Is today a good day to die?

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Why?

How does a terminally ill patient with clearly documented limitations of care on previous admissions, return to hospital only to have full resuscitation efforts for 30 mins on a Saturday night before he is pronounced dead?

This is the question his family asked.

Adverse event and patient feedback investigations showed us that the quality of the end-of-life care people received was like a roll of the dice …
Before the project
Mortality review – acute wards:

• **15%** Patients had no resuscitation plan in place at time of death;

• **21%** Patients did not have a resuscitation plan completed until late in their admission – often only within hours or days of death;

• **23%** of deaths - End of life decision was made by either the MET team or ICU doctors

• **24%** patients had the Liverpool care pathway (being trialled) in place at time of death.

• ACP in Residential aged care only
A Framework

• Comprehensive,
• Integrated,
• Coordinated

- To take the gamble out of end-of-life care
We needed to hear from the experts…

Review of the literature;

Ethics approval then..

What is end of life care like here at BHS?
• We asked 13 bereaved families (2013)

What does good end of life care look like to you?
• We set up focus groups with Doctors, Nurses, Allied Health staff and Consumers from BHS and from medical services outside BHS. (N=25)
• Consumer focus group (N=7)
Key Themes

• Preparation for death
• The care experience
• The dying experience
• Follow up after death
• Communication
Framework scope

Well  Diagnosis  Progression  Dying  Death  Post death

Initial scope
Culture, values behaviour

- Advance Care Planning
- Identifying people at risk of deteriorating or dying
- Goals of care planning
- Care of the dying management plan
- Bereavement

Communication
Goals of Care

Introduced May 2014

An alternative to the ‘DNR’ approach

• The challenge of medical engagement
• The role of the Medical Emergency Team
• Language: “Palliative” – not just active dying;
• Reviewed July 2015

Acknowledgements:
• Southern Tasmania area health network
• Dr Barbara Hayes, Northern Hospital
Then and now

Timely discussion of goals of care
Excl Paediatrics, Obstetrics and Short stay

<table>
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<th>Jun-14</th>
<th>&gt;48hrs</th>
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<td>8</td>
<td>51</td>
<td>41</td>
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<tr>
<td>Jul-15</td>
<td>75</td>
<td>12</td>
<td>13</td>
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Care of the Dying Management Plan (CDMP)

- Commenced when Goal of Care is D (patient is actively dying)
- Offers best chance of dying well
- Multidisciplinary
- Involves patient and family
- First question: “Do you want to die at home?”
- July 2014
Advance Care Planning

- Respecting patient choices
- Assoc. Prof Bill Silvester – Steering group member
- Developing the model for BHS – regional area has advantages (lesson from Barwon Health)
- Focus on primary care and community programs
- Education for facilitators already in place
- Partnering with a GP practice as a pilot.
- Business case 2015 -
“Tests and investigations are our failure to have the courage to have a difficult conversation”

Dr Ranjana Srivastava
Medical Oncologist
Author

The challenge of the difficult conversation
Communication

- Evidence suggested we needed to offer explicit communication skills training
- *Discussing goals of care* workshop developed at BHS
- Experiential (role play with an actor) and didactic
- Pitched to Registrars at this stage
- Introduced in April 2015
- A work in progress ..
EoL Framework

More than a roll of the dice …

• Over 90% patients who die have a goals of care plan in place within 48hrs of admission.
• Over 80% patients who die now are for either comfort measures and symptom management (Goal of care C) or terminal care (Goal of Care D) rather than curative or restorative.
• 80% of those who die in subacute are on CDMP
• CDMP use in acute after 3 month roll-out is still a work in progress - not yet embedded.
Next steps ..

- Roll out the Framework document;
- Advance Care Planning – business case and collaborations with primary care and other organisations;
- Building capability for having the difficult conversation – Communication Skills Training for medical staff.
- GoC form review analysis
- CDMP sustainability project
- Considering our role with bereavement;
- Goals of care and CDMP for Residential Aged Care – being trialled currently
- Repeating interviews
- Significant opportunities for research ...
Not yet there but we’re on our way…
Questions?