

Community Palliative Care Nurse Practitioner

Health Management Protocol

for the

Management of Palliative Care Patients in the adult population

Northside Primary and Community Health Service Community Palliative Care Consultancy Service

Description of Health Service ^[2]:

The Palliative Care Consultancy Service supports the care of patients/clients and their families in the end-of-life phase of their illness by providing a consultancy service to their primary care providers.

This support includes advising the client's treating GP, Specialists and domiciliary or residential nursing service on their palliative care needs. This support is provided within inpatient, outpatient, residential aged care facilities and home care settings.

Disclaimer

This document has been established to provide a framework for the clinical practice of the community palliative care nurse practitioner.

This document should not be considered exhaustive or be used in exclusion of other relevant reference, policies and clinical guidelines. It does not replace the need for professional and clinical judgement according to specific clinical requirements that may or may not be included in this document.

Plan for Dissemination, Implementation, Review and Evaluation

- The approved community palliative care nurse practitioner health management protocol will be held in a repository by the Office of the Chief Nursing Officer
- A copy of the approved health management protocol is to be held by the pharmacy for identification/signatory purposes
- Staff directly related to the practice of the nurse practitioner will be informed of the health management protocol
- This health management protocol will be reviewed and evaluated on a regular basis through a local multidisciplinary team to ensure that it meets the needs of the patients and the appointed nurse practitioner/s
- Formal review and evaluation of the health management protocol is required every two years. Interim updates to the office of the Chief Nursing Officer (OCNO) are required annually (or earlier if there is a population change or change in practice) to ensure that they remain current with best practice.

Scope of Practice Statement:

The nurse practitioner is responsible and accountable for making professional judgements about when the patient's condition is beyond their scope of practice and for initiating consultation with a medical officer or other member of the health care team.

All managements initiated under this HMP will be in accord with the recommendations published in: Primary Clinical Care Manual (PCCM)^[3] and Therapeutic Clinical Guidelines – Palliative Care^[4] and Australian Medicines Handbook (AMH)^[1] - except where specified in other referenced sources and will be adapted to be in line with local practices and conditions.

Patients of the Palliative Care Service may present with:

Pain, Dyspnoea, Cough, Nausea/vomiting, Dysphagia, Constipation, Confusion/delirium, Anorexia, Fever, Weakness/lethargy/fatigue, Anaemia, Panic/anxiety, Depression, Hiccups, Sleep disturbances, Seizures, Sensory disturbances, Skin breaks, Sweats/rigors, Sore mouth, Limb/body oedema or Carer Strain.

The Role of the NP in Palliative Care includes:

1. Clinical assessment. The above symptoms occur commonly, either singly or in any combination, and may require investigation and/or treatment
2. Developing a current treatment plan (pharmacological & non-pharmacological) which may require titration/adjustment/monitoring based on results of clinical assessment performed by NP with subsequent review by the treating Specialist.
3. Management of End-Of-Life Care
4. Monitoring and review of additional prescribed therapies initiated by another provider, which require monitoring for efficacy, adverse effects and/or drug interactions.
5. Referrals
6. Expected Health Outcomes

1. CLINICAL ASSESSMENT [See Appendix 1]

1.1 Subjective

- Presenting Symptom
- Systems Review
- Full medical history
- Previous treatment for current/main diagnosis
- Medications including recently ceased
- Drug history/allergy history/alcohol and tobacco & other drugs (ATOD)
- Complementary and alternative medication usage
- Family history /Genogram
- Carer Strain

1.2 Objective

- Cardiac examination (include pulse and BP)
- Respiratory assessment
- Musculoskeletal assessment
- GIT examination
- Neurological examination (include pupils)
- Genitourinary (if indicated)
- Nutritional status/weight
- Activities of Daily Living/Functional History
- Mental State assessment including Mini Mental State Examination (MMSE)

1.3 Assessment

Summary of findings will be used to guide NP investigations and care planning.

