Jane's journey

Hinchinbrook LGA – Coronary Artery Disease

Jane is an 82-year-old woman who lives alone on a small property 25kms from the township of Ingham. Jane has 2 adult children with their own families who live in Cardwell. Jane has lived alone for 10 years after her husband died and has been independent with her activities of daily living and is still driving. She drives to town once a week to pick up groceries and medications and attend any relevant appointments. However, Jane is not active outside of these activities due to her age, frailty, and medical conditions. Jane has recently been diagnosed with Coronary Artery Disease and was told by her cardiologist it would be too risky to perform surgery and she would be managed conservatively with medication to reduce her symptoms.

An initiative of PalliativeCare QUEENSLAND
PALLIATIVECAREQLD.ORG.AU

Supported by
phn NORTHERN QUEENSLAND An Australian Government Initiative
CELC Townsville CONNECTING END OF LIFE CARE

The CELC Townsville project is administered by Palliative Care Queensland and supported by funding from Northern Queensland Primary Health Network (NQPHN) through the Australian Government's PHN program.

REGULAR PRIMARY CARE

Jane visits her general practitioner & community pharmacist every month. She also sees the podiatrist & diabetes educator at the medical centre.

SPECIALIST CARDIOLOGY CARE

Jane's son takes multiple days off work to take her to Townsville for appointments and investigations including cardiologist, anaesthetist, angiogram & echocardiogram.

INCREASING HOSPITALISATION

Jane has more admissions, more often to Ingham Hospital.

Jane & her family are overwhelmed by so many people talking to them about acute resuscitation plan, wills, enduring power of attorneys, shower chairs, walkers & possibility of residential aged care.

A My Aged Care referral is made for ongoing support.

FAMILY SUPPORT

Jane's family travels to Ingham regularly as Jane needs more help than services can provide.

TELEHEALTH APPOINTMENT WITH CARDIAC TEAM

No other treatment options available.

CARE COORDINATION

Nurse Navigator liaises with family, GP & hospital doctors about a referral to specialist palliative care for pain and oedema management advice.

SPECIALIST PALLIATIVE RURAL TELEHEALTH SERVICE (SPaRTa)

Regular telephone & videoconferencing to assist with symptom control, advance care planning & Medical Aids Subsidy Scheme applications.

CARE TEAM

Jane's family have a roster so someone is always at home with her. The contracted community nursing service increases services and provides training to the family with the hospital occupational therapist.

BEREAVEMENT SUPPORT

Jane's family struggle to return to their old routines after caring for their mum.

PALLIATIVE CARE ROOM INGHAM HOSPITAL

Jane's daughter becomes unwell so Jane is admitted to the hospital. Jane dies in the palliative care room a week later.

Key Themes:

- Importance of primary care when living with chronic disease
- Frailty - declining function & independence
- Challenging without very supportive family
- 2 designated palliative care rooms at Ingham Hospital
- Geographical distance from town and family
- Advance Care Planning

Potential issues/barriers:

- Limited local transport options - taxis are expensive, transit care can be unreliable due to workforce shortages
- Ingham Travel to Townsville for specialist appointments but it's easy to miss the bus home
- Appointment Coordination
- Local Commonwealth Home Support Programme unable to offer services due to workforce shortages
- Only one nurse in the community who provides complex end of care including use of syringe drivers