How to support implementation of Advance Care Planning in your hospital

Advance care planning (ACP) is a process that supports adults at any age or stage of health to plan for their future health and personal care. A person's values, wishes and preferences can be made known to guide clinical decision-making at a time when that person cannot make or communicate their decisions due to lack of capacity.

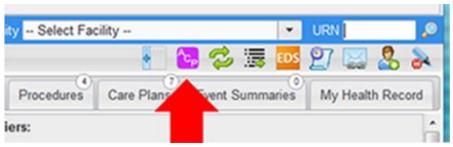
There is growing demand for person-centred care that reflects the wishes of a patient and a need to improve concordance between patient wishes and provided care. Ensuring patients' care preferences are known, documented and accessible is also a key action of the National Safety and Quality Health Service (NSQHS) Standards, particularly Standards 2 and 5.

Hospital staff (administration, medical, nursing and allied health staff) have key roles (within scope) to:

- identify if prior ACP documents have been made and/or view existing ACP documents
- identify the person's substitute decision-maker
- support voluntary completion of ACP documents
- activate/enact the person's statutory ACP documents and use non-statutory ACP documents to guide discussions with substitute decision-makers.

To support ACP, the following actions by hospital staff are recommended for all presenting and admitted patients.

Note: AO= Administration Officer, NO=Nursing Officer, MO=Medical Officer, AH=Allied Health staff

Identify and view existing ACP documents:	**AO**	**NO**	**MO**	**AH**
Ask if the patient has an ACP document e.g. Advance Health Directive (AHD), Statement of Choices (SoC), Enduring Power of Attorney (EPOA), and to provide it.	✓	✓	✓	✓
Check the ACP Tracker (via The Viewer icon or Advance Care Planning tab in ieMR) and view existing ACP documents/comments  For support with using the ACP Tracker please view the website: https://qheps.health.qld.gov.au/metrosouth/acp/acp-tracker	✓	✓	✓	✓
Send copies of ACP documents that are not on The Viewer to the Office of ACP via: Email: acp@health.qld.gov.au Fax: 1300 008 227, or Post: PO Box 2274, RUNCORN, QLD 4113	✓			
Retain a copy of the ACP document on the local medical record as per local policy	✓			

Note: AO= Administration Officer, NO=Nursing Officer, MO=Medical Officer, AH=Allied Health staff

Identify the person's substitute decision-maker	**AO**	**NO**	**MO**	**AH**
Identify if the patient appointed a substitute decision-maker for **health matters** in an EPOA or AHD		✓	✓	✓
Identify if a substitute decision-maker for health care has been appointed in a QCAT decision?		✓	✓	✓
If not already documented record substitute decision-maker details in the person's medical record/hospital systems	✓			
Support voluntary completion of ACP documents for patients				
Identify patients (i) with a diagnosis of chronic/life limiting illness, or (ii) where patient/family indicates willingness to discuss future care needs. For more information see ACP Quick Guide: https://www.health.qld.gov.au/__data/assets/pdf_file/0035/688265/acp-quick-guide.pdf		✓	✓	✓
Provide information about ACP e.g. ACP brochure, Statement of Choices		✓		✓
Respond to the patient's expressed wishes for future care. e.g. if the patient says, "I don't want to be a burden", ask "What does that mean to you?" (Exploring expressed wishes in more detail provides a better understanding of a patient's values (views, wishes and preferences), can be a trigger to completion of an ACP document or review of existing documents).		✓	✓	✓
Invite participation in ACP, including preparation of a written document		✓	✓	✓
Discuss how the patient's current health issues could influence their preferences for health care treatments		✓	✓	✓
Record ACP discussions/actions/outcomes in the ACP Tracker. This supports communication of ACP wishes with authorised clinicians in Queensland public hospitals, Queensland Ambulance Service and GPs		✓	✓	✓
Ensure ACP, goals of care and resuscitation management conversations occurring during a hospital stay are shared across care environments e.g. with usual GP, RACF		✓	✓	✓
Talk about ACP in clinical/multidisciplinary team meetings with all staff		✓	✓	✓
Link patients and families to other services for support if needed: ○ My Care, My Choices (www.mycaremychoices.com.au) ○ Office of ACP: ▪ Phone: 1300 007 227 ▪ Email: acp@health.qld.gov.au ○ Local ACP facilitators/champions	✓	✓	✓	✓
Activate/enact the person's statutory ACP documents and/or use non-statutory ACP documents to guide discussions with substitute decision-makers.				
Utilise ACP documents of patients with impaired capacity/liaise with substitute decision-maker(s) in consultation with the person with impaired capacity to the greatest extent practicable		✓	✓	✓
Integrate patient-centred care choices into medical goals of treatment plans /contribute to multidisciplinary team planning meetings		✓	✓	✓
Establish long-term goals of care – e.g. a preference to maintain quality of life even if that meant a reduced length of life		✓	✓	✓
Involve other services, where required, to ensure the patient can access care in their preferred place		✓	✓	✓