ADVANCE CARE PLANNING PROCEDURE

RATIONALE / KUPU WHAKATAKI:

The purpose of this document is to provide an outline of advance care planning (ACP) procedures in the Northland DHB and its community partners.

DEFINITION / KAUPAPA: What is Advance Care Planning?

ACP is a process of discussion and shared planning for future health care needs of the patient/client. The process is a reflection of society's desire to respect personal autonomy whilst also holding to the traditional medical values of beneficence (the moral obligation to act for the benefit of others) and non-maleficence (the obligation not to inflict harm on others – Beauchamp & Childress 2011).

An advance care plan is an articulation of wishes, preferences and personal goals relevant to all current and future care needs for an individual. An advance care plan is not intended to be used only to direct future medical treatments and procedures when the person loses capacity to make their own decisions (becomes incompetent). It can and should be used, however, to inform decision making in the current situation along with other measures such as discussions with the individuals (and their families) regarding their treatment and care management and end of life care planning. It may involve the appointment of an enduring power of attorney (EPA).

Where is information located about Advance Care Planning?

An advance care plan is a patient tool. The tool and information related to the tool is located on the national website for ACP: http://www.advancecareplanning.org.nz or email acpcoop@adhb.govt.nz.

Legal status of ACP

The rights of patients are set out in the New Zealand Code of Consumer Rights. Under the code, advance directives do not need to be formally written documents. An advance care plan is a voluntary process and tool which whilst is not legally binding has the ability to signal the patient's intentions (wishes, preferences for care and treatment and values to be upheld). If a patient has completed an advance care plan, health professionals will endeavour to honour the wishes and preferences of the patient as far as practically possible.

Legally binding "Directives" – these can include any treatment, not just life-sustaining treatments. For an advance directive to be legally binding the patient must meet the following criteria:

1. The patient must be competent at the time of making the directive.
2. Any decision the patient makes to refuse treatment, the patient must do freely without undue influence or limiting pressure, from anyone else.

3. When an advance directive is made, the patient must understand that it is intended to apply for the current situation. Every hospital event and major health journey event will differ and personal circumstances will also change.

ACP discussions – what is involved?

An ACP discussion should comprise of, but shall not be limited to, the following information:

- Develop the individual's understanding of their illness and prognosis;
- Identify the types of care and/or treatments that may be beneficial in the future and their potential availability;
- Identify the individual's preference for future care and/or treatments
- Identify the individual's concerns, goals, wishes, values and beliefs (world view)
- Identify the individual's preferred place of care (and how this will or may affect the treatment options available)
- Family/whanau members or others that they would like to be involved in decisions about their care (this may include appointing an enduring power of attorney);
- Identify the individual's personal views and understanding about the interventions that may be considered or undertaken in an emergency (such as cardiopulmonary resuscitation) and how the advance care planning process might support the person's preferences;
- Identify the individual's needs for spiritual, religious or other personal support that is required to support interventions and treatments.

ACP discussions – who and where?

Any staff member who comes into contact with patients (and/or their families), but is not involved in their care and management can enter into general discussions with the patient.

The basic criteria is that the staff member has a basic understanding ACP and can explain what ACP is and the benefits of ACP to patients and their families. Basic competency can be strengthened by undertaking the e-learning module on the ACP website http://www.advancecareplanning.org.nz. In addition, staff must also be aware of who in their organisation they can refer the patient and their family to for more detailed information and formal discussions.

All health care workers and professionals involved in the care and management of patients in the community and hospital settings, and who are funded by the DHB to provide health care or social care services are responsible for having appropriate ACP discussion with patients/clients. The basic and level 1 competency programmes in advance care planning would be minimum entry level for most staff whilst those health professionals involved in the supporting treatment and management care plans of patients will be required to complete level 2 competency.

Before an advance care plan or an advance directive is developed the patient must develop a reasonable understanding of their current health status and be aware of any health conditions and illnesses that might affect their decisions and future health needs. Therefore, advance care planning involves both the individual person (patient/client) and a trained health care professional responsible

for their care. The patient must be competent (medically) and **must not** be experiencing undue stress or in a situation of crisis when contemplating this type of planning.

It may involve the person's family/whanau and/or carers if that is the wish of the individual person (patient/client). An advance care planning process may result in the person choosing to keep the discussions at a verbal level only or have their health professional make formal entries into their personal medical files or alternatively they may wish to record their wishes and preferences in their own voice using the advance care plan tool.

