An End of Life Care Framework – Proactive Palliative Care for GPs

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Australian and New Zealand Society of Palliative Medicine Inc

Decision Assist is funded by the Australian Government

Presentation overview

- Background
- Palliative care framework of care based on prognostication
- Key processes within the framework to meet emergent clinical needs
- Case study: Jack and the Framework

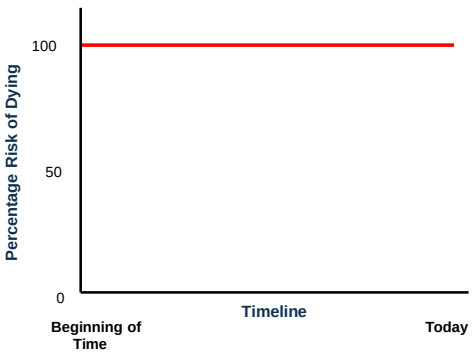
Decision Assist is funded by the Australian Government

Background

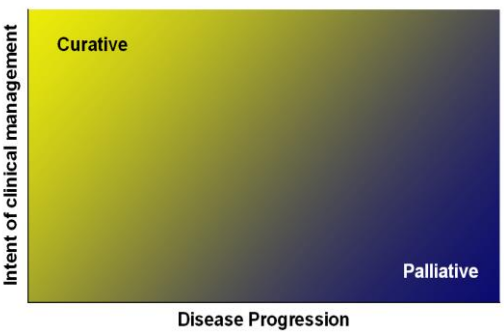
- Funding from Australian Government to rollout Decision Assist to support health care professionals who work with older Australians living in the community
- GP role is essential for achieving optimal patient and family outcomes in community based palliative care for aged care

Decision Assist is funded by the Australian Government

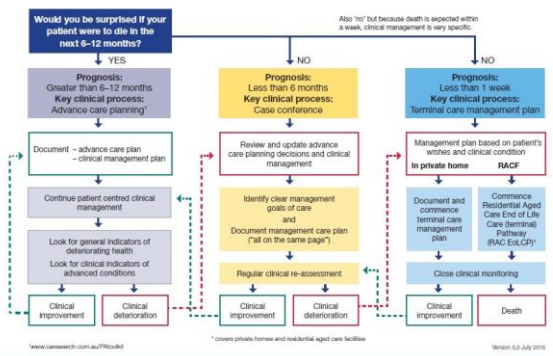
Individual's lifetime risk of death since time began



Reframing palliative care



A FRAMEWORK FOR PALLIATIVE CARE IN COMMUNITY-BASED* AGED CARE PATIENTS



Key processes to proactively manage clinical needs

- Advance care planning (ACP) and documentation
- Case conferencing and management plan documentation
- Use of a terminal care management plan for patients at home or an end of life (terminal) care pathway for RACF residents

Prognosis: Greater than 6–12 months **Key clinical process:** Advance care planning*

Prognosis: Less than 6 months **Key clinical process:** Case conference

Prognosis: Less than 1 week **Key clinical process:** Terminal care management plan

Case study: Jack and the framework

- 84 yrs old, lives with daughter, currently medically stable
- No documented advance care plan, but daughter and son EPOG – either jointly or independently
- PMHx
  - COAD, HT, CCF, diet controlled diabetes
  - 2013 - ICD implanted, no shocks to date
  - 2014 - 2 admissions for CCF
  - 2015 - admission for CCF; MRI – signs of vascular dementia
- Polypharmacy
- **Using the surprise question: which trajectory for Jack?**

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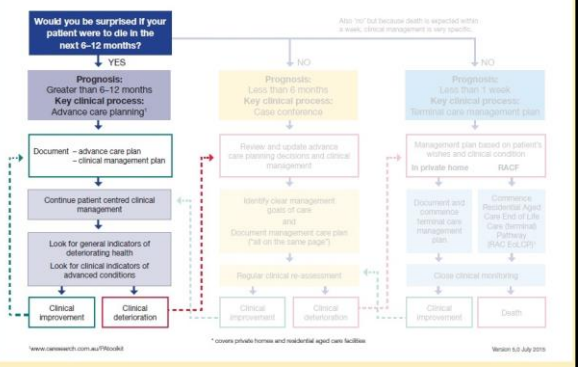
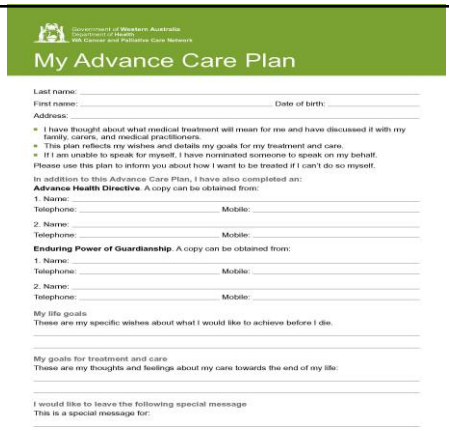


