TOOLS TO ASSIST
AFTER-HOURS TELEPHONE TRIAGE
of Community Palliative Care Clients

To be used by registered nurses

Gippsland Region Palliative Care Consortium
The purpose of this document is to guide nurses in their management of calls from registered community palliative care clients and carers after-hours, and in doing so, to enhance the quality and consistency of after-hours care.

Important considerations for the use of Tools to Assist After-Hours Telephone Triage of Community Palliative Care Clients:

- This document does not replace organisational protocols; each organisation is responsible for having their own protocols which set out their particular service options as these may differ from those described here.

- The tools are intended to be used as first-line management.

- The tools are to be used in conjunction with comprehensive evidence based guidelines such as:
  - Therapeutic Guidelines – Palliative Care¹
  - The Palliative Care Handbook²
  - the Department of Health’s After-hours palliative care framework³

- Nurses taking after-hours calls are expected to have access to up to date information about the client’s current phase of illness and symptoms. A sample form is located in the Appendix; Client Summary Palliative Care.

- Call information and outcome(s) should be documented to allow for evaluation. A sample form is located in the Appendix; After-Hours Call Summary.

Acknowledgements

The majority of the information in this document is based on the report Tools to Assist After-Hours Telephone Triage of Community Palliative Care Clients, authored by Catherine Duck and Irene Murphy for the Gippsland Region Palliative Care Consortium in January 2015.⁴

Another key reference was the Palliative Care Telephone Triage Protocols for Registered Nurses⁵, developed by the Wimmera Health Care Group, which provided a useful format for printing.
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Background

Tools to Assist After-Hours Telephone Triage of Community Palliative Care Clients is an initiative of the Gippsland Region Palliative Care Consortium (GRPCC) and forms part of the after-hours project.

Provision of after-hours support has been a requirement of all Victorian community palliative care services since 1997. The Department’s current requirements for the minimum level of service for after-hours community palliative care include:

- telephone advice to carers and families primarily (but not only) about symptom management if required;
- a nursing visit if required based on the client’s, carer’s and family’s needs (if it is safe for staff to undertake the visit); and
- an appropriately staffed after-hours service provided to all clients and carers on admission to the service.

Increasing the availability of after-hours support to clients and carers in their homes, particularly in rural areas, sits under Strategic Direction 2 in the Department’s Strengthening palliative care: policy and strategic directions 2011 – 2015. In this document the Department finds that the provision of telephone information and support, or a nurse visit if required after hours, has been associated with easing client and carer anxiety, improving family support and enhancing clients’ ability to stay in their own homes.”
Guide to using the Tools

Practical Principles
The Practical Principles are the starting point.

Flowcharts
The flowcharts are divided into three columns: **Find out**... **Decide**... **Act** ...

**FIND OUT** ... is designed to prompt the nurse to obtain a general sense of the client’s and carer’s situation, to consider possible causes and related issues, and to ask relevant questions.

**DECIDE** ... is designed to help the nurse to sort and analyse the information obtained.

**ACT** ... is designed to lead the nurse to possible actions according to the information and the nurse’s judgement.

- Black text relates to pharmacology
- Purple text relates to general nursing measures
- Pink text relates to psychological and spiritual care

Creating space and reflective practice
Principle 10, Create space, prompts the following question and script:

“Feeling overwhelmed? Don’t know what to do? Need to consult?

I need to think about what you’ve told me and to work out our options. I’m going to hang up now and call you back within 5-10 minutes.”

This principle should be implemented every time the nurse feels uncomfortable or uncertain. It will allow time to consult another clinician and/or appropriate texts.

When time allows, the same approach should be taken to reflecting on the calls, outcomes and opportunities for learning.”
Practical Principles

1. **Set the scene**
   - You and the caller are working as a team.
     
   "I'm going to ask you some questions so I understand what's happening and together we can work out what to do."

2. **Establish the phase of illness**
   - Stable, unstable, deteriorating, terminal or bereavement (see Appendix: GRPCC Client Summary Palliative Care) – this will guide your decision-making, e.g. you would probably not advise a client in the terminal phase with a new pain to go to the Emergency Department.

3. **Identify and separate the issues**
   - Start with the most significant issue and address the others one-by-one.
     
   "What are you finding most difficult?"³

4. **Speak to the client** (where possible and appropriate)
   - This will help you assess symptoms and distress more accurately.
   - Refer to the client by name – "Would it be possible to speak with Mr Jones/Jack?"

