Advance Care Planning in Hospitals

Hospitals have a key role in identifying whether any prior planning has occurred – whether the patient has appointed an Medical Treatment Decision Maker (MTDM) or completed an Advance Care Directive (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. Residential Aged Care Facility (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/liaise 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

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**

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

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North Western Melbourne PHN
(03) 9347 1188

nwmphn.org.au