**AMBER CARE BUNDLE**

A program\* of the Clinical Excellence Commission

**INSERT FACILITY NAME**

**LOCAL HEALTH DISTRICT**

**IMPLEMENTATION PLAN**

\* localised by the CEC from the AMBER care bundle

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**PROGRAM BACKGROUND**

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| **Program Title:** | AMBER Care bundle |
| **Program Aim:** | To improve the recognition and timely development of management plans which may include end of life issues for patients who are being actively treated but whose recovery is uncertain in xxxx hospital |
| **Program Background:** | In 2011/12, 34,446 patients died in NSW Acute Care Facilities. On average, these patients experienced four admissions or more that were greater than ten days per admission, in the 12 months prior to death. It has been identified that the greatest challenges for staff providing end of life care relate to staff discomfort initiating conversations with patients and carers; incomplete documentation; failure to recognise when patients are starting to die and then developing and documenting appropriate treatment plans; and poor communication between staff and patients and carers.Documentation rarely demonstrates that patients and carers have been consulted about their preferred place of care.Early identification of people who may have end of life care needs is the foundation for providing safe, high quality end-of-life care. It enables appropriate planning, transfer, interventions and communication with the person and their family. |
| **Program Benefits:** | The AMBER care bundle:* Provides a tool to help clinicians identify people for whom recovery is uncertain and who may have end of life care needs
* Simplifies key interventions to support best practice
* Supports staff to start conversations about possible outcomes, including dying and death
* Gives patients and carers and others close to them time the opportunity to be involved in decision making about their care and preferences for treatment, place of care and dying and to prepare for possible death.
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| **Program Objectives:**Use SMART objectives:* *Specific*
* *Measurable*
* *Achievable*
* *Relevant*
* *Timely*
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**SCOPE OF THE PROGRAM**

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| Name of facility and local health district |
| **This program will include:** | **This program will not include:** |
| *Which clinical wards or units will be included, or will it be a whole of facility approach?* | *What is out of scope?* |
| **Program Deliverables:** | *What will you deliver at the end of the implementation process?* *NOTE: these are the products you will have at the end of the process, e.g. an education program, end of life care tools adapted for local environments, improved awareness levels etc.* |
| **Program Milestones:** | *Key activities and dates (month/year) they will be completed* |
| **Evaluation:** | *How will you measure the success of the policy implementation?* *NOTE: evaluation criteria must be specific and measurable e.g.** *% clinical staff who attend an education session on the AMBER Care bundle*
* *# of patients identified who would benefit from the AMBER Care Bundle*
* *% of conversations that have taken place within 12 hours of activating the AMBER Care bundle*
 |
| **Resources:** | *What are the resources required to undertake the program?**Consider: people, space to meet and access to a computer and internet, etc.* |
| **Linkages:** | *Are there opportunities for this program to gain leverage or support from other groups? For example: national accreditation standards, clinical handover, risk management programs.* |

**RISK ASSESSMENT**

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| **Program Risks** | **Risk Rating** | **Mitigation Strategy** | **Residual Risk Rating** |
| *What are the risks to successful completion of the program?*  | *(high, medium, low)* | *List strategies to remove or minimise the risks* | *(high, medium, low)* |
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**COMMUNICATION PLAN**

*Who do you need to engage to make this program successful?*

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| **Stakeholder** | **Position** | **What are their information needs?** | **How and when are you going to let them know?** |
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**PROGRAM TEAM ROLES**

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| --- | --- |
| **Executive Sponsor:** | *Name and designation of Executive Sponsor**Role of the Executive Sponsor i.e. what do they do?* |
| **Program Leader:** | *Name and designation**Email**Phone number* *Role of the Program Leader* |
| **Clinical Leader(s):** | *Name and designations**Role of the Clinical Leader*  |
| **Program Team Members:** | *Name and designations* *Role of the Program Team Members*  |
| **Start Date:** |  | **Completion Date:** |  |

**ENDORSEMENT**

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| --- | --- | --- |
| **Facility Executive Sponsor** | *Name:* | *Signature and Date:*  |
| **Facility Lead** | *Name:* | *Signature and Date:*  |
| **LHD Lead** | *Name:*  | *Signature and Date:*  |
| **LHD Director Clinical Governance** | *Name:* | *Signature and Date:*  |

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