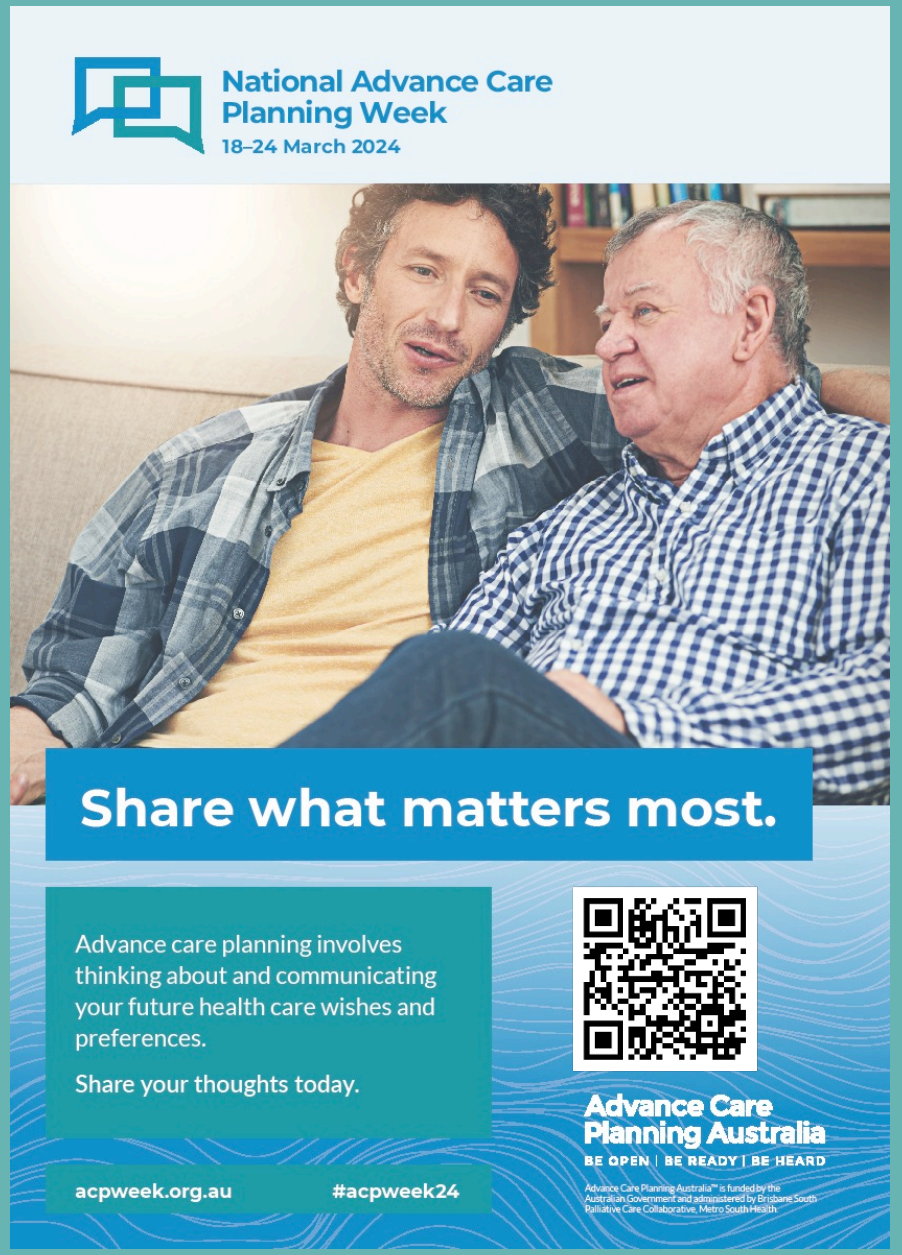
Advance Care Planning Week | Share what matters most



Palliative Care Project ECHO- Advance Care Planning

Metro South Health | Advance Care Planning

OACP
Statewide Office of Advance Care Planning

Advance Care Planning Australia
BE OPEN | BE READY | BE HEARD

Presenters:

- Alana Cresswell-MSH Advance Care Planning Service
- Jane Caldwell-Queensland Statewide Office of Advance Care Planning
- Greg Parker-Advance Care Planning Australia

Palliative Care Project ECHO- Advance Care Planning

Advance Care Planning Australia's **VISION** is that people:

- *Have a voice*
- *Can document their wishes and preferences*
- *Are listened to by care providers*
- *Have their wishes and preferences enacted*

Leading to care that is in line with their wishes and preferences.

