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Where do I fit in? A multi-setting approach to implementing Advance Care Planning

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NWM PHN acknowledges the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

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Context

Advance care planning: have the conversation

A strategy for Victorian Health Services 2014-2018

Consortium funded by DHHS in February 2015 to embed advance care planning (ACP) into routine care, within the primary care setting

Aim: ***to encourage conversations before people reach an acute stage of illness***

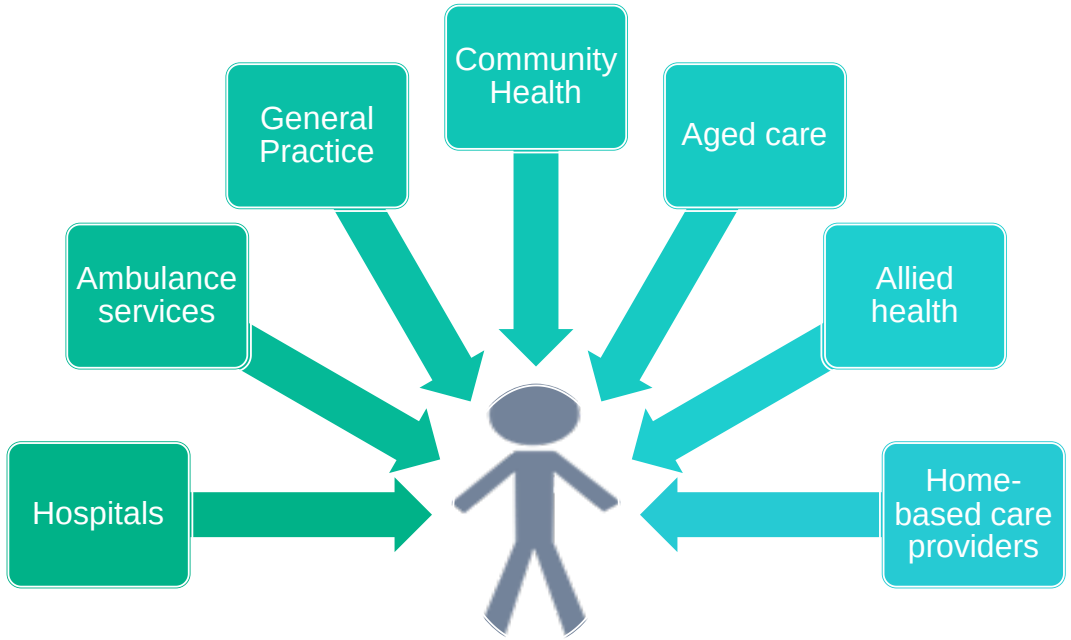
Who was involved?

5 General Practices

4 Residential Aged Care Facilities

2 Medical Deputising (Locum) Services

Where did we start?



Multiple service providers = great opportunity to introduce ACP

- systems lacking to support discussion, development or sharing ACP information with others

No ‘ACP Facilitators’ = need to build ACP into ‘usual practice’

