Better Together

www.integratedcare.nnswlhd.health.nsw.gov.au

NNSW INTEGRATED CARE MADE POSSIBLE BY STRONG LOCAL PARTNERSHIPS:

NSW GOVERNMENT Health Northern NSW Local Health District

phn NORTH COAST

NSW Ambulance

United in Aboriginal Health NORTHERN NSW

End of Life Care

– Richmond Valley

Presented by Anna Law

End of Life Care Lead; NNSWLHD

& Dr Sue Velovski BSc BMed FRACS

Specialist Surgeon, Lismore Base Hospital; NNSWLHD

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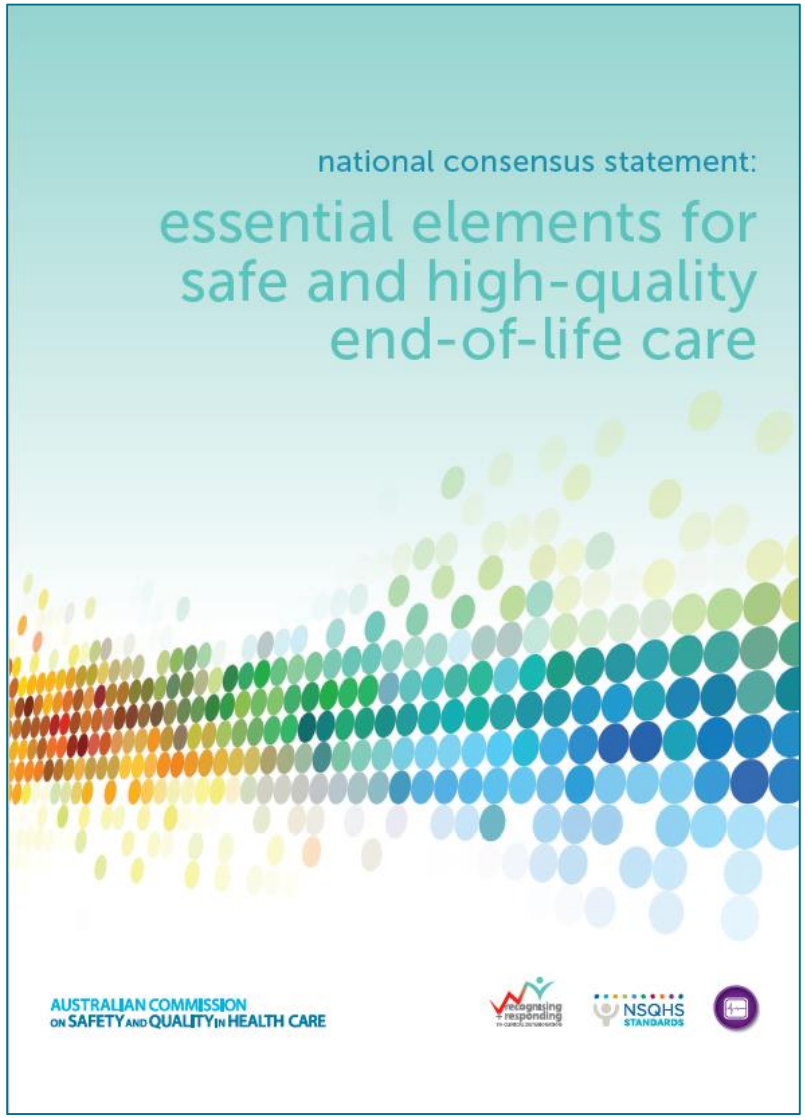
National Consensus Statement : Essential Elements for Safe and High Quality End of Life Care



Gold standards for End of Life Care:

- Dying is natural
- Empowering patients to direct own care
- Supports cultural, spiritual and psychological and physical needs.
- Honest and open
- Recognising people approaching end of life and providing timely care
- Patient and family centred
- Ethical
- Collaborative

Where we started:

- GROUNDSWELL from Senior Clinicians and strong Executive leadership
- End of Life Committee
- End of Life Multidisciplinary meeting
- Averting Futile Medical Care Evening “Enough is Enough“
- End of Life Care Lead (Richmond Valley) - collaborating

Health
Northern NSW
Local Health District

Decision Time — What Really Matters In The End MDT Meeting

Please join us for a multidisciplinary meeting to discuss what really matters in the end. Case presentations using real End of Life cases will be discussed.

