Victorian Nurse Practitioner Project
Phase 4, Round 4.9 Chronic Disease Management

Peter MacCallum Cancer Centre
Geriatric Oncology Nurse Practitioner
Proposed Model of Care

Report to
Nurse Policy Branch
Department of Health

Deliverable 1:
Description of the nurse practitioner in chronic disease management care model

Deliverable 2:
Nurse Practitioner Service Model: Five year plan

July 2012

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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACAS</td>
<td>Aged Care Assessment Service</td>
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<tr>
<td>AR-DRG</td>
<td>Australian Refined Diagnostic Related Group</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Group</td>
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<tr>
<td>GONP</td>
<td>Geriatric Oncology Nurse Practitioner</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>Peter Mac</td>
<td>Peter MacCallum Cancer Centre</td>
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<tr>
<td>RACF</td>
<td>Residential Aged Care Facility</td>
</tr>
<tr>
<td>RMH</td>
<td>Royal Melbourne Hospital</td>
</tr>
<tr>
<td>SIOG</td>
<td>International Society of Geriatric Oncology</td>
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<tr>
<td>WCMICS</td>
<td>Western and Central Melbourne Integrated Cancer Service</td>
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Deliverable 1: Summary of Proposed Service Model

1.1 Background
Peter MacCallum Cancer Centre (Peter Mac) is Australia’s only public hospital solely dedicated to cancer and a world leader in cancer treatment, research and education. Peter Mac provides multi-disciplinary services to patients from across Victoria and Australia, as well as overseas. The main campus is in East Melbourne where the majority of people with complex cancers are treated and our research laboratories are located. There are satellite campuses at Bendigo, Box Hill, Moorabbin, Richmond and Sunshine and many of our clinicians work from more than one location. More than 23% of new patient registrations to Peter Mac in 2011 were from rural and regional areas and people above the age of 65 years accounted for approximately 40% of the hospital’s patient population.

1.2 Advanced practice roles at Peter Mac
Nurses at Peter Mac are committed to advancing cancer care nursing practice based on the best evidence available for the benefit of patients and their carer. The development, implementation and evaluation of Nurse Practitioner roles within Peter Mac are recognised as key to achieving best possible outcomes for patients.

1.3 Geriatric oncology
In 2009 the proportion of people aged 65 and over in Victoria was 13.6% and this is expected to increase to 23.1% by 2056. “Population ageing is characterised by an upwards shift in the age structure, with the proportion of younger people declining as the proportion of older people increases.”. Approximately 57% of all new diagnoses of cancer and 73% of cancer deaths in Australia occur in people aged 65 years or older and the ratio of Australians aged over 65 years is set to double to one quarter of the population over the next 35 years. A cancer diagnosis, its treatment and associated toxicities, have a significant impact on older people. International best-practice guidelines indicate that patients over the age of 70 are significantly more at risk of suboptimal health outcomes because of age-related co morbidities or increasing age-related frailty, without appropriate and timely assessment of their needs. The SIOG priorities identify geriatric specific screening and assessment and prompt referral to specialist geriatric or general medicine services as essential to optimising outcomes for elderly people diagnosed with cancer.

1.4 Identifying a need for a geriatric nurse practitioner service at Peter Mac
In December 2011, Peter Mac was awarded a grant through the Department of Health (DoH), Victorian Nurse Practitioner (NP) Project Phase 4, Round 4.9 in Chronic Disease Management, to enable the development of a NP model for geriatric oncology care, spanning specialist cancer and residential aged care/community services.

During 2010-2012, Peter Mac had 2267 new patient registrations aged 70 years and over at the East Melbourne campus alone, accounting for 1219 inpatient admissions. The length of stay ranged from 1 to 162 days with 47 patient admissions recorded as being over the high boundary of their diagnostic related group...
(DRG) as defined by the Department of Health and Ageing Australian Refined Diagnosis Related Groups (AR-DRGs) classification. Patients were registered to the following tumour streams demonstrating the diversity of patient groups falling within the remit of the NP scoping project: Breast Cancer Service, Gastrointestinal Service, Gynaecological Oncology Service, Head & Neck Cancer Service, Haematology Service, Lung Cancer Service, Melanoma & Skin Service, Neuro Oncology Service, Uro Oncology Service, and Victorian Bone & Soft Tissue Service.