National Advance Care Planning Week
18–24 March 2024

Advance Care Planning Australia's **OBJECTIVES**:

1.To engage and inform the community about advance care planning

2.To engage and educate the health and aged care workforce about advance care planning

3.To engage, connect, and inform key stakeholders, working collaboratively to improve systems that support and enhance advance care planning

4.To contribute to the evidence base and knowledge sharing for advance care planning

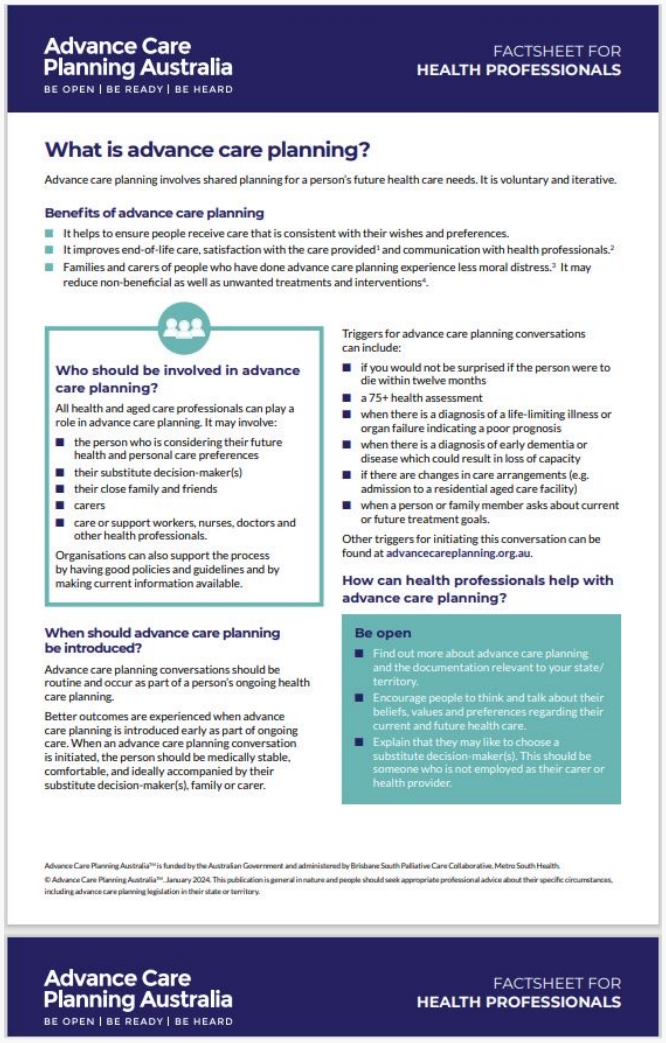
What is advance care planning?

Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.

- Sudore et al. 2017

- Factsheet for health professionals [fact-sheet-health-professionals.pdf (advancecareplanning.org.au)]



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FACTSHEET FOR HEALTH PROFESSIONALS

What is advance care planning?

Advance care planning involves shared planning for a person's future health care needs. It is voluntary and iterative.

Benefits of advance care planning

- It helps to ensure people receive care that is consistent with their wishes and preferences.
- It improves end-of-life care, satisfaction with the care provided[1] and communication with health professionals.[2]
- Families and carers of people who have done advance care planning experience less moral distress.[3] It may reduce non-beneficial as well as unwanted treatments and interventions[4].

Who should be involved in advance care planning?

All health and aged care professionals can play a role in advance care planning. It may involve:

- the person who is considering their future health and personal care preferences
- their substitute decision-maker(s)
- their close family and friends
- carers
- care or support workers, nurses, doctors and other health professionals.

Organisations can also support the process by having good policies and guidelines and by making current information available.

When should advance care planning be introduced?

Advance care planning conversations should be routine and occur as part of a person's ongoing health care planning.

Better outcomes are experienced when advance care planning is introduced early as part of ongoing care. When an advance care planning conversation is initiated, the person should be medically stable, comfortable, and ideally accompanied by their substitute decision-maker(s), family or carer.

Triggers for advance care planning conversations can include:

- if you would not be surprised if the person were to die within twelve months
- a 75+ health assessment
- when there is a diagnosis of a life-limiting illness or organ failure indicating a poor prognosis
- when there is a diagnosis of early dementia or disease which could result in loss of capacity
- if there are changes in care arrangements (e.g. admission to a residential aged care facility)
- when a person or family member asks about current or future treatment goals.