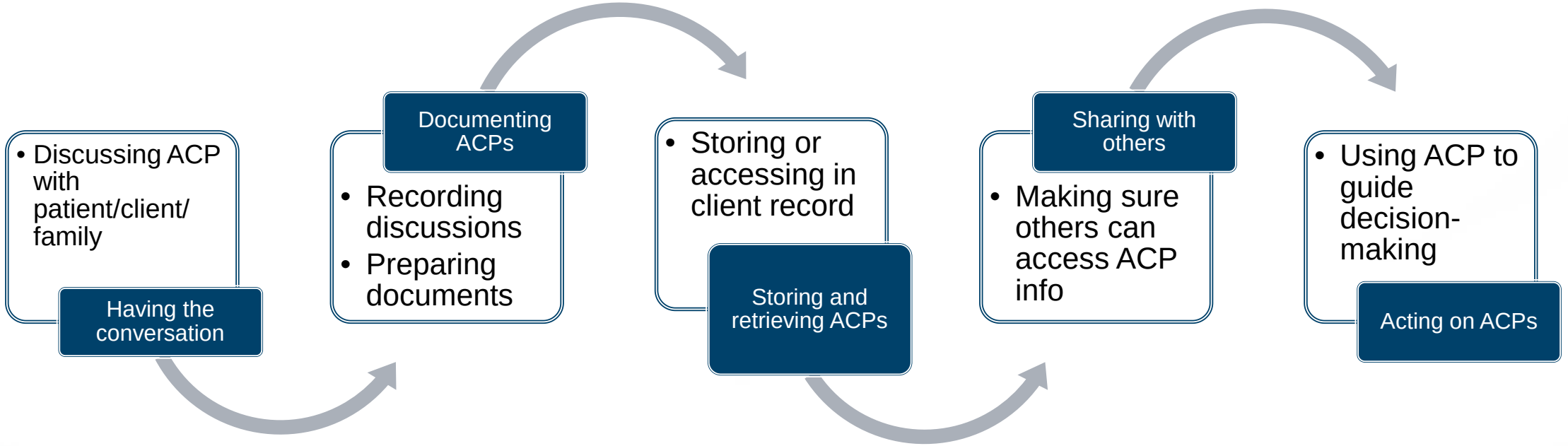
- roles in ACP not well defined and access to ongoing education and support needed to build skills and confidence

Quality Improvement

How can advance care planning be incorporated as part of usual care –*within* organisations and *across* settings?

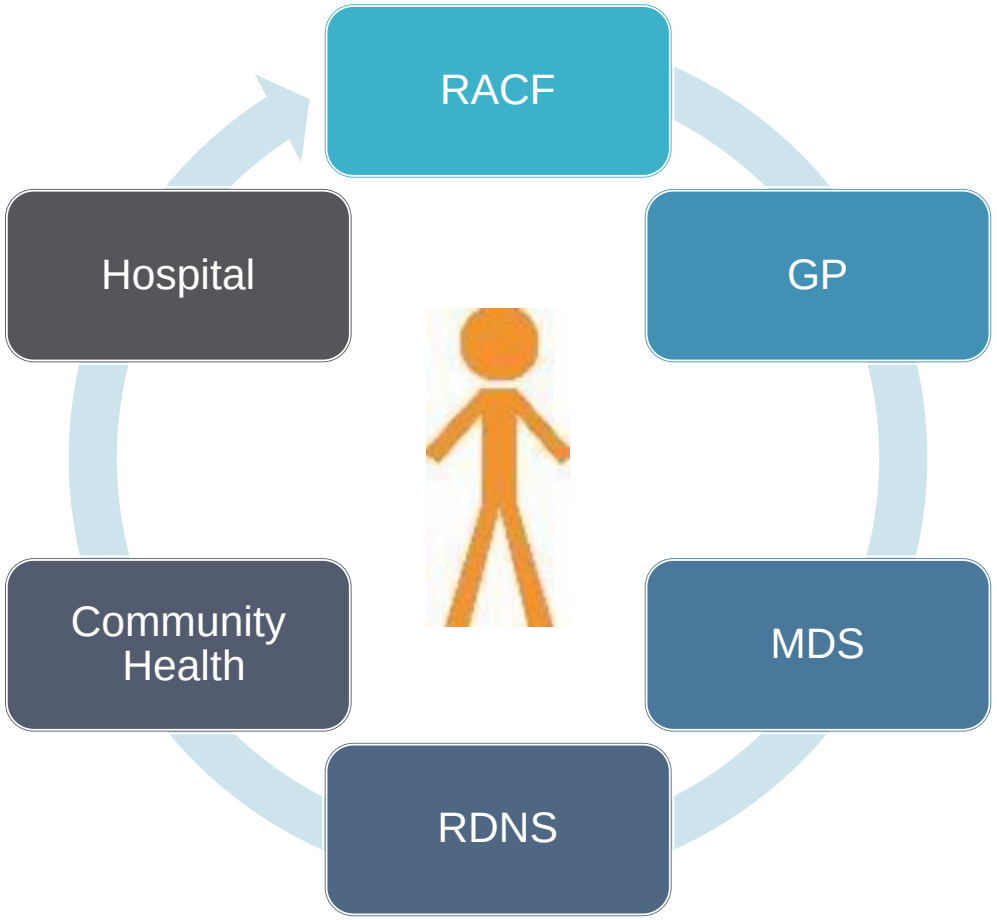
A key first step – defining roles

This included considering roles and processes across the following steps



i.e. – it's not just about the documentation

What did we find?



