Interface of renal supportive care, geriatrics & community palliative care – a case study

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Outline

- Brief overview of the role of Renal Supportive Care Service at St George Hospital
- Case presentation from a renal perspective
- Presentation of case study from other specialty services perspectives (Geriatric Flying Squad & Community Palliative Care Service)
- Discussion and question time to explore the collaboration of care during this case study

PATIENT-CENTERED CARE

Renal Supportive Care Service - St George

- Role of service
  - **Symptom management for patients with End-stage Kidney Disease** (ESKD)
    - In- patient and out-patient settings
    - Home visits to those unable to access service (Home and Residential Aged Care Facilities)
  - **End of life care**
    - Consultative service in the in-patient and out-patient settings
    - Point of referral to other services
  - **Advance care planning**
    - Involvement in discussions / family meetings
    - Facilitating Adult Palliative Care Plans with the NSW Ambulance Service
    - Uploading of ACP documentation to electronic medical records (eMR)
    - Crisis planning

Introduction to Mr G.S.

- 80 year old male (in 2015)
- Greek ethnic background (spoke limited English)
- Lived alone
- Divorced – Ex-wife who was still supportive
- Supportive son and daughter-in-law
- Very active – walking many km's / day
- ***Very independent personality***

Medical History of Mr G.S

- Chronic Kidney Disease – due to presumed diabetic nephropathy and hypertension
- Type 2 Diabetes Mellitus
- Hypertension
- Type 2 Respiratory failure / COPD / Obstructive Sleep Apnoea
- Gastric angio-ectasis (capillary type vascular malformation)
- Prostatic enlargement
- Gout
- Dyslipidaemia
- MGUS (monoclonal gammopathy of unknown significance)

Renal Story of GS - 2015….

- Introduced to the Renal supportive Care Service as an in-patient

- First seen in Pre-dialysis clinic August 2015
  - eGFR 14
  - Late for the appointment (he had gone to Pre-admissions Clinic)
  - No family present
  - Interpreter had to leave
- Admitted to STG hospital 3 days later with SOB & anaemia
  - L) pleural effusion/ Influenza A / LLL pneumonia / Pulmonary oedema
  - More issues than just the end-stage kidney disease

Renal story of GS – 2015…

- Aug 2015: SOB, Anaemia
- Sept 2015: L) pleural effusion, LLL pneumonia, Influenza A, APO
- Oct 2015: exacerbation of gout, new diagnosis: gastric antral vascular ectasia
- Dec 2015: eGFR 13

Renal story of GS – 2016

- Jan 2016: ↓ Hb from gastric bleed
- Feb 2016 – Fall, SOB, Febrile eGFR 14
- April 2016 – diagnosed with paraprotein (MGUS), declined a haematology review
- There was ongoing discussions regarding appropriate treatment pathways for Mr GS in the clinic setting & during many of his admissions
- Mr GS was ‘undecided’ about his decision to do dialysis or not

Renal Story of GS 2016…

- Pt seen in renal clinic with interpreter in April 2016, letter documents:
- ".. A bit of a challenge to manage.."
- Initial plans to create a fistula – ***patient cancelled this***
- Patient felt well, so 'very ambivalent' about choosing a treatment pathway
- "If the time comes and I need it, I will do it"
- The admissions to hospital continued…

Renal Story of GS - 2016…

- August 2016 – Indicated he would like to pursue a non-dialysis pathway eGFR 10
- Sept 2016: HT, SOB, Permanent Pacemaker for bradycardia, ***AKI requiring dialysis via a vascath***
- Nov 2016: SOB, dizzy, Given PD education (but deemed unsuitable) and had a ***creation of Atrio-Venous Fistula*** eGFR 9
- Never formally attended pre-dialysis education

Renal Story of GS - 2017…

- March 2017 : fistuloplasty + stent of AVF
- Due to the continually changing pathway (Dialysis v's Non-Dialysis) a decision was made to hold a Family Meeting
- Aim to determine future health care goals

Family meeting…

Family meeting arranged, APRIL 2017: eGFR 11

- Attended by: Nephrologist, Renal Supportive Care CNC, Social Worker, Mr GS, his son & an interpreter
- Advance Care Planning was attended with a formal decision:

