Plan Early: My Future Care

Delivering advance care plans to patients with chronic respiratory disease

Project Team: Trudy Hopkins, Louise Deady, Dr. Andi Dimitri, Dr. Meg Sands

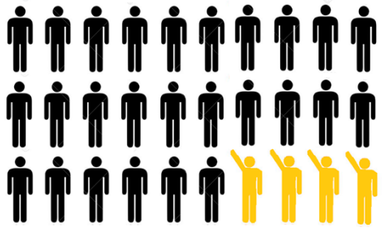
Prince of Wales Hospital, Randwick

Case for change

"I suffer everyday living with a chronic illness - some days I feel like I have no control over my health at all that's why it's important for me to have control over the way I die – I deserve that dignity at the end of my life. The decision should be mine, it should be known & honoured"
- Mary, 81 years old

60-70% of Australians prefer to die at home.

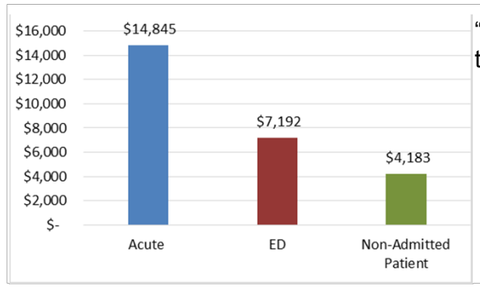
Only 14% do.



ISSUE: There is no process for identifying Respiratory Coordinated Care Program (RCCP) patients for whom advance care planning (ACP) is appropriate

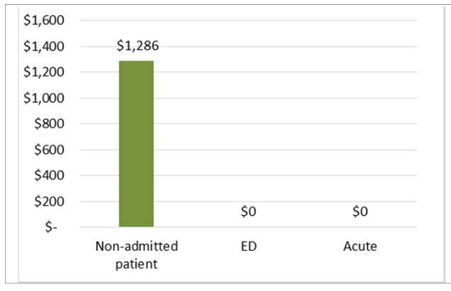
ISSUE: 0/250 RCCP patients have an ACP document (e.g. Advance Care Directive, NSW Ambulance Authorised Adult Palliative Care Plan, Resuscitation Plan) accessible to the RCCP team (none are in the RCCP database or hospital eMR).

HYPOTHESIS: Availability of ACP at the point of care will prevent emergency department presentations and/or hospital readmissions as well as inappropriate or unwanted levels of intervention or treatment once a person is admitted.



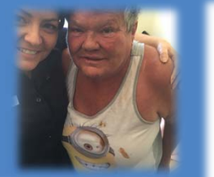
"Yanis" died in the respiratory unit

Total cost = $26,221



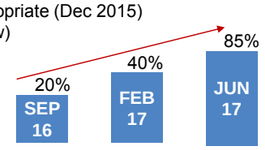
"Frances" died at home

Total cost = $1,286



GOAL	To improve the experience of patients, their carers and staff in the Prince of Wales Hospital RCCP towards the end of life
OBJECTIVES	• Identify patients for whom ACP is appropriate (Dec 2015) • Increase ACP documentation (as below)

Increase number of ACP documents for RCCP end-stage patients as follows

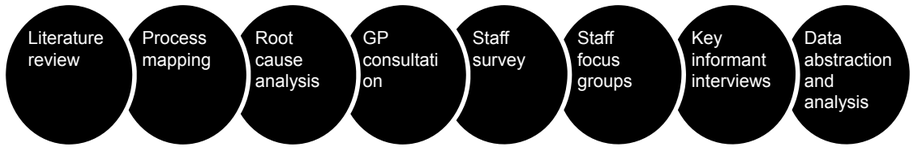


Method

The project followed the NSW Health Clinical Redesign methodology. Each project phase required deliverables to be signed off by project sponsors and submitted to the ACI Centre for Healthcare Redesign.

Key findings from diagnostics

The project used a variety of diagnostic activities to collect baseline data.



1 TIMING OF DISCUSSIONS AND IDENTIFYING NEEDS OF PATIENTS

Discussions occur late
Discussions do not occur at all
Patient needs identification is difficult

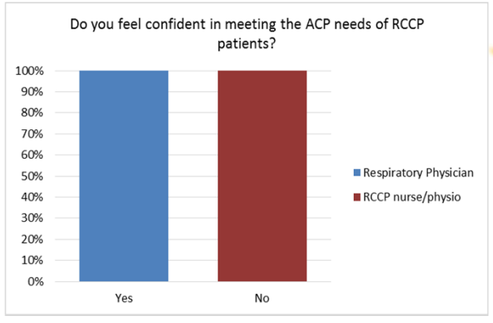
"I knew it was life threatening but I didn't know how fast it was going to happen" –RCCP Carer

2 CONFUSION OVER WHOSE ROLE ACP IS

Nursing	Medical
Allied health	Multidisciplinary

"Staff [are] not trained to bring up ACP, not confident…not sure who should broach ACP first (for example their GP, physician, RCCP)" – RCCP non-physician staff

3 RESPIRATORY STAFF NOT TRAINED IN ACP



4 ACPs NOT DOCUMENTS AND NOT AVAILABLE AT POINT OF CARE

"I have it [advance care plan] written in a book that my daughter & cousin has read [&] understands what's to be done." – RCCP Patient

5 LACK OF CARE INTEGRATION

"No one has ever discussed my end of life wishes with me in the past – not to my knowledge." – RCCP Patient

Solutions and results

SOLUTION	COMPLETION STATUS	
Implement a tool that predicts risk of death		Tool has been tested & identified patients for whom ACP is appropriate. Local IT solutions are being develop to spread the tool into a dashboard for all chronic care patients
Review patients at the morbidity and mortality meetings	ONGOING	4 RCCP patients have been discussed at the morbidity and mortality meetings. This will contribute to raising awareness of ACP and to continuous improvement in practice.
Clarify the ACP role		Robust process for how ACP occurs for RCCP patients has been mapped and endorsed by Steering Committee
Provide evidence based training to RCCP staff		4/5 RCCP staff trained by ACP CNC over 2 sessions. 1 session to go. Next step: Palliative Care nurses mentor/coach RCCP staff
Create eMR alerts for patients with ACP documentation		The ACP document(s) to use have been agreed (Advance Care Directive, NSW Ambulance Authorised Palliative Care Plan and Resuscitation Order)
Establish process of communicating plans with GPs		Engagement with GPs has been identified as needing to occur case by case

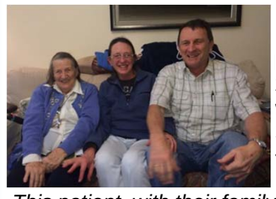
Quick wins

- The tool found 24 patients to have a mortality risk score predicting ≤60% chance of 12 months survival. We have completed 4 ACPs on these patients to date (16% of end stage patients now have ACPs)

Sustaining change

- Strong objective measures to keep project on track
- Robust data collection endorsed by Sponsors
- Clear and defined monitoring and reporting process
- Governance at District Executive level

Conclusion (and lessons learnt)



1. Advance care plans must be available at the point of care (every time!)
2. Patients and clinicians are change ready and want to be engaged in ACP
3. Our IT systems are difficult to use and need to be coordinated across the LHDs

This patient, with their family completed an advance care plan over 3 meetings.

Contact

Trudy Hopkins, CNC RCCP
P: 02 9382 3486
E: Trudy.Hopkins@health.nsw.gov.au

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