Living Longer and Dying Better in the Community: Palliative Care Revisited

Prof Liz Reymond MBBS (Hons) RACGP FAChPM PhD

Australian and New Zealand Society of Palliative Medicine Inc

Decision Assist is funded by the Australian Government

www.decisionassist.org.au
© Not to be used or modified without the permission of ANZSPM

Presentation overview

- Background
- Palliative care framework of care, that can be embedded into routine practice, that enables proactive quality management of older patients in the last year of life
- Key processes within the framework to meet emergent clinical needs
- Decision Assist resources



Decision Assist is funded by the Australian Government
www.decisionassist.org.au
© Not to be used or modified without the permission of ANZSPM

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

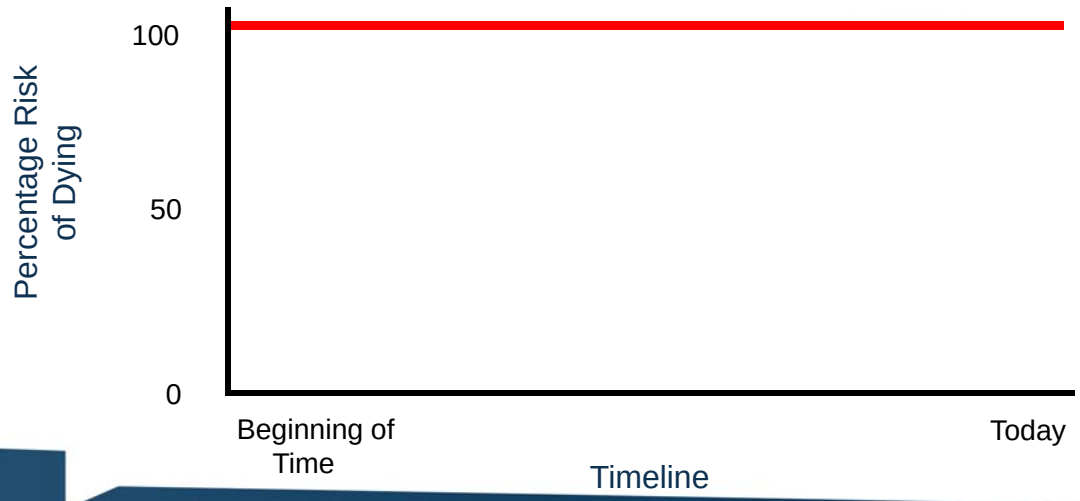


Decision Assist is funded by the Australian Government

www.decisionassist.org.au

© Not to be used or modified without the permission of ANZSPM

Individual's lifetime risk of death since time began



Decision Assist is funded by the Australian Government

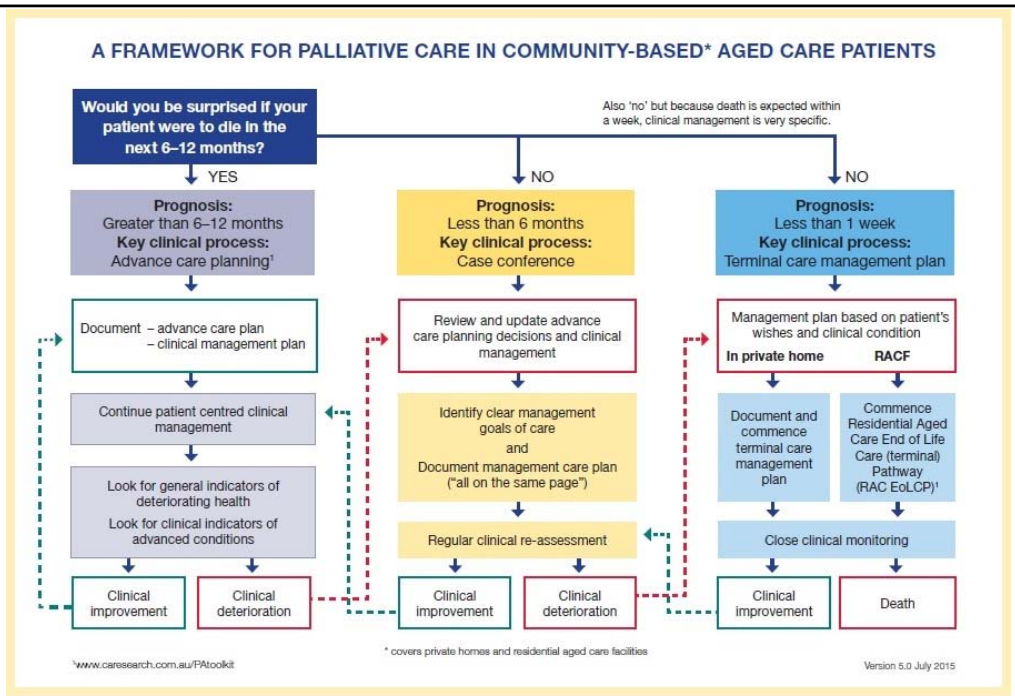
www.decisionassist.org.au

© Not to be used or modified without the permission of ANZSPM

Reframing palliative care



© Not to be used or modified without the permission of ANZSPM



© Not to be used or modified without the permission of ANZSPM

Some indicators of deteriorating health prompting consideration of the palliative approach[1]

- Performance status poor or deteriorating with limited reversibility
- Dependent of others for most care needs
