Advance Care Planning in Domiciliary Nursing Services

Domiciliary Nursing Services provide care to patients in their own homes across the health-illness continuum, from episodic care, early diagnosis of illness to end of life care. Domiciliary nursing staff can play a key role in raising Advance Care Planning (ACP) awareness amongst patients, making sure that patient preferences are documented in records and, depending on the staff role, having ACP conversations or referring patients to another health professional for this discussion. Domiciliary nursing staff also have a role in using Advance Care Directives (ACD) to guide their decision making.

Key roles in supporting ACP include:

- ✔ Provide information and explain ACP to patients/clients
- ✔ Encourage discussions with family/Substitute Decision Maker (SDM)/Medical Treatment Decision Maker (MTDM)
- ✔ Identify existing ACP documents/SDM/MTDM
- ✔ Record details in patient records, share with others and transfer across settings
- ✔ Refer to domiciliary nurse champions, GP, palliative care services for support to develop ACD
- ✔ Use ACP to inform decisions about care if patient loses capacity

> **Participation in the project has helped to not only enhance staff knowledge and skills in relation to ACP but has assisted in strengthening the supportive structures across the organisation.**
>
> - Domiciliary Nurse

Strategies for implementing ACP in domiciliary nursing services

1. Establish robust systems

- ☐ Involve managers/senior staff
- ☐ Develop ACP policy and procedure and get it endorsed by management
- ☐ Establish clear ACP systems

  e.g. Ensure computer system has fields and markers to alert nurses as to whether there is an ACD in place
- ☐ Record ACP discussions
- ☐ Store file in designated place (may include electronic)
- ☐ Create alerts so others know an ACD exists and how to access
- ☐ Build ACP into usual practice

  e.g. Nurses provide information and discuss ACP upon admission into the service, refer on as required to champions, GPs or specialist services to continue development
- ☐ Identify 'triggers' for discussions

  e.g. Upon new patient registration with the service, upon request by patient or their family, when patient's condition/situation changes

2. Evidence and quality

- ☐ Use quality audits to improve ACP processes

  e.g. Review patient files to identify who has an ACD, when last reviewed, and if content is clear and can inform decision-making
- ☐ Base policy on evidence
- ☐ Link with accreditation standards
- ☐ Monitor impact of ACP implementation

  e.g. Survey staff before and after educational activities about their knowledge and confidence in ACP

  e.g. Monitor numbers of ACDs that the service holds for patients (may have been shared by another service or developed by domiciliary nurse)

  e.g. Monitor numbers of ACDs developed

  e.g. Clinical audits
- ☐ Develop measures that make sense to your staff and patients

  e.g. What percentage of patients have an ACD?

"Changes have included significant review of current policy and procedure, adding ACP to the new assessment tool and including education in orientation to new staff as well as the development of recommendations for wider implementation.

- Domiciliary Nurse

3. Workforce capability

- ☐ Clearly define staff roles
- ☐ Provide training and professional development opportunities
- ☐ Identify champions
- ☐ Discuss ACP in clinical/team meetings and with all staff
- ☐ Provide admin staff with basic ACP training
- ☐ Ensure staff understand ACP procedures
- ☐ Ensure staff know where to get information and support
- ☐ Provide access to information about legal frameworks
- ☐ Use ACP HealthPathway* or other key ACP resources to support staff

*HealthPathways Melbourne is a website for health professionals with free, relevant and evidence-based information on the assessment and management of common clinical conditions, including referral guidance.

Go to **melbourne.healthpathways.org.au**

4. Enabling the person

- ☐ Ensure a person-centred approach
- ☐ Include MTDM/SDM/family to ensure they understand their role and the person's preferences
- ☐ Promote multiple opportunities for ACP discussions
- ☐ Identify key triggers for ACP discussion and review

  e.g. Upon new patient registration with the service, upon request by patient or their family, when patient's condition/situation changes

  Link patients and families to other services for

  - Usual GP
  - Office of the Public Advocate
  - Specialist Palliative Care
- ☐ Enact/activate ACD if patient loses capacity (use to inform decisions)
- ☐ Encourage patients to upload their ACP documents to their My Health Record

The Medical Treatment Planning and Decisions Act 2016 (which commenced on 12 March 2018) made some significant changes to medical treatment decision making for people who do not have the capacity to make their own decisions. Visit www2.health.vic.gov.au/Api/downloadmedia/%7B58139B8D-A648-4995-82F6-471129BAC322%7D to find out more.

For More Information

This information sheet is one of seven service setting extracts from the *Advance Care Planning - Roles and Responsibilities in Advance Care Planning* booklet, developed as part of a collaborative quality improvement project conducted between June 2015 and March 2016.
Visit nwmphn.org.au/clinical-community/advance-care-planning for a copy of the full booklet.

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We have ensured that the new electronic client information management system and documentation include ACP.

- Domiciliary Nurse

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