Key process: advance care planning

- ACP: interactive ongoing process of communication focussing on the person's preferences for their care in the future
- WA: legally binding components (e.g. Advance Health Directive, Enduring Power of Guardianship) or a less formal document (ACP)
- Identify a substitute decision maker
- Allows care providers to know the person's wishes and advocate for them
- Helps GPs to inform the clinical management plan for the person



My Advance Care Plan

Last name:
First name: Date of birth:
Address:

- I have thought about what medical treatment will mean for me and have discussed it with my family, carers, and medical practitioners.
- This plan reflects my wishes and details my goals for my treatment and care.
- If I am unable to speak for myself, I have nominated someone to speak on my behalf.

Please use this plan to inform you about how I want to be treated if I can't do so myself.

In addition to this Advance Care Plan, I have also completed an:
Advance Health Directive. A copy can be obtained from:
1. Name:
Telephone: Mobile:
2. Name:
Telephone: Mobile:

Enduring Power of Guardianship. A copy can be obtained from:
1. Name:
Telephone: Mobile:
2. Name:
Telephone: Mobile:

My life goals
These are my specific wishes about what I would like to achieve before I die.

My goals for treatment and care
These are my thoughts and feelings about my care towards the end of my life:

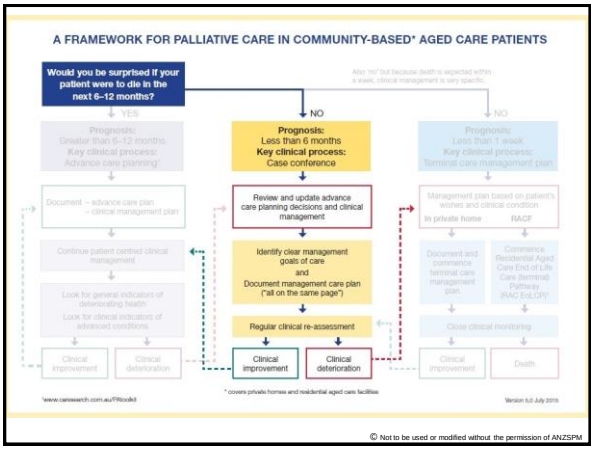
I would like to leave the following special message
This is a special message for:

Case study (con't)

- You are called on Saturday evening:
  - Jack suddenly unwell
  - Tachypnoeic, appears short of breath
  - Restless
  - Confused
- You organise ambulance

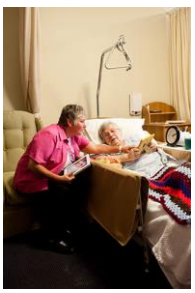
Case study (con't)

- Jack hospitalised and diagnosed with exacerbation of CCF and pneumonia
- ICU, intubated, IV inotropes and AB
- Son distressed. Had not been contacted and felt current aggressive treatment against his wishes
- Jack stabilised, though functionally deteriorated, significant weight loss, deconditioned, refused rehab: returned to daughter's house.
- **Using the surprise question, into which trajectory does Jack fit now?**



Key process: Case conference

- Identify clear comprehensive management goals of care so that "all on the same page"
- Identify the person's and/or substitute decision maker's concerns
- Document a clear comprehensive case management plan
- Share health information, estimated prognosis and what to expect as condition deteriorates

