"No specialist and no out of hours service!" - Audit and experience of end of life care in a rural Australian hospital

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Introduction

Australians, especially Indigenous Australians living in rural areas are disadvantaged in accessing palliative care compared with those living in urban areas, with a lack of specialist input affecting the quality of palliative care provision in rural areas[1]. There is little evidence to inform palliative care policy and service developments in rural settings[2].

Kempsey District Hospital is a local community, rural hospital within the Mid North Coast Local Health District, in New South Wales, Australia. It serves a population of 30,000 people over an area covering nearly 4,000 square kilometres. The fastest growing age group in Kempsey are over 65's and this group is projected to increase, making 30% of the total population. Indigenous Australians make up 13% of the population in Kempsey compared with 3% of the total Australian population. Kempsey has an Index of Relative Socioeconomic Disadvantage (IRSD) score of 880, placing it in the most socioeconomically disadvantaged areas in the country.

Current palliative care provision consists of a specialist nurse led consultancy service, a monthly satellite clinic from Sydney, no designated inpatient beds and no afterhours telephone support service or weekend service. There is no specialist physician cover. Local GP's estimate that 40% of palliative care patients require end of life care in a hospital.

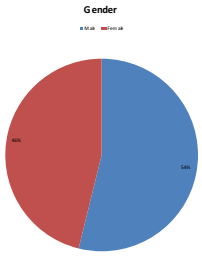
Our aims were to audit end of life care practice compared with state guidelines and assess staff opinions on hospital inpatient end of life care.

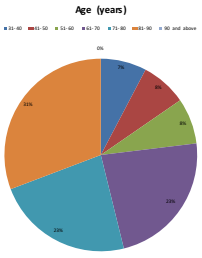
Methods

A retrospective case note review of all in hospital deaths between July and December 2014 identified via coding.

A 9 question survey was distributed to all staff involved in direct and clinical patient care and completed anonymously.

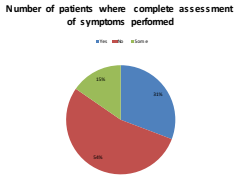
Results - Audit

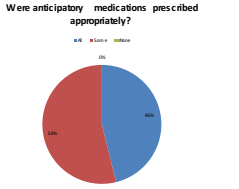


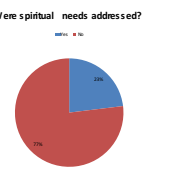


•8% of patients Indigenous Australian

•Diagnoses – 11 malignancies (85%), 1 sub arachnoid haemorrhage, 1 sepsis.



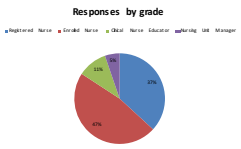




Results – Staff Survey

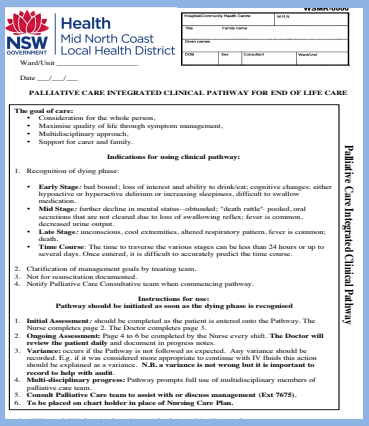
•Nearly 70% of Nurses reported a new end of life care pathway was required.

•85% requested more education and support in palliative care practice.



Conclusions

- This group of patients have a diverse range of conditions requiring end of life care.
- A redesigned end of life care pathway is being introduced to improve standards not currently being met. (See below)
- Our findings highlight the need for developing innovative educational programmes on end of life care for rural nurses, & video conferencing is being explored as a means of delivery.
- Lack of out of hours & specialist support are recognised barriers to rural palliative care.
- In response to the current lack of specialist service in Kempsey, locally designed and tailored educational programmes are being developed aimed at strengthening current hospital and community expertise.



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PALLIATIVE CARE INTEGRATED CLINICAL PATHWAY FOR END OF LIFE CARE

The goal of care:
- Consideration for the whole person.
- Maximise quality of life through symptom management.
- Multidisciplinary approach.
- Support for carer and family.

Indications for using clinical pathway:

1. Recognition of dying phase:
   - **Early Stage:** bed bound; loss of interest and ability to drink/eat; cognitive changes: either hypoactive or hyperactive delirium or increasing sleepiness, difficult to swallow medication.
   - **Mid Stage:** further decline in mental status--obtunded; "death rattle"- pooled, oral secretions that are not cleared due to loss of swallowing reflex; fever is common; decreased urine output.
   - **Late Stage:** unconscious, cool extremities, altered respiratory pattern, fever is common; death.
   - **Time Course:** The time to traverse the various stages can be less than 24 hours or up to several days. Once entered, it is difficult to accurately predict the time course.
2. Clarification of management goals by treating team.
3. Not for resuscitation documented.
4. Notify Palliative Care Consultative team when commencing pathway.

Instructions for use:

Pathway should be initiated as soon as the dying phase is recognised

1. **Initial Assessment***:* should be completed as the patient is entered onto the Pathway. The Nurse completes page 2. The Doctor completes page 3.
2. **Ongoing Assessment:** Page 4 to 6 be completed by the Nurse every shift. **The Doctor will review the patient daily** and document in progress notes.
3. **Variance:** occurs if the Pathway is not followed as expected. Any variance should be recorded. E.g. if it was considered more appropriate to continue with IV fluids this action should be explained as a variance. **N.B. a variance is not 'wrong but it is important to record to help with audit.**
4. **Multi-disciplinary progress:** Pathway prompts full use of multidisciplinary members of palliative care team.
5. **Consult Palliative Care team to assist with or discuss management (Ext 7675).**
6. **To be placed on chart holder in place of Nursing Care Plan.**

Palliative Care Integrated Clinical Pathway

References

1. Moorhouse C, George M, Smith B: Palliative care in rural Australia: involving the community in multidisciplinary coordinated care. *Aust J Prim Health 2000*, 6(4):141-146

2. Robinson CA, Pesut B, Bottorff JL, Mowry A, Broughton S, Fyles G: Rural palliative care: a comprehensive review. *J Palliat Med 2009*, 12(3):253-258.

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