Living Longer, Dying Better: A framework of palliative care for older Australians living in the community

Workshop overview

• Background
• Learning outcomes
• A palliative care framework of care based on prognostication
• Key processes within the framework to meet emergent clinical needs
• Case study
• Decision Assist resources
Background

- Funding from Australian Government to rollout Decision Assist to support health care professionals who work with older Australians living in the community

- Elements of Decision Assist

- GP role is essential for achieving optimal patient and family outcomes in community based palliative care for aged care

Learning outcomes

- Explain the contemporary scope of palliative care and how it supports the clinical management of older Australians

- Use a framework of care based on prognostic trajectories to proactively manage the palliative care needs of older Australians

- Access new resources and advisory services provided by Decision Assist
A FRAMEWORK FOR PALLIATIVE CARE IN COMMUNITY-BASED* AGED CARE PATIENTS

Would you be surprised if your patient were to die in the next 6-12 months?

YES

Prognostic:
Greater than 6-12 months
Key clinical process: Advance care planning

Review and update advance care planning decisions and clinical management

Document – advance care plan – clinical management plan

Continued patient centred clinical management

Look for general indicators of deteriorating health
Look for clinical indicators of advanced conditions

Clinical improvement
Clinical deterioration

NO

NO

NO

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

Identify clear management goals of care and Document management care plan (all on the same page)

Regular clinical re-assessment

Clinical improvement
Clinical deterioration

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

Management plan based on patient’s wishes and clinical condition

In private home

RACF

Document and commence terminal care management plan

Close clinical monitoring

Clinical improvement

Death

* covers private homes and residential aged care facilities

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Some indicators of deteriorating health prompting consideration of the palliative approach¹

- 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

¹SPICT™

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
Consider a patient you have seen recently where the framework of care may support your management and decision making.

Case study: Background

- 70 yr. old frail male with poor mobility secondary to cerebrovascular disease
- Co-morbidities include CCF, HT, COAD, PVD and diet “controlled” diabetes
- Polypharmacy
- No documented advance care plan
Background (con’t)

• He says so long as “I can roll my own smokes and bet on races, life is good. Mate, don’t send me to hospital, they don’t let you alone there.”

• Has lived alone for past 6 years; paid carers present for maximum time daily. Ongoing daily support from neighbour who has known him for 10 years

• Has a son in the Pilbara – “went bush” - last contact 4 years ago, no contact address

Background (con’t)

• You are now his new GP, and see him for the first time for his regular 3/12 review appointment.

• Your first impression is of frailty.

• Remembering the “Framework for Palliative Care”, you ask yourself the surprise question “Would you be surprised if this man died in the next 6-12 months?”
Based on your answer to the surprise question, into which framework trajectory is he likely to fit?
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.

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.
Background (con’t)

• At the consultation, a follow up long appointment is made to see the patient to discuss ACP.

Case study: Today

• Found collapsed on floor 09:00 by regular carer and he is transferred to hospital

• Alert but drowsy (needs repeated prompting)

• Quadraparesis, bilateral extensor plantars, unable to open mouth, speak, extend tongue or swallow, vertical eye movements present

• Carers distressed
Today (con’t)

- Transferred to hospital where the GP has visiting rights

- Requires regular nasopharyngeal suctioning – always elicits tears

- Biochemistry, CXR, ECG, CT – all unremarkable

- MRI

- PEG inserted
Case study: Later that week

- OT assessing patient daily – no consistent response, frequent crying, no meaningful communication

- Paid carers remain with patient during the day and report:
  - he said he never wanted to go to hospital
  - the regular suctioning elicits fear and much discomfort

Into which framework trajectory is he likely to fit?
Key process: Case conference

- A dialogue between all those concerned with the patient’s care
- Identify clear management goals of care so that “all on the same page”
- Key considerations:
  - Review the patient’s ACP if documented
  - Identify the person’s and/or substitute decision maker’s concerns
  - Share health information, estimated prognosis and what to expect as condition deteriorates
  - Document case conference outcome(s) and write up management care plan
Case study: Possible case conference components for GP and practice nurse

- Discuss with regular paid carers and neighbour to obtain a better idea of what the patient would want.