Other triggers for initiating this conversation can be found at advancecareplanning.org.au.

How can health professionals help with advance care planning?

Be open

- Find out more about advance care planning and the documentation relevant to your state/territory.
- Encourage people to think and talk about their beliefs, values and preferences regarding their current and future health care.
- Explain that they may like to choose a substitute decision-maker(s). This should be someone who is not employed as their carer or health provider.

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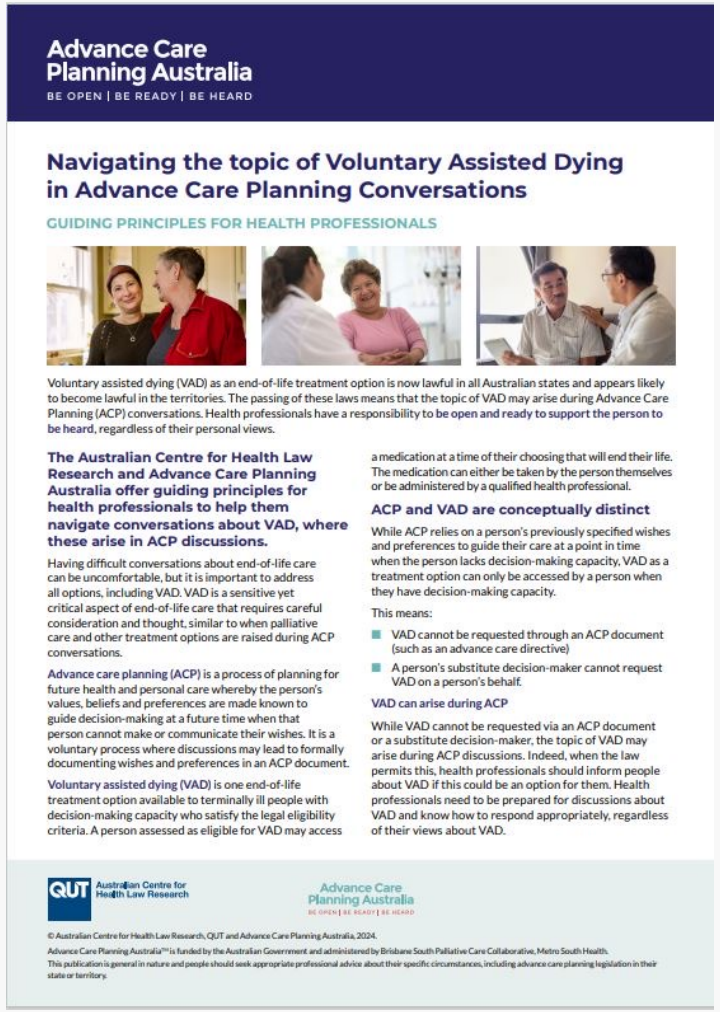
FACTSHEET FOR HEALTH PROFESSIONALS

Resources

- New guiding principles for VAD/ ACP
  [S1868_ACPA_GuidingPrinciples_QUT_FinalWEB.pdf (advancecareplanning.org.au)]



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Navigating the topic of Voluntary Assisted Dying in Advance Care Planning Conversations

GUIDING PRINCIPLES FOR HEALTH PROFESSIONALS

Voluntary assisted dying (VAD) as an end-of-life treatment option is now lawful in all Australian states and appears likely to become lawful in the territories. The passing of these laws means that the topic of VAD may arise during Advance Care Planning (ACP) conversations. Health professionals have a responsibility to **be open and ready to support the person to be heard**, regardless of their personal views.

The Australian Centre for Health Law Research and Advance Care Planning Australia offer guiding principles for health professionals to help them navigate conversations about VAD, where these arise in ACP discussions.

Having difficult conversations about end-of-life care can be uncomfortable, but it is important to address all options, including VAD. VAD is a sensitive yet critical aspect of end-of-life care that requires careful consideration and thought, similar to when palliative care and other treatment options are raised during ACP conversations.

Advance care planning (ACP) is a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their wishes. It is a voluntary process where discussions may lead to formally documenting wishes and preferences in an ACP document.