'Not For Dialysis'

'Not for ventilation / inotropes /CPR'

- Documentation of this placed onto electronic Medical Records eMR for future admissions
- Ambulance care plan discussed and given to patient & son to consider, however never completed

Renal Story of GS - 2017…

- June 2017: SOB, chest pain, hypoxic 80% SaO2 / R) pleural effusion / home 0^2 eGFR 9
- Aug - Sept 2017: SOB / APO / chronic back pain / functional decline / uraemic pruritus – admitted to RACF for a trial of respite care eGFR 8
- ***Pt resistant to placement & experienced a significant struggle settling into the RACF***
- Oct 2017: Admitted post fall from RACF, due to hypoglycaemia – discharged back to RACF with a palliative approach letter & EOL meds – last admission to the acute care setting eGFR 6

Palliative Approach Letter

Copy faxed to GP: Yes / No

Regarding: Date:

Dear Nursing Staff,

The above patient is returning to your facility today. As you can see from the attached discharge summary, the plan is for a palliative approach with no further active treatment.

The St George Renal Supportive Care Team has been involved during this admission, but at time of discharge the patient had no complex symptoms requiring specialist Palliative Care.

As a result I have not made a referral at present to the Calvary Community Palliative Care Team (CPCT).

We have advised the treating team to include PRN medications for potential symptoms as the patient deteriorates. If the patient's symptoms escalate please call the patient's GP. The GP can liaise directly with the Renal Supportive Care CNC or Calvary CPCT for advice if this patient's symptoms are of concern. If the GP is unable to be contacted, please phone Renal Supportive Care or Calvary for advice, mentioning this letter:

- Week days 0800 to 1630 hours phone the renal supportive care CNC (see contact details below) or alternatively phone 95533444 and ask for the Coordinator of CPCT.
- After hours/Weekends phone Calvary 95533111 and ask for the after-hours Nurse Unit Manager.

Regards,

Renal Supportive Care CNC
St George Hospital
Ph: 91131111 ask for pager 764 or 1164

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Deterioration to anticipated end-of-life

- October 2017: Pt restless and agitated, ?hallucinating, myoclonic jerks
- Referred by RSC to Community Palliative Care Team (CPCT) for complex symptom burden and to provide support to RACF staff to manage EoL
- 17th November 2017: Geriatric Flying Squad called in to review patient due to increased agitation and disruptive verbalizing that was distressing other residents and their families
- Collaborative care from the three teams from there on……


A team is
many hands & one mind.

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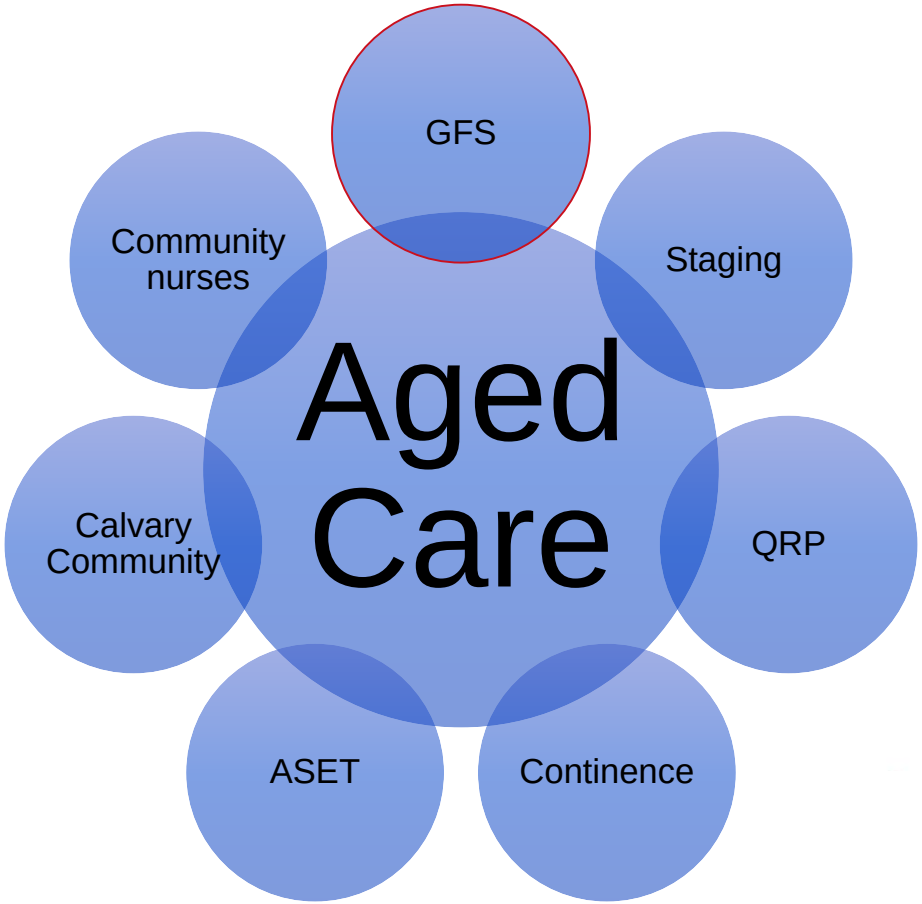
GFS SGH

