Example Policy and Procedure: Implementation of Advance Care Planning in Residential Aged Care Facilities

Improving end-of-life care for residential aged care residents project

February 2018
TABLE OF CONTENTS

TABLE OF CONTENTS .................................................................................................................. 1
Purpose ........................................................................................................................................ 3
What is ACP? ................................................................................................................................. 3
Why do you need an ACP policy and procedure? ........................................................................ 3
How can you use the example ACP policy and procedure? .......................................................... 3
How was the example ACP policy and procedure developed? ....................................................... 4
Definition of terms ........................................................................................................................ 5
Statement ...................................................................................................................................... 6
Purpose ........................................................................................................................................ 6
Policy statement ............................................................................................................................ 6
Guiding principles .......................................................................................................................... 6
Relevant standardised Queensland ACP documentation ............................................................... 7
Procedure ....................................................................................................................................... 8
  1. Information provision and ACP discussions ......................................................................... 8
  4. Training for staff .................................................................................................................... 9
  5. Quality improvement ............................................................................................................. 9
Relevant Queensland legislation ................................................................................................... 10
Related policies and documents .................................................................................................. 10
APPENDIX 1: DEFINITION OF TERMS ................................................................................... 11
APPENDIX 2: AUDITING OF SoCs DOCUMENTS ....................................................................... 12
APPENDIX 3: ORGANISING FOR A COMPLETED SoC TO BE UPLOADED TO THE VIEWER ......... 13
PART ONE: ABOUT THIS DOCUMENT

Purpose

This document provides an example advance care planning (ACP) policy and procedure that residential aged care facilities (RACFs) in the Brisbane South Primary Health Network (BSPHN) area may use to develop and/or review relevant ACP documentation within their own policies and procedures framework.

What is ACP?

Advance care planning refers to discussions between a resident, their family and/or substitute decision maker(s) (SDM(s)) and health care professionals enabling the resident’s preferences for future health care to be known should they become unable to participate in the decision making process. Ideally these preferences will be documented.

Advance care planning is an important component of quality person–centred end-of-life care and can improve resident and family satisfaction with care, reduce avoidable hospital transfers, reduce stress and anxiety for families and/or SDMs and improve staff satisfaction with the seamless care that can be provided for residents.¹ ²

Why do you need an ACP policy and procedure?

Best practice principles for ACP in RACFs in Australia have been developed. They emphasise the importance of written policies and procedures about ACP that are readily accessible and establish ACP as a routine component of care.³ Appropriate documentation will support a coordinated, systematic, patient-centred approach to ACP that has been shown to support resident’s wishes (as expressed in their advance care plan) being respected.²

How can you use the example ACP policy and procedure?

The example ACP policy and procedure is a resource for RACFs to use to develop and/or review their own documentation to support the implementation of ACP in their facility. It is not meant to be prescriptive. Managers in RACFs can adapt the content of the example ACP policy and procedure to meet their own identified needs.

The example ACP policy and procedure has been developed specifically to support RACFs participating in the ‘Improving end-of-life care for residential aged care residents’ project being conducted by Metro South Health (MSH) and BSPHN within the BSPHN geographical area. The aim of the project is to

³ Silvester W, Fullam RS, Parslow RA et al. Quality of advance care planning policy and practice in residential aged care facilities in Australia. BMJ Supportive & Palliative Care 2012. 00 1-7
support RACFs to embed an evidence-based ACP program, adapted for individual facilities, into their routine clinical care to support high quality end-of-life care for residents and their families.

How was the example ACP policy and procedure developed?

The example ACP policy and procedure was developed using:

