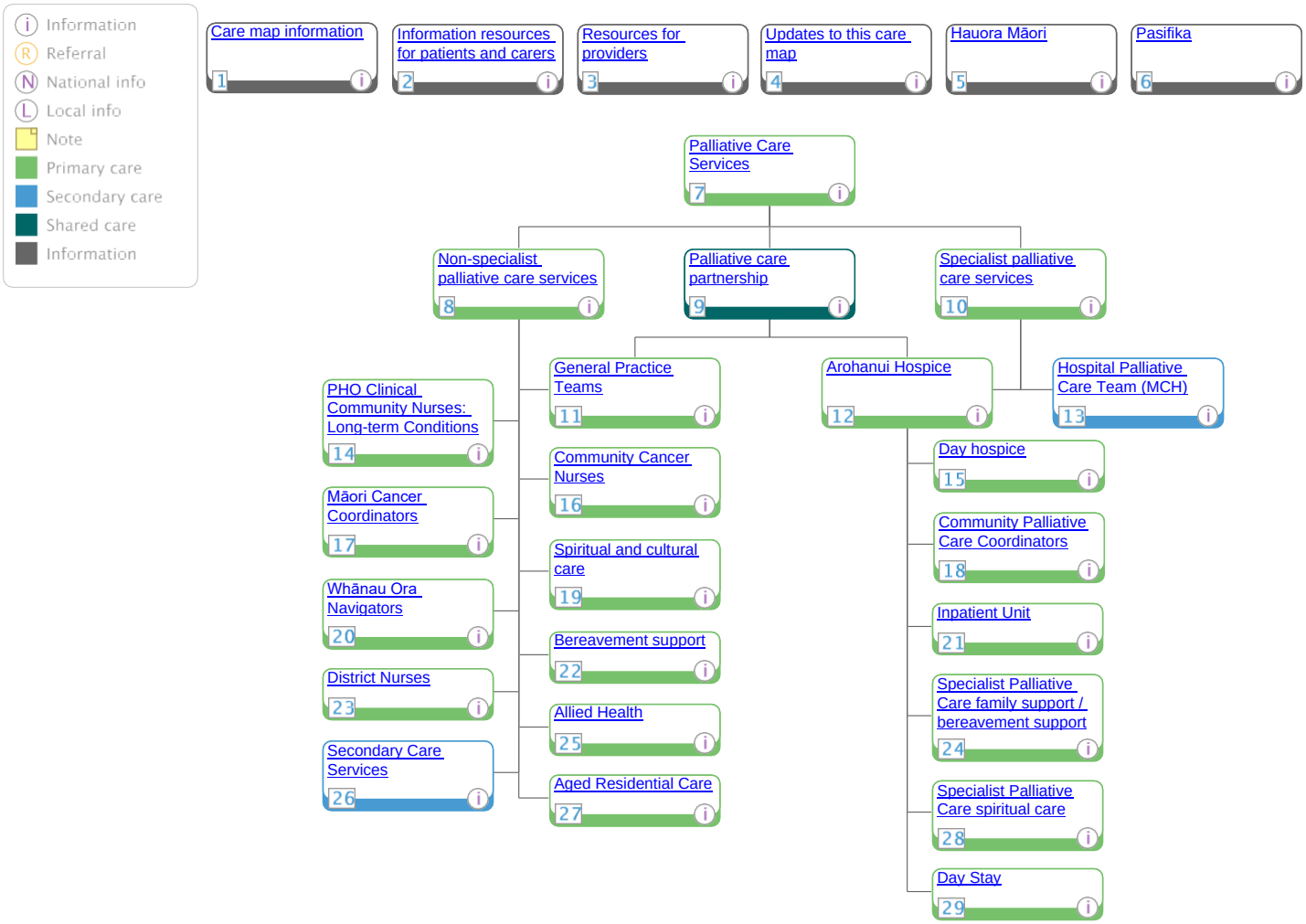
Palliative Care - Services

Medicine > Palliative Care > Palliative Care in Adults



1. Care map information

In scope:

- services appropriate to 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) 3569169 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 an 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

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 Sevices 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 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
- Coping with Bereavement
- Advance Care Planning

- 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 publication: March 2015

Date of republication: 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:

- day hospice service information added
- changes to the order of some nodes
- 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
- Central PHO Maori Health website

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 2010-2014
- Primary care for pacific people: a pacific health systems approach
- Tupu Ola Moui: The Pacific Health Chart Book 2004
- Pacific Health resources
- List of local Maori/Pacific Health Providers
- Central PHO Pacific Health website

7. Palliative Care Services

Palliative care is the domain of both non-specialist and specialist palliative care providers.

