

# Advance Care Planning

Roles and responsibilities  
in Advance Care Planning

**phn**  
NORTH WESTERN  
MELBOURNE

An Australian Government Initiative



# Acronyms

<b>ACP</b>	Advance Care Planning	Collectively refers to the process of either creating Advance Care Directives, or appointing a medical treatment decision maker, or both
<b>ACD</b>	Advance Care Directives	Documentation comprised of a values and/or instructional directive/s
<b>CMA</b>	Comprehensive Medical Assessment	
<b>HA</b>	Health Assessment	
<b>MTDM</b>	Medical Treatment Decision Maker	This is a person legally appointed under the Medical Treatment Planning and Decisions Act Vic (2016) to make medical decisions on your behalf if you lose the capacity to make those decisions. Is sometimes also referred to informally as a Substitute Decision Maker.
<b>MyHR</b>	My Health Record	Secure online summary of your health information
<b>RACGP</b>	Royal Australian College of General Practitioners	
<b>RACF</b>	Residential Aged Care Facility	
<b>SDM</b>	Substitute Decision Maker	See MTDM above

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It is the responsibility of individual organisations to ensure compliance with any relevant national and State or Territory legislation relating to advance care planning, privacy and patient care.

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# Background

This resource was developed as part of a collaborative quality improvement (QI) project conducted between June 2015 and March 2016.

The Department of Health and Human Services (DHHS) funded the project, through Networking Health Victoria, as part of the implementation of its Advance Care Planning Strategy, *Advance care planning: have the conversation – a strategy for Victorian health services 2014-2018*.

Representatives from general practices, aged care, hospitals, district nursing, community health and medical deputising/locum services (MDS) worked closely with North Western Melbourne Primary Health Network (NWMPHN) to systematically implement advance care planning (ACP) in each organisation as well as across all of the partners involved.

This resource draws on the experience of all participants and the strategies and activities that supported them to implement systems and processes for undertaking ACP with clients/patients.

The Project Committee which oversaw the QI activity implementation included representatives from all service types, as well as two consumer representatives. All committee members, including the consumer representatives, provided valuable input.

The Hume Medicare Local *ACP at a glance* document and the Northern Health *A-C-P in three steps*© resources have also informed the development of this resource.

## Aims of this resource

- To describe how advance care planning (ACP) can be undertaken across different health and care settings
- To highlight the importance of relationships between individuals, their families/carers and health professionals – as well as between community organisations, health care organisations and individual health professionals
- To summarise the roles that different people and organisations can play in the ACP process and provide tips on how to systematically incorporate advance care planning within an organisation.

This resource is informed by the evidence and key action areas within the *DHHS Advance care planning: have the conversation – a strategy for Victorian health services 2014-2018*. It focuses mainly on ACP in primary care, and the connections between primary care and local hospital services.

Each section looks at how different health care settings can implement ACP in line with the key action areas within the DHHS Strategy:

- 1 Establishing robust systems so that your organisation can have the conversation
- 2 Ensuring you have an evidence based and quality approach to have the conversation
- 3 Increasing your workforce capability to have the conversation
- 4 Enabling the person you are caring for to have the conversation.

You can find links to further resources at the end of the document.



# The philosophy and principles informing this resource

**Advance care planning** is “a process of planning for future health and personal care whereby a person’s values, beliefs and preferences are made known so they can guide decision making at a time when that person cannot make or communicate their decisions due to lack of capacity” (Australian Health Minister’s Advisory Council).

A patient’s preferences need to be accessible by practitioners at all points of care for informed decision-making to occur.

A person-centred approach recognises that patients often have to navigate a complex system. It aims to put the person at the centre.



