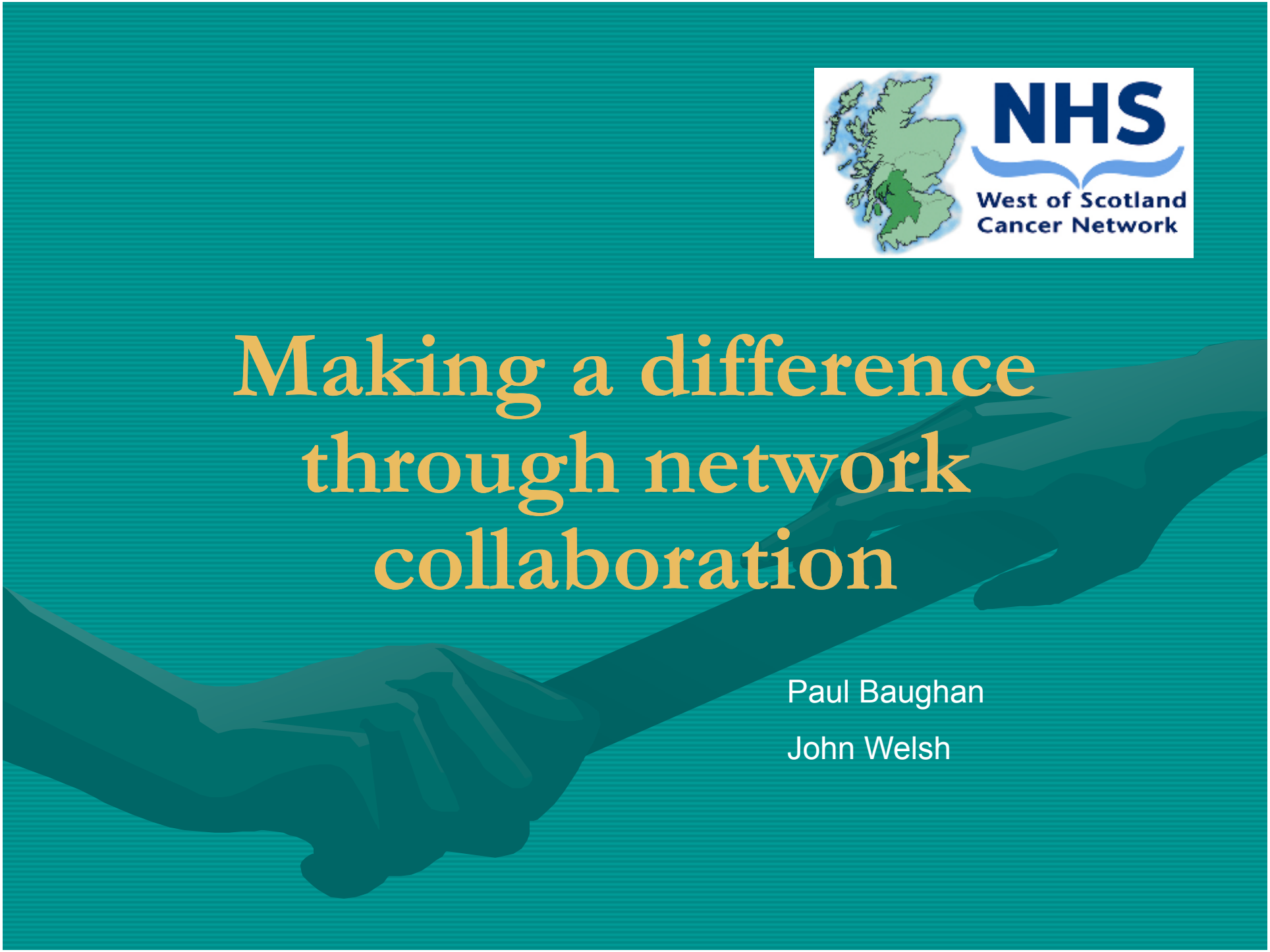
Scottish
Partnership
for Palliative Care

Palliative Care:
How can we make a difference?

