HealthPathways Melbourne

Putting knowledge into practice

CASE STUDY 7:

HealthPathways and palliative care

Ivy, a retired registered nurse, has been a patient of the practice for more than 20 years. Her current GP is new to the area after recently moving to Melbourne from interstate.

Her GP has started using HealthPathways Melbourne to update her knowledge on palliative care management, and to find local referral options.

Ivy and her brother John have lived together for 90 years. Both are fiercely independent, strong characters and adamant that they want to stay in their own home. They have cared for and supported each other with no external assistance.

Ivy's health deteriorated and she was subsequently diagnosed with vascular dementia. At this time, she was being cared for by her brother. Following an admission to hospital for pneumonia and heart failure, Ivy was diagnosed with lung cancer. It was at this stage that both Ivy and John accepted the support of the local palliative care team and home care services. The GP also recommended an ACAS assessment in order for Ivy to access home support, residential aged care or a home care package.

When her GP accessed HealthPathways to check Palliative Care Service referral options, she noted there was a Palliative Care Advice pathway with a statewide palliative care advice service available. (Ph: 1800 360 000 from 7am to 10pm)

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Despite recurring chest and urinary infections, Ivy and John stayed in their own home for a further 18 months. John began experiencing Transient Ischaemic Attacks (TIA) and had recurrent falls resulting in a fracture and admission to hospital. This led to Ivy requiring urgent respite care.

Ivy and John had both previously made advanced care plans. These and their goals of care were reviewed following the significant changes in their respective conditions. Both required greater care and support and, despite efforts by the GP, in home services and palliative care services, and with no family to assist, this meant that remaining in their home was no longer possible. They therefore moved into a local Residential Aged Care Home (RACH) in adjoining rooms.

Ivy's condition continued to deteriorate. She developed symptoms of increasing fatigue, dyspnoea, cough with haemoptysis and anorexia. Her GP reviewed the relevant pathways; Symptom Control in Palliative Care and Terminal Haemorrhage in Palliative Care to ensure best evidence management The GP found the Caring for a Dying patient in an RACH pathway's tools and resources useful.

A case conference was organised by the GP where the whole team (NOK, GP, palliative care, RIR, RACF RN and care staff) came together to ensure all of Ivy's wishes were accommodated. These included remaining at the RACH and not transferring to hospital. The GP checked the Guide to MBS Items pathway to ensure the correct item was billed.

An end-of-life care plan for Terminal Phase Management was then put in place for Ivy. This included:

- routine care (pressure, continence, mouth and eye care, nutrition and hydration and emotional care)
- anticipatory prescribing for pain management and symptom control
- catastrophic medication orders for terminal haemorrhage.

Ivy's symptoms were managed well, and her last days were pain-free and comfortable.

She remained with her brother until her death.

Following Ivy's death, the GP supported John and referred him for bereavement counselling after reviewing the Non-acute Older Adult's Mental Health Referral (> 24 hours) pathway.

She found a suitable service – the healthy aging service response (HASR) – that would visit John at the RACF and provide brief intervention (≤ 6 sessions).

Do you have a case study?

If you would like to be involved, submit a case study, or for more information email info@healthpathwaysmelbourne.org.au