



Embedding Advance Care Planning in Professional Practice

Looking for ways to make Advance Care Planning consistent, systematic and routinely conducted

Advance Care Planning is a process which can take some time to complete. For individuals, it can often be a task that is started but not completed, or one that is 'put down' when some kind of block is encountered. Unfortunately, there are many things that can get in the way of completing the process and or producing an Advance Care Plan. These might include:

- a lack of information to decide
- difficulty with understanding documentation
- social isolation
- lack of reminders to complete
- being too busy
- reluctance to acknowledge mortality
- limited clinician time

In order to improve the uptake of Advance Care Planning and the completion of Advance Care Directives, it is helpful if individuals and organisations dealing with members of the public who are keen to undertake Advance Care Planning, can act as enablers for the process. This might include, providing information sessions, providing support for those struggling with the process, supporting buddies to help complete the process, offering regular progress checks and providing opportunities, potentially through workshops for individuals to complete their documentation, and having frank conversations about End of Life.

One of the best ways for organisations and professionals to support this process is to embed Advance Care Planning into their systems, structures and checklists. This might play out differently for each organisation and/or type of organisation. Strategies to use might include:

- Making Advance Care Planning part of the discussion at 50 plus and 75 plus health checks
- Putting Advance Care Planning on checklists that are used when dealing with patients
- Issuing reminders for those who have commenced Advance Care Planning, triggered by electronic means
- Ensuring that at every appointment the question is asked about the progress of Advance Care Planning
- Making Partners in Planning Leaflet available: Advance Care Planning & Directives*
- Putting Advance Care Planning on the agenda of organisation meetings to be discussed on a regular basis
- Running regular workshops for Advance Care Planning both for staff and patients/clients
- Mail Advance Care Planning supporting documents to patients
- Conveying the importance of Advance Care Planning to those in outreach, especially to ageing Australians
- Having Advance Care Planning prompts built into software checklists and procedures
- Having the Partners in Planning/Marathon Health Advance Care Poster on the waiting room wall
- Consider playing some of the Advance Care Planning videos on rotation with your other health displays
- Consider running a competition or promotion for the completion of Advance Care Directives

1 Tips for successful advance care planning conversations*

- The individual needs to be ready for the conversation and mentally capable of participating — conversation cannot be forced, but at the same time clinicians, in most instances, need to take the lead in initiating such conversations.
- Capacity to engage in conversation must be maximised by treating any transient condition affecting communication and optimising sensory function (eg, by ensuring the patient's hearing aid is being worn).
- Conversations need to take place on more than one occasion (over days, weeks, even months) and should not be completed on a single visit in most circumstances.
- Conversations take time and effort and cannot be completed as a simple checklist exercise.
- Conversations should take place in comfortable, unhurried surroundings; time is a key factor.
- Conversations should be devoid of medical jargon, language should be positive, and trust must be built using empathic listening skills.
- A step-by-step approach to identifying and resolving issues should be used (see Box 2), coupled with "time-out" periods where doctors withdraw from the encounter for some minutes to allow patient and family to discuss between them the care options that have been presented.
- Individuals should be given realistic information on prognosis and treatment options with emphasis on how their illness is expected to impact on their daily function.
- Conversations should avoid focusing initially on medical interventions (eg, cardiopulmonary resuscitation, intubation) but rather determine values, goals, and preferences (eg, prolonging life and preserving mentation versus minimising suffering and avoiding undignified states or an unacceptable functional status).
- Look out for cues suggesting individuals are becoming uncomfortable talking about certain issues or may wish to end the conversation.
- Encourage patients to identify a surrogate decisionmaker and to discuss their wishes with that individual; if desired, offer to facilitate a conversation between patients and their surrogate or other family members; identify whether patients have specific desires for how information is shared among family members.
- Summarise and check patient's and, if they are present, surrogates' understanding of what has been discussed at end of sessions.
- Encourage patient and surrogates to have conversations documented but reassure them these documents are not necessarily final or binding.
- Plan for a review as clinical circumstances change.