The first phase of the DoH project has involved a detailed scoping exercise to identify multidisciplinary and consumer views of gaps in current service provision and opportunities for improvement through the introduction of a NP service. Benefits and challenges of introducing an NP service were also explored and a paper defining these issues is currently in preparation for publication in a peer-reviewed journal. Details of those involved in the scoping exercise are listed in Appendix 1. Key domains of need or service gaps identified are listed in Appendix 2.

The following areas were identified as key gaps in current service provision within Peter Mac and as areas for improved communication and coordination with outside agencies, including GPs, residential aged care facilities and other acute services:

1) Lack of a clinically relevant and sensitive screening tool to promptly identify frail and patients at risk of increasing frailty over the age of 70 years at time of referral to Peter Mac;
2) Lack of a coordinated approach to identification of existing or co-morbid conditions likely to be exacerbated by cancer or its treatments resulting in delayed referral to general medicine consultants, geriatricians, etc;
3) Lack of timely access to ACAS assessments resulting in delayed discharge to homelike or residential aged care facilities;
4) Lack of protocols and information to support care of elderly cancer patients away from the specialist cancer setting;
5) Lack of specialist knowledge (evidence-based protocols and guidelines) to inform the care needs of elderly cancer patients admitted to Peter Mac.

1.5 Scope of practice
This document articulates a model of care responsive to service gaps identified by multidisciplinary health care professionals and consumers undertaken as part of the DoH scoping project.

The NP Service deliverables will include and draw on existing evidence-based tools and resources available through the DoH "Best Care for Older People Everywhere Toolkit".
The focus of the Geriatric Oncology Nurse Practitioner (GONP) Service is to provide specialist aged and co-morbidity management either directly or indirectly to patients. The aims are:

- Comprehensive geriatric assessment of elderly patients who have been identified (following initial screening at Peter Mac) as frail or at risk of increasing frailty as a consequence of their cancer diagnosis and/or its treatment (Appendix 3 and 4)
- To provide a timely response to patients presenting in ambulatory settings with specialist aged care and co-morbid disease management needs
- To develop a care plan tailored to the unique needs of each person, initiating timely referral to and communication with all relevant health care providers, family members and carers (to include residential aged care facility staff (RACF))
- To improve liaison and integration between Peter Mac and external care providers to optimise continuity and coordination of patient care (to include discharge planning in the inpatient setting)

Core components of the proposed GONP service include:

- Advanced triage and assessment skills with associated referral within Peter Mac.
- NP led assessment and diagnosis of age-related patient problems and needs
- Referral for diagnostic tests
- Initiation of management plan and treatment and prescription within endorsed scope of practice and as outlined in the approved NP formulary
- Development and implementation of coordinated discharge planning pathways including prompt referral to multidisciplinary services, to include rehabilitative services.
- Improving access to psycho-oncology services, addressing the SIOG priority recommendation that elderly cancer patients receive psycho-oncology care)
- Contribute to multidisciplinary research that focuses on age related issues specific to the oncology setting
- Contribute to the development of a multidisciplinary educational program to embed geriatric oncology principles across the hospital and (with an additional funding source, contribute to the development of a cancer in the elderly training program for staff working in RACFs across Victoria)
- Contribute to the development of geriatric policies and procedures for Peter Mac, WCMICS and the new comprehensive cancer centre.

1.6 Defining the population for the NP Service

The target group for the NP service will include patients over 70 years, but some flexibility will be applied to the patient demographic to optimise access. The NP service will include the ability to review patients with chronic/complex conditions that may experience escalating health care requirements and subsequent decrease in functional capacity, potentiating inpatient admission if not supported (this definition has been adapted from the Bass Coast Regional Health model scoping project5).