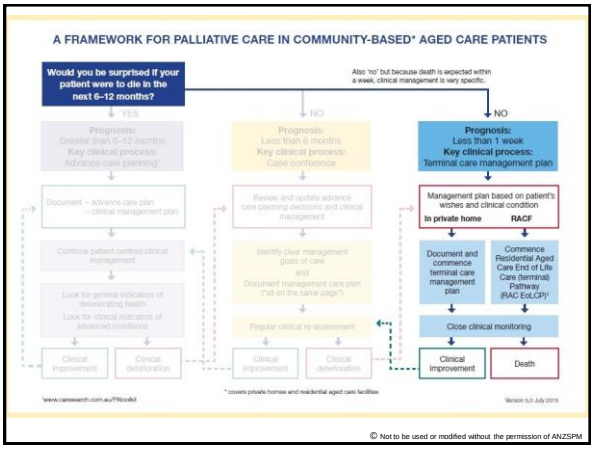


Case study (con't)

- You organise and run a case conference:
  - Jack does not have decision making capacity anymore but after last visit to hospital told son and daughter that did not want to go back to hospital ever
  - confirm son and daughter to make joint EPOA decisions (if no agreement go to Adult Guardian)
  - decision made to deactivate ICD
  - all future care to take place at home, with domicillary nurses
  - summary of palliative case conference, including agreed treatment goals, documented and signed
  - copy sent to deputising service

Case study (con't)

- You are called on Friday night six weeks later:
  - Bed bound last 2 weeks, profound weakness
  - Chest infection not improving; finished 2 courses oral antibiotics
  - Breathing moist and laboured
  - Fluctuating consciousness
  - Unable to swallow medications last 5 days
  - Minimal oral intake, no urine output 36 hours
  - Daughter questions: what is happening?
- **Into which trajectory does Jack now fit?**



Key process: Terminal management plan

- Use of a terminal care management plan for patients at home or an end of life (terminal) care pathway for RACF residents
- Diagnosis of dying, and likely course, communicated to patient/substitute decision maker, family and aged care service providers
- Document and implement co-ordinated management plan available to all those requiring it

RAC EoL (terminal) CP

- The Residential Aged Care End of Life (terminal) Care Pathway (RAC EoLCP) is a clinical guide, designed for Australian RACFs, to help promote best practice terminal care in RACFs
- Integral part of The Palliative Approach (PA) Toolkit for RACFs that aims to assist RACFs to deliver sustainable quality end-of-life care for residents
- Funded by Department of Social Services and rolled out nationally.
- Access www.caresearch.com.au/PAToolkit

RAC EoLCP Overview

Front page – Instructions

Section 1 - Commencing a Resident on the RAC EoLCP

[9 clinical indicators – 3 or more indicate commencement]

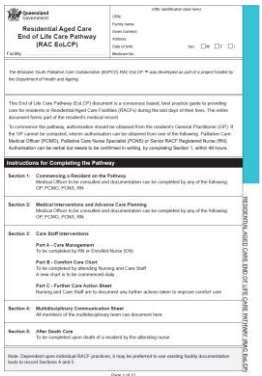
Section 2 - Medical Interventions & Advance Care Planning

Section 3 - Nursing Care Staff Interventions

- Part A - Care Management
- Part B - Comfort Care Chart
- Part C - Further Care Action Sheet

Section 4 – Multidisciplinary Communication Sheet

Section 5 - After Death Care


Queensland Government

Residential Aged Care End of Life Care Pathway (RAC EoLCP)

Instructions for Completing the Pathway

Terminal management plan for patients living independently

- Diagnosis of dying, and likely course, communicated to patient/substitute decision maker, family and aged care service providers
- Document and implement co-ordinated management plan available to all those requiring it
- Medications reviewed – essential medications prescribed, available, charted. Education for medication administration
- Death at home documentation available, including not for resuscitation order, expected death
- Bereavement follow-up plan

Medications endorsed by ANZSPM – *to use in terminal care in community-based patients*

MEDICATION	CONCENTRATION	PACKAGED as
Clonazepam liquid* (oral drops)	2.5mg/ml	10ml bottle (2.5mg/ml)
Clonazepam injection*	1mg/ml	box of 5 ampoules
Fentanyl citrate injection**	100mcg/2ml	box of 5 ampoules
Haloperidol injection	5mg/ml	box of 10 ampoules
Hydromorphone injection	2mg/ml	box of 5 ampoules
Hyoscine butylbromide (Buscopan) injection***	20mg/ml	box of 5 ampoules
Metoclopramide injection	10mg/2ml	box of 10 ampoules
Midazolam injection**	5mg/ml	box of 10 ampoules
Morphine sulphate injection	10mg/ml AND 30mg/ml	box of 5 ampoules