2. PLAN:

2.1 Investigations (may be initiated by NP within scope of practice or referred to treating Medical Officer/General Practitioner (GP) :

- Pathology – FBC;UEC;LFT; Corrected Calcium; Blood Glucose
- Microbiology – culture and sensitivity of urine, sputum, wound swabs, stool
- Medical imaging (plain radiology for eg. Chest /abdomen /limbs /spine)
- Bladder Scan
- Oxygen Saturation

2.2 Non-pharmacological Management (initiated and implemented by NP):

- Counselling, psychosocial and family support
- Education and support of primary carers
- Symptom management strategies (eg pain, dyspnoea)
- Nutrition
- Co-ordination of Allied Health interventions– physiotherapist, dietician, occupational therapist, pharmacist, social worker and volunteers
- End-of-Life care planning including advanced health directives
- Co-ordination and provision of carer support
- Referral to community agencies such as Non-Government Organisations (NGO's)
- Medication Review (in consultation where possible/practical with pharmacist)
- Initiating Palliative Care Program (PCP) funding for support of care needs as per guidelines

2.3 Pharmacological Management ^[1,4] (may be initiated by NP within scope of practice or referred to treating medical officer/General Practitioner (GP) :

- 2.1 Pain management: Information relating to equianalgesic opioid doses^[See Appendix 2]
- 2.2 Bowel Management
- 2.3 Nausea and vomiting
- 2.4 Dyspnoea
- 2.5 Delirium
- 2.6 Fungal Infections
- 2.7 End-of-Life Care Plan
- 2.8 Panic/Anxiety
- 2.9 Seizures
- 2.10 Sleep Disturbance
- 2.11 Provision of Consumer Medicine Information in line with Quality Use of Medicines (QUM)

MANAGEMENT OF END-OF-LIFE CARE

- Goals of care re-evaluated in consultation with patient and/or family including site of care.
- Management of medications - appropriate delivery/dose e.g. Syringe Driver, intermittently via subcutaneous infusion.
- A holistic approach with proactive planning addressing symptom control management, comfort measures, appropriate interventions and psychosocial/patient and family support.

FOLLOW-UP, MONITORING AND EVALUATION:

- The evaluation of therapeutic response and monitoring of test results will be in accordance with the individual treatment plan
- Phone Call as indicated to GP, and involved Community Agency within 24 hours of consultation
- Written letter with recommendations to GP/Specialist/Agencies within 24 hours of consultation
- Evaluate therapeutic response
- Monitor Test results
- Management of abnormal results within scope of practice
- Monitor progress – in particular medication therapy
- Referral for treatment that is outside scope of practice

REFERRAL:

The nurse practitioner role includes assessment and management of clients using nursing/midwifery knowledge and skills and may include but is not limited to:

- the direct referral of clients to other health care professionals
- prescribing medications
- requesting diagnostic investigations.

The NP&CHS CPCCS NP is able to refer patients to:

General Practitioner:

- Exacerbation of chronic disease (e.g. urinary tract infections, chest infection) or drug related adverse events that require ongoing follow-up and investigation

Other Referrals

- Pharmacist – Hospital or Community
- Occupational Therapist – home aids/environment assessment
- Dietician
- Physiotherapist – mobility assessment/aids
- Speech Pathologist – swallow assessment
- Social Worker
- Community Agencies – Nursing, Personal Care
- Volunteers

Currently in Australia nurse practitioners do not have access to a medicare provider number. Consequently, until this changes, a referral from a nurse practitioner may cause financial disadvantage for the patient. To ensure that patients are not financially disadvantaged all private referrals from the palliative care nurse practitioner will be completed in collaboration with the patients GP or senior medical officer with a provider number.

The nurse practitioner should consider referral to a medical officer in the following situations ^[4, p.157-62]

- NP assessment indicates rapidly escalating increase in severity of symptoms OR gradual worsening of existing symptoms or development of new but expected symptoms
- Potential Referral to Acute Services considering appropriateness of further investigation/treatment, in light of clinical context and patient and family wishes.
 - Suspicion of Spinal Cord Compression
 - Severe agitated delirium
 - Seizures
 - Unexplained or uncontrolled pain
 - Acute deterioration in respiratory status
 - Uncontrolled Nausea and Vomiting
 - Cardiac Failure
 - Urinary Retention
 - Abdominal Distension requiring assessment
 - Fracture
 - Hypercalcaemia
 - Chronic Obstructive Pulmonary Disease – infective exacerbation
 - Adverse Drug Reactions
 - New issues requiring timely investigation

DRUG THERAPY PROTOCOL

- Choice of pharmacological therapy must be guided by the Therapeutic Guidelines^[4] and the Australian Medicines Handbook^[1], within the parameters of the Standard Drug List for Queensland Hospitals.
- The Consultant/General Practitioner is the lead clinician for the co-ordination of the patients care and thus any new medications, titration of medications and recommended discontinuation of medications must be communicated to them.
- The nurse practitioner must verify that the choice of drug is suitable for the patient after carefully considering the following individualised patient information, such as:
 - Age
 - Previous allergies,
 - Adverse drug reactions,
 - Co-morbidities such as renal and hepatic dysfunction
 - Concomitant medications for potential drug interactions
 - Pregnant and or lactating women

The Queensland Health Safe Medication Practice Unit has identified specific medications and patient groups where extra precautions are necessary. These groups are listed below and must be considered carefully when selecting drug treatment to avoid adverse medication events.