For the purpose of this project “elderly” is defined as aged 70 years and over. The definition is based on a review of national and international literature, the SIOG priorities6, and data retrieved regarding new patients
registered to Peter Mac from January 2010-January 2012. “Frail” and “at risk of increasing frailty” is defined as co-morbidity and decreased physical and mental functioning.

Patients referred to the General Medicine service will be triaged to either the GONP service or for medical review according to pre-defined criteria developed and agreed by the multidisciplinary General Medicine team and broader body of key stakeholders at Peter Mac. Patients referred for GONP follow up will:

- Have stable or deteriorating problems that do not require advanced medical intervention.
- Be unlikely to need medications, investigations or treatments that have a red or yellow traffic light (that is, those that need to be checked with or ordered by a medical practitioner)

The NP will refer patients for medical review when individuals present with unstable, complex problems. Referral criteria will be informed by multidisciplinary consultation and best available evidence. Complexity will also be defined according to “traffic light” criteria (Appendix 6) where patients who have been given a red or amber traffic light will be referred for medical review.

1.7 Professional relationships to support the GONP candidacy and NP model of care

The NP will work in an autonomous advanced practice role within the context of a multidisciplinary team. The key relationship in terms of service structure will be with the General Medicine (GM) Consultant

1. General Medical support/Geriatrician
   a. Joint attendance and supervision at weekly outpatient clinic
   b. Joint attendance 3 times per week ward round
   c. Weekly supervision session with GM physician
   d. At least daily contact between GONP and GM registrars

2. Pharmacy
   a. Drug information line accessible during hours of practice
   b. Constant electronic access to drug databases

3. Department of Pain and Palliative Care
   a. Weekly meeting to discuss referral

4. Other 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. Infection Control
   a. Registrar available via pager
   b. Attendance at ward round

7. Advanced Nursing practice support
   a. Nurse practitioner interest group
b. Department of Cancer Experiences Research and

c. Department of Education

d. Nurse Practitioner steering committee

8. Inpatient Wards

   a. Referrals re: delirium, multiple falls, multiple co-morbidities

9. Allied Health

   a. Weekly meeting to discuss patient with complex discharge needs, ACAS referrals

1.8 Governance and accountability

The NP will report through the clinical structures determined by the organisation. A strategic framework document has been developed and endorsed by the Nursing Executive at Peter Mac where issues of governance and accountability are detailed. A steering committee (involving internal and external stakeholders) will be established to oversee the development and implementation of the NP service.

1.9 Location and service hours

The NP Service will be based at the Peter Mac East Melbourne Campus and will be available Monday-Friday 0800-1630Hrs for the first 12 months. After this time evaluation of the service may result in revision of service hours.

1.10 Key relationships

Key relationships to this position include;

- General Medicine Consultant and Registrar
- Tumour streams Nurse Co-ordinators and Medical Consultants
- Allied Health staff
- RMH (geriatric expertise) to include the Director, Medicine and Community Care at RMH.
- External – GP’s, specialists managing individual patients, palliative care services, RACFs
## Deliverable 2: 5 Year Plan

### 5 year plan for model/service delivery (summary)

<table>
<thead>
<tr>
<th>Year 1</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP service model development, appointment of GO NP candidate:</td>
<td></td>
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<tr>
<td>Development of supervision and mentorship program and commencement of academic preparation</td>
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<table>
<thead>
<tr>
<th>Year 2</th>
<th>2013</th>
</tr>
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<tbody>
<tr>
<td>Development of NP scope of practice and service</td>
<td></td>
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<tr>
<td>Establishment of service evaluation framework</td>
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<table>
<thead>
<tr>
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<th>2014</th>
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<tbody>
<tr>
<td>Annual review against NP service deliverables and development of state wide service scope</td>
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<table>
<thead>
<tr>
<th>Year 4</th>
<th>2015</th>
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<tbody>
<tr>
<td>Annual review and succession planning, workforce requirement and model evolution</td>
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<tr>
<td>Ongoing review of the service and plans for service evolution to include consideration of the service as a national resource</td>
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References


