Advance Care Planning in Residential Aged Care

Residential aged care staff play a key role in supporting residents and their families with Advance Care Planning (ACP). Staff in residential aged-care facilities (RACFs) are often the primary contact for residents, families, general practices, hospitals and others involved in the resident's care.

Key roles in supporting ACP include:

- ✔ Identify existing documents and/or Medical Treatment Decision Maker (MTDM), also known as a Substitute Decision Maker (SDM) for all residents as part of admission processes. Accurately record details
- ✔ Provide residents and families with user-friendly information about ACP
- ✔ Discuss ACP and how this relates to resident's health issues, condition and treatment options (key staff – depending on roles)
- ✔ Involve the resident's GP in discussions where possible/appropriate
- ✔ Encourage discussion with MTDM and involve MTDM/family where possible and appropriate
- ✔ Support the resident/family to document their Advance Care Directives (ACD), check any draft documents and help clarify wording or intentions (key staff)
- ✔ Record any discussions about ACP and ensure others can access this information if needed
- ✔ Store copies of ACD-related documents in resident's records so they are accessible
- ✔ Share information about the residents' ACD with others involved in care (with consent) – e.g. GP, MTDM, hospital, specialists, in-reach, locum, ambulance services
- ✔ Ensure ACD information is available if care is needed after hours (e.g. Medical Deputising Service (MDS)/Locum Service and agency nursing staff)
- ✔ Review regularly (e.g. Resident of the Day, Comprehensive Medical Assessment, when conditions change or resident deteriorates)
- ✔ Use ACD to inform care decisions (including when resident's condition deteriorates)
- ✔ Engage with community palliative care and residential in-reach/outreach services to ensure residents have access to the care they need in their preferred place

> "Participation [in Advance Care Planning] has brought our organisation in line with contemporary practice. Visiting health professionals have commented on this."
>
> - RACF Manager

Strategies for implementing ACP in residential aged care

1. Establish robust systems

- ☐ Involve managers/senior staff
- ☐ Develop ACP policy and procedures and get them endorsed by management
- ☐ Build ACP into usual practice

  e.g. Introduce the topic at admission, have the conversation at first resident review and at subsequent set times
- ☐ Establish clear systems for ACP

  e.g. Provide information about ACP to residents/ families on admission, include in care plan development process, review ACD as part of 'resident of the day', store in a designated place where staff can access it, create alerts on system
- ☐ Record all ACP discussions
- ☐ Create alerts so others know an ACP exists and where to find it
- ☐ Store or file in designated place (may include electronically)
- ☐ Develop process for sharing with others including after hours and communicate process
- ☐ Create reminders to review ACPs
- ☐ Identify 'triggers' for reviewing an ACD such as a change in medical condition, a significant event

  e.g. A change or deterioration in condition, a hospital admission, patient wishes, etc.
- ☐ Include ACP in routine assessments

2. Evidence and quality

- ☐ Use quality audits to improve ACP processes –

  e.g. Review resident 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. Take baseline data of number of residents with ACD in place and monitor quarterly for changes

  e.g. Conduct post-death audits to review whether resident had ACD and if so, was it followed?
- ☐ Develop measures that make sense to your staff and residents

  e.g. What % of residents have an ACD? When was the last review? Did the resident/family have a positive experience?

3. Workforce capability

- ☐ Take a multi-disciplinary approach
- ☐ Ensure staff roles are clearly defined

  e.g. Admissions staff include ACP brochure in admissions pack, RN is responsible for having the conversation and helping to document an ACD, personal care staff know where to go for information and who to direct a resident to with questions
- ☐ Provide training and professional development opportunities
- ☐ Identify ACP champions
- ☐ Talk about ACP in clinical/team meetings and with all staff
- ☐ Give admin, hospitality and personal care staff basic ACP training
- ☐ Make sure staff know ACP procedures
- ☐ Ensure staff know where to go for information and support
- ☐ Provide access to information about legal frameworks and responsibilities
- ☐ Use ACP HealthPathway*, Palliative Approach Toolkit or other key resources to support staff

> **Participation was the precipitating factor in getting our Policy & Procedure changed! Strong processes are in place to ensure that residents' wishes can be known and respected by the treating teams.**
>
> **- RACF Manager**

4. Enabling the person

- ☐ Provide user-friendly information in waiting areas and as part of admission process
- ☐ Take a person-centred approach and include MTDM/SDM/family to ensure they understand their role and the resident's preferences and values
- ☐ Promote multiple opportunities for ACP discussions
- ☐ Identify key triggers for ACP discussion and review
- ☐ Support all residents with ACP
- ☐ Link residents, family, friends and carers to other services if needed
  - Office of the Public Advocate
  - Palliative Care Services
  - Hospital ACP services
- ☐ Enact/activate ACD if resident loses capacity (use it to inform decisions)

*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

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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Participation encouraged our facility to initiate further in-house education in End of Life care, including having difficult conversations.

- RACF Manager

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