Recording ACP

1. When setting an appointment with the patient ask if they are aware of ACP and whether they have begun the process of planning for their future care and treatment;
2. If the patient is enrolled on the Care Plus programme check the status of the patient's ACP process on the Medtec system (GP setting);
3. Check the status of the ACP process on the patient's/client's file (ARC Provider, Hospice and NGO)
4. If the patient has regular outpatient appointments as part of a follow-up process, check the status of the ACP in the patient notes. Patient's preferences will be noted on their file.
5. Include a reference to patients attending hospital appointments to kindly bring their ACP with them. There will be an opportunity to discuss this with the specialist in the hospital setting.

NDHB commitment to implementing ACP

1. Northland DHB is charged with ensuring resources and education are available to support the development of skills and knowledge of staff and of the Northland population for advance care planning. The vision is that ACP will be normalised into every day clinical practice and eventually included in all Care Plans for people living with long term conditions.

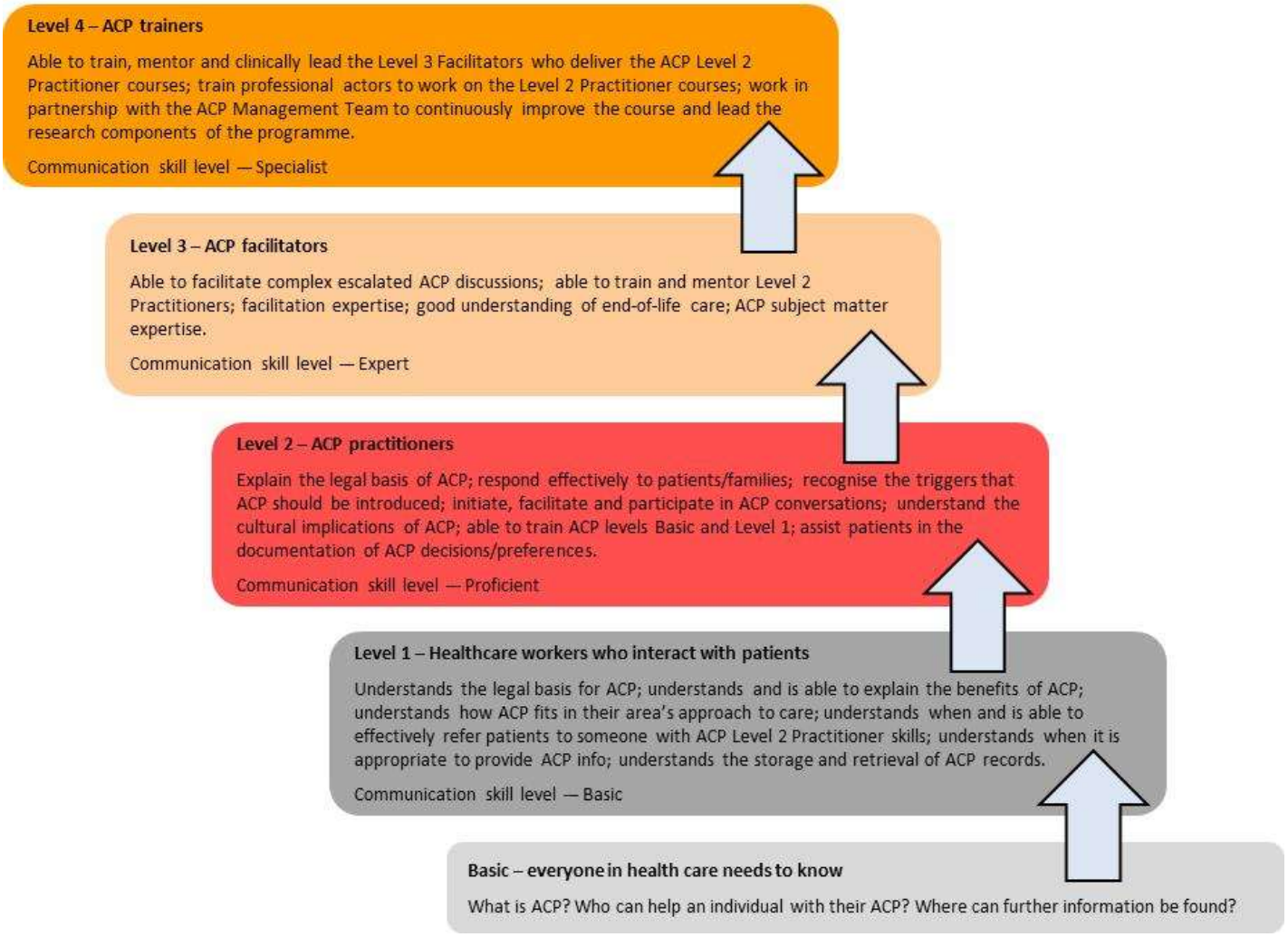
2. NDHB has developed a policy statement to support the strategy for introducing ACP into clinical practice. A review of how the ACP Policy is consistent with the DHB core values and congruent with the DHB (consumer related) policies will be carried out annually.

