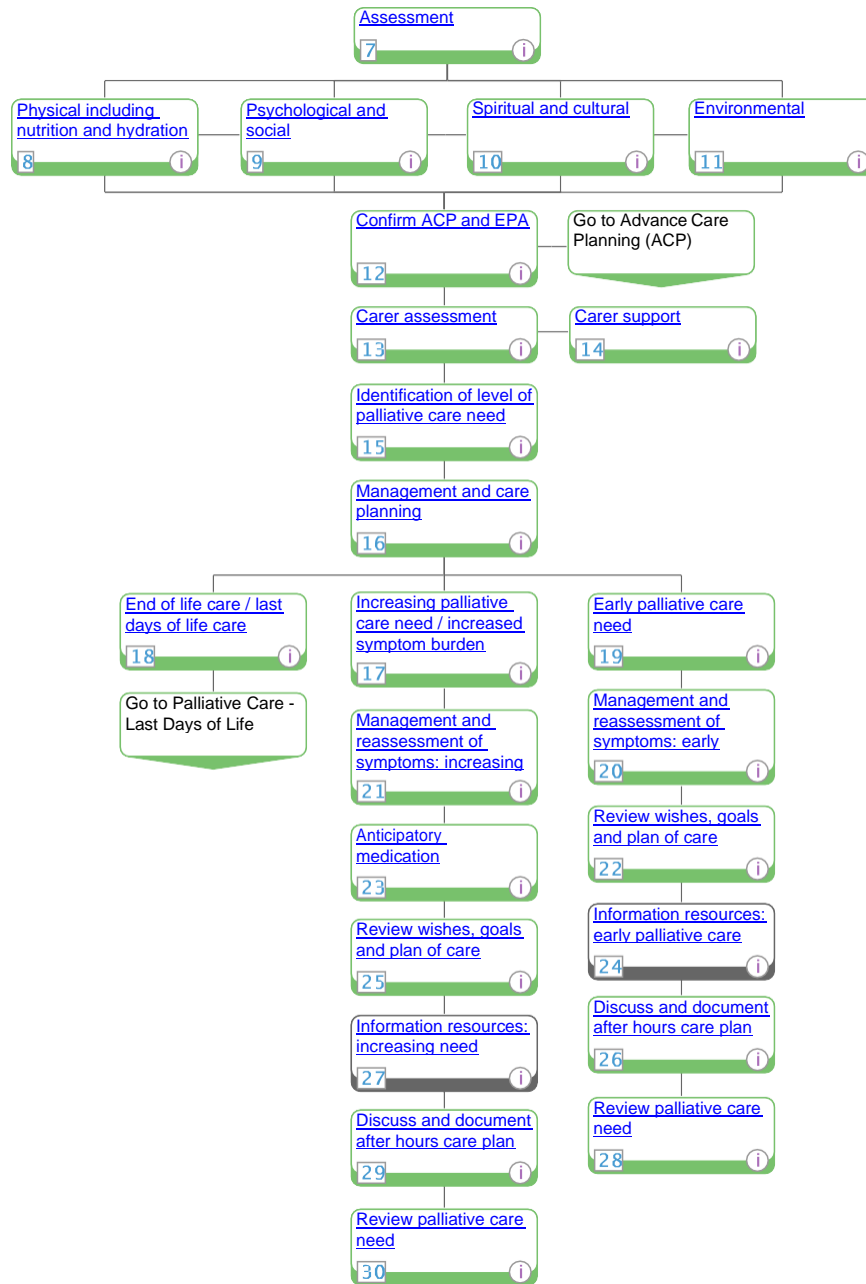


Palliative Care – Assessment and Management

Medicine > Palliative Care > Palliative Care in Adults

- i Information
- R Referral
- N National info
- L Local info
- Note Note
- Primary care
- Secondary care
- Information



1. Care map information

In scope:

- assessment and management of adults with life limiting illness who would benefit from a palliative care approach

Out of scope:

- children:
 - for paediatric palliative care contact MidCentral Health Children's Ward Charge Nurse
 - (06) 356 9169 ext. 7073

Definition and principles:

A palliative approach embraces the World Health Organisation (WHO) definition of palliative care. It incorporates a positive and open attitude toward death and dying by all service providers working with people and their families, and respects the wishes of people in relation to their treatment and care.

