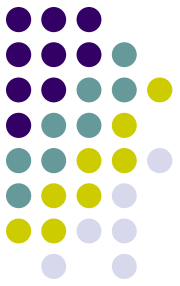


Advance Care Planning in Residential Aged Care

Anne Meller,
Clinical Nurse Consultant –
Chronic and Complex Care
Advance Care Planning
Northern Network - SESIAHS

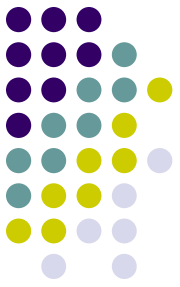


Aims



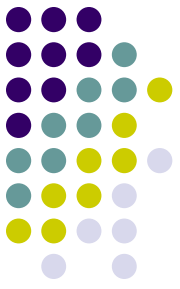
- What is Advance Care Planning?
- How does it relate to falls in RACFs?
- How can Advance Care Planning help?
- SESIAHS Project

What is Advance Care Planning?



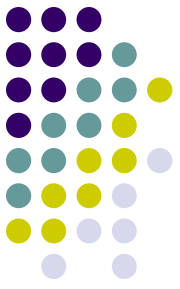
- *Advance Care Planning (ACP) refers to the process of preparing for possible scenarios near the end of life. It usually includes assessment of, dialogue about, and documenting of a person's understanding of their medical history and condition, values, preferences and personal and family resources.*

Advance Care Planning – 2 avenues



- *Appoint someone to make decisions about your health and lifestyle – An Enduring Guardian (E/G)
+/- Provide a values statement to assist them*
- *Complete an Advance Care Directive (ACD).
An Advance Care Directive (ACD) sometimes called a ‘living will’, is a document that describes one’s future preferences for medical treatment in anticipation of a time when one is unable to express those preferences due to illness or injury. Completion of an ACD ideally should be one component of the broader advance care planning*

The NSW Background



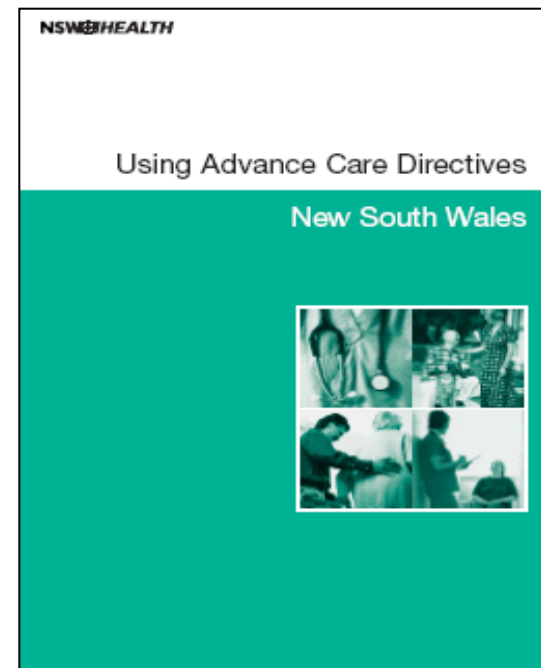
- Consent
 - Practitioners require a valid consent
 - Capable Patients have the right to refuse treatment
 - The Guardianship Act (1987) provides a mechanism for substitute consent for those who lack capacity to give a valid consent
- NSW Health
 - Using Advance Care Directives (June 04)
 - Guidelines for EOL care and decision-making (Mar 05)
 - Decisions regarding Not for CPR orders (Dec 08)
 - NSW Health Circular 2005_406 Consent (Dec 04)

