End-of-Life Care Framework: Last 12 months of life

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Presentation overview

- Context – why have a framework?
- End-of-Life Framework – last 12/12 of life
- Framework: 3 key clinical processes
  - Advance care planning
  - Case conferencing
  - Terminal care management plan
Learning outcomes

• Explain the value of the *End-of-Life Framework* – *last 12/12 of life* for your routine practice to ensure proactive and best practice end-of-life care for residents

• Identify the 3 key clinical processes in the Framework
Context: Individual’s lifetime risk of death since time began

Timeline

Percentage Risk of Dying

Beginning of Time

Today
Context: Why have a framework?

Intent of clinical management

Disease progression

Curative

Palliative
Clinical example of use of the Framework

- Grace, 87 year old lady with multiple co-morbidities, limited mobility, has lost 3kg in 2/12 (for no known reason) even though the fluid in her legs is getting worse

- no ACP

- Recently discharged from hospital – undergone a splenectomy

- Angry because in pain and felt that her family had bullied her into an operation that she did not want

Where in the framework could she be?
What is advance care planning (ACP)?

• ACP is an iterative process of planning for future health and personal care whereby a patient’s values, beliefs and preferences/choices are made known to their family members, substitute decision maker(s) and treating doctors.

• Can involve writing an advance care plan.

• Used by others to inform clinical decision making when the person is unable to communicate their wishes.

• It is the embodiment of person-centred healthcare and a response to the challenges that an ageing population and modern healthcare present.¹

¹ RACGP http://www.racgp.org.au/your-practice/business/tools/support/acp/#1 viewed 29 September 2017
Benefits of ACP

- Reduce stress, anxiety and depression in surviving family members
- Improves patient satisfaction and QOL
- Limits unwanted medical treatments
- Decrease use of intensive medical interventions with better control of mental and physical symptoms in last phases of life
- Results in fewer in-hospital deaths and ICU admissions and more comfort-orientated EOL care
- Fewer inappropriate transfers to hospital of patients living in RACFs with advanced illness

National Consensus Statement: Essential elements for safe and high quality end-of-life care
National Safety and Quality Health Service Standards
C. Personal Values

The things I most value in my life: (e.g. independence, enjoyable activities, talking to family and friends)

My family who I have told of this form.
My husband. Independence. I would like my independence.
My quality of life.

Future situations I would find unacceptable in relation to my health:

Any more overnight stays. Not being in control of my mind.
Unable to go to toilet. wheelchair.

Other things I would like known which may help with future medical decisions: (e.g. organ or body donation)

Not.

I would like the following person(s) to be included in discussions about my health care:

No. I would not wish to discuss my illnesses.
My body. My death. I make my decisions my own way.

If I am nearing death I would like the following: (including spiritual / cultural preferences)

Nothing. Reassure my family. own.

Great grief. Great love.

The place I would prefer to die:
(e.g. home, hospital, nursing home)

Home.
**A. Life Prolonging Treatments**

**Cardiopulmonary Resuscitation (CPR)**

*(tick appropriate box)*

- [ ] I want CPR attempted if it is consistent with good medical practice **OR**
- [x] I do **NOT** want CPR attempted under any circumstances **OR**

- [ ] Other: **I WISH TO BE KNOWN COMFORTABLE**

**Other Life Prolonging Treatments** *e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube*

*(tick appropriate box)*

- [ ] I want other life prolonging treatments if they are consistent with good medical practice **OR**
- [x] I do **NOT** want other life prolonging treatments under any circumstances **OR**

- [ ] Other:

**B. Medical Treatments**

I **want** the following specific treatments to continue to be part of my care if considered to be medically beneficial: *(tick appropriate box(es))*

- [x] Major operation  
- [ ] Intravenous fluids  
- [ ] Intravenous drugs  
- [ ] Blood transfusion

- Other: **NONE OR BOTH**

Specific treatments I **do NOT** want: *(tick appropriate box(es))*

- [x] Major operation  
- [ ] Intravenous fluids  
- [x] Intravenous drugs  
- [ ] Blood transfusion

- Other: **NONE**

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FORM A Page 1 of 3
Grace: 2/12 later

- Shortness of breath increasing, wheel chair bound, legs getting fatter with fluid, worsening cough, not eating much
- GP does routine bloods indicating that renal failure worsening, anaemic, hypoxic and some electrolyte imbalance
- Grace refuses to go to hospital ever again

Where in the framework could she be?
END-OF-LIFE CARE FRAMEWORK – LAST 12 MONTHS OF LIFE

HOME and COMMUNITY SERVICES
(includes general practice, home-based and residential aged care services and facilities)

Clinical processes across all care settings

- Advance care planning and patient-centred care based on need
- Transition of focus of care needs from restorative to palliative: patient-centred medical goals of care
- Terminal care needs including bereavement plan

HOSPITAL SERVICES

Important aspects of clinical care across all care settings

- At risk of dying
  - prognosis less than 12 months, but timing may be uncertain
  - Acknowledgement of uncertainty of prognosis and individual need
  - If not already commenced, begin advance care planning
  - Ongoing active treatment ± palliative approach
  - Medication review and deprescribing as appropriate
  - Continue clinical management while monitoring for indicators of deteriorating health
  - Care coordination and liaison across hospital and community services

- Likely to die soon
  - medium term, but timing may be uncertain
  - Review by senior clinician: care focus now palliative
  - Review advance care planning and patient-centred goal setting
  - Clear medical management planning (including limitations of medical treatment) after episodes of acute deterioration
  - Medication review and deprescribing as appropriate
  - Palliative approach for symptom management and psychosocial and family support (treating team ± specialist palliative care service)
  - Care coordination and liaison across hospital and community services

- Dying
  - short term, timing may be uncertain but likely within one week
  - Review by senior clinician
  - Review advance care planning and goal setting, if appropriate
  - Clear management planning (including limitations of medical treatment) relevant to preferred place of death
  - Interventions for symptom control, meeting spiritual and individual needs, family support, etc.
  - Medications only for symptom control
  - Provision of culturally appropriate terminal care
  - Begin bereavement care for significant others

Adapted from:
3. Reymond L et al. End-of-life care: Proactive clinical management of older Australians in the community. AFP 2016; 45(1-2)

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Metro South Health
Grace: time for a case conference

- All on the same page
- Review her advance care plan. What does she want for herself?
- What are the concerns of her family?
- Need medical management plan (limitations of medical treatment) with agreed goals of care clearly stating what to do when Grace deteriorates
- Medication review – de-prescribing
- Plan for activities of daily living
Grace: 3/52 later

- Grace has a high temperature
- Has not eaten or drunk any fluids for 3/7
- Lapsing into and out of consciousness
- GP diagnoses pneumonia
- Family agrees: keep comfortable, not for further treatment

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Grace needs terminal care management plan

- RAC End-of-Life Care management plan
- Diagnosis of dying, and likely course, communicated to patient/substitute decision maker and family
- Review ACP and goal setting, if appropriate
- Document and implement co-ordinated management plan including interventions for symptom control, meeting spiritual and individual needs, family support etc
- Medications reviewed – essential medications prescribed, available, charted.
- Bereavement follow-up plan
Thanks