Annual Conference 2009



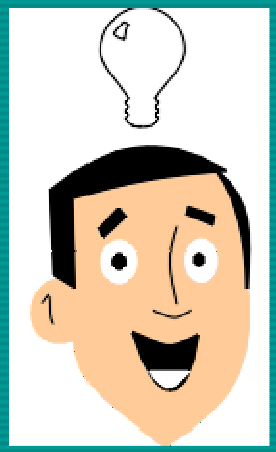
Making a difference through network collaboration

Paul Baughan

John Welsh

Network Collaboration

1. Advantages of network collaboration
2. Challenges to network collaboration
3. Examples of how we have made a difference through network collaboration

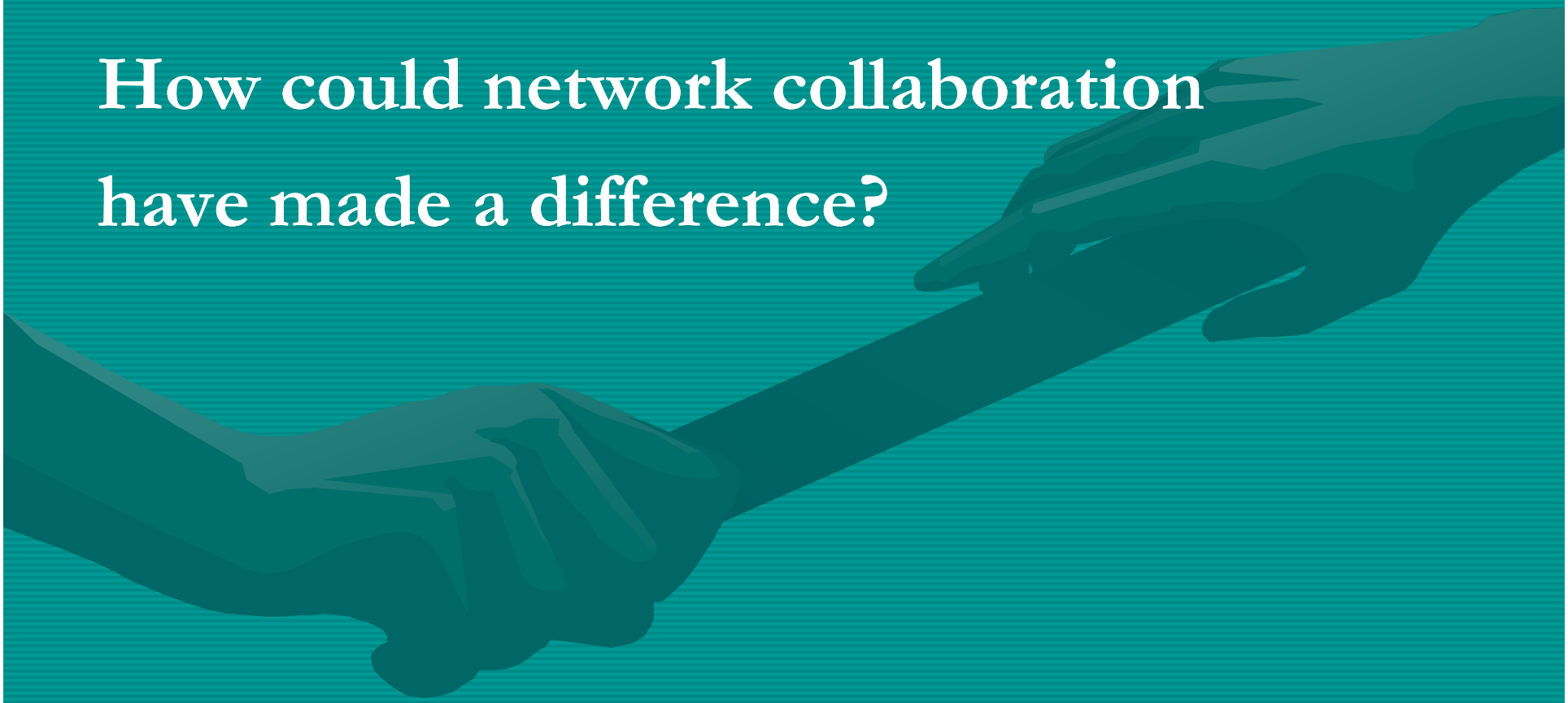


NHS
West of Scotland Cancer Network

Palliative Integrated Symptom Assessment and Goal Setting Flow-chart

‘PISA GSF’©

How could network collaboration have made a difference?



What is a network?

