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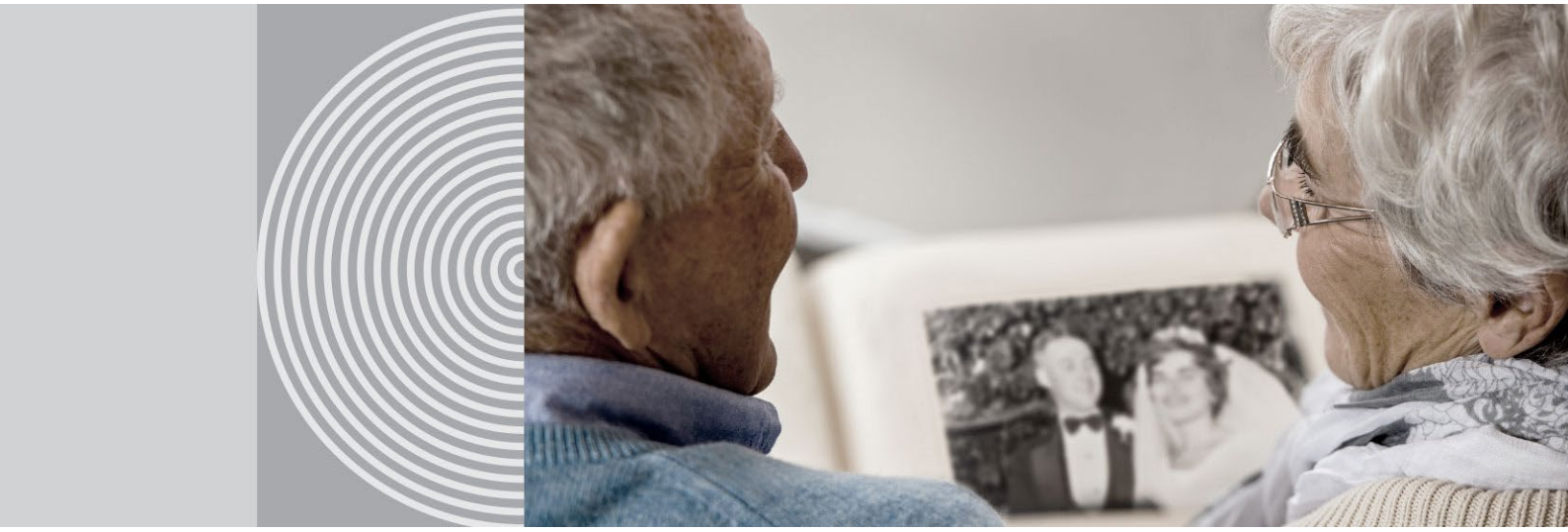
Part B. Anticipatory care



General principles

- Preplanning for anticipatory care ensures that the right thing is done at the right time by the right person with the right outcome.
- Anticipatory care education for people living in their own home and in RACFs has the potential to reduce unnecessary after-hours visits and hospitalisations.
- Anticipatory care planning is part of preventive interventions in older people and involves regular review and updates as the individual's condition changes and priorities change.
- Vulnerability can be detected through the use of risk predictive tools, occupational home environment assessment, falls risk assessment, frailty and polypharmacy.
- Optimal medication management involves not only the prescribing of regular medicines, but also providing medication and education about action to take when a flare or exacerbation of a diagnosed condition or an expected side effect is experienced.

Introduction

Anticipatory care planning is a person-centred, proactive, 'thinking ahead' approach that requires services, healthcare practitioners and care professionals to work with individuals, carers and their families to have the right conversations and set personal goals to ensure that the right thing is done at the right time by the right person with the right outcome.[1]

Anticipatory care planning can start at any stage of a person's care. It is about understanding the individual's situation and their health conditions, and helping people to navigate the system and make informed choices about their care, place of care and optimal quality of life. Anticipatory care planning is a 'living plan' rather than an end-of-life plan or

advance care directive (refer to Part B. Advance care planning). Therefore, it requires regular review and updates as the individual's condition or personal circumstances change and different things take priority.

Anticipatory care planning should highlight the person's personal goals, preferences, views and concerns. As care becomes more complex, it may be helpful to discuss legal and practical issues, as well as care and support preferences, and these may be used in conjunction with advance care directives.

Anticipatory care planning is particularly useful for those people with complex needs. It is important to be familiar with the community infrastructure to manage older people independently out of hospital, and to be able to access funding and local support agencies. It is also important to recognise that anticipatory care planning may be a factor in recognising and helping to reduce health inequalities. Socioeconomic disadvantage and health inequalities are interrelated.[1]

It is important for the individual (and healthcare practitioners) to understand that it is the older person's anticipatory care plan and they should have ownership of it.

