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| **Lesson Structure** |
| This document outlines the content to be covered in the introductory presentation and provides guidelines on resources required and local adaptation  ***N.B. this presentation is for introductory purposes only – if further information / specific education is required there are presentations and implementation guides for each of the areas of focus.*** |
| **Adjust the presentation to location setting:**   * + - 1. *Throughout presentation:*       * Where possible share individual stories and experiences       * use local data / results       1. *Local governance / set-up*       * Refer to your LHD/Facility approach including who is the Clinical Leads       * Insert local CERS protocol, where applicable include protocol for escalation beyond the facility  **Preparation** Ensure you have a good and practical understanding of the toolkit yourself. Learning and teaching are central to the implementation of the last days of life toolkit. It is recommended that before you attempt facilitating you develop a full understanding of the toolkit yourself and the benefits and challenges. Test using the tool/s with a patient in your clinical area who may have an uncertain recovery or is dying. Use and apply the toolkit implementation guides. Reflect on the following points to guide you lesson planning:  * How will the toolkit become part of everyday practice? * What are the benefits? For patients? For carers? For staff? * What systems need to be in place? * Who needs to be involved?   **Engagement**  The tools are only as good as the teams using them which require engagement with the entire multi-disciplinary team. Using the standard presentation and implementation guides as well as some patient stories:   * Meet with the Nursing Unit Manager, Nurse Educator and other team members on the clinical unit and introduce concepts of the toolkit * Ensure medical staff are happy for the tools such as medication guides to be used on their patients. * Introduce the toolkit to other members of the multi-disciplinary team including the social worker. * Identify where documentation will be stored and agree roles and responsibilities for monitoring and overview.   **Evaluation**  Make sure you formally evaluate the education session to enable continued improvement and measures of meeting staff needs in being able to implement and use the toolkit |

| **lide** | **Main Content** | **Core elements to be addressed** | **Resources** |
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| **Slide 1** | **Title Slide** | Introducing the Last Days of Life toolkit: how it works |  |
| **Slide 2** | **Introduction to toolkit** | * This workshop is directed at all clinicians who care for dying patients and outlines the essential elements of the tools for the recognition and management planning of the dying patient. During this session we will concentrate on the tools and how they can support you as well as touch on the role and responsibilities of the team * While clinical needs are similar, the approach to management of the dying patient varies across New South Wales (NSW) health facilities. * the toolkit was developed in collaboration with clinicians and consumer advisors * The toolkit provides tools and resources to ensure all dying patients are recognised early, receive optimal symptom control, have social, spiritual and cultural needs addressed, both patient and families/carers are involved in decision-making, and bereavement support occurs. * It has been specifically developed for use by generalist clinicians and is not intended to replace either local Specialist Palliative Care guidelines or advice given by Specialist Palliative Care clinicians. |  |
| **Slide 3** | **Dying in NSW** Background – why are we here? | * Half of all deaths occur in public hospitals and increasingly the way these patients are cared for is under review * there is lack of standardised approach in care of dying patients especially in their last days of life in NSW   ***If your facility / district has any tools / programs around caring for dying patients mention here especially how the toolkit will supplement / support work already in place***  ***contact LHD / facility Specialist Palliative Care Service for information*** |  |
| **Slide 4** | **Patient Story** | ***Use story from own experience / RCA / Complaint***  ***Use video provided / from CEC site*** |  |
| **Slide 5** | **NSW pilot results** | The pilot was undertaken between September and December 2016. Twenty hospitals from small rural facilities staffed by General Practitioner Visiting Medical Officers, to large urban specialist tertiary referral centres were involved – nine sites entered data during the pilot. Education and facilitator training was provided to each participating site  During the pilot 152 patients were managed using the various tools across nine sites:   * 103 (68%) used the Initiating Last Days of Life Plan * 126 (82%) used the COSA observation chart; * 83 (55%) used the medication guides; and * 11 (8%) used the Accelerated Transfer to Die at Home Plan   One of the main findings was that patients who were cared for using a standardized approach had a higher percent of their care being more structured i.e. symptoms and comfort assessed routinely and receiving medications within a best practice model. This also saw a decrease in the harm to patients (see figure)  ***Harm was described as* unresolved symptoms or distress, adverse events such as pressure injury, fall** |  |
