AMBER Care Bundle, Hornsby Ku-ring-gai Hospital

A local initiative of the Northern Sydney Local Health District

May 2023

END OF LIFE AND PALLIATIVE CARE NETWORK

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
- clinically led
- evidence-based
- value-driven.

aci.health.nsw.gov.au

Disclaimer: Content within this publication was accurate at the time of publication.

Contents

Hornsby Ku-ring-gai Hospital Palliative Care Service

Introduction

The Hornsby Ku-ring-gai Hospital (HKH) Palliative Care Service is a specialist inpatient consult team that directly supports people admitted to the hospital and provides advice to treating/admitting teams. The team consists of:

- a palliative care staff specialist (0.7FTE)

- a palliative care occupational therapist (1.0FTE)

- a palliative care advance trainee (1.0FTE)

- a clinical nurse consultant (1.0FTE).

The team also includes a transitional nurse practitioner (0.8FTE) who provides supportive and palliative care in-reach to residential aged care facilities (RACFs) and a transitional nurse practitioner (0.8FTE) who provides cardiac supportive care in the local area. Referrals are received electronically via the end of life electronic medical record (eMR). In 2020, the team received 345 patient referrals for symptom management, end of life care and referral to community teams on discharge.

Overview of the HKH palliative care team

The palliative care team collaborates with admitting or treating teams to provide:

- pharmacological and non-pharmacological management of distressing physical and psychological symptoms
- assistance and support with end of life care discussions and care planning (including transfer to a palliative care unit)
- the facilitation of referrals to the Northern Sydney Local Health District (NSLHD) community palliative care teams for patients being discharged home and requiring further support and case management.

Using the AMBER Care Bundle

The HKH palliative care team supports the use of the AMBER Care Bundle in HKH, providing a systematic way for the multidisciplinary team (MDT) to identify when a patient is deteriorating and their recovery is uncertain. AMBER refers to **A**ssessment, **M**anagement, **B**est Practice and **E**ngagement of patients and carers for patients whose **R**ecovery is uncertain. The AMBER Care Bundle takes a four-stage approach to patient care, outlined below.

1. Identification is criteria-based, where the patient is:

a. deteriorating, clinically unstable and with limited reversibility
b. at risk of dying during this episode of care, despite treatment.

If the multidisciplinary team agrees the answer is 'Yes' to both of these points, then they proceed to support using the AMBER Care Bundle.

Consideration of the seriousness of the patient's condition and a review of the patient's medical notes (including recent physical examinations) are included in the identification process.


Patients whose recovery is uncertain
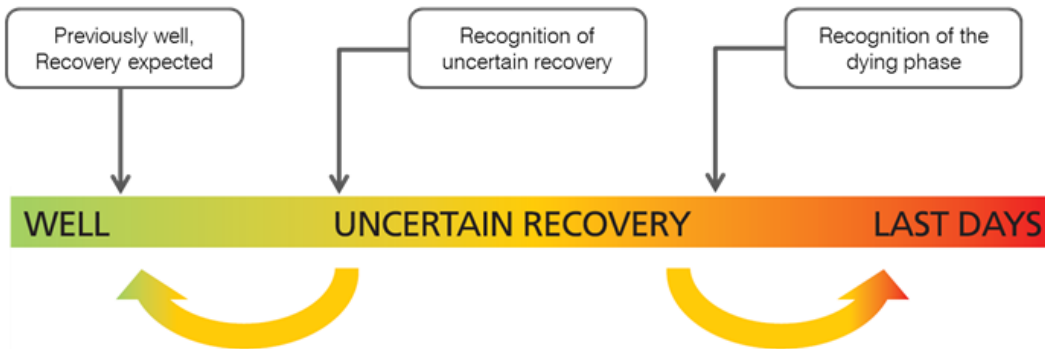
© Guy's and St Thomas' NHS Foundation Trust, UK. 2013

Source: AMBER Care Bundle, Clinical Excellence Commission

2. Intervention includes four key interventions for patients whose potential for recovery is uncertain, with a clear timeline for response. This involves:

- talking to patients and families about concerns with their condition, and discuss preferences and wishes
- confirming the current management plan
- identifying how the patient will be cared for should their condition get worse
- agreeing on a plan with the multidisciplinary team as well as the patient and family.