5. **Try prescribed regular/breakthrough medication for the symptom/s first**³
   - Is there a written plan in the home?
   - Don’t assume medications have been taken as prescribed – check.

6. **Be pragmatic and direct**
   - Your job is to apply a "dressing" that will hold till daylight.
   - What has been done?
   - What can be done now?
   - What can wait for daylight?

7. **Give the caller options**
   - What are the client/family's wishes about site of care and end-of-life?
   - What are the implications of going to hospital/not going to hospital?
   - How will they get there?

8. **Listen and respond to distress**
   - An apparently insignificant issue may be the tip of the iceberg.
   - It may be the middle of the night and the caller is sleep-deprived.
   - The caller doesn’t know they may have woken you and doesn’t need to know.
   - Offer calm, comfort and support.

9. **Modify behaviour in daylight**
   - The client hasn’t used his/her bowels for six days? The client has had pain since 10am?
   - Be pragmatic (see Principle no.6).
   - Arrange for education of client and caller during daylight hours when the crisis has passed and they have had some sleep.

10. **Create space**
    - Feeling overwhelmed? Don’t know what to do? Need to consult?
      
    "I need to think about what you’ve told me and to work out our options. I’m going to hang up now and call you back within 5-10 minutes."

    continued overleaf
Practical Principles cont.

Triggers for a nursing visit may include:
1. Symptom(s) persist, and
   - three ‘breakthrough’ doses of oral medication have been taken AND/OR
   - the client is unable to swallow oral medications AND
   - the means to give injectable breakthrough medications are accessible (medications, orders, needles and syringes).
2. Multiple calls have been received that day/evening/night, AND
   - no progress on the issue(s) has been made AND
   - the issue/s do not require immediate medical intervention.
3. Client death, where the carer/family is unprepared.
4. The client and/or carer/s are too distressed to hear instructions or manage alone.
5. You can’t work out what’s going on.

Triggers for seeking medical advice may include:
1. You need clarification of a medication order.
2. Medications and orders are urgently required but not accessible.
3. All available measures have been used and the client is still uncomfortable/in pain/distressed.
4. The client is febrile but not on chemotherapy (see below) or in the last hours of life when temperature control may be irregular.
5. There are signs of an acute and/or reversible condition, e.g. chest infection.
6. There are signs of a palliative care emergency, e.g. spinal cord compression.
7. The client’s condition has changed and you are unsure of the right course of action.

Triggers for transfer to hospital may include:
1. A nursing visit is not possible AND/OR you are unable to contact a doctor AND the client/carer agrees to transfer to hospital. Consider and discuss with them, if appropriate:
   - Their wishes about site of care and end-of-life;
   - The implications of going to hospital versus staying at home; and
   - The potential for reversal of the presenting condition and relief of symptoms.
2. A client who has had chemotherapy within the last 10-14 days is febrile, e.g. 38°C (check instructions from the treating hospital).
3. A client has a new symptom needing urgent assessment, e.g. acute respiratory distress, extreme pain, uncontrolled vomiting, haemorrhage, acute confusion.
4. The client and carer/s request transfer to hospital, and
   - They are experiencing major stress at home,
   - You have attempted to establish the phase of illness, and
   - You have discussed with them, if appropriate, the implications of going to hospital versus staying at home.
Flowcharts and how to use them

**FIND OUT...**

Use the prompts to get the general picture.

**DECIDE...**

Now you have the general picture, use the prompts to sort and analyse the information.

**ACT...**

Now you have more specific information, select the appropriate responses from this column.

Trust your judgement.

Get help if you need it:

- Create space by ending the call with a promise to phone back in 5-10 minutes
- Think
- Consult another clinician if you can
- Consult the referenced texts e.g. The Palliative Care Handbook.

When you have time, use your resources and colleagues to reflect on the calls and outcomes.

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**PAIN**
- NAUSEA and VOMITING
- DYSPNOEA/SHORTNESS OF BREATH
- ANXIETY and RESTLESSNESS
- LAST DAYS of LIFE
- LAST HOURS of LIFE
- DEATH
- CARER DISTRESS
- NIKI T34 SYRINGE PUMP

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Not sure if the client is in the LAST DAYS or LAST HOURS of life?

Doesn’t matter – use both flowcharts.
PAIN

FIND OUT...

Where is it? When did it start?

