A good death in residential aged care

...optimising the use of medicines to manage symptoms in the end-of-life phase.

North East Valley Division of General Practice *La Trobe University*

Presentation
Palliative Care(Vic) Aged Care SIG
Diana Cooper
August 2011

The *Good Death in Residential Aged Care* project was funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Aged Care (EBPAC) program

"Everyone hopes that when they die they will be able to die in comfort and with dignity"

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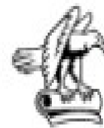
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Background to the Project

- Anecdotal evidence
  - symptoms managed poorly for some residents in RACFs at the end of their life

- Application to DoHA
  - EBPRAC (EBPAC) Program
  - 2008-2010 (2 Years)

Partners

- **Lead Agency: North East Valley Division of General Practice**
- **Lead Partner & Evaluator: La Trobe University** led by Professor Annette Street, Associate Dean (Research)Division of Health Research
- **Aged Care Homes** – Victoria (10), South Australia (9)
- **Community Palliative Care Services –**Banksia Palliative Care Service**,**

  Melbourne Citymission Palliative Care Service
- **Department of Health -** (Vic) Palliative Care
- **National Prescribing Service**
- **Divisions of General Practice in S.A.** – General Practice Network South, Adelaide North East Division of General Practice
- **DATIS** (Drug & Therapeutics Information Service South Australia)
- **Consultants**
  - Palliative Care Physicians
  - Geriatrician & Director, Aged & Residential Care Department, Austin Health
  - Consultant pharmacist
  - General Practitioners

RACF Demographics

- 19 Homes across 14 sites (Vic & SA)
- 1033 beds -range 30 - 134 beds
- 794 RACF staff
- 176 General Practitioners

Guidelines

- Guidelines for a palliative approach in residential aged care (enhanced version) *Australian Government Department of Health and Ageing. Canberra: Rural Health and Palliative Care Branch, Australian Government Department of Health and Ageing, 2006*.

- Therapeutic Guidelines: Palliative Care

  version 3 Melbourne: Therapeutic Guidelines Ltd., 2010.

other resources used:

- Australian Medicines Handbook 2010

- AMH Aged Care 2010 3rd edition

Definition of end-of-life care

End-of-life care or terminal care is care that is provided to people who have entered the phase where death may be expected within *hours, days, or weeks*

Project Goal

To implement evidence-based use of medicines to manage symptoms in the end-of-life phase for residents in aged care homes.

RESIDENT

Symptoms well- controlled

Best practice use of medicines

Project Objectives

- **Medicines**
  - Improved prescribing, including appropriate and effective use of “prn” medicines

- **Symptoms**
  - Improved recognition, assessment & monitoring of symptoms

Project Objectives: *cont*

- **People**
  - Improved collaboration
  - Improved processes to support informed choice
- **Pathways and Processes**
  - Improved systems to support use of medicines for symptom management at end of life

6 Symptoms

- Pain
- Agitation
- Breathing difficulties - dyspnoea
- Breathing difficulties - secretions
- Mouth discomfort
- Constipation

What did it take?

The project was implemented in 3 activity streams

Pathways & Processes

Education & Training

Clinical Support

Pathways and Processes

- Implementation of an End of Life Care Pathway
- Establishment of palliative care committees in RACFs
- Development of tool for RACFs to assess and plan palliative care policies and procedures

Print Form

Queensland Government

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

Facility: [Enter District/Facility/Service Here]

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Medicare No.:

The Brisbane South Palliative Care Collaborative (BSPCC) RAC EoLCP ™ was developed as part of a project funded by the Department of Health and Ageing. The RAC EoLCP is adapted from the Liverpool Care Pathway © (Royal Liverpool and Broadgreen University Hospitals NHS Trust and Marie Curie Cancer Care, operated under MCPIL 2010) and the NSW Central Coast Collaborative Pathway.

This End of Life Care Pathway (EoLCP) document is a consensus based, best practice guide to providing care for residents in Residential Aged Care Facilities (RACFs) during the last days of their lives. The entire document is to be placed in the resident's notes and forms part of their medical record.

To commence the pathway, authorisation should be obtained from the resident's General Practitioner (GP). If the GP cannot be contacted, interim authorisation can be obtained from one of the following: Palliative Care Medical Officer (PCMO), Palliative Care Nurse Specialist (PCNS) or Senior RACF Registered Nurse (RN). Authorisation can be verbal but needs to be confirmed in writing, by completing Section 1, within 48 hours.

