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# Start2Talk

## PLANNING AHEAD COMMUNITY AND HOME CARE TOOLKIT

### Guide to implementing sustainable systems for advance care planning (ACP)

Planning ahead can be assisted by a wide range of professionals across the community, home care and health sectors. It is important staff are aware of the types of planning that are important and can provide information or referral to an appropriate service. To create sustainable systems which support early planning, services need to develop systematic ways of engaging with clients and care partners to increase the likelihood that their wishes will be known and adhered to.

Planning ahead includes planning across a range of financial, health and personal issues including preparation of wills, power of attorney (financial), nomination of substitute decision makers (SDM) for personal and health care, advance care planning (ACP) and lifestyle planning e.g. accommodation, support services, work and driving.

The following are key activities that will allow your organisation to implement and improve specifically the advance care planning component of planning ahead into service delivery. It is important that staff also have the knowledge and are empowered to prompt and encourage their clients in in other areas of planning ahead or provide information and referral to other professionals who can assist them including but not limited to: GPs and GP practice nurses, accredited financial advisors or counsellors, social workers, lawyers, driving licence authorities and authoritative planning ahead websites.

Additional tools are available in the community and health professionals section of the Start2Talk website at [www.start2talk.org.au](http://www.start2talk.org.au)

# Key areas requiring action

## Key contact

Identify a 'go to person' or a working group that will be the contact for implementation of ACP.

## ACP policy

Develop an organisation policy on ACP as well as incorporating ACP into other relevant organisational policy documents e.g. palliative care; working with clients with dementia; transfer of client between care settings and handover between care settings.

## Champions

Identify champions throughout the organisation, in each occupation group e.g. nursing, case or care managers who are strong advocates of ACP and who can support ACP systems and quality improvement.

## Client care planning sessions

Schedule opportunities for clients to discuss, record and update their wishes and choices including ensuring that:

- Initial care planning session includes discussion of the benefits of early planning including ACP and appointing a substitute decision maker. Information and planning materials can be given to the client at this time.
- Follow up of planning including ACP occurs at subsequent routine review care planning sessions e.g. 3, 6 or 12 month as per your organisation policy.
- ACP conversations continue at 'reassessment' care plan meetings following a health incident or other major life transition e.g. change of place of residence, change in availability of support networks, deterioration or improvement in health of the person, or their partner or carer.

## Documentation

### Appointing a substitute decision maker

The terminology and documentation for appointing a substitute decision maker varies between jurisdictions. It is important that the information and legal or prescribed documents for the jurisdiction in which the person lives are used.

Where the home care provider operates across jurisdictions then it is important that the organisation includes a statement on how this is handled in their policy documents. State or territory specific information should be included in the operating procedure documents of each state or territory organisation as well as included in staff training.

## **Advance care plan (ACP)**

Terminology for advance care plans vary between states and territories. Sometimes they may be referred to as advance care directives, health care directions or 'living wills'. Likewise the legal or prescribed forms may also vary between jurisdictions. Links to state and territory planning tools are available at [www.start2talk.org.au](http://www.start2talk.org.au)

## **Discussion record**

A 'Discussion record' document is useful to record discussions that staff have with clients around advance care planning. This is a valuable record in the ACP process and an important step towards clients completing formal ACP document(s). Some clients may only want to express their wishes and choices and may choose not to complete formal documents. Refer to appendix A for a sample advance care planning discussion record.

## **Client care file**

Ensure that documents are kept in a clearly identified place on the client's file for review, updating and use as required.

Ensure that any relevant planning documents are transferred with the client to other care facilities as needed to ensure continuity of care.

## **Electronic records management system**

Including ACP within electronic records can ensure documents are accessible, but certain precautions need to be taken. Some legal documents for instance Enduring Power of Attorney, Advance Care Directives or Health Directions, have legal requirement that the document cannot be modified. Usually a new document must be completed if any changes need to be made. There may be exceptions such as a change of address. If in doubt check with the appropriate government agency in your state or territory. Be aware that if this not done and the original document is amended then this document may no longer be legal and be rendered null and void.

Consider the following questions when planning how ACP will be incorporated into electronic records systems.

