PETER MACCALLUM CANCER CENTRE

PALLIATIVE CARE NURSE PRACTITIONER

MODEL OF CARE SUMMARY 2009

Deliverables 1 & 2

Report to
Nurse Policy Branch
Department of Health

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- The Nurses Board of Victoria
- The Australian Nursing Midwifery Council
- The Department of Health
- The Advancing Nursing Practice Committee
- The Department of Pain & Palliative Care
Deliverable 1: Description of the nurse practitioner in palliative care model

PETER MACCALLUM CANCER CENTRE: SETTING AND CONTEXT

PETER MACCALLUM CANCER CENTRE

Peter MacCallum Cancer Centre (Peter Mac) is a world leader in cancer treatment, research and education. Currently the largest independent comprehensive cancer treatment centre in Australia with five sites in metropolitan Melbourne and regional Victoria; Peter Mac provides services to patients residing across Victoria, Australia and travelling from overseas. The main campus in East Melbourne provides care and treatment for the majority of complex cases in addition to housing the research laboratories. Satellite campuses include Bendigo, Box Hill, Moorabbin and Richmond with many clinicians working from more than one location. All of our sites offer state of the art radiation therapy which allows many of our patient’s access to treatment closer to their homes. In January 2009, the first sod was turned to mark the start of construction on a sixth location for Peter Mac in Sunshine. This site will bring much needed radiotherapy services to the western suburbs of Melbourne from late 2011. More than 23% of new patient registrations to Peter Mac were from rural and regional areas. The Nursing Service at Peter Mac has long been committed to advancing cancer and palliative care nursing practice based on the best evidence available for the benefit of patients and their carer’s. The development, implementation and evaluation of Nurse Practitioner roles are a key to achieving best possible outcomes for patients.

PALLIATIVE CARE

"Palliative care is specialised health care and practical support for people living with a terminal illness. It is provided in the home, aged care or other residential care facility and hospital or hospice settings. Experienced staff provides expert pain and symptom management as part of any ongoing treatment as well as other practical support services for the individual and their families. Palliative care is an adjunct to ongoing treatment and can be delivered from diagnosis to bereavement.” (Palliative Care Victoria, 2009

THE DEPARTMENT OF PAIN AND PALLIATIVE CARE

The Department of Pain and Palliative Care (DPPC) delivers expert psychosocial care, specialist cancer pain and complex symptom management to patients attending Peter Mac. The DPPC also provides specialist consultation to adolescents and young adults, including working with the onTrac@petermac program. In keeping with its state-wide role, the DPPC conducts a monthly outpatient clinic at Mildura (Appendix 1). In addition, the team provides specialist consultation to multidisciplinary health care professionals in Peter Mac and across Victoria; for example, in 2008-09, the DPPC had multiple contact with 27 external community-based palliative care providers.
The DPPC is a multidisciplinary team functioning in close collaboration with medical oncologists, radiation oncologists, surgeons, nurses and allied health professionals across all tumour streams. The DPPC recognise that symptoms, both physical and emotional, are present at any and all stages of the illness. For this reason, the team advocates and promotes palliation, the relief of symptoms, to be available as necessary to patients from the time of diagnosis through to recovery or death. The DPPC is committed to the delivery of quality care throughout an individual’s illness and that irrespective of setting, strive to deliver coordinated, timely and individualised care for all patients referred to the service.

UNDERSTANDING THE JOURNEY FOR PATIENTS CURRENTLY REFERRED TO THE DPPC

An overview of the current model of care for patients referred to the DPPC is outlined in appendix II. Triaging of patient referrals to the DPPC occurs according to urgency. In the outpatient department, the majority of referrals are conducted by a palliative care registrar in collaboration with a palliative care Clinical Nurse Consultant (PCCNC). Patients referred for review with complex or unstable problems are assessed jointly by the PCCNC and a registrar. However, patients who require assessment of their needs yet are unlikely to need major adjustments to their treatment plan, may be reviewed by the PCCNC alone.

