FAR WEST NSW
PALLIATIVE AND END OF LIFE MODEL OF CARE

phn WESTERN NSW — An Australian Government Initiative

Far West NSW Palliative and End of Life Model of Care

NSW Health Far West Local Health District

NSW Health Western NSW Local Health District

ADVANCING LIFE-LIMITING ILLNESS — **DYING** — **DEATH**

STABLE last year of life ↔ **DETERIORATING** last months to weeks of life ↔ **TERMINAL** last days of life → **BEREAVEMENT** days, weeks & months after death

↕ **UNSTABLE** potentially reversible deterioration, with uncertain recovery and prognosis

TRIGGERS FOR COMMENCING PALLIATIVE & END OF LIFE MODEL OF CARE

1. **Patient has a life-limiting disease**
(including metastatic cancer, end-stage chronic disease or dementia)

AND

2. **Patient:**
- **in primary care who requires GP Chronic Disease Management Plan** (terminal illness)
OR
- **unplanned hospital admission via Emergency Dept who is aged ≥65 or Indigenous aged ≥55** (mortality 25% at 1year)
OR
- **admitted to Residential Aged Care Facility who is aged ≥65 or Indigenous aged ≥55** (mortality 27% at 6months & 38% at 1year)

AND

3.
- **fulfils 'Surprise Question'**
"Would you be surprised if your patient were to die in the next 6-12 months?"
AND
- **fulfils SPICT Criteria** (www.spict.org.uk)

FAR WEST NSW PALLIATIVE & END OF LIFE MODEL OF CARE

An individualised yet standardised needs-based approach for the care of patients and carers with life-limiting disease in the last year of life to ensure:

- **TIMELY IDENTIFICATION** of all patients with advancing life-limiting illness
- **PROMPTS** to identify when patients move between palliative care phases
- **HOLISTIC ASSESSMENT** to identify needs of these patients and their carers
- **CARE PLANNING** to address current and anticipate their future care needs
- **CARE COORDINATION & CASE CONFERENCING** to facilitate multi-disciplinary care and communication

With CLINICAL & EDUCATIONAL TOOLS to assist clinicians to provide best-practice care

and REPORTING & BENCHMARKING TOOLS to facilitate clinical audit and evaluation

STABLE

Prognosis: Last year of life
Key Process: **ADVANCE CARE PLANNING**

HOLISTIC MDT ASSESSMENT and CARE PLAN
- **Patient/carer holistic needs assessment** (including physical, psychological, emotional, social, spiritual and cultural domains)
- Determine goals of care & instigate holistic care plan

COMMUNICATION
- Communicate with patient and carer
- Provide 'palliative approach' information leaflet

ADVANCE CARE PLANNING (ACP)
- **Initiate Advance Care Planning discussion and complete documentation, if appropriate (including Advance Care Directive (ACD))**
- **Identify surrogate decision maker**
- **Initiate resuscitation discussion, if appropriate**
- **Complete Resuscitation Plan, if appropriate**
- **Complete Ambulance Plan, if appropriate**

SYMPTOM MANAGEMENT
- Optimise symptom management
- Rationalise regular medications

EQUIPMENT PROVISION
- Provide aids and equipment, if required
- Refer to allied health team, if required

CARER SUPPORT
- Register for carer respite
- Apply for carer allowance +/- payment
- Refer to home care services, if required

FOR PATIENTS WITH COMPLEX NEEDS:
- Refer to Specialist Palliative Care (SPC) Team
- Discuss at Specialist Palliative Care MDT Meeting
- 24/7 Palliative Care on-call service, if available

DETERIORATING

Prognosis: Last months-weeks of life
Key Processes: **MDT CARE COORDINATION**

HOLISTIC MDT ASSESSMENT and CARE PLAN
- Reassess holistic care needs frequently
- Review goals of care and holistic care plan to address current and future anticipated need
- **Discussion at MDT Case Conference**

COMMUNICATION
- Communicate with patient and carer

ADVANCE CARE PLANNING (ACP)
- Review and update ACP/ACD and goals of care
- Confirm Preferred Place of Care (PPC) and consider transfer to PPC, if appropriate
- Initiate or review resuscitation discussion
- Complete Resuscitation Plan, if not already done
- Complete Ambulance Plan, if not already done
- Complete Expected Death form, if at home

SYMPTOM MANAGEMENT
- Optimise symptom management
- Rationalise regular medications
- Prescribe anticipatory crisis drugs and orders
- Ensure drug administration equipment in situ

EQUIPMENT PROVISION
- Provide aids and equipment
- Refer to allied health team, if required

CARER SUPPORT
- Initiate carer respite, if required
- Refer to home care service, if required

FOR PATIENTS WITH COMPLEX NEEDS:
- Refer to Specialist Palliative Care (SPC) Team
- Discuss at Specialist Palliative Care MDT Meeting
- 24/7 Palliative Care on-call service, if available

TERMINAL

Prognosis: Last days of life
Key Process: **COMFORT CARE**

HOLISTIC MDT ASSESSMENT and CARE PLAN
- Reassess care needs at least daily
- Review care plan, in line with goals of care
- **Initiate Last Days of Life Toolkit or Residential Aged Care End of Life Pathway**

COMMUNICATION
- **Communicate with patient and carer**
- **Provide 'last days of life' information leaflet**

CARE IN LINE WITH ADVANCE CARE PLAN
- Confirm Preferred Place of Death (PPD) and consider transfer if appropriate
- Complete Resuscitation Plan, if not already done
- Complete Ambulance Plan, if not already done
- Complete Expected Death form, if at home and not already done

SYMPTOM MANAGEMENT
- Optimise symptom management
- Discontinue non-essential medications
- Prescribe anticipatory crisis drugs and orders
- Ensure drug administration equipment in situ

EQUIPMENT PROVISION
- Provide aids and equipment

CARER SUPPORT
- Refer to home care services, if required
- Provide carer medical certificates, if needed
- Identify carers 'at risk' of bereavement

FOR PATIENTS WITH COMPLEX NEEDS:
- Refer to Specialist Palliative Care (SPC) Team
- Discuss at Specialist Palliative Care MDT Meeting
- 24/7 Palliative Care on-call service, if available

BEREAVEMENT

Days, weeks and months after death
Key Process: **BEREAVEMENT SUPPORT**

CARE AFTER DEATH
- Undertake verification of death
- Complete Coroner's Checklist
- Complete Medical Certificate of Cause of Death
- Completed Attending Practitioner's Cremation Certificate, if required
- Provide after death care

COMMUNICATION
- Communicate with family and carers
- Provide bereavement information to carer

BEREAVEMENT SUPPORT
- Refer carers 'at risk' of bereavement for early follow-up
On-going bereavement, counselling and/or psychological support, as required

MDT COMMUNICATION and REFLECTION
- Notify healthcare professionals involved
- Wider MDT reflection and debrief, if required
- **For deaths in hospital:** Complete CEC death screen
- **For deaths known to Specialist Palliative Care:** After Death Discussion at SPC MDT Meeting

UNSTABLE

Urgent assessment and treatment of potentially reversible deterioration in line with wishes and advance care planning
Frequent reassessment, review of goals of care and communication with patient and carer; if in hospital, consider initiating **AMBER Care Bundle**

Model of care underpinned with: EDUCTION, TRAINING & CLINICAL SUPPORT plus CLINICAL AUDIT, RESEARCH & EVALUATION

Far West NSW Palliative and End of Life Model of Care: SHARE version
(Adapted from the Fylde Coast North West End of Life Care Model, UK)
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