The WHO defines palliative care as [1]:

- an approach that improves the quality of life of people and their families facing the problems associated with life-limiting or life-threatening conditions, through the prevention and relief of suffering by means of:
 - early identification
 - impeccable assessment
 - treatment of pain and other problems:
 - physical
 - psychosocial
 - spiritual

Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten nor postpone death
- integrates the psychological and spiritual aspects of a person's care
- offers a support system to help people live as actively as possible until death
- offers a support system to help the family cope during the person's illness and in their own bereavement
- uses a team approach to address the needs of people and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

A New Zealand specific definition of palliative care is [2]:

Care for people of all ages with a life-limiting or life-threatening condition which aims to:

- optimise an individual's quality of life until death by addressing the person's physical, psychosocial, spiritual and cultural needs
- support the individual's family, whānau, and other caregivers where needed, through the illness and after death

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may be suitable sometimes when treatments are being given aimed at improving quantity of life:

- it should be available wherever the person may be
- it should be provided by all health care professionals, supported where necessary, by specialist palliative care services
- palliative care should be provided in such a way as to meet the unique needs of individuals from particular communities or

groups. These include Māori, children and young people, immigrants, refugees, and those in isolated communities

End of life:

The end of life phase begins when a judgement is made that death is imminent. It may be the judgement of the health/social care professional or team responsible for the care of the individual, but it is often the person or family who first recognises its beginning.

Considerations for people who would benefit from a palliative approach who also have learning disabilities:

- remember that even people with a mild learning disability may understand language in a literal, non-euphemistic manner and therefore anything that is communicated should take account of this
- avoid the use of abstract language in discussions about palliative care approach, e.g. talk about 'dying' rather than 'passing away'
- as the person's ability to concentrate may be impaired it is better to have a number of short, single-focus conversations rather than to try to communicate everything in one session - give the time needed to help the person understand
- take into account the environment in which discussions about a palliative care approach are to be held
- work within mental capacity legislation - to assert the rights of the individual to make important decisions whilst expressing empathy and understanding for the concerns of the family

For references see Provenance Certificate.

2. Information resources for patients and carers

Recommended resources for patients and carers:

- [A Guide for Carers](#)
- [Home Nursing Tips](#)
- [Coping Tool for Caregivers](#)
- [Oral Care for Someone who is Dying](#)
- [When Death is Near: Things to Know and Do](#)
- [What to Expect When Someone is Dying](#)
- [Talking about Dying - Child Focussed](#)
- [What to Expect When You Are Grieving](#)
- [Being Prepared for Death - Practical Steps](#)
- [Bereavement Support Services and Resources in MDHB](#)
- [Advance Care Planning \(ACP\) pathway](#)
- [Enduring Power of Attorney](#) (Ministry of Social Development)

Te Ara Whānau Ora:

- [Te Ara Whānau Ora Brochure](#)

3. Resources for providers

Recommended resources for clinicians:

- [Pain Assessment Tools](#)
- [Good Practice in Decision Making](#).
- [Assessment of Psychological Symptoms](#)
- [Te Ara Whakapiri - Principles and Guidance for the Last Days of Life](#)
- [Treatment and Care Towards the End of Life: Good Practice in Decision Making](#) (General Medical Council - UK)
- [More Care, Less Pathway - A Review of the Liverpool Care Pathway](#)
- [Advance Care Planning \(ACP\) pathway](#)

- [Enduring Power of Attorney](#) (Ministry of Social Development)

Te Ara Whānau Ora:

- [Te Ara Whānau Ora Brochure](#)

4. Updates to this care map

Date of first publication: March 2015

Date of re-publication: July 2016

This care map has been reviewed in line with consideration to evidenced based guidelines. Below summarises changes made to the pathway following review:

- some structural changes made to improve flow of pathway
- resources updated

Please see the care map's Provenance for additional information on references, accreditations from national clinical bodies, contributors, publication schedule, and the editorial methodology.

5. Hauora Māori

Māori are a diverse people and whilst there is no single Māori identity, it is vital practitioners offer culturally appropriate care when working with Māori whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health.