Instructions for Completing the Pathway

Section 1: **Commencing a Resident on the Pathway**
Medical Officer to be consulted and documentation can be completed by any of the following: GP, PCMO, PCNS, RN

Section 2: **Medical Interventions and Advance Care Planning**
Medical Officer to be consulted and documentation can be completed by any of the following: GP, PCMO, PCNS, RN

Section 3: **Care Staff Interventions**

Part A - Care Management
To be completed by RN or Enrolled Nurse (EN)

Part B - Comfort Care Chart
To be completed by attending Nursing and Care Staff
A new chart is to be commenced daily

Part C - Further Care Action Sheet
Nursing and Care Staff are to document any further actions taken to improve comfort care

Section 4: **Multidisciplinary Communication Sheet**
All members of the multidisciplinary team can document here

Section 5: **After Death Care**
To be completed upon death of a resident by the attending nurse

Note: *Dependent upon individual RACF practices, it may be preferred to use existing facility documentation tools to record Sections 4 and 5.*

DO NOT WRITE IN THIS BINDING MARGIN

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Education

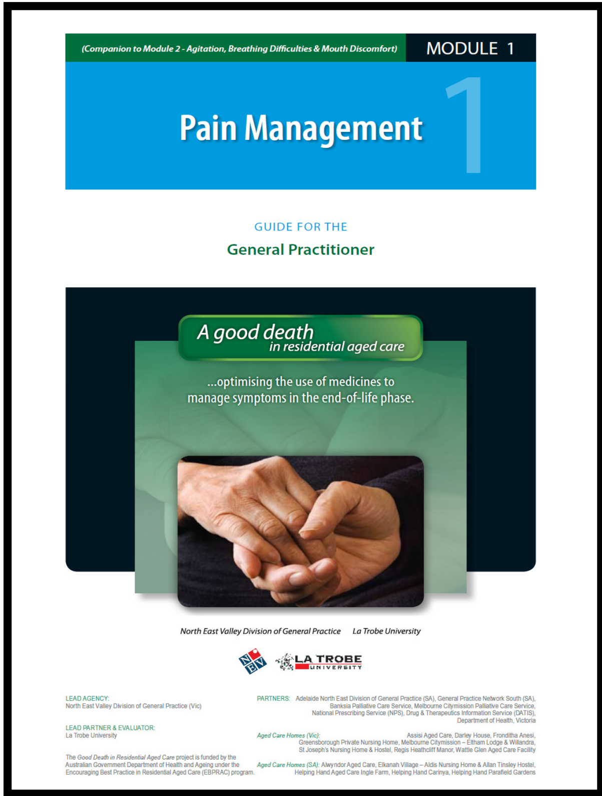
2 Modules developed -multidisciplinary expert opinion

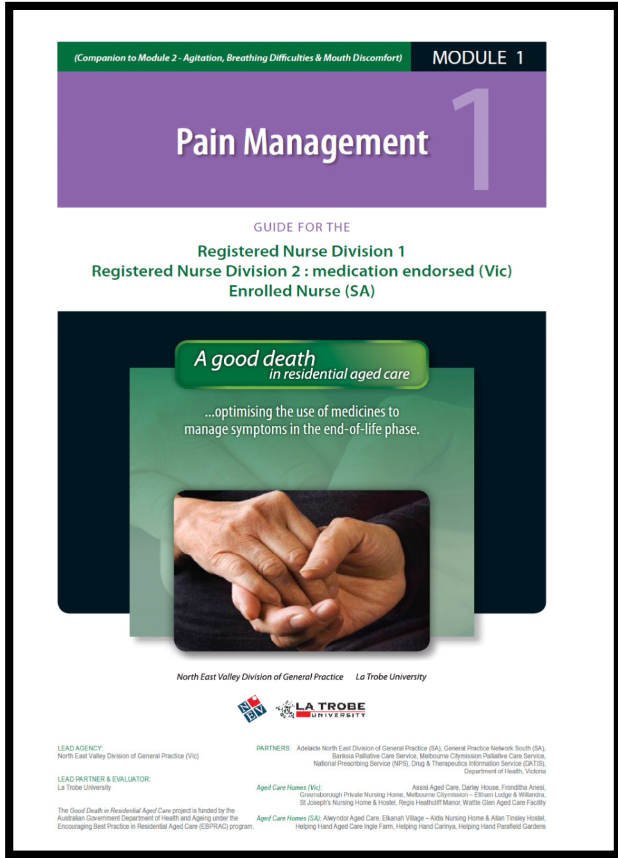
- Module 1: Pain
- Module 2: Agitation, Breathing Difficulties & Mouth Discomfort

