A3 EOL Education Plan Storyboard

Author: Diana Moore, End of Life Working Party

Ensuring clarity at the end of Life

… Advance Care Planning = excellence in End of Life care

Doctor

BACKGROUND

Education of clinicians around values based decision making and advance care planning is essential to ensure patients that are in the last years, months, weeks, days of their lives in acute settings receive care that is aligned with patient preferences.

Effective end of life planning requires open and systematic communication with the patient and their family and carers. Early engagement with patients to discuss values based decision making allows people and their substitute decision maker to make personal decisions about life goals and preferred outcomes. This in turn allows medical practitioners to make medical decisions that respect those preferences.

NS5 Comprehensive Care2018 ; National Consensus Statement: Essential elements for safe and high-quality end-of-life 2015

WHAT IS THE PROBLEM?

There is a disconnect between people's expressed wishes with regards to End of Life care …..
And what actually happens…..
Surveys consistently show that 60-70% of Australians would prefer to die at home

Few (14%) Australians over age 65 die at home

54% die in hospital
32% die in residential care

AND…

There is evidence that healthcare providers are causing harm at the end of life ….

Acute interventions – "non beneficial treatments" often continue until the time of death…. This includes any treatment, procedures or tests administered to patients who are naturally dying and these

- Will not make a difference to their survival
- Will probably impair their remaining quality of life
- May cause pain or prolonged suffering
- May leave them in a worse state of health than before

WHAT DOES THIS MEAN - Internationally?

Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem.
M.Cardona-Morrell et. al.
International Journal for Quality in Health Care 2016 28(4), 456-469

ICU admission last 6 weeks of life
Prevalence 10%

Chemotherapy last six weeks of life
Prevalence 33%

"2 weeks in ICU can save you 1 hour of difficult conversation." Dr Will Cairns, Palliative Care Physician

DIAGNOSTICS – at Mater?

84% expected adult deaths had a resuscitation plan in place … **but only** 49% expected adult deaths commenced on EOL carepath

GOAL

Timely and appropriate documentation available should patient deteriorate suddenly

FUTURE STATE – So what is EOL working party doing about it?

Develop multidisciplinary advance care planning procedure

Promote use of Statement of Choices kit - to support end of life decision-making and facilitate shared decision-making

Revise Adult Resuscitation plan (ARP) - pink form – consistent with best practice

Revise End of Life carepath
Implement observation chart for palliative care
Develop bereavement resources (handover bag/door sign/card) & booklet

ACTIONS – Integrating advance care planning (ACP) into practice

1. Is your patient at risk of deteriorating or dying?
   - Would you answer "No"to surprise question?

Have a conversation with the patient/family/carer.

Referrals can be made to Social Work to assist in ACP conversations and documentation

2. Document ACP discussion in chart including
   - What forms/written information provided

ACP is a shared responsibility of all healthcare workers.

For complex patients refer to registrar or consultant and consider calling Palliative Care Specialist for advice

3. Patients record their values and preferences
   - Know who would speak for them if they couldn't speak themselves

Complete relevant ACP form e.g. Statement of choices

Ensures treatment and care a patient receives in the future aligns with their preferences

4. Consultant or registrar document plan of care
   - Plan defines clear outcomes – values based

Resuscitation plan- aligns with patients goals of care.

Planning ahead = timely and appropriate documentation of resuscitation plan

OUTCOMES – document ACP discussion / forms using clinical alerts

- Improved recognition of patients at the end of life – SPICT toll on ARP (Pink) form
- Improved communication and shared decision making – Statement of choices form
- Improved care of patients and their families at the end of life – End of life carepath
- Use IPM Clinical alerts to document ACP discussion & Resuscitation plan in use

WHAT ELSE DO I NEED TO KNOW?

Review resources developed by EOL working party available on **MDC**

Start the conversation with
Your family members
Your patients
Your colleagues

LAUNCH 29th January