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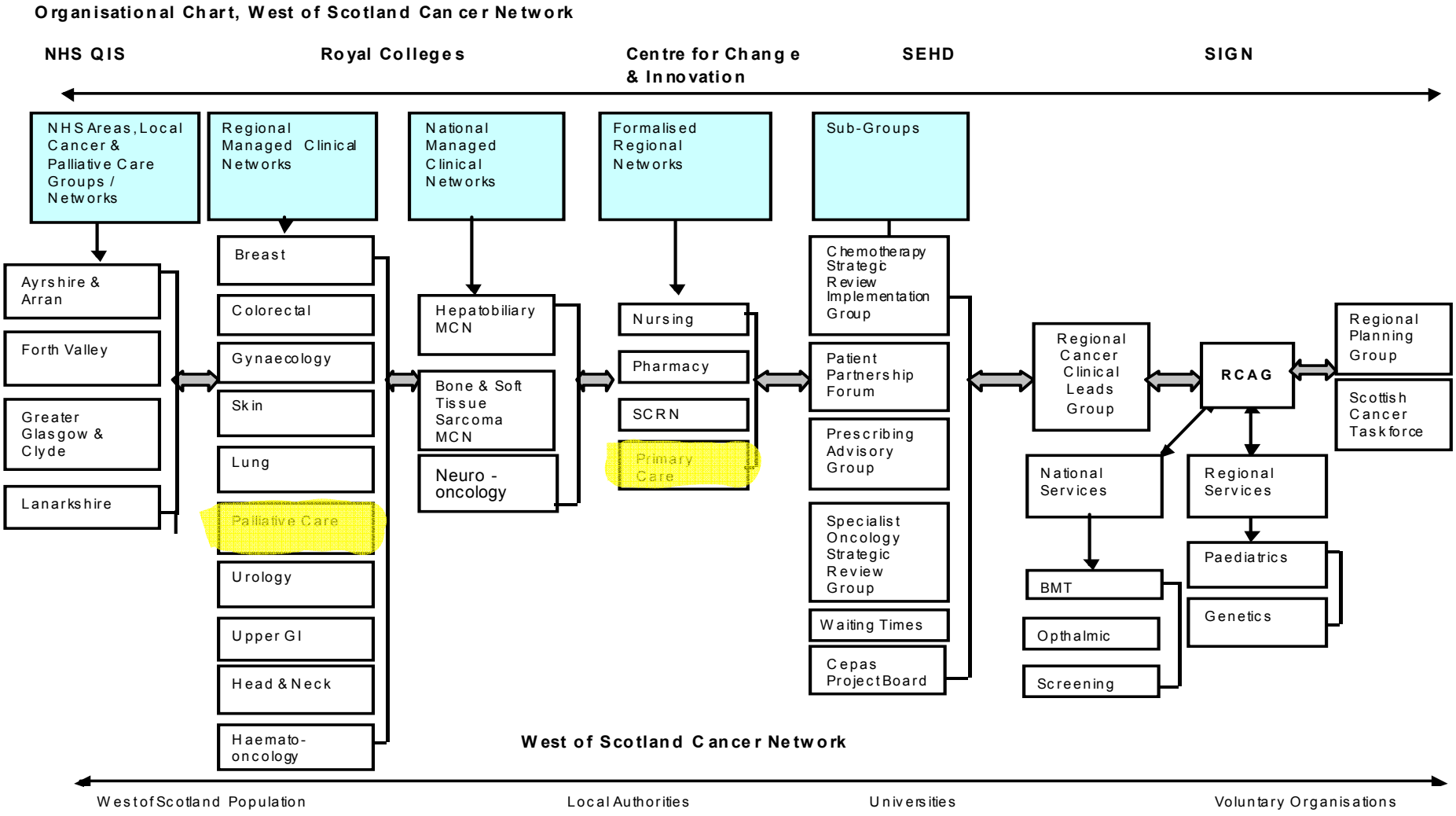
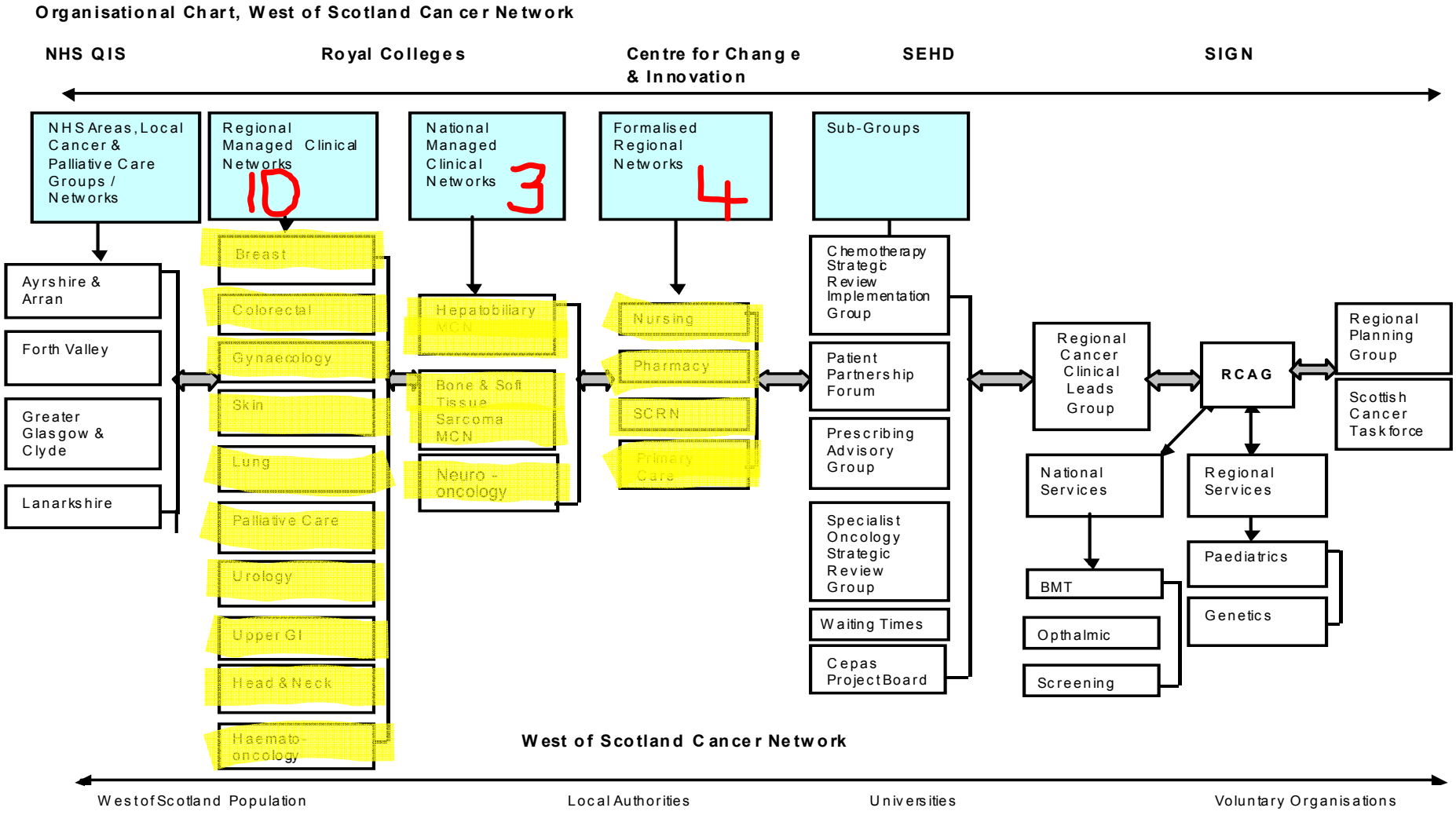
'An extended group of people with similar interests or concerns who interact and remain in informal contact for mutual assistance or support'

