Health Variations 5

1. Introduction to Palliative Care

"**Palliative care** aims to improve the **quality of life** of patients and the families of patients, who face the problem associated with life-threatening illness. It involves the early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems. It both prevents and relieves suffering.

Palliative care can be provided in three ways:

1. Promotes **quality of life**
2. Providing **specialist palliative care** for the assessment/treatment of complex symptoms
3. Providing **end of life care** at the terminal phase the client's illness

* These will incorporate **holistic care** principles*

1. Palliative Approach

A palliative approach to care aims to promote the **quality of life** of people living i the community who have

- Initial diagnosis
- Life limiting/threatening illness
- Becoming progressively frailer during old age
- Does not attempt to lengthen or shorten the client's life
- Acknowledges death is near, takes away the fear of death
- Recognises that a range of symptoms may need to be addressed t
- Improve overall comfort during life and around time of death

2. Specialised Palliative Service Provision

Provide expert advice on complex issues related to a person's care. The specialist palliative care teams **do not usually take over care** but rather provide advice on issues and support to GPs and health care teams. Examples of

General Practitioners	Specialist Services
Nursing Staff	Counsellors
Care Coordinators	Allied Health Professionals
Oncologists	The Aged Care Assessment Team (ACAT)
Care Aides/Workers	Chaplains
Meals on Wheels / Social Support Services	Volunteer

3. End of Life Care - Terminal phase of Client's Illness

Is appropriate when a person in final days/weeks of life when care decision need to be reviewed more frequently. We focus on resident's immediate physical, emotional and spiritual **comfort needs** and support for patient's family.

How do we know when they're in their terminal phase of their life?

- Cheyne Stoking : several breaths than pause / shallow breathing
- Depression
- Poor circulation - blue peripheries
- Weight loss
- Change in appetite
- Bowel / Urine Incontinent
- Fluid loss/ Fluid collection

What is life limiting illness

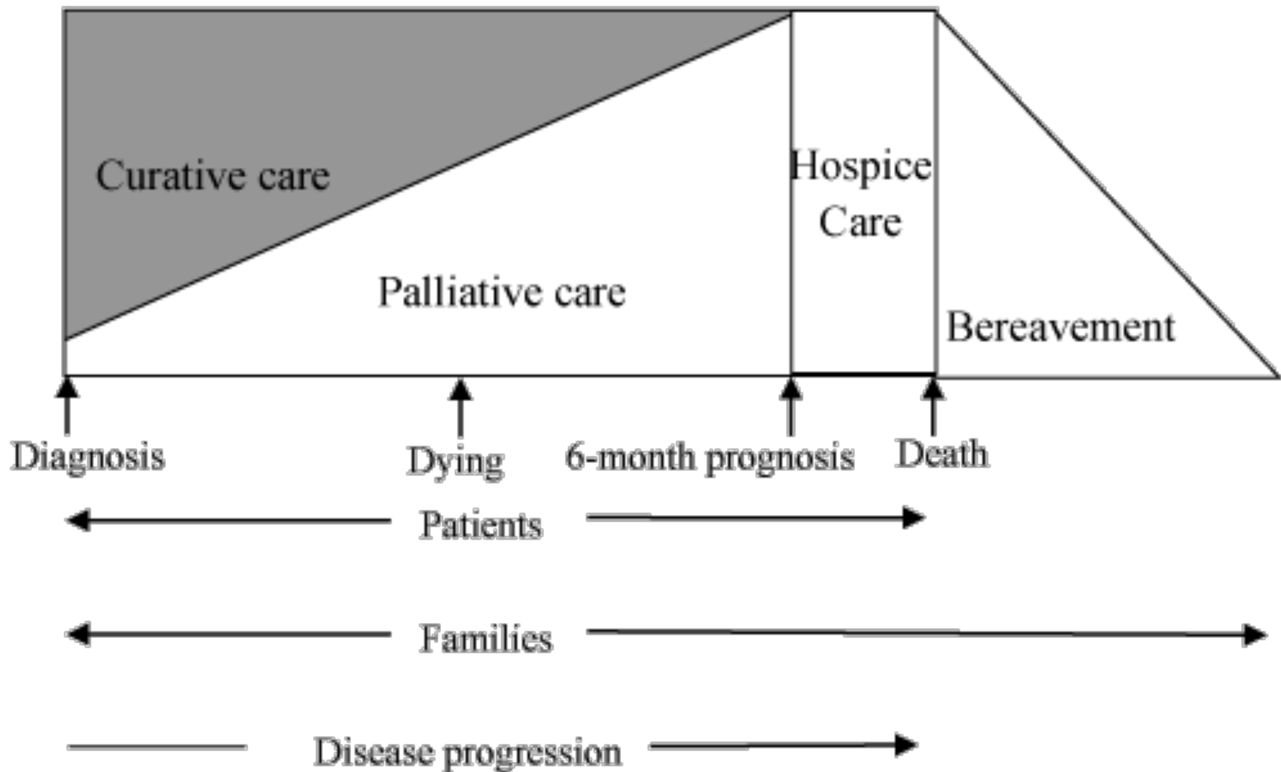
The term **life-limiting illness** is used to describe illnesses where it is expected that death will be a direct consequence of this illness. Examples of such illness is