## Appendix 1: Key Stakeholders involved in Scoping Exercise

### Internal – Peter Mac

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cathie Pigott</td>
<td>Education Department</td>
</tr>
<tr>
<td>Denise Spencer</td>
<td>Education Department</td>
</tr>
<tr>
<td>David Speakman</td>
<td>Executive</td>
</tr>
<tr>
<td>Sandy Heriot</td>
<td>Surgical Oncology</td>
</tr>
<tr>
<td>John Zalcberg</td>
<td>Cancer Medicine</td>
</tr>
<tr>
<td>Danny Rishkin</td>
<td>Cancer Medicine</td>
</tr>
<tr>
<td>John Seymour</td>
<td>DHMO</td>
</tr>
<tr>
<td>Gill Duchesne</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Bernhard Riedel</td>
<td>Anaesthetics</td>
</tr>
<tr>
<td>Richard Sullivan</td>
<td>Anaesthetics</td>
</tr>
<tr>
<td>Annabel Pollard</td>
<td>Allied Health</td>
</tr>
<tr>
<td>Sue Kirs</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Danielle Murray</td>
<td>Clinical Governance</td>
</tr>
<tr>
<td>Fiona Watson</td>
<td>Clinical Governance</td>
</tr>
<tr>
<td>Rebecca Paterson</td>
<td>Clinical Director Patient Services</td>
</tr>
<tr>
<td>Sue Beck</td>
<td>Patient Liaison Officer</td>
</tr>
<tr>
<td>Darren Gray</td>
<td>Manager Hospital In The Home</td>
</tr>
<tr>
<td>Michael Collins</td>
<td>Nurse Practitioner - Palliative Care</td>
</tr>
<tr>
<td>Odette Blewitt</td>
<td>Nurse Practitioner - Palliative Care</td>
</tr>
<tr>
<td>Yvonne Panek-Hudson</td>
<td>Nurse Practitioner - Allograft</td>
</tr>
<tr>
<td>Natasha Michael</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Soo Wee Kheng</td>
<td>Palliative Care Registrar</td>
</tr>
<tr>
<td>Renee Menser</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Imogen Windle</td>
<td>General Medicine Registrar</td>
</tr>
<tr>
<td>Karin Thursky</td>
<td>Infectious Diseases Fellow</td>
</tr>
<tr>
<td>Louise Creati</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Shay Morrisey</td>
<td>Special Clinics Nurse Unit Manager</td>
</tr>
<tr>
<td>Liz LeHunt</td>
<td>Skin Nurse Consultant</td>
</tr>
<tr>
<td>Alison Hocking</td>
<td>Social Work</td>
</tr>
<tr>
<td>Alexis Butler</td>
<td>GP Liaison Officer</td>
</tr>
</tbody>
</table>

### External

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanessa Simons</td>
<td>Royal Park Educator</td>
</tr>
<tr>
<td>Bernie Street</td>
<td>ex Peter Mac Geriatrician</td>
</tr>
<tr>
<td>Tony Snell</td>
<td>Royal Melbourne Geriatrician</td>
</tr>
<tr>
<td>Peter Mac patients and their nominated carers</td>
<td>Estimated 24 interviews</td>
</tr>
</tbody>
</table>
Appendix 2: Key domains of need or service gaps identified

General Medicine Assistance / Support / Input:
- Lack of general medicine assistance on all patients, not just Geriatric
- Lack of a medical / geriatric model that enables quickly identifying patients when they are admitted with co-morbidity or age related issues
- Risk of cardiac / pulmonary / renal toxicity from their treatments is increased due to their chronological age
- Lack of co-morbidity management
- "We want holistic medicine, not just to be treated for our cancer"
- Polypharmacy

