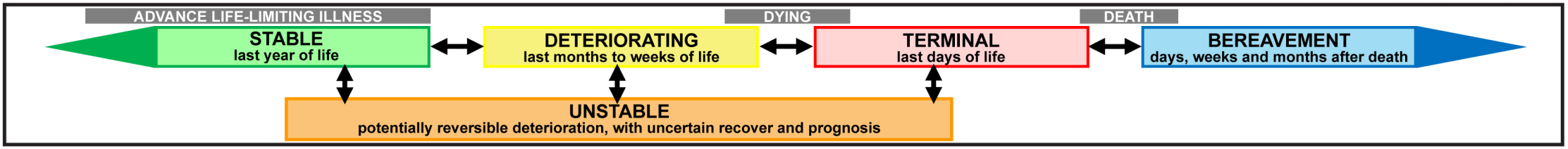
phn WESTERN NSW
An Australian Government Initiative

Far West NSW Palliative and End of Life Model of Care

Medical Goals of Care

in partnership with the Western NSW and Far West Local Health Districts

NSW GOVERNMENT Health



GOALS OF CARE	CURATIVE	STABLE Palliative Care Phase	UNSTABLE Palliative Care Phase	DETERIORATIVE Palliative Care Phase	TERMINAL Palliative Care Phase	BEREAVEMENT Palliative Care Phase
Definition of Palliative Care Phase		• Problems and symptoms are adequately controlled by established plan of care • Family and carer situation is relatively stable • No new issues apparent	• Existing problems rapidly increase in severity • New problems develop that were not anticipated in existing plan of care • Family and carer circumstances change suddenly and impact on patient care	• Overall functional declining • Gradual worsening of existing problems • New, but anticipated, problems develop • Family and carers experience gradual worsening distress which impacts patient care	• Death likely within days	• Patient has died • Bereavement support provided to family & carers
Goals of care	Cure or prolonged remission, with restoration of health status and function with no limitations of care and treatment	Maintenance of symptom control, function and quality of life within context of life-limiting diagnosis; limitations of care and treatment likely	Treatment of potentially reversible cause of acute deterioration, as well as symptom control and functional support within context of life-limiting diagnosis; limitations of care and treatment likely	Symptom management and support of functional decline to sustain quality of life in context of life-limiting diagnosis and within limitations of expected deterioration	Comfort, dignified and compassiate care in the last days of life	After death bereavement support for family and carers
Clinical scenario	• Reasonable chance of cure • Reasonable expectation of complete recovery from acute medical problem	• Incurable life-limiting disease • Prognostic Indicators? • Surprise question – 6-12 months? • Living, whist anticipating death	• Incurable life-limiting disease • Acute deterioration due to potentially reversible cause • Recovery uncertain: may recover to stable phase or may transition to deteriorating/terminal phase	• Incurable life-limiting disease • No sustained response to treatment • Disease progression despite maximal therapy • Gradual but steady decline in health • Functional decline and increasing dependency • Anticipating and preparing for death	• Incurable life-limiting disease • No sustained response to treatment • Disease progression despite maximal therapy • Clincal indicators suggesting a diagnosis of dying • Surprise question – this week?	
Prognosis	• Indefinite • Normal life-expectancy with complete recovery	• Months, sometimes years	• Uncertain	• Weeks	• Days or hours	
Key clinical process		• Holistic Assessment & Advance Care Planning	• AMBER Care Bundle	• Care Coordination & MDT Case Conferencing	• Last Days of Life Toolkit	
Investigation and monitoring	• As indicated to assess clinical situation and determine appropriate management plan	• Routine medical, nursing and allied health not usually required • May be clinically indicated to assess for potentially reversible acute deterioration • May also be clinically indicated to guide symptom management or support quality of life • Must be acceptable to the patient	• As clinically indicated to assess potentially reversible acute deterioration • May also be clinically indicated to guide symptom management or support quality of life • May have altered calling criteria, but must be in line with goals of care • Must be acceptable to the patient	• Discontinue routine medical, nursing and allied health investigations and monitoring • Should only be undertaken if clinically indicated to guide symptom management or to support quality of life • May have altered calling criteria, but must be in line with goals of care • Must be acceptable to the patient	• Discontinue all invasive medical, nursing and allied health interventions including observations, blood tests, pathology, radiology, etc. • Only continue if contributing to comfort care	
Active treatment of underlying disease	• All active treatment given to cure disease and manage treatment-related adverse effects	• Palliative treatment of disease may be considered (for specific symptom control or to maintain quality of life) • Active management of treatment-related adverse effects	• Palliative treatment of disease may be considered (as in stable phase) • Active management of treatment-related adverse effects • Active treatment of potentially reversible cause of acute deterioration	• Discontinue all disease-modifying palliative treatments • Some medical therapies may be considered for symptom control or to support quality of life	• Disease-modifying palliative treatment of disease inappropriate, and should be discontinued • Discontinue all active medical therapies • Only continue treatments if contributing to comfort care	