Every organisation has a role

What else did we find?

- Roles are not the same for all organisations
- Even organisations of the same type can have different roles
  - Some GP clinics do a lot of aged care work
  - Community Health Services vary
  - Some hospitals have an ACP facilitator role
  - Business processes within MDS also vary
- Roles are not the same for all staff
  - Clinical, admin, support (and based on skills and confidence)

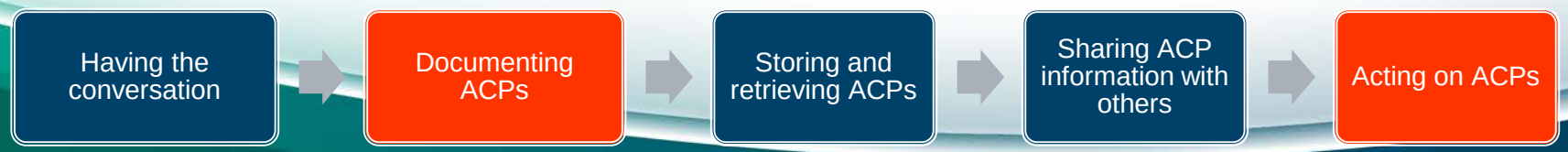
A summary of key roles

Having the conversation → Documenting ACPs → Storing and retrieving ACPs → Sharing ACP information with others → Acting on ACPs

General Practice

- ✓ Identify existing ACP documents SDM or POA
- ✓ Provide information and record discussions
- ✓ Discuss condition, treatment options and ACP
- ✓ Encourage discussion with SDM
- ✓ Assist/document ACP and POA
- ✓ Store copies of ACP-related documents
- ✓ Share with others involved in care
- ✓ Review regularly/as needed
- ✓ Use ACP to inform care decisions

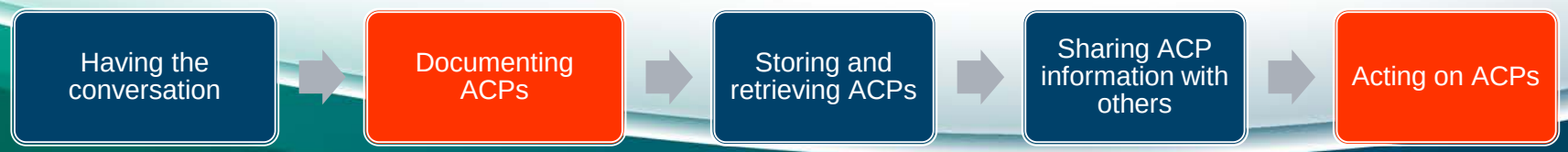
- **General practices have a key role across all steps**
- **Not just clinical staff – also admin staff**
- **Roles vary – some will have greater role**
- **GP and PN can support the role of the family/SDM**
- **ACP can be part of 'normal' practice**



Residential Aged Care

- ✓ Identify existing documents
- ✓ Provide information and discuss ACP
- ✓ Record discussions
- ✓ Encourage discussion with SDM/family
- ✓ Assist with documentation (key staff)
- ✓ Involve GPs in discussions (where possible)
- ✓ Store copies of ACP-related documents
- ✓ Ensure others involved in care access ACP
- ✓ Transfer information between care settings
- ✓ Review regularly
- ✓ Use ACP to inform care decisions