- Two or more unplanned hospitalisations in past 6 months
- Significant weight loss (5-10%) over past 3-6 mths
- Persistent troublesome symptoms despite optimal treatment of any underlying conditions
- Patient requests supportive and palliative care or treatment withdrawal

[1]SPICT™


Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assess for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating with limited reversibility, is in bed or a chair for 50% or more of the day.
- Dependant on others for most care needs.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more advanced conditions:

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; swallowing difficulties; difficulties with nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

NYHA Class III/IV heart failure, or extensive, unbeatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30 ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Review supportive and palliative care and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

SPICT™ March 2015

Please register on the SPICT website (www.spict.org.uk) for information and updates.

Decision Assist is funded by the Australian Government
www.decisionassist.org.au
© Not to be used or modified without the permission of ANZSPM

Key processes to proactively manage clinical needs

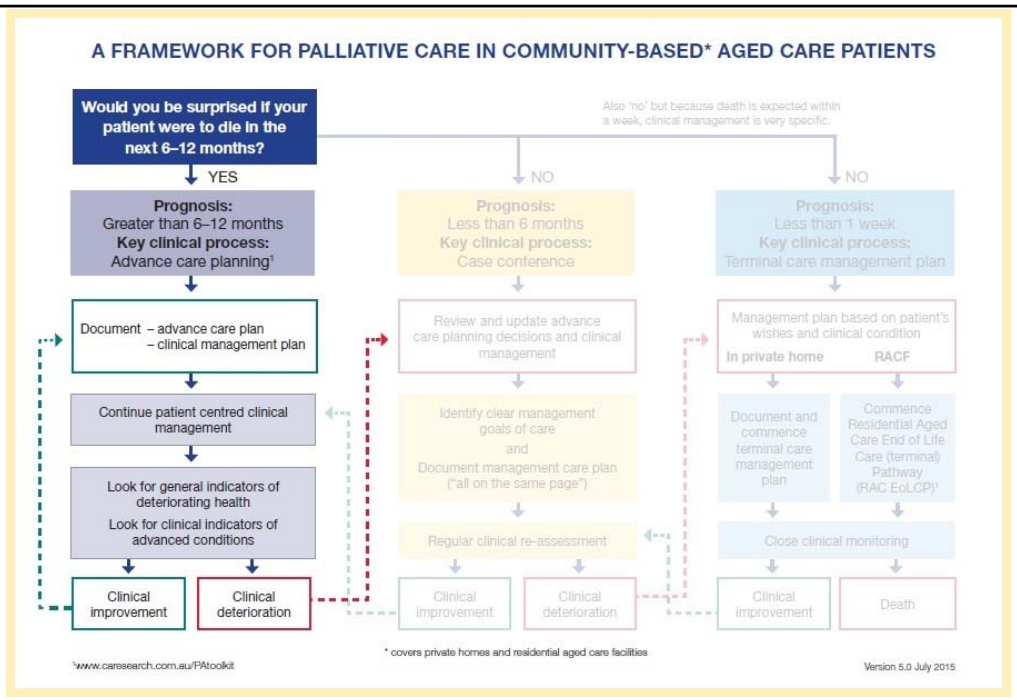
- Advance care planning (ACP) and documentation
- Case conferencing and management plan documentation
- Use of a terminal care management plan for patients at home or an end of life (terminal) care pathway for RACF residents