- The best practice principles regarding ACP identified in the literature as:\(^4\)\(^5\)\(^6\)
  - Written policies about ACP should be readily accessible in every RACF. Policies should include the systems needed to establish ACP as a routine component of care and all aspects of documentation, including where the advance care plan is to be kept and when it is to be reviewed.
  - Education about ACP should be regularly provided to all RACF staff, residents, families and/or SDMs.
  - Information about ACP is best provided to residents, families and/or SDMs before entry, followed by well-planned individual discussions as soon as practicable after entry; normally within 28 days unless there are unforeseen circumstances.
  - ACP should be incorporated into routine clinical decision making and care planning, and regularly reviewed, particularly when circumstances change (e.g. exacerbation of illness, health deterioration or hospital admission), or at least annually.
  - ACP involves open and comprehensive discussions with the resident, family and/or SDM(s) initiated by a health professional with relevant skills in this area.
  - The general practitioner (GP) should be included in ACP discussions.
  - ACP documents clearly specify (at a minimum): (a) an appointed SDM, where available, and contact details where available; (b) current state of health; (c) values and beliefs (things that matter most in life); (d) future unacceptable health conditions; (e) the level of preferred future medical treatment; (f) specific wanted/unwanted treatments, where applicable; (g) goals for end-of-life care; (h) appropriate signatures (clear, complete, dated, and, if a legally binding document witnessed); and (i) evidence of GP review.
  - Facilities have effective information transfer systems in place to enable communication of resident ACP information across health transition points.
- Relevant standardised Queensland ACP documentation encompassing:
  - Advance Health Directive (AHD)

\(^4\) Silvester W, Fullam RS, Parslow RA et al. Quality of advance care planning policy and practice in residential aged care facilities in Australia. BMJ Supportive & Palliative Care 2012. 00 1-7
\(^5\) Silvester W, Parslow RA, Lewis VJ et al. Development and evaluation of an aged care specific Advance Care Plan. BMJ Supportive & Palliative Care 2013. 0 1-8
- **Enduring Power of Attorney (EPOA)**
  - **About the EPOA**
  - The EPOA short form (the same attorney appointed for both financial and personal matters)
  - The EPOA long form (different attorneys appointed for financial and personal matters)

- **Statement of Choices (SoC)**
  - **About the SoC**
  - The SoC Form A (to be completed by resident)
  - The SoC Form B (to be completed by SDM(s))

- The new standardised processes for ACP in MSH based upon use of the SoC:
  - Metro South Health has introduced a district-wide system incorporating the SoC, together with a mechanism to audit and upload SoC documents directly onto The Viewer for easy retrieval by clinicians. The Viewer is an electronic platform that allows Queensland Health clinicians to directly read SoC documents. In 2017, The Viewer will become available to GPs and the Queensland ambulance service.
  - In Queensland, individuals, if deemed to have capacity, have the option to complete a legally-binding Advance Health Directive.
  - Implementation of the SoC by RACFs, and uploading of these documents to The Viewer, provides the opportunity to use a coordinated, systematic patient-centred approach to ACP.

- The review process of the Steering Committee for the ‘*Improving end-of-life care for residential aged care residents*’ project.

**Definition of terms**

See Appendix 1
PART 2: ADVANCE CARE PLANNING (ACP) POLICY AND PROCEDURE

Statement

NAME OF FACILITY is committed to offering all residents with/or their significant others the opportunity to participate in ACP discussions to ensure that the resident’s wishes and choices for future health care are known in the event that they become incapable of participating in decision making.

Purpose

- To ensure that NAME OF THE FACILITY understands and considers the wishes of all residents concerning their future health care.

Policy statement

Advance care planning refers to discussions between a resident, their family and/or substitute decision maker(s) and health care professionals enabling the resident’s preferences for future health care to be known should they become unable to participate in the decision making process. Ideally these preferences will be documented.

Guiding principles

- Residents have a right to be involved in their health care decisions, including agreeing to or refusing treatment.

- The values and needs of a resident should be known and respected by those providing health care to that individual.

- ACP discussions must involve open communication and respect a resident’s specific spiritual, religious and cultural needs.

- An offer to participate in ACP is made to all residents, families and/or SDMs. Participation in ACP is voluntary and it is recognised that some individuals may decline to engage in these discussions.

- If a resident has capacity at the time of illness, the treatment decisions they make take precedence over any advance care plans developed. The written advance care plan is not required until the resident has lost capacity to make a decision.