Friday February 24
7:00am
UCRH Building

Topic of discussion:
"End of Life care in end stage respiratory disease"

Chairperson— Dr Austin Curtin

For Further Information:
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Anna.Law@ncahs.health.nsw.gov.au

End of life Multidisciplinary Meeting

What is it About?

- Meets bi-monthly 7am
- Discuss real case studies
- Well attended – 68 people at last MDT
- Most disciplines represented
- Issues arising taken to EOL Committee for action

LAST DAYS OF LIFE Toolkit (CEC):

- Provides a framework for Clinicians to aid in recognising the dying patient and management planning.
- Consists of “Initiating Last Days of Life Management Plan” and “Comfort and Symptom Assessment Chart”.
- Also includes a standardised approach to medications for the dying patient.

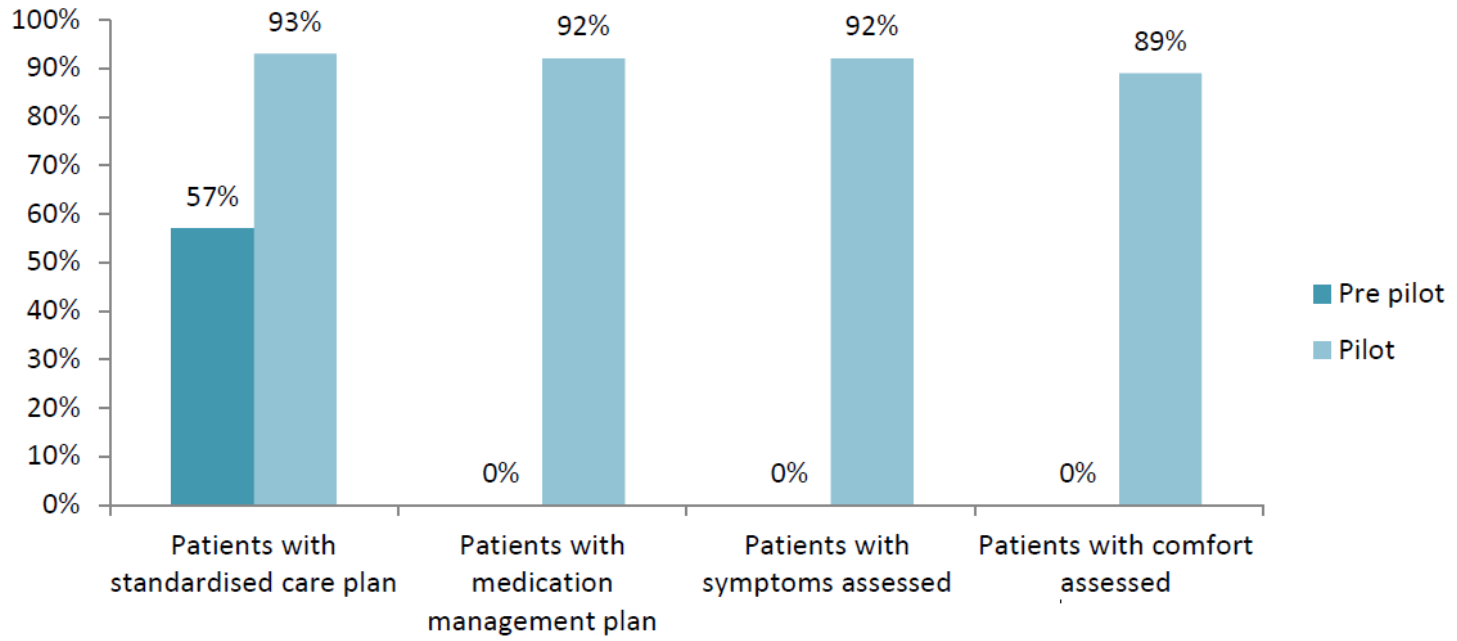
Last Days of Life

CLINICAL EXCELLENCE COMMISSION

Comfort Observations & Symptom Assessment Chart

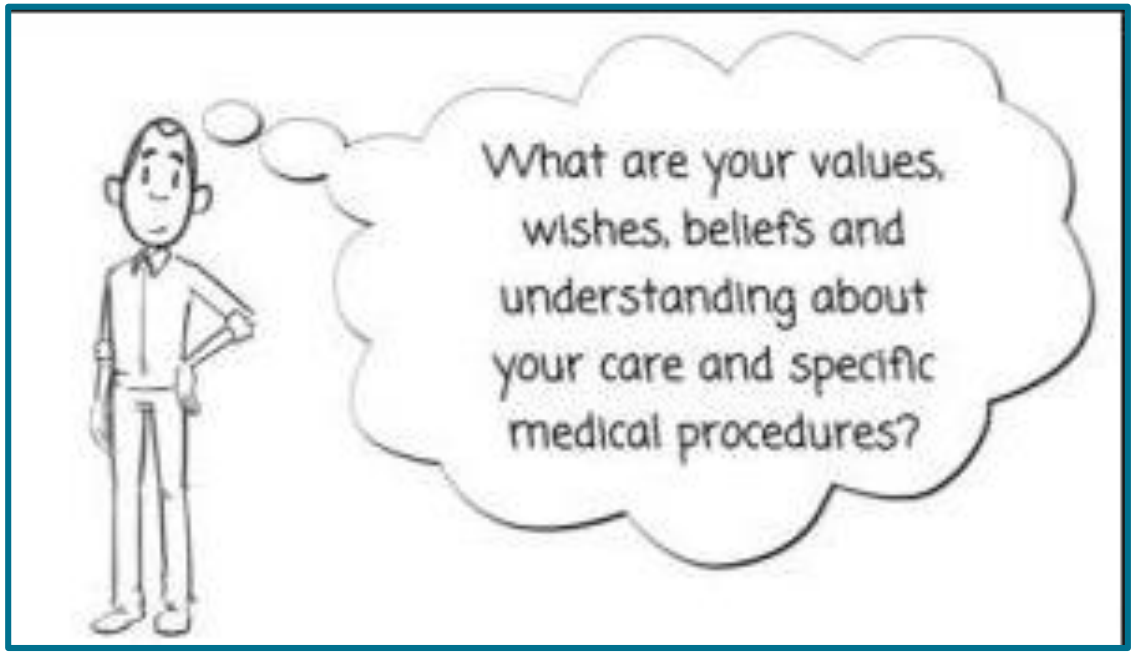
- Prior to the pilot 22% of patients audited had a standardised care plan in place in the 24-72 hours prior to dying.

- During the pilot 93% of patients were managed with a standardised care plan – this saw a high percent of patients' care being more structured i.e. symptoms and comfort assessed routinely and patients receiving medications within a best practice model.

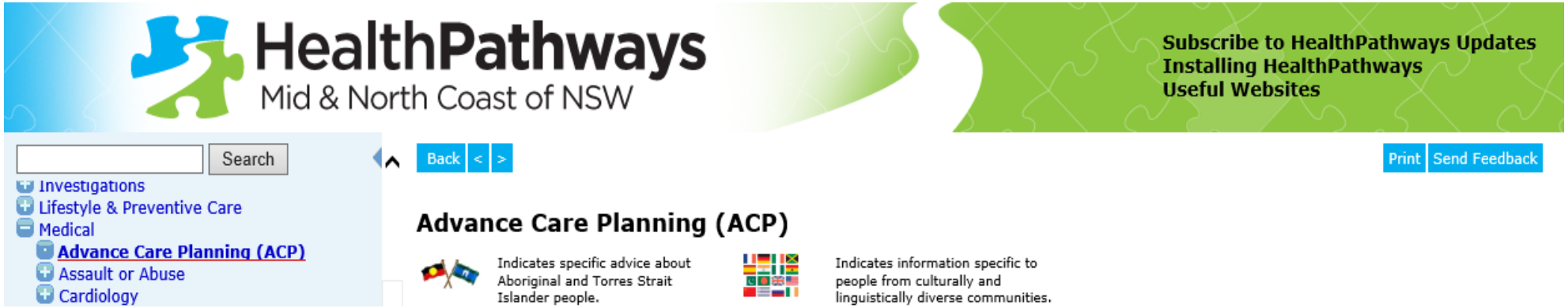


Advance Care Planning

Collaboration with North Coast Primary Health Network to improve Advance Care Directives use and transfer of information – working towards having ACD uploaded and visible on My Health Record.