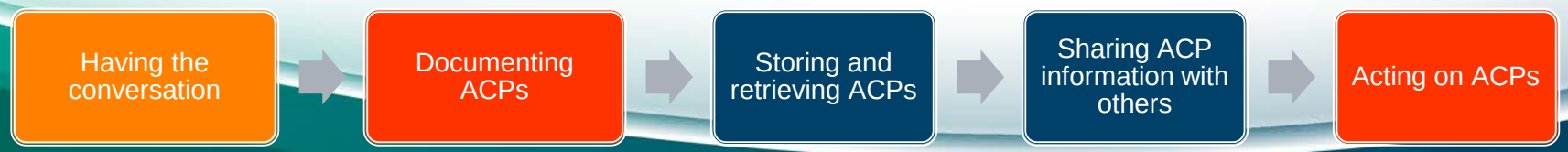
- **RACF also have multiple roles in ACP process**
- **Not just for clinical staff - admin and support staff**
- **Key staff document and implement**
- **Most staff – know how and when to intro ACP and who to refer to**
- **Make sure ACP info is available across points of care**



Hospitals

- ✓ Identify existing documentation
- ✓ Provide information and discuss ACP in context of diagnosis and treatment decision
- ✓ Record discussions
- ✓ Encourage discussion with SDM/family
- ✓ Assist with documentation (key staff)
- ✓ Store copies of ACP related documents
- ✓ Ensure others involved in care can access ACP (flag/alerts/discharge summary)
- ✓ Use ACP to inform care decisions
- ✓ Provide support for community providers at acute/primary interface

- **Hospitals play a role across various steps**
- **Includes various services e.g. specialist clinics, outreach services**
- **Ideally, ACP introduced early (not at time of crisis)**
- **All clinical staff have a role in raising consumer awareness of ACP**
- **Key staff will assist to document / act on ACP**
- **Other staff roles will vary**
- **ACP information coming in and going out (GP/RACF)**



Medical Deputising Service/Locum

- ✓ Identify existing documents/SDM
- ✓ Involve SDM/family in decision-making
- ✓ Discuss how existing ACP relates to patient's health issues, condition, prognosis and treatment options
- ✓ Record any ACP discussions and ensure others can access
- ✓ Use ACP to inform care decisions if patient loses capacity (in context of current visit)
- ✓ Communicate with patient's usual GP/care provider regarding ACP

- **Key role involves acting on existing information**
- **MDS provide care *on behalf of* usual GP**
  - **Role is not the same as usual GP**
- **Involve other services (e.g. palliative care) to ensure patient can access care in their preferred place**
  - **Must be confident that care is available to implement ACP**
- **Consider the "2am test"**

Community Health Services

- ✓ Provide information and explain ACP
- ✓ Incorporate ACP as part of Goal Directed Care
- ✓ Encourage discussions with family/SDM
- ✓ Identify existing documents/SDM
- ✓ Record details in patient records
- ✓ Refer to organisational Champions, GP, palliative care for support to develop ACP
- ✓ Encourage patients to share with others involved in their care

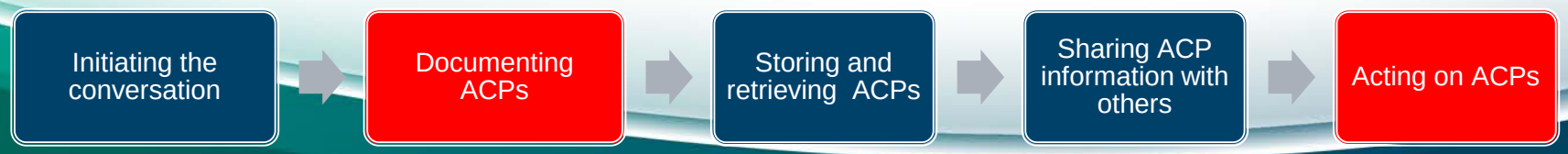
- **Roles vary based on service type and staff role**
- **Services include GP clinics, Allied Health, Planned Activity Groups, Mental Health, Youth services, Refugee Health, Aged Care**
- **Some staff have key roles in initiating discussion and supporting documentation**
- **Most roles involve providing information and referring to 'Champions' or other HP for support**

