person can't make it now. Their family may say - "We are keeping them" and ask for them back.' We go and look after this one. Then they sit down and talk it through.  
Artist: Wendy Ways  
Thank you to the Yarnan Women's Art Project.

Department of Health WA  
(Advance Care Planning Information Line)  
General queries and to order free advance care planning resources.  
Phone: 9222 2300  
Email: [ACP@health.wa.gov.au](mailto:ACP@health.wa.gov.au)  
Website: [healthy.wa.gov.au/advancecareplanning](http://healthy.wa.gov.au/advancecareplanning)

\* An Enduring Power of Guardianship form enables the appointment of an enduring guardian. An enduring guardian is someone who can make personal, lifestyle and treatment decisions for you, when you no longer can.  
† An Enduring Power of Attorney form enables the appointment of an enduring attorney. An enduring attorney is someone who can make financial and property decisions for you.

This document can be made available in alternative format on request for a person with disability.

Produced by End-of-Life Care Program  
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Interpreting service – please ask for an interpreter if you need help to speak to a health service in your language.

health.wa.gov.au



**Advance care planning**

What is advance care planning?  
Advance care planning is about planning for your future health care. An Advance Health Directive is for people 18 years and above but advance care planning can be for anyone. This 3 step process will help you decide what to ask, who to ask and how to put your plan into action.

**1. Ask**



Ask about:

- your health care options
- what can happen down the track
- where to go for more help
- who you can yarn with.

**Remember**  
You can ask for an interpreter, if needed.

**2. Yarn**



You can talk with anyone:

- loved ones, family, friends, work mates
- doctor or nurse or anyone you see about your health
- spiritual leader or adviser
- community support network
- enduring guardian\* (if you have appointed one).

\* An enduring guardian is someone who you can appoint to make personal, lifestyle and treatment decisions for you, when you no longer can.

**3. Do**



You can:

- tell others about what is important to you
- keep the conversations going
- put it in writing:
  - Advance Health Directive
  - Values and Preferences Form: Planning for your future care
  - Enduring Power of Guardianship\*
  - Enduring Power of Attorney†
  - Will.

You can update this as you go along.

health.wa.gov.au





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# Pilbara Region



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# Community Consultation

- Project Overview
- Consent
- Outreach



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# Community Education Sessions



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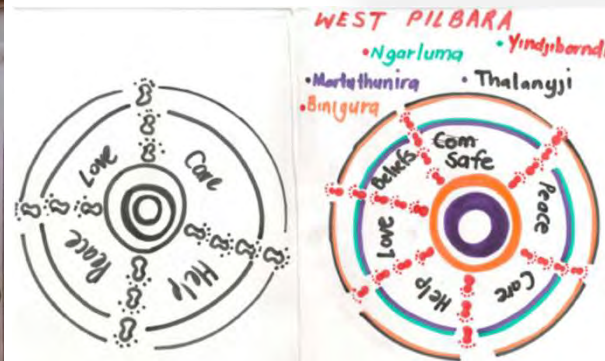
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# Working Group



We can support you when **Page 2+3**  
**PAGE 3**

"Living well with your illness"

Palliative Care is about:

- Beliefs - church, spiritual guide,
- Safe -
- Peace -
- Care - Medical - symptoms
- help -
- connect



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# ACP, Values and Preference form



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# Artist Competition



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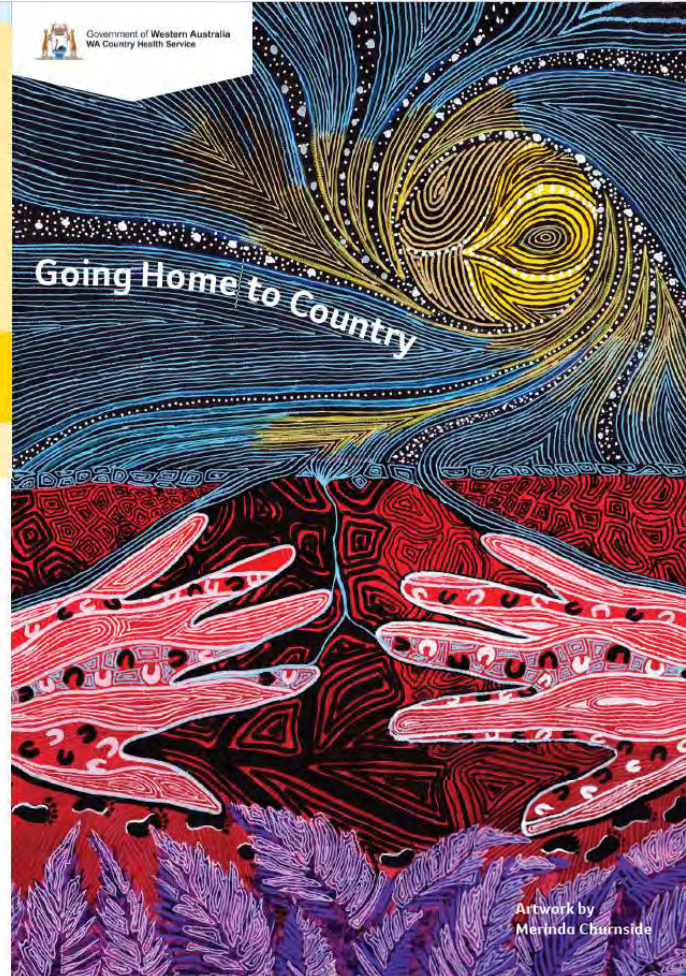
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# Pilbara Palliative Care Brochure



