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Ethics in Aged Care
Two Areas for consideration

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Today's presentation

1. The use of Advance Care Plans

2. Raise the Bar

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1. The Use of Advance Care Plans

One of the ways that VMCH has been able to assist residents in decision-making regarding end of life care, is to use Advance Care Plans (ACP).

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The Use of Advance Care Plans

The VMCH approach respects advanced care planning as non-coercive.

Some VMCH residents choose not to have an ACP, and this right is not clearly articulated in the RPC model, but is in the CHA model.

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The Use of Advance Care Plans

When you were a child, what did you want to be when you grew up?

Did you stick to your plan? What happened?

Ongoing conversations

‘the person I am today is not the person I will be tomorrow’.

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The ‘Ongoing Conversations’

Pre-admission: family members are encouraged to have a discussion with their relative and the relative’s medical practitioner as early as possible.

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The ‘Ongoing Conversations’

Admission: when the relevant VMCH staff member goes through the ACP with the resident to ensure there is clarity.

If the resident does not have an ACP, then sufficient information about advanced care planning is provided to the resident and family so they can chose whether to engage in the ACP process. If yes, then VMCH staff will facilitate this.

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The ‘Ongoing Conversations’

When a significant event changes the resident’s condition (such as a deterioration in their condition), which may necessitate a conversation about their wishes in light of this new event.

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The ‘Ongoing Conversations’

End of Life pathway: when the resident moves into active dying and palliation.

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2. Raise the Bar

Mission in action!

The Raise the Bar project embodies all of our values:

- Compassion
- Dignity
- Integrity
- Collaboration

Hospitals 'Patients in the firing line'

Two days on trolleys: wait times blasted

Julia Medew
Health Editor

Some Australian hospitals are so full that patients are waiting longer than two days on trolleys to be admitted for further treatment such as surgery, a study conducted last month has revealed.

An audit of 114 public hospital emergency departments at 10am on Monday, August 31 found that seven out of 10 patients had been waiting longer than eight hours to be transferred into the main hospital, even though emergency staff had completed their job of stabilising the patients and determining what they needed next.

The queues were so bad that 78 patients in 29 hospitals had been waiting longer than 24 hours to get into a hospital ward for further care. Six patients had been waiting for more than two days.

Emergency doctors said the phenomenon, known as "access block" was causing dangerous chaos for doctors, nurses and patients, as well as paramedics who get "ramped" waiting to hand over new patients to emergency department staff.

Drew Richardson, an associate professor of medicine at Australian National University who conducted the survey, said the findings reflected a "hospital system that is critically overburdened and that is putting patients into the firing line".

He said over half of the hospitals had at least one patient who had been waiting for a bed for more than 12 hours – the point at which British authorities require a report to be made to the health minister.

"A statistic like that should be sending an alarm bell to healthcare authorities across the country. It's completely unacceptable."

President of the Australasian College for Emergency Medicine Dr Anthony Cross said it was well established that "access block" contributed to worse outcomes for patients and higher death rates because people waited longer for treatments they need in a busier environment.

He said patients could also "fall through the cracks" when emergency department staff felt as though they had been dealt with and doctors on the wards had not yet fully taken over their care because the patients were not physically in their view.

Research conducted at Canberra Hospital this year found older patients who waited more than four hours to be transferred to a bed in the hospital were 51 per cent more likely to die than patients who waited less than four hours.

Melbourne emergency physician Dr Simon Judkins said access block was extremely stressful for staff who have to juggle large numbers of patients, including some being treated in chairs and corridors.

"It leads to staff doing things quicker and with less time to think," he said. "It's a significant contributor to stress and burn out in emergency medicine."

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Compassion

Compassion, because too many times our care staff stand by and watch as a fearful and bewildered resident is taken to hospital to lie in the emergency department, often for numerous hours and alone.

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Dignity

Dignity, because we acknowledge that this is their home and they want to stay where they are loved and all is familiar. We know their names, their families, their life stories, what they like and do not like. They feel secure and known.

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Our **residents** do not live in our workplace…
we work in their **home**!

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Integrity

Integrity, because this initiative acknowledges and empowers care staff to utilise all the skills and potential in their power to say that they KNOW the residents and are able to care for them at most times.

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Collaboration

And most of all, **collaboration**, because this initiative could not possibly be successful if it was owned by only one person.

Raise the Bar required the commitment and collaboration of every member of staff: the food attendants, the personal care staff, the gardener, the maintenance man, the lifestyle team, the laundry team, the pastoral care team, the enrolled and registered nurses and the residential care leadership team.