3. NDHB is responsible for developing district-wide strategies that identify and remove barriers across the spectrum of health services to enable patients to gain equitable access to ACP tools. E-learning will be supported by the NDHB. Commitment by NDHB and MoH funded services will be required to allow staff to undertake on-line learning modules to build their awareness, knowledge and competency in advance care planning. General practitioner training has already been incorporated into the CME framework.

ACP competency framework and training

The National ACP Cooperative is responsible for producing the education and resources for the Northern Region. A website has been developed and provides a range of resources for both patients and health professionals alike. The Advance Care Planning Training & Competency Framework offers the following stages of stepped learning platforms.

Advance Care Planning Training Competency Levels



- Basic Competency: two videos available to view on the national ACP website
- ACP Level 1 Competency: (online learning linked through NDHB Moodle).
- ACP Level 2 Competency: (2-day interactive training in advance communication skills) – all requests to be forwarded to the NDHB ACP Programme Support Administrator.
- The priority to the ACP Level 2 Advanced Communication course is based upon the following criteria:
  - General Practitioners and Nursing Staff involved in chronic care management
  - Registered Nurses employed in Aged Residential Care Facilities (rest homes)

- Palliative Care Medical Specialists and Nurse Specialists (hospice)
- Hospital Outpatient Clinic Medical Specialists and Nurse Specialists
- Community based rehabilitation multidisciplinary teams
- Hospital based rehabilitation multidisciplinary teams
- Allied Health Staff

- ACP Level 3 Facilitator/Educator role: Palliative Care expertise.

ACP - Informing End of Life Care (planning processes)

Any decision to participate in the advance care planning process, any utilisation of advance care plans and advance directives is entirely voluntary on the part of the patient/client. However, if a person is identified as having strong views or preferences about medical treatments and procedures, they should be advised to consider completing an advance medical directive.

An advance directive is a written or oral directive/instruction that enables a person to make choices about possible future health care treatment/s and becomes effective only when the person loses the capacity to make those choices for themselves. An advance directive may be developed and informed by the advance care plan for use in end of life care and planning. An advance medical directive involves a General Practitioner or health Professional and in most cases a legal representative for the patient (enduring power of attorney).

APPENDICES

PILOT SITE EXAMPLES OF ACP PROCESSES

Appendix 1: Whangaroa Health Service

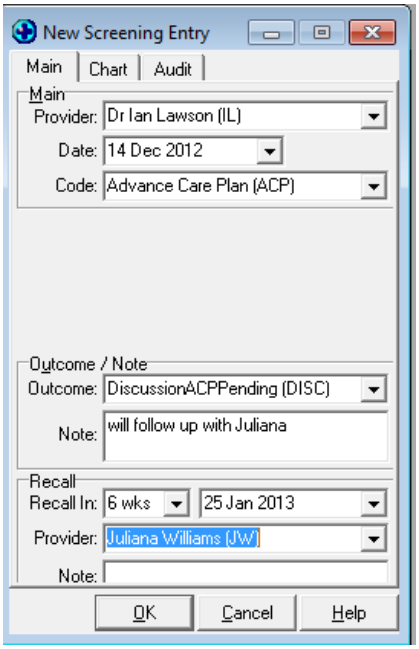
Appendix 2: Kauri Lodge Residential Care

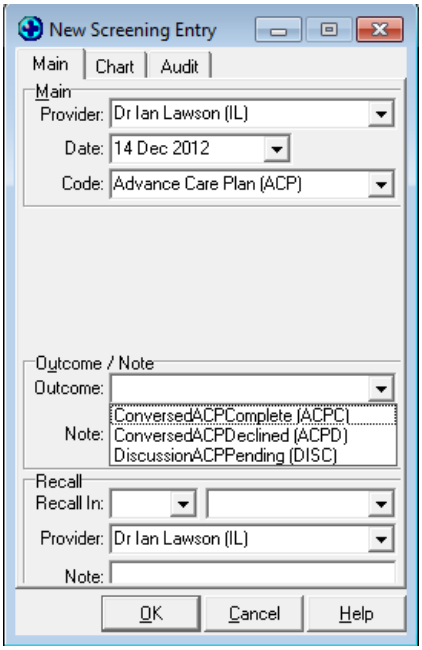
Appendix 3: Claud Switzer Residential Care