Prognosis: Greater than 6–12 months
Key clinical process: Advance care planning[1]

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

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

Decision Assist is funded by the Australian Government
www.decisionassist.org.au
© Not to be used or modified without the permission of ANZSPM



© Not to be used or modified without the permission of ANZSPM

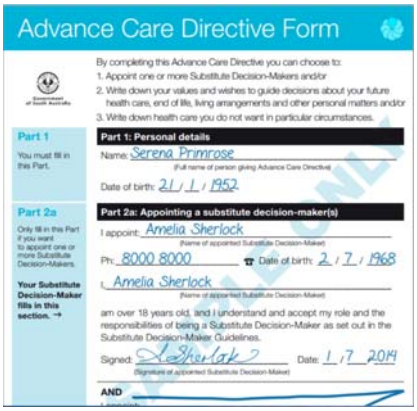
Advance care planning



© Not to be used or modified without the permission of ANZSPM

Key process: ACP

- ACP is an interactive ongoing process of communication focussing on the person's preferences for their care in the future
- Can have legally binding components (e.g. Advance Care Directive and Enduring Power of Attorney) or be a less formal document
- Allows care providers to know the person's wishes so that they can advocate for the person
- Helps GPs to inform the clinical management plan for the person


Advance Care Directive Form

By completing this Advance Care Directive you can choose to:
1. Appoint one or more Substitute Decision-Makers and/or
2. Write down your values and wishes to guide decisions about your future health care, end of life, living arrangements and other personal matters and/or
3. Write down health care you do not want in particular circumstances.

Part 1
You must fill in this Part.

Part 1: Personal details
Name: Serena Primrose
(Full name of person giving Advance Care Directive)
Date of birth: 21 / 1 / 1952

Part 2a
Only fill in this Part if you want to appoint one or more Substitute Decision-Makers.

Part 2a: Appointing a substitute decision-maker(s)
I appoint: Amelia Sherlock
(Name of appointed Substitute Decision-Maker)
Ph: 8000 8000 Date of birth: 2 / 7 / 1968
I, Amelia Sherlock
(Name of appointed Substitute Decision-Maker)
am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.
Signed: Amelia Sherlock Date: 1 / 7 / 2014
(Signature of appointed Substitute Decision-Maker)

