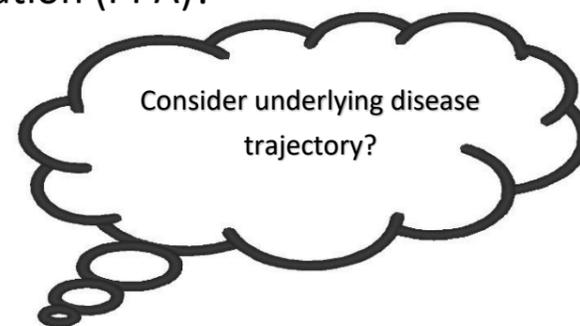


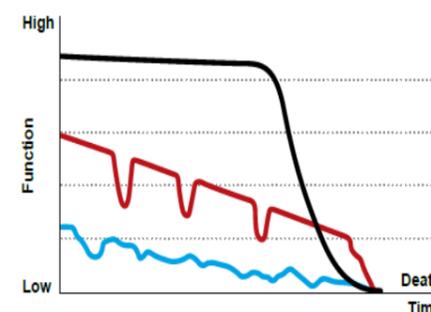
Palliative Pathway Activation Process Flow Chart

When should I consider completing a Palliative Pathway Activation (PPA)?

Lets consult our Poi tools



Australian-modified Karnofsky Performance scale	
100	Normal with no complaints or evidence of disease
90	Able to carry on normal activity but with minor sign of illness present
80	Normal activity but requiring effort. Signs and symptoms of disease more prominent
70	Able to care for self, but unable to work or carry on other normal activities
60	Able to care for most needs, but requires occasional assistance
50	Consideration assistance and frequent medical care required
40	In bed more than 50% of the time
30	Almost completely bedfast
20	Totally bedfast and requiring extensive nursing care by professionals and or family
10	Comatose or barely rousable
0	Death



Source: Murray, S.A. et al'

- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)

WHEN WE LOOK WITH THE PALLIATIVE PERSPECTIVE

- What is the **AKPS** score?
- What is the **PHASE**? What is the **UNDERLYING** disease burden/trajectory?
- Are there any general/clinical indicators **SPIC?**
- Does this overall picture suggest last **6-9MTHS OF LIFE**?
- Does **EVERYONE KNOW** what is happening with the person?



Supportive and Palliative Care Indicators Tool (SPIC™)

The SPIC™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day), reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition(s).
- Patient asks for supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more advanced conditions

Cancer	Heart/vascular disease	Kidney disease
Functional ability deteriorating due to progressive metastatic cancer.	NYHA Class III/IV heart failure, or extensive, unstable coronary artery disease with:	Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
Too frail for oncology treatment or treatment is for symptom control.	• breathlessness or chest pain at rest or on minimal exertion.	Kidney failure complicating other life limiting conditions or treatments.
	Severe, inoperable peripheral vascular disease.	Stopping dialysis.
		Liver disease
		Advanced cirrhosis with one or more complications in past year:
		• diuretic resistant ascites
		• hepatic encephalopathy
		• hepatorenal syndrome
		• bacterial peritonitis
		• recurrent variceal bleeds
		Liver transplant is contraindicated.

Review supportive and palliative care and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

Potential actions following Phase assessment		
Palliative Care Phase	Actions if this is a new Phase	Actions if Phase is the same as previous assessment
Stable	<ul style="list-style-type: none"> Continue as per plan of care. 	<ul style="list-style-type: none"> Continue as per plan of care. Commence discharge planning if appropriate.
Unstable	<ul style="list-style-type: none"> Urgent intervention and escalation required. Change plan of care. Urgent medical review and or allied health services. Review within 24 hours. 	<ul style="list-style-type: none"> Continue urgent action, adjust plan of care, refer, and intervene. When no further changes to the care plan are required, change Phase.
Deteriorating	<ul style="list-style-type: none"> Change in plan of care required to address increasing needs. Referral to medical or allied health may be required. Family / carer support may increase. 	<ul style="list-style-type: none"> Review and change plan of care. When deterioration plateaus, change Phase to Stable.
Terminal	<ul style="list-style-type: none"> Commence end of life care (adjust plan of care if required). Discuss change in condition with family and those important to the patient. <p>Consider: <i>Te Ara Whakapiri Toolkit – National MOH End of life guidelines</i></p>	<ul style="list-style-type: none"> Continue end of life care as per plan of care. Communicate changes to family and others important to the patient. If patient not likely to die in the next few days, change Phase. End the Episode of Care when patient dies.
Bereavement	<ul style="list-style-type: none"> Provide bereavement support to family and those important to the patient. 	<ul style="list-style-type: none"> If family require ongoing support, refer to appropriate service (family member becomes a client in their own right).

SUPPORTIVE AND HOLISTIC PALLIATIVE CARE PLANNING

- Let's have a **CONVERSATION** and Whānau meeting
- Complete a **PPA**
- Consult with the Poi Team – **PAS** feedback
- Documentation/care planning **CLEARLY COMMUNICATED** in Facility
- Ongoing **support** through Poi.
<https://www.poiproject.co.nz/>