

Palliative Care in Aged Residential Care

Julie Hollingsworth
Nurse Practitioner
CCDHB



Health Services – Kapiti Coast

- ▶ 10 general practitioner surgeries – many provide services to ARC – scheduled clinics
- ▶ No services after 10pm – closest service is 40 minutes away.
- ▶ UCC – Wellington Free Ambulance service 24 /7.
- ▶ Secondary / tertiary care services in Wellington over an hours drive away
- ▶ Mary Potter Hospice Community team and day service
- ▶ Outpatient and outreach services from Kapiti Health Centre (DHB), these include: district nursing, Q&A service, General Practitioner and NP

Aged Residential Care – Kapiti Coast

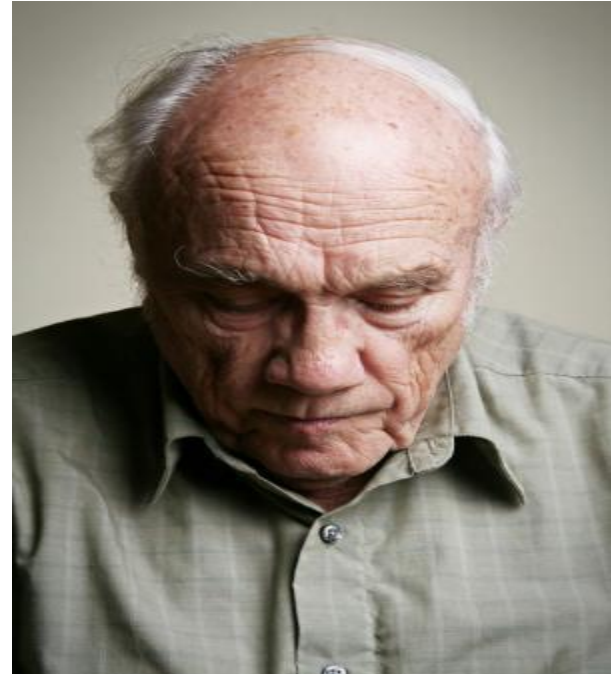
- ▶ Double the number of older adults in the region as compared with nationally.
- ▶ Range of retirement villages, rest homes, hospital level facilities, and dementia care.

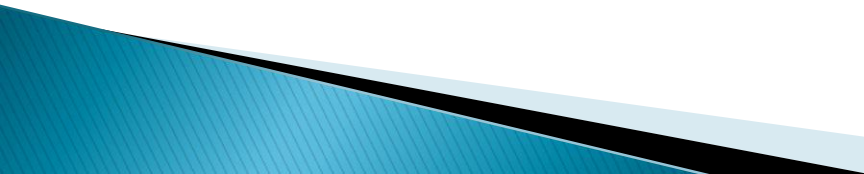
▶ 12 ARC facilities
Approx. 750 beds

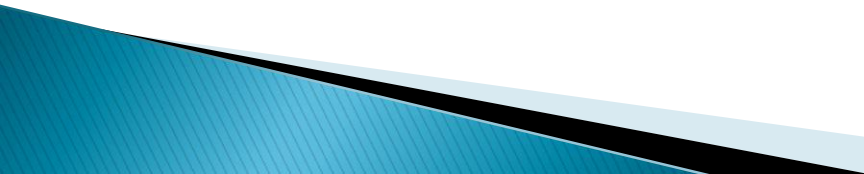


Mr B.

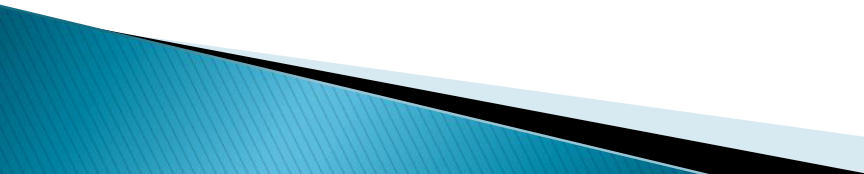
- ▶ 81yr old man
- ▶ Cholangiocarcinoma
- ▶ Diagnosed early 2013
- ▶ Multiple medical problems:
 - HTN
 - Type 2 diabetes
 - AAA – previous dissection and surgical repair



- ▶ 3 admissions to hospital in 6 months.
 - ▶ Rapid deterioration on last admission:
 - Ascites
 - Abdominal pain secondary to ascites + constipation
 - Obstructive jaundice
 - ▶ Palliative approach – discharged to inpatient hospice for symptom control
 - ▶ Subsequently discharged to residential care facility.
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- ▶ Complex symptoms – pain, nausea, ascites, constipation and restlessness.
 - ▶ Shortly after transfer to ARC – hepatic failure
 - ▶ Syringe driver – fentanyl, clonazepam, nozinan, buscopan + PRN medication
 - ▶ Regular review of medications to relieve symptoms
 - ▶ Hospice advice and involvement
 - ▶ Family in permanent attendance – high levels of distress – differences of opinion
 - ▶ Mr B died within 1 month of admission
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Challenges

- ▶ Family expected same care provision in ARC as in the Hospice – RN cover, daily medical rounds.
 - ▶ Family distress – often expressed as anger towards the staff
 - ▶ Communication between family and ARC and hospice
 - ▶ Mr B unable to always verbalise his needs
 - ▶ Complex symptoms – difficulty in gaining good symptom control
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Mrs E.


- ▶ 89 year old lady – living independently until late 2012
- ▶ 2012 – 2x falls – Right sided subdural haematoma with burr hole evacuation
- ▶ 2013 Right sided hemispheric stroke left sided weakness – 6 weeks in rehab, discharged to ARC
- ▶ Pneumonia
- ▶ Other medical problems:
 - Dementia
 - Sub clinical hypothyroidism
 - ***Congestive heart failure – ? no clear data to support***



- ▶ Over the next month Mrs E deteriorated.
- ▶ Increased restlessness and anxiety - ?
Delirium - no obvious cause
- ▶ Calling out at night - cough, SOB, AR, extensive oedema - treated for CHF and LRTI
- ▶ Discussed with family - no further acute admissions - to be cared for at facility
- ▶ Placed on O2 for symptomatic relief of breathlessness.

- ▶ Evening disturbance / distress continued calling out with periods of drowsiness.
- ▶ Syringe driver commenced morphine + haloperidol
- ▶ Becoming more vocal calling out “I am falling out of my chairlift me up” even though she was safe in the chair.
- ▶ No respiratory distress, oedema both legs and arm. Pump changed to oxycodone due too small side effects.
- ▶ Unsettled +++ midazolam added to pump.

Challenges

- ▶ No clear diagnosis to explain deterioration
 - ▶ Difficulty in identifying the cause for Mrs E's distress due to cognitive impairment
 - ▶ Poor response to medication
 - ▶ Limited staffing numbers
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Our Challenges

- ▶ Recognising the challenges of the sector – respect for our nursing colleagues
 - ▶ Transfer of patients from acute / specialist care to residential care – managing the expectations
 - ▶ Timely advice and support – building trust
 - ▶ Developing a national framework to support the ARC sector
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