This knowledge can be actualised by (not in any order of priority):

- acknowledging [Te Whare Tapa Wha \(Māori model of health\)](#) when working with Māori whānau
- asking Māori clients if they would like their whānau or significant others to be involved in assessment and treatment
- asking Māori clients about any particular cultural beliefs they or their whānau have that might impact on assessment and treatment of the particular health issue ([Cultural issues](#))
- consider the importance of [whānaungatanga \(making meaningful connections\)](#) with their Māori client / whānau
- knowledge of [Whānau Ora, Te Ara Whānau Ora and referring to Whānau Ora Navigators](#) where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

For further information:

- [Hauora Māori](#)

6. Pasifika

[Pacific Cultural Guidelines \(Central PHO\) 6MB file](#)

Our Pasifika community:

- is a diverse and dynamic population:
 - more than 22 nations represented in New Zealand
 - each with their own unique culture, language, history, and health status
 - share many similarities which we have shared with you here in order to help you work with Pasifika patients more effectively

The main Pacific nations in New Zealand are:

- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging *The FonoFale Model (pasifika model of health)* when working with Pasifika peoples and families.

Acknowledging general pacific guidelines when working with Pasifika peoples and families:

- [Cultural protocols and greetings](#)
- [Building relationships with your pasifika patients](#)
- [Involving family support, involving religion, during assessments and in the hospital](#)
- [Home visits](#)
- [Contact information](#)

Pasifika Health Service - Better Health for Pasifika Communities:

- the Pasifika Health Service is a service provided free of charge for:
 - all Pasifika people living in Manawatu, Horowhenua, Tararua and Otaki who have long term conditions
 - all Pasifika mothers and children aged 0-5 years
- an appointment can be made by the patient, doctor or nurse
- the Pasifika Health Service contact details are:
 - Palmerston North Office - 06 354 9107
 - Horowhenua Office - 06 367 6433
- [Better Health for Pasifika Communities brochure](#)

Additional resources:

- Ala Mo'ui - [Pathways to Pacific Health and Wellbeing 2014-2018](#)
- Primary care for pacific people: [a pacific health systems approach](#)
- Tupu Ola Moui: [The Pacific Health Chart Book 2004](#)
- Pacific Health [resources](#)
- [Central PHO Pasifika Health Service](#)

7. Assessment

Please complete all below.

Accurate assessment ensures appropriate management:

- accurate and meticulous assessment is essential
- assess and address physical and non-physical symptoms – a holistic approach is required
- difficult to control symptoms may require several different approaches
- aim for highest possible quality of life
- use risk vs benefit assessments when side-effects of therapy occur
- listening to the person's story and language used assists assessment
- explain issues as much as possible to the person, family/whanāu and carers
- use a multidisciplinary approach
- assess and reassess continuously

8. Physical including nutrition and hydration

Physical:

Most commonly experienced physical symptoms for those with advanced disease are:

- pain:

- there are different types of pain and many people have more than one
- fatigue
- anorexia and weight loss
- anxiety
- dyspnoea
- nausea and vomiting
- change in bowel habits including constipation

Most people experience a combination of these symptoms which may change rapidly and require regular reassessments. Functional ability may change with deteriorating condition.

Assessment tools aid objectivity and lead to accurate diagnosis and management:

- [pain assessment tools](#)

Nutrition and hydration:

NB: There are no designated tools to guide the use of nutrition and hydration at the end of life.

Consider benefits, burdens and risks of providing clinically assisted nutrition and hydration. This will be influenced by the prognosis, the best interest of the patient, and the views of the person and/or Enduring Power of Attorney (EPA).

The guidance for health professionals is that people are supported with oral hydration and nutrition unless there is a strong reason not to do so. Useful references include:

- ['Meeting patients nutritional and hydration needs' \(pp52-53\)](#) and ['Decision making models' \(pp14-19\)](#) - (extracted from ['Treatment and care towards the end of life' - UK General Medical Council](#)).
- for those people in the last hours to days of life, the independent 'Review of the Liverpool Care Pathway Review' (2013) identifies pertinent aspects related to this issue - [see pages 26-28](#).

9. Psychological and social

Psychological:

- assess psychological effects on:
 - mood
 - anxiety
 - relationship
- listen to the person's story and language used
- use validated assessment tools to assess psychological distress including anxiety and depression:
 - [assessment of psychological symptoms](#)

The person and their family/whānau are the unit of care. Relationships with others are significant at end of life and there may be many changes in roles within relationships due to progressive illness.

