Developing an End-of-Life framework

Ballarat Health Services

- Principal referral hospital for the Grampians region in Western Victoria (48,000 sq kms) with a population of 250,000.
- > 300 acute and sub-acute beds
- > 402 Residential Aged Care beds across 10 facilities
- Community Programs servicing the Grampians region

1. Designing the framework

Reviewing the evidence
- Reviewing the literature – nationally and internationally;
- Establishing current Eol care at BHS using baseline mortality review data.

Asking stakeholders
Bereaved families BHS 2013 (N=13)
Interested consumers (N = 7)
Bereaved families BHS 2013 (N=13)

Health care professionals - BHS and regional (N= 25)

2. Putting the pieces in place

Framework elements:

a) Moving beyond Do Not Resuscitate: medical Goals of Care Summary form:
- Promotes improved decision-making and documentation relating to limitations of medical treatment.
- Age, ACP and Supportive and Palliative Care Indicators Tool (SPLICIT™) to guide minimum inclusion criteria;
- Completed by senior medical staff at the level of Registrar or above
- Records the person who is in the position to consent to treatment for a person who no longer has capacity.

b) A Care of the Dying Management Plan (CDMP)
- CDMP introduced July 2014 (based on LCP);
- Adapted for use in acute, sub acute and residential aged care settings.

c) Advance Care Planning:
- Systems to support ACP access by hospital staff
- Focus on completion when people are well or not in crisis
- Community programs and chronic illness settings (dialysis)
- Established Primary Care partnership with GPs

d) Communication
Stakeholder consultation highlighted a need to build capability to have the difficult conversation.

e) Caring for families and carers as well as the patient – during and after dying.

Results

Defining the framework scope

Integrating the elements

Culture, values, behaviour

Adventure Planning
Recognising people at risk of deteriorating or dying
Goals of care planning
Care of the dying management plan
Bereavement

Goals of Care
The goals of care discussion with those at risk of deteriorating or dying should occur within 48 hours of admission.

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

% Within 48hrs % >48hrs % No Goal %

Jun-14 8 51 41

Jul-15 75 12 13

July 2015: N = 85. Point prevalence survey of same cohort but on one day.

CDMP use
Acute setting: 25 – 55%
Sub acute setting: Up to 80%
Plan to continue to embed use of the CDMP in the acute setting.

Background

Good end-of-life care can minimise the distress and grief that individuals and those who care for them experience in the last years, months and days of life. Ballarat Health Services recognised that while we had implemented some of the elements required to provide safe and high-quality end-of-life care including:

- Advance Care Planning only in place in Residential Aged Care (RAC);
- Liverpool Care Pathway - piloted in several units, . the implementation was patchy and uncoordinated.

Aim

To develop a comprehensive, integrated and coordinated approach to delivering best-practice end-of-life care.

So what now?

- Organisation-wide roll out of the aspirational BHS End-of-Life Framework document which will then be used to inform future work.
- Embedding the elements – audit and evaluation
- Advance care planning coordinator appointment
- Development of supporting consumer information
- Research – many opportunities including repeating the bereaved family interviews and focus group interviews.

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