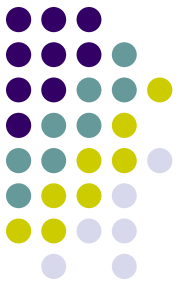
Circular 2005_406 is MANDATORY POLICY



NSW Health Guidelines

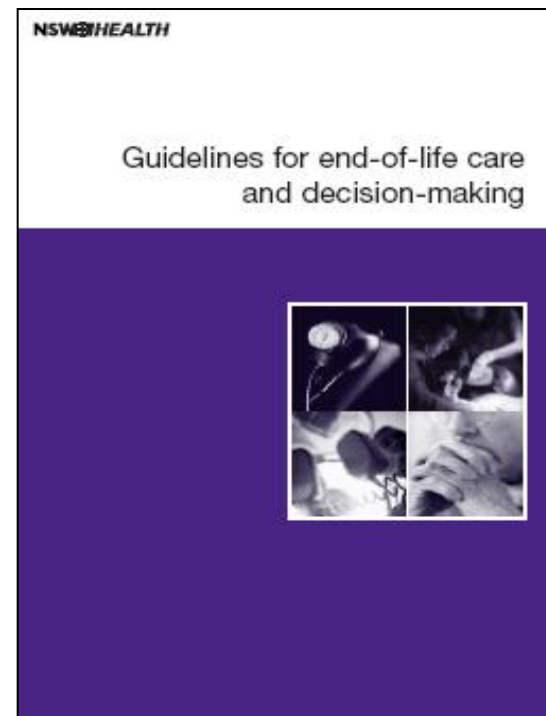
- Using Advance Care Directives

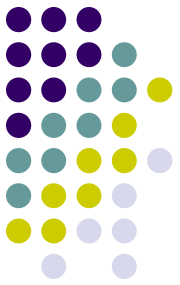




NSW Health Guidelines

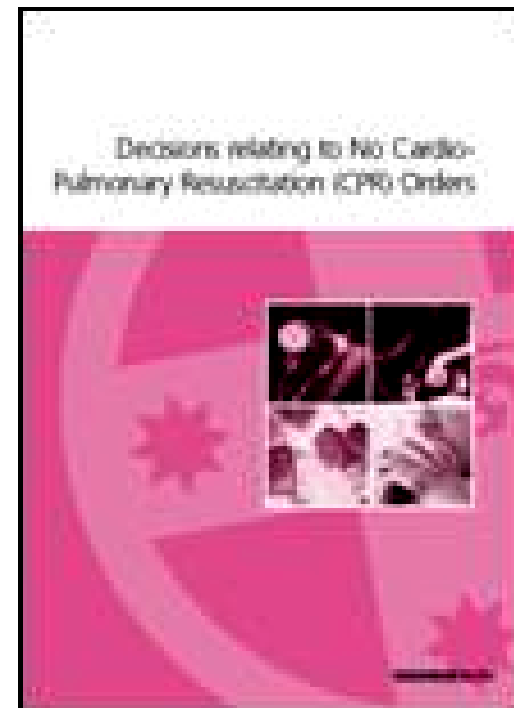
- Guidelines for end-of-life care and decision-making



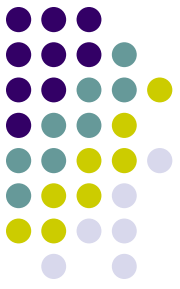


NSW Health Guidelines

- Decisions relating to No Cardio- Pulmonary Resuscitation (CPR) Orders

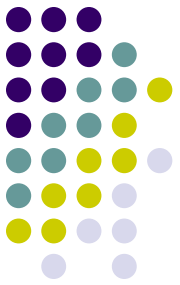


NSW Health Guidelines re ACDs



- Specific
 - It needs to be sufficiently specific to relate to the circumstances that have arisen.
- Currency
 - Reflect the currently known wishes of the person
- Competency/Capacity
 - You can only make an ACD while you are mentally competent to understand the treatment choices you are making. Must not be subject to undue influence from others
- Witness
 - Assists if there is any concern about undue influence; if done as part of E/G appointment witness must be certified

6/8/09....



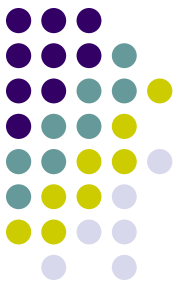
- NSW Supreme Court case
- Hunter and New England Area Health Service v A [2009] NSWSC 761
- “Legally binding”



MY LIVING WILL.....