Renal supportive care symposium
July 2018

GFS (2012 – current)

- Rapid response outreach service for 35 RACF's (~3000 residents) in St George area
- Service grown to now comprise of 7 team members
- Provide specialist geriatric assessment in real time:
  - Rapid review
  - Acute deterioration
  - Hospital transfer being considered

SGH Aged Care Services



GFS service – scope of practice

- Delirium
- Infection management
- End of life care
- Advanced Care Planning
- Post discharge follow up
- Facilitate hospital admission if required
- Liaison service
  - Continence
  - Nutritional support
  - CPCT
  - Renal Supportive Care
  - Surgical specialties

Case Mr GS

- 82M in RACF
- Nov 2017 referred to GFS NP for concerns of increasing agitation, vocally disruptive behaviour
- Past history
  - End stage renal failure – conservative pathway
  - Type 2 Diabetes Mellitus
  - Chronic Obstructive Airway Disease
  - Ischaemic Heart Disease
- Advanced care plan – palliative approach

Mr GS

- Medications
  - Frusemide 500mg PO tds
  - Sodibic mouthwash
  - Hydromorphone 0.25mg SC QID
  - Clonazepam 0.25mg nocte SC/liquid drops
  - Pantoprazole 40mg mane
  - Evening primrose 1 tab bd
  - Coloxyl and senna 2 tab bd
  - Gabapentin 100mg second daily
  - Seretide 250/25mg inh bd
  - Tiotropium 18mcg inh daily
  - Salbutamol 5mg neb tds
  - Linagliptin 5mg mane
  - Aqua spray QID
- Nil known allergies

Mr GS

- RSC RN reviewed day prior
- Minor medication recommended but not charted (GP unable to visit)
- GS complaining of generalised pain and dysuria
- Sitting on bed SBP 160 HR 60 Temp 36.7 O2 ??
- Anxious ++ dyspnoeic ++ RR 40
- Speaking constantly, grunting
- Confused answering questions but not always related to questions
- Generalised abdominal discomfort

Mr GS

- Bilateral crepitations to chest midzones
- Very distended and firm abdomen, reduced BS
- Minimal pedal oedema
- Urine bottle by bed (150ml clear urine)
- UA – positive for blood, protein, glucose and leucocytes

- Impression
  - Delirium secondary to likely UTI
  - Keflex
  - Aperients
  - Increased clonazepam 0.75mg nocte
  - Added regular paracetamol

Mr GS

- Phone call follow up (18-19 Nov)
- Ongoing agitation, sleeping only 2 hours
- Phone advice for PRN haloperidol
- Responded to haloperidol
- 20 Nov GFS NP review
  - Not responding to PRN medication
  - Responded to massage, company
  - Kept pulling out subcut needle
  - Hydromorphone changed to oral
- Still dyspnoeic
- Calling for staff to shave his hair
- Bowels opened day prior

