Driven to change, the sequel.

Mira Glavan [1], Dina Baytieh [2]
1. Illawarra Shoalhaven Local Health District Palliative Care Service

KEYWORDS

Anticipatory medicines, End of Life Care, PCOC Phase, Clinical conversations

EXECUTIVE SUMMARY (100 words maximum)

The review, update and further implementation of a standardised anticipatory symptom control medication process for Community Palliative Care clients to ensure safe and timely care within the district has ensured best practice. This process is initiated with a focus on PCOC assessment and clinical conversations with specialist palliative care health clinicians in an MDT huddle.

INTRODUCTION

Up to 70% of Australians would prefer to die at home. For persons with a life limiting illness who have expressed a wish to die at home the clinicians involved in their care aim for the delivery of high-quality end of life care in the home. One strategy to achieve this is the use of anticipatory medications in the injectable form to enable rapid response to symptoms such as pain, breathlessness, nausea, vomiting, anxiety, agitation, delirium and respiratory secretions. Anticipatory medications usually include an opioid analgesic, an antiemetic or antipsychotic, an anxiolytic and an anti-secretory. This is especially important when other routes of medication administration become ineffective or inappropriate.

Evidence shows that anticipatory prescribing can optimise effective symptom management, provide reassurance to the dying person and their family, improve likelihood of achieving preferred place of death and prevent unplanned and inappropriate hospital admissions. However anticipatory prescribing is associated with potential disadvantages and harms that must be acknowledged and managed. These concerns include injudicious prescription and administration of medicines, potential waste of medicines, financial cost to patient and potential for drug diversion. This means that most appropriate timing for the implementation of anticipatory medicines is essential.

This district has implemented a standardised, best practice anticipatory medicine process to ensure seamless transition to the subcutaneous route for medications. This initiative was implemented within this district in 2014 with a regular review of processes.

HIGHLIGHTS

- Community Palliative Care clients have access to a timely, standardised, best-practice anticipatory medication process in the community setting.
- Use of validated PCOC tools, multi-disciplinary team review and use of escalation pathways to facilitate appropriate and timely initiation of process in collaboration with General Practitioners to optimise patient outcomes, medication safety and cost effectiveness
- Comprehensive education to MDT palliative care specialist team, community health nurses and GP's to increase knowledge and proficiency in the process
- Retrospective and prospective chart review to evaluate effectiveness of the process.
- Patient information leaflet in easy-to-understand format

METHODOLOGY/ PROCESS

The original methodology for this initiative followed a strict Clinical Practice Improvement (CPI) process that was diagnostics and solution focused. This also included incident data review, staff surveys and General Practitioner consultation. In 2023 an evaluation of the original initiative and existing district process for initiating anticipatory medications was required. Therefore, a working group was formed including representation from the Specialist Palliative Care Team (Medical, Nursing), nursing management and Community Health Nursing. The existing processes and anticipatory medication chart were assessed and updated in line with new medication policies and palliative care best practice.

The updated standardised medication chart and process was approved by the district Drugs and Therapeutics committee, the forms committee, and the palliative care executive committee.

Education on the new standard medication chart, processes and escalation pathways was delivered tor community specialist and generalist nurses and General Practitioners

Information and new forms were disseminated to General Practitioners and updated on Coordinaire website for healthcare professionals.

A ‘Go Live’ date was set and process implemented.

The MDT huddles were used to evaluate best practice processes and ensure best implementation post initiation.

RESULTS/ OUTCOMES

Better anticipatory care for palliative care patents in the community setting.

Surveillance of process through escalation of patients in the deteriorating and terminal phase at multi-disciplinary huddles every morning and afternoon. (M-F)

Retrospective and prospective patient chart reviews to evaluate adherence to process and patient outcomes.

Deviation from process based on individualised needs discussed and approved by senior clinicians.

Optimised palliative care patient outcomes, medication safety and cost effectiveness.

CONCLUSION

In conclusion, this initiative has updated LHD current practices to ensure a safe standardised pre-emptive symptom control medication process for Community Palliative Care clients. This has also provided a supportive framework to staff with clinical conversations in huddles and escalation of deteriorating patients to ensure they have appropriate use of anticipatory palliative care medications in place for symptom management in the home.