Voluntary assisted dying (VAD) is one end-of-life treatment option available to terminally ill people with decision-making capacity who satisfy the legal eligibility criteria. A person assessed as eligible for VAD may access a medication at a time of their choosing that will end their life. The medication can either be taken by the person themselves or be administered by a qualified health professional.

ACP and VAD are conceptually distinct

While ACP relies on a person's previously specified wishes and preferences to guide their care at a point in time when the person lacks decision-making capacity, VAD as a treatment option can only be accessed by a person when they have decision-making capacity.

This means:

- VAD cannot be requested through an ACP document (such as an advance care directive)
- A person's substitute decision-maker cannot request VAD on a person's behalf.

VAD can arise during ACP

While VAD cannot be requested via an ACP document or a substitute decision-maker, the topic of VAD may arise during ACP discussions. Indeed, when the law permits this, health professionals should inform people about VAD if this could be an option for them. Health professionals need to be prepared for discussions about VAD and know how to respond appropriately, regardless of their views about VAD.

QUT Australian Centre for Health Law Research

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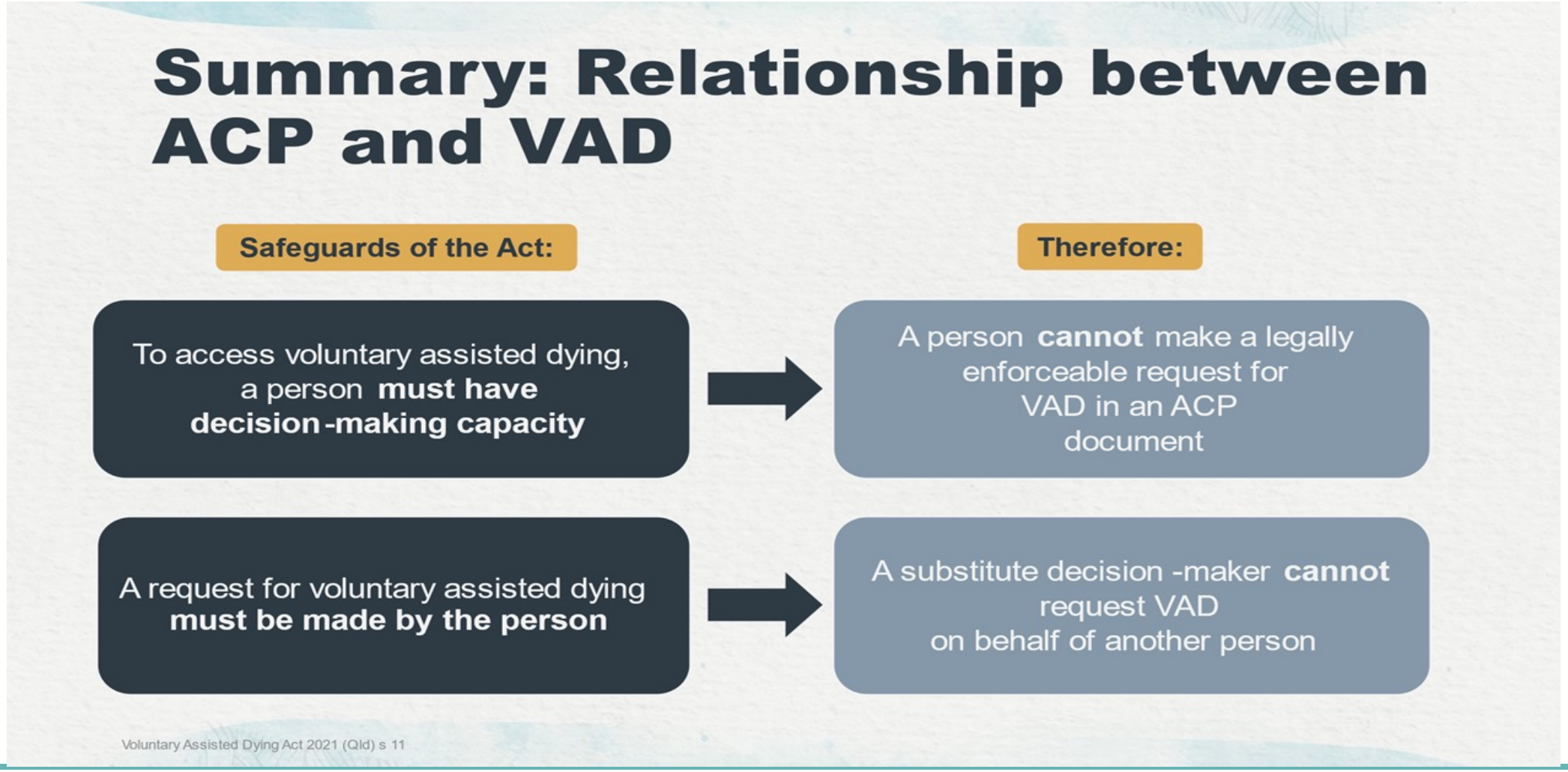
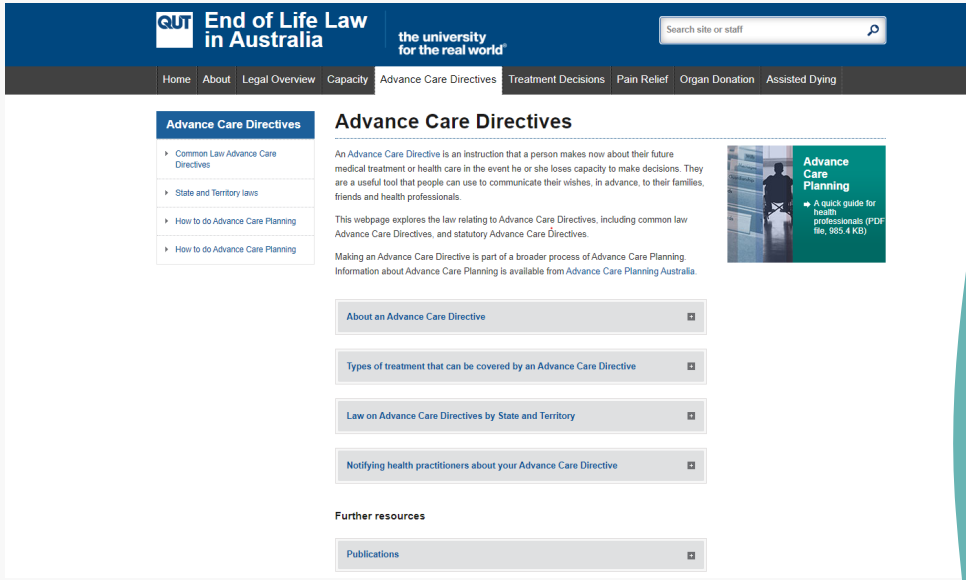
Resources