“Have you had it before or is it new?”
“Can you score the pain out of 10? If no, is it mild, moderate or severe? Or worse?”

“Do you have a written plan for pain? If yes, what does it say to do? Have you been able to do that?” OR

“Do you take something at the same time every day for pain? Have you taken it today? At what times?”

“What do you take for extra or ‘breakthrough’ pain?” (Should be 1/6 or 1/12 of a regular opioid dose over 24 hours).
“Have you taken any today? At what times? How much? Did it help? How much did it help?”

“Do you feel anxious?”

“Can you swallow medications?”

“Do you have injectable pain medications in the home?”

DECIDE...

IF...

- Pre-existing pain, OR
- New pain <4/10 (mild) and no obvious cause, e.g. fall

Anxiety is present AND

- Oral meds are in the home
- Able to swallow

IF...

- Unable to swallow OR
- Unresponsive to oral prn meds

AND

- Injectable meds are in home

IF...

- Unresponsive to oral prn meds

AND/OR

- Injectable meds are not in home

AND/OR

- Pre-existing or new pain is >4/10 (moderate – severe)

AND/OR

- Nursing visit is unavailable

ACT...

ADVICE

Take regular pain meds at the right times e.g. q12h MS Contin.
Take pm oral meds and wait 30-45 minutes. Do this twice more if needed (to a maximum of 3 doses, 30-45 minutes apart).
Consider paracetamol, up to 2 tablets qid.
Consider anxiolytic for anxiety.

NURSE TO VISIT

MEDICAL REVIEW/ HOSPITAL
NAUSEA and VOMITING

FIND OUT...

“Are you nauseated?”
“Can you score the nausea out of 10? If no, is it mild, moderate or severe? Or worse?”

“Have you vomited?”
When did it start?
How many times since then?”

“Can you describe the volume, smell, appearance?”

“Do you have abdominal pain?”

“Are you having chemotherapy?”

“Do you have a fever?”

“Do you have a written plan for nausea and vomiting?”
If yes, what does it say to do?
Have you been able to do that?” OR

“Do you take something at the same time every day for nausea?”
Have you taken it today?
At what times?”

AND

“Do you take something as needed? What is it?”
Have you taken any today? At what times?
How much? Did it help? How much did it help?”

“Can you swallow medications?”

“Is the medication staying down?”

“Do you have injectable medication for nausea in the home?”

DECIDE...

IF...

■ Nauseated AND/OR
■ Vomiting

AND

■ Oral meds are in the home
■ Able to swallow
■ Able to keep meds down

IF...

■ Unable to swallow OR
■ Unresponsive to oral prn meds OR
■ Unable to keep meds down

AND

■ Injectable meds are in home.

IF...

■ Unresponsive to oral prn meds

AND

■ Injectable meds not in home

AND/OR

■ Bright red blood or faecal odour or severe abdominal pain are present
■ Fever is present

AND/OR

■ Nursing visit is unavailable

ADVICE

Take regular nausea and vomiting meds at the right times e.g. qid metoclopramide
Take prn oral meds and wait 30 – 45 minutes; call back if not better

Sips of clear fluids/ice chips

NURSE TO VISIT

MEDICAL REVIEW/ HOSPITAL

References
Appendix
Niki T34
Syringe Pump
Carer
Distress
Death
Last HOURS of Life
Last DAYS of Life
Activity and Restlessness
Shortness of Breath (SOB)
Nursing Visit
Syringe Pump
Appendix
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**DYSPNOEA/SHORTNESS OF BREATH (SOB)**

(There is limited evidence that oxygen helps SOB at end of life*)

### FIND OUT...


does your SOB come on gradually or suddenly?

Have you had it before?

If sudden onset, “are you feverish or clammy?”

(pulmonary embolus?)

*Can you score your SOB out of 10?*

If no, is it mild, moderate or severe? Or worse?*

*Do you have a written plan for SOB?*

If yes, what does it say to do?

Have you been able to do that?” OR

*Do you take something at the same time every day for SOB?*

Have you taken it today?

At what times?”

*What do you take for extra or ‘breakthrough’ SOB?” (Should be 1/6 or 1/12 of a regular opioid dose over 24 hours and/or an anxiolytic).*

*Have you taken any today?*

At what times?