* Non-PBS unless for seizure control
** Not on the PBS
*** Non-PBS unless for colicky pain. Unrestricted via the Repatriation Schedule

ANZSPM

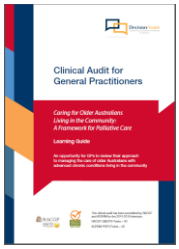
Decision Assist resources for GPs

- Range of educational opportunities and resources for GPs in preparation – see *Decision Assist* website www.decisionassist.org.au
- Palliative Care Phone Advisory Service (24/7) & Advance Care Planning Phone Advisory Service (8am-8pm 7 days per week)

1300 668 908

Accredited educational activities

- Clinical audit – pre and post audit with intervention based on this presentation or online module or workshop
- Active Learning Module (RACGP) / Theory Practice Activity (ACRRM)
- RACGP: 40 Cat 1 QI&CPD points
  ACRRM: 30 PRPD points
- Contact: karencooper.ANZSPM@bigpond.com



Other educational opportunities for GPs

- ***Online 'case of the month' discussion***

  This is an opportunity for GPs to participate in an online 'case of the month' discussion. The forum will be moderated by a palliative medicine physician.

  Access: https://www.rrmeo.com/decisionassist

- ***Videos***

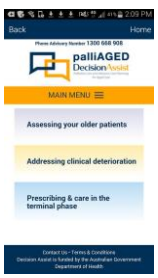
  An introduction to managing 4 common palliative care symptoms – pain, dyspnoea, nausea and vomiting, delirium

  www.decisionassist.org.au

Get the app

palliAGED

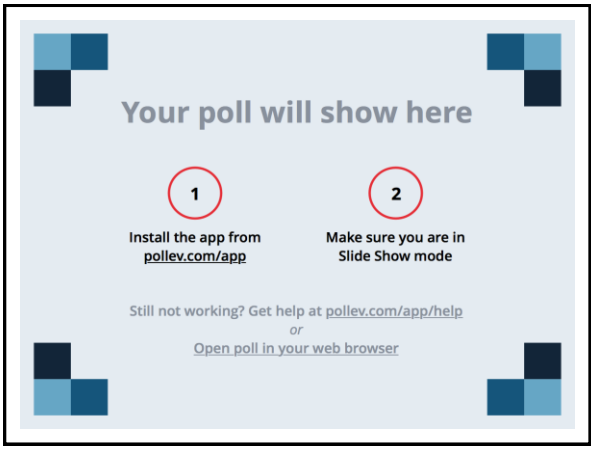
- Prescribing and management advice to care for dying patients, and simple tools to identify older age patients moving into a palliative phase of care.
- Available at the following stores:
  - ✓ Google Play
  - ✓ Windows phone store
  - ✓ Apple iTunes
- More information and links to stores: www.decisionassist.org.au



Take home messages

- A palliative care approach is important in supporting the clinical management of older Australians living in the community
- GPs can use a framework of palliative care based on prognostic trajectories to proactively manage the palliative care needs of older Australians living in the community
- *Decision Assist* offers GPs access to new resources and advisory services to inform their practice of palliative care

Thanks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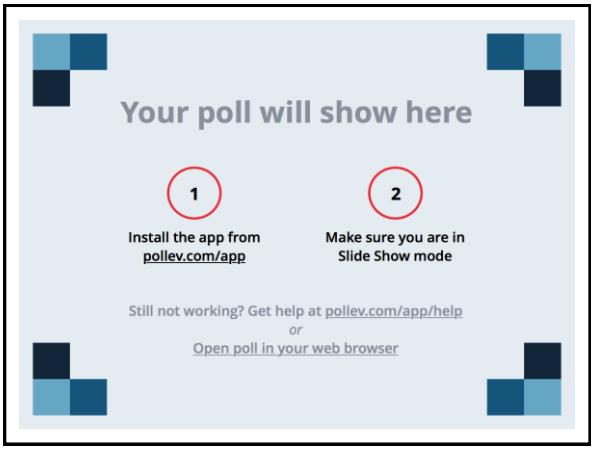
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