The Advance Care Planning Toolkit

A practical guide to implementing Advance Care Planning in general practice as a CQI activity and for PIP QI and CPD purposes

Quality Improvement Toolkit for General Practice

COORDINARE

phn SOUTH EASTERN NSW
An Australian Government Initiative

Contents

COORDINARE acknowledges that this resource has been adapted from the Patient Population Groups Last Days of Life Toolkit developed by Brisbane South PHN.

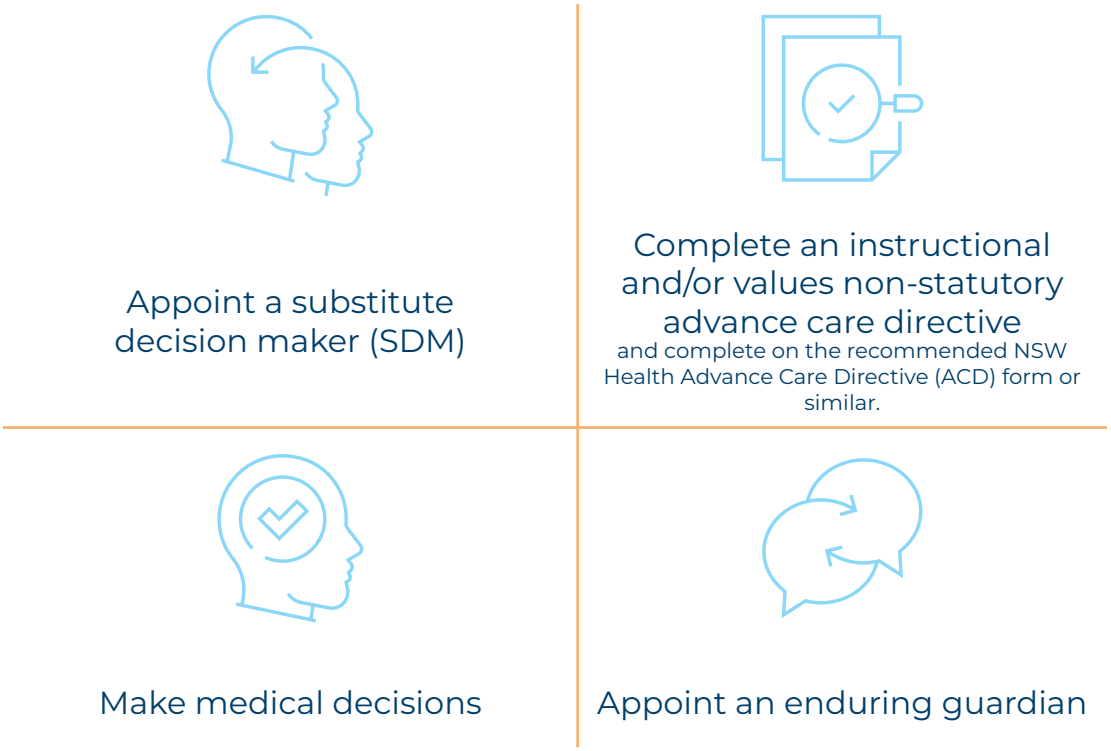
Please note: due to constant developments in research and health guidelines, information in this document may be subject to change. Please contact info@coordinare.org.au if you have any feedback regarding the content of this document.

1. About the Advance Care Planning toolkit

Advance Care Planning (ACP) is a person-centred approach that aims to guide current and future decision making about a person's treatment and care that it is consistent with their goals, preferences, and values. The ACP process is proactive, ongoing and should be integrated into routine care. It involves ongoing communication and collaboration between patients, their families or people closest to them and health professionals.(1)

The ACP process has different iterative steps and can result in an individual's preferences and values being recorded in Advance Care Directives (ACDs). Advance Care Directives forms a subset of ACP documents. As there is no national Advance Care Directive legislation in Australia, each state and territory determine their own legislation and ACDs/ ACP documents to use. (2) ACD's made in other states are enforceable in NSW. (3)

In NSW a person with decision making capacity can:



General Practice is an important setting for initiating and promoting ACP, as planning future health care is best discussed with patients at the time when their health is stable. (4) Evidence suggests that ACP achieves successful outcomes, reducing unnecessary and aggressive treatments at the end of life, higher satisfaction with quality of care and reduces unnecessary hospitalisations for patients at the end of life. (5)

This Toolkit provides a practical guide for general practice teams to assist patients to navigate the advanced care planning process. It describes how to successfully implement advance care planning in a practice as a CQI activity, and for PIP QI and CPD purposes.