## Principles for implementing advance care planning (ACP) within and across organisations

- ✓ Include ACP as part of patient and family-centred care
- ✓ Discuss ACP as part of routine care
- ✓ Promote ACP at multiple opportunities
- ✓ Support ACP as an ongoing process
- ✓ Provide an individualised approach
- ✓ Provide user-friendly information
- ✓ Support people to document advance care directives (ACD) (through referral to others if required)
- ✓ Ensure access to documented ACD information (patient preferences) to guide decision-making across the health system

## The role of the individual

- ✓ Have the conversation – think about future care and let others know your values and preferred care choices
- ✓ Appoint someone you trust to make decisions for you if you are unable to speak for yourself
- ✓ Chat and communicate – talk to friends, family, health professionals
- ✓ Put it on paper – write down the things that are really important to you

Adapted from Northern Health's A-C-P in 3 Steps©



# ACP in General Practice

General practices provide ongoing care to patients, often over many years, and are a key part of a person's care team. Staff within GP clinics can play a role throughout the Advance Care Planning process, from introducing the topic to activating (enacting) plans at the end of a person's life.

## 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
- ✓ Give patients information about ACP
- ✓ Discuss health issues, condition, treatment options, prognosis and ACP
- ✓ Encourage discussion with the patients' MTDM and involve MTDM/family where possible and appropriate
- ✓ Help the patient to document their Advance Care Directives (if required), check any draft documents and help to clarify wording or intentions
- ✓ Record discussions about ACP in medical software and ensure others can access this information if needed
- ✓ Store copies of ACP-related documents, including Advance Care Directives (ACD) in medical records so they are accessible when needed
- ✓ Share information about the patient's ACD with others involved in their care (with patient consent) – e.g. hospital, specialists
- ✓ Encourage patients to give copies to anyone who may be involved in making decisions about their care, and to upload copies of the ACD to their MyHealth Record (MyHR).
- ✓ Ensure that information is available if care is needed after hours (e.g. by MDS/Locum Service)
- ✓ Review ACDs regularly, particularly when the patient's situation changes
- ✓ Activate (enact) the ACD when needed – use ACDs to inform medical treatment and care decisions if the patient loses capacity.



**Recording an Advance Care Directive highlights its existence when transferring clinical information to relevant significant stakeholders.**

- GP

# Strategies for implementing ACP in general practice

## 1. Establish robust systems

- ☐ Involve senior clinicians/managers
- ☐ Develop ACP policy and procedure and get it endorsed by management
- ☐ Build ACP into usual practice
  - e.g. Include discussion as part of Health Assessments and chronic disease management*
- ☐ Establish systems for ACP in your practice:
  - Use practice software to record discussions and create alerts
  - Have an agreed process to code ACD within practice software so that you can search for patients with an ACD
  - Store or file ACDs in a designated place
  - Develop a process for sharing with others (e.g. MDS/locum)
    - e.g. MDS can flag that your patient has an ACD in their system, contact your MDS to let them know patients with ACD or Palliative pathway, hospitals can store copies of ACDs on their patient files, refer to HealthPathways for contacts at your local hospitals, encourage patient to upload ACDs to their MyHR*
  - Create reminders for ACD review
  - Identify 'triggers' for having the conversation
    - e.g. Health Assessments, advanced chronic illness, patient is about to enter an aged care facility, has a new significant diagnosis, see HealthPathways for further details*
  - Include ACD in templates for Health Assessments (HAs) or Comprehensive Medical Assessments (CMAs).
- ☐ Use **\*HealthPathways** to access forms and information
- ☐ Book longer appointments (see Medicare Benefits Schedule (MBS) guide on ACP HealthPathway\*)

## 2. Evidence and quality

- ☐ Use quality audits to improve ACP processes
  - e.g. Identify all patients 75+, or who are having a health assessment and review to see if they have an ACD*
- ☐ Base your policy on evidence
- ☐ Link with RACGP standards
- ☐ Monitor the impact of ACP implementation
  - e.g. Take baseline data*
    - *What proportion of your patients aged 75+ have an ACD?*
    - *What proportion of your patients with chronic disease or life-limiting illness have had an ACP discussion?*
    - *Monitor quarterly for any change*
- ☐ Develop measures that make sense to your staff and patients
  - e.g. What proportion of your RACF residents have an ACD?*