Mr GS

- Issues
  - Poor pain control
  - Ongoing agitation with poor response to meds
  - PRN confusing staff, unclear order to give for which symptoms
- Plan
  - Simplify regime – hydromorphone 0.5mg o QID + PRN (1st line)
  - Lorazepam 1mg o tds PRN (2nd line)
  - Haloperidol 0.5mg QID PRN (3rd line)

Mr GS

- GFS linked in with RSC + CPCT
- CPCT reviewed
- “Fed up” “just wants to die”
- Felt family left him in RACF
- Son and daughter visit regularly
- Eating and drinking well

Mr GS

- Geriatrician/NP review + RSC
- Dyspnoeic, agitated, shoulder pain +
- Crepitations left base
- Issues:
  - Complex symptom management
  - Robust and not terminal
  - Vocally disruptive behaviour (formal complaints from residents)
  - Pre-morbid personality/cultural/situational
- Ceased lorazepam and increased clonazepam to 0.5mg/1mg
- Increased hydromorphone to 0.5mg q4hrly
- Added midazolam 2.5-5mg q4hrly PRN
- Discussed with CPCT registrar

Mr GS

- Discussed with CPCT registrar
- Updated son and GP
- CPCT Registrar reviewed next day
- Not terminal
- Complained of pain (felt agitation due to pain)
- Anxiety and fear of dying
- Advised hydromorphone to subcut
- Stop haloperidol
- Continue clonazepam
- Consider levomepromazine

Calvary

Hospitality
Healing
Stewardship
Respect

Calvary Kogarah Palliative Care Service in Residential Aged Care

Articulation with SGH Renal Supportive Care

Specialist clinicians involved

- Palliative care CMO with consultant support
- Palliative care community CNS2
- Palliative care RACF social worker

Weaving in and out of outreach care teams into RACF

- First reviewed in RACF end of October 2017 by CPCT CNS2- small dose of Benzodiazepam for nocte agitation

- Further reviews by medical and nursing team with GFS interaction regarding ongoing management of agitation including titration and rotation of medications, both oral and subcutaneous through until the end of December 2017

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Priorities

- Pain a significant cause of agitation
- Anxiety a significant cause of agitation
- Symptoms need to be managed in challenging setting
- Symptoms need to be managed in a timely way to avoid presentations to acute care if possible
- Staff need support in managing the patient
- Family need support in navigating transition of parent into RAC

Main focus

With support of Calvary Medical director to

- establish sufficient capacity within RACF to manage GS
- Provide a holistic approach to this person beyond pharmaceutical management of agitation
- Optimise palliative care approach with use of MDT
- Avoid admission to specialist palliative care unit if at all possible and if safe for resident

Psychosocial support for CPCT social worker

- Possibility of going to local cafe and to visit family home
- Review of diet to accommodate more Greek foods- using home cooked meals as part of this strategy
- Support with financial complications
- Possible relocation of GS to another RACF closer to family
- Comprehensive instruction to the RAC staff so competent delivery of medication regimen could be expected, including symptom assessment/indication for medications

Facilitators and barriers to delivering complex palliative care in RACF setting

Barriers

- Skill of staff delivering the care
- Lack of RNs delivering care over 24hrs
- Limited continuity of nursing staff care
- Evidence supporting palliative care interventions- specifically medications for agitation, in this patient group toward the end of life- without causing intolerable side effects
- Engagement with GP
- Which service to call?

Facilitators

- Availability and range of outreach services that this resident and his family have access to
- Communication and articulation between these outreach services
- Engagement with GP
- Calvary Kogarah palliative care afterhours support
- Engagement with facility leadership team

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CHCK Current Palliative Care RAC service

- RACF serviced by 2 full time palliative care nurse practitioners- aligning with two local GFS services
- New model of care into RACF to address the current inequities of access to palliative care experienced by people living in RACFs

Focusing on

- Advance care planning
- Recognition of person who may be in the last 6 months of their life
- building capacity around palliative care/death and dying in RACF

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In summary

- GS had access to good specialist outreach services into RAC in a timely way so as to avoid admission to acute care and thus avoiding dying in hospital- not always the case for people living in RACF