High Risk Medications

- Drugs with a narrow therapeutic range i.e. digoxin, lithium
- Drugs requiring specialised monitoring or interpretation i.e. therapeutic dose monitoring
- Anticoagulants
- Cytotoxics
- NSAIDS or COX-2 Inhibitors
- Opiate analgesics
- Aminoglycosides

- Anti-epileptics
- Insulin
- IV Electrolyte supplementation
- Weekly dosing regimens i.e. methotrexate

High Risk Patient Groups

- Renally impaired
 - Cardiac disease
 - Liver disease
 - Transplantation
 - Mental Health problems
 - Cancer
 - Paediatrics
 - Elderly
 - Pregnant and Breastfeeding
-
- Currently in Australia nurse practitioners do not have access to the pharmaceutical benefits scheme. Consequently, until this changes, prescriptions from a nurse practitioner may cause financial disadvantage for the patient. To ensure that patients are not financially disadvantaged arrangements for dispensing of the nurse practitioner prescription are as follows:
 - Patients will be requested to present their prescription at the Prince Charles Hospital Pharmacy. If the patient is unable to do this they will be given a script written by a medical officer with a prescriber number to ensure they are not financially disadvantaged.
 - A copy of the approved HMP/DTP must be available in the pharmacy for identification and signatory purposes.

DRUG THERAPY PROTOCOL

- 1. Pain management**
 - a. Analgesics
 - b. Opioid analgesics
 - c. NSAIDS
 - d. Corticosteroids
- 2. Bowel Management**
 - a. Laxatives
- 3. Nausea and vomiting**
 - a. Antiemetics
 - b. Dopamine antagonists (antiemetic)
- 4. Dyspnoea**
 - a. Opioid
 - b. Benzodiazepines
- 5. Delirium**
 - a. Antipsychotics
- 6. Fungal Infections**
 - a. Other antifungals
- 7. End-of-Life Care Plan**
 - a. Other antiepileptics
 - b. Opioids
 - c. Antipsychotics
 - d. Other drugs for nausea & vomiting
 - e. Benzodiazepines
- 8. Panic/Anxiety**
 - a. Benzodiazepines
- 9. Seizures**
 - a. Benzodiazepines in epilepsy
- 10. Sleep Disturbance**
 - a. Benzodiazepines

PHARMACOLOGICAL

Generic Name	Form	Strength Route Recommended Dosage	Duration of Script
1. PAIN MANAGEMENT			
Paracetamol 500mg 120mg/5ml, 240mg/5ml 500mg	Tablet Suspension* *(Caution – various strengths also available) Suppository	AMH 3.1 (Non-Opioid Analgesics) ^[1, p.42-45]	1 month
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS			
Ibuprofen 200mg,400mg 100mg/5ml 5%	Tablet Suspension Gel	AMH 15.1.1 (NSAIDS) ^[1, p.597-602]	1 month Local Pharmacy
Diclofenac 25mg, 50mg 50mg, 100mg 1%	Tablet Suppository Gel (Voltaren®)	AMH 15.1.1 (NSAIDS) ^[1, p.597-602]	1 month Local Pharmacy
Dexamethasone 0.5mg, 4mg 4mg/ml	Tablet Ampoule	AMH 14.5.2 (Corticosteroids) ^[1, p.580-584]	1 month