Triggers for anticipatory care planning

Starting anticipatory care planning can be prompted by a range of triggers, including:

- frequent unscheduled contacts with medical practitioners
- carer and family stress
- multicultural needs, including the use of interpreters
- unplanned hospital admissions
- complex physical needs
- complex mental health needs
- disability needs
- palliative care needs
- need for respite care
- patients who are housebound
- people living alone
- vulnerability due to social or environmental circumstances (eg housing stability, nutritional requirements)
- deteriorating long-term conditions (eg dementia, heart failure, chronic obstructive pulmonary disease [COPD], neurological diseases [eg Parkinson's disease, motor neurone disease, multiple sclerosis], terminal cancer)
- requirement for visiting home nursing/carers[2]
- requirement for Hospital in the Home services,[3] which are often conducted in conjunction with local hospitals
- requirement for medical needs (eg multidisciplinary care, specialist care, podiatry, dental, physiotherapy, wound management, specialist centres, counselling, financial aid, medicines, dose administration aids [DAAs], dose delivery devices)
- requirement for aids for daily living (eg independent living aids, invalid beds, walking aids, continence aids, pumps, sleep apnoea equipment, medical alarm setup)
- transportation needs
- social support needs.

Vulnerability

Vulnerability can be detected through the use of risk predictive tools, occupational home environment assessment, falls risk assessment (refer to Part A. Falls), frailty (refer to Part A. Frailty) and polypharmacy (refer to Part A. Polypharmacy).

Medication-related problems may cause unnecessary hospital admissions, adverse drug reactions and other adverse outcomes for older people living in the community. General practitioners (GPs) should review medications in older people, particularly for vulnerable groups.

There is a growing body of evidence that drug therapy in older adults may contribute to frailty. Providers conduct medication reviews (refer to Part A. Medication management) on all prefrail or frail older adults to identify medications for possible deprescribing (ie decreasing the dose, in some cases discontinuation; refer to Part A. Deprescribing). Providers should not wait until individuals have become frail before conducting the review. There is value in taking a more preventive approach. By increasing awareness of the potential problems of drug therapy that may otherwise be missed, the development of frailty may be decreased and possibly delayed.[4]

Further information on preventive interventions in older people as part of anticipatory care planning (eg medication reviews, immunisation, physical activity, and assessments for falls, visual and hearing impairment and dementia) can be accessed in the RACGP's *Guidelines for preventive activities in general practice*.[5]

The use of anticipatory care is increasing in Australia in order to optimise the healthcare system and care of vulnerable people using a population-based approach. A recent Australian paper found that potentially preventable hospitalisations are minimised when adults (usually with multiple morbidities ± frailty) benefit from alternatives to emergency hospital use. A complex systems and anticipatory journey approach to preventing hospitalisations, using the patient journey record system, has been proposed and is being evaluated.[6]

A current anticipatory care project in Tasmania is:[7]

- aiming to find effective ways of reaching people who need care most
- identifying and assessing future risk
- enabling people to improve their health
- improving people's experience of the health system
- using local health data and consumer input to plan care.

The use of My Aged Care may assist in location of resources.

As required medication

Optimal medication management involves not only the prescribing of regular medicines, but also providing medication and education about action to take when a flare or exacerbation of a diagnosed condition occurs. This should allow older people living in the community to self-manage, but also to know their limitations and when they should contact their GP, call an ambulance or proceed to hospital. Written plans able to be understood by the person will be of benefit to assist correct use of as required medication (ie *pro re nata* [PRN] medications).

In residential aged care facilities (RACFs), PRN medicines are those prescribed by a medical practitioner for a specific person and recorded on the medication chart. These are administered by a person qualified to administer medications using their clinical judgement to initiate when necessary. The administration of PRN medicines must be recorded on the person's medicine record, as well as whether the medication was effective.

The GP must state the specific indication of each medicine and the maximum dose that may be given every 24 hours, as well as when the GP wants to be notified about the administration of a PRN dose.

Specific use of PRN medicines

The use of PRN medication orders will differ depending on the facility (ie low-care versus high-care facility, availability of registered nurses [or enrolled nurses who are medication endorsed]) to administer medication and/or injections.

Examples of conditions where pre-planning (ie PRN medication orders, supplies of medicines) for specific residents can assist in optimal management include:

- allergic reaction and anaphylaxis
- angina
- asthma and COPD
- constipation
- diarrhoea
- epilepsy
- falls
- management of changed behaviour
- pain
- palliative and end-of-life care
- nausea and vomiting
- urinary tract infections.

Allergic reaction and anaphylaxis

Severe allergic reaction after drug administration is defined as urticaria, angioedema or anaphylaxis, and occurs most commonly after the first or second dose of an antibiotic. Severe allergic reactions may also occur after vaccination and to those with anticipated anaphylactic reactions (eg peanuts, monosodium glutamate [MSG], bull ants, wasps, bees). Usual products required include:

- EpiPen autoinjector
- adrenaline 1:1000 ampoules.