At presentation the PCCNC undertakes a comprehensive assessment using validated tools including (appendix III):

- The Symptom Assessment Score (SAS)
- Edmonton Classification System of Cancer Pain (ECSCP) Palliative Prognostic Score (Pap) and
- The Palliative Care Phase

IDENTIFYING OPPORTUNITIES FOR ENHANCING PATIENT OUTCOMES

As demand for service provision from the DPPC increases (outpatient referrals have increased from 30% of all new referrals to Peter Mac in 2006-7 to 46% in 2008-9), it is becoming increasingly difficult for the current service model to meet patient need for individualised, co-ordinated care, in a timely manner. In 2009, Peter Mac was successful in obtaining a grant in Phase 4 of the DHS VNPP to develop a proposed model and implementation of the NP role in palliative care. This model has been developed under the auspice of the Advancing Nursing Practice Committee (ANPC) at Peter Mac and in collaboration with the relevant stakeholders. The ANPC has oversight of the progress of the Peter Mac nursing service model for advancing nursing practice across the whole of nursing workforce at Peter Mac, within which the development of the Nurse Practitioner role sits and reports to Peter Mac Executive.
The Peter Mac Executive has considered the merits of introducing a PCNP in the context of the Peter Mac *Advancing Nursing Practice: Specialist and Advanced Practice Roles at Peter MacCallum Cancer Centre* (2007), *Peter MacCallum Cancer Centre Nurse Practitioner Strategic Framework* (2009), organisational and local government strategic plans; and the review of the existing service delivery model conducted through stakeholder consultation, literature review, and utilising extensive patient and service data already collected by the DPPC.

The opportunities for enhanced service delivery and patient outcomes were identified as:

- **The median length of time between first contact and death or discharge has increased due to improved survival in palliative phase and better service integration between palliative care and treating teams**
  
  Median time an individual may remain under the care of the DPPC time has increased from 74 days to 90 days over the past 2 years. This results in additional consultations by the members of the DPPC and increasingly, patients have ongoing involvement with the service that extends beyond the time span of rotational registrars. These issues impact on the DPPC’s ability to deliver a consistent and coordinated service to all patients.

- **The potential for a more streamlined approach to outpatient review and onward referral for patients with complex needs**
  
  The majority of patients referred to the DPPC are from oncology outpatient clinics. Whilst there are 300 new outpatient referrals per year, these do not occur in an even distribution. On a regular basis there have been around five new outpatient referrals per week in addition to six to 12 outpatient review contacts per day.

- **Response times to requests for advice and consultation**
  
  In the ambulatory care setting, response times vary between 10 minutes and three hours, restricting optimal interface for patients between acute and palliative care services.

- **Patients referred to the DPPC commonly have multiple health care needs with many professionals involved in their care.**
  
  Ensuring continuity of care through effective liaison is therefore problematic. This includes the rotation of registrars. The introduction of a clinical expert with dedicated responsibility for expert review and continuity of care would make a considerable contribution to sustaining the quality and safety of care provided.

- **Improve access to care for patients from rural and regional areas**
  
  Many patients attending out patients are from rural and regional areas. There is significant benefit for these patients to be reviewed by a palliative care specialist at their oncology outpatient appointment rather than having to attend the dedicated palliative care clinic in addition to the oncology clinics.
Peter Mac Executive recognises the benefits of introducing a Palliative Care Nurse Practitioner (PCNP) into the DPPC. Peter Mac fully supports the appointment of a PCNP to improve access to services within ambulatory care settings for patients requiring specialist pain and palliative care services. The recruitment of a Nurse Practitioner Candidate is currently underway.

