GUIDANCE DOCUMENT: PALLIATIVE CARE NEEDS REVIEW

DEFINITION

"PALLIATIVE CARE NEEDS REVIEW" is a monthly one hour triage meeting to identify and prioritise care for the most at risk older adults in aged residential care facilities for unplanned dying with inadequately controlled symptoms.

PURPOSE

Identifying palliative care need is fundamental to providing quality palliative care for individuals and their family and whānau. Identifying palliative care need and end of life care planning in the older person with co-morbidities can be challenging. The Palliative Care Needs Review supports a collaborative approach to identifying and responding to residents changing condition and needs.

Regular triage meetings in aged care facilities will provide an opportunity to;

- Identify and anticipate symptom management needs,
- Plan appropriate care in alignment with the person's goals and changing needs
- Identify and organise family and whanau meetings as required
- Respond in a timely manner that supports the person, their family and whanau
- Refer to the most appropriate services to meet the persons needs
- Prevent unnecessary interventions and/or admission to hospital
- Provide teaching/learning opportunities for staff
- Facilitate residents wishes to die in their preferred location

PROCESS

1. The Clinical Lead/Manager of the aged care facility (ARC) will identify six to eight (this is facility dependant) residents who meet the criteria for the Palliative Care Needs Review using the "Triggers" on the document.
2. The Clinical Lead/Manager and senior RN will arrange a time (monthly) to meet with the Palliative Care CNS to meet and review the identified residents.
3. The Clinical Lead/Manager will complete the necessary preparations prior to the meeting using the working document as a template. See PC Needs Review Working Document.
4. The Palliative Care CNS, Clinical Lead/Manager and senior RN and/or other appropriate staff members will meet and review the residents identified.
5. Actions will be agreed upon and carried out by those identified as most appropriate.

A review of the completed actions and results will be carried out at the next months meeting.

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Triggers to discuss resident at needs review

One or more of:

1. You would not be surprised if the resident died in the next six months ⇨ Refer to Palliative Care Indicator Tool
2. Physical or cognitive decline or exacerbation of symptoms in the last month
3. No plans in place for last six months of life/no advance care plan
4. Conflict within the family around treatment and care options
5. Transferred to our facility for end of life care
6. CHESS score 4 or 5
7. Deteriorating condition as seen on SPICT

Reviews

- ☐ Have all actions been implemented?
- ☐ Have any new symptoms or concerns emerged
- ☐ Give positive feedback on actions that the staff managed well
- ☐ Decide if the resident should be kept on the palliative care review list, for ongoing monthly reviews.

New Referrals

- ☐ What are the resident's diagnoses and co-morbidities?
- ☐ What are their palliative care needs (including physical, psychosocial and spiritual symptoms)?
- ☐ What are staff current concerns around treatment or goals of care?
- ☐ Who supports the resident outside the facility (e.g. family/friends)

Actions

- ☐ Medication review (e.g. change meds, anticipatory meds) if appropriate.
- ☐ Organise surrogate decision maker?
- ☐ Develop a care plan appropriate to resident needs and goals of care (e.g. ACP, LDCP)
- ☐ Organise a family meeting.
- ☐ External referrals (e.g. pastoral care, dementia support services, wound care)?
- ☐ Refer to specialist palliative care?
- ☐ GP/NP review
- ☐ Provide care-based education (e.g. recognising deterioration and dying, bowel management, pain assessment, talking to GP's)