The timelines help to empower staff who have a concern about a patient and provide a sense of urgency to put the plan in place. The intervention is recorded in the eMR under the advance care planning tab. This has shown to improve recording of a patient's AMBER care status and enable improved reporting and auditing capabilities. Screen shots of the AMBER module in the eMR are shown below.
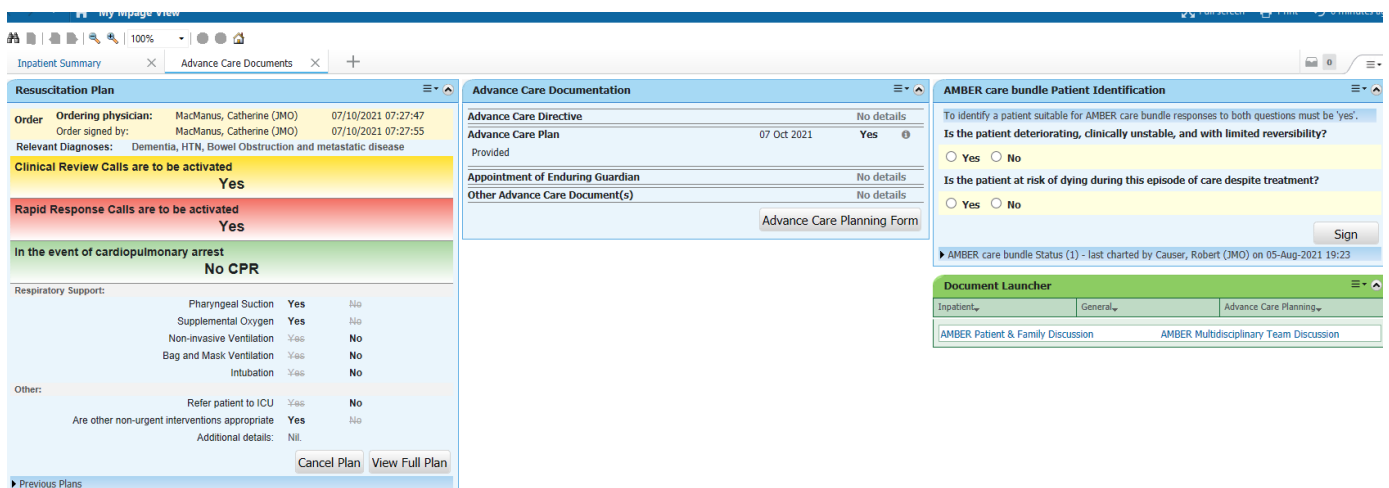
3. Daily ACT is a simple approach to follow up AMBER patients on a daily basis to ensure that communication takes place between the MDT and the patient and their carer.

While a patient's potential for recovery remains uncertain, both the patient and their carers (as appropriate) should expect to receive daily contact from medical and/or nursing staff.

4. Cessation acknowledges that once a patient is identified as suitable for the AMBER Care Bundle, they will continue to be suitable until they either recover, a Last Days of Life plan is started or they die. The bundle may also be stopped if the patient is discharged from the hospital to another location. If this happens, staff should:

- record the reason the AMBER Care Bundle has stopped in the patient's notes and discontinue it on the eMR
- ensure that key information is communicated to all colleagues in the community who are caring for the patient, including the patient's general practitioner (GP).

The AMBER Care Bundle encourages clinicians, patients and families to continue with treatment if it is clinically appropriate, while talking openly about end of life preferences and plans for care. The bundle supports treating teams to have timely discussions with patients who have an uncertain recovery or are approaching the last days of their life, as well as their family and carers. The AMBER Care Bundle advocates for conversations to take place at the patient and carers' pace and for it to be clearly documented if the person does not want to have conversations or understand their condition.

Benefits of the AMBER care model

The AMBER Care Bundle has become a component of daily 'board rounds' (or MDT meetings) and it enables teams to stop and consider current care outcomes for patients. It also provides junior medical officers with support to make goals of care decisions and facilitate conversations with patients and families.

Since the introduction of the AMBER Care Bundle in HKH, between 14 July 2020 and April 2021, there were 165 patients identified as AMBER. Of these: 49 died in HKH; 16 were transferred to the

Neringah Hospital Palliative Care Unit where they subsequently died; and 3 died at home. The remaining 116 patients were discharged to their usual place of residence or placed in a RACF, with only 32 patients experiencing an inpatient readmission.

