



*Last Days
of Life*

Last Days of Life Toolkit Measurement & Evaluation Guide

Version 1 - September 2020



CLINICAL
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Introduction

Measurement, reporting and evaluation ensures that clinical practice changes are actually being carried out and provides a source of feedback and learning. The purpose of this guide is to outline the recommended approach to collecting information and data on the implementation and effect of the Last Days of Life Toolkit.

Available Data Sources

Many data sources will have information available to review – some include:

Data source	What to look for
Death review database	<ul style="list-style-type: none"> Review death screening data and note number of patients cared for with a standardised care plan or medication plan Number of adverse outcomes in the 24-48 hours prior to dying
IMS+ / incident review	
HIE data	No. of readmissions due to not being able to be cared at home to die

Getting Started

It is important to plan your measurement requirements and have a plan for what you want to or need to demonstrate, and to whom. Data from the initial collection can be used to engage organisational and clinician support for improvement. Regular collection of data will indicate the effectiveness of strategies used.

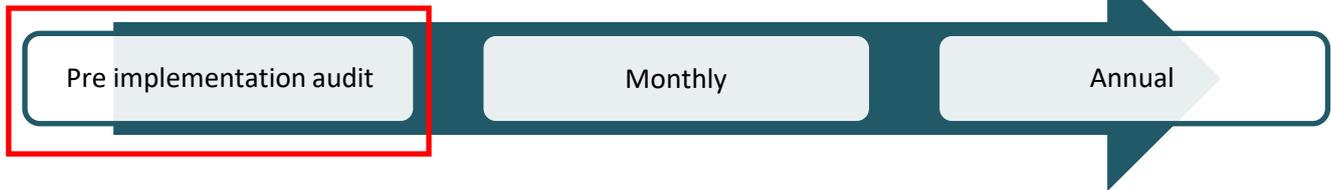
Ask your team the questions below.

Self-Assessment

Measurement / outcomes	Yes	Somewhat	No	Don't know
The metrics / measures that the team want to use to assess the impact of the LDOL toolkit have been agreed				
<ul style="list-style-type: none"> outcome measures process measures 				
The process for data collection has been developed				
The responsibility of overseeing the measurement activities has been assigned				

- If there is a 'no' or 'don't know' response to any of the questions direct action is required
- If a 'somewhat' response is chosen further action is required.
- If a 'yes' response is chosen no further action is required.

Baseline/pre-implementation data collection



- The pre-implantation audit is based on retrospective data, so you can begin to implement the LDOL toolkit at the same time or prior to these being completed.
- The baseline audit will provide you with a case for change and a means to monitor improvement.

The purpose of the baseline audit is to assess the current reliability of practice in your hospital towards patients who are in the last days of life. It takes the form of a retrospective review the notes of the last **10-15 patients** who died in hospital.

Selecting the sample for the baseline audit

- To avoid statistical bias the sample of cases you audit should be of consecutive deaths or discharge dates; you should contact your medical records department to help get this sample.
- You may experience problems obtaining notes for each and every patient identified in your sample. To reduce this problem we recommend oversampling (i.e. initially identifying more than the 10 patients required for the audit), so that you can make sure you can retrieve enough records to complete the required number.

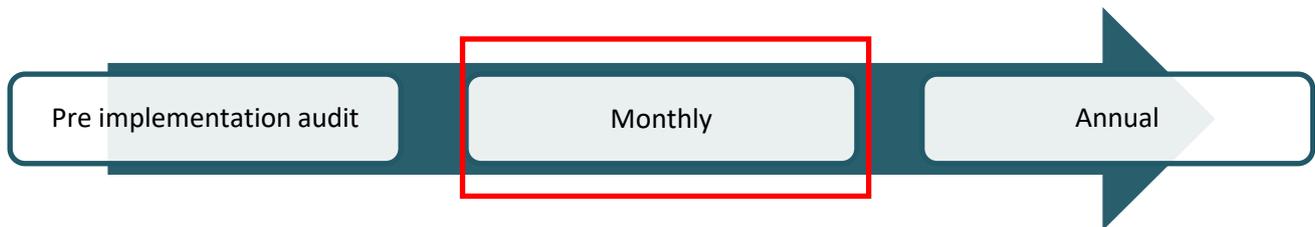
The LDOL audit spreadsheet

- We have developed a spreadsheet to help you complete the audits required for the baseline dataset.
- The audit is available in QARS

Limitations of the baseline audit

- The audit includes limited information on outcome measures and does not include data on patient experience.