\*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.communityhealthpathways.org](http://melbourne.communityhealthpathways.org)

### 3. Workforce capability

- ☐ Take a multi-disciplinary approach
- ☐ Involve practice nurses in ACP discussions – e.g. introduce topic & give information during health assessments
- ☐ Ensure staff roles are clearly defined
  - e.g. Nurse provides brochure and starts conversation as part of HA. GP discusses as part of care plan. Reception staff ask about ACD when registering new patients, add to new patient form*
- ☐ Provide training and professional development opportunities
- ☐ Identify your practice's ACP champions
- ☐ Talk about ACP in clinical/team meetings
- ☐ Include admin staff in basic ACP training
- ☐ Ensure staff know ACP procedures and where to get more information and support
- ☐ Provide access to information about legal frameworks and legal responsibilities
- ☐ Use ACP HealthPathway
- ☐ Work with RACF staff to develop/review ACDs for residents

### 4. Enabling the person

- ☐ Provide user-friendly information in waiting areas & treatment rooms
- ☐ Take a person-centred approach; include MTDM/ 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
- ☐ Support people who have chronic conditions with ACP
- ☐ Link people to other services for support
  - Office of the Public Advocate
  - Palliative Care Services
  - Hospital ACP services
- ☐ Use ACD to guide decisions if person loses capacity
- ☐ Encourage patients to upload their ACP documents to their My Health Record



**There has been a noticeable increase in clients having advance care plans. Plans that were previously in place are being audited and streamlined into current policy guidelines.**

**- Practice Nurse**





Clinical nurses now routinely include the discussion of ACP when formulating a care plan for >75yrs, HA or CMA.

- GP





# ACP in Residential Aged Care

Residential aged care staff play a key role in supporting residents and their families with 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 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. 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 ACP] 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?*





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

- RACF Manager



### 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

### 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](https://melbourne.healthpathways.org.au)



**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



# ACP in Hospitals

Hospitals have a key role in identifying whether any prior planning has occurred – whether the patient has appointed a Medical Treatment Decision Maker (MTDM) or completed an Advance Care Directives (ACD). Hospitals also have a key role in activating or enacting someone's ACD. In an acute health crisis requiring hospitalisation, knowing the person's values and preferences helps clinicians provide appropriate care.

## Key roles in supporting ACP include:

- ✓ Identify existing documents or MTDM for patients as part of admission process. Practitioners must make reasonable efforts to locate ACP documents. Record details
- ✓ Receive copy of ACD from patients or other health services (e.g. RACF, GP) – provide clear instructions on how they should share the documents
- ✓ Give patients and families plain language information about ACP
- ✓ Discuss ACP and how this relates to the patient's current health issues, condition, prognosis and treatment options
- ✓ Encourage discussion with MTDM and involve MTDM/family where possible and appropriate
- ✓ Support the patient/family to document their ACD if not already documented, check any draft documents and help clarify wording or intentions (key staff)
- ✓ Record any ACP discussions and ensure others can access this information when needed (e.g. discussion record, on e-systems)
- ✓ If ACP or goals of care and resuscitation management conversations occur during a hospital stay, inform GP and encourage formal ACP documentation (if not already done)
- ✓ Store copies of ACP-related documents in patient's records so they are accessible
- ✓ Create alerts so all staff know ACP-related documents exist
- ✓ Share information from ACP discussions with others involved in care (with patient consent) – e.g. RACF, patient's usual GP
- ✓ Use ACP/liase with MTDM to inform care decisions if patient loses capacity
- ✓ Provide clear point of contact for community-based health professionals to seek advice on ACP
- ✓ Involve other services (e.g. Specialist Palliative Care, Community Nursing) where required to ensure patient can access care in their preferred place