COORDINARE wishes to advise the content in the Advance Care Planning Toolkit was peer reviewed. COORDINARE would like to acknowledge the subject matter experts who participated in the review process, providing feedback that informed the scope and direction of the quality improvement resource.

2. Aim of this toolkit

To provide a simple and practical guide for general practices to increase the number of advance care planning documents completed with patients as a CQI activity.

The Toolkit provides a multistep process to implement Advance Care Planning into general practice as a CQI activity.

The steps being: Identification, Assessment and Implementation, Discussion, Planning, Coordinate, Revision.

The toolkit supports general practice teams to:

- successfully implement Advance Care Planning in general practice as a CQI activity.
- make best use of practice data.
- document Advance Care Planning as a CQI activity
- use the CQI activity for PIP QI and CPD purposes.
- make measurable and sustainable improvements in a feasible manner to patient care.
- increase knowledge of CQI principles and practical application.

3. The Quality Improvement Methodology (QIM)

This QI toolkit is **designed to support your practice to make easy, measurable, and sustainable improvements to provide best practice care for your patients.** The toolkit will help your practice complete QI activities using COORDINARE's continuous Quality Improvement Methodology (QIM).

Throughout the toolkit you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the QIM.

The QIM methodology uses SMART goal setting as the overarching framework to ensure goals are specific (S), measurable (M), achievable (A), realistic (R) and time based (T). It is a simple but structured approach that anyone can apply. There are four components:

1. Define and analyse,
2. Plan and implement,
3. Document and communicate,
4. Monitor and evaluate.

See the full QIM process

COORDINARE provides key tools to help you plan and monitor QI:

The Improvement Plan

This template supports you to identify areas for improvement, set SMART goals and monitor improvements over time.

PIP QI

Some of the activities in this toolkit relate to the Practice Incentive Program Quality Improvement (PIP QI) measures. Keep an eye out for this icon throughout the toolkit.

4. Where to go for more support

Your Health Coordination Consultant (HCC) can provide support to undertake the activities in this toolkit. You can contact your HCC directly or via these details.

info@coordinare.org.au

1300 069 002

5. HealthPathways

HealthPathways is a free web-based portal designed to support health professionals in planning patient care through primary and secondary health care systems within the local region. It will help you manage and refer your patient to the right care, in the right place, at the right time.

HealthPathways content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals. They are designed to be efficient, simple and quick for GPs to use. HealthPathways are tailored to best meet the needs of the local communities and aim to help GPs support their patients by outlining:

- the best management and treatment options for common medical conditions
- information on how to refer to the most appropriate local services and Specialists
- educational resources and information for patients to enable better self-management of health.

Within South Eastern NSW there are two different HealthPathways initiatives supporting each Local Health District. To access them use the links below.

ACT and Southern NSW	**Illawarra Shoalhaven**
Username: together Password: forhealth	Username: connected Password: 2pathways

6. How to use this toolkit

There are checklists included in this toolkit that will guide you and your practice.

- The toolkit is broken down into 6 elements with 18 steps to guide you through the advance care planning journey.
- Each element contains processes, activities, tools and resources designed to help you reflect on your current practice to enable you to identify areas for improvement.
- Once you have completed the simple reflection activities you will reach the end of the section. Now you have identified possible areas for improvement you could consider setting a goal using COORDINAREs Quality Improvement Methodology (QIM) to develop your Improvement Plan.

  Look out for this symbol as a prompt to consider writing up an Improvement Plan.

- Remember to contact your HCC if you need help with these activities and supporting tools.
- If you find your process is not working and you are not seeing improvements, then review your process and start again.
- **Please note:** Some GP practice services e.g., prevention or chronic disease management (CDM) may be difficult to provide or need to be postponed during a pandemic/natural disaster as resources are finite or reduced (in the practice and more generally in the health system). It is important that the practice has a team approach to establishing priorities to ensure vulnerable populations receive the care they need.

7. Advance Care Planning (ACP) Elements, Processes and Activities

With an aging population, and most deaths due to a non-malignant cause, there is urgency to review the nature of end-of-life care (EoLC) to minimize gaps in service provision. Early introduction of EoLC benefits patient and carers, so identification of those at risk of dying 6 to 12 months before death is highly desirable.

Advance care planning (ACP) is a process of ongoing communication between a patient, their family and healthcare professionals to clarify the patient's goals, values and wishes for future healthcare should they lose decision-making capacity. The ACP discussion often results in a written document such as an Advanced Care Directive (ACD).