How much? Did it help? How much did it help?*

*Do you have chest pain? Secretions? Noisy breathing?*

*Can you swallow medications?*

*Do you have injectable medications in the home?”*

### DECIDE...

**IF...**

- Pre-existing SOB/secretions OR
- New SOB/secretions

**AND**

- Oral meds are in home and client is able to swallow

**AND/OR**

- Oral or SL anxiolytic are in home (e.g.lorazepam or clonazepam drops)

**IF...**

- Client/carer is anxious/distressed

**AND**

- Unable to swallow OR

- Unresponsive to oral/SL prn meds

**AND**

- Injectable meds are in home

**IF...**

- Unresponsive to oral/SL meds

**AND**

- Injectable meds are not in home

**AND/OR**

- Sudden onset of severe SOB +/-

- Chest pain +/-

- Fever or clamminess (?)PE

- Loud stridor (with head, neck, trachea or bronchus tumour)

**AND/OR**

- Nursing visit is unavailable

### ACT...

**ADVICE**

Take regular meds for pain and SOB at the right times e.g. q12h MS Contin

Take anxiolytic

Take prn oral meds for pain and SOB and wait 30-45 minutes. Do this twice more if needed (to a maximum of 3 doses, 30-45 minutes apart)

Apply or increase oxygen if available and acceptable to client

**Move air** (window/fan)

**Position** on pillows or at 45º side-to-side if too unwell

**NURSE TO VISIT**

**MEDICAL REVIEW/HOSPITAL**

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*References*

Appendix

Niki T34 Syringe Pump Carer Distress Death Last HOURS of Life Last DAYS of Life Death Carer Distress Niki T34 Syringe Pump Appendix References
ANXIETY and RESTLESSNESS

(A&R occur commonly at end-of-life and can often be attributed to multiple causes)

FIND OUT...

Has the client been anxious or restless before?
“Do you think there might be a specific cause?”

Does the client have cognitive impairment, e.g. dementia?

“Do you have a written plan for A&R?
If yes, what does it say to do? Have you been able to do that?” OR
Does the client take something at the same time every day for A&R?
“Have they taken it today?” At what times?”
What do they take for extra or ‘breakthrough’ A&R?
“Have they taken any today? At what times? How much? Did it help? How much did it help?”

Does the client have Pain? Shortness of breath (SOB)? Fever?
When did they last pass urine (colour, volume), use their bowels?

Can the client swallow medications?

Has the client started a new med?
Is the client taking steroids?

“What do they take for extra or ‘breakthrough’ A&R?”

DECIDE...

IF...

- Pre-existing or new A&R
- A new med is a suspected cause
- Recently commenced steroids +/- taken late in the day
- Oral meds are in the home and able to swallow AND/OR
- Anxiolytics are in the home, e.g. lorazepam or clonazepam drops
- Urine output is diminished OR
- Fever (no chemo in 10-14 days)

ADVICE

Take regular meds for A&R, pain and SOB at the right times
Take prn meds for A&R
Cease new med and medical review next day
Take steroids before midday and medical review
Take prn meds (if needed and/or client has cognitive impairment) for pain and SOB. Wait 30-45 minutes. Do this twice more if needed (to a maximum of 3 doses, 30-45 minutes apart)

Encourage urination
Speak in a quiet & natural way
Read or play music softly
Have familiar people in the room
Light the room according to time of day, e.g. night light
Give tepid sponge

IF...

- Unable to swallow OR
- Unresponsive to oral/SI prn meds
AND
- Injectable meds are in home
AND/OR
- Possible urine retention
- Constipation

IF...

- Unresponsive to prn meds
AND
- Injectable meds are not in home
AND/OR
- Means to address bladder/bowel issue are not in home
- T 38º (chemo in last 10-14 days)
- A&R is too distressing
- Nursing visit is unavailable

NURSE TO VISIT

MEDICAL REVIEW/ HOSPITAL

Page 14
LAST DAYS of LIFE

FIND OUT...

Are Pain, Nausea and Vomiting or Dyspnoea present?
Is the client showing signs of terminal restlessness? (unable to relax, picking at clothing/sheets, trying to climb out of bed)

Is the dying client talking of:
- Travel or change?
- Sensing the presence of someone the carer can’t see?
- Their destination?
- When they will die?
- Dreams?
- Reconciliation with a loved one?
- Fears?

DECIDE...