Palliative care services:

- should be available to meet the needs of people, and whānau, regardless of their diagnosis or place of care
- should provide support for:
  - physical
  - psychological
  - spiritual and cultural needs
- should enable people at the end of life to live and die in their place of choice

If you are unclear if specialist palliative care is required please contact Arohanui Hospice to discuss 06 356 6606.

8. Non-specialist palliative care services

Non-specialist palliative care is provided by:

- all organisations and individuals that deliver palliative care as a component of their service
- their substantive work is not the care of people who are dying

It is palliative care provided:

- for those affected by a life-limiting or life-threatening condition as an integral part of standard clinical practice

A non-specialist palliative care provider:

- may have a broad health focus or
- be specialised in a particular field of medicine:
  - cardiology
  - respiratory
- may assess and refer people to specialist palliative care services when the person's needs exceed their services capacity

9. Palliative care partnership

The palliative care partnership (PCP) is:

- a partnership between:
  - Central PHO
  - Arohanui Hospice
  - General Practice Teams
- includes key linkages with District Nursing Services

The aim of the partnership is to provide enhanced palliative care through coordination between General Practice Teams and Specialist Palliative Care Services.

The key components of the PCP include:

- specialist assessment
- care planning
- ongoing support provided by the Palliative Care Coordinator (a Specialist Palliative Care Nurse)
- mandatory education
- funding for services

For further information regarding PCP contact Arohanui Hospice (06) 356 6606.

10. Specialist palliative care services

Specialist palliative care is:

- palliative care provided by those who have undergone specific training and/or accreditation in palliative care/medicine
- working in the context of an expert interdisciplinary team of palliative care health professionals

Specialist palliative care may be provided by:

- hospice or
- hospital based palliative care services where people have access to at least medical and nursing palliative care specialists

Specialist palliative care is delivered in two key ways:

- directly:

- to provide direct management and support of people and whānau where more complex palliative care need exceeds the resources of the primary provider

- indirectly:
  - to provide advice, support, education and training to other health professionals and volunteers to support the primary provision of palliative care provision

For paediatric palliative care contact MidCentral Health Child Health Services Ph 356 9169 ext. 8661.

11. General Practice Teams

General Practice Teams provide:

- person-centred, continuing, comprehensive, co-ordinated health care to individuals and families in their communities
- these teams work closely with a wide range of community and hospital-based providers to meet the needs of individuals
- palliative care services are an important part of this service

General Practice Teams deliver Palliative Care Services in many ways, including:

- direct management and support of individuals and their families/whānau
- close collaboration with Community Health providers, e.g. District Nurses, Social Workers, Counsellors
- in partnership with Specialist Palliative Care Services where additional resources, expertise is required

Within the MidCentral area, General Practice Teams have the opportunity of joining the Palliative Care Partnership which facilitates access to Specialist Palliative Care services, co-ordination and funding.

12. Arohanui Hospice

Arohanui Hospice provides:

- specialist palliative care for people who have a life-limiting illness
- care that enables people to achieve the best possible quality of life
- services both in community and hospice inpatient
- support to families and loved ones
- 24/7 telephone support
- education and training support for health professionals

Services are delivered by a diverse team which is made up of:

- a wide range of health professionals
- support staff
- volunteers

The team works together to provide individual care for people and their family/whānau.

All key medical and clinical staff have specialist qualifications for the work they do.

For information phone Arohanui Hospice (06) 356 6606.

13. Hospital Palliative Care Team (MCH)

Hospital Palliative Care Team:

- is a dedicated hospital team made up of a Medical Consultant and Clinical Nurse Specialists

- is consultative based - no dedicated beds
- accepts referrals from hospital teams
- follows up patients known to the hospice acutely admitted to hospital
- liaises with Arohanui Hospice and primary services, including general practice, to facilitate smooth transition on discharge
- hours are Monday - Friday, 8.30am - 5pm
- is supported after hours by Arohanui Hospice team

14. PHO Clinical Community Nurses: Long-term Conditions

PHO Clinical Community Nurses Long Term Conditions (CCN-LTC) specifically:

- diabetes
- cardiac
- respiratory

Work holistically with individuals and family/whānau, in partnership with General Practice Teams and secondary care specialists to help people manage their conditions and ensure that the support and services they require are put in place and delivered in an integrated manner.

15. Day hospice

Day hospice;

- The Arohanui Hospice Day Service Clinic is provided by Clinical Nurse Specialist and Social Worker
- It is a responsive option for patients/family/whanau
- Assessment and ongoing response to palliative care needs are the focus of the Day Service
- Access to the multidisciplinary team members such as Doctors, Chaplains and, Family Support
- Patients and family/whanau will transfer to the Community Hospice Team when required

For information phone Arohanui Hospice (06) 356 6606

16. Community Cancer Nurses

This **community based cancer service** is provided to anyone with a possible, probable or definite diagnosis of cancer and who are enrolled with a PHO and/or is resident in the PHO area.

