Simple, sustainable advance care planning processes in the MPS aged care setting

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**Background**

The Peel Cluster, located within the Hunter New England Local Health District, undertook an Advance Care Planning (ACP) Project in 2010. The aim of the project was to sustainably implement advance care planning processes into routine care for aged care residents in the Multi-Purpose Service (MPSs) facilities of Barraba, Manilla and Walcha.

Advance care planning helps residents and their families/carers discuss and prepare for future health care options\(^1\). These discussions often specifically include end of life care wishes. Recording a person’s wishes in an advance care plan enables their own choices and preferences to be used to guide decision making if the person is unable to speak for themselves in the future\(^1\).

Advance care planning helps define the residents’ wishes, allows for clear documentation and can be called upon if necessary when difficult health care decisions need to be made by carers\(^1\).

There is a growing body of evidence demonstrating an increased expectation by consumers and carers that they should be closely involved in making treatment choices, particularly regarding end of life care. These choices should take into account the individual’s personal beliefs, values, life experiences and how these factors will inform their decisions and wishes with regards to end of life care\(^2,3\).

Improving a person centred approach to end of life care for the older person was identified as a priority implementation area in the HNELHD Older Person’s Model of Care. Advance care planning provides consumers and their carers (professional and informal carers) with:

- clear pathways to facilitate the initiation of end of life discussions
- clear identification of a ‘person responsible’ for substitute medical decision making
- educated and trained professionals who will promote advance care planning/End of Life discussions with clear guidelines for documenting the resident’s preference for health care treatments, including end of life care.\(^4\)

A review of advance care planning activity across HNELHD identified that while online and face to face training had been broadly undertaken by staff, implementation of advance care planning process was inconsistent across the LHD\(^4\). In facilities with an ‘advance care planning Champion’ actively raising advance care planning awareness, integration and implementation of the advance care planning process was higher.

The Peel Cluster did not have any distinct ‘local Champions’ to promote advance care planning and results from an annual HNELHD audit\(^4\) identified that advance care planning processes were not well implemented within the Peel Cluster MPS facilities.

**Methods**

Improving advance care planning process implementation was identified as a Cluster priority by the Peel Cluster Executive Team in 2010.

A working group was formed consisting of a MPS Manager, a nurse representative from each of the MPS facilities, the Cluster Palliative Care Clinical Nurse Consultant, an Aged Care Assessment Team (ACAT) representative and the Cluster Practice Development Officer- Chronic Disease. Very clear
governance and reporting mechanisms for this project working group were established through the Peel Cluster Patient Safety and Quality Committee.

The first priority was to understand the barriers impacting on the uptake of advance care planning in the Peel Cluster. A survey tool was designed to gather data on staff awareness and knowledge of advance care planning, previous advance care planning training undertaken by staff and staff attitudes towards advance care planning in their work environment. Results identified that across the Cluster:

- there was limited understanding and/or awareness of advance care planning
- there was uncertainty regarding which documentation and patient resources should be used. In NSW there is no single form for writing down a person’s wishes, values or specific goals of care
- staff lacked confidence to have end of life discussions with residents and their carers, and were unsure if it was “their job” to do so
- ad hoc advance care planning conversations were being undertaken with residents but very few staff were documenting the discussion. The anecdotal evidence suggested staff lacked confidence to document discussions—not knowing what resource to use, where to write it down or how to document it.

The Advance Care Planning Working Group identified the following strategies to increase staff confidence to have advance care planning discussions with residents and carers, and to embed sustainable advance care planning practices in the facilities:

- identify standardised resources and processes associated with advance care planning, including: documentation, filing and retrieval of advance care planning documents, routine clinical review, and transferring of advance care planning documents with resident transfers
- develop an education package on ‘how to’ implement advance care planning in local MPS facilities for all staff
- identify and support advance care planning Champions for each MPS local site
- increase community awareness of advance care planning.

Resources

The working group sourced and assessed a number of available advance care planning resources for suitability for use in the MPS facilities. A select number of standard resources were identified and localised resources developed for Cluster MPS use. These resources were compiled into an Advance Care Planning Resource Folder for each Peel MPS. The Folder included/s:

- Flowcharts
  - introducing advance care planning to new residents/families
  - deteriorating residents to facilitate clinical review and consideration of advance care plans
- ACP standard documentation including the locally developed advance care planning form (see below)
- specific resources for advance care planning for people with dementia
- various advance care planning consumer resources
- a contact list with the key advance care planning resource staff for the Cluster
the DVD staff training PowerPoint presentations

a community advance care planning awareness PowerPoint presentation.

While the Peel Cluster MPS advance care planning project was in progress, Tamworth Rural Referral Hospital (the major hospital located in the Peel Cluster) commenced an advance care planning project to develop a user friendly, Cluster endorsed, standardised advance care plan documentation.

Members of the Peel Cluster Working Group worked collaboratively with the Tamworth Rural Referral Hospital ACP Steering Committee. This Committee was chaired by Tamworth Rural Referral Hospital’s (TRRH) Director of Rural Critical Care, with membership from local Residential Aged Care Facilities (RACF), North West Slopes Division of General Practice, University Department of Rural Health, local GP Practice Nurses and TRRH Nurses.

This combined group had input into the development of an agreed advance care planning form which was adopted for use in HNELHD Tamworth and Peel Cluster facilities, local RACF and some local GP practices.

The Director of Rural Critical Care promoted the form widely to GPs and private RACFs in the Cluster. The form is available on the North West Slopes Division of General Practice (now New England Medicare Local) website for professional and private use (http://www.nwsdgp.org.au/assets/documents/ACP_Information_Pack_Apr_2011.pdf).