Initiating the conversation → Documenting ACPs → Storing and retrieving ACPs → Sharing ACP information with others → Acting on ACPs

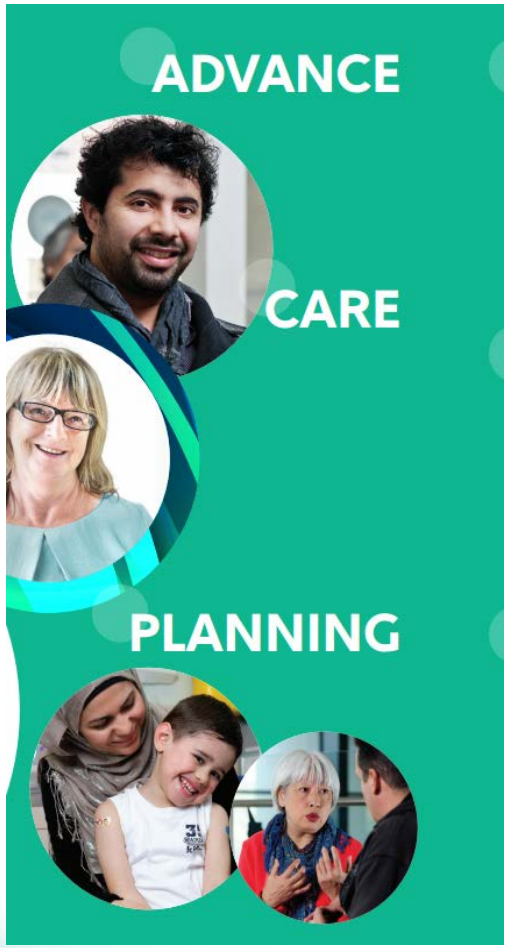
RDNS

- ✓ Provide information and explain ACP
- ✓ Encourage discussions with family/SDM
- ✓ Identify existing documents/SDM
- ✓ Record details in patient records, share with others and transfer across settings
- ✓ Refer to RDNS Champions, GP, palliative care for support to develop ACP
- ✓ Use ACP to inform decisions about care

- **Roles vary based on service and staff role**
- **Some staff have key roles in initiating discussion, supporting documentation and acting on patient preferences**
- **Most roles involve providing information and referring to 'Champions' or other HP for support**



What's changing in organisations that are implementing ACP?



"Strong processes now in place to ensure that residents' wishes can be known and respected by the treating teams" (RACF manager)

"Advance care plan discussions have become part of normal consults and standard practice" (PN)

"Clinical nurses now routinely include the discussion of ACP when formulating Care Plan >75yr HCA or CMA" (GP)

"[Our] in-house system now has fields and markers to alert the after-hours doctor if there is an ACP in place" (MDS)

"Through training and information sessions, staff have become more and more engaged with the concept of ACP" (Community Health)

"Educational sessions have enabled [our] doctors to be more proactive and comfortable requesting and discussing ACP within nursing homes" (MDS)

Implementation: *what can help?*

- Policy/procedure – endorsed by management
- A multi-disciplinary approach
  - Clearly define roles
  - Make sure **all** staff have basic ACP awareness
  - Training and PD opportunities
  - Identify champions
  - Ensure staff know where to go for information and support
- Include SDM/family so they understand their role
- Share ACP info with others (think outside the organisation)
- Develop clear systems for ACP *process* and staff roles in this
- Identify key set of resources to support staff and patient/client

Implementation: *what needs more work?*

- **Momentum to maintain expertise** and knowledge, including organisational support for **Champions** to continue in their role;
- Continued access to **quality education** for capacity-building across sectors (including a mix of face-to-face, online, basic and in-depth options and covering legal/mental health, improving quality of documentation);
- **Community education/communication** campaigns covering different population groups and more research into consumer experience of ACP;
- Continued work on **improving systems to share/communicate** ACP information between services and to **'activate'** ACPs;
- Improve **variation in quality of ACP** content, GP sign-off, documentation of various elements

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