Palliative Care Service Access & Management
Flow Chart for General Practitioners

July 2015

Gippsland Region
Palliative Care Consortium
Clinical Practice Group

Policy No. GRPCC-CPG001_1.1_2015
Title Palliative Care Service Access & Management
Flow Chart for General Practitioners
Keywords Service, Access, Management, Guideline,
General, Practitioner, Palliative, Care, Clinical,
Practice
Ratified GRPCC Clinical Practice Group
Effective Date July 2015
Review Date July 2017
Purpose This policy has been endorsed by the GRPCC
Clinical Practice Group and is based on current
evidence based practice and should be used to
inform clinical practice, policies and procedures
in health services. The intent of the policy is to
promote region wide adoption of best practice.
Enquiries can be directed to GRPCC by email
GRPCC@gha.net.au

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Indicator that referral to a palliative care service may be appropriate:
Consider this question - ‘would you (the GP) be surprised if this patient were to die in the next 6-12 months’? If the answer is no and the patient meets either criteria (see reverse) consider referral to a palliative care service, after discussion with the patient and family.

Patient meets criteria for referral to local Palliative Care Service (see reverse)
Refer to palliative care service using the Victorian Statewide Referral Form (VSRF) see http://www.gpv.org.au/resources.asp?type=36 (recommended) or via a GPMP/TCA

Local community palliative care service. Contact details and hours of operation:

Local palliative care service triages all referrals according to criteria (see reverse) and if required obtains additional information

If pt is assessed as inappropriate for pall care service – feedback is provided to GP

Patient assessed as NON COMPLEX
Local palliative care service organises & completes initial assessment. Care plan discussed with GP
Patients discussed with Specialist Team at regular MDT on admission or as issues develop
Local palliative care service provides feedback of MDT to GP
Follow up organized and local team liaises with GP

Patient assessed as COMPLEX
Local service organises & completes initial assessment. Advises GP of complexity and planned discussion with Specialist Palliative Care Physician +/- GP
Local service discusses initial recommendations and care plan with GP
Patients discussed with Specialist Team at regular MDT on admission or as issues develop
Local palliative care service provides feedback of MDT to GP
Follow up organized and local team liaises with GP

Ongoing care by local palliative care service and GP & discussion with specialist team as required

If pt is assessed as inappropriate for pall care service – feedback is provided to GP
Pt reviewed by Specialist Palliative Care Physician if required
GP invited to participate in regular MDT - face to face or via teleconference

OPTIONAL
If in doubt as to whether pt meets referral criteria discuss with local palliative care service OR secondary phone consult to specialist team.
GOAL OF CARE

1. SYMPTOM ASSESSMENT AND MANAGEMENT
   - The patient is experiencing ongoing problems from physical symptoms due to their illness and care of the patient requires substantial supportive intervention
   - The patient has a significant level of emotional distress associated with illness, treatment or prognosis that requires substantial clinical intervention

2. TERMINAL CARE
   - The patient is in the terminal phase of their illness with complex symptom issues or significant family distress
   - Requires support for preferred place of care
   - Death is anticipated within four to eight weeks

3. RESTORATIVE CARE
   - The patient has become de-conditioned, the goal is to optimise the patient’s level of function which requires a multidisciplinary approach with a defined management and discharge plan

4. RESPITE CARE
   - This is the temporary care of a dependent patient for a defined period of time (usually 1 – 2 weeks), to enable the carer to continue in their caring role and for the patient to remain in their preferred environment into the future
   - The family or carer is experiencing distress associated with the illness, treatment, and prognosis and would benefit from a period of relief from care giving.

GENERAL INDICATORS for referral to Local Palliative Care Services

At least one of the following:
- Progressive deterioration in physical ability
- Dependence in 3 or more activities of daily living
- Multiple co-morbidities
- Symptoms cannot be alleviated by treating underlying disease
- Signs of malnutrition due to illness – cachexia; albumin <25g/l
- Severe progression of illness over recent months

DISEASE SPECIFIC INDICATORS for referral to Local Palliative Care Services

1. CARDIAC DISEASE
   At least one of:
   - Advanced heart failure
   - Three or more hospital admissions in last 12 months with symptoms of heart failure
   - Physical or psychological symptoms despite optimal tolerated therapy
   - And patient has declined attempted cardiopulmonary resuscitation or CPR will not be of benefit

2. REQUIRING DISEASE
   Unable/ unwilling to undergo dialysis or transplant and at least one of:
   - Patient wishes to stop dialysis
   - Signs of renal failure (nasea, pruritus, restlessness, altered consciousness)
   - Intractable fluid overload
   - Rapid deterioration anticipated by renal team