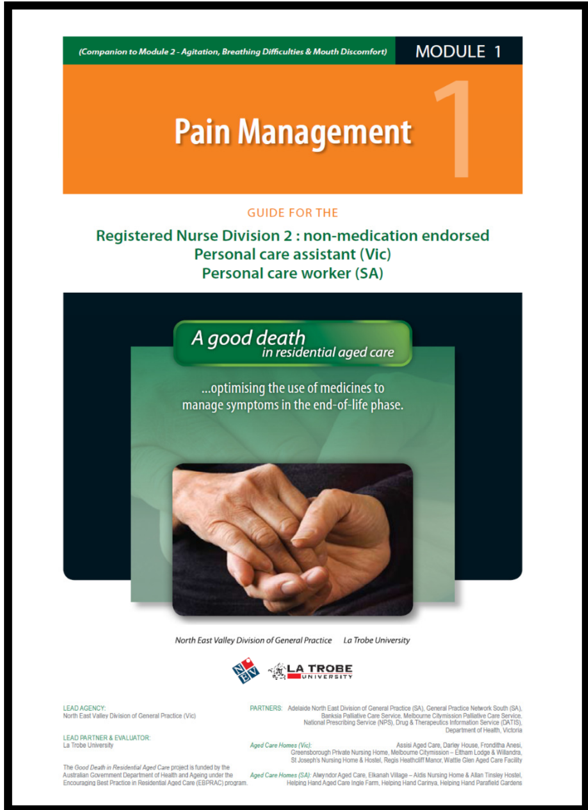
3 versions of each module developed applicable to different roles across the care team

- GP
- RN/EN
- PCA/PCW

Education Module 1







Education Module 2

(Companion to Module 1 - Pain Management) MODULE 2

Agitation, Breathing Difficulties & Mouth Discomfort

GUIDE FOR THE

General Practitioner

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(Companion to Module 1 - Pain Management) MODULE 2

Agitation, Breathing Difficulties & Mouth Discomfort

GUIDE FOR THE

Registered Nurse Division 1

Registered Nurse Division 2 : medication endorsed (Vic)

Enrolled Nurse (SA)

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(Companion to Module 1 - Pain Management) MODULE 2

Agitation, Breathing Difficulties & Mouth Discomfort

GUIDE FOR THE

Registered Nurse Division 2 : non-medication endorsed

Personal care assistant (Vic)

Personal care worker (SA)

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Education

- **How?**

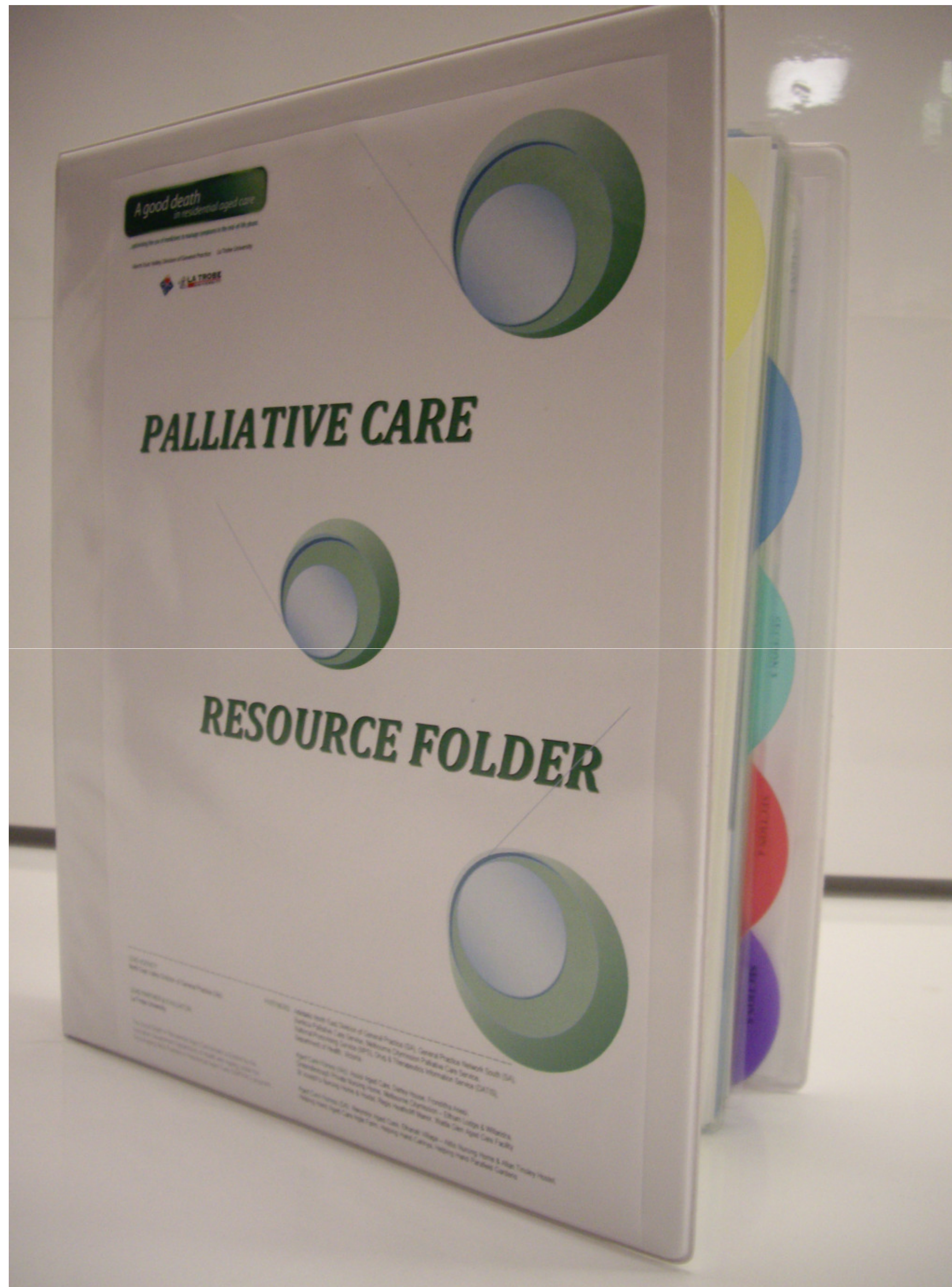
Delivered via 1:1 academic detailing (NPS model) & group education