Screening Tools suitable to address age-specific needs:
- How do we screen, support and identify people with needs?
- How well do we manage age related issues?
- Reduced opportunities for treatment because of age
- Identifying these patients as a special group

Referral back to General Practice (GP) Physicians / Other specialists or hospitals / Health Care Practitioners (HCP):
- Due to problems that arise from their cancer treatment (once they are cancer free)
- Linking patients back to their GP’s
- Transitioning back to their home environment

Aged Care Assessment Service (ACAS):
- No geriatrician / Geriatric Oncologist / geriatric service at Peter Mac
- External referrals are completed by Social Work to Western Metropolitan Regional Aged Care Assessment Service - North West at Royal Park
- Delays causing ‘bed blocking’ – risk of hospitalisation and institutionalisation
- No links to rehabilitation centres

Tumour Stream based System:
- Fragmentation
- Does not support the holistic management of patients
- Care breaks down when people are over a couple of tumour streams

Growing population / Area / Specialist Care in the Community:
- 50% of patients that are diagnosed with cancer are in this age group of greater than 65.
- Lack of trained oncology staff in the wider community setting – causing issues when people require treatment in their home environment

Advocacy:
- Patients receiving information targeted to an age specific audience
- Proper assessment of cognition prior to consent for treatments – informed choices
- Carers receiving the same information as patients (if the patients have consented)
Appendix 3: Comprehensive Geriatric Assessment (CGA)

The Comprehensive Geriatric Assessment model above is adopted from the Bass Coast Regional Health model, “based around the gerontic syndromes, and aligned to the Long Stay Older Patient and Improving Care for Older People domains. The purpose of the CGA is to identify health issues from these commonly occurring gerontic syndrome domains and implement a plan of care to prevent functional decline, or improve functionality utilising a person centred approach. For this reason it is the assessment that is pivotal, and that it occurs, rather than where across the continuum it occurs – focussing on where the best information can be elicited from the patient, and how the best potential outcome is to be achieved.”

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Appendix 4: Royal Adelaide Screening Tool – Screening questionnaire for assessment of older people with cancer

Patient information sheet

Screening questionnaire for assessment of older people with cancer

By completing the following questionnaire you are giving your medical oncologist the best opportunity to gain relevant insight into your health, daily routine and social support. This will help ensure you receive the best possible care.

If you have health problems that may affect your treatment, your case will be discussed at a meeting with other health professionals, who will discuss treatment recommendations to ensure you receive treatment and support most appropriate for you.

Do you give permission for your case to be discussed at the team meeting if required?

☐ Yes  ☐ No

Date  

Signature  

Name  

Date of birth  

Postcode

Office use only:

UR  

Consultant  

Age  
General health
In general, would you say your health is:
(please tick one)
☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

Compared to one year ago, how would you rate your health in general now?
☐ Much better now than one year ago
☐ Somewhat better now than one year ago
☐ About the same now as one year ago
☐ Somewhat worse now than one year ago
☐ Much worse now than one year ago

Other medical conditions
Do you have any other medical conditions besides the current diagnosis of cancer? Please list.
1.
________________________________________________________________________
2.
________________________________________________________________________
3.
________________________________________________________________________
4.
________________________________________________________________________
5.
________________________________________________________________________
6.
________________________________________________________________________

Medications and other natural medicines
If you take any prescribed medications, including over the counter medications, please list below.

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Used for</th>
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If you take any other products such as vitamins, herbal medicines or health supplements that are not prescribed by a doctor, please list below.