IF...
- Pain, Nausea and Vomiting or Dyspnoea are present
- The client is terminally restless

IF...
- The dying client is trying to communicate
  - About subjects that puzzle or upset the carer
  - In an apparently odd, agitated or confused way

AND/OR

IF...
- Practical issues cannot be resolved according to flowcharts
  - The client +/- carer is distressed
  - You are worried

ADVICE
Follow the relevant flowcharts
Terminal restlessness is a common symptom occurring in the last days of life
Follow the flowchart for Agitation and Restlessness

Dying people often try to express their needs or share their experiences with carers
They seem to find these experiences reassuring and comforting
Respond with calm acceptance and reassurance using their language
Listen for the meaning
Don’t argue, challenge or push
If possible, resolve underlying issues
Don’t worry if you can’t understand the meaning – “We’ll keep trying and maybe it will come later”

ACT...

NURSE TO VISIT

MEDICAL REVIEW/HOSPITAL

Page 16
LAST HOURS of LIFE

Find Out...

What does the carer think is happening?

Is the carer worried about:
- Dehydration?
- Incontinence?
- Sleepiness?
- Unresponsiveness?
- Confusion?
- Discoloured/hot/cold limbs?
- Gurgling or rattling sound?
- Irregular breathing?

Is the carer alone?
- Does the carer have family/support?
- Does the carer wish to be alone?

Decide...

If...
- Death is approaching
- The carer understands death is approaching
- The carer and client wish to remain at home

Advice

Dehydration
Natural process; moist swabs, ice chips, lip balm

Incontinence
Pads, bed protection, sheets

Sleepiness/Unresponsiveness
‘Being with’ is more important than ‘doing for’. Assume they can hear you.

Confusion
Speak softly, clearly, truthfully

Discoloured/Hot/Cold Limbs
Circulation decreases and temperature control is irregular. Cool/warm client as appropriate.

Gurgling/Rattling
Saliva and mucus may collect in throat as swallow/cough reflex diminish. Client is usually unaware. Turn side-to-side, raise head on pillow.

Irregular Breathing
Common, with intervals of seconds to minutes when no breathing occurs. May continue for minutes, hours or days.

Act...

Nurse to Visit

If...
- The client and/or carer is distressed
- The carer is alone and unsupported
- You are worried

Medical Review/Hospital

If...
- As above
- The client and/or carer do not wish to remain at home
- Nursing visit is unavailable
DEATH

FIND OUT...

Has the client died?
Is the carer telling you:
- The client is not breathing?
- They can’t rouse the client?
- The eyelids are partially open with eyes in a fixed stare?
- The mouth has fallen open?
- The client has released bowel and bladder contents?

- Has a funeral director been organised?
- Has the client been seen by a doctor in the last month?

From available documentation:
- Does the funeral director require verification of the death prior to removal of the body?
- Who will verify the death? (See GRPCC Verification of Death Guideline)

Is the carer alone?
- Does the carer have family/support?
- Does the carer wish to be alone?

IF...
- The client has died

ADVICE
Contact LMO if a 24-contact number is provided
Don’t ring 000
Equipment can stay with the client for now
There is no urgency to do anything
The body can remain overnight and the carer can call the LMO and funeral director in the morning
If appropriate, contact a minister of religion

“Are you OK?”
“Is there someone you can call to be with you?”
“There is no rush”
“There is time now for you all to be with him/her”
“Do and say whatever you need to”
“Put the kettle on”

IF...
- The carer is unprepared and distressed
- The carer is alone and unsupported
- You are worried

NURSE TO VISIT

IF...
- As above
- Nursing visit is unavailable OR
- Client has not been seen by a doctor in the last month

AMBULANCE

DECIDE...

IF...
- The client has died

ADVICE
Contact LMO if a 24-contact number is provided
Don’t ring 000
Equipment can stay with the client for now
There is no urgency to do anything
The body can remain overnight and the carer can call the LMO and funeral director in the morning
If appropriate, contact a minister of religion

“Are you OK?”
“Is there someone you can call to be with you?”
“There is no rush”
“There is time now for you all to be with him/her”
“Do and say whatever you need to”
“Put the kettle on”

NURSE TO VISIT

IF...
- The carer is unprepared and distressed
- The carer is alone and unsupported
- You are worried

NURSE TO VISIT

IF...
- As above
- Nursing visit is unavailable OR
- Client has not been seen by a doctor in the last month

AMBULANCE
CARER DISTRESS
(Simply talking about distress helps relieve it)\(^{10}\)

FIND OUT...

What are the **individual issues** – “Tell me what’s been happening.”

What is the most **significant issue**? “What is most difficult for you?”