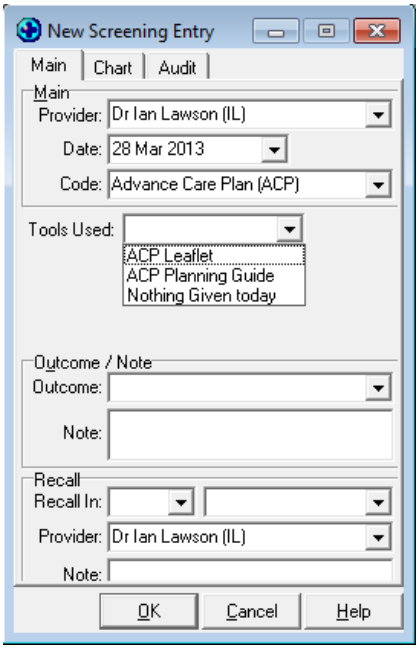
Appendix 3: NDHB Renal Service

APPENDIX 1: WHANGAROA HEALTH SERVICE ACP PROCESS

1. In the Whangaroa Health Centre, the Care Plus team will work with patients to complete an Advance Care Plan.
2. Other nurses and GPs may see and patient and offer them an opportunity to start a conversation about ACP but they should encourage the patient to link in with the Care Plus team to progress and complete it.
3. For any discussion about ACP, you should always complete a screening record - as shown below.
4. To record the outcomes of the discussions/conversations the following status should be used:
   - DISC - for any discussion about ACP where the ACP is not completed – create a record for every discussion so that they can be counted
   - ACPD - if a patient says they do not wish to complete an ACP
   - ACPC - if an ACP is completed
5. Use the recall system to maintain the progress status and as a reminder process to offer the conversation again (particularly if the patient has declined previously).
6. The DHB has requested that we report quarterly on the activity/numbers to support the regions commitment to advance care planning.
7. In the Care Plus waiting room there is a continuous short slide presentation on the TV monitor; this will need to be switched on daily.
8. Supplies of the official ACP leaflets and ACP booklets will need to be available in each consult room of the Health Care Centre (Chronic Care).
9. ACP leaflets will need to be available in the Health Care Centre (Chronic Care) waiting area.
10. ACP booklets are to be issued by the Chronic Care Nurse once the conversation process has commenced with the patient.
11. Recording the issuance of resources can also be recorded on the screening tools. See below.







APPENDIX 2: KAURI LODGE, WHANGAROA HEALTH RESIDENTIAL CARE ACP PROCESS

1. Information about ACP can be located on the ACP website – familiarise yourself with the concepts: http://www.advancecareplanning.org.nz.
2. The attached ACP Process v3 is a flowchart showing the **process** of ACP implementation in Kauri Lodge.

   Adobe Acrobat Document
3. The attached ACP form shows how you can record **progress** for the residents.

   Microsoft Word 97 - 2003 Document
4. The attached "My Advance Care Plan Form" is the form that is completed to **record** the resident's wishes for their future care.

   Adobe Acrobat Document
5. For each of the residents for whom you are responsible, please check their file to ensure a copy of each of these is in section 9, completed or ready for completion.
6. Work with RN for Kauri Lodge towards completion of ACPs where appropriate for your group of residents. The RN can start conversations and supply you with leaflets and information when needed.
7. The residents should fall into one of the following groups:
   - ACP discussion not yet started
   - ACP discussion in progress
   - ACP declined
   - ACP completed
   - Not competent for ACP
8. The DHB has requested that we report quarterly on ACP activity/numbers. Files will be reviewed regularly as part of the internal audit process. Therefore, kindly assist us to capture the wishes of the residents using the ACP process.

If you have any questions or need support about ACP, please ask the RN for Kauri Lodge or the Clinical Manager of Whangaroa Health.

APPENDIX 3: CLAUD SWITZER RESIDENTIAL CARE ACP PROCESS

Flow chart and progress form for Advance Care Planning:


Adobe Acrobat Document


Microsoft Word 97 - 2003 Document

Procedures and forms for Advance Medical Directives for Nurses and Physicians:


Adobe Acrobat Document


Adobe Acrobat Document


Adobe Acrobat Document


Adobe Acrobat Document

APPENDIX 4: NDHB RENAL SERVICE ACP PROCESS

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