Documentation of advance care planning – Time for a new form

Mater HEALTH Brisbane

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Effectively planning for clinical deterioration

Clinical Risk

- Given that not all individuals approaching the end of their lives are being recognised there is a concern that clinicians are not effectively communicating with patients and their family, friends and carers and planning for episodes of clinical deterioration resulting in individuals not receiving high quality care that is aligned with their preferences

Since 2016 HRT - How do we plan & document EOL care

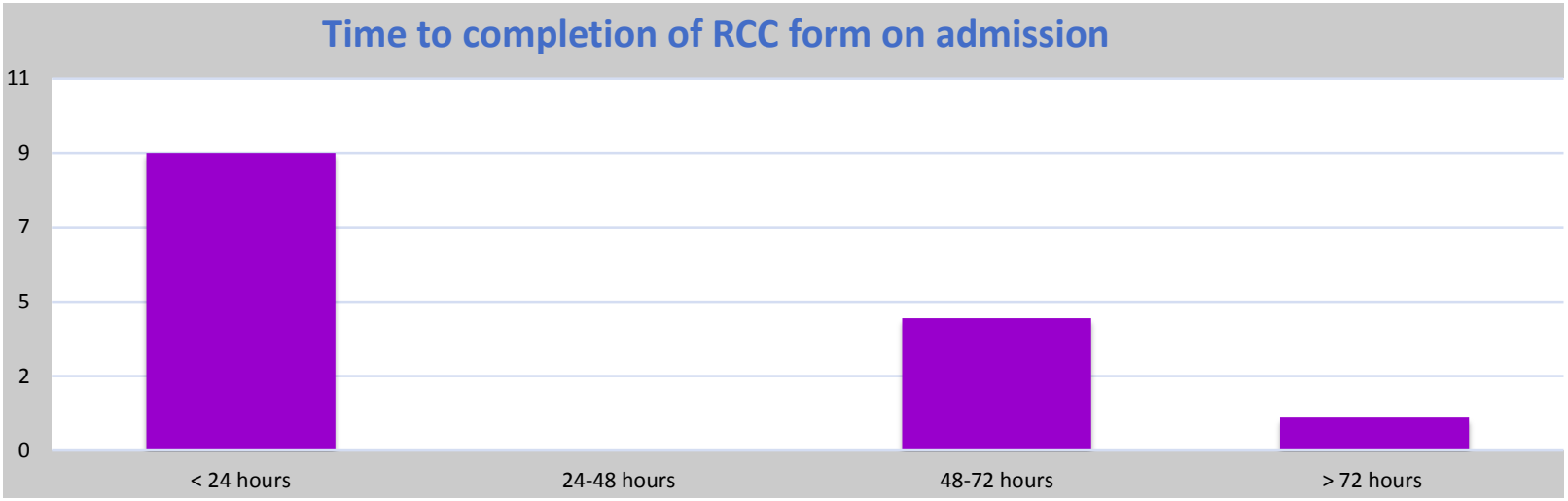
Aim

- Deliver end of life care to patients across a large acute health care organisation delivering medical, surgical, cancer services that align with patient's preferences.
- Increase compliance of clinicians completing and documenting advance care planning using the recommendations for clinical care (RCC) form ensuring form is valid

How

- Documentation audit was completed on patients that had died in hospital during a one month period
- Identify when RCC form is being completed and identify gaps in care
- Identify number of patients receiving end of life care

Audit results



Audit Period: April 2016
Sample Size: 19 patients who died
Retrospective audit reviewing completion of RCC form & documentation of EOL conversation

Findings
79% (15 of 19) patients had a completed RCC form
47% (9 of 15) had RCC form completed within 48 hours of admission
33% (5 of 15) patients had a valid RCC form
58% (11 of 19) patients had documentation of EOL conservation with patient/family/carers
37% (7 of 19) patients had a palliative care review
21% (4 of 19) patients were admitted to ICU within a fortnight prior to death

Morbidity & Mortality Meeting
Compliance issues with documenting end of life

- Missed opportunities to discuss patient wishes regarding end of life care potentially leading to unwanted treatment, distress, and bad death

<u>Limitations of current form</u>

- Form often incorrectly completed/voided due to lack of clear instructions and amended without clear documentation of when and why amendments made causing confusion
- No standardised form used across state – increasing confusion for rotating medical staff
- Not patient centred i.e. 'shopping list' of treatment options which can often be meaningless to patients and impedes discussion
- Not always clear if the completed RCC form was discussed with the legal substitute decision maker
- Multiple MET calls for patients who would not benefit from escalation of care beyond ward based treatments - due to registrar concern of ticking 'not for METS'
- Poor understanding of Queensland laws with regards to substitute decision makers and provision of care when there is disagreement between patients / decision maker and doctors

Compliance issues with documenting end of life

- ✓ What form will we use
  - Following review of other hospital forms
    - Qld Acute Resuscitation plan; SA Resuscitation plan 7 step pathway; ACT Health; Tasmanian Health forms
  - Acute resuscitation plan developed
    - Tips for completing form; Guide to Capacity Assessment;
    - Legal considerations – substitute decision maker
    - Supportive and Palliative Care Indicator Tool (SPICT™)
- ✓ Who completes the form
  - consultant and registrar
- ✓ When to complete form
  - Triggers for which patients should have a form
- ✓ What does it cover
  - Includes patient wishes
  - Goals of Care
  - Resuscitation plan
- ✓ Transparency
  - Who was involved in discussion and completion of form
  - Period form is valid - episode of care; defined period or indefinitely
  - Copies provided to patient (or substitute decision-maker)

Outcomes so far

- ✓ Development of form led by Consultant - General physician
- ✓ Multidisciplinary end of life care working party formed
- ✓ Form amendments based on feedback
- ❑ Who will trial form?

Lessons Learnt

- Organisational restructure “slowing improvement process”
- Not everyone happy - How do you teach old dogs new tricks
- Education will be essential in developing advance care planning

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