# Strategies for implementing ACP in hospitals

## 1. Establish robust systems

- ☐ Involve executives, managers/senior staff
- ☐ Develop ACP policy and procedure and get it endorsed by management
- ☐ Build ACP into usual practice and identify triggers for having the conversation

*e.g. All presenting and admitted patients are asked about whether they have an ACD. If not, this is a trigger for having the conversation*
- ☐ Establish clear systems for ACP

*e.g. Identify if ACD exists for all patients presenting to, or admitted to hospital. Receive copies of ACDs from individuals and other health services*
- ☐ Record ACP discussions
- ☐ Create alerts so others know ACD exists and how to access
- ☐ Store in designated place (may include electronic)
- ☐ Develop process for sharing with others (including usual GP and RACF if relevant)

*e.g. Ensure RACFs (if relevant) and GPs are informed about ACP discussions and/or documentation that has occurred within hospital setting (discharge documentation)*
- ☐ Governance – ensure staff roles are clearly defined and there are specified ACP leads/champions that staff can go to for help.

## 2. Evidence and quality

- ☐ Use quality audits to improve ACP processes

*e.g. Identify if ACD exists for all patients presenting or admitted to hospital. Receive copies of ACDs from individuals and other health services. Identify MTDM and document in patients record*
- ☐ Base policy on evidence
- ☐ Link with accreditation standards
- ☐ Monitor impact of ACP implementation

*e.g. Conduct post death audits – include whether patient had an ACD and if so, was it accessible*
- ☐ Develop measures that make sense to your staff and patients

*e.g. What % of admitted patients had an ACD? What % of presenting patients had an ACD? What % of patients had an ACP conversation or developed an ACD whilst in hospital? What % of patients had that information shared with their regular GP and/or RACF?*

“

**Linking with GPs and aged care homes in our area has helped improve communication about ACP.**

**- Hospital ACP coordinator**



### 3. Workforce capability

- ☐ Take a multi-disciplinary approach
- ☐ Ensure roles are clearly defined
  - e.g. Admission form includes question about ACD, nurse provides brochure to patient /carer, and assistance to complete ACD if required.*
- ☐ Provide training and professional development opportunities
- ☐ Identify champions
- ☐ Talk about ACP in clinical/team meetings and with all staff
- ☐ Give admin staff basic ACP training
- ☐ Ensure staff know ACP procedures (including where documentation is stored)
- ☐ Make sure staff know where to get information and support
- ☐ Provide access to information about legal frameworks
- ☐ Use ACP HealthPathway or other key 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](https://melbourne.healthpathways.org.au)

### 4. Enabling the person

- ☐ Provide user-friendly, multiple language information, in waiting areas and as part of admission process,
- ☐ Provide a person-centred approach and include MTDM/SDM/family to ensure they understand their role and the patient's preferences and values
- ☐ Promote multiple opportunities for ACP discussions
- ☐ Identify key triggers for ACP discussion and review
  - e.g. Diagnosis of chronic/life limiting illness, patient/family indicates willingness to discuss future care needs*
- ☐ Support all patients with ACP
  - e.g. Hospital ACP coordinator to provide information to facilitate the conversation. Provide opportunity for patient/family to discuss*
- ☐ Link patients and families to other services for support if needed
  - Office of the Public Advocate
  - Palliative Care
  - Hospital ACP coordinator or other staff member with ACP role
- ☐ Enact/activate ACP if patient loses capacity (use it to inform care decisions)



**Offering education to all hospital staff and to other health service providers is helping to increase awareness of the importance of ACP for patients.**

- GP Liason Officer





We now have  
information  
for patients  
and families  
available  
in different  
languages.





# ACP in Medical Deputising (Locum) Services

Medical deputising (locum) services (MDS) play a key role in providing care to people when their own GP is not available in the after hours period. This includes visiting people in their homes and in residential aged care facilities (RACFs). Their main role in ACP is to receive, interpret and enact Advance Care Directives (ACDs) where appropriate.