Has there been a **change** in the client’s condition?

Has the client become **incontinent**?

Is the client **immobile**?

Is the client having **difficulty swallowing** medications?

Is the **carer exhausted**?

What would the carer like to happen?

What is possible now? In **daylight**?

DECIDE...

IF...

- The issues seem mainly about **carer burden and distress**

LISTENING

Listen

Don’t interrupt

Don’t rush

Sit with distress

Respond to humour

“Help me understand a bit more”

“You sound upset/low…”

“If I’ve got that straight, you feel…”

“Have you thought about trying…”

“How are you feeling now?”

“I am concerned about you. What would you think about talking with a Lifeline Counsellor?”

(13 11 14)

IF ...

The issues are also of a **practical nature**: 
- Those covered by the other **flowcharts**
- General deterioration
- Incontinence
- Gradual inability to get out of bed
- Difficulty swallowing medications
- Not eating or drinking much

ADVICE

Follow **flowcharts** as appropriate

Protect** bed with pads and sheets

**Turn side-to-side** support pillows

Reduce **meds** to those for comfort

Normalise reduced intake

Mouth care moist swab/ice chips

NURSE TO VISIT

IF...

- Practical issues cannot be resolved
- The carer remains distressed
- You are worried

IF...

- As above
- Nursing visit is unavailable

MEDICAL REVIEW/HOSPITAL
NIKI T34 SYRINGE PUMP

FIND OUT...

Is the pump alarming?

When the alarm is activated:
- The infusion stops
- An audible alarm sounds
- The keypad LED turns to red
- The screen displays a message and instructions to help identify/resolve the cause

What is making the pump alarm?

Is the SC needle site blocked or painful?

Is the infusion running but pain control is inadequate?

What is the carer’s capacity to follow instructions?

DECIDE...

IF...
- ‘OCCLUSION’

IF...
- ‘LOW BATTERY’ or ‘END BATTERY’

IF...
- ‘SYRINGE DISPLACED’ or ‘END OF INFUSION’ or Syringe is nearly empty
- Pain/symptom management is inadequate
- Site looks red and/or swollen
AND
- Carer is able to give SC meds

ACT...

ADVICE
Check the line is not kinked or clamped
Press ‘YES’ to restart infusion
If the alarm repeats and there is no sign of obstruction press STOP
Turn the pump OFF by holding the ON/OFF key
Nurse to visit

Open the battery compartment
Remove old battery
Replace with new 9V battery
Turn pump on by holding ON/OFF
Press YES to confirm syringe size and type
Press YES to resume program
Press YES to confirm infusion
Press YES to start infusion

Turn pump off by holding ON/OFF
Give regular SC ‘breakthrough’ pain relief overnight

Reconnect syringe and line OR line and butterfly

IF...
- Any of the above and you are not confident the carer can manage till daylight AND/OR
- Nursing visit is unavailable

NURSE TO VISIT

MEDICAL REVIEW/HOSPITAL
## Appendix 1 – Sample form – Client Summary Palliative Care

<table>
<thead>
<tr>
<th>Patient name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home address</td>
<td>Gender</td>
</tr>
<tr>
<td>Phone – home</td>
<td>Phone – mobile</td>
</tr>
<tr>
<td>Patient living alone</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GP name and phone</th>
<th>Available – home visits □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contactable by phone after-hours □ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main carer</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (if different to patient address)</td>
<td>Phone</td>
</tr>
<tr>
<td>Admission to service date</td>
<td>Reason for admission</td>
</tr>
<tr>
<td>Main diagnosis</td>
<td>Medical history</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client alerts</th>
<th>Cautions / allergies / risk management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase of illness</td>
<td>Karnofsky scale</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current treatments:</th>
<th>chemotherapy, radiotherapy, other, Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current symptoms:</td>
<td>Physical, Psychosocial and Other</td>
</tr>
<tr>
<td>Current Medication:</td>
<td>Doses</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>
Phase Definitions

The Palliative care phase is the stage of the patient’s illness. Palliative care phases are not sequential and a patient may move back and forth between phases. Palliative care phases provide a clinical indication of the level of care required and have shown to correlate strongly with survival within longitudinal prospective studies.

