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Grampians Regional Palliative Care Team

ESSENTIAL MEDICINES FOR PALLIATIVE CARE

The World Health Organisation released the 18th Edition of Essential Medicines in April this year. The second section lists those thought to be essential for pain and palliative care. It is the list that we should expect to be available to all dying people. Unfortunately the grim truth is that many, perhaps most, people die without access even to this limited choice because of inaction by governments, misunderstandings about the safety of opioids, and other reasons.

Codeine and morphine are the only opioids on the list. Codeine is included only as a 30mg tablet, but the list includes morphine in short acting and long acting forms and injectable morphine in 10mg ampoules. Acceptable alternatives are hydromorphone and oxycodone.

Medicines for neuropathic pain are restricted to amitriptyline and dexamethasone. Antiemetics are cyclizine, metoclopramide, haloperidol and ondansetron. Apart from amitriptyline, the only other antidepressant is fluoxetine. Docusate is there for constipation, and loperimide for diarrhea. Midazolam and diazepam (oral, injectable and rectal) are included, so there is choice between haloperidol and these drugs for sedation. Both hyoscine butylbromide and hyoscine hydrobromide are included for colic and chest rattles.

This list has been very thoughtfully built, based on need, effectiveness and affordability for societies who have little to spend. It is a very short list in comparison with the drugs we use here day to day, but the majority of patients we care for could be kept comfortable even with this limited number of medicines.

Another good reason to keep this list short is that access alone is no guarantee that the patient will be comfortable. Without the prescriber knowing how to use the drugs, there will be little clinical benefit. The obvious example is the knowledge doctors and nurses need to prescribe morphine appropriately. This is still a problem in our society, and compounded by the difficulties presented by an increasing number of formulations of alternative opioids. For example, I know that many doctors are unaware of the very significant difference in dosage between hydromorphone and morphine. Hydromorphone is approximately five times as potent as morphine, and so major toxicity can result if morphine doses of hydromorphone are given.

Morphine should remain the opioid of first choice for cancer pain in Australia as well as elsewhere. Not because it is intrinsically and for all patients a better drug than others, but because it is best known, and therefore safer in general use.

The website for the essential medicines is:
http://www.who.int/medicines/publications/essentialmedicines/en/
David Brumley

BHS END OF LIFE PROJECT

Advance Care Planning (ACP), as embedded in the Respecting Patient Choices® (PRC) model provides a quality-assured system of discussing, recording and documenting a patient's preferences for their future healthcare, in preparation for a time when they might not be able to competently contribute to their end-of-life decisions. It is frequently (but not always) about end-of-life medical treatment.

With funding from the National Institute of Clinical Studies, Respecting Patient Choices® was first introduced as a pilot program at the Austin Hospital, in Melbourne, during 2002-03.

The guiding principle of the RPC Program is:
"If your choices for future healthcare are known, they can be respected".
Training in the RPC Program enables doctors, nurses and allied health workers to discuss advance care planning helpfully and sensitively with patients and their families.

There is strong Board of Management and Executive Staff Council support for advance care planning and key medical clinical interest. The Clinical Director of ICU in particular has advocated for the organization to support a funded and systematic approach to ACP for a number of years.

Dr. Bill Sylvester, of Austin Health and Director of Respecting Patient Choices, visited BHS and provided a presentation to the Board and key staff in 2011. Following this very informative presentation, there was in principle support from the Board for this program. Two budget bids have been previously made for appointment of key staff to implement a program at BHS as recommended under the RPC model. Both were not funded on both occasions in 11/12 and 12/13 due to fiscal constraints and risk assessment relative to competing budget bids.

The ACP/RPC program is fully implemented within Residential Services at BHS. The Executive Director of Residential Care included ACP/RPC project co-ordination as a key component of the new Residential Aged Care Quality Coordinator role that was established in the beginning of 2011. There are now staff trained to have advance care planning conversations with residents in every BHS facility and the goal is to for 100% of BHS residents to have an ACP conversation and plan offered to them by the end of 2014.

Despite having some of the best palliative care services in the world, almost two thirds of deaths in Australia occur in an acute hospital setting. It is estimated that 70% of people who die in hospital receive active treatment right up until the moment of death which may not be in accordance with their end of life (EOL[1]) choices. The acute care sector focuses on treatment and cure, along with increasing survival rates and reducing mortality and our challenge is to ensure that the dying patient and their family receive optimal care in accordance with EOL choices (J Odgers, Grampians Regional Palliative Care Team).

Potential Benefits

- Improved patient experience and provision of patient centred care through involving patients and families in a clear care planning process about end of life
- Improved end of life care
- Improved ability to achieve new National Safety and Quality Health Service Standards 2 & 9
- Potential for admission prevention, reduced length of stay, improved referral to Liverpool Care Pathway process and Palliative Care services, reduced unnecessary admissions to ICU

Proposed Plan

There are a number of elements of a comprehensive End of Life Framework. All need to be present to provide a decent experience for BHS patients as they move through the final twelve months of life.

These include:

- End of life framework: A guiding document that establishes the BHS policy and approach;
- Diagnosis of End of Life
- Advance Care Planning
- Resuscitation Planning Process
- Palliative Care Services
- Case Conferencing
    - multi-disciplinary
    - patient centred
- Clinical Handover
- Liverpool Care pathway
- Suite of EOL indicators to enable monitoring of BHS performance in providing a 'good death' to patients across the sectors and as a driver of improvement

For further information please feel free to contact Denise Fitzpatrick denisef@bhs.org.au or Jade Odgers jadeo@bhs.org.au

[1] End of Life is generally understood to be the last 12 months of a person's life. Within this is the time frame that is the last few days of a patient's life immediately before death.
[2] Advance Care Planning is a process for determining and communicating to those involved in their care, the person's wishes for a range of EOL choices.

With best wishes for Christmas and the New Year,

Jade, Greg, David, Maziar, Regina, Lawrence & Bernadette

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