Note: There is variation terminology and legislation of ACD's between different jurisdictions within Australia. The content provided in this module relates to NSW legislation and terminology.

The aim of this activity is to review your practice's approach to advanced care planning with your at-risk and vulnerable patients. The activity will also provide information to ensure relevant people in your practice know the importance of end of life/last days of life conversations and planning.

The activities can be undertaken as a whole of practice (organisational) and/or an individual QI process.

Consider whether your practice will need an advance care planning leader/champion to implement planning activities

It is suggested that you meet as a practice team to discuss how you will provide care for your at risk and vulnerable patients.

7.1 Identify suitable / at risk patients

Processes and Activities	Things to consider
Does your practice have a systematic approach to identify and screen suitable patients who are most likely to benefit from advanced care planning? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column. PIP QI	**1. Use data extraction to identify suitable patients** **Step 1:** Use Pen CAT4 to identify active patient groups who are at risk of deteriorating and dying. ◗ Pen CS has provided a number of CAT recipes to help you Identify Patients at Risk - CAT Recipes - PenCS Help **Step 2:** Identify a suitable group (sample) of patients to discuss advance care planning with or who require completion of documents as part of their health assessments. Potential patient groups could include patients: ◗ Over 70 years with chronic conditions ◗ At high risk of dementia ◗ With diabetes, CVD, CKD ◗ Eligible for 75+ Health assessment ◗ Eligible for 45-49 years or 55 + Aboriginal or Torres Strait Islander health assessment ◗ Turning 50 and eligible for bowel and/or breast screening **2. Use Clinical Assessment Tools to identify patients at risk of deteriorating and dying.** Use a combination of below tools to identify patients at risk of deteriorating and dying. The Surprise question: "*Would you be surprised if the person died in the next twelve months?*" ☐ Yes: Prognosis greater than 6 to 12 months Key clinical process: Advance Care Plan (ACP) ☐ No: Prognosis of less than 6 months Key clinical process: ACP and Palliative care case conference ☐ No: Prognosis very limited, usually less than 1 week Key clinical process: Terminal Care Management Plan

Processes and Activities	Things to consider
7.1 - Identification (continued)	The SPICT tool - helps identify people with one or more general indicators of poor/ deteriorating health and clinical indicators for advanced conditions. ☐ Yes: Review current treatment plans, ACP discussions, review current ACD ☐ No: Schedule ACP discussion, and review current care plan (CDM Plan) **Tip:** Plan ahead for ACP discussions if loss of decision-making capacity is likely. **3. Do you have a process in place to provide Health Assessment, General Practice Management Plans (GPMP) recalls and reminders to these patients?** ☐ Yes Who is this, what is their role and how is the process conveyed to relevant staff members? ☐ No Which staff member is responsible for the creation and implementation of this process? **Further Guidance** **Systemise:** the surprise question and SPICT into the Medicare Health Assessments for Older Persons (75+ or 55+ for Aboriginal and Torres Strait Islander Persons) **Develop:** an agreed process to code ACD within practice software to enable you to search for patients with an ACD. ◗ Advance Care Planning Australia FAQ for General Practice ◗ The Start2Talk ACP Continuous QI audit tool ◗ SPICT Guide ◗ REDMAP Framework and resources to guide conversations about care planning. ◗ Home Support Plan **Tip:** Contact your HCC for guidance in using CAT4 and you would like to discuss further. **Tip:** Collecting, analysing and sharing aggregated practice data are PIP QI requirements. Refer to COORDINARE's - quality improvement tools and resources to assist you to improve practice workflow processes.

7.2 Assessment and Implementation

Processes and Activities	Things to consider
Do all relevant practice team members know how to locate patients previous ACP discussions and documentation? ☐ Yes ☐ No Assessing patient records for evidence of conversations/documentation. Assessing appropriate opportunities and timing for ACP conversations. Strategies for implementing ACP.	**Step 3:** Check patient records for evidence of previous ACP discussions and/or documentation **Step 4:** Assess and document the person's condition and decision-making capacity. *Consider if patients condition includes cognitive decline. **Task:** Establish a system for ACP in your practice ◗ Use practice software to record discussions and create alerts ◗ Create reminders for ACD review ◗ Identify "triggers" for having the conversation (eg Health Assessments, SPICT tool) ◗ Book longer appointments (MBS schedule) ◗ Use Health Pathways to access forms and information
ACP information and ACP documents Do all relevant practice team members know where and how to locate advance care planning information and documentation? ☐ Yes ☐ No Does your practice team understand what an ACP is and the ACP documents used in NSW? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	**Tip:** Refer to the Advance Care Planning Australia Create your plan in NSW to find relevant ACD forms, including Making an Advance care directive information booklet and ACD form. **Refer:** to the National Advance Care Planning Support Service – a **free** information and support service for healthcare workers and individuals on all matters relating to advance care planning. Call **1300 208 582** with your questions. **Free patient/client support service:** Refer your patient/client to the support service where they will be guided through the ACP process and provided ACP support tailored to meet their needs. **Task:** Identify and order any resources or publications required. Refer to list of factsheets in the Advance Care Planning Australia website. **Develop:** a process for communicating this information to relevant practice team members? **Additional Resources** ◗ Factsheet for healthcare professionals ◗ Factsheet for Individuals ◗ ACP Documents for Gay, Lesbian, Bisexual, Transgender and Intersex people