- ACP provides opportunities for residents, families and/or SDMs to participate in planning for the resident’s preferred end-of-life care needs and discussions should include frank discussions about death and dying and the consequences of treatment choices.
Relevant standardised Queensland ACP documentation

- **Advance Health Directive (AHD)**
  - About the AHD
  - The AHD form

- **Enduring Power of Attorney (EPOA)**
  - About the EPOA
  - The EPOA short form (the same attorney appointed for both financial and personal matters)
  - The EPOA long form (different attorneys appointed for financial and personal matters)

- **Revocation of EPOA** (Form 6)

- **Statement of Choices (SoC)**
  - About the SoC
  - The SoC Form A (to be completed by resident)
  - The SoC Form B (to be completed by SDM(s))

- **Translator/interpreter Statement** (may be attached to AHD/EPOA documents for people who speak/read little English)
Procedure

1. Information provision and ACP discussions

Pre-entry/initial contact with resident, family and/or SDM

- Include information about ACP, e.g. a brochure, in information packs

- If there have not been any prior discussions about ACP, introduce ACP and its benefits using a suitably trained staff member

- Request copies of existing ACP documentation e.g. AHD, EPOA

- If a legal SDM has not been appointed, discuss the benefits of identifying a SDM on entry

- Document discussion according to RACF policies and procedures.

On entry

- Confirm with the resident, family and/or SDM(s) their engagement in ACP discussions. If required, offer further discussions with a suitably trained member of staff, e.g. the ACP champion. Conversation/engagement is to be voluntary, and if declined at this time, document according to RACF policies and procedures.

- Ensure that:

  - **certified** copies of existing **legally-binding** ACP documentation, e.g. the AHD and the EPOA, are kept in the resident’s file in the designated area.

  - copies of other existing ACP documentation, e.g. the SoC, are kept in the resident’s file in the designated area.

  - If the resident/SDM(s) consents send copies of the document to the Office of Advance Care Planning for uploading to The Viewer.

- If not already provided, confirm the SDM(s), their contact details and the method by which they are appointed (Tribunal-appointed Guardian, SDM(s) appointed in EPOA or AHD).

Within four to six weeks post-entry

- Undertake ACP discussions with the resident, their family and/or SDM(s) who agree to participate

- If not already completed, support residents and/or SDMs to document their wishes in the (standardised Queensland) chosen ACP documentation – the AHD, the EPOA - if that is their wish.

- For the SoC, ensure that all essential fields in the document(s) are completed. For completion of SoCs (see **Auditing of Statement of Choices Documents in Appendix 2**).
• If residents and/or SDMs do not wish to complete standardised documents, record discussion outcomes and wishes according to RACF policies and procedures.

• Engage GPs in ACP to contribute to and sign completed documents as required

• Send a copy of the completed ACP document(s) to the Office of ACP for uploading to The Viewer (see Organising for a Completed SoC to be Uploaded to The Viewer in Appendix 3) and to relevant parties and place documents in designated place within a resident’s file.

• Place alerts to identify to all staff that current ACP document(s) are in place

• Inform resident and/or SDM(s) that reviews are undertaken annually or as required.

2. Ongoing review

• Encourage ongoing conversations and discussions regarding ACP with resident and/or SDM(s)

• Review ACP documents every 12 months or as clinically required. Timing of review should be guided by prompts, e.g. deteriorating/functional decline, observed withdrawal from social events, increasing symptom burden, or a resident expressing a change in wishes.

• In the event that changes are required to a current ACP document, a new document will need to be completed, and a copy sent to the Office of ACP so that current documents are accessible at all times. A more recent document supercedes a previous version of the document.

3. Clinical decision making

• Completed ACP documentation is used to guide decision making by RACF staff, the GP, other clinicians, and the SDM(s) if the resident does not have capacity to participate in decision making. This facilitates care provision in accordance with the resident’s wishes.

4. Training for staff

• Training induction and a sustainable, ongoing staff training process is implemented to ensure all staff have an awareness of the principles and importance of ACP for all residents in their care.

• A cohort of nursing staff are offered additional training to enable high levels of communication skills and expertise to guide ACP discussions with residents, families and/or SDMs.

5. Quality improvement

• After-death audits are undertaken as part of a continuous quality improvement process to monitor if residents’ wishes are being used to inform clinical care.

6. Documentation

• Establish a designated place within residents’ files for all ACP documentation.
• Establish alerts to identify to all staff that current ACP documents have been completed.

Relevant Queensland legislation

• Powers of Attorney Act 1998
• Guardianship & Administration Act 2000
• Public Guardian Act 2014 (Queensland)

Related policies and documents

• Facility specific
• Office of Public Guardian:
  The Office of the Public Guardian (OPG) is an independent statutory office established to protect the rights, interests and wellbeing of adults with impaired decision-making capacity. For adults with impaired decision-making capacity the OPG can:

  • makes personal and health decisions if the Public Guardian is their guardian or attorney
  • investigates allegations of abuse, neglect or exploitation
  • advocates and mediates on behalf of adults with impaired decision-making capacity
  • educates the public on the guardianship and attorney systems.