ACP and VAD


Summary: Relationship between ACP and VAD
Safeguards of the Act:
Therefore:
To access voluntary assisted dying, a person must have decision-making capacity
A person cannot make a legally enforceable request for VAD in an ACP document
A request for voluntary assisted dying must be made by the person
A substitute decision-maker cannot request VAD on behalf of another person
Voluntary Assisted Dying Act 2021 (Qld) s 11

Resources



[QUT - Advance Care Directives]

Statewide Office of ACP - Key functions

- A team of clinicians and administration officers
- Helping plan and share a person's health care wishes
- A free service funded by the Queensland Department of Health

- ☑ **Provide** information and resources about ACP.
- ☑ **Receive** and review copies/scans of ACP documents.
- ☑ **Upload** ACP documents to the QLD Health electronic health record.
- ☑ **Share** health care wishes with clinicians involved in care.
- ☑ **Notify** the GP about uploaded documents.
- ☑ **Connect** people to ACP services in their local area.

OACP
Statewide Office of Advance Care Planning

Metro South ACP Service - Key functions

ACP Facilitators

- 4.6 FTE Clinical Nurse Consultants +1 FTE Nurse Unit Manager working across Acute Care Hospitals and Community settings
  - ACP facilitation
  - Professional education
  - Capacity building
  - Community education and awareness
  - Outpatient Clinics – Community Health Care setting

ACP is a process that involves

1. **Thinking** and **talking** about what is important to you and learning about treatments and outcomes
2. **Choosing** a trusted decision-maker who will advocate for you; and ideally formally appointing them as your substitute decision-maker(s)
3. **Writing** down your views, wishes, preferences/directions for health care and completing ACP document.
4. **Sharing** documents with those involved in your care i.e. family/substitute decision-maker(s)
5. **Reviewing** your documents

What are the benefits of ACP?

