

# **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).

<sup>-</sup>Q<sup>-</sup>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 <u>individual ACP discussions</u> 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).
- 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 <u>The Advance Project®</u> 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.
  - o Alfred Health ACP Service
  - Monash Health ACP Service
  - o 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).

# Quality Improvement Activity



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	Team leader	Week 1
(baseline data collection). Instructions on page 6 (Best Practice software).		
Complete The Advance Project <sup>®</sup> online modules (Modules available for GP, PN &	Relevant Staff	Week 1 - 4
PM. Please note, full module can take up to 2 hours per staff member)		
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	Relevant staff	Week 1 - 4
of ACP forms and resources:		
SEMPHN Advance Care Planning webpage		
<u>-Advance Care Planning Australia</u> and the <u>Advance Care Planning Health</u>		
Professionals factsheet noting section Where should advance care directives be kept?		
- <u>Victorian Department of Health</u> website for information and understanding of Victorian Advance Care Planning forms:		
-Advance Care Directive		
-Medical treatment decision maker		
-Support person		
<sup>+</sup> Q <sup>-</sup> Team leader may consider printing resources for use by staff as required.		
Connect with your Local Hospital (LH) Advance Care Planning Service for local	Team Leader	Week 2
information and/or support for in-clinic group patient information session.		
Alfred Health ACP Service		
Monash Health ACP Service		
Peninsula Health ACP Service		
<sup>-</sup> Team leader may consider printing LHN ACP information & brochures to		
support practice staff with ACP conversations.		
Book date and time for LH ACP Service to facilitate in-clinic Group Patient	Team Leader	Week 2
Information Session		
<sup>2</sup> Consider booking in 4-6 weeks' time to allow for identification of suitable		
patients & promotion of the session.		
Identify patients suitable for invitation to the group information session. E.g.,	Team Leader &	Week 3-4
patients aged 65+, two or more complex chronic diseases.	Relevant Staff	
(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).		
Promote session in-clinic and invite patients to group patient information session.	Team leader &	Week 4
<sup>-Q-</sup> Invitation method will be individual to each clinic (e.g., SMS, email, clinic	Relevant Staff	
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.		
Hold one group patient ACP information session facilitated by LH ACP staff	Relevant Staff &	Weeks 5-8
alongside participating practice staff (GPs, PNs and PM)	LHN ACP facilitator	
	Relevant Staff	Weeks 9.14
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	Relevalit Stall	Weeks 8-10
applies to patients who had an individual ACP introduction discussion in a GP		
consult, health assessment or care plan appointment)		
tonsait, neutral assessment of care plan appointment)		
Team leader to run a report of ACDs in clinic software.	Team Leader	Week 12



### Goal:

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

### **Plan** Develop a plan to test the change.

Task	Person responsible	Timeframe		

Prediction	Measures				
What you think will happen when the test is carried out	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.

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File Open Request Clinical View Utilities Help		
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Name: Felix Adams Address: 35 Yarrabine Road Landsborouch 4550	D.O.B.: 30/12/1928 Age: 54 yrs Bith Sex: Male 4m 41 s h Pinalise visit Phone: (h) 07/24456587 Gender: Not Recorded Phonouna:	
Medicare No: 4133180466 - 1 01/05 Record No.: 245		
Occupation:	Tobacco: Alcohol: Elte sports: Eltrricity:	No phono
Blood Group:	Advance Health Directive:	
Allergies / Adverse Drug Reactions: Reactions	Notifications:	Fact Sheets Preventive Health Actions Reminders
Item Reaction Severity Not recorded	Type Due Reason Outstanding requests 29/03/2004 There is 1 outstanding request for this patient!	^
The recorded	Preventive health 13/04/2023 Influenza vaccination is due!	
	Preventive health 13/04/2023 Vaccination against pneumococcus is due!     Preventive health 13/04/2023 Vaccination against shingles should be considered!	1
	Preventive health 13/04/2023 A sofiking history should be recorded! Preventive health 13/04/2023 A mentia Risk Assessment should be considered!	
		×
	There are unchecked reports for the	
Expand Collapse	Family Social Oct	
E-4 Mr. Felix Alexander Adams	Family history:	Social history:
- Martin Today's notes	Mother:	Occupation:
⊛–————————————————————————————————————	Father:	Marital status:
Europe Current Rx	ratner.	marital status:
⊪ 💑 Past history	Other details:	Sexual Orientation:
Immunisations		
Investigation reports	Created By: Best Practice Clinic on 05/11/2004	Advance Health Directive:
Correspondence in	Updated By: Frederick Findacure on 23/02/2006	Enduring Power of Attorney:
Correspondence Out		Is a Carer: No Has a Carer: Yes
Past prescriptions		
Observations		Alcohol:
Family/Social history		
Cinical images		Smoking:
B 🥷 Enhanced Primary Care		
•		Other social history:
		Created By: Best Practice Clinic on 11/02/2004
		Updated By: Frederick Findacure on 30/03/2012
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2. In the pop-up box click on Advance Health Directive drop down, click on Yes to record, click Save.

R	Family & Social History
	Marital status:
Family	Sexuality:
	Elte Athlete: Yes No
Social	Advance Health Directive:
ß	On screen comment:
Occupation	Recreational activities:
	Accommodation:
<u> </u>	Has carer: Yes V Carer details Is carer: No V
Alcohol	Do you feel safe in your own home? Yes No
	Other social history:
Tobacco	
	Save
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# **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.

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Setup search:	Demographics Drugs Conditions	atons Central screening Observations Femily/Social	
SQL Query:	SELECT * FROM RES Satua Text + "Active" WHERE Satua Text + "Active" AND Internal D In (SELECT Internal D FROM Vist Reason WHERE ORDER BY sumame, firstname	RE Reson LINE Tochance Health Directive TV AND RecordStatus = 1)	
	Include inactive patients Include deceased patients	et	
Name	Addieco	D.0.B. Age Medicare No. Medicare expiry File No. Hene phone Work phone Mobile	

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.

Medicare expiry	File No.	Home phone	Work phone	Mobile	
R		Search for	Past history		X
	nce Health				
Diag	nosis				
Adva	nce Health Direc	tive		istory	
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4. Click on Run query.

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Setup search:	Demographics	Ugs Conditions	Visita	Immunisations	Cervical screening	Observatio	Family/Social					
SQL Query:	SELECT* FROM BPS_Palients WHERE StatusText = 'Active' AND InternalID IN (SELECT Inte ORDER BY sumarre, fintname	malID FROM VistReason WHERE Re	rason LIKE %Advar	nce Health Directive%' A	ND RecordStatus = 1)		Aun query     Bun query     Load query     Save query     New query					
	Include inactive patients	Include deceased patients										
Name	Address		D.0.8. A	ge Medicare No.	Medicare expiry	File No.	Home phone	Work phone	Mobile			

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