When appointed by the Queensland Civil and Administrative Tribunal (QCAT) as guardian, the Public Guardian routinely makes complex and delicate decisions on health care and accommodation, and guides adults through legal proceedings in the criminal, child protection and family law jurisdictions.

• General enquiries: 1300 653 187
• Health care decisions: 1300 753 624
• Office of Advance Care Planning: 1300 007 227
APPENDIX 1: DEFINITION OF TERMS

- **Advance Health Directive (AHD):** In Queensland, an AHD is a legally binding advance care planning document stating a formal set of instructions for future health care. It is used to inform doctors about a person’s choices for health care when they become unable to make health care decisions. This document allows a person to record their wishes relating to specific medical circumstances if they eventually lose the capacity to make decisions. It can only be completed by a person with capacity. It must be completed with a doctor and witnessed by a Justice of the Peace, Commissioner for Declarations, a lawyer or notary public.

- **Enduring Power of Attorney (EPOA):** An EPOA is a legally binding document that enables a person to appoint another individual to make personal, health and/or financial decisions on their behalf. More than one individual can be appointed. The EPOA can only be completed by a person with capacity.

- **Statutory Health Attorney (SHA):** A Statutory Health Attorney is someone with automatic authority to make health care decisions on behalf of a person who is unable to make them because of illness or incapacity. A Statutory Health Attorney cannot be appointed ahead of time; the individual acts in this role only when the need arises. The first available individual who has a relationship with the person and is culturally appropriate becomes their Statutory Health Attorney. Usually this would be a spouse or de facto partner, an individual who is responsible for the person’s primary care but not paid to be a carer, or a close friend or relative over the age of 18. The Public Guardian may under certain circumstances become the person’s Statutory Health Attorney.

- **Advance Care Planning (ACP):** Advance care planning means thinking about what health care would be wanted in the future and communicating those wishes. Advance care planning provides the opportunity for a person to discuss their beliefs and values, and helps give peace of mind that the person will receive the right care, at the right time, in the right place.

- **Statement of Choices (SoC):** The SoC is a document designed to help a person (or their significant other if the person does not have decision-making capacity) record their wishes, values and beliefs to guide those close to them to make health care decisions on their behalf if they are unable to make those decisions. The SoC has legal effect as a means of expressing a resident’s wishes and values but is not a legally binding document.

- **Substitute Decision Maker (SDM):** A SDM is a general term used to describe a person who has legal power to make decisions on behalf of an adult when that adult is no longer able to make their own decisions. A person can appoint an individual, while they still have legal capacity to do so, using the EPOA form or an AHD document. If a person has not previously appointed anyone and if they are no longer able to make decisions or complete legal documents then the law provides for a Statutory Health Attorney to speak on their behalf.

- **Capacity:** Capacity refers to a person’s ability to make a specific decision in a particular area of their life. A person has capacity when they have the ability to understand the information provided by a doctor about their health and treatment options and are able to make a decision regarding their care. The person also needs to be able to communicate their decision in some way and the decision must also be made of the person’s own free will.

---

APPENDIX 2: AUDITING OF SoCs DOCUMENTS

Auditing of Statement of Choices Documents
Office of Advance Care Planning

The clinical audit of each Statement of Choices (SoC) document received by the Office of Advance Care Planning (ACP) is an important and systematic process which provides quality assurance of readability, ensures adequate completion, clarity of values and consistency of selected treatment preferences prior to upload to The Viewer.

Where issues are identified, the Office of ACP will contact the person who submitted the SoC.

Adequate completion of the SoC
A person may complete all or part of the SoC. Certain elements of the SoC are mandatory before the SoC can be uploaded to The Viewer (see below).

Completion of all elements maximises the SoC utility. Completion of the personal values section is highly recommended and provides important information for substitute decision makers and the medical team (who may not have previously known the individual) about the values and beliefs of the individual which may clarify decisions related to medical options.