*Adapted from Advance care planning. Concise Guidance to Good Practice series, No. 12. London: Royal College of Physicians, 2009.34 ♦

2 Concerns and safeguards in advance care planning (ACP)

Concerns

Lack of understanding and recall

- Poor patient understanding following ACP discussions
- Low concordance between recollections of patient and physicians or proxies
- Lack of recall of care decisions into the future
- Patient uncertainty about care wishes, especially among patients from non-English speaking backgrounds or with low levels of literacy

Coercion

- Undue influence of clinicians in care decisions who may rate patient quality of life considerably lower than patients themselves
- Coercion of patients and proxies to agree to limitations of life-sustaining therapy

Inflexibility

- Inflexibility of "locked-in" ACP documents that are not responsive to changes in clinical circumstances and/or patient and proxy preferences

Safeguards

- Provide comprehensible information sufficient to allow patients to feel comfortable with their level of understanding
- Before terminating conversations, reiterate decisions to ensure patients, clinicians and proxies are all "on the same page"
- Provide copies of summaries of conversations (including videorecordings of the sessions) on request at their conclusion
- Involve family and interpreters in ACP conversations and documentation. Conduct conversations at the appropriate level of literacy and involve health professionals of similar ethnic background

- Involve more than one health professional in ACP conversations and include individuals who have not been directly involved in the patient's care up to that point in time
- Emphasise and reiterate the goals of ACP that respect patient autonomy and wishes within the bounds of care that is not deemed to be futile

- Use a range of ACP procedures — one size does not fit all — with initial emphasis on eliciting values and preferences rather than concrete treatment decisions
- Apply any ACP document or advance health directive only to a decisionally incompetent patient or a patient who is unable to communicate. Competent and conversant patients can always speak for themselves
- Undertake ACP conversations in non-emergent situations when patients are clinically stable and not mentally impaired by reversible illness
- Update ACP documents regularly and whenever circumstances change significantly

3 System-wide strategies for embedding advance care planning (ACP) into routine care

Primary care settings

Use computer reminders to initiate ACP discussions in eligible patients at upcoming doctor appointments.
Mail introductory ACP material to eligible patients.
Dedicate time for ACP within annual comprehensive medical assessments and extended primary care consultations.
Train practice nurses or social workers to act as case managers in ACP for patients following initial discussions with doctors.

Hospitals

Initiate conversations about ACP when admitting frequently hospitalised patients, formulating acute resuscitation plans or care pathways for chronically ill patients and caring for patients transferred from or to residential care facilities.
Place clinicians skilled in ACP in all units with sizeable numbers of chronically ill patients (general and geriatric medicine, oncology, cardiac and respiratory), tasking them with identifying and counselling suitable patients and imparting ACP skills to other staff.
Document the status of ACP discussions in discharge summaries. Discharge co-ordinators ensure ACP information is communicated to all external clinicians.
Foster staff awareness of ACP using screensaver messages on workstation computers and posters and brochures on noticeboards.

Residential care facilities

Routinely initiate ACP conversations between senior nurses and patients and their proxies following admission, after any major change in clinical status and at yearly intervals, or more frequently depending on change in clinical status.
Make easy-to-read ACP information available to all new residents, and display promotional material for staff and facility visitors.
Require facility-affiliated general practitioners and geriatricians, working with senior nurses, to undertake ACP training and information sessions and implement and audit ACP processes according to best practice.
Accessibility, standardisation and auditing of ACP documents
Require hospital and health services, Medicare locals and residential care facilities to generate and use area-wide ACP document templates that are standardised, simple, patient-friendly and readily downloadable at the point of care. File copies of completed advance care plans and/or AHDs in a consistent manner, flag them on all patient records (including patient-controlled electronic health records) and ensure they are able to be rapidly retrieved, preferably via a centralised electronic registry.
Store ACP documents with electronic medical records to enable quick communication regarding changes in plans to all parties involved through shared portals.
Provide patient-held wallet cards or alert bracelets to flag the existence of ACP documents for the benefit of ambulance services and emergency physicians at times of crisis.
Regularly audit ACP processes and document the level of congruence between expressed patient wishes and the care actually received.

Professional training

Ensure all clinicians, especially doctors, case managers and social workers, undergo training in ACP and appropriate communication skills using simulation techniques, role-play, scenario analyses and computer-based decision aids.
Include measures of competency in ACP in professional credentialing processes.

Public awareness

Display brochures and texts that introduce ACP (such as Planning your future care, available at www.endoflifecareforadults.nhs.uk) in clinics and interview rooms and on noticeboards.
Recruit health professionals to sponsor and participate in public engagement campaigns that serve to both educate and prompt patients in discussing ACP.
Create a national clearinghouse for ACP information, document templates and related laws that cover all Australian state and territory jurisdictions.
Highlight user-friendly websites and resources for consumers and professionals in lay and professional news media.
Educate the public in the skills and benefits of shared decision making.