Social:

Assessment of social effects on:

- family and whānau:
 - referral to Whānau Ora Navigator may be appropriate:
 - **Palmerston North, Manawatu, Tararua:**
 - Te Tihi o Ruahine Whānau Ora Alliance (06) 357 3400
 - **Otaki, Levin, Horowhenua:**
 - Te Runanga o Raukawa (06) 368 8678, Muaupoko Tribal Authority (06) 367 3311
- carers:

- see 'carer assessment' node
- social interaction
- sexuality
- employment and financial status:
 - a person with advanced disease may have had to stop work and a change in family income can be extremely stressful
 - a social worker referral may be required to assist and navigate to access maximum support and entitlements:
 - phone: (06) 350 8320
 - fax: (06) 350 8122
 - postal: Central Referral Management Rehabilitation Service, Palmerston North Hospital, Private Bag 11036, Palmerston North

10. Spiritual and cultural

Assess spiritual and cultural needs:

- person's feeling of self-worth and identity
- need for hope
- cultural / spiritual attitudes towards:
 - disease
 - suffering
 - dying
 - death

Some useful prompts:

- what can we do now to help you and those people important to you to feel safe and comfortable?
- do you have beliefs and family traditions that are especially important to you?
- what are the important things about you and your whānau / family that we need to know right now?

To assist in the assessment of a patient's spiritual needs a series of questions follows below.

Each question has the potential for exploring a particular aspect of a patient's spirituality:

- what are the things in life that give you strength and sustain you?
- what keeps you going each day?
- what is helping you get through this present crisis?
- how has your illness affected your attitude to life?
- how do you express your philosophy of life?
- do you belong to any specific religion, faith or community?
- is God, religion or any other spiritual belief significant to you?
- are your beliefs being challenged by your current experiences?
- is prayer, scripture, music, meditation or reading helpful?
- what does suffering mean to you?
- have you been with anyone else going through the same thing / dying?
 - how was it for them?
 - is there anything about what happened to them that worries you?

11. Environmental

Assess environmental needs:

- quality of environment has a direct effect on people's experience of care

Consider living conditions:

- safety
- nutrition
- warmth
- security
- support
- transport
- equipment required:
 - refer to Occupational Therapist:
 - phone: (06) 350 8320
 - fax: (06) 350 8122
 - postal: Central Referral Management Rehabilitation Service, Palmerston North Hospital, Private Bag 11036, Palmerston North

12. Confirm ACP and EPA

Confirm:

- confirm the following discussions have taken place and appropriate documentation completed:
 - Advance Care Planning (see [Advance Care Planning](#) pathway)
 - [Enduring Power of Attorney](#) (Ministry of Social Development)

Communicate and explain:

- do not resuscitate decisions where appropriate with due respect for confidentiality with the person's family / whānau, other carers, or other representatives

Ensure ACP read codes have been entered.

13. Carer assessment

Carers are:

- the family, whānau or friends who have the role and responsibility of assisting in the care of the person with palliative care need
- frequently untrained and unpaid

Caregiving for a person at end of life requires:

- knowledge
- time
- skill

It is important to ask carers how they are managing and whether they need extra support. Support could include:

- information
- practical skills training (turning, medication management)
- emotional support for themselves

Asking open ended questions with carers is useful e.g.:

- what concerns do you have about caring for?
- how are you caring for yourself?

- how are you sleeping?

14. Carer support

Give carer information as condition worsens.

Refer to [Palliative Care - Services Pathway](#) for information on support available for carers.

15. Identification of level of palliative care need

Identifying the level of palliative care need:

- is not based on exact timelines but on the needs of that person and their family
- will change over time with the different disease trajectories
- earlier recognition of possible illness trajectories means needs can be better anticipated and addressed

Early palliative care:

- a person may be recognised as having a life limiting illness however may have stable symptoms and have months or years to live

Increasing palliative care need / increased symptom burden:

- palliative care need may be increasing and symptoms may be changing frequently requiring frequent reassessment and change in management
- prognostic timeframe may be estimated to be within weeks or approximately up to 6 months

End of life care / last days of life care:

- prognosis estimated to be within hours or days
- symptoms can change frequently in the last hours and days of life

16. Management and care planning

Management and care planning for:

- early palliative care need
- increasing palliative care need / increased symptom burden
- end of life / last days of life care

17. Increasing palliative care need/increased symptom burden

Increasing palliative care need / increased symptom burden - care planning and management:

- each person should receive coordinated care in accordance with their care plan, across sectors including after hours
- the lead provider is the General Practice Team in collaboration with Specialist Services and Specialist Palliative Care Services when required
- General Practice Teams may consider referral to Specialist Palliative Care Services if required (see Arohanui [Hospice Referral Form](#))
- communicate between all healthcare workers and organisations involved in the person's care in a timely manner

18. End of life care/last days of life care

Recognising dying provides an opportunity to review care needs and goals with people (if able), family and GP. It allows:

- implementation of a last days of life care plan
- care to be given in line with previous direction from the person, if they are now unable to give direction
- appropriate management of symptoms
- withdrawal of treatments, activities, medication that are no longer appropriate or benefiting the person
- opportunities for support to the person, family and staff

The following general indicators may be useful when considering a change in status:

- weight loss (more than 10% of body weight in last 6 months); BMI below 18
- serum albumin less than 25g/l
- general physical decline; dependent in ADL's, bed / chair bound
- multiple diseases impacting on wellbeing
- increased frequency of admissions to acute care

Factors that may indicate that the phase of dying has commenced include:

- person is bed bound
- increased need for help with activities of daily living
- less able to take tablets if difficulty in swallowing
- not eating and poor or absent fluid intake
- increasing weakness and lethargy
- less alert and reduced response to verbal commands
- increased confusion, restlessness, or agitation
- increasing shortness of breath and noisy breathing
- incontinence or urinary retention

End of life care / last days of life care - care planning and management:

- each person recognised as dying should receive coordinated care in accordance with their care plan, across sectors including out of hours
- the lead provider is the General Practice Team in collaboration with Specialist Services and Specialist Palliative Care Services as required
- communicate between all healthcare workers and organisations involved in the person's care in a timely manner

[Treatment and care towards the end of life: good practice in decision making](#)

19. Early palliative care need

Early palliative care - care planning and management:

- each person should receive coordinated care in accordance with their care plan, across sectors
- the lead provider is the General Practice Team in collaboration with specialist services
- communicate between all healthcare workers and organisations involved in the person's care in a timely manner

20. Management and reassessment of symptoms: early

Address and manage symptoms as assessed:

- earlier in the trajectory other services, including secondary care specialists such as medical and radiation oncology, and Arohanui Hospice, may be involved and contribute to the person's symptom control management

- communication between all the services and with the General Practice is vital so care is well coordinated
- refer to:
 - [Palliative Care Symptom Management - Community](#)
 - [Drug information for Palliative Care](#)
 - [Syringe Driver Management in Palliative Care](#)
- for symptoms that maybe more difficult to manage, a referral to Arohanui Hospice maybe indicated - please discuss with the Arohanui Hospice Team (06) 356 6606

21. Management and reassessment of symptoms: increasing

Address and manage symptoms as assessed:

- increasing disease burden can often result in escalating or new symptoms
- re-assessment / review may be indicated to ensure current management is effective, and any new symptoms are identified and managed
- ongoing communication with other services remains very important so care remains well coordinated
- refer to:
 - [Palliative Care Symptom Management - Community](#)
 - [Drug information for Palliative Care](#)
 - [Syringe Driver Management in Palliative Care](#)
- for symptoms that are becoming more difficult to manage and/or requiring frequent review, a referral to Arohanui Hospice maybe appropriate- please discuss with the Arohanui Hospice Team (06) 356 6606

22. Review wishes, goals and plan of care

If discussions have been had, review documentation and update status to ensure patient's wishes and goals are well known:

- advance care planning (see [Advance Care Planning \(ACP\) pathway](#)):
 - work through the plan or review
- advanced directives:
 - advise and refer on to appropriate person to achieve this or review
- enduring power of attorney (EPOA):
 - achieved or enacted / review
- will:
 - achieved and where it is held and review
- Internal Cardiac Defibrillator (ICD):
 - discussions around deactivation of this device may occur early (see [End of Life Management of Implantable Defibrillators](#))
- conversations:
 - document all relevant conversation as to patient's wishes and goals, update and review at each visit and/or regularly

23. Anticipatory medication

Supply anticipatory medication as needed:

- symptoms can change rapidly and require frequent assessment
- anticipatory prescribing ensures responsiveness for changing needs particularly for after hours
- when prescribing anticipatory medication consider:
 - route of administration
 - after hours access of medication
 - who is to administer medication