ACP Resources



It's Now or Never – EOL Conversations – HNE Initiative

Education Days aimed at gaining confidence

- Find ways to deepen compassion and connection with the dying and their families
- Promote wisdom and authenticity through patient and family stories
- To flourish and thrive as a strong communicator and clinician

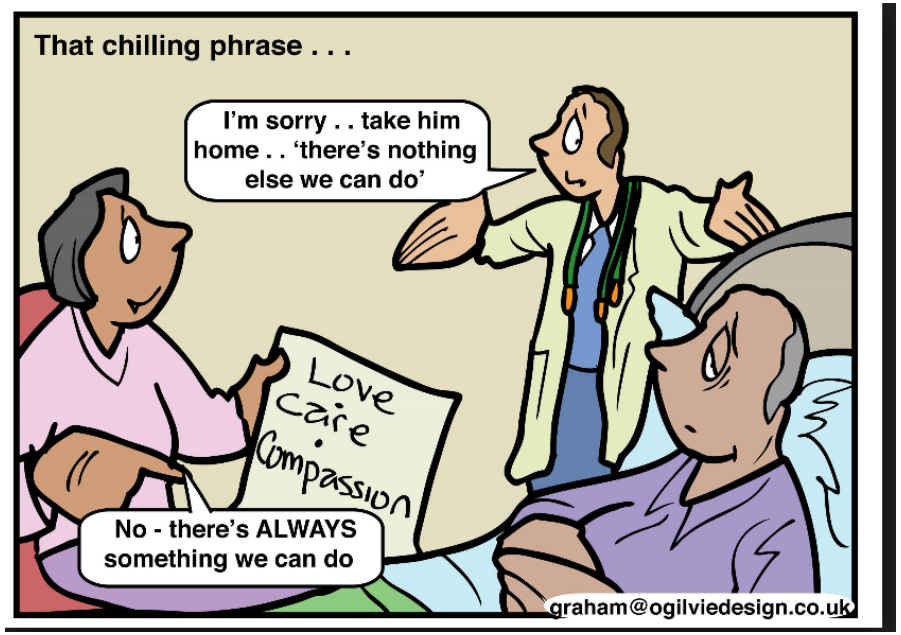
Community Education

Education around end of life planning

What Next?

- Continue with Last Days of Life toolkit implementation
- Train local people for teaching EOL education sessions
- Work towards improving transfer of information with Advance Care Directives
- Grow the community education sessions
- Starting in Lismore with a view to spread to Grafton. Sharing lessons with other parts of the Local Health District

Conclusion



"To offer our community empathetic and holistic medical care that respects the views of the people we care for, I think we may need to put aside an apparently faultless goal of 'saving lives and curing people', and perhaps instead consider our role as 'helping postpone death if we can do that without causing intolerable suffering'."

Dr Rachel Heap (EOL MDT Lismore, Feb 2017.)

Combined Anaesthesia /ICU/Surgery BiAnnual Seminar Series -

"When Enough is Enough" : Averting Futile Medical Care in 2016 Knowing your Medical & Legal Obligations

Guest Speaker :Mr Andrew Saxton, Partner Dibbs Barker

Ramada Hotel Ballina Thursday 13th October 2016 630 for 7pm

Northern Integrated Care Showcase – "Better together "

- *The benefits of being an innovator*
- *Setting the scene*
- *Transformation*
- *Partnerships*
- *System Wide Change*
- *Sustainability*
- *Measuring the difference (evaluation)*
- *Commitment to quality improvement*

Combined Anaesthesia /ICU/Surgery
BiAnnual Seminar Series

"Privilege & Integrity in Medical Practice- Good Ideals So Why Spoil Them?"