PALLIATIVE CARE PHASE OF ILLNESS

Clinician rated

1. **STABLE** Symptoms are adequately controlled by established management

2. **UNSTABLE** Development of a new problem or a rapid increase in the severity of existing problems

3. **DETERIORATING** Gradual worsening of existing symptoms or the development of new but expected problems

4. **TERMINAL** Death likely in a matter of days

5. **BEREAVED** Death of a patient has occurred and the carers are grieving

Refer to complete Phase Definitions

KARNOFFSKY SCALE

AKPS (Australian modified Karnofsky Performance Scale)

Clinician rated

100 Normal, no complaints or evidence of disease

90 Able to carry on normal activity, minor signs or activity

80 Normal activity with effort, some signs or symptoms of disease

70 Care for self, unable to carry on normal activity or to do active work

60 Occasional assistance but is able to care for most needs

50 Requires considerable assistance and frequent medical care

40 In bed more than 50% of the time

30 Almost completely bedfast

20 Totally bedfast & requiring nursing care by professionals and/or family

10 Comatose, barely rousable

PROBLEM SEVERITY SCORE

Clinician rated

0 = Absent

1 = Mild

2 = Moderate

3 = Severe
Appendix 1 – Sample form – Client Summary Palliative Care

<table>
<thead>
<tr>
<th>Current signed anticipatory medication and syringe driver orders</th>
<th>Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are anticipatory medication and syringe driver orders available in the home? □ Yes □ No

Is injectable medication available in the home? □ Yes □ No

Are syringes/needles available in the home? □ Yes □ No

Is there a sharp container in the home? □ Yes □ No

### Planning

<table>
<thead>
<tr>
<th>Does the client want to be cared for at home?</th>
<th>□ Yes □ No</th>
<th>Is the caregiver managing care at home?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the client want to die at home?</td>
<td>□ Yes □ No</td>
<td>Does the caregiver want the client to die at home?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

GRPCC Carer’s Symptom Management Sheets provided? List symptoms for which provided

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GRPCC Carer’s Kit provided

<table>
<thead>
<tr>
<th></th>
<th>Date commenced</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning (ACP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life Care (EOLC) Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Enduring Power of Attorney (MEPOA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funeral arrangements made</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Date: Name of Nurse completing summary: Position and department:
### Appendix 2 – Sample form – After-Hours Call Summary

<table>
<thead>
<tr>
<th>Date of call:</th>
<th>Name of Triage Nurse:</th>
<th>Position and department:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person making after-hours phone call:</th>
<th>Client</th>
<th>Caregiver</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason(s) for call**

<table>
<thead>
<tr>
<th>Symptom related</th>
<th>New</th>
<th>Exacerbation</th>
<th>Problem severity score 0-3</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety – client / caregiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea and/or vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathlessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terminal restlessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other symptom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other reason(s)**

<table>
<thead>
<tr>
<th>Response to call</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue resolved through phone call only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home visit after-hours required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit recommended following day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacted palliative care nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance called</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission to hospital</td>
<td></td>
<td></td>
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**Other response**

<p>| | | | |</p>
<table>
<thead>
<tr>
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**Appendix 2 – Sample form – After-Hours Call Summary**

<table>
<thead>
<tr>
<th>Reason(s) for call</th>
<th>Yes</th>
<th>No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom related</td>
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**Other response**
References

1. Palliative Care Expert Group 2010, Version 3, Therapeutic Guidelines: Palliative Care, Therapeutic Guidelines Limited, Victoria Australia


3. Department of Health 2012, After-hours palliative care framework, State Government of Victoria, Melbourne

4. Gippsland Region Palliative Care Consortium 2015, Tools to Assist After-Hours Telephone Triage of Community Palliative Care Clients

5. Wimmera Healthcare Group 2011, Palliative Care Telephone Triage Protocols For Registered Nurses


7. University of Wollongong, The Palliative Care Phase,

8. Brisbane South Palliative Care Collaborative, Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents,


12. University of Wollongong, Palliative Care Outcomes Collaboration
Resources

Gippsland Region Palliative Care Consortium (GRPCC)

CareSearch Palliative Care Knowledge Network

Residential Aged Care Palliative Approach Tool Kit

The Palliative Care Outcomes Collaboration (PCOC)

Therapeutic guidelines: palliative care
http://www.tg.org.au/?sectionid=47
electronic access may be available to you via eTG complete or miniTG

WA Cancer and Palliative Care Network, Evidence based clinical guidelines for adults in the terminal phase

MacLeod R, Vella-Brincat J, MacLeod S 2014, The Palliative Care Handbook, HammondPress, Australia