Gippsland Region
Palliative Care
Consortium

# Palliative Care Service Access & Management Flow Chart for General Practitioners

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**Gippsland Region**
**Palliative Care Consortium**
**Clinical Practice Group**

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| *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.Enquiries@wghg.com.au |
| *Pages* | 5 |

## Disclaimer

The intent of the clinical guidelines endorsed and made available by the GRPCC Clinical Practice Group is to assist health services and clinical staff across the Gippsland region to facilitate evidence-based practice in palliative care.

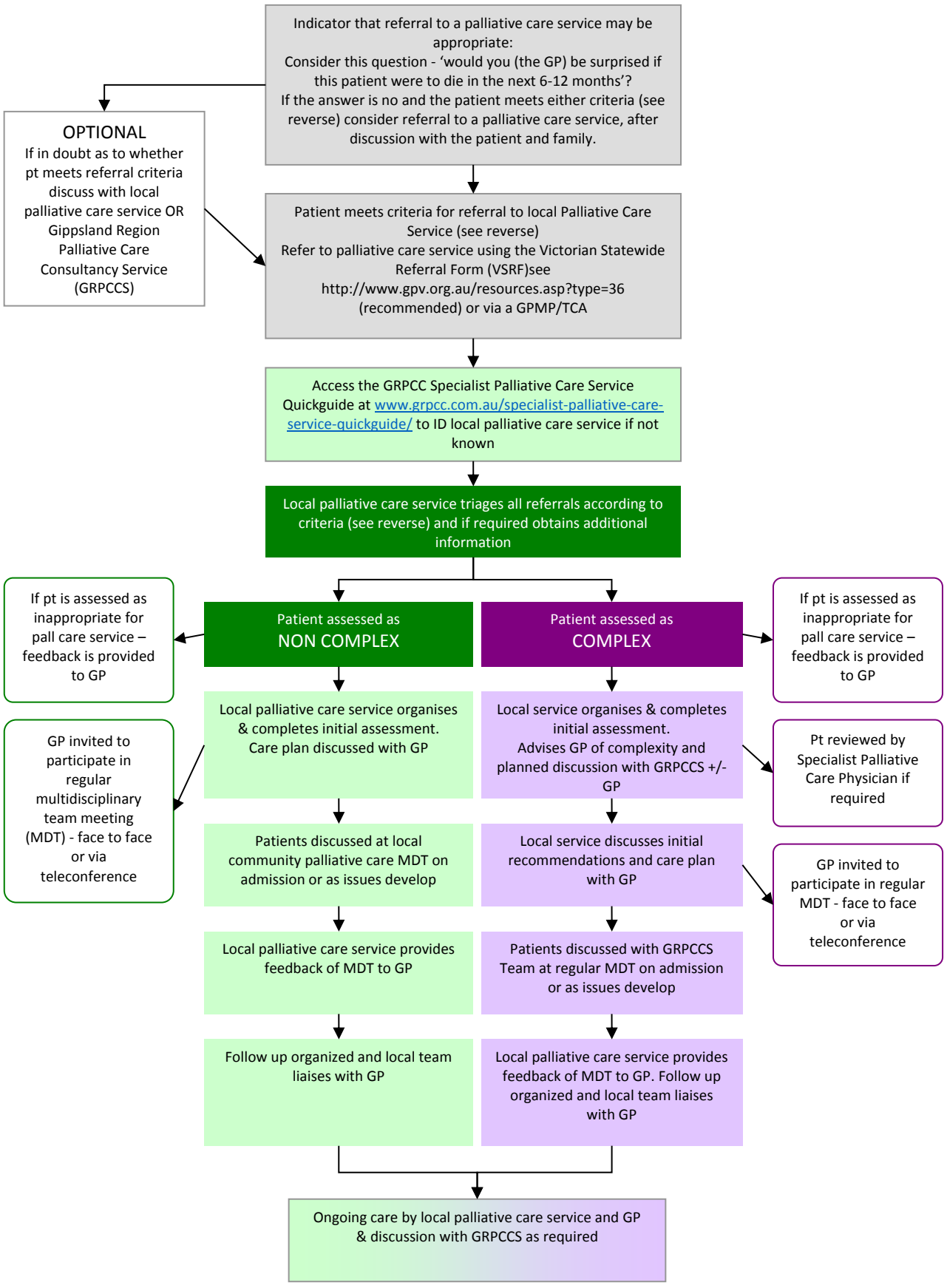
Clinical guidelines are intended to provide general advice to the medical, nursing, and allied health staff working with clients who have life limiting illness. They should never be relied upon as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient or organisation. There may be sound clinical reason for therapy that is different to that suggested in these guidelines. In all cases, clinicians should assess the individual clinical situation, and exercise independent clinical judgement when basing therapy on these guidelines. These guidelines are not a substitute for seeking appropriate consultation advice from the palliative care service.

Whilst the GRPCC endeavours to ensure these clinical guidelines are accurate at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become available after the issued or reviewed date.

The guidelines may be used by providers to develop protocols and procedures tailored to the requirements of their individual service or facilities.

Organisations and health care professionals should ensure that in using the GRPCC guidelines that they are complementary to their current organisational governance structures, and individual clinicians scope of practice.

# Palliative Care Service Access & Management Flow Chart for General Practitioners (this information also available on Gippsland Health Pathways- Palliative care)



# Suggested Criteria for Referral to Local Palliative Care Services

**Progressive incurable disease, either malignant or non-malignant.**
**Consider this question - 'would you (the GP) be surprised if this patient were to die in the next 6-12 months?'**

## 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
- ☐ Symptomatic arrhythmias resistant to treatment
- ☐ And patient has declined attempted cardiopulmonary resuscitation or CPR will not be of benefit.

### 2. RENAL DISEASE
*Unable/ unwilling to undergo dialysis or transplant and at least one of:*
- ☐ Patient wishes to stop dialysis
- ☐ Signs of renal failure (nausea, 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 interventional nutrition 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
- ☐ PTT > 5seconds above control
- ☐ Encephalopathy persisting despite therapy
- ☐ Recurrent variceal bleeding

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

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

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

*And 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

### 9. OTHER SITUATIONS
- ☐ 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 4)
- ☐ 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 features 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 and declines feeding tube
- ☐ Wishing to stop ventilation
- ☐ Uncontrolled pain secondary to the disease
- ☐ Dyspnoea, secretion management or other symptom