Linking to existing education options: e.g. PEPA, local palliative care services

Clinical Support

- Development of
  - Development of Clinical Resource Folder
  - Clinical Support List

- Sourcing of
  - Short-list of medicines commonly used to manage symptoms at end of life
  - Opioid conversion chart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PALLIATIVE CARE
RESOURCE FOLDER

PALLIATIVE CARE CLINICAL SUPPORTS FOR RESIDENTIAL AGED CARE HOMES NORTH EAST VALLEY REGION

Name of Organisation	Address	Telephone Number	Services Offered	Referral Process	Cost
Banksia **Palliative Care Service**	Suite 4 50 Upper Heidelberg Rd Ivanhoe 3079	9497 2100	• 24 hour telephone availability • Coordination of health services • Expertise in controlling symptoms • Palliative Care Nurse Practitioners • Staff education	• Anyone may refer • Contact Banksia on 9497 2100 to discuss the resident • Complete referral form • Fax referral to Banksia 9497 5330 www.banksiapalliative.com.au	Free to clients in catchment area
Melbourne Citymission **Palliative Care Service**	472 Nicholson Street North Fitzroy 3065	9486 2666	• Coordination of care • Pain & symptom management • Information & education • Links to hospital and Pall care units • Consultancy to other health professionals • 24 Hour emergency support	• Anyone may refer • Contact team member on 9486 2666 to discuss www.melbournecitymission.org.au	Free to clients in catchment area
Austin Health **Residential Outreach Service**	Austin Health 145 Studley Rd Heidelberg 3084	0422 006 655	• Service will visit RACF when a resident is unwell (Note-does not replace GP responsibility) • Outreach medical & nursing service where appropriate • Support palliative care in the aged care home • Advice available 0900-2300hrs	• Telephone before 1400-2pm- (Mon-Fri) –ROS will visit that day. • Normal service hours 0900-1700 (Mon-Fri) • After hours advice available between 1700-2300 (Mon-Fri) & 0900-2300 (Sat-Sun) from Emergency Department Consultant on 9496 3368 or 9496 3774	Public Hospital
Austin Health **Palliative Care Unit (PCU)**	Austin Health Repatriation Campus 300 Waterdale Rd Heidelberg West 3081	9496 5000	• Inpatient palliative care services • Palliative Care Consultancy	• PCU will admit directly for symptom management and terminal care. • All residents will require an SCTT (1) to be completed by the GP, Community Palliative Care Service or RACF. • Telephone admission enquiries on 9496 2277/ 2542. • Austin Health Palliative Care Consultancy may also be able to assist with the referral process-telephone 9496 5961	Public Hospital
Northern Health HARP **RECIPE** and **Residential Response Program**	Northern Hospital 180 Cooper Street Epping 3076	8405 8712 (RECIPE) 0400 595 188 (Residential Response)	• Review medications • End stage palliative care • Advance Care Planning • Education to staff & family • Family support meetings • Medical treatment & assessment in the facility using HITH if appropriate	• RACF or GP may refer Mon-Fri 0800-1700 • Contact 8405 8712 • Resident >65 years • RACF must be within 30 minute drive from TNH • Resident & family consent required	Public Hospital