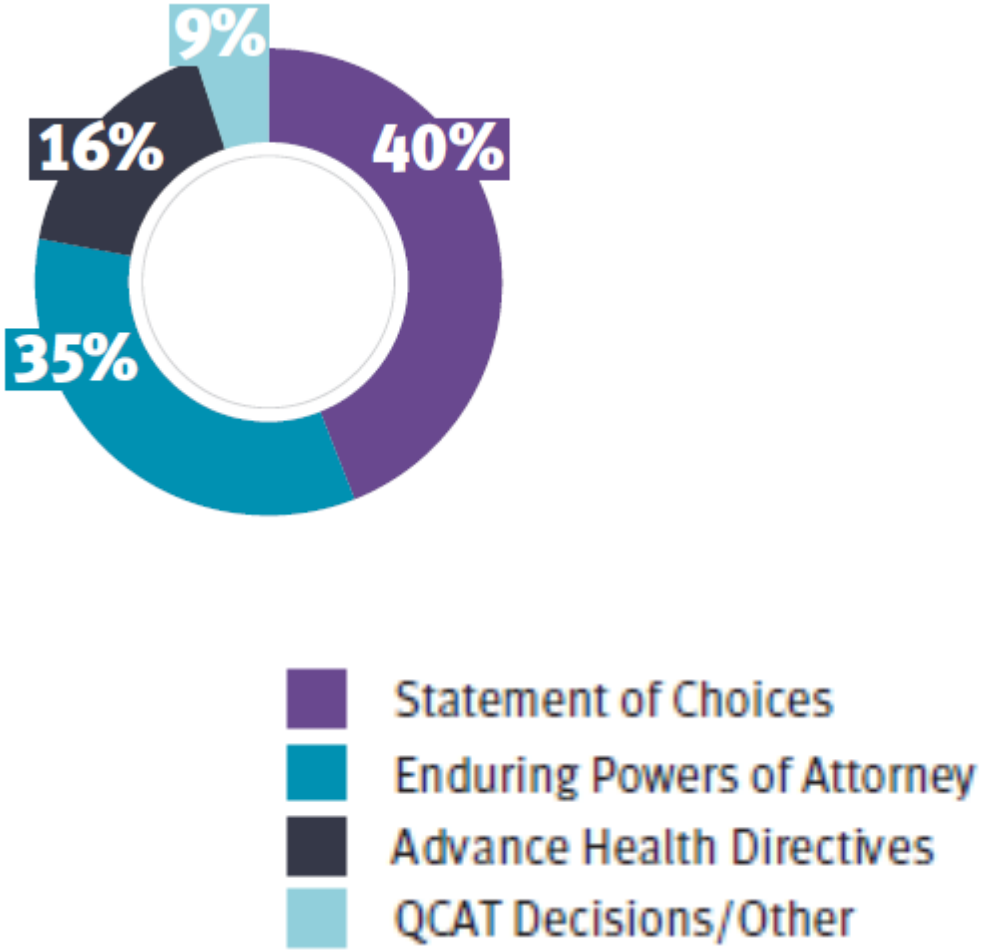
- ☑ Health wishes and expectations are discussed, known and more easily met by your health team.
- ☑ Reduced stress and anxiety for loved ones if they are making decisions.
- ☑ Improved family and decision-maker(s) satisfaction with care provided.
- ☑ Reduced hospital transfers when/if it is the preference not to go.

ACP activity bites

165,003
ACP documents received by the OACP since 2015

2,948
Average ACP documents received per month this FY

132,072
Effective ACP documents uploaded to The Tracker



ACP Tracker

- ☑ An online repository providing real-time access to ACP documents
- ☑ For registered health professionals across care settings including Queensland Health Hospitals and Health Services, primary care and general practice, residential aged care facilities and Queensland Ambulance Service.
- ☑ The ACP Tracker is launched on average 76,859 times per month (FY22-23)

ACP Tracker Overview (via The Health Provider Portal)

ACP Case Study

- Peter 79 years
- arrived in ED from home via ambulance
- multiple recent presentations with CCF and history of AMI x 3, obesity, DM2, PVD, OSA
- known to Palliative Care Service

Metro South ACP Service

- Day 2 of admission Metro South ACP CNC receives referral to talk to the Peter about ACP; asks Peter about any existing ACP documents – Peter has an EPOA document at home, in the filing cabinet.
- Brief discussion with Peter about his current situation and future health care wishes. The TT had told him “things were getting bad” and he mentioned:
    - he did not want CPR or to ever be on a ventilator – he spent a month in ICU and “it was hell”

ACP Case Study cont….

