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*)

*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

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?

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