Rationale for mandatory SoC elements

1. Completion of personal details (or the addition of a patient identification label) is required to help the Office of ACP locate existing records of this person on The Viewer, ensure the SoC is uploaded to the right person's records and provide doctors with certainty the SoC belongs to the right person.

2. Information about health and medical conditions indicates the person's knowledge of health at the time they completed the SoC and can inform health professionals' discussion/decision making if an individual is unable to make or communicate decisions.

3. Provides guidance to the health care team/substitute decision makers about preferences regarding life prolonging and medical treatments and informs discussion/decision making if an individual is unable to make or communicate decisions.

4. A SoC signed and dated declaration by an individual/substitute decision maker acknowledges their understanding as to the importance and purpose of the SoC, when it will be used, their request for wishes, beliefs and values to be respected, and consent to share information with persons/services relevant to their health.

5. Substitute decision maker's information provides the health care team with contact details of the appropriate person/s to speak with if an individual is not able to make or communicate decisions.

6. A signed and dated Doctor's review provides confidence to the health care team that on the date signed, the person had the capacity necessary to make the SoC (Form A) or for substitute decision makers (Form B) that they understand the importance and implications of the SoC and are acting in the best interests of the person.

Mandatory SoC elements
The minimum and mandatory elements of the SoC required to be completed prior to upload to The Viewer include:

1. personal details
2. current health conditions (Form A) or current medical conditions (Form B)
3. life prolonging and medical treatment preferences
4. signed and dated declaration
5. substitute decision maker's contact details
6. signed and dated Doctor's review of plan

It is preferable that sections of the SoC that have been intentionally left blank are clearly marked to reflect this e.g. ‘nil’ or line drawn through.

Office of Advance Care Planning  p: 1300 007 027  OR  E: acp@health.qld.gov.au

Please ensure copies of all completed SoC from acute and community services in your HHS are sent in, either via you or directly, to the Office of ACP.

Disclaimer: This example ACP policy and procedure is intended to assist residential aged care facilities develop and/or review their own documentation within their policies and procedures framework. Neither Metro South Health nor Brisbane South PHN, nor any person associated with developing this document, accepts liability for an injury, loss or damage incurred as a result of anyone using or relying on the example ACP policy and procedure.
APPENDIX 3: ORGANISING FOR A COMPLETED SoC TO BE UPLOADED TO THE VIEWER

Steps for a completed advance care planning documents to be uploaded to The Viewer

The flow chart below shows how residential aged care facilities can ensure their residents’ documented advance care plans can be uploaded to The Viewer™ and made accessible across health sectors.

If you have any queries about this process or would like help with advance care planning, Statement of Choices or resource support for health professionals and consumers, please call the Office of Advance Care Planning (ACP) on 1300 007 227 (1300 007 ACP).

Office of Advance Care Planning
Phone: 1300 007 227 | Email: acp@health.qld.gov.au | Fax: 1300 008 227
www.mycaremychoices.com.au

Office of ACP staff acknowledge receipt of and clinically review the ACP

ACP suitable for uploading
- Office of ACP staff
  - upload ACP to The Viewer™
  - notify sender of document issues

ACP not suitable for uploading
- Office of ACP staff
  - notify sender of document issues
  - if issues resolved: suitable for uploading
  - if issues are unable to be resolved: not suitable for uploading

RACF nursing staff submit a copy of the document (with ID sticker) to the Office of ACP by:
- email: acp@health.qld.gov.au
- fax: 1300 008 227 OR
- post: PO Box 72, Corinda QLD 4075

Office of ACP staff
- notify sender of outcome
  - Document not suitable for uploading
  - re-submission invited

Resident’s ACP is completed

The Viewer is a read-only web-based application which sources key patient information from a number of existing Queensland Health enterprise clinical and administrative systems. Uploading an ACP to The Viewer enables clinicians in Queensland Health hospitals to have direct access to the patient’s document. GPs can learn more and register for access to The Viewer at https://www.health.qld.gov.au/digital-health/database-toolkit/providersportal/resources

Disclaimer: This example ACP policy and procedure is intended to assist residential aged care facilities develop and/or review their own documentation within their policies and procedures framework. Neither Metro South Health nor Brisbane South PHN, nor any person associated with developing this document, accepts liability for an injury, loss or damage incurred as a result of anyone using or relying on the example ACP policy and procedure.