7.3 - Discussion

Processes and Activities	Things to consider
Starting the conversation can occur through various stages of the illness trajectory depends upon several factors: ◗ Workforce capability ◗ Enabling the person ◗ Capacity Do any of the practice team require training/assistance to initiate and /or follow up with advance care planning conversations? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	**Starting the conversation** **Step 5:** Obtain appropriate consent; confirm if any substitute decision maker/s (SDM) and document consenting discussions ***(legal requirement).*** Obtain the person's consent to involve others in discussion ***(part of confidentiality requirements).*** If the patient has impaired capacity, ACP discussions can also be held with their SDM. **Step 6:** Establish what the person understands about their health care; elicit the person's goals, values, and preferences. **Step 7:** Introduce the concept of ACP and other follow up consultation session/s. **Step 8:** Provide ACP information and discuss formalizing decisions ***(legal docs voluntary).*** **Early conversations and getting started:** ◗ Guidance for starting advance care planning conversations ◗ Dying to Talk Discussion Starters **Conversations about the Last Days of Life** ◗ PREPARED - A guide for clinicians for conversations about the Last Days of life. ◗ Information for carers, friends and families; **Workforce Capability** ◗ Involve practice nurses in ACP discussions- e.g. introduce topic and give information during health assessments. ◗ Training and Professional development opportunities. ◗ Include admin staff in basic ACP training. ◗ Ensure staff know ACP procedures and where to get more information and support. ◗ Provide access to information about legal frameworks and legal responsibilities. ◗ Use ACP HealthPathways. ◗ Roles and responsibilities ie Nurse provides brochure and starts conversation as part of Health Assessment. GP discusses as part of care plan. Reception staff ask about ACD when registering new patients, add to new patient form. **Enabling the person/patient** ◗ Provide user-friendly information in waiting areas and treatment rooms. ◗ Identify key triggers for ACP discussion and review. ◗ Support people who have chronic conditions with ACP ◗ Link to other services for support: Palliative Care Services, Aged Care Services, National Advance Care Planning support service ◗ Use ACD to guide decisions if a person loses capacity. ◗ Encourage patients to upload their ACP documents to their My Health Record.

7.4 - Planning ACP, documentation and storage

Processes and Activities	Things to consider
Does your practice have a process for documentation sharing, access, and storage of a current and completed Advance Care Planning (ACP/ACD) document? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	**Advance Care Planning Laws NSW** A completed advance care directive must be written in English and should include the person's full name, date of birth, address and be signed. It is recommended that the ACD is signed by the person and witnessed by two (2) adults; one of whom is the treating health professional. Neither witness can be a person appointed as an Enduring Guardian (EG). Witnesses must certify the person completing the ACD has decision making capacity, they acted freely and voluntarily. **Important**: **Has the patient provided consent to share the ACD?** **ACP Treatment Plan- documentation** **Step 9:** Confirm the patient's preferences and goals for current and future treatments and care. **Step 10:** Prepare treatment plan based on ACP discussions with patient, SDM or family member (if consented). **Step 11:** Document treatment and care plan including outcome of all ACP discussions: cross reference in patient records. (this should include NFR plan and after 28/11/23 VAD if preference). **Step 12:** Ensure treatment plan is appropriately documented and communicated to ensure access by MDT and other consented providers. **Step 13:** Sharing and uploading of the ACD ◗ Upload a copy My Health Record (MHR) ◗ GP's and PN can upload patients ACD to their MHR if using Best Practice clinical software. ◗ Copy stored on general practice clinical software ◗ A copy to the Local Health District (see HealthPathways for process) Illawarra Shoalhaven HealthPathways ACT and SNSW HealthPathways ◗ A copy for the Person Responsible (PR)/Substitute Decision Maker (SDM) ◗ Other care providers ie homecare ◗ Other family members ◗ A copy for home easily accessible to paramedics during home visit **Task:** Develop a process within your practice for sharing an ACD with others and how this information will be communicated to the practice team members. **Accessing an ACD from My Health Record** ◗ Access procedure to ACP/ACD documents on My Health Record