**PROPOSED MODEL OF PRACTICE**

The focus of the PCNP role will be to provide specialist palliative care either directly or indirectly to patients incorporating extensions to the existing CNC scope practice. The role will aim to reduce the gaps in the following areas (aims) whilst further gaps identified above will be addressed by the wider DPPC. The aims of the role are:

- To provide a rapid response to patients presenting in ambulatory settings with specialist pain and palliative care needs
- To improve liaison and integration between Peter Mac and external care providers to optimise continuity and coordination of patient care
- To provide specialist nursing expertise to inpatients when required or when prior involvement with those patients in the ambulatory setting

The benefits of a PCNP include:

- A permanent nurse practitioner position has a high level of organisational awareness and can respond consistently to a high standard
- The introduction of PCNP to the outpatient DPPC team will develop greater capacity to assess, review and initiate treatment for patients in a timely manner within the range of the NP scope of practice.

It is proposed that the PCNP service will be available from 8.30 to 1700 hrs Monday to Friday. The focus of the role is to be the East Melbourne ambulatory service however, the PCNP will function across inpatient and outpatient settings as necessary to maintain continuity with a further aim to develop the role in other areas as the service requires. Telephone support to satellite centres will be offered with plans for a possible future role at Mildura based satellite clinic following endorsement as a NP.

Core components of the proposed PCNP service include:

- Advanced, independent triage and assessment skills with associated referral and admission rights within Peter Mac
- Advanced independent diagnosis, planning implementation and evaluation of patient problems and needs
- Initiation of diagnostic tests, treatment and prescription within endorsed scope of practice

To support optimal referral to the PCNP service, referral criteria is adapted from current palliative care assessment tools. This will also facilitate onward referrals from the PCNP service to other relevant tumour streams within Peter Mac and with
external service providers. The PCNP will assess, diagnose, plan, implement and evaluate patients independently. In the presence of a deteriorating, unstable phase and complex needs; the PCNP would respond by referral of patients to the palliative care medical team. Phase definition would be defined according to the Palliative Care phases (see appendix III). Complexity would be defined by patients with neuropathic pain, incidental pain, as well as the presence of psychological distress or addiction in their ECS CP profile. Patients that present with any of these factors will require the PCNP to consult palliative care medical staff in the establishment of a management plan. Complexity would also be identified by patients who require interventions, investigations and or treatment that are outside the identified scope of practice. Should the patient move to an unstable phase whilst under the care of the PCNP, this would also act as a trigger for referral for medical assessment.

To assist with stakeholder clarification and patient safety in relation to the PCNP initiation of diagnostic tests, treatment and prescriptions; a project is currently underway to support the clarification of the PCNP scope of practice within Peter Mac. For example, prescribing, pathology and imaging will be categorised as available to the PCNP to initiate: ‘at any time’, those that require consultation with responsible medical staff prior to ordering; and those which are outside the PCNP scope of practice.

The refined patient journey post-implementation of the NP role is outlined in appendix IV

Evaluation of the PCNP role is essential to providing evidence that the role is functioning effectively and is relative to the service model in which it is functioning. The evaluation framework will be lead by the service and will include a pre and ongoing evaluation. Timetabling for this is included in the 5 year plan summary.

**CHARACTERISTICS OF NURSE PRACTITIONER CASE LOAD**

The following list identifies the major characteristics required of patients for inclusion in the PCNP case load:

- Palliative Care Prognostic Score group A (Greater than 70% probability of surviving month)
- Unlikely to need medications, investigations or treatments that are outside scope of practice
- Patients where nurse practitioner regularly attends outpatient clinic or clinical stream meeting
- Patients with specialist needs e.g. Adolescent and Young Adult patients

**PROFESSIONAL RELATIONSHIPS TO SUPPORT MODEL OF CARE**

Day to day professional support for the role is demonstrated in the model below, and in more detail below that. Additional support will be identified in specific clinics and
also through the relationship with the identified clinical supervisor. The NP and NP candidate will also be encouraged to attend the NP/candidate special interest group.