Local Champions

The Advance Care Planning Working Group delegates, through the process, increased their confidence and became passionate advance care planning Champions at their local MPS facility. The value in this is to have ongoing support for advance care planning practice and staff development.

Education packages

As the facilities are small and based in small rural communities it was decided that all staff should have some form of advance care planning education as they have a role to play in promoting advance care planning. Tailored training packages were developed to support the introduction of the ACP Resources Folder for each of the following staffing groups:

- Health Services Support (HSS)
- Administration
- Nurse/Allied Health/Visiting Medical Officer (VMO).

The Health Service Support training was delivered by the site Champion at a regular staff meeting. The 20 minute session introduced the concept of advance care planning and explained why it is an important part of health care. The different roles health staff have in the advance care planning process was outlined and included who to refer residents/community members to, if required.

The Administration training was 30 minutes face to face training delivered by the site Champion using a prepared PowerPoint presentation. The session introduced the concept of advance care planning and why it is an important part of health care. It outlined:

- how health staff in different roles can contribute to the advance care planning process
- the Cluster’s standardised and endorsed systems and resources including flowcharts, documentation and resources
- how to identify a ‘person responsible’ using the NSW Guardianship Act hierarchy
• the roles and responsibility of a 'person responsible' for substitute decision making

• what actions to take if an advance care planning document is provided by a resident or community member to the facility for inclusion in their medical record

• the process to follow when a resident is transferred to another facility to ensure their advance care planning documentation is transferred with them and the receiving staff are alerted to the documentation.

As part of the Nurse/Allied Health/VMO's package staff were encouraged to complete the HNELHD online training or a face to face equivalent prior to attending the 30 minutes session delivered by the Peel Cluster Palliative Care CNC and the local facility advance care planning Champion. This session focused on:

• the contents of the ACP Resource Folder

• the processes associated with advance care planning in their facility such as:
  - how and where to document advance care planning discussions
  - storing and retrieval of advance care planning plans
  - routine review of residents’ advance care planning documentation.

The facilities now have the resources to provide ongoing education and advance care planning education has been incorporated into the orientation package for new staff.

Community awareness
A generic community advance care planning awareness presentation was developed for staff to use to promote advance care planning to community groups such as the CWA, Rotary, Apex, Hospital Auxiliary and Cardiac Rehabilitation groups.

The site Champions worked with their local medical practices to promote advance care planning. As a result one MPS now has community members completing advance care plans with their GP and sending them to the MPS to be filed in their medical record. They have also reported an increase in the number of admitted patients with an advance care plan.

Results
In March 2012 the Peel Cluster advance care planning survey was repeated following the implementation of the ACP Resource Folder and the facilitated advance care planning training.

Overall, the 2012 survey demonstrated a positive increase in advance care planning awareness and process implementation within the Peel Cluster MPS facilities. The survey return response rate increased by 5%. There was a 15% increase in respondents’ awareness of advance care planning, with 100% of respondents indicating an awareness and understanding of advance care planning in the 2012 survey.

Staff training in advance care planning had increased by 280%, following the implementation of the project as shown in Figure 1.
This increased training included the online training, HNELHD training and training provided by external providers, highlighted in Figure 2.

There was an 85% decrease in respondents indicating ‘not interested in advance care planning training’ in the 2012 survey. This demonstrates a positive attitude change across the multi-disciplinary teams’ understanding that advance care planning is part of their role. In the 2010 survey respondents thought it was mainly the responsibility of the GP and Registered Nurses to attend to advance care planning discussions/documentation. In the 2012 survey however there was a perception change that the following health professionals should have a role in advance care planning:

- administration staff
- assistant in nursing
- allied health
- enrolled nurse
- health support services.

Self-reported staff confidence to have advance care planning discussions with resident and their carers increased, Figure 3.
A 45% increase in ability to identify advance care planning documentation was demonstrated in the 2012 survey. (43% in 2010 compared to 88% in 2012).

There was a 34% increase in the self-reported number of advance care planning discussions with residents/carers in the 2012 survey (26% in 2010 to 60% in 2012). Self-reported documentation of advance care planning discussions also increased in the 2012 survey.

Since the inception of the advance care planning MPS project, Peel Cluster MPS facilities have demonstrated a 60% increase in advance care planning process implementation and documentation. One MPS went from 0% advance care planning documentation for the residents in the 2009 audit to 100% of residents with advance care planning documentation in their medical record in a recent audit.

An audit of the ACP Resource Folder was also conducted. The three facilities indicated that they had consistent and easy access to the resources listed in the Resource Folder. There was a varied response to the use of the resources but all the resources were rated as either 'useful' or 'very useful'.

The advance care planning community presentation was used frequently by one facility and rated as 'very useful'.

Comments provided by staff at the facilities were generally positive, particularly the HSS staff who reported that they took the information home and discussed it with family members and/or completed an advance care plan themselves.

**Key messages**

Key success factors of the project were:

- the establishment of a clear governance structure which provided ongoing management support
- integrating with the Tamworth Rural Referral Hospital project to develop user friendly, Cluster endorsed standardised advance care plan documentation that was recognisable across care sectors
- the identification of agreed upon HNELHD and Peel Cluster endorsed advance care planning resources
- linking and engaging with the local GP.

Ultimately the project’s success was due to increasing staff awareness of not only what advance care planning is but also their role in advance care planning. This was achieved with the ongoing support of
local advance care planning Champions and the introduction of a simple set of standardised resources and processes that were formally integrated into routine care.

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**References**

1. Guidelines for a Palliative Approach in Residential Aged Care Palliative Care Australia 2005