Developing an End-of-Life framework

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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
- > 420 Residential Aged Care beds across 10 facilities
- Community Programs servicing the Grampians region

Ballarat Health Services
Putting your health first

The Story...

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 end-of-life care we provide requires significant improvement.

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.

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)
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 (SPICT™) 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

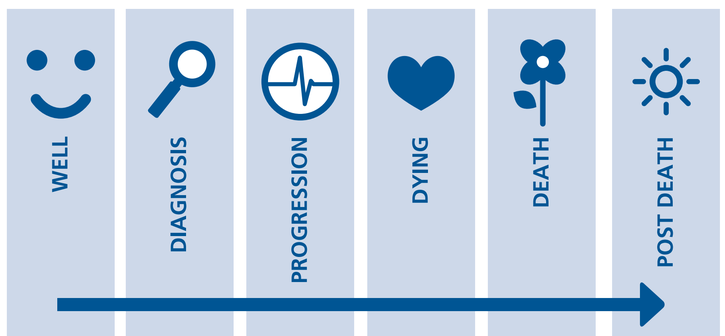
Stakeholder consultation highlighted a need to build capability to have the difficult conversation.

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

Results

Defining the framework scope

Framework scope



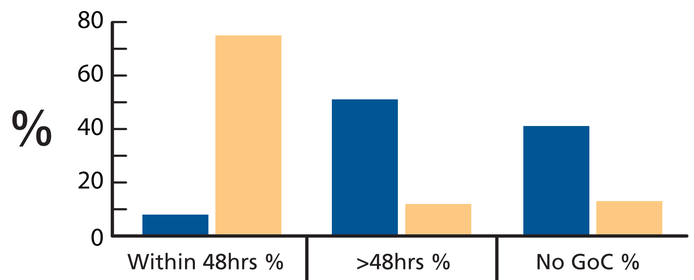
Integrating the elements

Culture, values, behaviour				
Advance Care Planning	Recognising people at risk of deteriorating or dying	Goals of care planning	Care of the dying management plan	Bereavement
Communication				

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 GoC %
Jun-14	8	51	41
Jul-15	75	12	13

June 2014: N = 1280. One month of medical / surgical admissions.
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.

ACP

System to scan ACP in to the digital medical record

Facilitators in place in areas where people are at risk of decline (HARP, dialysis)

Training and collaboration with primary care together with *Decision Assist*

DecisionAssist
Palliative Care and Advance Care Planning for Aged Care

Communication

Discussing goals of care: evidence-based communication skills in action programme offered to all registrars. Developed locally.

Bereavement

Literature review provides a guide for future work

Lessons from the build:

Engagement

- Significant Board and Executive support – Two executives on project steering committee
- Medical engagement – ICU and Palliative Care initial drivers but increased engagement with medical and surgical groups over time.
- Staff engagement through involvement and feedback.

A major change management project

Conversations and activities have changed around the organisation:

- Goals of care (what we can do) are being discussed routinely rather than resuscitation status (what can't be done).
- Increased referrals to Palliative Care team by acute care staff
- Increased interest in outcomes - patient stories referred to end-of-life project coordinator by staff.
- Organisation-wide mortality review supports EoL framework aims.

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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