## Key roles in supporting ACP include:

- ✓ Identify existing documents and/or Medical Treatment Decision Maker (MTDM) for patients
- ✓ Receive ACP information from RACF and usual GP
- ✓ Where ACDs exist, interpret and discuss how this relates to patient's health issues, condition, prognosis and treatment options
- ✓ Encourage discussion with MTDM and involve MTDM/family where possible/appropriate, including in decision-making
- ✓ Record any ACP discussions and ensure others can access this information if needed (e.g. on e-systems)
- ✓ Create alerts in medical records, so all staff know an ACD exists, or that ACP has been started
- ✓ Use ACD to inform care decisions if patient loses capacity (in context of current visit)
- ✓ Communicate with patient's usual GP/care provider regarding ACP
- ✓ Involve other services (e.g. specialist palliative care, residential in-reach) where required to ensure patient can access care in their preferred place



**Educational sessions have enabled [our] doctors to be more proactive and comfortable requesting and discussing ACP within nursing homes and aged care facilities.**

- MDS Manager

# Strategies for implementing ACP in medical deputising 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. In-house system has fields and markers to alert after hours doctor if there is an ACD in place*
- ☐ Record any discussions about ACP
- ☐ Create alerts so others know an ACD exists and how to access it
- ☐ Build ACP into usual practice
  - e.g. Call centre asks all patients at point of booking if an ACD exists, existing ACDs to be provided to locum doctors prior to visit where possible, doctors to actively ask all patients about ACP*
  - e.g. Provide clear instructions on how RACF and usual GP can inform MDS of any ACP information or specific patient needs (e.g. palliative care)*

## 2. Evidence and quality

- ☐ Use quality audits to improve ACP processes
- ☐ Base policy on evidence
- ☐ Link with accreditation standards
- ☐ Monitor impact of ACP implementation
  - e.g. Survey of locum doctors about concerns re ACP pre- and post-educational activities and materials.*
  - e.g. Monitor reporting of situations where ACDs have not been followed*
  - e.g. Clinical audits*
  - e.g. Increased receipt of ACDs from clients' GPs*
- ☐ Develop measures that make sense to your staff and patients
  - e.g. What proportion of RACF patients in our records have an alert for ACP documentation?*
  - e.g. What proportion of GPs are providing us with specific information about patients?*







### 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.

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### 4. Enabling the person

- ☐ Use a person-centred approach
- ☐ Include MTDM/SDM/family to ensure they understand their role and the patient's preferences
- ☐ Promote multiple opportunities for ACP discussions
  - e.g. Equip locum doctors with information/ education to commence ACP discussions with the patient/family member*
- ☐ Locum doctors can place a record of the discussion in the patient file outlining what has been discussed, for GP follow up
- ☐ Identify key triggers for starting an ACP discussion or review such as
  - e.g. Any RACF patients without an ACD, patients without an ACD who've called the locum service with regards to their chronic condition*
- ☐ Link patients and families to other services for support
  - Usual GP
  - Office of the Public Advocate
  - Specialist Palliative Care Services
- ☐ Enact/activate ACD if patient loses capacity (use to inform decisions)
- ☐ Encourage patients to upload their ACP documents (including ACD) to their My Health Record.



**Our in-house system now has fields and markers to alert the after hours doctor if there is an ACP in place.**

- MDS Manager



# ACP 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 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 ACDs to guide their decision making.

## Key roles in supporting ACP include:

- ✓ Provide information and explain ACP to patients/clients
- ✓ Encourage discussions with family/SDM/MTDM about ACP
- ✓ 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?*



### 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](https://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



**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





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

**- Domiciliary Nurse**



# ACP 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 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/SDM/MTDM
- ✓ Identify existing documents/SDM/MTDM and record details in client records
- ✓ Refer to organisational champions, GP or other services for support to develop 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*







### 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](http://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)

“

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

- Manager, Community Health Services



# Primary Health Network role in ACP

Primary health networks (PHNs) can play a key role in supporting both health care providers and the local community in ACP. This can be done by integrating ACP activity into existing program areas and working with others to improve systems and processes for ACP across different settings.