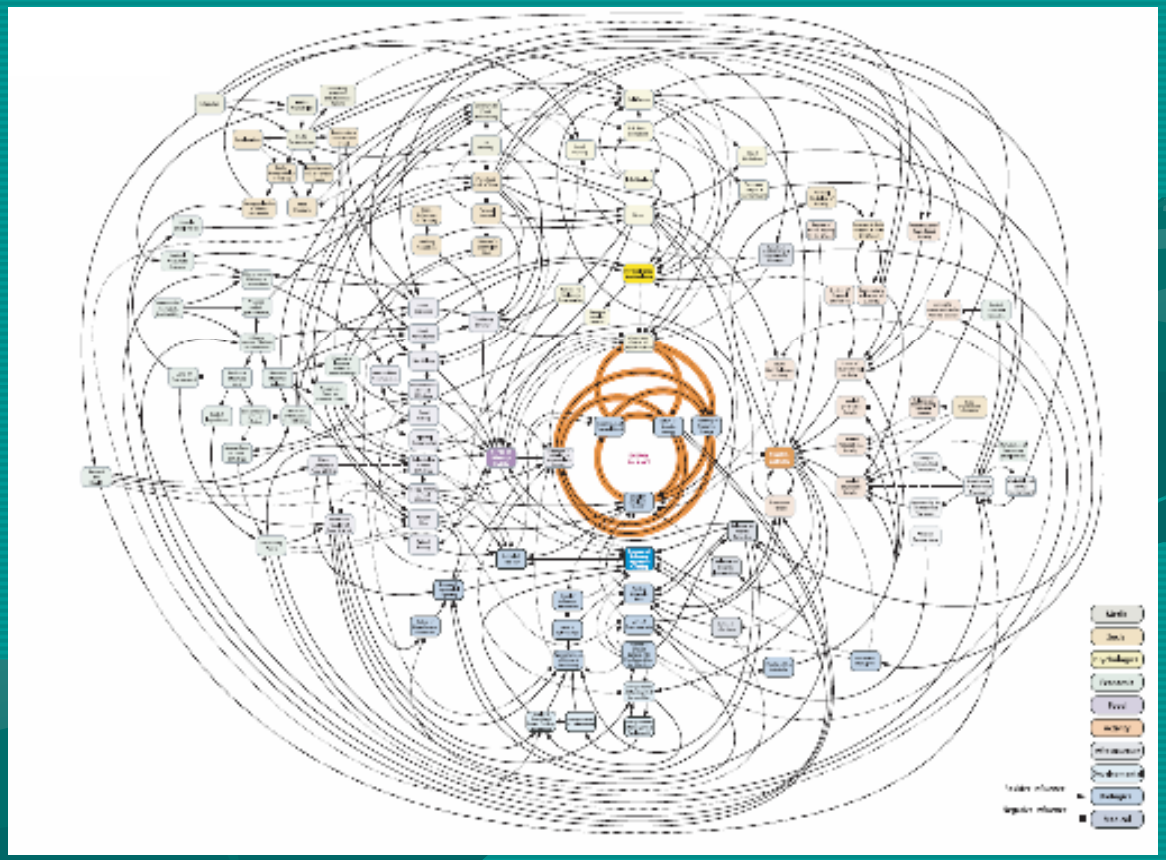
Complexity of West of Scotland Cancer Network