Your Substitute Decision-Maker fills in this section. →

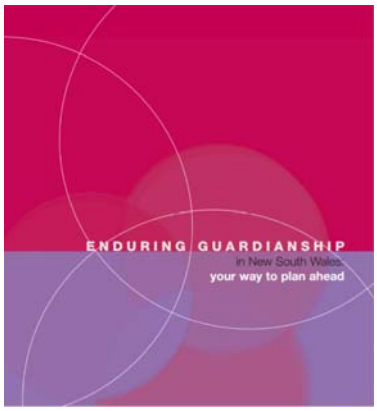
AND

SAMPLE ONLY

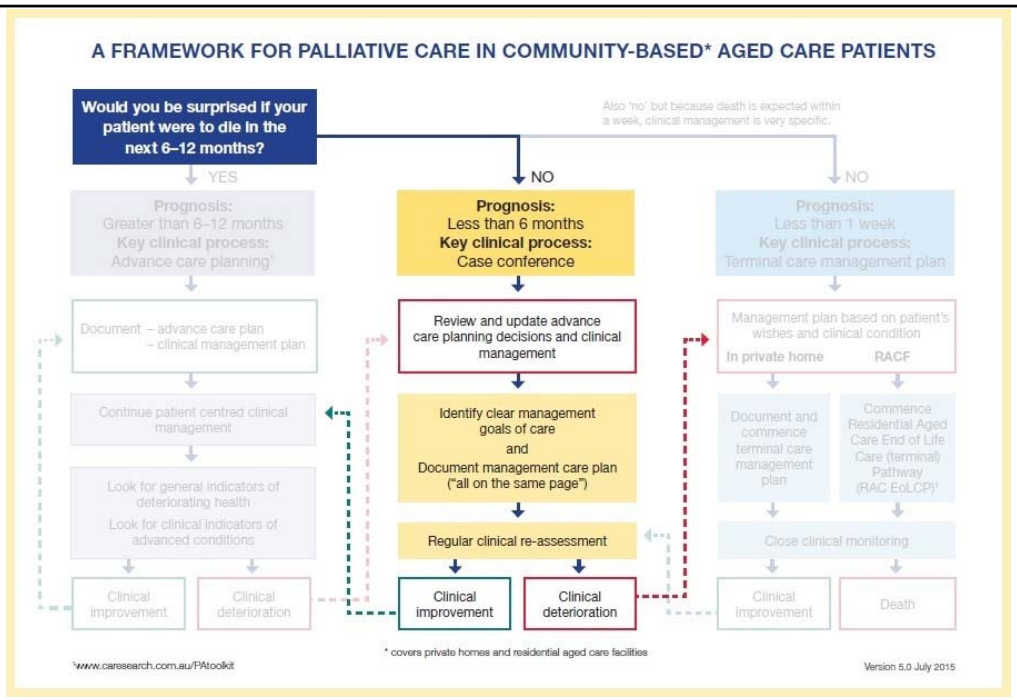
© Not to be used or modified without the permission of ANZSPM

Key process: ACP (con't)

- Identify the appropriate substitute decision maker for a person
- A person's substitute decision maker may not always be a family member.



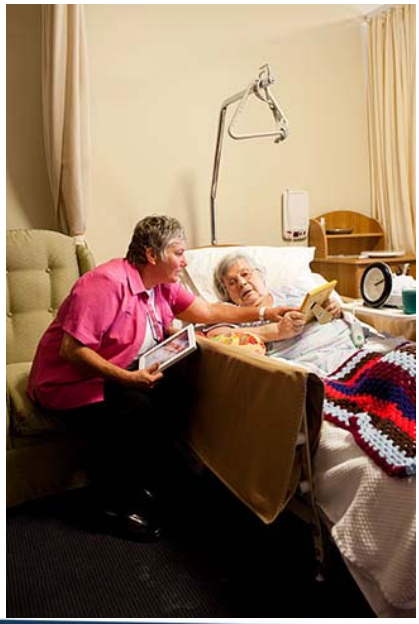
© Not to be used or modified without the permission of ANZSPM



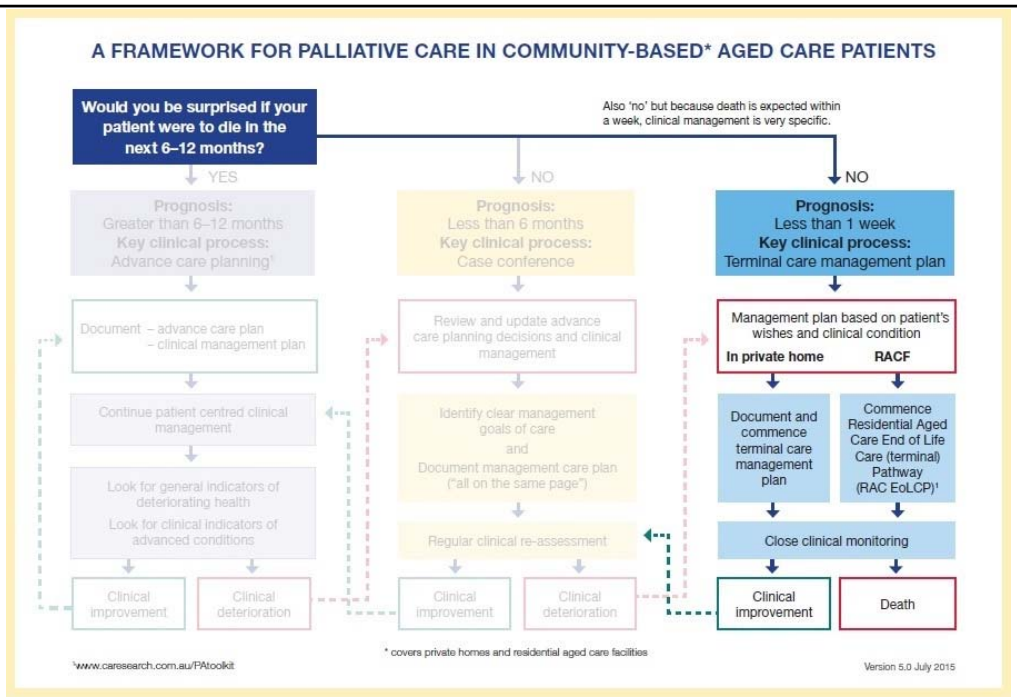
© Not to be used or modified without the permission of ANZSPM