The main focus is to assist people and their family to self-manage, facilitate interaction with secondary services and coordinate care.

Contact:

- Manawatu locality:
  - Ph (06) 354 9107
- Horowhenua locality:
  - Ph (06) 367 6433
- Tararua Health Group:
  - Ph (06) 374 5691

17. Māori Cancer Coordinators

This Iwi based community support is a free service that provides support to ensure the best possible cancer service is provided to people and their whānau:

- improving communication
- linking to whānau and services for additional support

There are four Māori Cancer Coordinators who work within each of the Māori health providers:

- **Palmerston North/Manawatu:**
  - Best Care (Whakapai Hauora) Charitable Trust:
    - ph: 06 353 6385
    - fax: 06 353 1883
  - Te Wakahuia Manawatu Trust:
    - ph: 06 357 3400
    - fax: 06 357 3425
- **Horowhenua/Otaki:**
  - Te Runanga O Raukawa Inc:
    - ph: 06 368 8678
    - fax: 06 368 8679
- **Tararua:**
  - Te Kete Hauora:
    - Ph: 06 374 6860
    - Fax: 06 374 5209

18. Community Palliative Care Coordinators

Arohanui Hospice Community Palliative Care Coordinators (PCCs):

- are specialist registered nurses with expertise in palliative care
- they work as part of a team with doctors, a pharmacist, family support and pastoral care staff at Arohanui Hospice specialist palliative care service
- are responsible for co-ordinating individual's assessment and care in the community, including:
  - support
  - education
- work in partnership with general practice teams (GPTs), district nurses and other providers
- GPT's remain the primary care provider

For information phone Arohanui Hospice (06) 356 6606.

19. Spiritual and cultural care

Things spiritual and things cultural are two completely different aspects of a person.

A lack of attention to spirituality and cultural needs can lead to distress for adults.

Open and respectful communication with the person and their family/whānau will ensure their needs are assessed and integrated into care planning.

People and whānau may already have contact with spiritual and cultural support systems and these need to encouraged and integrated into care.

Spiritual or cultural care support and advice can be accessed through:

- consumer advisory services
- services that the person is accessing such as:
  - Hospital Chaplaincy services

- individuals spiritual/cultural advisor
- specialist palliative care services

Resources and prompt questions to help assess a persons individualised needs can be accessed via the information resources for patients and carers node.

20. Whānau Ora Navigators

Whānau Ora Navigator Service

Te Ara Whānau Ora is a free service that that works directly with whānau using a strengths based process - Te Ara Whānau Ora.

Te Ara Whānau Ora is facilitated by a Whānau Ora Navigator and is a process that supports whānau to identify their own goals and aspirations, thus empowering whānau to realise their potential. Through this process a plan is created that supports whānau to excel.

Contact for:

- **Palmerston North, Manawatu, Tararua:**
  - Te Tihi o Ruahine Whānau Ora Alliance - Miriama Kereama - 021 499 298 or (06) 357 3400
- **Otaki, Levin, Horowhenua:**
  - Te Runanga o Raukawa (06) 368 8678
  - Muauopoko Tribal Authority (06) 367 3311

21. Inpatient Unit

Arohanui Hospice inpatient unit has 10 beds where people can be admitted for short episodes of care (typically 1-7 days), or as day patients.

Reasons for admission include:

- symptom management
- care in the final days of life
- carer support management

Admission is arranged via the inpatient charge nurse or palliative care coordinator in consultation with the medical team.

The length of stay is determined on an individual basis, with most people returning to their homes.

The inpatient unit is unable to provide long term residential care.

For information phone Arohanui Hospice (06) 356 6606.

22. Bereavement support

Bereavement support is a key element of palliative care.

Family, whānau and friends play a fundamental role in supporting those who are bereaved, especially older people.

MidCentral bereavement support guidelines provide evidence-based strategies to guide health professionals in providing optimal support while the family/whānau are providing care, preparing for dying and after a person's death.

Family and whānau require information, preparation and support to assist them before and following death. Use available resources to assist with this (see information resources node).

The use of existing community organisational supports, previously known to people, is to be supported and encouraged.

Complex grief can occur in a small number (10-20%) of family, whānau caregivers and validated assessment tools for complicated grief are recommended and appropriate support should be accessed if identified as being needed.

23. District Nurses

Community district nursing service (DNS) provides home based nursing assessment and interventions, enabling and assisting patients, their family and the wider health care team with community and home based palliative care and support. Nursing assessment and interventions generally focussed on:

- symptom prevention/management
- personal care, hygiene and continence support
- pressure area prevention/management
- end of life care and support
- equipment to support safe and effective care in the home
- liaison and co-ordination with the palliative patients other primary care services as well as Arohanui Hospice and their Palliative Care Co-ordinators

Home based service delivery is available 24/7 throughout the region - services are co-ordinated centrally in Palmerston North with District Nursing bases also in Feilding, Foxton, Levin, Otaki, Pahiatua and Dannevirke.

