DELIVER CARE SERVICES USING A PALLIATIVE APPROACH

CHCPA301B

Page 499 – 500 & 60 - 61 in Text Book
Page 320 – 322 (Activity 6) in Learner Study Guide
OUTCOMES

By the end of this session the learner will be able to:

• Understand legal & ethical implications of the need to follow advanced care directives
• Comply with end-of-life needs and refer concerns to appropriate team member
• Recognise impact of client’s end-of-life needs
• Deliver services in a manner that supports the right of clients to choose the location of their end-of-life care
ASSESSMENT 2 OF 2

Watch a video and then complete a theory assessment date changed to:

Wednesday 3/04/2013
Palliative care information for people who work in residential aged care and the people they care for:

WHAT IS AN ADVANCED CARE DIRECTIVE

Sometimes called a living will. This is when a person makes decisions about their future preferences for medical treatment in cases where they may become incapacitated. They are always optional. An ACD is legally binding in NSW and failure to comply with a directive by a health professional could lead to civil or criminal proceedings.
WHAT IS AN ADVANCED CARE DIRECTIVE

Currently, Australian states and territories vary in the legislation relating to ACD’s.
Completion of and ACD ideally should be one part of the broader advanced care planning process. Two elements are recognised within and ACD:
• The written directive
  &
• The appointment of a substitute decision maker
WHAT IS AN ADVANCED CARE DIRECTIVE

• The ACD basically acknowledges the right of a client to make his/her own decisions – i.e. ‘autonomy’ to say no to certain procedures
USING ADVANCED CARE DIRECTIVES (NSW)

FOLLOW ADVANCED CARE DIRECTIVE IN THE CARE PLAN

• There is no one approach to caring for someone whose death is imminent. Although various strategies and interventions can be suggested, the circumstances will always vary.

• Respecting the client’s and family’s end-of-life choices will contribute greatly to the family’s satisfaction with the care provided.
END-OF-LIFE CARE

COMPLY WITH END-OF-LIFE DECISIONS AS PER CARE PLAN

• Carers should be familiar with a care plan at all times and must ensure that it is a ‘living’ document i.e. that it is always up-to-date, reflecting changes in condition and care as they occur

• Care plans should be continuously evaluated and reassessed for effectiveness of the interventions and modified where necessary to achieve optimal outcomes for clients and their families
REPORT THE CLIENTS NEEDS/ISSUES IN RELATION TO END-OF-LIFE

• Often it is the carer who senses what the client is feeling and what questions he/she wants to ask the medical practitioner but cannot.
• Barriers such as lack of privacy or a busy practice prevent clients discussion end-of-life issues with medical practitioners unless the subject is specifically brought up.
• Such vital information should be reported to your supervisor for entry in the clients care plan.
DELIVER SERVICES IN A MANNER THAT SUPPORTS THE RIGHT OF CLIENTS TO CHOOSE THE LOCATION OF THEIR END-OF-LIFE

Surveys have been conducted which have led to the 12 ‘principles of a good death’. These are to:

• have an idea of when death is coming and what can be expected
• be able to retain reasonable control of what happens
• be afforded dignity and privacy
• have control of pain and other symptoms
• have access to necessary information and expertise
• have access to any spiritual or emotional support required
• have access to quality palliative care in any location
• have control over who is present and who shares the end
• be able to issue advanced directives to ensure one’s wishes are respected
• have time to say good-bye and to arrange important things
• be able to leave when it is time and not to have life prolonged pointlessly
• have reasonable choice and control over where death occurs