Monthly data collection



During the initial 6 months after implementing the toolkit we recommend at a minimum you should aim to collect monthly data.

As a minimum, we recommend your patient-level data include:

- The date the patient was identified as dying
- the date the patient died
- Were there any unexpected adverse outcomes or benefits associated with using the tool/s?

At a minimum you should collect for all charts used:

- Involvement of palliative care team
- Number of patients commenced on the various tools

Initiating Last Days of Life Management Plan

- Who initiated the chart? e.g. Home team/Rapid Response Team/Palliative Care team
- Were all sections complete/signed off
- Family/carer discussion documented

Comfort Observation and Symptom Assessment Chart

- were all observations taken at least 4th hourly
- formal medication management guidelines used in association with chart
- if symptoms not controlled appropriate escalation occurred

Care after death in hospital

- Were all sections complete/signed off

Medication Management guides/flowcharts

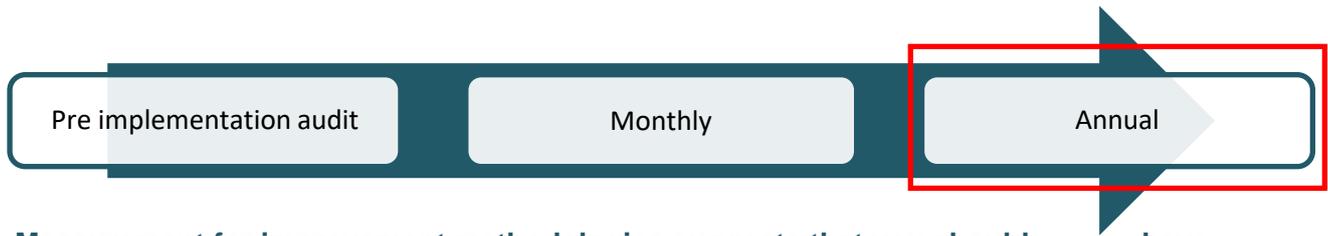
- Which charts were used
- Recommended nonpharmacological treatment implemented

- Medication dose and route given as / flowchart prescribed
- if symptoms not controlled appropriate escalation occurred

Accelerated Discharge to Die at Home

- Patient met all criteria for accelerated transfer home
- Relevant staff available and able to complete tasks
- Medication management checklist complete
- if unable to go home to die the reason is documented on plan
- Was the patient a non-elective readmission within 30 days after a successful transfer?

Annual (12-monthly) data collection



Measurement for improvement methodologies suggests that you should have outcome, process and balancing measures.

When repeating your audit, it's important not to set your expectations too high as you may still have quite a way to go towards completing your LDOL toolkit implementation. You should also make sure that you collect your information using the same methods you used initially, or if you have to change your methods (e.g. if an exact repetition of your measure is no longer possible) make sure you document what you changed and why.

Annual audit / Reporting

- The purpose of the follow up audit is to assess your hospital's progress in implementing the LDOL toolkit and to demonstrate the impact that your implementation has had.
- Select a sample of the last 10 - 15 consecutive patients who have died, complete a retrospective review of their case notes using the LDOL audit spreadsheet.

You can also use this stage to collect all the information you have gathered into a report. This could include:

- A graph of patients whose care is supported by the tools over time to see how this has increased

Your audit results by ward or specialism to provide feedback to clinical colleagues.

Qualitative data collection

Numbers alone cannot communicate the impact that a program is having on the individuals and communities it serves. Including stories in evaluation reports brings the impact of a program to life (Sole, D. & Wilson. D.G. 2002).

Through implementation the opportunity may come to gain patient/family/carer/friend/staff feedback about the use of, or effect of, the tool/s – good and bad. If you can, please take the time to write them down – this kind of information can provide different insights into program processes, show impact, identify unintended consequences from the tools use, demonstrate innovation and support the quantitative data.