Guest Speaker DR JOHN GRAHAM FRACS

University Centre for Rural Health Friday 27th May at 7am

NOT TO BE MISSED! LIMITED SEATING AVAILABLE

RSVP to: surgicalednorthernrivers@gmail.com by 20th May 2016

Combined Anaesthesia /ICU/Surgery BiAnnual Seminar Series -

"When Enough is Enough" : Averting Futile Medical Care in 2016 Knowing your Medical & Legal Obligations

Guest Speaker :Mr Andrew Saxton, Partner Dibbs Barker

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Aims of Seminar

1.Look at some of the situations that give rise to futile and indeed harmful care ?

2. Discuss "Futile Treatment of patients in the the context of Evidence Based Treatment ?

(3)(Hope to) set a structure to minimize these situations ***in our community*** *by improving communications between patients , their health care providers and their families*

(4) To educate and understand the legal context of our medical decisions

["We all know what should be done" – Do we fear our decisions may be somehow perceived as inappropriate legally]

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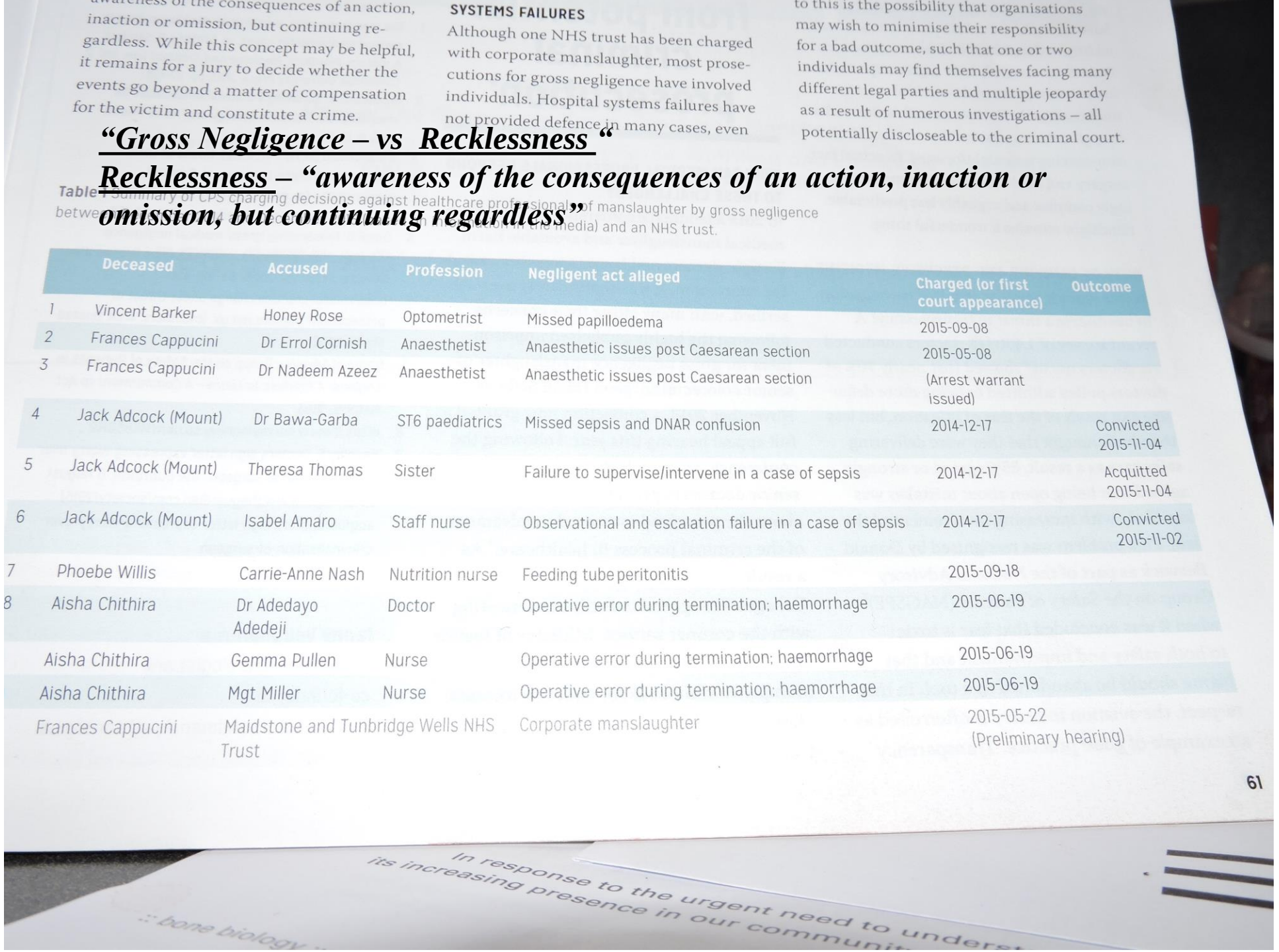