Processes and Activities	Things to consider
7.4 - Planning (continued)	**Is there an alert and/or process for when changes are made to an ACP document in the clinical software?** ☐ Yes – What is the process and who is responsible for communicating and how? Who is this and what is their role? ☐ No Which staff member is responsible for the creation and implementation of this process? **Useful Resources** • The National Guidelines- Using My Health Record to store and access advance care planning and goals of care documents • Advance Care Planning (ACP) - Community HealthPathways Illawarra Shoalhaven • Advance Care Planning (ACP) – Community HealthPathways ACT and SNSW **Tip:** • Uploading copies of ACP documents: ensure the process is followed when replacing new versions with older versions. • Download and print a wallet card for patients to keep on self, this lets others know they have an ACD. • Advance care planning can be as simple as discussing a person's wishes and ensuring that the family or other substitute decision maker is aware of these wishes. Make sure they are noted in the clinical record.

7.5 Coordinate

How does your practice coordinate treatment and care plans with other clinicians? Are relevant documents easily accessible to all care providers involved? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	Continuity of known primary providers is important informing multidisciplinary teams in palliative care. **Step 14:** Involve other teams as appropriate, such as social workers, aged care, spiritual carers, and cultural representatives. **Step 15:** As the person's condition/prognosis deteriorates, coordinate with community care and/or palliative care teams for ongoing support as appropriate. **Step 16:** Any potential for misunderstanding or dispute should be resolved by this stage - involve senior clinicians and/or escalate to facility management. **Step 17:** Ensure processes are in place to manage place of dying and bereavement, including emotional, cultural, spiritual, and social support to those closest to the person. Has your practice considered introducing an Integrated Shared Care platform (INCA) to simplify the coordination of patient care, documentation, and real time communication? **Tip:** Contact your HCC for further information regarding INCA and available support to implement into your practice.

7.6 - Review of ACD and associated documents

Processes and Activities	Things to consider
Review care plan regularly to ensure currency and consistency with the person's goals and preferences. Does your practice have a system in practice have a process to review the ACP regularly? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	An individual can make changes and revoke ACP documents as often as they like, at any time if they have capacity. Indicators for when review should occur: ◗ When the individual's preferences change ◗ If their substitute decision maker (SDM) changes ◗ When their medical condition changes **Step 18:** Review ACP regularly to ensure currency and consistency with the patients' goals and preferences – for example during annual 75+ health assessment. ◗ Revisit treatment and care goals and discuss with the person and their family; escalate if any disputes remain unresolved. ◗ Revisit resuscitation planning to ensure earlier decisions about cardiopulmonary resuscitation (for example), reflect person's current goals for treatment and care. ◗ Review previous ACP discussions if, for example: person's circumstances change, hospital admission, unplanned surgery, deterioration in medical condition etc. ◗ Review paperwork to ensure all relevant documents remain valid, current, and accessible. **Consider an alert and /or process for when changes are made to an ACP document in the clinical software?** Example: Add a recall/reminder for annual ACD review, align with annual health assessment (if applicable) Edit health assessment template to include the following ACP/ACD questions: ◗ Is there a current ACP? Does it require a review and update? ◗ Has the patient been provided the original new or updated ACD/ACP document? ◗ Has a copy been uploaded to MHR? ◗ Has a copy been provided to the medical treatment decision maker, GP, local hospital, and those involved in providing their care? ◗ Create an alert in the patients' medical record stating there is an advance care directive and/or an appointed medical treatment decision maker and the date. **How will this process be shared amongst practice team members?** Your Health Coordination Consultant (HCC) can provide support to undertake the activities in this toolkit. You can contact your HCC directly or via these details info@coordinare.org.au or 1300 069 002

8. Advance Care Planning and the law

Processes and Activities	Things to consider
Are the practice staff aware that there is advance care planning law and policy in Australia and in NSW? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	An informed advance care plan requires an understanding by the patient of their own health problems, and about the realistic implications of the possible treatment options. Legal competence and capacity should be considered. Formal advance care planning is only legally possible when a person is competent or has decision-making capacity. Without this, they are unable to make informed decisions. An adult is presumed to have decision-making capacity unless there is evidence to the contrary. ACP conversations can occur with individuals who have lost decision making capacity, if they had a previous legally appointed substitute decision maker (SDM) **Ensure** all staff have the opportunity Making available to all staff an opportunity to complete relevant modules and have access to the NSW Capacity Toolkit. ☐ Yes – What is the process and who is responsible for communicating and how? ☐ No – Consider making available the training for all staff due to any changes in law and policy. **Resources – education and information** • NSW Capacity Toolkit • End of Life Law for Clinicians • Advance Care Planning Laws NSW • Ethics in advance care planning