<table>
<thead>
<tr>
<th>Product name</th>
<th>Used for</th>
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</table>
Memory
Do you or your family think that you have any memory problems?
☐ Yes  ☐ No

If yes, would you like your memory to be checked?
☐ Yes  ☐ No

Vision
How is your eyesight (with glasses or contacts)?
☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor  ☐ Totally blind

How much does your sight trouble you?
☐ Not at all  ☐ Somewhat  ☐ A great deal

Hearing
How is your hearing (with a hearing aid if needed)?
☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor  ☐ Totally deaf

How much does your hearing trouble you?
☐ Not at all  ☐ Somewhat  ☐ A great deal

Nutrition
What is your weight? ________________________

Have you lost weight without trying over the past six months?
☐ Yes  ☐ No

If yes, how much? ________________________

Falls
How many times have you fallen in the last six months?
______________________________

If you have fallen, do you know why? ________________________

Instrumental activities of daily living
The following questions are about your daily activities. Please tick the response that most pertains to you:

1. Can you use the telephone...
   ☐ without help, including looking up and dialling
   ☐ with some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialling) or
   ☐ are you completely unable to use the telephone?

2. Can you get to places out of walking distance...
   ☐ without help (drive your own car, or travel alone on buses, or taxis)
   ☐ with some help (need someone to help you or go with you when travelling) or
   ☐ are you unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?

3. Can you go shopping for groceries or clothes...
   ☐ without help (taking care of all shopping needs yourself, assuming you had transportation)
   ☐ with some help (need someone to go with you on all shopping trips) or
   ☐ are you completely unable to do any shopping?

4. Can you take your own medicines...
   ☐ without help (in the right doses at the right time)
   ☐ with some help (able to take medicine if someone prepares it for you and/or reminds you to take it) or
   ☐ are you completely unable to take your medicine?

5. Can you handle your own money...
   ☐ without help (write cheques, pay bills, etc)
   ☐ with some help (manage day-to-day buying but need help with managing your chequebook and paying your bills) or
   ☐ are you completely unable to handle your money?

6. Can you prepare your own meals...
   ☐ without help (plan and cook full meals yourself)
   ☐ with some help (can prepare some things but unable to cook full meals yourself) or
   ☐ are you completely unable to prepare any meals?

7. Can you do your housework...
   ☐ without help (can clean floors, etc)
   ☐ with some help (can do light housework but need help with heavy work) or
   ☐ are you completely unable to do any housework?
Physical functioning

The following items are activities you might do during a typical day. Please tick one that applies to you.

**Bathing**
- Able to wash self completely or needing help with only a single part of the body, such as the back or legs.
- Need help with washing more than one part of the body, getting in or out of the bath or shower.

**Dressing**
- Able to get on and put on clothes, including fastenings, zips and buttons. May have help tying shoes.
- Need help with dressing.

**Toileting**
- Able to go to the toilet, get on and off, arrange clothes and wipe myself without help.
- Need help getting on and off the toilet, wiping myself or using bedpan or commode.

**Movement**
- Can get in and out of bed or chair without help with or without the use of a walking frame or sticks.
- Need help getting from bed to chair or require complete assistance to move around (e.g. wheelchair only).

**Continence**
- Have complete control over bladder and bowel actions.
- Partial or total lack of control over bowel or bladder.

**Feeding**
- Able to eat meals without help. Preparation of food may be done by another person.
- Need partial or total help with feeding (cutting foods, spooning into mouth).

Performance status

Please check only one response that is most accurate for you at this time.

- Normal, no complaints, no symptoms of disease
- Able to carry on normal activity, minor symptoms of disease
- Normal activity with effort, some symptoms of disease
- Care for self, but unable to carry on normal activity or do active work
- Require occasional assistance but able to care for most of personal needs
- Require considerable assistance for personal care
- Disabled, require special care and assistance
- Severely disabled, require continuous nursing care

Social support

We would like to understand the support you have from the person you live with, family members and friends. For each type of support, please tick the answer that reflects your situation.