- Is an example of how medical specialties work together, maximising input at different times in patient illness trajectory- sharing care to provide the most appropriate outcome for resident and family

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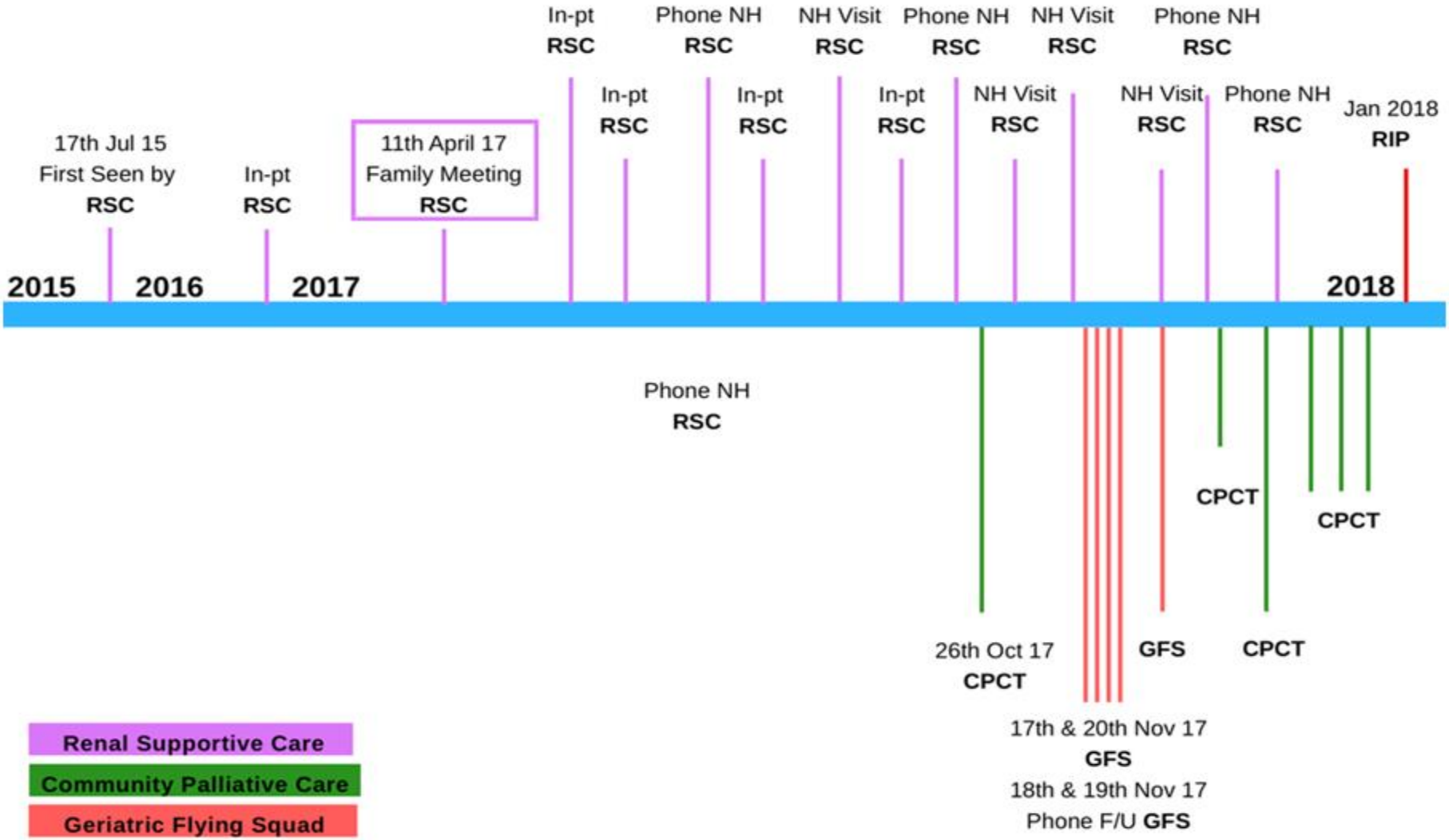
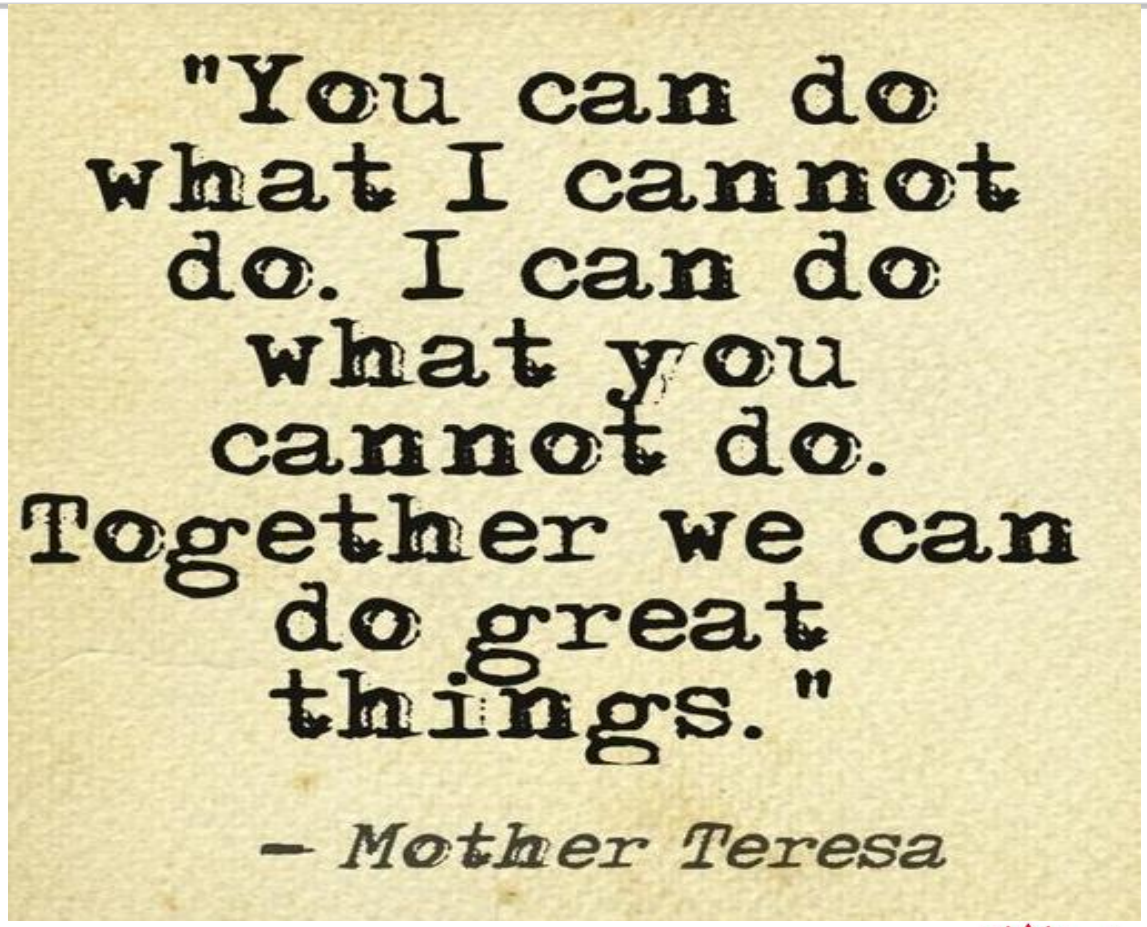
Collaborative Care Timeline




"You can do what I cannot do. I can do what you cannot do. Together we can do great things."
– Mother Teresa

Reflections from a renal perspective….

- Language barrier despite use of interpreters / impact of culture on decision making
- Health literacy (often wondered his understanding of information given)
- Respect of peoples decisions & prerogative to change their minds (regardless if good or bad) and autonomy
- Importance of supporting the ‘whole’ person, social impact significant in this case (struggled being in a RACF)
- Care Plans appropriate to setting (RACF)
- Importance of collaboration & communication

Discussion / Questions ??