1. Palliative Care Medical support
   a. Joint attendance and supervision at twice weekly outpatient clinic
   b. Weekly team meeting and client review
   c. Weekly supervision session with palliative care physician
   d. At least twice daily contact between palliative care nurse practitioner and palliative care registrar
2. Pharmacy
   a. Drug information line accessible during hours of practice
   b. Palliative care pharmacist attendance at outpatient clinic and weekly team meeting
   c. Constant electronic access to drug databases
3. Diagnostic Imaging
   a. Attendance at weekly diagnostic imaging review meeting for palliative care clients
4. Other non palliative care specialist assistance
   a. Attendance at outpatient clinics
   b. Attendance at clinical stream meetings
5. Department of Psycho oncology
   a. Registrar available via pager
   b. Weekly attendance at team meeting
6. Infectious Control
   a. Registrar available via pager
   b. Co located clinic with palliative care on Mondays
7. Advanced Nursing practice support
   a. Nurse practitioner interest group
   b. Department of Nursing research and education
   c. Nurse Practitioner steering committee
**Deliverable 2: Nurse Practitioner service model’s five year plan (summary)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Year 1 2009</th>
</tr>
</thead>
</table>
| Sept to Nov | • Model development, including gap analysis undertaken within service delivery model  
                • KPI's identified                                                       |
| December    | • Model ratified by relevant stakeholders, Nursing Executive                  |

<table>
<thead>
<tr>
<th>Month</th>
<th>Year 2 2010</th>
</tr>
</thead>
</table>
| January     | • Submission of deliverables 1 & 2 to DoH                                    
                • Appointment of NP Candidate                                            
                • Stakeholder engagement                                                |
| July        | • Review/evaluate at six months, measure against: aims and objectives, issues that may/have impact on successful implementation  
                • Report on outcomes                                                   
                • Refine role/model/ in response to current and future patient needs   |
| December    | • Annual review/evaluation                                                   
                • Annual report                                                       |

<table>
<thead>
<tr>
<th>Month</th>
<th>Year 3 2011</th>
</tr>
</thead>
</table>
| July        | • Palliative Care Nurse Practitioner endorsed                                
                • Stakeholder engagement regards endorsement                           |
<p>| Dec         | • Annual review/evaluation                                                   |</p>
<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Dec   | Year 4 2012 | • Annual review/evaluation  
• Annual report  
• Benchmarking state-wide and national                                         |
| Dec   | Year 5 2013 | • Annual review/evaluation  
• Annual report  
• Well established Palliative Care NP recognised as state-wide and national resource |
APPENDIX I

Table 1: Referrals to the DPPC, January-July 2008, Metro vs. Regional

1.1 Region (Metropolitan versus Regional)

<table>
<thead>
<tr>
<th>Region</th>
<th>Metro</th>
<th>Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>METROPOLITAN</td>
<td>68%</td>
<td>29%</td>
</tr>
<tr>
<td>REGIONAL</td>
<td></td>
<td></td>
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<tr>
<td>INTERSTATE</td>
<td>4%</td>
<td></td>
</tr>
</tbody>
</table>

Jan - July: Referrals (Metro vs Regional)

Table 2: Referrals to the DPPC by region, January-July 2008

1.2 Regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>WESTERN METRO</td>
<td></td>
</tr>
<tr>
<td>S E METRO</td>
<td></td>
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<tr>
<td>CENTRAL METRO</td>
<td></td>
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<tr>
<td>EAST METRO</td>
<td></td>
</tr>
<tr>
<td>N W METRO</td>
<td></td>
</tr>
<tr>
<td>GOULBURN</td>
<td></td>
</tr>
<tr>
<td>SOUTH METRO</td>
<td></td>
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<tr>
<td>N E METRO</td>
<td></td>
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<tr>
<td>LODDON</td>
<td></td>
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<tr>
<td>EAST GIPPSLAND</td>
<td></td>
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<tr>
<td>MALLEE</td>
<td></td>
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<tr>
<td>INTERSTATE</td>
<td></td>
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<tr>
<td>W &amp; S GIPPSLAND</td>
<td></td>
</tr>
<tr>
<td>BARWON</td>
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<tr>
<td>CORANGAMITE</td>
<td></td>
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<tr>
<td>CENT HIGHLANDS</td>
<td></td>
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<tr>
<td>WIMMERA</td>
<td></td>
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<tr>
<td>NORTH EAST</td>
<td></td>
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<tr>
<td>GLENELG</td>
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</tbody>
</table>

Jan - July: Referrals by Region
APPENDIX II

Patients journey under the current Department of Pain & Palliative Care model of care
APPENDIX III

Palliative care phases (Box 10.24) [NB]

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/carer 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 requires 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 multidisciplinary 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**
   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 focused 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.