- Where will the ACP documents be located in the system?
- Who will access the ACP documents? –are there any limitations e.g. Case/care managers only. Consider the implications on weekends and during periods of leave.
- How can you make sure legal documents are not modified?
- Have Alerts been set up on the system to alert staff to ACP documents?
- Are there routine processes in place for planning documents to be transferred with the client to other care settings? E.g. hospital, residential aged care facility (RACF); respite care facility etc.

## Availability of ACP resources and forms

To ensure that information, planning materials and forms are available to staff, clients, substitute decision makers and families, it may be useful if the organisation compiles a handy 'pack' that includes all materials together. This can be given to the client and family at the initial care planning session.

## Quality improvement

Ensure there are quality improvement mechanisms in place to assess your current ACP practices. Quality improvement processes can be used to identify, plan and implement quality improvements to ensure quality client service and evidence based practice e.g. audit of ACP activity and patient experience data. Refer to ACP Continuous Quality Improvement Guide in the health professionals section of the Start2Talk website for further information on using quality improvement methodology to implement ACP.

## Increasing awareness

Ongoing promotion of ACP systems within the organisation is needed to ensure systems are effective. Promotion may occur via posters, accessible print resources or by online communication and newsletters. Including real life stories that promote the benefits to consumers and the staff can be beneficial.

## Staff training

Staff training will enhance your workforce capability to initiate ACP conversations and encourage early planning. ACP training is not a one off training session but a continuous learning experience. Training may include:

New employee orientation: Where all new staff receive introductory information about ACP.

Formal training in ACP: This training should be given to all staff who are responsible for client care planning e.g. care/case managers. It should include practical components, dementia specific information and how to have potential 'difficult conversations'. Training techniques can include role play, real life de-identified scenarios, small group discussion and case conferencing scenarios. Practicing mediation and conflict resolution techniques can also be useful.

Annual refresher training; It is important that skills are maintained by including ACP in annual staff development schedules for all previously trained staff.

Mentoring: Utilises experienced and trained staff to mentor less experienced staff undertaking ACP conversations and planning. Mentoring can include 'buddy sessions' where less experienced staff 'sit in' with more experienced staff in a client session. Followed by less experienced staff taking the lead in the client session with the mentor 'sitting in' with them.

Further resources are available on the *Helping your patients* page of the Start2Talk website at [http://start2talk.org.au/helping\\_your\\_patients](http://start2talk.org.au/helping_your_patients)

## Stakeholder engagement

Involving other local services or organisations can help to increase consistency and ensure a person's plans can be understood and followed if they are transferred to another facility.

Work with local health services including GP clinics and local hospitals to ensure mutual recognition of ACPs.

With clients consent ACP documents can be shared with their GP and local hospital medical records.

## Acknowledgment

This project was funded by the National Health and Medical Research Council's (NHMRC) Cognitive Decline Partnership Centre (CDPC).

Gratitude for ideas behind this guide are attributed to:

1. South Western Sydney Local Health District. *Systems to support the implementation of ACP in residential aged care facilities*, Sydney NSW. My Wishes Advance Care planning; 2016 [Accessed 30 Nov 2016] Available from <http://www.swslhd.nsw.gov.au/myWishes/default.html>
2. Victoria Health. *Implementing advance care planning*. Melbourne: Victoria Health; 2015.

We would also like to acknowledge the generous support and contributions made by the Stakeholder Advisory Committee and our project partners HammondCare, Alzheimer's Australia, Brightwater Care Group and Kinicare. We would also like to thank our community partners Alzheimer's Australia ACT, National Seniors Illawarra and the representatives from the Alzheimer's Australia's National Dementia Consumer Network who so generously offered their time and energy in developing these resources.

# Appendix A: Sample advance care plan discussion record

## Advance care plan discussion record

### Record of advance care planning discussions

Date and name of care worker	Summary of discussion and materials given	Who was involved in the discussion?	Date Discussion record added to the client's care file

### Advance care plan

Date an Advance Care Plan (ACP) completed or reviewed	Name of person entering ACP onto the client's care file	ACP has been shared with: e.g. GP, local hospital, SDM

**Acknowledgment:** Sample Advance Care Plan Discussion Record based on the Respecting Patient Choices, Advance Care Plan Discussion Record. Australian Capital Territory: Respecting Patient Choices; 2016.