Acceptable level of adverse effects	• High level of adverse effect are accepted • Risk of treatment-related mortality may be accepted	• Some level of adverse effects may be acceptable • All treatment-related adverse effects must be proportionate to goals of care and acceptable to the patient	• Some level of adverse effects may be acceptable • All treatment-related adverse effects must be proportionate to goals of care and acceptable to the patient	• Only minimal treatment-related adverse effects are acceptable • The symptomatic benefit of treatment must outweigh the burden of adverse effects and be acceptable to the patient	• No treatment-related toxicity is acceptable from any medical, nursing or allied health intervention	
Life-sustaining treatment for other conditions	• All given as needed and clinically indicated	• Usually continued, but consider rationalisation of non-essential treatments	• Usually continued, but consider rationalisation of non-essential treatments	• Discontinue, unless doing so would result in preventable unpleasant symptoms, reduced quality of life, or premature death unrelated to life-limiting diagnosis	• Discontinue, unless doing so would result in preventable unpleasant symptoms • Implantable cardiac defibrillator (ICD) devices must be deactivated in the deteriorating or terminal palliative care phases *	
Symptomatic management	• Yes, alongside active management	• Yes • Oral medications usually tolerated	• Yes, alongside acute management • Oral medications usually tolerated • If acute deterioration has compromised oral route, temporary alternative medication administration may need to be considered • Consider provision of Palliative Care Crisis Medications if recovery uncertain	• Yes • Oral medication usually tolerated • Alternative route for medication administration may need to be considered as expected deterioration occurs • Provision of Palliative Care Crisis Medications in anticipation of transition to terminal phase	• Yes • Palliative Care Crisis Medications	
Medical provision of hydration and nutrition	• Yes, and given as needed and clinically indicated	• Given if clinically indicated and desired by the patient	• Given if clinically indicated and desired by the patient	• May be considered for symptom control or to support quality of life • Even if at risk of aspiration, oral intake may be appropriate to support of quality of life desires	• Usually non-commenced or ceased • Oral sips and feeding at patient's request • Regular and effective mouthcare is essential	
Acute resuscitation (including CPR)	• All acute resuscitation given if clinically indicated (including CPR, defibrillation, intubation, Ventilation, ICU admission and/or transfer to high acuity facility)	• Not usually recommended • Should not be required in stable phase • As part of advance care planning conversations, may be discussed with patient if competent, and/or person responsible if not competent, in context of underlying life-limiting illness • CPR, defibrillation, intubation and ventilation not usually recommended • ICU admission or transfer to high acuity facility may be considered in unstable phase for treatment of potentially reversible cause of acute deterioration, but must be proportionate to goals of care and acceptable to the patient	• Not usually recommended • CPR, defibrillation, intubation and ventilation not usually recommended • ICU admission or transfer to high acuity facility may be considered for treatment of potentially reversible cause of acute deterioration, but must be proportionate to goals of care and acceptable to the patient • Usually discussed with patient if competent, and/or person responsible if not competent, in context of life-limiting illness and advance care planning conversations	• Not clinically appropriate; should not be offered • Discussion with patient and family should focus on progression of incurable and life-limiting illness, importance of symptom control and anticipation of death and dying • Specific discussion regarding resuscitation may not be warranted, unless requested by patient or family	• Not clinically appropriate; should not be offered • Discussion with patient, if able, and family should focus on dying, imminent death, and importance of comfort care • Specific discussion regarding resuscitation is not usually warranted, unless pateint or family wish	