In some cases antihistamine orders may be required.[8]

Angina

Ensure residents have PRN orders for sublingual, short-acting nitrates (eg glyceryl trinitrate) available for breakthrough angina. Regular checks on dating are essential, as glyceryl trinitrate sublingual tablets have an expiry of 90 days after opening, while the glyceryl trinitrate sublingual concentrate spray has a longer dating.

Asthma and chronic obstructive pulmonary disease

Ensure residents with asthma have PRN orders for salbutamol metered dose inhaler (MDI) plus a spacer for emergency use. Residents using budesonide/formoterol (two lowest doses) products may use this for their action plan.[9]

Residents with COPD may have initial treatment with salbutamol or ipratropium MDIs. Nebulisers using salbutamol, terbutaline or ipratropium may be required by some residents for asthma or COPD.[10]

Constipation

Regular aperients should be ordered when opioid medications are prescribed to older people. Bowel management plans should be put into place to avoid severe impaction. The resident should have PRN orders for appropriate preparations (eg enema, suppositories, docusate and senna tablets) and a care plan outlining when such preparations should be administered.

Diabetes

Residents with diabetes require a care plan outlining action to take in the event of hypoglycaemia or hyperglycaemia. Orders should be written for glucagon or short-acting insulin. A suggested protocol is:

When blood glucose level (BGL) falls below … mmol/L give … glucose tablets or glucose gel

… mmol/L give glucagon injection

When BGL is above … mmol/L give … units insulin

Specify instances when the RACF should notify the prescriber.[11]

More information on the early identification and optimal management of people with type 2 diabetes is available in the RACGP's *General practice management of type 2 diabetes*.

Diarrhoea

The use of oral rehydration solutions may be included in nurse-initiated medicines (NIMs) at some RACFs. If the resident's requirement for such preparations is predictable, they should be included on PRN orders, and used prior to intravenous (IV) or subcutaneous hydration.

Epilepsy

PRN orders for seizure management should be developed for individual residents at risk of seizure. It is important to note that the absorption of intramuscular (IM) diazepam is erratic. Options may be intrarectal diazepam or midazolam IM.

Falls

Medical examination will be required in most cases of falls. Protocols for prevention should be reviewed following a resident's fall (eg medication review, physical restraints, use of hip protectors).

Management of changed behaviours

Residents displaying behavioural and psychological symptoms of dementia (BPSD; eg physical aggression, risk of harm to self or others, severe agitation, hallucinations, paranoia delusions) require regular review by their GP (refer to Part A. Behavioural and psychological symptoms of dementia).

An individualised care plan should be established, including appropriate person-centred non-pharmacological strategies to manage concerning behaviour with behaviour charting. If medication is prescribed PRN as a chemical restraint, the decision should be documented in the progress notes. The resident and/or family should be informed.[12,13] The appropriate PRN medication orders should be provided by the GP, together with instructions on when, why, maximum doses per 24 hours and when the GP should be contacted. A three-monthly GP review should be scheduled and, where possible, the medication ceased.

Pain

Anticipate additional pain needs with PRN orders; it is important to include guidance for RACF and nursing staff as to mild, moderate or severe pain requirements (refer to Part A. Pain). Specify the maximum doses per 24 hours, and take into account regular doses. All residents on regular analgesics should have a PRN analgesic for incident pain.

Palliative and end-of-life care

GPs, RACF staff and nursing staff should work in collaboration to ensure the resident remains pain free and comfortable. The use of protocols to assist in maintaining comfort may improve end-of-life care and quality of dying (refer to Part A. Palliative and end-of-life care).

Nausea and vomiting

When predicted, PRN protocols should be clearly stated, including the maximum number of domperidone, metoclopramide and prochlorperazine to be used before calling a prescriber.

Urinary tract infections

If the patient frequently encounters urinary tract infections, consider preventive strategies such as increase fluid, prophylactic antimicrobial use, oestrogen creams, frequent changing of pads, hygiene, and catheter care (refer to Part A. Infection and sepsis).

Nurse-initiated medications

NIMs are non-prescription medicines approved at the medication advisory committee (MAC) meetings, and disseminated to qualified prescribers and nursing staff in the RACF. NIMS should only be administered when the need arises and with the prior agreement of the resident's GP. The list of NIMs must be signed by the GP for each resident in their care, with any changes noted signed.

Registered nurses may use their clinical assessment and judgement to initiate administration of over-the-counter medications within their state or territory legislation, and according to organisation guidelines. A record of any NIM should be included on the resident's medication chart. In most cases, the medication can be administered only once without reference to the medical practitioner.

NIM protocols should include indication/s for the drug, dosage and contraindications. The use of NIMS should be documented on the medication chart.

Many RACFs are no longer using NIMs; if this is the case, the anticipated medicines must be written on the PRN ordered (eg simple analgesics such as paracetamol, antacids, aperients).

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