9. MBS – guidance on the use of MBS items for ACP and palliative care in general practice

Has the practice considered how the use of MBS items can contribute to Advance care planning and palliative and end of life conversations? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	There are no specific MBS items for palliative care and ACP, instead other MBS items can be used to reimburse the delivery of ACP and palliative care. The following links provide practical funding streams for palliative care activities undertaken by health professionals within Primary Health Care. **Resources** Guidance on the use of MBS item numbers that may be used by GPs for advance care planning. • Advance care planning in general practice Guidance on the use of MBS item numbers that may be used by GPs for palliative care services where clinically appropriate. • MBS items for general practitioners for patients in primary health care • MBS Items for general practitioners for patients in RACF • MBS items for Nurse Practitioners • MBS items for Community Pharmacists • ELDAC Palliative care practice in primary care MBS items • PIP General Practitioner Aged Care Access Incentive (ACAI)

10.Workforce Capacity: Education and Training for staff

Processes and Activities	Things to consider
Do any of the practice team require training/assistance to initiate and /or follow up with advance care planning conversations? ☐ Yes, confirm all the items under 'Things to consider' are in place and then move to the next step. ☐ No, refer to the 'Things to consider' in the next column.	Identify how practice team members can be upskilled and to ensure all relevant team members understand how to implement ACP in general practice. To assist staff to navigate advance care planning conversations the following list of free online education modules, toolkits and resources are useful: **Early conversations and getting started:** ◗ Guidance for starting advance care planning conversations ◗ Dying to Talk Discussion Starters **ACP e-learning Modules for GP, PN, PM and others** ◗ Training and education - Advance Care Planning Australia ◗ Caresearch ◗ End of Life Essentials ◗ The Advance Project -General Practice **Toolkits and Checklists** ◗ End of Life Essentials **Factsheets** ◗ Advance Care Planning Australia (ACPA) Factsheet **Video** ◗ Advance Care planning as part of routine care How will this information be communicated to the practice team members and by whom? **Consider conducting a staff learning needs analysis to identify and target staff learning needs.** **Consider an all-staff training session to view available resources.** **Consider including training into new staff inductions.**
 **After reviewing your practice's process for early identifying and screening suitable patients for Advance Care Planning conversations along with ACD documentation processes, are there any changes you would like to implement in the practice to help manage and support patients over the next 12 months?**	Highlight some of the key learnings from this activity: Outline actions to be taken: Refer to the Improvement Plan- see examples and blank template on the following pages.

Improvement Plan Template

If you are setting more that one goal, click here to download the template.

PRACTICE NAME:

1. WHAT ISSUES DID YOU FIND?

This is where you list any of the issues that you discovered through your initial audit. The issues could be based on practice data e.g. Clinical Audit Tools and clinical database audits, cultural audit tool, readiness tool, near misses and patient and/or staff feedback. It could also include issues or challenges identified with internal processes and workflows. Once you have a detailed list you can use it in future Improvement plans.

2. WHAT ARE YOU TRYING TO IMPROVE?

Pick one area - Quality Improvement Measure (QIM) you are going to work on. You could pick something from the list you identified above. Other useful resources to help you pick your QIM is your benchmarking report or your Sentinels Practice Data Sourcing (SPDS) quarterly data quality snapshot.

3. WHAT IS YOUR BASELINE?

In order to measure your improvement you need to know where you are starting from. Without measuring, it is impossible to know whether the change has resulted in an improvement.

4. SET YOUR GOAL

Use SMART goal setting to ensure your goal is specific (S), measurable (M), achievable (A), realistic (R) and time based (T).

5. IMPROVEMENT PLAN – START DATE

6. IMPROVEMENT PLAN – END DATE

7. WHO IS YOUR PRACTICE CHAMPION

This is the staff member who is dedicated to leading the work. Consider a contingency if practice champion is unavailable.

8. WHAT WILL YOUR PRACTICE CHAMPION DO?

Provide an overview of the actions and responsibilities of the Practice Champion for the duration of the Improvement Plan

9. WHO WILL BE SUPPORTING THE PRACTICE CHAMPION?

The Practice Champion should consult with the practice team to establish who else in the practice will support the activity and what their role will be. Provide an overview of the actions and responsibilities of any other staff that will be supporting the Practice Champion for the duration of the Improvement Plan.

