Palliative Pathway Activation Process Flow Chart

poi Community of Care
Auckland's Specialist Hospices

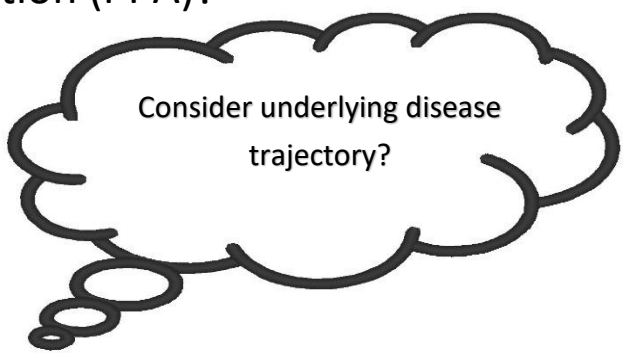
When should I consider completing a Palliative Pathway Activation (PPA)?

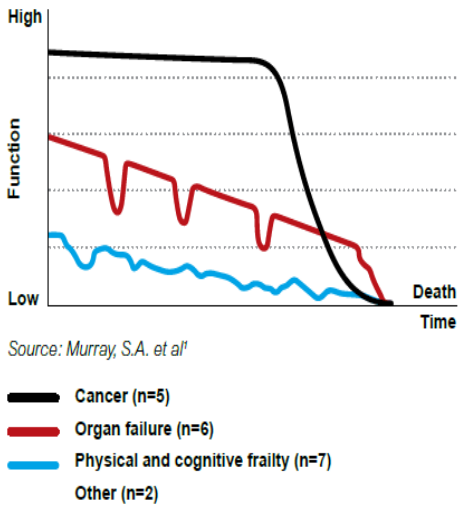
Lets consult our Poi tools ….

Australian-modified Karnofsky Performance scale	
100	Normal with no complaints or evidence of disease
90	Able to carry on normal activity but with minor sign of illness present
80	Normal activity but requiring effort. Signs and symptoms of disease more prominent
70	Able to care for self, but unable to work or carry on other normal activities
60	Able to care for most needs, but requires occasional assistance
50	Consideration assistance and frequent medical care required
40	In bed more than 50% of the time
30	Almost completely bedfast
20	Totally bedfast and requiring extensive nursing care by professionals and or family
10	Comatose or barely rousable
0	Death

PPA

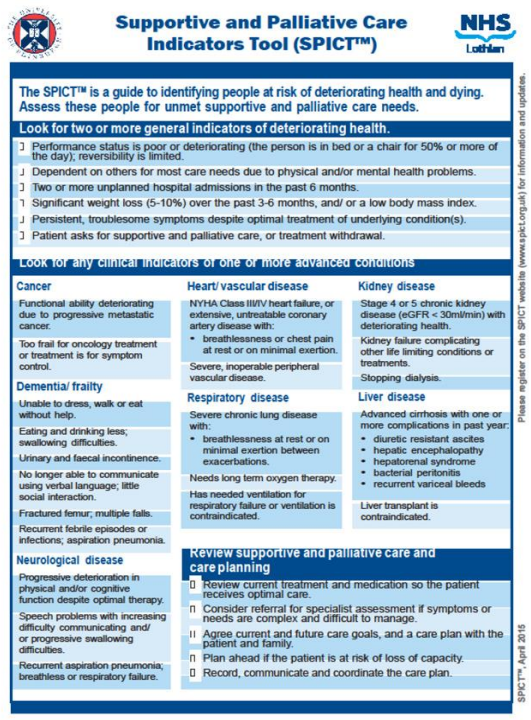
ACP





WHEN WE LOOK WITH THE PALLIATIVE PERSPECTIVE

- What is the **AKPS** score?
- What is the **PHASE**? What is the **UNDERLYING** disease burden/trajectory?
- Are there any general/clinical indicators **SPICT**?
- Does this overall picture suggest last **6-9MTHS OF LIFE**?
- Does **EVERYONE KNOW** what is happening with the person?



Potential actions following Phase assessment		
Palliative Care Phase	**Actions if this is a new Phase**	**Actions if Phase is the same as previous assessment**
Stable	▪ Continue as per plan of care.	▪ Continue as per plan of care. ▪ Commence discharge planning if appropriate.
Unstable	▪ Urgent intervention and escalation required. ▪ Change plan of care. ▪ Urgent medical review and or allied health services. ▪ Review within 24 hours.	▪ Continue urgent action, adjust plan of care, refer, and intervene. ▪ When no further changes to the care plan are required, change Phase.
Deteriorating	▪ Change in plan of care required to address increasing needs. ▪ Referral to medical or allied health may be required. Family / carer support may increase.	▪ Review and change plan of care. ▪ When deterioration plateaus, change Phase to Stable.
Terminal	▪ Commence end of life care (adjust plan of care if required). ▪ Discuss change in condition with family and those important to the patient. **Consider:** ***Te Ara Whakapiri Toolkit*** *– National MOH End of life guidelines*	▪ Continue end of life care as per plan of care. ▪ Communicate changes to family and others important to the patient. ▪ If patient not likely to die in the next few days, change Phase. ▪ End the Episode of Care when patient dies.
Bereavement	▪ Provide bereavement support to family and those important to the patient.	▪ If family require ongoing support, refer to appropriate service (family member becomes a client in their own right).

SUPPORTIVE AND HOLISTIC PALLIATIVE CARE PLANNING

- Let's have a **CONVERSATION** and Whānau meeting
- Complete a **PPA**
- Consult with the Poi Team – **PAS** feedback
- Documentation/care planning **CLEARLY COMMUNICATED** in Facility
- Ongoing **support** through Poi.
  https://www.poiproject.co.nz/

A Regional Resource developed and shared by the Totara Hospice Poi Clinical Resource Team