Information flyer for General Practitioners (GPs)

For GPs who work within aged care homes participating in PACOP

What is PACOP?

The Palliative Aged Care Outcomes Program (PACOP) aims to systematically improve resident, family & carer outcomes for palliative aged care. It is fully funded by the Australian Government Department of Health. The Royal Commission into Aged Care Quality and Safety identified the need for immediate action to improve the quality of care for residents who are deteriorating and dying in aged care homes. It is essential that we help aged care staff, aged care homes (ACHs) and organisations to identify, understand and address the palliative care needs of their residents in a timely manner.

PACOP is able to provide evidence-based, standardised assessment tools and protocols for assessing resident's palliative care needs. PACOP supports ACHs to embed the PACOP framework and processes, and to use the information gathered from assessments and clinical review of the resident to respond effectively to their palliative care needs. In an effort to acknowledge the critical role that GPs play in the care of older people in ACHs, PACOP has created this document to inform GPs of the PACOP framework by discussing the clinical assessment tools and the process for their use in ACHs participating in PACOP.

ACHs participating in PACOP

ACHs participating in PACOP embed standardised, evidence-based clinical assessments of residents using two collections:

- The PACOP **Profile Collection** (for all residents in the ACH); and
- The PACOP **Outcomes Collection** (for residents identified as needing palliative care).

The PACOP Profile collection

Standardised evidence-based assessment of every resident, screens for deterioration and screens for the need to commence palliative care. PACOP Profile Clinical Assessment Tools include:

- **Profile Clinical Assessment** – a comprehensive, holistic clinical assessment and process, completed every 3 months on every resident (aligns with 'resident of the day' or 'routine care planning')
- **Deteriorating Resident Tool** – used when there is change in the resident's status or due to a clinical concern, completed anytime within the 3-month period mentioned above

Facilitating early identification of the need to commence palliative care

Each of these tools listed above include a section to assist ACH staff to 'Identify the need for palliative care' (see figures 1 & 2, below). This section also includes a checklist incorporating admission criteria, clinical decision making and the results of relevant clinical assessments. ACH staff use these processes and validated tools to make clinical decisions regarding commencing palliative care and are able to transition the resident to the PACOP Outcomes Collection if palliative care needs are identified. Built into this process is a referral to the GP to initiate a range of strategies to anticipate and meet the palliative/end of life needs of the resident and their family.

Decisions to commence palliative care

Figure 1 – PACOP Profile Clinical Assessment Tool

Identifying the need for Palliative Care

YES to ANY of these statements/questions:

☐ Yes	☐ No	Resident is a **new admission, admitted as AN-ACC Class 1** – Admit for palliative care
☐ Yes	☐ No	Resident is a **new admission, admitted from a** palliative care unit
☐ Yes	☐ No	The resident has a palliative care plan developed by a GP or palliative care health professional/team
☐ Yes	☐ No	The resident has documented palliative care needs by a GP or palliative care health professional/team
☐ Yes	☐ No	Based on clinical judgement, the current assessment and all the information available to you **do you believe the resident has a prognosis of <3 months?**

***OR* Yes to 2 of the 3 assessments below:**

☐ Yes	☐ No	One or more **moderate/severe** symptom distress (SAS) or problem severity (PSS) score
☐ Yes	☐ No	An AKPS of 40 or less
☐ Yes	☐ No	A Rockwood Clinical Frailty Scale (RCFS) score of 8 or 9

If YES to *ANY* – Resident would benefit from Palliative Care (e.g. PACOP Outcomes Collection)

If NO to *ALL* – Continue to monitor using PACOP Profile Collection

Figure 2 – PACOP Deteriorating Resident Tool

Identifying the need for palliative care

YES to ANY of these statements/questions/assessments below:

☐ Yes	☐ No	Based on clinical judgement, the current assessment and all the information available to you, do you believe the resident would benefit from palliative care?
☐ Yes	☐ No	The resident and/or family is requesting palliative care
☐ Yes	☐ No	Based on clinical judgement, the current assessment and all the information available to you **do you believe the resident has a prognosis of <3 months?**
☐ Yes	☐ No	One or more **moderate/severe** symptom distress (SAS) or problem severity (PSS) score
☐ Yes	☐ No	An AKPS of 40 or less
☐ Yes	☐ No	A Rockwood Clinical Frailty Scale (RCFS) score of 8 or 9

YES to *ANY* – Resident would benefit from Palliative Care (e.g. PACOP Outcomes Collection)

NO to *ALL* – Review care plan to address deterioration & continue to monitor using PACOP Profile Collection

These sections include results from assessments used in the PACOP Clinical Assessment Tools (SAS, PSS, AKPS, RCFS). A brief description of all evidence-based assessments used in the PACOP Clinical Assessment Tools (Profile & Outcomes), including the significance of scores allocated is provided in Table 1.

The PACOP Outcomes collection

Residents identified as needing palliative care are commenced on the PACOP Outcomes Collection.

This collection includes clinical assessment tools and an evidence-based protocol for responding to assessed needs. The PACOP Outcomes Collection tools include:

- **Outcomes FULL clinical assessment** – comprehensive assessment of palliative care needs, will be conducted ***daily*** OR ***weekly*** depending on Phase (described below)
- **Outcomes DAILY symptom assessment** – daily assessment of distress related to a range of symptoms important in palliative care (SAS described below)

Tools used in PACOP – a 'new language' for clinical assessment

Table 1 – Validated palliative aged care tools used within the PACOP Clinical Assessment process

The Symptom Assessment Scale (SAS)
Resident rated (where possible), measures **symptom distress** over past 24 hours for each of the following symptoms: Pain, Fatigue, Breathing, Bowels, Nausea, Appetite, Sleeping & Other. Scores range from zero (0) no distress, 1-3 mild distress, 4-7 moderate distress & 8-10 severe distress each symptom.
The Problem Severity Score (PSS)
Clinician rated, scores **problems** over the past 24 hours for 4 domains: Pain, Other, Psychological/Spiritual & Family/Carer. Scores range from zero (0) absent problems, 1 mild problems, 2 moderate problems & 3 severe problems for each domain.
PainChek
For participating ACHs, the App gives a final score for **pain** out of 42 where: 0-6 = no pain, 7-11 = mild pain, 12-15 = moderate pain & 16-42 = severe pain.
Australia-Modified Karnofsky Score (AKPS)
Clinician rated, **measures performance status** of the resident at time of assessment, scores range from 100 (normal, no disease, no complaints) to 10 (comatose/barely rousable). Most residents in ACHs will have an AKPS of 70 – 40. An AKPS of ≤40 is significant and can indicate the need for palliative care.
Resource Utilisation Groups-Activities of Daily Living (RUG-ADL)
Clinician rated, **measures functional status** of the resident at time of assessment across 4 ADLs that a resident will lose last as they deteriorate/approach death including: Bed Mobility, Toileting, Transfers & Eating. A total score is used for decision making, lowest score possible is 4 = resident is independent, highest score is 18 = resident requires full assistance of two people for all care.
The Rockwood Clinical Frailty Scale (RCFS)
Clinician rated, **measures physical & cognitive frailty** of the resident at time of assessment. Has nine levels, where level 1 = fittest for their age, nil issues, levels 2-8 describe increasing frailty (levels 7-8 are common for residents approaching end of life in ACHs), level 9 is for those who are terminally ill but not otherwise frail. Levels 5, 6 & 7 tend to correspond to mild, moderate & severe dementia respectively.
The Palliative Care Phase (Phase)
Clinicians allocate a Phase after assessments are complete, the 'Phase' is related to how urgently a residents care plan needs to be updated to meet their palliative care needs. There are 4 Phases including: **Stable** (care plan is addressing all needs), **Unstable** (Urgent changes required to care plan to address needs), **Deteriorating** (timely changes required to care plan to address needs), **Terminal** (trumps all other Phases – terminal care plan needed to address immediate needs).

For more information: Please contact us at pacop@uow.edu.au