2016 AIM Statements – HRT1605 EOLC Meeting

Code Name	Aim Statement	Collaboration Opportunity
Asklepios & Artemis	Smart goal – by October we will understand the current situation and have clear/smart goals based on this understanding Target: patients and carers understand end of life, agreed goals, potential outcomes and decisions	What are you trying to/waiting to understand? How will this be measured?
Polaris	Change vision: decrease falls presentation to ED from RACF Strategy: - Scope the problem - → data ED - → data In Reach - Develop resources - → Post fall Ax (QLD RAC pathway) - → indicators for transfer - ED protocol for head-strike→ CT brain or not - Deliver education - → RACF - → locum GP - → ED - Evaluate (of course) repeat audit Other data sets? Existing post-fall assessment and decision aids for RACF? Any data on post-fall H.I. outcomes? Papers on criteria for imaging? Criteria for n/surg suitability? How do we know we have not harmed by not transfer to hospital or not scan? Send info to: Andrea.bee@easternhealth.org.ai Paul.yates@austin.org.au	- "Mobile x-ray - CARE-PACT QLD" - "Only way is follow up with review of non-transferred patients. This requires increase resources for the project."
Ballarat	100% increase in use of the Care of the Dying Management Plan (CDMP) in patients expected to die within 12 months associated with increased medical engagement in End Of Life care through implementation of a last day's quality audit. CDMP use (100% increase) Increase quality of death audit score Relevant to our EOL framework implementation	Create nurse- 1, a2, a3. With this portfolio as the champion for the ward

	Aligns to our strategic goals around quality of care and patient experience	
Picus	To introduce a ceiling of intervention form to aged residential care in 75% of facilities by March 2017. Q: how do we get aged residential care to engage/embrace/implement? Q: how will we know our change is an improvement?	- Link to accreditation and/or funding - Reduction in hospital transfers - Have a contact number on the bottom of discharge summary of the ward to RACF can contact them if post discharge issues - Monthly/quarterly meeting. Have a RACF liaison officer for the hospital? (similar to GP liaison role) - Consider consumer engagement survey of residents and families about their qualitative experience in hospital – my provide evidence for alternative services/at the RACF - We have an integrated meeting w/ ARRC – BUPA, religious, trust. Call Kate Yeo Waikato - Happy to show our medical guidance plan to non-competent patients (currently being trialled) – Kate CDHB - Nameless of forms completed ph patient in RACF e.g. aim for >65% - Decision assist has a "goals of medical care for people in RACF" which we are introducing to Ballarat. We trialled another version but DA's works for us
Dionysis	Quality measures of death for goal setting project will be defined within the next 12 months	- See Kate from Canterbury - Whose perspective? Chart audit, staff, and consumers? - Don't forget consumer input for their "measure"
CanterburyNZ	To develop and implement a pathway for Palliative Patients coming into or through the Emergency Department – over 2016. (By end of) Problem – ED perception that a) Pal care is not our business b) That there are inappropriate admissions from ARCF Supplementary aim – to develop a decision assist tool for High Level Care Residential Care to use for those	Polaris paul.yates@austin.org.au - We'd be happy to discuss/show. - Tell re: our experience with this scenario and send some RACF education resources we've developed Polaris juli.moran@austin.org.au - We are doing something similar happy to discuss (for non RACF patients also) Create a direct admission – bypass ED –

	patients being considered for transfer to ED – to be consistent with primary Aim Pathway Measurements – 1) There is a pathway working in ED 2) The Pathway is visible on Hospital Health Pathways by end 2016	something like 4 hour plan for palliative patients Panther: - Happy to email you the pathways we presented yesterday
Fury	We will roll out the Amber Care Bundle and End of Life framework to 50% of In Patient areas by April 2017 Q: how do we draw together different concepts into one framework?	
Echidna	To improve Advance Care Planning (awareness, engagement, and uptake) throughout the whole hospital. Barriers: how can we improve the involvement of the Emergency Department in ACP? Q: How can we engage other non-palliative care specialties to engage in ACP?	- Doctors like data (then case studies). Nurses like case studies (then data) - Make it personal! Case studies from the area you are trying to engage to demonstrate how ACP will benefit patients/and them in their area - Focus on the community/EP awareness. Develop work instructions to guide clinicians in how to open conversations - Suggest emailing Redland ACP CNC. Rosie Laidlaw (part of Brisbane Metro South Health ACP and/org acp@health.qld.gov.au. Rosie.laidlaw@health.qld.gov.au for advice/suggestions - ACP consultants (trained) are managed by safety and quality unit not pall care in our hosp. loads of in services grand round etc. presentations and anyone can call them - Talk to ED + arrange "rep" to be on EOL committee High Level Mx buy in needed
Demeter	Develop a trial an End of Life care Pathway for palliative care inpatient unit within in 3/12. Measureable: survey monkey – before and after. Clinical audit – compliance of completing documentation Achievable: - Time	- Happy to share RBWH clinical guidance for the dying patient with you (formally EOCCP) carol.hope@health.qld.gov.au - Suggest we "Care plan" rather than "pathway" then it does not sell like a conveyor belt