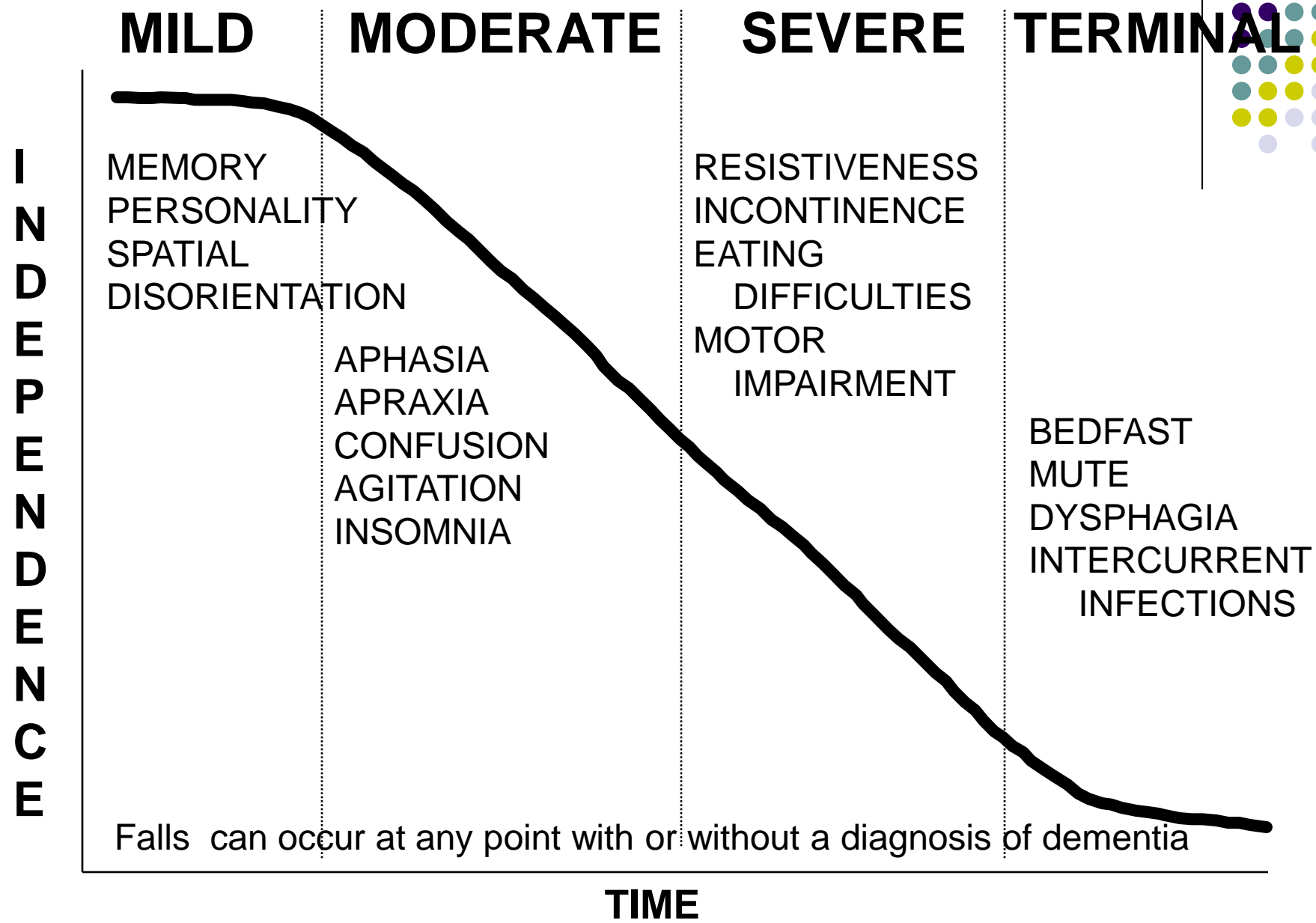
Last night, my friend and I were sitting in the living room and I said to her, 'I never want to live in a vegetative state, dependent on some machine & fluids from a bottle. If that ever happens, just pull the plug.

'She got up, unplugged the Computer, and threw out my wine.....



However....

