# Tips for Nurses: End-of-Life Care Pathways

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**What it is:** A care pathway is a tool which outlines what is recognised as best practice for a certain disease or condition with an expected course. A care pathway guides and monitors a person's journey of best practice care between health professionals and across sectors. End-of-life care pathways can help prompt terminal care and encourage discussion with the person and their family.

**Why it matters:** Care pathways aim to:

- prompt and guide clinical decisions
- improve the timeliness of the start of care
- improve the consistency of care between different professionals
- reduce the risk of errors
- prevent unnecessary emergency treatments
- streamline care and therefore may reduce costs
- give confidence that the right care is being provided.

For long-term or chronic conditions, care pathways can guide healthcare professionals on when and/or how to:

- start treatment
- follow-up
- monitor change
- check for and monitor complications
- refer to other health professionals.

**What I need to know:** Care pathways differ from care plans. Care plans are based on the needs and preferences of an individual, and on the services available. Advance Care Directives should be included in planning.

Understanding the most common plans and pathways, and factors that influence these transitions can help medical practitioners and others to inform and advise older Australians who are:

- about to start using aged care services
- already using the aged care services.

## Actions

**Care pathways** are based on available guidelines and evidence. They support clinical judgement but do not replace it.

**When** implementing a care pathway remember to discuss it with the person and their family, and ensure that GPs and relevant staff are aware of this change. Discuss any concerns.

**A care pathway** represents the ideal way to manage people with a specific problem or long-term condition.

A care plan is based on the individual, and on the services available.

**Care pathways** use documents, sometimes flowcharts, to outline the steps of care to be followed by members of multidisciplinary teams.

**Good** communication within the care team and between the team and the person and their family is essential so that the person and the family understand the benefit of the care pathway.

## Tools

Tools that may be useful include:

**The Residential Aged Care End of Life Care Pathway (RAC EoLCP)** – this tool guides the provision of good quality terminal care in residential aged care. It includes guidance on comprehensive planning, delivery, evaluation and documentation of terminal care.

**Name:**

## My reflections:

How do care pathways and care plans differ?

When was the last time I used a care pathway for an older person, and how did this improve care?

## My notes:

See related palliAGED Practice Tip Sheets:

Advance Care Planning

Case Conferences

Continuity of Care

References used to develop this sheet are available at
**www.palliaged.com.au**

CareSearch is funded by the Australian Government Department of Health. Printed March 2019

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