## Support local primary and community health care providers:

- ✓ Ensure access to ACP education and training (both 'basic' and 'champion' level training)
- ✓ Provide access to resources and tools to implement ACP as part of usual practice
- ✓ Facilitate engagement with hospital ACP programs and across health care settings
- ✓ Support improvements in systems for integration and transfer of ACP information (e.g. eHealth)
- ✓ Act as advocate to state and federal departments of health regarding ACP-related issues that affect primary health care providers and their patients/clients in the PHN region

## Support local community members:

- ✓ Help increase the knowledge and skills of health and community care providers – to support their patients and clients
- ✓ Ensure appropriate ACP information is available to the community – e.g. by working with other health care organisations, service providers, consumer groups, community organisations and local councils
- ✓ Act as advocate to state and federal government departments regarding ACP-related community issues identified in PHN region



**The collaborative approach offered the opportunity to find out/understand how different service areas relate to ACP, how the community fits in, compare notes in terms of challenges, successes and strategies, and develop a common plan of action in order to promote ACP.**



# Strategies for supporting ACP in primary health networks

## 1. Establish robust systems

- ☐ Use a collaborative, whole-of-life approach. Integrate ACP across relevant programs, e.g.
  - Older persons/Aged Care
  - General Practice Support
  - Chronic Disease Management
  - Nursing in General Practice
  - Consumer engagement
  - Allied Health Support
  - Acute-primary interface
  - HealthPathways
  - eHealth
- ☐ Work closely with local hospitals and other providers to improve transferability of ACP across settings
- ☐ Support health and care services to develop robust ACP systems
- ☐ Support inter-sectoral system improvement

## 2. Evidence and quality

- ☐ Base policy and project/program activity on evidence
- ☐ Link with accreditation standards for organisations supported by PHN
- ☐ Develop appropriate measures for monitoring impact of ACP activity
  - e.g. Monitor number of people and roles receiving training/education, surveys for attendees before and after education events to monitor change in knowledge and confidence, monitor number of organisations supported in ACP, monitor usage of the ACP HealthPathway*
- ☐ Support local health providers' access to evidence for ACP



**It was useful to be able to see what other sectors were experiencing and what the barriers were and how other people were dealing with these issues.**



### 3. Workforce capability

- ☐ Multiple online and face-to-face ACP and palliative care education opportunities may be available through other organisations. To make the most of available resources:
  - Work with other organisations to identify quality education, training and professional development opportunities
  - Routinely integrate ACP awareness into education forums, e.g. dementia updates, chronic disease, palliative care forums
  - Ensure access to multi-disciplinary education for ACP 'champions' as well as basic ACP education
  - Provide access to information regarding legal frameworks and implementation steps
  - Use ACP HealthPathway or other key ACP resources to support health and care professionals
  - Support access to education and training to boost skills in palliative and end-of-life care and enable more ACP

### 4. Enabling the person

- ☐ Work with local community organisations to ensure consumer groups have access to information and support
- ☐ Utilise a person-centred approach
- ☐ Help develop appropriate ACP patient resources
- ☐ Support MTDM/SDM/family to ensure they understand their role and the person's preferences
- ☐ Promote multiple opportunities for ACP discussions
- ☐ Identify and promote linkages for patients and families to obtain other support services
  - Usual GP/PN
  - Office of the Public Advocate
  - Other local services
- ☐ Support health professionals to use ACP information to inform decision-making when people lose capacity

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Go to [melbourne.healthpathways.org.au](https://melbourne.healthpathways.org.au)