Complexity of West of Scotland Cancer Network



Flow chart for information sharing between different networks



What is collaboration?

NHS
West of Scotland Cancer Network

'Working in association with another group'

'assisting or co-operating with (an enemy)'

1. Advantages of network collaboration

- Reduces risk of overlap and wasting of resources by different networks progressing similar ideas
- Sharing of ideas and taking account of a wide range of views
- Sharing of workload for big projects
- 'Ownership' and 'Buy-in' from different networks especially if project has implications for them (can also help with implementation)

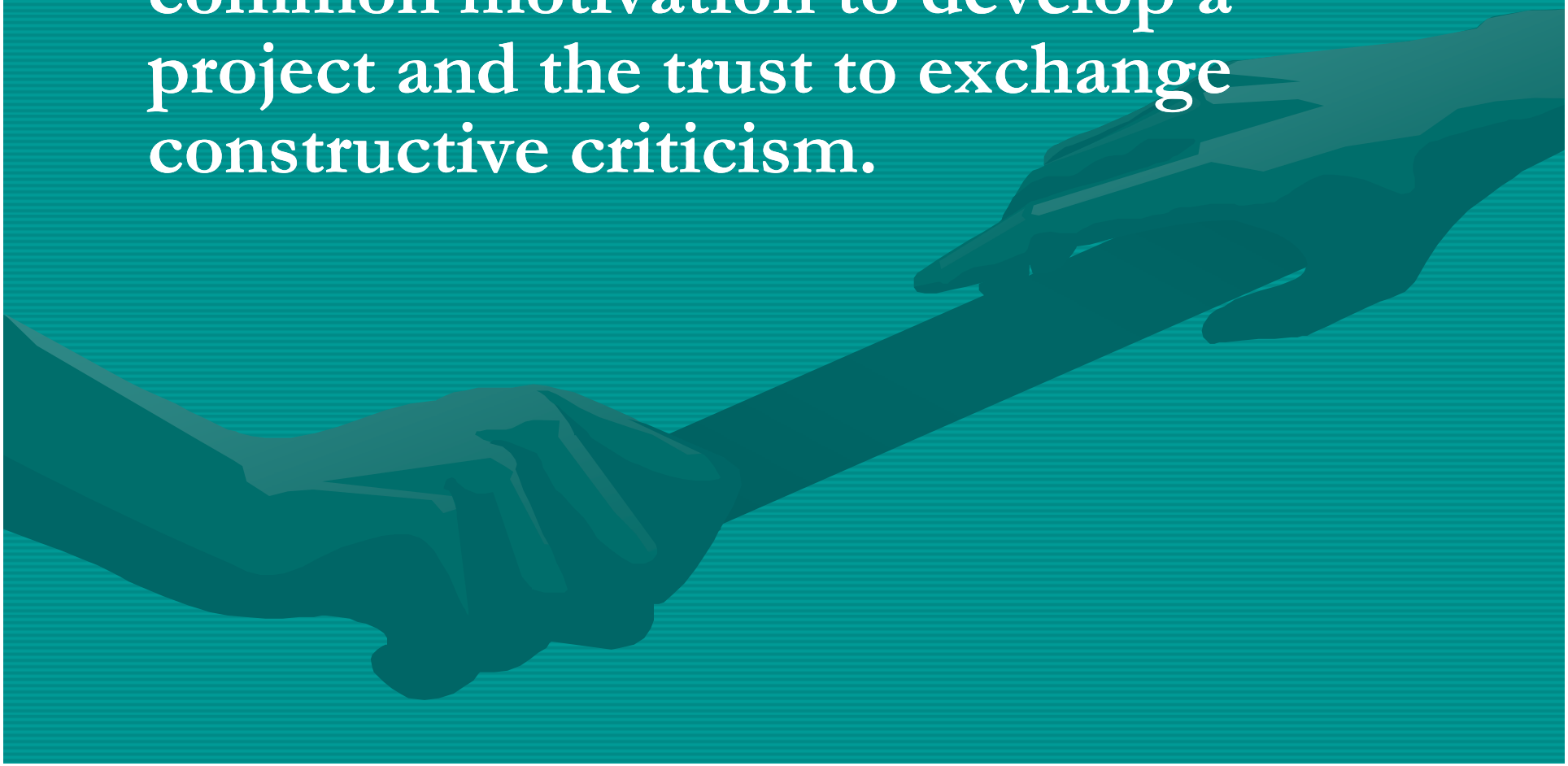
Specific advantages for Palliative Care & Primary Care collaboration