- Paid carers report cannot provide 24 hr cover. Already receiving maximum care package

- Contact police who are unable to find any family members

- Discuss management dilemma with colleagues

- Contacts specialist palliative care service for further advice

Case study (con't)

- The case conference plan includes:
  - Approach to Adult Guardian to withhold active treatments (including PEG), commence comfort palliative treatments. Adult Guardian agrees.
  - Plan to discharge to residential aged care facility (RACF), after PEG use ceased
  - Clinical care management plan documented
Into which framework trajectory is he likely to fit?
RAC EoL (terminal) CP

- A clinical guide to help promote best practice terminal care in Australian RACFs
- Integral part of The Palliative Approach (PA) Toolkit 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.

Medications endorsed by ANZSPM for use in terminal care in RACFs & suggested imprest stock quantities

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<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Stock</th>
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</thead>
<tbody>
<tr>
<td>Clonazepam drops*</td>
<td>2.5 mg/ml</td>
<td>1 bottle (10mls)</td>
</tr>
<tr>
<td>Fentanyl citrate injection**</td>
<td>100 mcg/2ml</td>
<td>10 ampoules</td>
</tr>
<tr>
<td>Haloperidol injection</td>
<td>5 mg/ml</td>
<td>10 ampoules</td>
</tr>
<tr>
<td>Hydromorphone injection</td>
<td>2 mg/ml</td>
<td>5 ampoules</td>
</tr>
<tr>
<td>Hyoscine butylbromide (Buscopan) injection**</td>
<td>20 mg/ml</td>
<td>5 ampoules</td>
</tr>
<tr>
<td>Metoclopramide injection</td>
<td>10 mg/2ml</td>
<td>10 ampoules</td>
</tr>
<tr>
<td>Midazolam injection**</td>
<td>5 mg/ml</td>
<td>10 ampoules</td>
</tr>
<tr>
<td>Morphine sulphate injection</td>
<td>10 mg/ml</td>
<td>5 ampoules</td>
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</tbody>
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* PBS listed for seizures only
** Not listed on PBS
Pharmacological guide for terminal symptom management

- Features:
  - list of medications endorsed by ANZSPM
  - evidence-based symptom management flowcharts
- Part of the Palliative Approach (PA) Toolkit
- On a USB card in workshop packs

Case study (con’t)

- Mr Smith dies peacefully at the RACF.
Terminal management plan for patients living independently

- Communicate diagnosis of dying, and likely course, to patient/substitute decision maker, family and aged care service providers
- Document and implement co-ordinated management plan available to all those requiring it
- Review medications – essential medications prescribed, available, charted. Education for medication administration
- Ensure death at home documentation is available, including ‘not for resuscitation’ order
- Develop, document and implement a bereavement follow-up plan

Decision Assist resources for GPs, practice nurses and aged care providers

- Range of educational opportunities and resources – see Decision Assist website [www.decisionassist.org.au](http://www.decisionassist.org.au)
Clinical support

- Specialist Palliative Care Phone Advisory Service – 24/7
  1300 668 908

- Advance Care Planning Phone Advisory Service – 7 days/week 8am-8pm
  1300 668 908

Clinical Audit

- An opportunity for GPs to review their approach to managing the care of older Australians with advanced chronic conditions living in the community

- RACGP: 40 Cat 1 QI&CPD points
  ACRRM: 30 PRPD points

- Contact: karencooper.ANZSPM@bigpond.com
Active Learning Module (RACGP) / Theory Practice Activity (ACRRM)

- An opportunity for GPs to increase their capacity to manage the care of older Australians with advanced chronic conditions living in the community
- 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](http://www.decisionassist.org.au)

Summary

- 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, educational opportunities and advisory services to inform their practice of palliative care