	- Personnel - Education - Management - Safety and quality/governance - Relevant: core business/accreditation/PCOC Time bound: survey/audits – 1st Monday. Draft End Of Life plan Specific: workable protocol for EOL care	
Hera	Increase compliance with limitations of care towards EOL, focus on Gen Med patients who have died in hospital – MHB ACP within 48 hours. Identifying goals of care Measure – completion rates of clinical recommendations e.g. resuscitation plans - Audit (retrospect) review charts of decease patients for completion of measurable data/indicators e.g. ARP/RCC, EOL pathway, obs/met calls. 3month – all deaths in hosp. - Analysis of gaps. Action plan to improve compliance. Target strategies/engagement over 3-4 months - Evaluation of change through continual chart audit. 12 months - Recommendations re changes e.g. EDC pathway, EOC obs forms, ACP up take, involvement of pall care	Engage service management support to champion the change
Panther	To develop and implement a framework for care at the end of life at Panther within 6 months Problem: work being under taken surrounding care at the end of life in our hospital is currently uncoordinated – occurring across multiple committees, service lines + departments without good communication Barriers: getting key stakeholders on board (getting them to recognise the problem exists) (difficult to measure in terms of patient outcomes). Time as a critical resource	- We made a sb committee of standard 9 + looks at all improvement projects around EOL care. Reports back monthly - Consider family as key stakeholder - → survey them - → representative on committee→ very powerful - Phoenix - End of Life Committee - → working group for ALHS standard 12 (meets monthly) - → consumer reps on committee - → Committee reports to exec & quality & safety. (exec don't necessarily need to attend)

Flame	To develop a standardised process for transfer of care from acute hospitals into RACF’s to maintain patients’ goals of care irrespective of the setting Measurements- At 7 day follow up with RACF telephone call establish congruency with patients’ goals and plan of care Relevance – aligns with CARE-PACT (hospital specialist aged care team) objectives Timeframe – 6/12 review	
Rebel	Specific: 1) Clarity q snap to clinicians, in pall care, as there is funding capacity 2) Pall care identification Measurable: 1) Coding – explore and analysis (how many + time period) 2) CRISTAL – retrospective analysis (+ CRISTAL in the nursing home trial) A: engagement funding capability exploration T: in 12 months Statements: 1) A retrospective analysis using CRISTAL tool to identify need for patients to receive palliative care (CRISTAL in nursing home trial) 2) Increasing SNAP education/information through collaboration Barriers: 1) Lack of funding 2) Resources – time etc.	- All patients who are receiving care which is focused on improving QOL or death in our hospital are snapped to pall care type so there is an independent SNAP. Team who SNAP the whole hospital managed by quality and safety - Go to palliative care outcomes collaboration (Website) for more educational info
Phoenix	Smart goal: Increased recognition of patients at end of life on (joint med/pall care project) - CRISTAL (prognostic assessment) tool completed for each patient >65 within 48 hours of admission – 100% by July 2017 Barriers: - Time taken to complete the tool/project - Who will do this? (limited resources)	“Cheap labour - medical student projects - trainee/registrar projects agree also go to nursing research” “Build capacity for medical ward staff to provide ‘non-complex’ palliative care concurrently as part of this project (education, resources, champions etc.) “share the pain as well as the privilege and remember palliative care is everyone’s business

	- Engagement of all clinicians - Ethics approval Risks: - Increase demand vs. pall care capacity to respond to - increase referrals - potential communication issues on completion of tool → conveying outcome to patient/family "difficult conversations"	
Centauri	Develop comprehensive governance structure and framework for delivering quality EOL care in SALHN (goal to achieve strategy) within 3 months Barriers: - leadership/executive engagement and support (Inc. resource) - clinician engagement - Other network priorities e.g. Health reform	"Work in partnership with stakeholders to develop to help with buy in." "Need health board support and CEO/governance buy in which means face to face discussion and commitment. Tell them some horror stories." "we made or ED committee a sub group of standard 9 it reports back monthly and filters all projects related to improving EOL care so there is no doubling up" Polaris juli.moran@austin.org.au - we have a 2 year old EOLC committee, happy to take more "To include ALL key stakeholders (private, GP's, hospitals, ambulance, local hospice, BOARD local engagement to buy into concept" "use patient stories and data to engage executives" Denise: "Set a realistic time frame. It has taken 2 years to get where we are and this is with a project resource at Ballarat – happy to chat- see Denise"

Salus & Vega	1. Provide community education focused on death literacy to (4/year) a cohort of patients decreases cares from chronic disease groups 2. Develop voice of the customer about “what is ‘value’ in death/end of life care via community consultation. Measurable – increased up take of ACP in patient’s presenting to Hospital Achievable – probable-can do attitude Barriers – staffing/funding. Networks – access to target group “topic” → taboo → resistance to change Risks – failure to engage. Lack of support	- Make it personal –case studies/stories relevant to each ‘stakeholder’ group to engage them. Show them how they will make a difference. - Conversation that count – developed by ACP cooperative in NZ. For communication to become involved in education and supporting themselves. - Ensure you empower not take over palliative care in chronic disease groups. chronic disease health care workers know their clients very well - Tap into community focus groups e.g. advanced care info sessions, senior’s conventions etc. - louisef@wboppho.org.nz Presentations on ACP to aged care villages and facilities to residents and family. Had great reception
Sirius	Improve collaboration between outreach service providers with RACF’s - form a working party within a month - regular meetings – 2monthly - organise education sessions to RACF’s • 70% RACF’s • 5 core topics on palliative care • By 12/12 - Organise roadshows to advertise existing outreach services	