- *For a large percentage of residents of aged care facilities, (especially in high level care) the ability to understand and articulate their wishes is decreased and an alternative mechanism may be required to assist decision making and inform advance care planning. For this purpose a Plan of Care may be developed with substitute decision-maker to guide decisions.
(not “binding”)*





MILD MODERATE SEVERE TERMINAL

**C
A
P
A
C
I
T
Y**

Consider
Preferred
substitute
decision-
maker

Appoint
EPOA
E/G
Discuss and
document
values
? ACD

GREY AREA

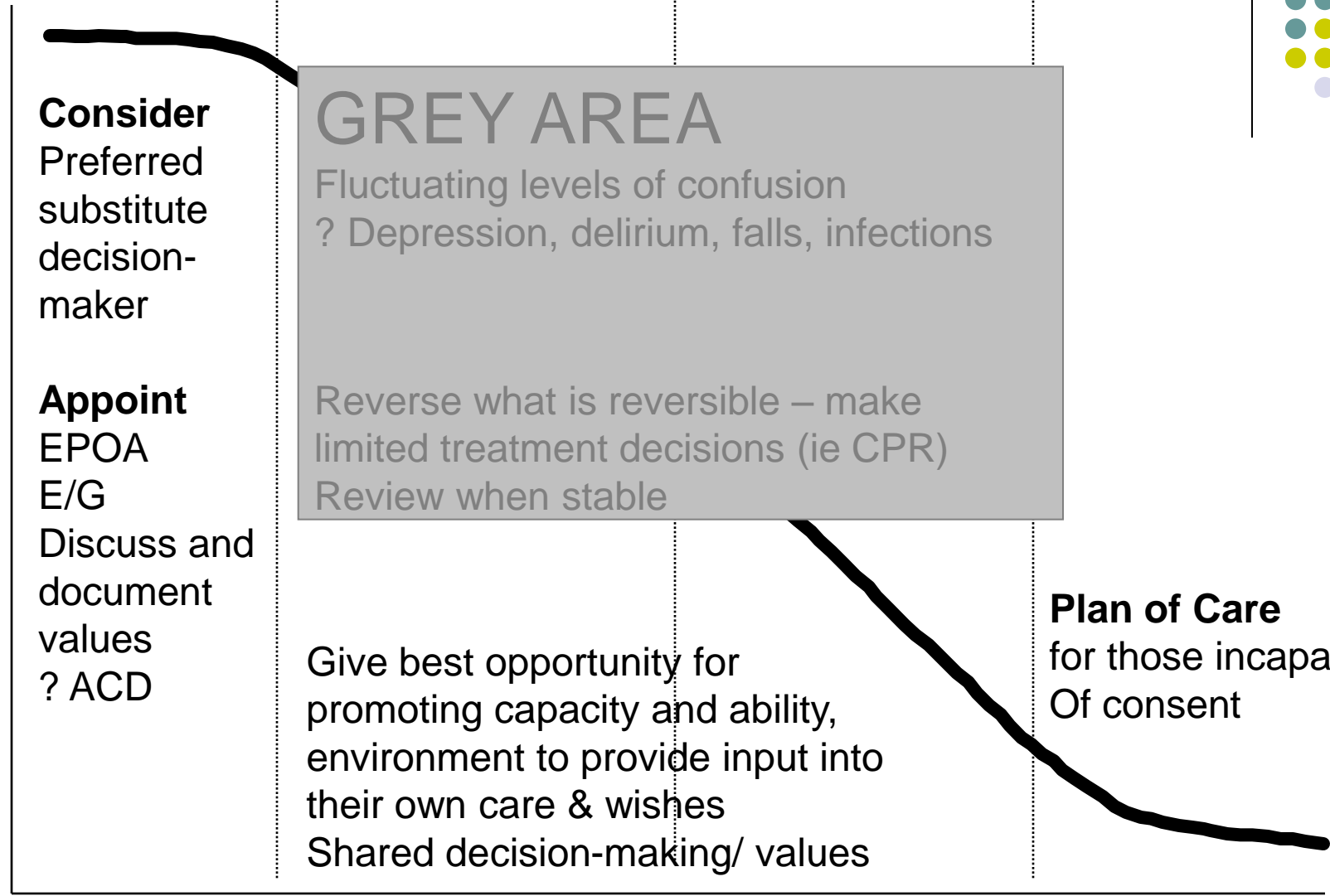
Fluctuating levels of confusion
? Depression, delirium, falls, infections

Reverse what is reversible – make
limited treatment decisions (ie CPR)
Review when stable

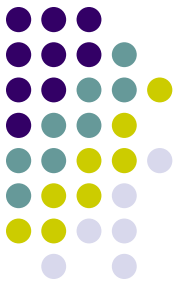
Give best opportunity for
promoting capacity and ability,
environment to provide input into
their own care & wishes
Shared decision-making/ values

Plan of Care
for those incapable
Of consent

TIME



ACP when capacity is lost....