- Both networks where symptom control plays an important part of patient care.
- Most people requiring palliative care are living at home in community setting
- Up-skilling of generalists by specialists and allowing specialists insight into realities of busy community palliative care

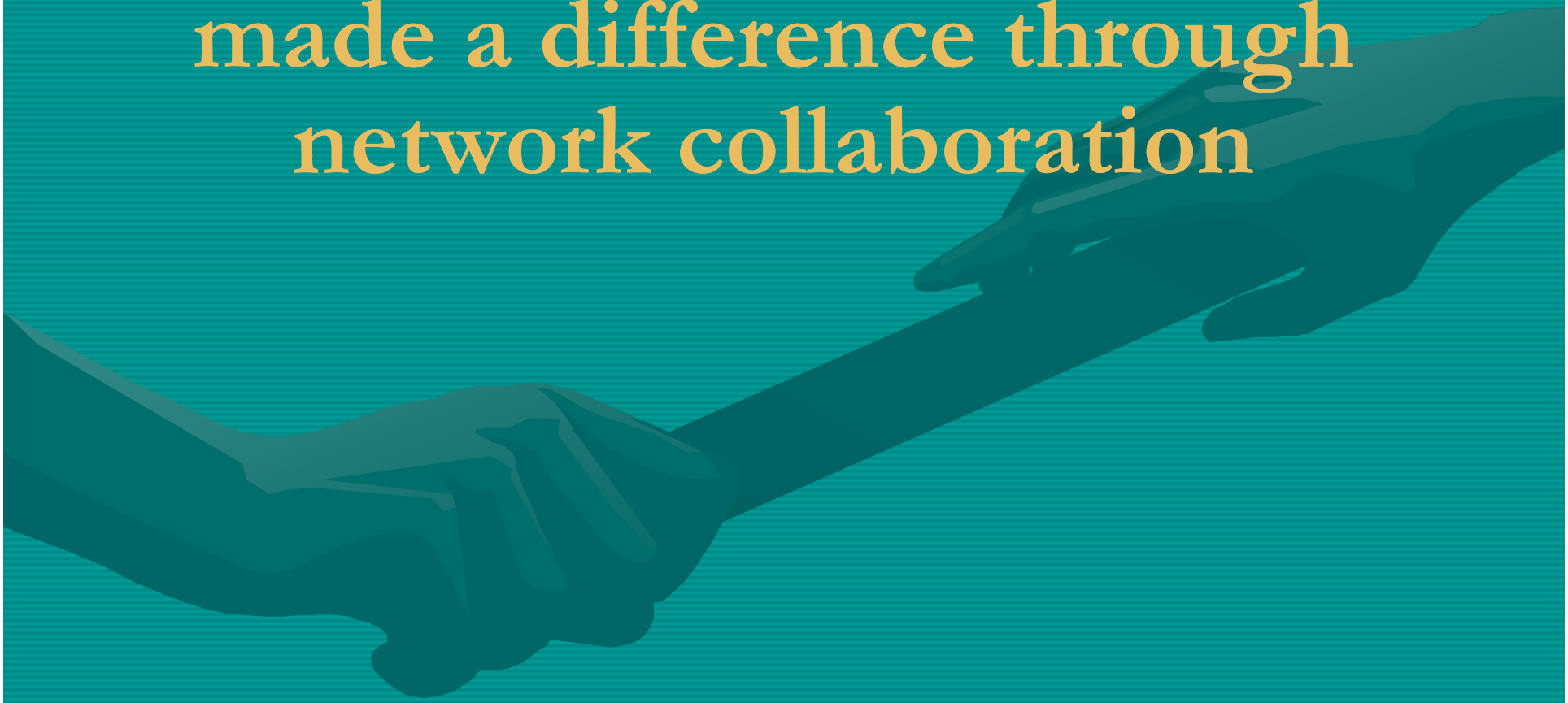
2. Disadvantages and challenges to network collaboration

- Projects moving more slowly
- Too many people wanting to comment and then harder to gain consensus
- Who is accountable or responsible?
- Often focused on cancer – what collaboration needs to take place with non-malignant care

Successful collaboration requires a common motivation to develop a project and the trust to exchange constructive criticism.