- COPD
- Cancer
- Organ Failure
- Motor Neuron Disease
- Dementia
- Renal Disease
- Parkinson's disease

Inclusive of both malignant and non-malignant nature

Model of Continuum of Care Diagram

"A Model of Care… broadly defines the way health services are delivered. It outlines **best practice care and services** for a person or population group or patient cohort as they **progress through the stages of a condition, injury or event**. It aims to ensure people get the **right care, at the right time, by the right team and in the right place**" (Agency for Clinical Innovation, 2013, n.p.).



Where can it be provided? 🏠🏥

The patient's homes , acute hospitals, hospices – may be community based or led by tertiary facilities, general practices, specialist clinics, aged care facilities, other organisations people may be living such as correctional facilities, locations caring for people living with severe mental illness/severe disabilities

The multidisciplinary team needs to take into account:

- Cultural Beliefs
- Client & Family Perspectives
- The support of the family caregiver

The importance components of developing a good interpersonal relationship:

1. **Provide Information**
   Checking they understand their diagnosis and identifying any issues with the management of their symptoms and the psychosocial and emotional support. Do not overwhelm, only provide relevant information in a timely manner. Also provide written information.

2. **Provide Care Options**
   Information about an illness pathway and care options available as the illness

progresses. Knowing that there are options will enhance the quality of life and provide comfort to clients.

3. **Give Enough Time**
   Time to consider the care options available to them

Advanced Care Planning
Advance care planning is the process by which people consider their values and goals in discussions with their family and the health care professionals providing their care and treatment. Their preferences for future care are made known.

An advance care plan communicates the results of these discussions. For the plan to be written the client and the family need to know what their options are in order to make an informed decision about their ongoing care needs.

The plan should be reviewed if and when the client's situation changes.

Advanced Care Directives
Advance care directives are legally binding documents that must be followed at all times. Advance care directives are designed to be used when people are unable to make decisions for themselves. They extend the person's autonomy, allowing them to continue to stipulate their wishes and direct the type of care they would prefer. Their formation formalises the advance care plan.

By writing an advance care directive the client is able to inform the care providers of their needs and wishes during the illness trajectory. The advance care directive will be supported by the decisions the client and family have made. The health care team should explain the risks and benefits of all options, including options for palliative and supportive care This document must be witnessed and signed, typically by the client's GP. It should include an appointing a substitute decision maker.

<u>Examples</u>:

- Cardiopulmonary resuscitation
- Mechanical ventilation
- Artificial feeding and hydration
- The use of medication
- Surgical procedures

Barriers
There are many barriers to writing an advanced care directive