## Palliative Care Services in the Pilbara

**Pilbara Palliative Care**  
WA Country Health Service  
Karratha Health Campus  
62 Balmoral Rd  
KARRATHA WA 6714  
www.wacountry.health.wa.gov.au  
WACHS-Pilbara.PalliativeCare@health.wa.gov.au  
(08) 9144 7952



Artwork by  
Merinda Churnside



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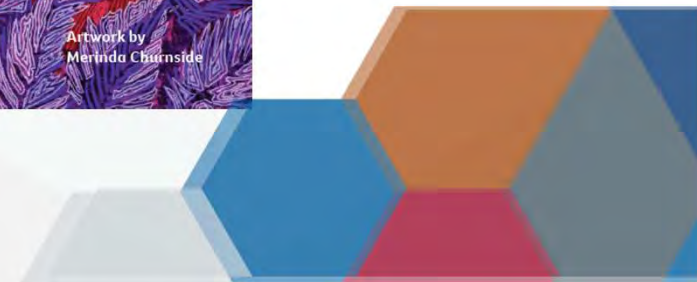


Pilbara Working Group



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COMMUNITY | COMPASSION | QUALITY | INTEGRITY | EQUITY | CURIOSITY





# Inside Brochure



## Living well with your illness

We can support you when your illness can't be fixed by keeping you most settled how you want.

We will help with what matters most to you, mob and carer's.

**Mob are here to help support you through this, it's free and anyone can access it.**

We help with:

**Physical** - Medicines and pain

**Spiritual** - Country and belief's

**Culture** - Values and ways

**Emotional** - Kids and family

**Social** - Money worries and home worries

## Palliative Care is about

### Support Services

Phone, Telehealth, home visits, rest or breaks, caring@home box

### Physical Needs

Nursing, medical and social work team, beds, equipment, moving around, teaching family to care, special support packages



### Journey Planning

Legal papers (AHD, EPA, EPG) End wishes, order and instructions, funeral plans

### Spiritual Support for Mob

Safe space to yarn, advocacy, cultural support, religious support, traditional foods, bush medicines, smoking ceremony, traditional healers



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# Launch Evening



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# Community Outcomes

- Relationships
- Community Discussions
- Referrals
- Education workshops
- Connecting with Metro services
- Advance Care planning, Values and Preferences





# Returning Home

- Patient Choices
- Where
- Coming home





## Where To Next

- Kimberley's
- Midwest
- Great Southern
- Goldfields
- Wheatbelt





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# Any Questions?



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# Palliative Care Resources



**PEPA** Program of Experience in the Palliative Approach

**PEPA** Indigenous Program of Experience in the Palliative Approach

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**caring  
@home**



Symptom management resources for palliative patients



**PalliativeCare**  
WESTERN AUSTRALIA

**caring@home resources for Aboriginal and Torres Strait Islander families**

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**Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)**

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

**Does this person have signs of poor or worsening health?**

- Unplanned (emergency) admission(s) to hospital.
- General health is poor or getting worse; the person never quite recovers from being more unwell. (This can mean the person is less able to manage and often stays in bed or in a chair for more than half the day)
- Needs help from others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Has lost a noticeable amount of weight over the last few months; or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

**Does this person have any of these health problems?**

Cancer	Heart or circulation problems	Kidney problems
Less able to manage usual activities and getting worse.	Heart failure or has had attacks of chest pain. Short of breath when resting, moving or walking a few steps.	Kidneys are failing and general health is getting poorer.
Not well enough for cancer treatment or treatment is to help with symptoms.	Very poor circulation in the legs: surgery is not possible.	Stopping kidney dialysis or choosing supportive care instead of starting dialysis.
<b>Dementia/ frailty</b>	<b>Lung problems</b>	<b>Liver problems</b>
Unable to dress, walk or eat without help.	Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best.	Worsening liver problems in the past year with complications like: <ul style="list-style-type: none"> <li>• fluid building up in the belly</li> <li>• being confused at times</li> <li>• kidneys not working well</li> <li>• infections</li> <li>• bleeding from the gut</li> </ul>
Eating and drinking less; difficulty with swallowing.	Needs to use oxygen for most of the day and night.	A liver transplant is not possible.
Has lost control of bladder and bowel.	Has needed treatment with a breathing machine in the hospital.	
Not able to communicate by speaking; not responding much to other people.	<b>Other conditions</b>	
Frequent falls; fractured hip.	People who are less well and may die from other health problems or complications. There is no treatment available or it will not work well.	
Frequent infections; pneumonia.	<b>Nervous system problems</b> (eg Parkinson's, MS, stroke, motor neurone disease)	
	Physical and mental health are getting worse.	<b>What we can do to help this person and their family.</b>
	More problems with speaking and communicating; swallowing is getting worse.	<ul style="list-style-type: none"> <li>• Start talking with the person and their family about why making plans for care is important.</li> <li>• Ask for help and advice from a nurse, doctor or other professional who can assess the person and their family and help plan care.</li> <li>• We can look at the person's medicines and other treatments to make sure we are giving them the best care or get advice from a specialist if problems are complicated or hard to manage.</li> <li>• We need to plan early if the person might not be able to decide things in the future.</li> <li>• We make a record of the care plan and share it with people who need to see it.</li> </ul>
	Chest infections or pneumonia; breathing problems.	
	Severe stroke with loss of movement and ongoing disability.	

Please register on the SPICT website: [www.spsict.org.au/](https://www.spsict.org.au/) for information and updates.  
SPICT-4ALL™ - June 2017