10. HOW WILL YOU COMMUNICATE YOUR PROGRESS?

Provide an overview of how you will communicate any issues or concerns, as well as share your results and progress with both your practice team and external stakeholders like patients and COORDINARE.

11. HOW OFTEN WILL YOUR PRACTICE TEAM MEET?

Provide an overview of how often your practice team will meet. Consider an ongoing / recurring calendar appointment for the duration of the Improvement Plan.

Improvement Plan Example

PRACTICE NAME: ABC Practice

1. WHAT ISSUES DID YOU FIND?

This is where you list any of the issues that you discovered through your initial audit. The issues could be based on practice data e.g. Clinical Audit Tools and clinical database audits, cultural audit tool, readiness tool, near misses and patient and/or staff feedback. It could also include issues or challenges identified with internal processes and workflows. Once you have a detailed list you can use it in future Improvement plans.

- 4 out of 7 clinicians are familiar with the SPICT tool.
- All staff rated their confidence in having an ACP conversation with a patient as 2/10
- 5 from 25 active patients with a coded diagnosis of cancer have a current ACD on record, nil ACP conversations documented.
- Nil was aware of the Appointment Reminder Translation tool for non-English speaking patients.

2. WHAT ARE YOU TRYING TO IMPROVE?

Pick one area - Quality Improvement Measure (QIM) you are going to work on. You could pick something from the list you identified above. Other useful resources to help you pick your QIM is your benchmarking report or your Sentinels Practice Data Sourcing (SPDS) quarterly data quality snapshot.

Proactive management and early recognition of patients who may benefit from advanced care planning conversations.

3. WHAT IS YOUR BASELINE?

In order to measure your improvement you need to know where you are starting from. Without measuring, it is impossible to know whether the change has resulted in an improvement.

BASELINE MEASUREMENT: 23% of active patients with a cancer diagnosis have had an ACP or ACD recorded since May 4, 2022 (past 12 months).

4. SET YOUR GOAL

Use SMART goal setting to ensure your goal is specific (S), measurable (M), achievable (A), realistic (R) and time based (T).

Increase the number of suitable patients proactively identified and increase and document the number ACP's conversations on patients with a cancer diagnosis by 10% by 30th October.

5. IMPROVEMENT PLAN – START DATE

1st May 2023

6. IMPROVEMENT PLAN – END DATE

30th October 2023

7. WHO IS YOUR PRACTICE CHAMPION

This is the staff member who is dedicated to leading the work. Consider a contingency if practice champion is unavailable.

Nurse Cindy – will lead and delegate tasks appropriately.

Receptionist Anne will support Nurse Cindy and is 2IC for the role.

Practice Manager Lilly and Medical Director Dr Gibson will provide management and governance over the implementation and should Nurse Cindy be absent processes will be in place to handover to.

8. WHAT WILL YOUR PRACTICE CHAMPION DO?

Provide an overview of the actions and responsibilities of the Practice Champion for the duration of the Improvement Plan

- Undertake data cleansing to ensure we are working with an up-to-date database, e.g., patients who have not been active for 2 years.
- Contact our COORDINARE Health Coordination Consultant for advice on running some of the queries.
- Search for any patients with an uncoded diagnosis of cancer by checking the coded diagnosis list and by searching patients taking antineoplastic (anticancer) medications but without a coded diagnosis.
- Identify active patients with a cancer diagnosis who do not have an ACD recorded in the past 12 months.
- Collaborate with GPs and PNs to discuss opportunities in identifying patients and having the conversations – eg annual Health Assessments
- Develop a checklist/cheat sheet for practice staff- opportune times for conversation (75+HA), how & where to access information and documentation, how to complete and store in the practice software, identify who needs copies, supports and services.
- Training needs identified for any relevant staff members on effective communication, documentation etc.
- Source and provide endorsed patient education resources (in waiting rooms, toilets etc.).
- Re-run the CAT4 report each month and contact patients who have not responded and any newly eligible patients.
- Plot our results for each month using COORDINARE's Tracking Sheet.

9. WHO WILL BE SUPPORTING THE PRACTICE CHAMPION?

The Practice Champion should consult with the practice team to establish who else in the practice will support the activity and what their role will be. Provide an overview of the actions and responsibilities of any other staff that will be supporting the Practice Champion for the duration of the Improvement Plan.

