Innovation Poster Session
HRT1310 – End Of Life
June 20-21 2013

Regional planning and implementation of ACP

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Hospital Code Name: Thunder

KEY PROBLEM

- Admission to hospital may be inappropriate when the goal of care is comfort and quality – need to improve documentation.
- Re-admission to acute care is the default when goals of care are not elicited or documented.
- Poor quality of “Advance Directives” from Aged Residential Care – these are often impossible to interpret and therefore to honour.
- Poor understanding within the health care sector and in society about what ACP is and the benefits that it can bring.

AIM OF THIS INNOVATION

- ACP is an internationally recognised concept that is being increasingly explored in many health care settings, despite the difficult and sensitive nature of the conversations.
- People do want to have their wishes known and honoured so we have an obligation to set up appropriate processes.
- The aim of ACP is to:
  - Offer the opportunity for people to express their values and preferences formally with a HP
  - Have plans of care documented for people who have undergone ACP that are able to retrieved and able to be altered as required
  - Prevent inappropriate admissions wherever possible

BASELINE DATA

- No specific data available but LOTS of anecdotes!!

KEY CHANGES IMPLEMENTED

- Multi-disciplinary work group formed involving both primary and secondary care.
- Decision made by the group to create an ACP form to be used in our region. This form includes a section completed by the person which documents their personal values and preferences PLUS a section outlining their care decisions (including life-prolonging treatments and CPR).
- Some members have attended the National ACP L2 training.
- IT involved to create an electronic version that can be universally accessed by community/secondary/tertiary care (currently a work in progress).

OUTCOMES SO FAR

- Multiple education sessions carried out involving primary and secondary care
- “HealthPathways” has created a resource for health professionals that is being utilised
- Patient portal available on www.healthinfo.org.nz
- However, only a handful of ACPs have been completed so far
- Palliative Care Specialist currently available to read them all for quality/audit/feedback.
- No electronic version yet; only able to be filed in notes
  - patient advised to keep own copy and disseminate to key people.

LESSONS LEARNT

- It's a BIG project - need to be in it for the long haul!
- Requires an IT solution that makes the document visible to everyone who needs it, before starting to implement ACP – this is a challenge in itself…..
  - If it works and we get incremental health professional buy-in along with an electronic version that records both pt preferences (part A) and "physician orders" (part B) this will be a major achievement
- Ongoing confusion about ACP v Advance Directives.
- Ultimately, we need to concentrate on having the conversations and documenting goals of care, even if a formal ACP is not completed
  - Initially focus on the "surprise question" as a trigger