**Edmonton Pain Classification System**

Patients with neuropathic pain, incidental pain, as well as the presence of psychological distress or addiction are factors that define complex pain. Patients that present with any of these factors nurse practitioner will involve palliative care medical staff in establishing pain management plan.

**Mechanism of Pain**

The definition for *mechanism of pain* is as follows:

- No pain syndrome
- Nc Any nociceptive combination of visceral and/or bone or soft tissue pain
- Ne Neuropathic pain syndrome with or without any combination of nociceptive pain
- Nx Insufficient information to classify

**Incident Pain**

Pain can be defined as incident pain when a patient has background pain of no more than moderate intensity with intermittent episodes of moderate to severe pain, usually having a rapid onset and often a known trigger (Panel B, December 2004).

- Io No incident pain
- II Incident pain present
- IX Insufficient information to classify

**Guidelines for Use** (Panel B, December 2004):

There are six key characteristics of *incident pain*, as defined in the ECS:

- *Relationship with background pain*: The intensity of incident pain is significantly greater than background pain.
- *Severity*: The intensity of incident pain is moderate to severe.
- *Predictability*: The trigger is often known, such as movement, defecation, urination, swallowing and dressing change. However, clinically significant episodic pain (i.e. no predictable trigger) can be included (e.g. bladder or bowel spasm).
- *Onset*: Its onset is rapid, with intensity often peaking within 5 minutes.
- *Transiency*: Incident pain is transient, and may return to baseline shortly after the trigger is stopped or removed.
- *Recurrence*: It is intermittent, recurring when the trigger is reinitiated or reapplied.
c Insufficient information to classify due to factors such as questionable/unknown diagnosis, patient’s unwillingness to participate or physical impairments (e.g. aphasia).

**Psychological Distress**
- Po – No psychological distress present
- Pp – Psychological distress present
- Px – Insufficient information to classify c

Psychological distress, within the context of the pain experience, is defined as a patient’s inner state of suffering resulting from physical, psychological, social, spiritual and/or practical factors that may compromise the patient's coping ability and complicate the expression of pain and/or other symptoms (Panel B, December 2004).

**Guidelines for Use** (Panel B, December 2004):
There are five key characteristics of *psychological distress*, as defined in the ECSCP:

- **Relationship with pain:**
The definition of psychological distress is limited to
  - Patients who are experiencing psychological distress within the context of the pain experience and who appear to express their suffering through physical symptoms.
  - **Relationship with suffering:** It is an expression of suffering, often referred to as total pain.
  - **Multidimensional:** It is multidimensional in nature, influencing many spheres of a patient’s experience, including but not necessarily limited to physical, psychological, social, and spiritual factors.
  - **Relationship with coping:** It may impair a patient's ability to cope with his/her illness.
  - **Physical symptom expression:** It is often expressed as an exacerbation of pain and/or other symptoms, which may be conceptualized as a form of somatization.

**Assessment** (Panel B, December 2004):
Assessment of psychological distress may include, but is not necessarily limited to, the following:
- · Assessment of patient’s experience in multidimensional domains
- · Patient's behavioral presentation and symptom reporting profile
- · Collateral history from primary caregivers

**Addictive Behavior**
- Ao Addictive behavior not present
- Aa Addictive behavior present
- Ax Insufficient information to classify c

c Insufficient information to classify due to factors such as questionable/unknown diagnosis, patient’s unwillingness to participate or physical impairments (e.g. aphasia).
Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. (AAPM, APS, ASAM, 2001)

**Guidelines for Use** (Panel B, December 2004):

There are five key characteristics of addictive behavior, as defined in the ECS:

- **Chronicity**: It is a chronic disorder, which may have periods of relapse and remission.
- **Multidimensional**: It is multidimensional in its development and expression, including genetic, psychosocial and environmental factors.
  - compulsivity
  - persistent use despite harm
  - craving

This definition is limited to the following:

- A remote history of prior alcohol/substance use may not be considered relevant as a complicating factor in ongoing pain assessment and management.
- Substances of abuse include alcohol, prescription/non prescription medications, and illicit drugs.
- It does not include chronic tobacco use.