**It was great to see the cross sectoral commitments. Our organisation has found an increased level of engagement on the topic.**







# Resources for planning and implementing ACP within organisations

Adapted from DHHS Strategy – Implementation:

Getting your organisation ready to have the ACP conversation (p 69-89)

Priority Action Area	Examples of actions	Example measures
Establishing robust systems	Establish organisation-wide policy endorsed by clinical leaders and executive/management	<ul style="list-style-type: none"> <li>• ACP policy is in place</li> <li>• Other policies reviewed for consistency with ACP policy</li> </ul>
	Create alert systems for advance care plans and provide access to related documentation for all who need access	<ul style="list-style-type: none"> <li>• ACP resources are available (e.g. storage sleeves in patient files and discussion cards)</li> <li>• ACP alert system is in place</li> <li>• System is in place to record and store ACPs</li> </ul>
	Use quality audits to inform planning and improve ACP systems	<ul style="list-style-type: none"> <li>• Clinical leaders respond to results of audit process</li> </ul>
	Establish mechanisms that support recognition of ACPs developed in other settings (including sharing of information)	<ul style="list-style-type: none"> <li>• ACPs (with MTDM/SDM details) noted in communication templates between health services and other care providers</li> </ul>
Ensuring evidence-based and quality approach	Inform ACP practice through review of activity, quality and patient experience data  Embed ACP in quality and redesign practices	ACP included in assessment of outcomes, including: <ul style="list-style-type: none"> <li>• Mortality and morbidity review reports</li> <li>• Patient experience</li> <li>• Routine data collection</li> </ul>
	Shape ACP practice with available evidence	<ul style="list-style-type: none"> <li>• Organisations' ACP implementation plan based on evidence</li> </ul>
Increasing workforce capability	Staff informed and educated about their role in ACP through: <ul style="list-style-type: none"> <li>• position descriptions</li> <li>• induction programs</li> <li>• access to training programs</li> <li>• mentoring and support</li> </ul>	<ul style="list-style-type: none"> <li>• PDs describe role in ACP</li> <li>• induction programs include ACP</li> <li>• number of training sessions and attendance</li> <li>• mentoring is identified in implementation plan</li> </ul>
Enabling the person you are caring for to have the conversation	ACP is delivered in context of person-centred practice  Provide clients/patients with opportunities to discuss and record their wishes and preferences at clearly identified points in their care	Number and % of people with an ACP <ul style="list-style-type: none"> <li>• client information collected includes identification of substitute decision maker</li> <li>• people are offered ACP as part of usual care</li> </ul>

# ACP Resources and Links

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## Advance Care Planning Australia

[advancecareplanning.org.au](https://advancecareplanning.org.au)

National Specialist Advisory Line  
9am–5pm, Mon–Fri

Advance Care Planning: 1300 208 582

Palliative Care (select 1): 1300 668 908

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## Office of the Public Advocate

[publicadvocate.vic.gov.au](https://publicadvocate.vic.gov.au)

Advice Service  
9am–4.45pm, Mon–Fri

1300 309 337

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## Department of Health Victoria

[health.vic.gov.au/patient-care/advance-care-planning-1](https://health.vic.gov.au/patient-care/advance-care-planning-1)

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## HealthPathways Melbourne

[melbourne.communityhealthpathways.org](https://melbourne.communityhealthpathways.org)

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## CareSearch knowledge hubs

[caresearch.com.au](https://caresearch.com.au)

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## North Western Melbourne PHN

[nwmpnhn.org.au/advance-care-planning](https://nwmpnhn.org.au/advance-care-planning)

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## Partner Organisations

The Collaborative (Royal Melbourne Hospital, cohealth, Merri Health and NWMPHN)

RDNS/Bolton Clarke

National Home Doctor Service

Doctor Doctor (previously Australian Locum Medical Service)

North Western Melbourne Metropolitan Palliative Care Consortium

Inner North West Melbourne Primary Care Partnership

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