Generic Name	Form	Strength Route Recommended Dosage	Duration of Script
OPIOIDS – Short Acting			
***Opioid naïve – dose titration dependent on total daily requirement			
Morphine HCL 2mg/ml, 5mg/ml, 10mg/ml Morphine sulphate 10mg, 20mg Morphine Sulphate 5mg/ml, 10mg/ml, 15mg/ml,30mg/ml Morphine tartrate 120mg/1.5ml, 400mg/5ml	Liquid Tablet (Sevredol®) Ampoules Ampoules	AMH 3.2 (Opioid analgesics) ^[1, p.45-58] ***OPIOID NAÏVE 0.5mg-1.5mg 2-4hrly as required	2 weeks 2 weeks
Oxycodone 5mg 5mg,10mg, 20mg 5mg/5ml 30mg	Tablet (Endone®) Capsule (Oxynorm®) Liquid Suppository (Proladone®)	AMH 3.2 (Opioid analgesics) ^[1, p.45-58] ***OPIOID NAÏVE 2.5-5mg 4-6hourly as required.	2 weeks
Hydromorphone 2mg, 4mg, 8mg 1mg/ml 2mg/ml, 10mg/ml, 50mg/5ml, 500mg/50ml	Tablets Liquid Ampoules	AMH 3.2 (Opioid analgesics) ^[1, p.45-58] In consultation with medical officer	

Generic Name	Form	Strength Route Recommended Dosage	Duration of Script
Fentanyl 50mcg/ml 100mcg/2ml	Ampoules	AMH 3.2 (<u>Opioid analgesics</u>) ^[1, p.45-58] In consultation with medical officer	
OPIOIDS – Long Acting			
Oxycodone 5mg,10mg,20mg, 40mg,80mg	Tablets (Oxycontin CR®)	AMH 3.2 (<u>Opioid analgesics</u>) ^[1, p.45-58] Titration according to total daily requirement	2 weeks
Morphine sulphate 5mg, 10mg, 15mg, 30mg, 60mg, 100mg, 200mg 10mg,20mg, 50mg, 100mg 20mg,30mg,60mg, 100mg,200mg	Tablets (MS Contin CR®) Capsules (Kapanol SR®) Sachet (MS Contin CR®)	AMH 3.2 (<u>Opioid analgesics</u>) ^[1, p.45-58] Titration of doses according to total daily requirement	2 weeks
Fentanyl 12mcg/hr 25mcg/hr 50mcg/hr 75mcg/hr 100mcg/hr	Transdermal Patch (Durogesic®)	AMH 3.2 (<u>Opioid analgesics</u>) ^[1, p.45-58] In consultation with medical officer	
Methadone 10mg 25mg/5ml 10mg/ml	Tablets Liquid Ampoules	AMH 3.2 (<u>Opioid analgesics</u>) ^[1, p.45-58] In consultation with medical officer – Refer to opioid equianalgesic guide ^[Appendix 2] .	

Generic Name	Form	Strength Route Recommended Dosage	Duration of Script
Buprenorphine 5mcg/hr, 10mcg/hr 20mcg/hr	Transdermal Patch (Norspan®)	AMH 3.2 (<u>Opioid analgesics</u>) ^[1, p.45-58] In consultation with medical officer.	
2. BOWEL MANAGEMENT			
Docusate with senna 50mg/8mg	Tablet (Coloxyl with senna®, Soflax®)	AMH 12.4.1/12.4.2 (Laxatives) ^[1, p.476-480]	1 month
Macrogol	Sachet (Movicol®)	AMH 12.4.3 (Laxatives) ^[1, p.480-482]	1 month
3. NAUSEA & VOMITING			
Metoclopramide 10mg 10mg/2ml	Tablet Ampoule	AMH 12.3/12.3.1 (Antiemetics/Dopamine antagonists) ^[1,p.468-471]	1 month
Haloperidol 0.5mg, 1.5mg, 5mg 5mg/ml	Tablet Ampoule	AMH 12.3.1 (Antiemetics/Dopamine antagonists) ^[1,p.468-471] 0.5-1.5mg (max 3mg/day)	1 month
4. DYSPNOEA			
Morphine Sulphate 10mg,20mg 2mg/ml, 5mg/ml 10mg/ml 5mg/ml, 10mg/ml 15mg/ml,30mg/ml	Tablets (Sevredol®) Liquid (Ordine®) Ampoule	AMH 3.2 (Opioid analgesics) ^[1, p.45-58] ***OPIOID NAÏVE 1mg-5mg PO ***OPIOID NAÏVE 0.5-2.5mg SC 2hrly PRN	2 weeks
Oxygen		Nasal prongs 2L/min	
Lorazepam		AMH 18.4.1 (Benzodiazepines) ^[1, p.739-742]	2 weeks