Do you have someone to help if you were confined to bed:
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

take you to the doctor if needed:
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

prepare your meals if you were unable to do it yourself:
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

help you with daily chores if you were sick:
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

confide in or talk to if you have a problem?
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time
Emotional wellbeing
During the past month, have you often been bothered by feeling down, depressed or hopeless?
☐ Yes  ☐ No

During the past month, have you often had little interest or pleasure in doing things?
☐ Yes  ☐ No

Distress scale
Please indicate on the scale below your overall feeling of distress over the last seven days:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no distress at all</td>
<td>worst distress imaginable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pain scale
Please indicate on the scale below your overall feeling of pain over the last seven days:

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>no pain at all</td>
<td>worst pain imaginable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Exhaustion
How often in the last week did you feel that ‘everything you did was an effort’?
☐ Some or none of the time (less than one day)
☐ Some or little of the time (one to two days)
☐ Moderate amount of time (three to four days)
☐ Most of the time

How often in the last week did you feel that ‘you could not get going’?
☐ Some or none of the time (less than one day)
☐ Some or little of the time (one to two days)
☐ Moderate amount of time (three to four days)
☐ Most of the time

Demographics
Who do you live with? Please tick all that apply
☐ Spouse/partner
☐ Children
☐ Live alone
☐ Other, please specify ___________________________

Do you currently receive any of the following services? Please tick all that apply
☐ RNNS Nurse
☐ Palliative Care Nurse
☐ Personal Care Assistance
☐ Cleaning/home maintenance
☐ Equipment provision
☐ Food services (eg Meals on Wheels, Adelaide Food Service, Italian/Greek food service)
☐ Social worker
☐ Mental health worker
☐ Church support services group
☐ Other, please specify ___________________________

Did you complete this questionnaire on your own?
☐ Yes  ☐ No

If not, who provided you with assistance, and do they have any concerns to express?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Appendix 5: Complex Discharge Planning Pathway

Team members of the MDT include: GO NP, Social work, Pharmacy, Physiotherapy, Occupational Therapy, Palliative Care, Dietetics, General Medicine Registrar.
Appendix 6: Traffic Light Criteria for Medical Review

Traffic light criteria will be developed in consultation with the General Medical Consultant / Registrar based on the Palliative Care Nurse Practitioner model at Peter Mac. Patients will be triaged and categorised according to three colours of Green, Amber and Red and seen by the appropriate Health Care Practitioner.
# Appendix 7: Financial Statement – 30 June 2012

## Financial Statement – 30 June 2012

**Department of Health - Victorian Nurse Practitioner Project**  
Phase 4, Round 4.9 Chronic Disease Management

<table>
<thead>
<tr>
<th>Institution</th>
<th>Peter MacCallum Cancer Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Recipients</td>
<td>A/P M Krishnasamy</td>
</tr>
<tr>
<td>Project</td>
<td>Geriatric Oncology Nurse Practitioner Proposed Model of Care</td>
</tr>
</tbody>
</table>

### Revenue Received

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant income: Received</td>
<td>$37,000.00</td>
</tr>
<tr>
<td>- Role development and implementation</td>
<td></td>
</tr>
<tr>
<td><strong>Total Grant Income</strong></td>
<td>$37,000.00</td>
</tr>
</tbody>
</table>

### Less Expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role development and implementation:</td>
<td></td>
</tr>
<tr>
<td>- Salary</td>
<td>$3,451.22</td>
</tr>
<tr>
<td>- Consumables</td>
<td>$500.00</td>
</tr>
<tr>
<td>Nurse Practitioner Candidate Support</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>$3,951.22</td>
</tr>
</tbody>
</table>

### Balance carried forward

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance carried forward</strong></td>
<td>$33,048.78</td>
</tr>
</tbody>
</table>

I certify that:

a. Monies received under this award, provided by the Department of Health, and

b. This Financial Statement is signed by an authorised financial officer at the Peter MacCallum Cancer Centre.

<table>
<thead>
<tr>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>David Butler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Financial Controller, Peter MacCallum Centre Cancer</td>
</tr>
<tr>
<td>E-mail</td>
<td><a href="mailto:David.Butler@petermac.org">David.Butler@petermac.org</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>03 9656 2714</td>
</tr>
</tbody>
</table>