Quality Improvement Activity

phn SOUTH EASTERN MELBOURNE
An Australian Government Initiative

Advance Care Planning in General Practice

Advance Care Planning Group Patient Information Sessions

First steps

Goal What are we trying to accomplish? By when?
Example: Increase the number of Advance Care Planning (ACP) conversations with patients and documented Advance Care Directives (ACD) by # (set number) by ## (date).

Consider starting small. Small wins increase confidence & motivation toward larger impact & change. E.g., Increase of 2-5 patients putting ACD in place by end of PDSA cycle by set timeframe (e.g., 3 months).

Person responsible Nominate a team leader for this activity. This may be clinical or non-clinical staff.

Measures How will the change be measured?
Example: Number of ACD recorded in clinical software pre and post PDSA cycle.

Improvement idea

- **Increase the number of Advance Care Planning (ACP) conversations with patients and documented Advance Care Directives (ACD) using Group Patient ACP Information sessions.**

  ✓ Activity may also be tailored for individual ACP discussions with patients during GP consults, Health Assessment or Care Plan appointments.

How?

Utilise a Plan-Do-Study-Act (PDSA) cycle, a useful tool for documenting change.

The cycle's steps are: Develop a plan to test the change (Plan), carry out the test (Do), observe and learn from the consequences (Study), and determine what modifications should be made to the change (Act).

Practices can undertake several PDSA (cycles) for **continuous improvement** until you've achieved the goal or move to a different goal.

What worked well? What were the challenges? Practices can tailor the next PDSA cycle to their needs.

Use the editable worksheet template (page 4) to document the change and store completed documents together.

Notes for consideration:

Availability of a separate room on site for the group session
Consideration should be given to availability of a room on site in the clinic to host the group face to face information sessions.

It is recommended the room should be large enough to safely accommodate 8 – 12 patients during business hours to optimise attendance. It is also worth considering the age group of patients and booking the session at an appropriate time of day (e.g., mid-morning).

Utilising the patient waiting room would not be recommended during business hours due to limited privacy for open discussion and patient questions during the session.

Length of session
Recommendation to book a one hour session allowing time for presentation by the LHN ACP facilitator and patient questions and discussion.

Family and Carers
Patients' family/carers should be welcomed to attend the ACP information session.

Whole of practice approach
A whole of practice approach is required for the best outcomes with QI in general practice.
While not all practice staff may be participating in the activity, all staff should have awareness of the QI activity and understand the benefits to the practice, patients, and staff.

Promotion
Promotion of the session via several channels may create greater awareness and lead to higher attendance rates and engagement from patients. (e.g., invitation being raised by GP or practice nurse in health assessments, care plans in addition to posters/flyers/information being readily available in reception area).

Example Steps:

1) Run report to record number of active patients with ACD in practice software (baseline data collection). Instructions on page 6 (Best Practice software).
2) Complete QI template "Increase Advance Care Planning (ACP) Knowledge in General Practice" or practice staff visit listed websites (as listed on pg. 3) to increase understanding of ACP, forms & resources.
3) Complete The Advance Project® online modules (Clinical and Administration staff).
4) Connect with Local Hospital Network (LHN) ACP Service for local information and support for in-clinic group patient information session.
    - Alfred Health ACP Service
    - Monash Health ACP Service
    - Peninsula Health ACP Service
5) Book date and time for LHN ACP Service to facilitate in-clinic Group Patient Information Session.
6) Identify patients suitable for invitation to the group information session. E.g., patients aged 65+, two or more complex chronic diseases. (For individual discussions, ACP can be raised & introduced in GP consultations, health assessments, and care plan appointments with take home resources provided).
7) Promote session in-clinic and invite patients to group patient information session.
8) Hold one group patient ACP information session facilitated by LHN ACP staff alongside participating practice staff.
9) Book follow up individual GP appointments for patients who attended the session for further ACP discussion and/or document signing and witnessing. (This step also applies to patients who had individual ACP introduction discussions in a consultation, health assessment or care plan appointment).
10) Record number of active patients with ACD in practice software (post activity data collection).

Plan Develop a plan to test the change. (Example 12wk PDSA cycle below can be broken down into small cycles)