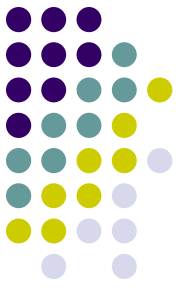


- Plan of Care developed with family and GP; identifying the “person responsible”
- Outlines aims of care in the event of deterioration (for RACF residents)
- Documents a consensus meeting and aims for future care, & where treatment is to be provided
- Consider acute care transfer risks and benefits
- What is foreseeable?
- Does not replace need for substitute consent for specific events
- Includes CPR decision, levels of intervention for treatment and feeding
- Often implies education re end stage dementia

Caplan et al *Age & Ageing*. 35(6):581-5 2006 Nov

Meller AE & Caplan GA *Dementia* 8 (3), p391-405 2009

How is ACP relevant to falls in RACFs?



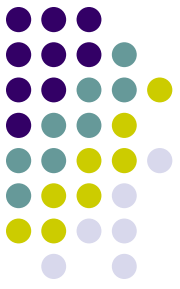
- Large percentage of residents with dementia
 - 33% fallers in RACFs sustain a #₁
- Of those # femurs 50% will not fully recover₂
- 30% will die within 12 months₃
- A fall may “herald” terminal phase sooner
- Therefore falls (post treatment phase) may “trigger” an opportunity to consider ACP

1. Kallin K et al. Public Health 2002; 116(5): 263-71.

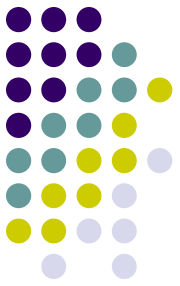
2. Magaziner et al Journal of Gerontology 1990; 45:M 101-7.

3. Jette et al Archives of Physical Medicine & Rehabilitation 1987; 68:735-740.

A Palliative Approach (Volicer & Hurley)



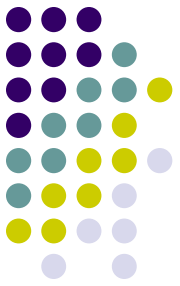
- Focus on care by maximising function & Quality of Life
- Minimise all negative factors
 - Anticipate complications (such as aspiration pneumonia)
 - Manage symptoms (HITH or Palliative Care)
- Maximise positive factors
- Enjoyment ~ balance risk
- **Namaste (Simard)**
- Sensory stimulation
 - Massage/ Aromatherapy
 - Music
 - Simulated presence
 - Taste



SESIH ACP Project in RACFs

- KPIs
 - Organisational Preparedness Survey
 - ASET Survey
 - Workshops
 - Attendance
 - CQI (& repeat)
 - Resource Development (now distributed)
 - Evaluation
 - CQI change
 - Workshop Evaluations
 - Pre/Post Knowledge Test
 - Post delivery survey (re Resource Folder)

Organisational Preparedness Survey



- Initial Survey 2009 -22 responses SESIH scored overall mostly Cs and Ds (No “A”s)
- Survey MAY 2010 – mainly Cs and Ds again (10% reduction in Ds) and (10% increase in Bs) (2% increase in As)

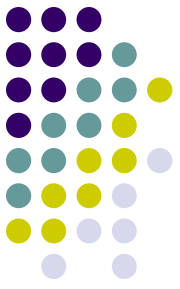
ASET Survey

ACF Residents presenting to Aged Services in Emergency Team for one week



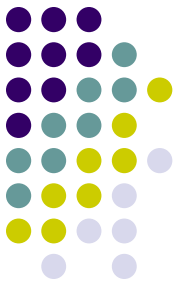
	2009	2010
Responses (n)	83	79
Person Responsible identified	28%	39%
AC Directives	2.40%	14%
AC Plans by GP/Others	2.40%	8.90%
Other documents	1.20%	12.70%