| **Slide 6** | **NSW / National Standards and best practice** | As part of the toolkit development all relevant local, state and National policies and documents as well as international literature was reviewed to ensure the toolkit is developed in line with current policy and evidence based recommendations. |  |
| **Slide 7** | **What is the toolkit** | Divided into four sections   * Recognition and management planning   + Initiating last days of life management plan   + Comfort Observation and Symptom Assessment chart   + Care after death in hospital   + Bereavement * Medication Guides   + Anticipatory prescribing guide   + Flowcharts for 5 most commons symptoms * Accelerated Transfer to Die at Home   + Accelerated Transfer to Die at Home Plan   + Accelerated Transfer to Die at Home – Nursing Transfer Letter   + Accelerated Transfer to Die at Home – Paramedic Transfer Letter * Information for patients / families / carers |  |
| **Slide 8** | **Recognition and Management planning** | These tools have been developed to assist the multi-disciplinary team to recognise the dying patient and assist in the development of individualised management plans:   * Initiating last days of life management plan * Comfort Observation and Symptom Assessment chart * Care after death in hospital * Bereavement survey |  |
| **Slide 9 &10** | **Initiating last days of life management plan** | **Slide 9 – what is it used for**  Used to identify the dying patient and commence management planning, includes:   * Signs & symptoms of dying * Mandatory criteria around assessment, communication and documentation * Care planning   **Slide 10 – the form**  A two sided form that can be used as checklist / prompts for action in identifying the dying patient and putting an individualised management plan together  **Click:** Important to stress that while these tools provide a framework for care planning for dying patients it is the responsibility of the MDT to ensure that the plan of treatment developed is individualised to meet the dying person’s own needs and wishes  ***There should be a mechanism to review and monitor the local system through mortality and morbidity reviews, death reviews, RCAs/ and reliability audits.***  ***This information allows for targeted training on specific topics/emerging issues while also setting up the local governance to investigate strategies for building high reliability teams and encouraging a culture centred on safety for dying patients*** |  |
| **Slide 11 &12** | **Comfort Observation & Symptom Management chart** | **Slide 11**  Once patient recognised the Comfort Observation and Symptom Assessment (COSA) chart is commenced. The COSA chart has been intentionally designed in the same style of the SAGO chart i.e. a track and trigger tool that provides information on abnormal observations and prompts for escalation using the same established colours.   * page 1- instructions for use and comfort assessment planning checklist * page 4 is information around: * non pharmacological measures for symptom management which should be tried out by themselves or with medication support. * **YELLOW** and **BLUE** Zones **-** It is important that the local Clinical Emergency Response System (CERS) protocol is referred to for instructions on how to make a call to escalate care for your patient **however initial escalation should be to the Nurse in charge who would assess the patient as per the symptoms outlined on the COSA chart**. * If further escalation is appropriate it should be a COMFORT MEDICAL Clinical Review escalated by the nurse in charge   ***INSERT the local CERS System***  **Slide 12**   * page 2 – Symptom Management * Assess the patient at least 4th hourly. * Assessing the patient based on their verbal response, where able. * Entering ‘P’ for Patient, ‘C’ for Carer, and ‘S’ for Staff to identify source of assessment * Assessing each symptom and documenting whether Absent / Mild / Moderate / Severe * In case of discrepancy between assessments, (e.g. perception of carers and staff, or patient and carers) separately document relevant severity for each assessment with ‘P’ for Patient, ‘C’ for Carer, and ‘S’ for Staff * Escalating symptom management to senior nursing staff if assessment in the **BLUE** or **YELLOW** zone. * page 3 – Comfort Observation   + Assess the patient at least 4th hourly. * Complete an action for each assessment as required - If there are any concerns or symptoms, document what is being done to address these, and whether the measures taken were helpful   ***There should be a mechanism to review and monitor the local system through mortality and morbidity reviews, death reviews, RCAs/ and reliability audits.***  ***This information allows for targeted training on specific topics/emerging issues while also setting up the local governance to investigate strategies for building high reliability teams and encouraging a culture centred on safety for dying patients*** |  |
