

## END OF LIFE CARE PATHWAYS – WHAT DO WE THINK?

Since the 1980's clinical pathways have been developed in health care settings to guide high quality and consistent patient care which is underpinned by evidence based practice. There has been much work done in hospitals throughout the world to develop pathways to guide consistent, evidence based practice and it is now recognized that such pathways also contribute to efficient and effective work practices in the health setting (Ellershaw & Wilkinson, 2011).

Vanhaecht (2010) defines a care pathway as a “complex intervention for the mutual decision making and organisation of care processes for a well defined group of patients during a well defined period” (pg.2). Care pathways provide key elements of care based on evidence and best practice in relation to the management of patients' conditions or recovery. They can also facilitate collaboration and communication among team members by coordinating the roles and activities of the multidisciplinary team and identify appropriate resources. Studies have demonstrated that the use of End of Life Care Pathways result in a marked improvement in documentation - a key requirement for ongoing organisational accountability and governance (Hardy 2005; Tolson, McIntosh, Loftus, & Cormie. 2007; Department of Health 2011). Implementation requires high level organisational support and provides a useful quality assurance tool, often including the opportunity for internal and external benchmarking and auditing to enable the continuous review of practice. Care pathways promote patient centred care and facilitate support, communication and allow documentation of discussions with patients & families (Chan & Webster 2011; Ellershaw & Wilkinson, 2003; Phillips et al. 2011).

An integrative review conducted by Phillips, Halcomb and Davidson (2011) on EoLC pathways in the acute and hospital settings concluded that the use of EoLC pathways in improving care of the dying patients. The authors identified four qualitative studies that used semi structured interviews and focus groups to collect data. The outcomes of these studies revealed the perception of a positive outcome of the quality of care during the dying process. Most other studies were non experimental studies that reported on pre and post EoLC pathway audit data. The sample sizes were small which limited data analysis. There were three studies that focused on symptom control data and one study examined physician prescribing. Although quantitative data is not a preferred research method when looking at end of life care this article sited that there was an absence of randomized control data and therefore reiterated the need for ongoing research in this area.

While end of life care pathways have a range of benefits, it is important to appreciate that there remains challenges to effective implementation in acute and hospice settings (Phillips et al. 2011). These challenges include the timely recognition that the person is dying, poorly defined death indicators and criteria for going on the pathway (Dee & Endacott 2011). Implementing a palliative philosophy of care into a 'cure culture' and inconsistent links to palliative care pathways requires strong clinical leadership. This leadership requires the time and capacity required to successfully lead the change process and provide ongoing monitoring. Implementation also requires a financial commitment to establish designated pathway facilitators and to provide necessary learning opportunities required for clinicians to be confident about determining if the patient is dying and use of the pathway.

Some studies state that there is conjecture that end of life care pathways promote best possible patient outcomes, recent opinions have suggested possible adverse effects including the premature use of the pathway, leading to death due to premature diagnosis of imminent death, the care pathway masking the signs of improvement in patients and causing carer dissatisfaction (Chan & Webster 2011; Bloomer et al. 2011). However Chan & Webster concluded that the Liverpool Care Pathway (LCP) has the potential to improve symptom management, clinical documentation and assessment, knowledge of end of life care, prescription of medications for end of life and support for relatives. More importantly the UK Health Care Commission and the National Institute for Clinical Excellence has also found that the use of the LCP constitutes best practice in all care settings (Dee & Endacott 2011).

Clearly palliative care and end of life care is not the domain of only specialist staff or specialist services. End of life care is a vital focus in the last days and hours of the dying and their family/carers, and it is essential that health professionals in all settings are equipped to provide the highest possible standard of care at that time. The quality of care and the specific needs of each patient should not be dependent on the skill, understanding and expertise of the treating staff. End of life care pathways provide a supportive

tool for use in services that have limited access to palliative care specialists, and for services seeking to provide a standardised tool to aid decision making by less experienced practitioners (Hardy 2005; Chan & Webster 2010; Ellershaw et al. 2001; Ellershaw 2007; Veerbeek et al. 2006; Department of Health 2011). In this respect end of life care pathways, with the guidance they provide on what should be done to support the dying patient and when, offer a positive step towards better management of patients at end of life (Le and Watt 2010; Department of Health, 2011). The National Palliative Care Strategy (2010) recommend that action be taken to support the national roll out of an integrated care pathway across primary, acute and aged care sectors, including incorporating specific references to palliative care and the end of life phases in all relevant national and state plans, frameworks and clinical guideline documents. Therefore the introduction of an end of life care pathway is a practical approach to addressing gaps in care that could potentially be improved and is recognised as the gold standard in end of life care.

*Jade Odgers*

*Manager, Grampians Regional Palliative Care Team*

Thanks to the GRPCT LCP Project Report

---

## PALLIATIVE CARE PARTNERSHIP WITH NEPAL

Each year AAA (Aussie Action Abroad: a Not For Profit Community Development Provider) is committed to providing teams of people from Australia to partner with Nepali NGO's to work with local communities who identify areas in which they would like assistance, support & resources. The teams consist of people with varying skills that are matched with projects specific to those skill areas e.g. construction, education, health, community development etc.

In 2011 a formal partnership was established between the GRPCT & NAPCare (Nepalese Association for Palliative Care). This came about following several trips to Nepal with AAA to discover more of what was happening with the provision of palliative care in Nepal.

A Palliative Care Team from Ballarat went to Pokhara (200km west of Kathmandu) in 2011 to facilitate a workshop for nurses.

The GRPCT in partnership with AAA has an on-going commitment to continue to support such projects at the request of our Nepali partners and welcomes anyone interested in joining a medical/nursing team to go to Nepal in Dec/Jan. Further information is available on the AAA website <http://www.aussieactionabroad.com> or by contacting Lyn Edwards (Palliative Care nurse formerly from Ballarat Hospice Care, currently at Peninsula Home Hospice) on 0407 302 371.

---

## CONTACTS

### **Grampians Regional Palliative Care Team**

Ph 5320 3553	Fax 5320 6493
Dr David Brumley	davidb@bhs.org.au
Dr Greg Mewett	gregm@bhs.org.au
Jade Odgers	jadeo@bhs.org.au
Regina Kendall	reginak@bhs.org.au
Lawrence Habegger	lawrenceh@bhs.org.au
Bernadette Matthews	bernadette@bhs.org.au

### **Ballarat Hospice Care Inc**

Ph 5333 1118	Fax 5333 1119
Carita Potts	eo@ballarathospice.com

### **Central Grampians Palliative Care**

Ph 5352 9328	Fax 5352 9425
Jane Bourman	jane.bourman@eghs.net.au

### **Djerriwarrh Palliative Care**

Ph 5367 2000	Fax 5367 9641
Pam Ryan	pamr@djhs.org.au
Jane Cape	janec@djhs.org.au

### **Gandarra Palliative Care Unit**

Ph 5320 3895	Fax 5320 3763
Dr David Brumley	davidb@bhs.org.au
Dr Greg Mewett	gregm@bhs.org.au
Maree Kewish	mareek@bhs.org.au

### **Wimmera Hospice Care**

Ph 5381 9363	Fax 5381 9170
Melanie Hahne	mhahne@whcg.org.au
Jennifer Noonan	jnoonan@whcg.org.au
	hospice@whcg.org.au

### **Grampians Region Palliative Care Consortium**

Peter Marshall	gpalcareconsort@gmail.com
Teresa Arnold	gpalcareproject@gmail.com

JULY/AUG 2013



[www.grpct.com.au](http://www.grpct.com.au)