LEAD AGENCY:
North East Valley Division of General Practice (Vic)

LEAD PARTNER & EVALUATOR:
La Trobe University

PARTNERS: Adelaide North East Division of General Practice (SA), General Practice Network South (SA), Banksia Palliative Care Service, Melbourne Citymis sion Palliative Care Service National Prescribing Service (NPS), Drug & Therapeutics Information Service (DATIS), Department of Health, Victoria (DHV)

Aged Care Homes (Vic): Assisi Aged Care, Darley House, Fronditha Anesi, Greensborough Private Nursing Home, Melbourne Citymission –Eltham Lodge & Willandra, St Joseph's Nursing Home & Hostel, Regis Heathcliff Manor, Wattle Glen Aged Care Facility

Aged Care Homes (SA): Alwyndor Aged Care, Elkanah Village – Aldis Nursing Home & Allan Tinsley Hostel ,Helping Hand Aged Care Ingle Farm, Helping Hand Carinya, Helping Hand Parafield Gardens

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List 2: Doctor's bag palliative care medication

Medication	Formulation	Presentation	PBS Qty	Palliative care indication	Route of administration	Usual dose range
atropine	injection	600 micrograms in 1mL	10	Drying respiratory secretions	subcutaneous injection or infusion	Stat dose: 600 micrograms Ongoing therapy: 1200-2000 microgram daily by infusion
benztropine	injection	2 mg in 2 mL	5	Reversing extrapyramidal drug reaction	intramuscular or intravenous	Stat dose: 1 mg Repeat after 30 minutes if needed
clonazepam	drops	2.5 mg per 1 mL	1	Seizure management OR anxiety OR delirium in combination with haloperidol	oral or sublingual	Stat dose: 0.5 - 1 mg Ongoing therapy: 0.5 -1 mg bd
dexamethasone	injection	8 mg in 2 mL	5	Multiple indications including bowel obstruction, spinal cord compression, pain, vomiting	subcutaneous injection	Stat dose: 2-16 mg
haloperidol	injection	5 mg in 1 mL	10	Vomiting OR delirium	subcutaneous injection or infusion	Stat dose: 0.5-2.5 mg Ongoing therapy: 1-5 mg daily by infusion
hyoscine butylbromide	injection	20 mg in 1 mL	5	Colic OR drying respiratory secretions	subcutaneous injection or infusion	Stat dose: 20 mg Ongoing dose: 80-120 mg daily by infusion
metoclopramide	injection	10 mg in 2 mL	10	Vomiting	subcutaneous injection or infusion	Stat dose: 10 mg Ongoing dose: 30-60 mg daily by infusion
morphine	injection	30 mg in 1 mL	5	Pain OR dyspnoea	subcutaneous injection or infusion	Stat dose: 2.5-5 mg if opioid naive OR 1/6th -1/12th of current daily subcutaneous dose
naloxone	injection	2 mg in 5 mL	1	Reversing opioid induced hypoxaemia	intravenous injection or infusion	100 microgram repeated every 2 mins as needed followed by infusion
promethazine	injection	50 mg in 2 mL	10	Vomiting OR allergic reaction	intramuscular injection or subcutaneous injection or infusion	Stat dose: 6.25-12.5 mg Ongoing dose: 12.5-50 mg daily by infusion

Acknowledgements

The WA Cancer and Palliative Care Network would like to thank the expert panel who developed the resources for the palliative care Community Medications project.

Developed by: WA Cancer & Palliative Care Network, Community Medications Project
Funded by: Department of Health & Ageing, Palliative Care for People Living at Home Initiative
Website: www.healthnetworks.health.wa.gov.au/cancer/home

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AVPU SCGH Ref No: 0466-10

Government of **Western Australia**
Department of **Health**

WA Cancer and Palliative Care Network
Essential palliative care medication lists for community pharmacists and general practitioners

Good palliative care involves anticipatory sourcing of medications and pre-emptive prescribing.

Evaluation

- External evaluators
  - La Trobe University (Victoria)
- Method
  - Action research process
- Evaluation of
  1. Practice change
  2. Systems to support practice
  3. Clinical support
  4. Preparation for end of life

Key Results – Practice Change

Practice Change evaluated in:

- Use of End of Life Care Pathway
- Medicine management