Collaborative Approach to Improving End-of-Life Care at Canossa Services Oxley.

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Canossa Services

- Independent living units
- Hostel style rooms
- Aged care facility – high and low care needs with dementia specific unit
- 24 bed rehabilitation unit
- 24 bed palliative care unit
- Day oncology unit.
Our aims were ...

- Develop end-of-life care pathways and protocols
- Deliver quality end-of-life care.
Improving End-of-Life Care

- Why
- What we did
- What we did then
- What we are doing now
- What we will continue to do
- Lessons we have learned.
Audit of charts using principles of “good death” as guideline …

- To know when death is coming and to know what to expect.
- To be able to maintain a sense of control … to have your wishes respected.
- To be given dignity and privacy.
- To have control over pain and any other symptoms that may develop.
- To have a choice over where death occurs.
- To have a choice about who is present at this time.
- To have access to relevant information and excellent palliative care.
- To have spiritual and emotional support as needed.
- To have time to say good-bye.
- To not have life prolonged unnecessarily.

**Audit Tool for Existing Documentation**

<table>
<thead>
<tr>
<th>Date of Audit:</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>1. Was patient/family aware of imminence of death</td>
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<td>2. Was patient/family aware of what to expect during dying process</td>
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<td>3. Were all non-essential medications ceased</td>
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<td>4. Were all non-essential tests ceased</td>
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<td>5. Hydration issues discussed and same documented</td>
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<td>6. Was patient observed regularly for comfort/symptom management and documented</td>
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<td>7. Were appropriate prn medications ordered</td>
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<td>8. Was a record kept of effectiveness of prn medications</td>
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<td>9. NFR orders documented in chart and on care plan</td>
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<td>10. Advanced Health Directive/Enduring Power of Attorney in chart/care plan</td>
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<td>11. NOK and other contact persons noted clearly… including 24 hour contact</td>
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<td>12. Organ donation discussed with patient and family and documented</td>
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<td>13. Special needs for care of body following death noted</td>
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<td>14. &quot;Will&quot; completed and documented</td>
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<td>15. Unfinished business… funeral arrangements, family relationships, financial issues</td>
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<td>16. Patients ability to communicate clearly discussed and addressed as needed</td>
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<td>17. Counselling/pastoral care offered… patient/family</td>
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<td>18. Family conference if appropriate</td>
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<td>19. Follow up bereavement arranged as needed</td>
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<td>20. Patient express wish as to who be present at time of death</td>
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<td>21. Family/Carers given information about visiting, meals, parking etc</td>
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<td>22. GP and community services contacted at deterioration/death</td>
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<td>Date of death:</td>
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<td>Date put on EOL path:</td>
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<td>Comments:</td>
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Chart audit showed us that …

- No standard process for care delivery
- No formal framework to measure the care
- Difficult to assess effectiveness or outcomes.
What we did …

- Sought funding from DoHA
- Project officer appointed
- Establish a working party / advisory panel
- Survey of nurses
- Reviewed the literature.
What we did next …

- Develop end-of-life care pathways
- Trial them in Palliative Care Unit
- Introduce the pathways in Aged Care … educate
- Develop role of Resource Nurses in Aged Care Facilities … Nurse Champions
- Encourage support network from Palliative Care Unit.
What we are doing now …

Ongoing chart audits …

- Know death is coming and what to expect
  - Before: 40%
  - After 4 months: 86%
  - After another 6 months: 90%

- Appropriate medications ordered
  - Before: 41%
  - After 4 months: 95%
  - After another 6 months: 100%

- Unnecessary medications and tests ceased
  - Before: 60%
  - After 4 months: 91%
  - After another 6 months: 93%

- Unfinished business
  - Before: 30%
  - After 4 months: 50%
  - After another 6 months: 65%

- Access to information
  - Before: 41%
  - After 4 months: 86%
  - After another 6 months: 88%

- Have symptoms managed and effect recorded
  - Before: 50%
  - After 4 months: 100%
  - After another 6 months: 95%

- Spiritual and emotional support
  - Before: 25%
  - After 4 months: 41%
  - After another 6 months: 47%
What we are doing now …

- Questionnaires for families and nurses
- Education program for aged care nurses
- Nurse Champions role strengthened
- Palliative care nurses role reinforced.
What we will continue to do …

- Ongoing education program for aged care nurses
- Promote role of our Nurse Champions
- Promote palliative care nurses role
- Measure effectiveness of program.
Lessons we have learned …

- Engage all nurses
- Provide support
- Communicate
- Engage GP’s … most difficult.
To sum up ...

- We assessed the need
- We developed and educated
- We surveyed nurses and families and reviewed documents
- We demonstrated improved outcomes
- We ensured sustainability.
Thank you for your attention.