The NSLHD Intranet hosts a suite of resources from the 'Compassionate Hospitals Program', which is an initiative of NSLHD and the Clinical Excellence Commission. This has resulted in improvements in overall end of life care for patients referred to the HKH Palliative Care Service, as well as patients who were not referred. The Compassionate Hospitals Program uses evidence-based practice for the assessment of distressing symptoms in dying patients. A screen shot of these resources is provided below.

Patient, carer and family experience

The AMBER Care Bundle provides a systematic approach for identifying those patients whose recovery is uncertain during their hospital admission. This enables care planning conversations to be initiated with patients and families earlier and allows them to have a better understanding of their condition. It also promotes ongoing conversations and advance care planning with a patient's community care providers if the person recovers to the point where they can be discharged.

Staff experience

The AMBER Care Bundle allows all MDT members to have a voice and a role in care planning for patients. At HKH, medical teams rotate through inpatient services every 12 weeks; nursing and allied health staff are based permanently on the various wards. As HKH serves an elderly population, nurses and allied health staff often see the same patient over multiple admissions and are well placed to identify any ongoing functional decline or changes in the care needs of these patients. Medical staff find their input with the AMBER care bundle supportive and helpful, and feel it is a useful tool in identifying patients whose recovery may be uncertain.

"The AMBER Care Bundle is empowering for all staff. It helps with decision making and plans." Neurology CNC

Implementation tips from HKH staff

Staff education is key when implementing the AMBER Care Bundle locally. At HKH, all medical, nursing and allied health staff are educated in the use of the bundle. Training is provided by the palliative care CNC and staff specialist to rotating junior medical officers and other clinical staff.

HKH has found that the most challenging aspect of the AMBER Care Bundle is that it is often confused with palliative or end of life care. The bundle is a screening and identification tool for deterioration that supports planning and decision-making. To promote use of the bundle, identifying a local clinical sponsor who is not associated with a specialist palliative care team is useful to distinguish it from palliative and end of life care.

The implementation of the AMBER Care Bundle into the eMR has supported uptake of the tools (Identification, Intervention, Daily ACT, Cessation, mentioned above) and promoting the features of these with clinical teams has increased their use. Some tools that have been well received include the templates for holding family discussions and multidisciplinary team meetings. These tools ensure that conversations and goals of care decisions are recorded and accessed across all clinical teams. Advanced trainees can complete quality improvement projects as part of their training. One planned project at HKH is to look at the quality of the screening conversation and the documentation of a patient's agreed plan.

Supporting documents

Clinical Excellence Commission: AMBER Care Bundle tools and resources

- Quality Improvement Toolkits
- A Guide to Implementation
- Introducing the AMBER Care Bundle: How it works
- AMBER Care Bundle: Guide for Facilitating Program Introduction
- Pre-Implementation Checklist
- Information for Patients, Families and Carers

- Conducting an Initial Team Meeting
- Guide for Multidisciplinary Teams
- Data collection and reporting
- Guide to Developing a Measurement Reporting and Evaluation Plan
- AMBER Monthly data collection

Appendix

Alignment of the AMBER Care Bundle initiative with the Clinical Principles for End of Life and Palliative Care Guideline

Key action area		Evidence of alignment
1. Screening and identification	✓	Use of the AMBER Care Bundle across Hornsby Ku-ring-gai Hospital
2. Triage		
3. Comprehensive assessment	✓	The AMBER Care Bundle prompts team to conduct a clinical assessment to determine if the patient's condition is serious enough - that even with active treatment, there is uncertainty that they will recovery
4. Care planning	✓	The AMBER Care Bundle prompts goals of care and advance care planning discussions with the patient, family and carers
5. Open and respectful communication	✓	The AMBER Care Bundle supports hospital staff to have conversations about possible clinical outcomes with patients, families and carers (including death and dying) It also gives patients, families and carers the opportunity to be involved in decision-making about their care and preferences for treatment, place of care and to prepare for possible death
6. Symptom management		
7. 24/7 Access to support		
8. Place of death	✓	The AMBER Care Bundle prompts care planning discussions to determine the patient's preferred place of care and death
9. Grief and bereavement support		

Acknowledgements

Alison Hession, Palliative Care CNC, Hornsby Ku-Ring-Gai Hospital

Bernadette King and the Clinical Excellence Commission (CEC)