**Assessment** (Panel B, December 2004):

Assessment of addictive behavior may include, but is not necessarily limited to, the following:

- Use of CAGE as screening tool for possible alcohol abuse
- Patient's behavioral presentation over a series of visits
- A strong clinical history of substance abuse provided by patient
- Collateral history from primary caregivers

**Cognitive Function**

The definition for cognitive function is as follows (Panel B, July 2004):

- **Co No impairment**: Patient able to provide accurate present and past pain history unimpaired (normal cognitive function)
- **Ci Partial impairment**: Sufficient impairment to affect patient's ability to provide accurate present and/or past pain history
- **Cu Total impairment**: Patient unresponsive, delirious or demented to the stage of being unable to provide any present and past pain history
- **Cx Insufficient information to classify**: Insufficient information to classify cognitive function due to factors such as questionable/unknown diagnosis, patient's unwillingness to participate or physical impairments (e.g. aphasia)
The Palliative Prognostic Score (PaP)

The Palliative Performance Scale for another prognostic tool used in palliative care patients. The PaP uses the Karnofsky Performance Score (KPS) and five other criteria to generate a numerical score from 0 to 17.5 to predict 30 day survival (higher scores predict shorter survival).

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>ASSESSMENT</th>
<th>PARTIAL SCORE</th>
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<tbody>
<tr>
<td>Dyspnoea</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Anorexia</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1.5</td>
</tr>
<tr>
<td>Karnofsky Performance Status</td>
<td>≥30</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>10 - 20</td>
<td>2.5</td>
</tr>
<tr>
<td>Clinical Prediction of Survival (weeks)</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>11-12</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>7-10</td>
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<td></td>
<td>5-6</td>
<td>4.5</td>
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<tr>
<td></td>
<td>3-4</td>
<td>6</td>
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<tr>
<td></td>
<td>1-2</td>
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<td>Total WBC (x10⁹/L)</td>
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<td>8.6 - 11</td>
<td>0.5</td>
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<tr>
<td></td>
<td>&gt;11</td>
<td>1.5</td>
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<tr>
<td>Lymphocyte Percentage</td>
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<td></td>
<td>12 - 19.9%</td>
<td>1</td>
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<tr>
<td></td>
<td>&lt; 12%</td>
<td>2.5</td>
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<th>RISK GROUP</th>
<th>30 DAY SURVIVAL</th>
<th>TOTAL SCORE</th>
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<tbody>
<tr>
<td>A</td>
<td>&gt;70%</td>
<td>0 - 5.5</td>
</tr>
<tr>
<td>B</td>
<td>30 - 70%</td>
<td>5.6 - 11</td>
</tr>
<tr>
<td>C</td>
<td>&lt; 30%</td>
<td>11.1 - 17.5</td>
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APPENDIX IV

Patient journey for an individual referred to the Department of Pain and Palliative Care under the Palliative Care Nurse Practitioner Model

Referral

Triage

Nurse Practitioner Assessment

Collaboration

Registrar Assessment

Communication with external care providers e.g. Community Based Palliative Care/General Practitioner

Stable

Team Meeting

Unstable, deteriorating and terminal phases

Not returning to Peter Mac

External care agency Follow up

Returning to Peter Mac

Shared Group

Nurse Practitioner Follow up

Collaboration

Medical Follow up

Communication with external care providers e.g. Community Based Palliative Care/General Practitioner

No Follow up Planned

17