Task	Person responsible	Timeframe
Run report to record number of active patients with ACD in practice software (baseline data collection). Instructions on page 6 (Best Practice software).	Team leader	Week 1
Complete The Advance Project® online modules (Modules available for GP, PN & PM. Please note, full module can take up to 2 hours per staff member)	Relevant Staff	Week 1 - 4
If QI Activity 1 "Increase Advance Care Planning (ACP) Knowledge in General Practice" available on SEMPHN website has not been completed, please ask staff to visit the following websites for information and resources to increase understanding of ACP forms and resources: -SEMPHN Advance Care Planning webpage -Advance Care Planning Australia and the Advance Care Planning Health Professionals factsheet noting section *Where should advance care directives be kept?* -Victorian Department of Health website for information and understanding of Victorian Advance Care Planning forms: -Advance Care Directive -Medical treatment decision maker -Support person Team leader may consider printing resources for use by staff as required.	Relevant staff	Week 1 - 4
Connect with your Local Hospital (LH) Advance Care Planning Service for local information and/or support for in-clinic group patient information session. Alfred Health ACP Service Monash Health ACP Service Peninsula Health ACP Service Team leader may consider printing LHN ACP information & brochures to support practice staff with ACP conversations.	Team Leader	Week 2
Book date and time for LH ACP Service to facilitate in-clinic Group Patient Information Session Consider booking in 4-6 weeks' time to allow for identification of suitable patients & promotion of the session.	Team Leader	Week 2
Identify patients suitable for invitation to the group information session. E.g., patients aged 65+, two or more complex chronic diseases. (For individual discussions, ACP can be raised & introduced for suitable patients in GP consults, health assessments, and care plan appointments with take home resources provided).	Team Leader & Relevant Staff	Week 3-4
Promote session in-clinic and invite patients to group patient information session. Invitation method will be individual to each clinic (e.g., SMS, email, clinic newsletter or website, raised in health assessments, care plans, or GP consults). Consider printing posters to display in-clinic with details of the upcoming session.	Team leader & Relevant Staff	Week 4
Hold one group patient ACP information session facilitated by LH ACP staff alongside participating practice staff (GPs, PNs and PM)	Relevant Staff & LHN ACP facilitator	Weeks 5-8
Book follow up individual GP appointments for patients who attended the session for further ACP discussion and/or document signing and witnessing. (This step also applies to patients who had an individual ACP introduction discussion in a GP consult, health assessment or care plan appointment)	Relevant Staff	Weeks 8-10
Team leader to run a report of ACDs in clinic software.	Team Leader	Week 12

Quality Improvement Activity

Goal:

Description of this change:
Person responsible:
When to be done:

Plan Develop a plan to test the change.

Task	Person responsible	Timeframe

Prediction ***What you think will happen when the test is carried out***	**Measures** ***What will determine if the predictions are correct***
Example: Increase the number of Advance Care Planning (ACP) conversations with patients and documented Advance Care Directives (ACD) with Group Patient ACP Information sessions (or individual ACP discussions)	*Example: Pre & post activity data from practice software*

Do

Carry out the plan. Record data. What actually happened when you ran the test.

We implemented: (Example: list activity undertaken)

Study

Observe and learn from the data. Describe the measured results and how they compared to the predictions.

Did you achieve your goal? What worked well? Challenges and barriers? What needs to be changed?

Act

Describe what modifications you'll make for the next cycle based on what you've learned.

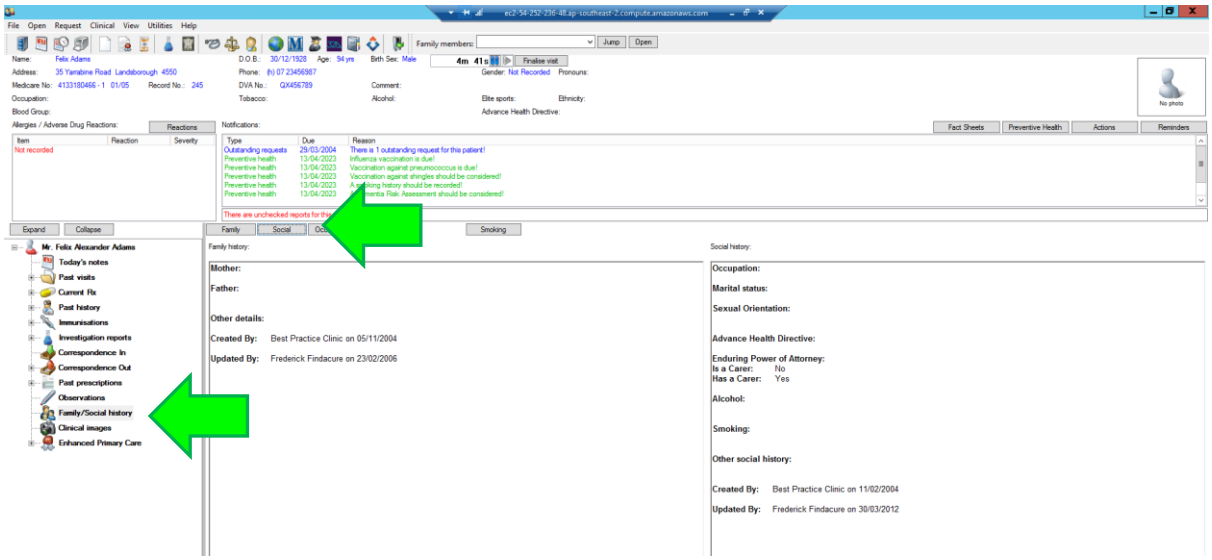
Does this activity need to be repeated? Do changes or improvements need to be made?

Share and celebrate the improvements made with practice staff.