- refer to:
 - [medication information for Palliative Care](#)
 - [Syringe Driver Management in Palliative Care](#)
- consider referral to District Nursing for after hours management of unstable symptoms
- after hours plan needs to be completed and known to all involved in care, see:
 - [individualised after hours care plan](#)
 - [individualised after hours care plan - example](#)

24. Information resources: early palliative care

Ensure person and family have palliative care information including written information:

- [Coping Tool for Caregivers](#)

For further information see:

- 'Information resources for patients and carers' node

25. Review wishes, goals and plan of care

If discussions have been had, review documentation and update status to ensure patient's wishes and goals are well known:

- advance care planning (see [Advance Care Planning \(ACP\) pathway](#)):
 - work through the plan or review
- advanced directives:
 - advise and refer on to appropriate person to achieve this or review
- enduring power of attorney (EPOA):
 - achieved or enacted/review
- will:
 - achieved and where it is held and review
- Internal Cardiac Defibrillator (ICD):
 - discussions around deactivation of this device may occur early (see [End of Life Management of Implantable Defibrillators](#))
- conversations:
 - document all relevant conversation as to patient's wishes and goals, update and review at each visit and/or regularly

26. Discuss and document after hours care plan

GP team or normal after hours arrangement.

Care plan should include:

- main contacts with specified times of availability

Ensure after hours care plan has been given to person's family/whānau and sent to those involved in care:

- [individualised after hours care plan](#)
- [individualised after hours care plan - example](#)

An action plan regarding management of specific symptoms may have been developed by a health professional involved in care.

27. Information resources: increasing need

Ensure person and family have palliative care information including written information:

- [Home Nursing Tips](#)
- [Coping Tool for Caregivers](#)
- [What to Expect When Someone is Dying](#)
- [Talking about Dying – Child focused](#)

For further information see:

- 'Information resources for patients and carers' box

28. Review palliative care need

As condition changes review palliative care needs.

29. Discuss and document after hours care plan

GP team or normal after hours arrangement.

Care plan should include:

- main contacts with specified times of availability

Ensure after hours care plan has been given to person's family/whānau and sent to those involved in care:

- [individualised after hours care plan](#)
- [individualised after hours care plan - example](#)

An action plan regarding management of specific symptoms may have been developed by a health professional involved in care.

30. Review palliative care need

As condition changes review palliative care needs.

Palliative Care

Provenance Certificate

[Overview](#) | [Editorial methodology](#) | [References](#) | [Contributors](#) | [Disclaimers](#)

Overview

This document describes the provenance of MidCentral District Health Board's **Palliative Care** pathway. This pathway is regularly updated to include new, quality-assessed evidence, and practice-based knowledge from expert clinicians. Please see the Editorial Methodology section of this document for further information.

This localised pathway was last updated in **July 2016**.

For information on changes in the last update, see the information point entitled 'Updates to this care map' on each page of the pathway.

One feature of the "Better, Sooner, More Convenient" (BSMC) Business Case, accepted by the Ministry of Health in 2010, was the development of 33 collaborative clinical pathways (CCP).

The purpose of implementing the CCP Programme in our DHB is to:

- Help meet the Better Sooner More Convenient Business Case aspirational targets, particularly the following:
 - Reduce presentations to the Emergency Department (ED) by 30%
 - Reduce avoidable hospital admissions to Medical Wards and Assessment Treatment and Rehabilitation for over-65-year-olds by 20%
 - Reduce poly-pharmacy in the over-65-year-olds by 10%
- Implement a tool to assist in planning and development of health services across the district, using evidence-based clinical pathways.
- Provide front line clinicians and other key stakeholders with a rapidly accessible check of best practice;
- Enhance partnership processes between primary and secondary health care services across the DHB.

To cite this pathway, use the following format:

Map of Medicine. Medicine. MidCentral District View. Palmerston North: Map of Medicine; 2014 (Issue 1).

Editorial methodology

This care map was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of medicine editorial methodology. It has been checked by individuals with front-line clinical experience (see Contributors section of this document).

Map of Medicine pathways are constantly updated in response to new evidence. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the pathways through the quarterly publication cycle.

References

This care map has been developed according to the Map of Medicine editorial methodology. The content of this care map is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. This localised version of the evidence-based, practice-informed care map has been peer-reviewed by stakeholder groups and the CCP Programme Clinical Lead.