Key process: Case conference

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



© Not to be used or modified without the permission of ANZSPM



© Not to be used or modified without the permission of ANZSPM

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

Decision Assist is funded by the Australian Government

© Not to be used or modified without the permission of ANZSPM

Key process: Terminal management plan

Medication	Concentration	Stock
Clonazepam drops*	2.5 mg/ml	1 bottle (10mls)
Fentanyl citrate injection**	100 mcg/2ml	10 ampoules
Haloperidol injection	5 mg/ml	10 ampoules
Hydromorphone injection	2 mg/ml	5 ampoules
Hyoscine butylbromide (*Buscopan*) injection**	20 mg/ml	5 ampoules
Metoclopramide injection	10 mg/2ml	10 ampoules
Midazolam injection**	5 mg/ml	10 ampoules
Morphine sulphate injection	10 mg/ml	5 ampoules

* PBS listed for seizures only
** Not listed on PBS

ANZSPM

BRISBANE SOUTH PALLIATIVE CARE COLLABORATIVE
Queensland Government Griffith University

Decision Assist is funded by the Australian Government
www.decisionassist.org.au
© Not to be used or modified without the permission of ANZSPM

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

Decision Assist is funded by the Australian Government
www.decisionassist.org.au
© Not to be used or modified without the permission of 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



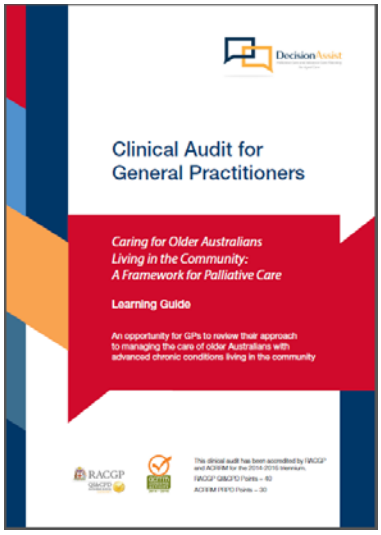
© Not to be used or modified without the permission of ANZSPM

Accredited educational activities

- Clinical audit
- Active Learning Module (RACGP) / Theory Practice Activity (ACRRM)
- RACGP: 40 Cat 1 QI&CPD points
  ACRRM: 30 PRPD points
- Contact: karencooper.ANZSPM@bigpond.com

acrrm ACCREDITED ACTIVITY 2014—2016

RACGP QI&CPD Accredited Activity CATEGORY 1



© Not to be used or modified without the permission of ANZSPM

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***

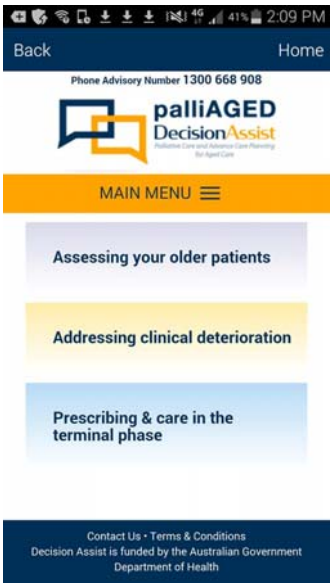
  An introduction to managing 4 common palliative care symptoms – pain, dyspnoea, nausea and vomiting, delirium
  www.decisionassist.org.au

© Not to be used or modified without the permission of ANZSPM

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



© Not to be used or modified without the permission of ANZSPM

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

DecisionAssist
Palliative Care and Advance Care Planning for Aged Care



Decision Assist is funded by the Australian Government

www.decisionassist.org.au
© Not to be used or modified without the permission of ANZSPM