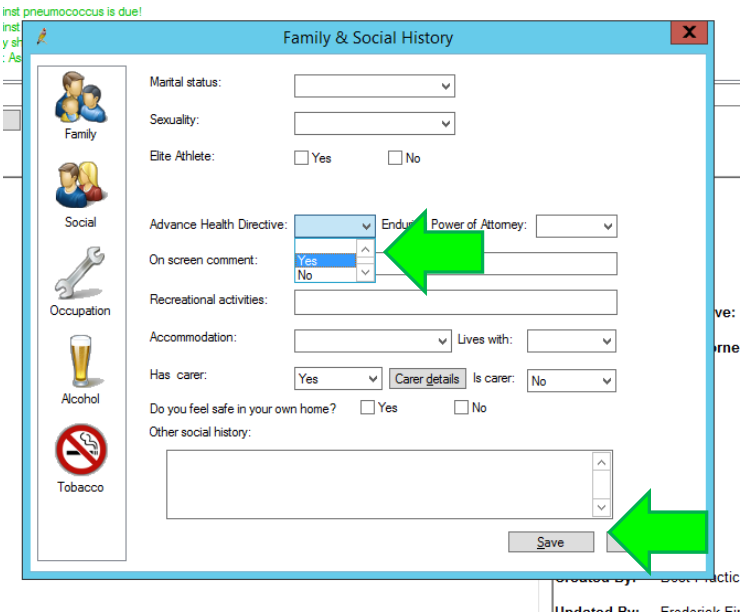
Best Practice Software - How to record that a patient has an Advance Health Directive (Advance Care Plan)

The examples used in this guide are dummy data.

1. In Best Practice, open a patient record, from the menu on the left-hand side of the screen click on Family/Social History. Click on the Social button.



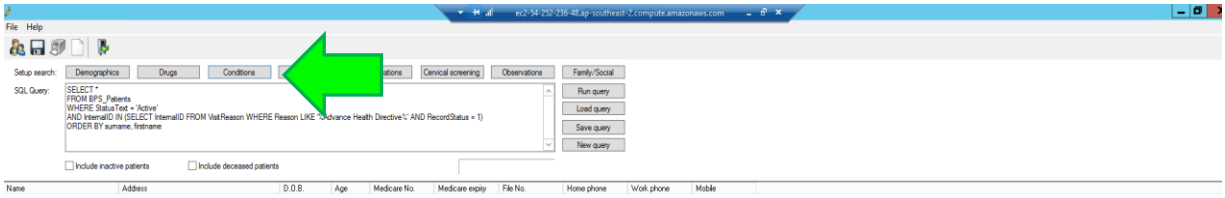
2. In the pop-up box click on Advance Health Directive drop down, click on Yes to record, click Save.



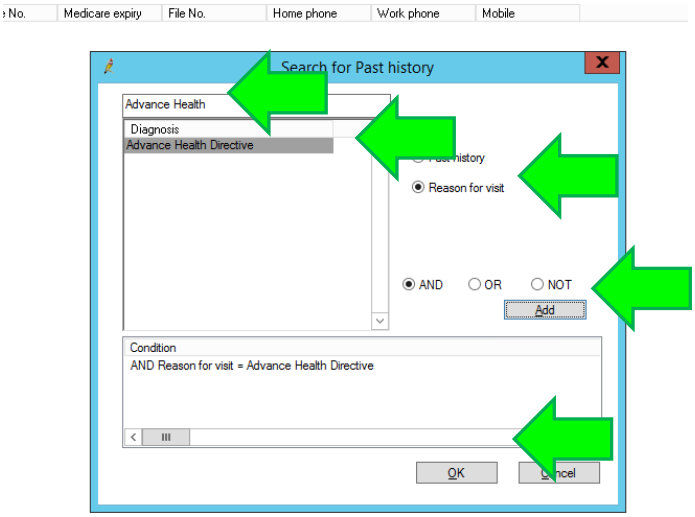
Best Practice Software - How to search for patients that have an Advance Health Directive (Advance Care Plan) in place.

The examples used in this guide are dummy data.

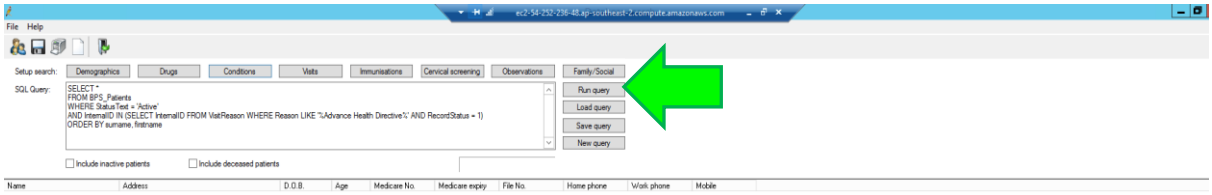
1. In Best Practice, go to Utilities from the top menu. Click on Search.
2. Click on the Conditions button.



3. In the pop-up box type in Advance Health Directive, click on Advance Care Directive from the menu, click on Reason for Visit button, click on Add button, click OK.



4. Click on Run query.



The list of patients showing will be the patients who have an Advance Health Directive.