3. Examples of how we have made a difference through network collaboration



Examples of where collaboration helps

NHS West of Scotland Cancer Network

Carers project

- Objective -assess Aims L&DW
- Feed back from Carers
- WOS Partnership Forum
- WOS Primary Care Network
- WOS Palliative Care MCN
- Regional perspective identifies ‘experts’

Examples of where collaboration helps

2. Psychosocial reference group

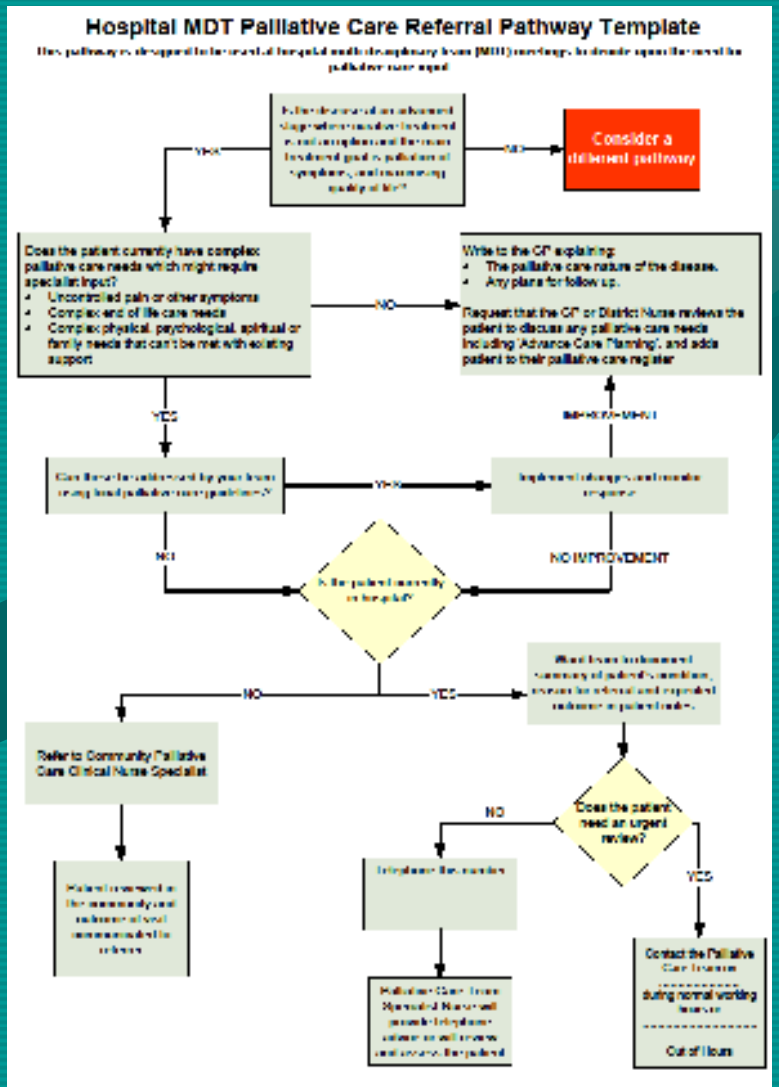
- Patient satisfaction
- Patient distress screening /assessment
- Ideas
- Utilising 'local' expertise regionally

Examples of where collaboration helps

NHS West of Scotland Cancer Network

3. MDT referral to GP or Specialist palliative care

- Across all settings
- Different models
- Consider all involved
- Local/regional/ national communication



Examples of where collaboration helps

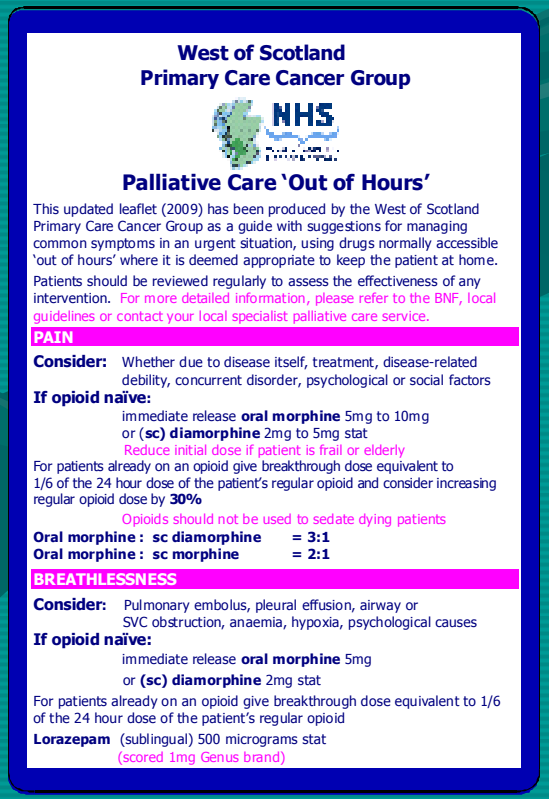
4. Living and Dying Well Group 3

- National -collaboration of existing networks
- Assessment tools
- Prognostication
- Anticipatory care planning