awareness of the consequences of an action, inaction or omission, but continuing regardless. While this concept may be helpful, it remains for a jury to decide whether the events go beyond a matter of compensation for the victim and constitute a crime.

SYSTEMS FAILURES

Although one NHS trust has been charged with corporate manslaughter, most prosecutions for gross negligence have involved individuals. Hospital systems failures have not provided defence in many cases, even

to this is the possibility that organisations may wish to minimise their responsibility for a bad outcome, such that one or two individuals may find themselves facing many different legal parties and multiple jeopardy as a result of numerous investigations – all potentially discloseable to the criminal court.

"Gross Negligence – vs Recklessness "

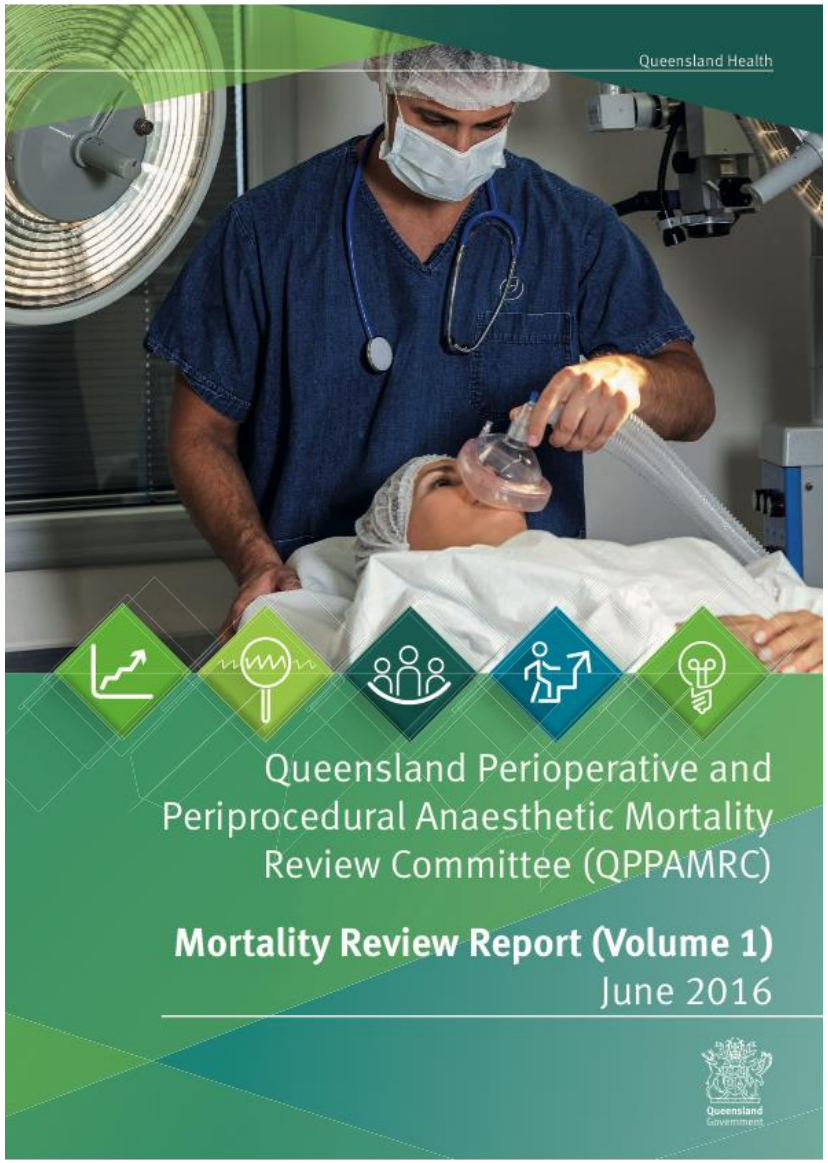
Recklessness – "awareness of the consequences of an action, inaction or omission, but continuing regardless"

Table 1 Summary of CPS charging decisions against healthcare professionals between [illegible] of manslaughter by gross negligence [illegible] media) and an NHS trust.

