Advance Care Planning in Community Health

A community health approach addresses the medical, social, environmental and economic aspects that affect health. Community health services in Victoria provide a range of services to many different client groups including older people, people with complex care needs and people from diverse backgrounds. The wide range of health and social care professionals in this sector can play a key role in promoting Advance Care Planning (ACP) with their clients.

Key roles in supporting ACP include:

- ✔ Provide user-friendly information to clients and explain ACP
- ✔ Provide information about where clients can go for further support if needed
- ✔ Encourage discussions with family/Subsitiute Decision Maker (SDM)/Medical Treatment Decision Maker (MTDM)
- ✔ Identify existing documents/SDM/MTDM and record details in client records
- ✔ Refer to organisational champions, GP or other services for support to develop Advance Care Directived (ACD)
- ✔ Encourage clients to share ACP information with others involved in their care

> “The Policy and Procedure will provide direction to our staff on the implementation of advance care planning.”
>
> - Community Health Nurse

> “Forming a working group of enthusiastic people including clinical staff and managers has greatly assisted with the project.”
>
> - Community Health Occupational Therapist

Strategies for implementing ACP in community health services

1. Establish robust systems

- ☐ Have a whole-of-agency response to starting conversations and building ACP into practice
- ☐ Involve managers/senior staff
- ☐ Ensure alignment of ACP with goal-directed care planning
- ☐ Develop ACP policy and procedure and get it endorsed by management
- ☐ Establish clear ACP systems

  e.g. Agree on which clients are suitable for ACP conversations, use software to record discussions, agree process for storing/creating codes/alerts so that ACDs are easily accessible, create methods of sharing information including discussions which alter wishes, agree on when to refer to other staff or health professionals for discussions

  e.g. Record ACP discussions
- ☐ Record MTDM/SDM in client records
- ☐ Encourage clients to share their ACP documents and keep an easily located copy available for ambulance or other services
- ☐ Build ACP into usual practice

  e.g. Talk about and display ACP information to normalise the topic, include ACP as standard items in checklists and assessments, talk about ACP regularly during staff meetings, have a standard procedure for referring conversations onto others if appropriate

2. Evidence and quality

- ☐ Use quality audits to improve ACP processes –

  e.g. Review client files to identify who has an ACP, when last reviewed, and if the 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 (shared by other services)

  e.g. Monitor numbers of ACDs developed by the organisation

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

  e.g. What percentage of our clients have an ACD?
- ☐ Identify key triggers for ACP discussion and review

  e.g. Change in client's condition, discharge from hospital, when client requests it, etc

Through training and information sessions, staff have become more and more engaged with the concept of ACP.

- Manager, Community Health Services

3. Workforce capability

- ☐ Promote and utilise a multi-disciplinary approach to ACP
- ☐ Clearly define staff roles
- ☐ Ensure all staff know where to refer people for further ACP support
- ☐ Identify champions
- ☐ Discuss ACP in clinical/team meetings and with all staff
- ☐ Provide admin staff with basic ACP training
- ☐ Provide training and professional development opportunities to support staff in their roles
- ☐ Make sure staff are familiar with policy and procedures for ACP
- ☐ 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

- ☐ Support community education and consultation
- ☐ Provide user-friendly information in waiting areas and include in registration process
- ☐ Provide a person-centred approach
- ☐ Ensure MTDM/SDM/family (where available) understand their role and the person's preferences
- ☐ Promote opportunities for ACP discussions in all relevant service areas/programs

  e.g. At clearly identified points during a person's care such as regular reviews or assessments
- ☐ Identify key triggers for ACP discussion

  e.g. When client's condition changes, upon discharge from hospital, upon client/family request
- ☐ Support clients with ACP (key staff depending on role)
- ☐ Link clients and families to other services for support if needed
  - Office of the Public Advocate
  - Hospital
  - Their regular GP or nurse
- ☐ If client loses capacity, include MTDM/SDM and use ACP to inform decisions (role dependent and aligns with policy and procedure)

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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NORTH WESTERN
MELBOURNE
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North Western Melbourne PHN
(03) 9347 1188

nwmphn.org.au