Training Workshops



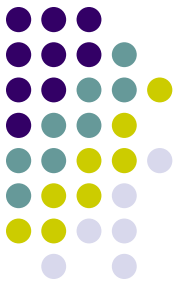
- 9 Workshops across SESIH
 - 124 attendees; 49/143 (35%) facilities across SESIH
 - Knowledge test (117 Pre and Post matched pairs)
 - Ave. Change in correct responses from 10.9 (65%- pre) to 13.2 (78% -post)
 - Evaluations (90% beneficial or very beneficial)
 - CQI activity.. 19 self rated yes/ no Qs
- Further direction/need determined via teleconferences
 - Led to resource folder development for participating facilities
 - Repeat CQI

43 facilities (88%) completed and repeated CQI activity



CQI activity-self rated		
YES Responses (out of possible 19)	Initial	Repeat
Average	6	12
Mode	2	13

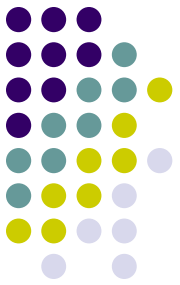
Items showing most improvement (%)



	INITIAL	REPEAT
RACF has a copy of Using ACDs (NSW Health)	42	94
Discussion of ACP is part of the admission process	28	65
Interview with resident/family addresses ACP	26	65
ACP document is sent when resident transferred	14	71
ACP reviewed regularly	19	58

These results were *prior* to resource folder/ CD being distributed

Resource Folder



- Developed and delivered recently to participating facilities and governance committee reps.
- Feedback (anecdotally) positive to date.

1. Advance Care Planning (ACP) Overview

Individual chooses to make an Advance Care Directive (ACD)

Person completes an ACD independently or with a solicitor

Goes to GP/Physician or trained health professional for assistance

Requires support via community services or is in residential care (1A)

Capacity is assumed

Does the person have the capacity to participate in the ACP process?

YES

UNSURE?

NO

2. TRIGGER QUESTIONS

ASSESSMENT

3. Identify the Person Responsible

5. ADDRESS POTENTIALLY REVERSIBLE AND RELEVANT IRREVERSIBLE CONDITIONS THAT IMPACT ON DECISION-MAKING

3. Identify the Person Responsible

4. OPTION 1
- Appoint an Enduring Guardian

6. CAPACITY SCREEN

OPTION 2
Document an Advance Care Directive (ACD)

7. DETERMINE THE NEED FOR ADVANCE CARE PLANNING

8. DETERMINE GOALS FOR CARE & TREATMENT via Case Conference

Consider documenting a Plan of Care via shared decision-making in a care planning (or case) conference; with person responsible, treating doctor/s and relevant others,

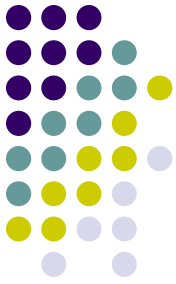
9. DRAFT PROCESS
PATIENT PRESENTS TO ACUTE CARE

With an ACD written by patient

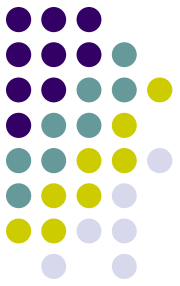
With a Plan written by person responsible & treating doctor

No documentation

DRAFT processes **NOT** included in RACF manual



Tools



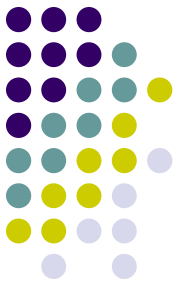
- My Health, My Future, My Choice:

<http://www.advancecaredirectives.org.au>

The Advance Care Directive Association NSW (Inc) will be launching a book “A Plan of Care” to assist families and friends - 30th July.

- www.mywishes.org.au (SSWAHS)
- Planning My Future Medical Care (Catholic Healthcare)
- *planningwhatiwant.com.au*
- *Respectingpatientchoices.org.au*
- *Hard choices for loving people (Hank Dunn)*

Contact details



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- 9382 2984