Generic Name	Form	Strength Route Recommended Dosage	Duration of Script
1mg	Tablets	½-1 tab SL (max 3mg/day)	
5. DELIRIUM			
Haloperidol 0.5mg, 1.5mg, 5mg	Tablet	AMH 18.2 (Antipsychotics) ^[1, p.725-729,732] 0.5-2.5mg PO 6/24 PRN (max dose 8mg/day)	1 month
5mg/ml	Ampoule	0.5-2.5mg Subcutaneous PRN (max dose 8mg/day)	
6. FUNGAL INFECTIONS			
Nystatin 100 000U/ml	Drops (Nilstat®)	AMH 5.2.2 (Other Antifungals) ^[1, p. 162,166] Oral 1ml QID or 1 drop hourly	2 weeks
7. END-OF-LIFE MEDICATIONS			
Midazolam 5mg/ml 15mg/3ml	Ampoule	AMH 16.1.2 (Benzodiazepines) ^[1, p.739-742] 2.5mg Q2hrly PRN to max 10mg/24hours	2 weeks
Morphine 10mg/ml 15mg/ml 30mg/ml	Ampoule	<u>AMH 3.2 (Opioids)</u> ^[1, p.45-58] <u>***OPIOID NAÏVE</u> 0.5-2.5mg subcutaneous Q2hrly PRN	2 weeks
Haloperidol 5mg/ml	Ampoules	AMH 18.2 (Antipsychotics) ^[1, p.732-733] 0.5-3mg over 24 hours	2 weeks
Hyoscine hydrobromide 400mcg/ml	Ampoules	AMH 12.3.5 (Other drugs for nausea & vomiting) ^[1, p.476] 400mcg Q2-4hrly to max 1200mcg over 24hours	2 weeks
Clonazepam 1mg/ml 2.5mg/ml	Ampoules Drops	AMH 16.1.2 (Benzodiazepines) ^[1, p.629-630] 0.5mg-1mg nocte + 0.5mg prn to max 3mg over 24hours 0.5mg(0.2ml) – 1mg(0.4ml) nocte plus 0.5mg(0.2ml) PRN to	2 weeks

Generic Name	Form	Strength Route Recommended Dosage	Duration of Script
	(Rivotril®)	max 3mg over 24 hours	
8. PANIC/ANXIETY			
Lorazepam 1mg	Tablet (Ativan®)	AMH 18.4.1 (Benzodiazepines) ^[1, p.739,740,742] Sublingual ½-1 tablet PRN up to max 3mg in 24hr	2 weeks
9. SEIZURES			
Midazolam 5mg/ml	Ampoule	AMH 16.1.2 (Benzodiazepines in epilepsy) ^[1, p.629-631] Subcutaneous 2.5-5mg subcutaneous prn for seizures	2 weeks
Clonazepam 1mg/ml 2.5mg/ml	Ampoule Drops (Rivotril®)	AMH 16.1.2 (Benzodiazepines in epilepsy) ^[1, p.629-631] Subcutaneous Sublingual 0.5-1mg prn to max 3mg in 24hrs 0.5mg(0.2ml) – 1.0mg(0.4ml) to max 3mg in 24 hours	2 weeks
10. SLEEP DISTURBANCE			
Temazepam 10mg	Tablet	AMH 18.4.1 (Benzodiazepines) ^[1, p.743]	2 weeks

APPENDICIES:

Appendix 1: Patient Assessment tool FRC313 09/06

Appendix 2: Opioid Equianalgesic dose guide

REFERENCES:

1. Australian Medicines Handbook. (2009). Australian Medicines Handbook Pty. Ltd. Adelaide, South Australia:
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4. Therapeutic Clinical Guidelines. Palliative Care. Version 2, 2005. Available: <http://etg.hcn.net.au/>

OTHER RESOURCES:

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- Clinicians Knowledge Network (CKN). Available: <https://sp.cknservices.dotsec.com/ckn/>
- Guidelines for palliative approach in aged care. (May 2006). The National Palliative Care Program. Available: www.health.gov.au/palliativecare
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- *Palliative Care Australia Standards*. Available: <http://www.palliativecare.org.au/Default.aspx?tabid=1221>

HMP/DTP Developed by:

Name	Signature	Date

Endorsed by
DDON/Chair, District Nurse Practitioner Steering Committee

Signature: Date: / /

Endorsed by:
District Manager

Signature: Date: / /

FINAL APPROVAL
CHAIR, Queensland Nurse Practitioner Advisory Committee

Signature: Date: / /

Effective Date:	
Review Date:	
Reviewing Position:	