Phone, fax or email referrals are welcomed.

Phone 24/7 (06) 350 8182 or 0800 001 491.

Fax (06) 350 8102.

24. Specialist Palliative Care family support/bereavement support

Arohanui Hospice specialist palliative care family support / bereavement support:

- registered social workers are available to provide personal and practical support to people and family/whānau
- counselling services are also available
- the team can provide information about, and access to, services or support that might be available and can advise on eligibility and funding assistance to obtain those services
- bereavement service can provide support for those who have experienced the loss of someone significant in their lives
- this support is available to people of all ages and at any point in their grief, especially as they experience the more difficult times in their journey
- support and a variety of resources are available

For information phone Arohanui Hospice (06) 356 6606.

25. Allied Health

Occupational Therapy offers:

- assessment
- treatment
- access to appropriate equipment

Enables clients to maximise their independence in daily activities and maintain quality of life.

Physiotherapy offers:

- assistance in the maximisation of potential to enable clients to self manage and maintain quality of life

Social work offers:

- interventions to help people with a palliative care need including:
  - crisis interventions
  - counselling support for health related issues
  - advocacy
  - coordination of, and support to access support services
  - support for families and carers of a person with a palliative care need

For allied health referrals:

- phone: (06) 350 8320 Fax: (06) 350 8122
- postal: Central Referral Management Rehabilitation Service, Palmerston North Hospital, Private Bag 11036, Palmerston North

26. Secondary Care Services

Palliative care can be provided in the secondary care settings by healthcare professionals. These include:

- Palmerston North Hospital
- Star 4 Ward at Horowhenua Hospital

Many hospital-based healthcare professionals will have experience managing patients with palliative care needs.

Most healthcare professionals working with the frail elderly with multi morbidity will have had training/teaching in palliative care. Collaborative working with specialist palliative care services and general practice teams, using a shared care model will enable the patient's palliative care needs to be met.

27. Aged Residential Care

Palliative care can be provided to residents in Aged Residential Care (ARC) facilities settings by healthcare professionals.

Many healthcare professionals in ARC have experience in managing patients with palliative care needs.

Collaborative working with general practice team and if required with specialist palliative care services using a shared care model will enable the resident's palliative care needs to be met.

When considering admission to ARC for palliative care the following should be taken into account:

- identified needs are unable to be met by supports in the community
- needs overnight care
- unsafe in the home environment
- self neglect/elder abuse

Refer to Supportlinks:

- "a person over the age of 65 years (55 years for Māori) who has been identified as having a physical, neurological, intellectual, sensory or age related disability (or a combination of these) which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is required"
- for referral phone (06) 350 6671

28. Specialist Palliative Care spiritual care

Arohanui Hospice specialist palliative care spiritual care:

- offers support and care for individuals and families
- assistance is provided to help family and whānau, friends and carers cope with a wide variety of feelings and concerns that

can arise in these circumstances
- spiritual care coordinator can facilitate contact with other support networks in the community

For information phone Arohanui Hospice (06) 356 6606.

29. Day Stay

Arohanui Hospice Day Stay activities programme provides:

- a variety of opportunities for people to participate in:
  - arts and crafts
  - music
  - listen to speakers, etc.
- a relaxed and friendly environment
- a welcome change of scenery
- the chance to enjoy the company of others
- people can choose how often they wish to attend
- respite for carers

Hospice can arrange assistance with transport to and from the Day Stay programme if required.

For information phone Arohanui Hospice (06) 356 6606.

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.

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 the CCP Executive Team and with stakeholder groups.

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
3	Ministry of Health. (2015). *Te Ara Whakapiri: Principles and guidance for the last days of life*. Wellington: Ministry of Health.

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.

Working group members included:

- Syed Zaman, Consultant Geriatrician, MidCentral Health (Secondary Care Clinical Lead)
- Pauline Blackmore, General Practitioner, Tararua Health Group (Primary Care Clinical Lead)
- Clare Randall, Chief Executive, Arohanui Hospice
- Jean Clark, Clinical Nurse Specialist Palliative Care, MidCentral Health
- Karen Sherward, Clinical Nurse Specialist Palliative Care, MidCentral Health
- Simon Allan, Director of Palliative Care, Arohanui Hospice
- Karen Lowe, Nurse Practitioner, Cook Street Health Centre
- Bridget Marshall, Palliative Care Network Coordinator (Pathway Facilitator)
- Liz Elliott, Nurse Coordinator Practice Development, Health Care Development, MidCentral DHB (Pathway Editor)

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.