1	Hospice New Zealand. (2001). Hospice New Zealand standards for the care of people approaching the end of life. Wellington: Hospice New Zealand.
2	World Health Organization. (2002) National cancer control programmes, policies and managerial guidelines (2nd edn). Geneva: World Health Organization.
3	Palliative Care Subcommittee, NZ Cancer Treatment Working Party (2007). New Zealand Palliative Care: A Working Definition. [Online]. Available from: http://www.moh.govt.nz/moh.nsf/pagesmh/2951/\$File/nz-palliative-care-definition-oct07.pdf .
4	Supportive and Palliative Care Indicator Tool, available http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/LivingandDyingWell/SPICTool .
5	Gold standards framework, available on http://www.goldstandardsframework.org.uk/ .
6	MacLeod, R., Vella-Brincat, J., MacLeod, S. (2012). Nurse Maud Palliative Care Guidelines, Guidelines for clinical management and symptom control. 6th ed. Soer Printers. Available on http://www.hospice.org.nz/cms_show_download.php?id=377 .
7	Bellamy, G., Gott, M., Waterworth, S., McLean, C., & Kerse, N. (2014). "But I do believe you've got to accept that that's what life's about: older adults living in New Zealand talk about their experiences of loss and bereavement support. Health and social Care in the Community. Vol 22(1), 96-103.

Contributors

MidCentral DHB's Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

The following individuals contributed to the original development and review and update of this care map:

- Bridget Marshall, Palliative Care Network Coordinator (Pathway Facilitator)
- Dr Syed Zaman, Consultant Geriatrician, MidCentral Health (Secondary Care Clinical Lead)
- Clare Randall, Chief Executive, Arohanui Hospice
- Nikki Twigg, Palliative Care Coordinator, Arohanui Hospice
- Karen Sherward, Clinical Nurse Specialist, Hospital Palliative Care Team
- Paul Cooper, General Practitioner, Central PHO (Primary Care Clinical Lead)
- Liz Elliott, Nurse Coordinator Practice Development, Health Care Development, MidCentral DHB (Pathway Editor)

The following individuals also contributed to this care map

- Mark Beale, Clinical Director, Medical Services

Disclaimers

Clinical Board Central PHO, MidCentral DHB

It is not the function of the Clinical Board Central PHO, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.

Palliative Care: Last Days of Life

Provenance Certificate

[Overview](#) | [Editorial methodology](#) | [References](#) | [Contributors](#) | [Disclaimers](#)

Overview

This document describes the provenance of MidCentral District Health Board's Palliative Care: Last Days of Life pathway.

This localised pathway was last updated in March 2017.

One feature of the "Better, Sooner, More Convenient" (BSMC) Business Case, accepted by the Ministry of Health in 2010, was the development of 33 collaborative clinical pathways (CCP).

The purpose of implementing the Last Days of Life pathway in our DHB is to:

- facilitate better understanding of the principles and practices of care for people in their last days of life
- provide guidance to health professionals in recognizing dying
- encourage appropriate use of resources and efficient use of services
- Promote and provide standardized care plans for last days of life
- Promote and provide resources to support symptom management in last days of life
- promote consistency with New Zealand best practice guidelines Te Ara Whakapiri
- provide easy access to information resources for patients/carers and providers

The scope of the pathway includes use by all health professionals caring for adults who are recognized as being in their last days of life regardless of diagnosis or care setting.

Editorial methodology

This care map was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of medicine editorial methodology. It has been checked by individuals with front-line clinical experience (see Contributors section of this document).

Map of Medicine pathways are constantly updated in response to new evidence. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the pathways through the quarterly publication cycle.

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1	World Health Organization. (2002) National cancer control programmes, policies and managerial guidelines (2nd edn). Geneva:World Health Organization
2	Palliative Care Subcommittee, NZ Cancer Treatment Working Party (2007). New Zealand Palliative Care: A Working Definition. [Online]. Available from: http://www.moh.govt.nz/moh.nsf/pagesmh/2951/\$File/nz-palliative-care-definition-oct07.pdf
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MidCentral DHB's Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

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This pathway was distributed widely for consultation and comments received have been acknowledged and taken into consideration in the final document

Disclaimers

CCP Executive Team, MidCentral DHB

It is not the function of the CCP Executive Team, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.