- Receptionist Anne will work closely with Cindy
- Practice Manager Lilly and Medical Director Dr Gibson will provide management and governance over the implementation and should Nurse Cindy be absent processes have been documented.
- The Practice Manager Lilly will meet with Nurse Cindy to discuss progress and any issues that arise.
- The Senior Receptionist will send reminder SMS to call patients in for HA.
- The Senior Receptionist, Nurse Cindy and/or Anne will call those patients who don't respond to the SMS.
- When a patient books in for an appointment, they will be asked to bring all medications with them to the practice and the practice nurse will see the patient prior to the GP consult to update patient measures including BP, height, weight, BSL, urine analysis and contact & carer details, ACD insitu
- Doctors will be requested to code all newly diagnosed cancer patients and not to free text.

10. HOW WILL YOU COMMUNICATE YOUR PROGRESS?

Provide an overview of how you will communicate any issues or concerns, as well as share your results and progress with both your practice team and external stakeholders like patients and COORDINARE.

- Progress results will be presented at monthly team meetings.
- A graph of each month's results will be posted on staff information board/Staff tea room.
- Results to date will be provided to COORDINARE at catchups with our Health Coordination Consultant

Celebrate any achievements big or small

11. HOW OFTEN WILL YOUR PRACTICE TEAM MEET?

Provide an overview of how often your practice team will meet. Consider an ongoing / recurring calendar appointment for the duration of the Improvement Plan.

Monthly.

Other SMART GOAL examples

The most predictive patient characteristics of a risk of death within 6 to 12 months are: deteriorating performance status, weight loss, persistent symptoms, request for palliative care or treatment withdrawal, impaired activities of daily living, falls ± fractured hip, neurological deterioration, advanced lung disease, and estimated glomerular filtration rate <30 mL/min/1.73 m^2 with deteriorating health. Our predictive model has a sensitivity and specificity of 67% and 87%, respectively, with a predictive accuracy of 78%.

- Within 6-months all patients will be assessed as at risk of dying within the index admission
- Within 12-months all patients identified as approaching end of life will have documentary evidence that the patient was assessed, and a management plan was in put in place that reflect patient / family / carer wishes.

References

1. Advance Care Planning in Australia – Royal Commission Background paper June 2019
2. Advance Care decision making and planning – Australian Journal of General Practice
3. Advance Care Planning Laws in NSW – Advance Care Planning Australia
4. RACGP Position Statement – Advance Care Planning
5. Advance Care decision making and planning – Australian Journal of General Practice

Appendix A

The Processes and Activities outlined in the above table have been included as an easy-to-follow list.

Identification

- **Step 1:** Use Pen CAT4 to identify active patient groups who are at risk of deteriorating and dying.
- **Step 2:** Identify a suitable group (sample) of patients to discuss advance care planning with or who require completion of documents as part of their health assessments.
- **Step 3:** Check patient records for evidence of previous ACP discussions and/or documentation

Assessment and Implementation

- **Step 4:** Assess and document the person's condition and decision-making capacity.
- **Step 5:** Obtain appropriate consent; confirm if any substitute decision maker/s (SDM) and document consenting discussions (legal requirement)

Discussions

- **Step 6:** Establish what the person understands about their health care; elicit the person's goals, values, and preferences.
- **Step 7:** Introduce the concept of ACP and other follow up consultation session/s
- **Step 8:** Provide ACP information and discuss formalizing decisions (legal docs voluntary)
- **Step 9:** Confirm the patients' preferences and goals for current and future treatments and care.

Planning

- **Step 10:** Prepare treatment plan based on ACP discussions with patient, SDM or family member (if consented)
- **Step 11:** Document treatment and care plan including outcome of all ACP discussions: cross reference in patient records. (This should include NFR plan and after 28/11/23 VAD if preference)

Coordinate

- **Step 12:** Ensure treatment plan is appropriately documented and communicated to ensure access by MDT & other consented providers.
- **Step 13:** Sharing and uploading of the ACD.
- **Step 14:** Involve other teams as appropriate, such as social workers, aged care, spiritual carers, and cultural representatives.
- **Step 15:** As the person's condition/prognosis deteriorates, coordinate with community care and/or palliative care teams for ongoing support as appropriate.
- **Step 16:** Any potential for misunderstanding or dispute should be resolved by this stage - involve senior clinicians and/or escalate to facility management.
- **Step 17:** Ensure processes are in place to manage the place of dying and bereavement, including emotional, cultural, spiritual, and social support to those closest to the person.

Review

- **Step 18:** Review ACP regularly to ensure currency and consistency with the patients' goals and preferences – for example during annual 75+ health assessment.

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