	Deceased	Accused	Profession	Negligent act alleged	Charged (or first court appearance)	Outcome
1	Vincent Barker	Honey Rose	Optometrist	Missed papilloedema	2015-09-08	
2	Frances Cappucini	Dr Errol Cornish	Anaesthetist	Anaesthetic issues post Caesarean section	2015-05-08	
3	Frances Cappucini	Dr Nadeem Azeez	Anaesthetist	Anaesthetic issues post Caesarean section	(Arrest warrant issued)	
4	Jack Adcock (Mount)	Dr Bawa-Garba	ST6 paediatrics	Missed sepsis and DNAR confusion	2014-12-17	Convicted 2015-11-04
5	Jack Adcock (Mount)	Theresa Thomas	Sister	Failure to supervise/intervene in a case of sepsis	2014-12-17	Acquitted 2015-11-04
6	Jack Adcock (Mount)	Isabel Amaro	Staff nurse	Observational and escalation failure in a case of sepsis	2014-12-17	Convicted 2015-11-02
7	Phoebe Willis	Carrie-Anne Nash	Nutrition nurse	Feeding tube peritonitis	2015-09-18	
8	Aisha Chithira	Dr Adedayo Adedeji	Doctor	Operative error during termination; haemorrhage	2015-06-19	
	Aisha Chithira	Gemma Pullen	Nurse	Operative error during termination; haemorrhage	2015-06-19	
	Aisha Chithira	Mgt Miller	Nurse	Operative error during termination; haemorrhage	2015-06-19	
	Frances Cappucini	Maidstone and Tunbridge Wells NHS Trust		Corporate manslaughter	2015-05-22 (Preliminary hearing)	

61

In response to the urgent need to unders
its increasing presence in our communi
:: bone biology



“Many patients were assessed as unlikely to survive before anaesthesia was undertaken. “

“As indicated in the report, 496 (sixty-two per cent) out of the798 reviewed cases were classified by the QPPAMRC as Category 5 (inevitable death, which would have occurred irrespective of anaesthesia or surgical procedures).”

The Panel

- *Intensivist /Anaesthetist*
- *JMO – Emergency Department*
- *Lawyer – Dibbs Barker -specialist in Health Care / HC litigation*
- *Medical Indemnity Risk Education Officer*
- *General Practitioner*
- *Senior Specialist General Surgeon*

Hypothetical –”First Do No Harm “

Patient "Betty " 85 years

Initially lived in QLD Advanced Care Directive QLD

Shifted to Northern Rivers 5yrs ago

Independent "Residential Lifestyle Care " : " Independent Resort Style Living for the over 55"

"Utopia Village " – Stewart Beach Resort

Shifted to"Utopia" when became less mobile (Youngest daughter lives in Ballina)

Regular GP visits- fortnightly at Utopia . Weekly visits from daughter in Ballina

12 months ago - became more "Fragile" – more falls , CCF , CRF , Parkinson's

Shifted from "Paradise Ward to " to H : EAVEN Ward

H:EAVEN – more regular GP visits, more (1:1) nursing care , Falls prevention , Medication Review ; General Physician Review

Noted by EEN to be confused/ "not usual self"

"Abdominal pain and fever" / Disoriented / "Foul smelling urine"

GP called – Febrile; Tachycardiac; Gurgly Chest ;? Peritonitis

GP Locum advises - ?to send to ED

COMMITMENT TO QUALITY IMPROVEMENT

(Understanding Patient / Information preferences – A Framework For Discussion)

Prognosis
Goals
Fears /Worries:What are your biggest fears / worries about the future of your health?
Function:What abilities are so critical to your health that you cannot imagine living without?
Trade Offs – If you become sicker ,how much are you willing to go through, to gain more time ?
Family : How much does your family know?

Thank You

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