Advance Care Planning 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 (RACF). Their main role in ACP is to receive, interpret and enact Advance Care Directives (ACD) 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.

Go to **melbourne.healthpathways.org.au**

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**

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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