Examples of where collaboration helps

5. Guidance for Out of hours GPs on management of symptoms

..although collaboration has delayed roll out, it has allowed wider perspective



West of Scotland
Primary Care Cancer Group

Palliative Care 'Out of Hours'

This updated leaflet (2009) has been produced by the West of Scotland Primary Care Cancer Group as a guide with suggestions for managing common symptoms in an urgent situation, using drugs normally accessible 'out of hours' where it is deemed appropriate to keep the patient at home.

Patients should be reviewed regularly to assess the effectiveness of any intervention. For more detailed information, please refer to the BNF, local guidelines or contact your local specialist palliative care service.

PAIN

Consider: Whether due to disease itself, treatment, disease-related debility, concurrent disorder, psychological or social factors

If opioid naïve:
immediate release **oral morphine** 5mg to 10mg
or **(sc) diamorphine** 2mg to 5mg stat
Reduce initial dose if patient is frail or elderly

For patients already on an opioid give breakthrough dose equivalent to 1/6 of the 24 hour dose of the patient's regular opioid and consider increasing regular opioid dose by **30%**

Opioids should not be used to sedate dying patients

Oral morphine : sc diamorphine = 3:1
Oral morphine : sc morphine = 2:1

BREATHLESSNESS

Consider: Pulmonary embolus, pleural effusion, airway or SVC obstruction, anaemia, hypoxia, psychological causes

If opioid naïve:
immediate release **oral morphine** 5mg
or **(sc) diamorphine** 2mg stat

For patients already on an opioid give breakthrough dose equivalent to 1/6 of the 24 hour dose of the patient's regular opioid

Lorazepam (sublingual) 500 micrograms stat
(scored 1mg Genus brand)

NAUSEA / VOMITING

Consider: Gastric stasis, intestinal obstruction (incl. constipation), drug induced, biochemical causes, raised ICP

Levomepromazine (sc) 5mg stat or 5mg / 24hrs via **CSCI***
long duration of action so can be given as once a day sc bolus dose

CONFUSION / AGITATION

Consider: Infection, Hypoxia, Physical (pain, urinary retention, constipation) Psychological distress, Drugs (opioid toxicity; acute withdrawal of antidepressants, steroids, alcohol, nicotine)
Metabolic (uraemia, hypercalcaemia, low sodium, glucose, liver failure)

Haloperidol (sc) 2mg to 5mg stat; 5mg to 15mg / 24hrs via **CSCI***
Levomepromazine (sc) 5mg stat; 10mg to 25mg / 24hrs via **CSCI*** and titrate as needed

RESPIRATORY SECRETIONS

Consider: Repositioning patient with explanation and reassurance for family and carers

Hyoscine butylbromide (sc) 20mg stat; 40mg to 80mg / 24hrs via **CSCI***

ANXIETY / TERMINAL RESTLESSNESS

Midazolam (sc) 2mg to 5mg 1-2 hourly; 5mg to 20mg / 24hrs via **CSCI*** and titrate as needed
Short duration of action, early consideration of CSCI*

ACUTE TERMINAL EVENT (e.g. bleeding / choking / seizure)

Midazolam (iv / im / buccal) 10mg stat

Local Telephone Numbers

For more detailed information, please refer to the current BNF, or contact your local specialists. This document is also available at http://www.woscan.scot.nhs.uk/index.php?action=cms.Primary+Care (click on guidelines link)

* CSCI - continuous subcutaneous infusion via syringe pump

V2 Produced September 2009 **Review December 2012**

Examples of where collaboration helps

6. Regional Specialist Pharmacy Advisory group

- Morphine diamorphine debate
- Methylnaltrexone guideline
- *Fast acting Fentanyl formulations*

Examples of where collaboration helps

7. MacMillan Regional Advance Planning Coordinator

- Joint steering group
- Objectives
- Anticipatory care planning

Summary

- Allows SLWP to input for greater good of larger nos. patients
- Promotes understanding of issues affecting others
- Reduces duplication/promotes sharing
- Need agreement from local MCNs
- Requires trust

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