3. STROKE
   At least one of:
   - Persistent vegetative state
   - Severe dysphagia and/or neurological symptoms not indicated, or not chosen by the patient
   - Post stroke dementia
   - Poor nutritional state

4. LIVER DISEASE
   At least one of:
   - Ascites despite maximum diuretics; spontaneous peritonitis
   - Jaundice
   - Hepatorenal syndrome
   - PT T > 5 seconds above control
   - Enteral feeding persisting despite therapy
   - Recurrent variceal bleeding

5. CANCER
   - Incurable metastatic disease or inoperable disease
   - Symptomatic, psychological and/or social problems

6. PULMONARY DISEASE
   At least one of:
   - Cachexia of breath at rest or minimal exertion
   - Documented progressive disease
   - Symptomatic right heart failure

7. DEMENTIA
   - Inability to dress or walk with without assistance and
   - Urinary and faecal incontinence and
   - No consistent meaningful verbal communication

At least one of:
- Difficulty swallowing/eating; weight loss (>10% loss over 6 months)
- Recurrent urinary / or respiratory tract infections
- Multiple stage III or IV decubitus ulcers
- Symptoms causing distress

8. NEUROLOGICAL DISEASE
   - Significant progressive decline in function
   - Unable to walk
   - Dependent on assistance with activities of daily living
   - Barely intelligible speech; difficulty in communication
   - Cachexia
   - Difficulty eating and drinking
   - Significant dyspnoea and/or requires oxygen at rest
   - Declines assisted ventilation
   - Multiple co-morbidities
   - Patient medically unfit for surgery for life-threatening disease
   - Failure to respond to Intensive Care, death therefore inevitable

Criteria for Referral for Palliative Care Specialist Consult

Progressive incurable disease with complex palliative care needs (physical, spiritual, psychological) which are not being met.

COMPLEX PALLIATIVE CARE NEEDS may include:

1. Tumours or disease that are likely to require specialist input
2. Uncontrolled symptoms (e.g. ESAS score > 5 for pain, delirium, nausea and vomiting )
3. Two or more symptoms
4. Two or more sites of pain
5. Symptoms that have undergone a rapid deterioration ( unstable or deteriorating phase of care)
6. Significant side effects from medications
7. More than 2 medications required for pain control (not including paracetamol).
8. More than 4 medications required for overall symptom control
9. Complex psychosocial issues including dysfunctional family, lack of carer/social supports
10. Complex psychiatric history
11. History of prior substance abuse
12. Lack of clear advance care plan or difficulty with current goals of care
13. Paediatric or young adults

DISEASE SPECIFIC INDICATORS for referral to Specialist Palliative Care Consult

1. CARDIAC DISEASE
   PATIENT HAS DECLINED ATTEMPTED CARDIOPULMONARY RESUSCITATION OR CPR WILL NOT BE OF BENEFIT
   At least one of:
   - Advanced heart failure (e.g. NYHA IV)
   - Physical or psychological symptoms despite optimal tolerated therapy
   - Symptomatic arrhythmias resistant to treatment

2. RENAL DISEASE
   Dialysis or transplant not indicated, or not chosen by the patient, and at least one of:
   - Patient wishes to stop dialysis
   - Clinical indication of renal failure (nausea, pruritus, restlessness, altered consciousness)
   - Intractable fluid overload

4. LIVER DISEASE
   - Ascites despite maximum diuretics; spontaneous peritonitis
   - Hepatorenal syndrome
   - Encephalopathy
   - Recurrent variceal bleeding

5. CANCER
   - Paediatric/adolescent patients that are not for further treatment
   - Mesothelioma
   - Head and neck tumours
   - Symptomatic pelvic tumours
   - Malignant bowel obstruction
   - Symptomatic multiple bone metastases
   - Neuropathic pain

6. PULMONARY DISEASE
   - Shortness of breath at rest or minimal exertion
   - Symptomatic right heart failure

7. DEMENTIA
   - Difficulty swallowing/eating; weight loss (>10% loss over 6 months)
   - Recurrent urinary / or respiratory tract infections
   - Multiple stage III or IV decubitus ulcers
   - Symptoms causing distress

8. NEUROLOGICAL DISEASE
   - Difficulty eating and drinking
   - Significant dyspnoea and/or requires oxygen at rest
   - Declines assisted ventilation
   - Multiple co-morbidities
   - Patient medically unfit for surgery for life-threatening disease
   - Failure to respond to Intensive Care, death therefore inevitable