- once he got home he only wanted to be transferred to hospital for an acute episode eg. fracture and then to return home asap. Peter said he was sick of coming to hospital
- he wanted to die at home, surrounded by his family and with his Jack Russell “Jacko” by his side
- he didn’t want to suffer, wanted to be pain free with support and care from GP and community Palliative Care team
- His daughter was getting married in 3 months and he wanted to be there to give her away
- Peter wanted his wife and daughter to be part of the conversation
- He was going to be discharged that afternoon.
- An outpatient ACP clinic appointment was made for the following week for Peter to attend with his wife and daughter.
- They were asked to bring the EPOA to the appointment.

ACP Case Study cont….

- In Clinic the ACP facilitator, Peter, his wife and daughter had a conversation about formalising his views, wishes and preferences in an ACP document –
  - discussion around values based (Statement of Choices) or legal document (AHD).
  - Peter decides on Statement of Choices as he has an EPOA.
  - SoC completed and signed by Peter who knows it requires a GP signature before being sent to OACP

- Peter sends completed EPOA and SoC to OACP
- ACP facilitator makes a clinical note + Tracker comment

ACP Case Study cont…

Statewide Office of ACP

- OACP reviewed both the SoC and EPOA received from Peter.
  (Please note: The OACP regularly receives ACP documents from local ACP services/facilitators, acute, community and aged care services as well as individuals)
- The SoC was assessed as complete and uploaded to the ACP Tracker
- The EPOA however must comply with the formal requirements of the legislation (*s44 Powers of Attorney Act 1998*) and was found to have an issue regarding the witnessing of the document – it had not yet been dated by the witness.

- The OACP:
  - Notified Peter and supplied options of how to remedy the witnessing issue.
    (Please note: The OACP will notify the service/individual who sends the document, of any issues preventing the successful completion of the documents)

ACP Case Study cont…

  - Entered a comment in the ACP Tracker to ensure that clinicians were aware that the document was not complete at this time.
- Peter contacted the witness who added the date to the original EPOA. Peter then sent the finalised EPOA document to the OACP.
- The OACP:
  - Uploaded the completed EPOA to the ACP Tracker where it was available to the QAS and clinicians to access.
  - Notified Peters GP to advise that the documents had been uploaded to the ACP Tracker

- Peter was able to give his daughter away
- He died peacefully at home, a month later, with his symptoms well managed, surrounded by his family - in accordance with SoC and EPoA
- His family were grateful to have had ACP conversations which ensured his views wishes and preferences were respected

More information

advancecareplanning.org.au

National Advance Care Planning Support Service

1300 208 582

9am - 5pm (AEST) Monday to Friday

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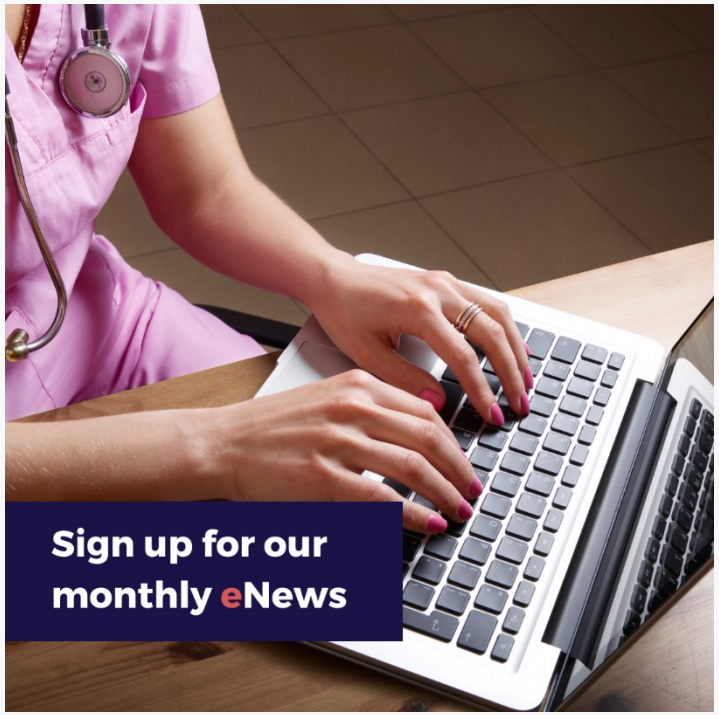
eNews



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