| **Slide 13, 14, 15 &16**  **X minutes** | **Medication Guides** | **Slide 13**  Developed to provide generalist (non-specialist palliative care) clinicians caring for patients dying in all in-patient hospital settings guidance on how to prescribe anticipatory subcutaneous medications for the symptoms that may be experienced by patients in the last days of life. It is designed to promote and systematise consistent, best practice, patient-centered use of medication in the last days of life.  **Slide 14**  When a patient is diagnosed as dying and being in the last days of life, it is expected that they will have as required (PRN) subcutaneous medication prescribed for anticipated symptoms***.*** Recommended **STARTING PRN** doses for the five symptoms commonly experienced by patients in the last days of life and the rationale for choosing the drug and dose for each symptom are provided. In addition, guidance is also provided for starting doses of regular medication via a 24 hour syringe driver or, as some in-patient facilities and wards are not able to access subcutaneous syringe drivers, by regular subcutaneous injection.  **Slide 15**  Flowcharts developed for the 5 most common symptoms  Pain flowchart includes a guide to switch to subcutaneous opioids  **Slide 16**  Example of flowchart / decision support for patients in pain – any issues Specialist Palliative Care services should be consulted  **Of note**: Throughout the pilot there were suggestions to add HYDROmorphone to the guides especially in relation to its use in patients with renal failure. Due to a number of fatal incidents occurring in NSW that related to HYDROmorphone a decision was made not to recommend its use and reiterate the need to seek specialist advice if required.  ***There should be a mechanism to review and monitor the local system through mortality and morbidity reviews, death reviews, RCAs/ and reliability audits.***  ***This information allows for targeted training on specific topics/emerging issues while also setting up the local governance to investigate strategies for building high reliability teams and encouraging a culture centred on safety for dying patients*** |  |
| **Slide 17, 18 & 19**  **X minutes** | **Accelerated Transfer to Die at Home** | **Slide 17**   * Key principles of end-of-life care remain the same in all settings. Having inadequate family support and / or community-based palliative care services is often, in practice, a limiting factor for patients who wish to die at home. * Planning the care for a patient dying in the non-acute care setting requires an assessment of the setting in which the person is being cared for, and of the capacity and needs of the caregivers. * Caregivers, including the family, need to understand the plan of care, and be able to contribute to decision-making and ongoing assessment of the patient. * Good teamwork, good documentation, and good communication are essential.   **Slide 16**   * page 1 – checklist that must be completed and have all criteria met for the patient to be considered suitable and the transfer safe   **Click:** It is important to highlight that both clinical staff and families/carers need to be realistic about the time frame to organise an accelerated transfer home for last days of life, particularly when care is complex  ***There should be a mechanism to review and monitor the local system through mortality and morbidity reviews, death reviews, RCAs/ and reliability audits.***  ***This information allows for targeted training on specific topics/emerging issues while also setting up the local governance to investigate strategies for building high reliability teams and encouraging a culture centred on safety for dying patients*** |  |
| **Slide 19** | **Information for patients/family/carers** | When a patient appears to be entering the dying phase, a meeting with the patient and/or family/carer should be set up as soon as possible. Ideally the conversation should be led by a senior doctor – Consultant or senior Registrar/Fellow – and senior nurse – Nursing Unit Manager, CNC or CNS.  The various information leaflets have been designed to provide information and support to the patient and their family/carers. Providing patients/family/carers with this information does **NOT** replace the clinical staff’s responsibility to commence and continue communicating with the patient and/or their family/carers to identify their goals and wishes and ensure that all care is aimed at what is the most important to them at this time. |  |
| **Slide 22** | **Documentation** | An emerging theme within RCAs/complaints is the lack of documentation around end of life management planning and discussion with the patient/ family/carer. It is important that the documentation for end of life/last days of life management include at least the following components:   * Involvement of the Attending Medical Officer – consultation over the phone, ward round * Diagnosis (Provisional and/or differential) * Clear management plans * Schedule for re-assessments and observation frequency * The patient  and/or family / carer understanding of the patient’s condition and the goals of care * The patient’s preference for place of death * Indicators of symptom/pain control, psychosocial and spiritual support (including family care) addressed |  |
| **Slide 20** | **Summary** | * The toolkit provides a variety of tools – use only those that are appropriate for your patient’s needs * It is what we are already/should be doing for our patients and their families i.e. best practice * Empowers and promotes confidence in nursing staff and junior doctors to be their patients’ advocates * Means the patient/family/carer is heard and has control * Enhances MDT working * Should give staff no extra work, if anything it should save staff time |  |