Nepean Blue Mountains Local Health District

Advance Care Planning

NBMPHN General Practice Nurse Education Day
May 2024

Maree White
Advance Care Planning Coordinator
0429 234 675

Acknowledgement of Country

The Nepean Blue Mountains Local Health District acknowledges the traditional custodians of the lands and waterways within its boundaries including the Darug, the Gundungurra and the Wiradjuri people. We acknowledge and pay respects to Elders past and present. We extend that respect to our local Aboriginal community and staff. We celebrate their strength and enduring connection to culture.

Artwork: ‘We All Share the Same Water’ by Leanne Watson, Shay Tobin and Leanne Tobin

A MOMENT TO REFLECT

IF YOU WERE CRITICALLY ILL AND COULD NOT SPEAK FOR YOURSELF - WHO WOULD SPEAK FOR YOU?

WOULD THEY KNOW WHAT YOU WOULD WANT THEM TO SAY?

KNOWING VERSUS GUESSING

WHAT IS ADVANCE CARE PLANNING?

- Advance Care Planning involves planning for future health and personal care should a person lose decision making capacity
- Captures people's values and wishes
- Enables them to continue to influence treatment decisions when they can no longer actively participate

Adapted from Department of Health Victoria

BENEFITS OF ADVANCE CARE PLANNING

- People are more engaged with care
- Receive care consistent with preferences
- Reduces unwanted and unnecessary transfers to acute care and unwanted treatment
- Improves ongoing and end-of-life care, along with personal and family satisfaction
- Families of people who have undertaken advance care planning have less anxiety, depression, stress and are more satisfied with care

PLANNING IS FOR EVERYONE

- Everyone should consider advance care planning, regardless of age or health
- Ideally should start planning when healthy – before there is an urgent need for a plan

CAN BE INTRODUCED THROUGH:

- Usual assessments and care planning such as the 75+ Health Assessment and Chronic Disease Management planning
- Routine consults with patient with chronic illness, is at risk of losing capacity, has just received a significant diagnosis
- Follow up consultations after a hospital admission

ADVANCE CARE PLANNING PROCESS

- REFLECT
- IDENTIFY GOALS, VALUES AND PREFERENCES
- IDENTIFY A SUBSTITUTE DECISION MAKER
- CREATE A DOCUMENT

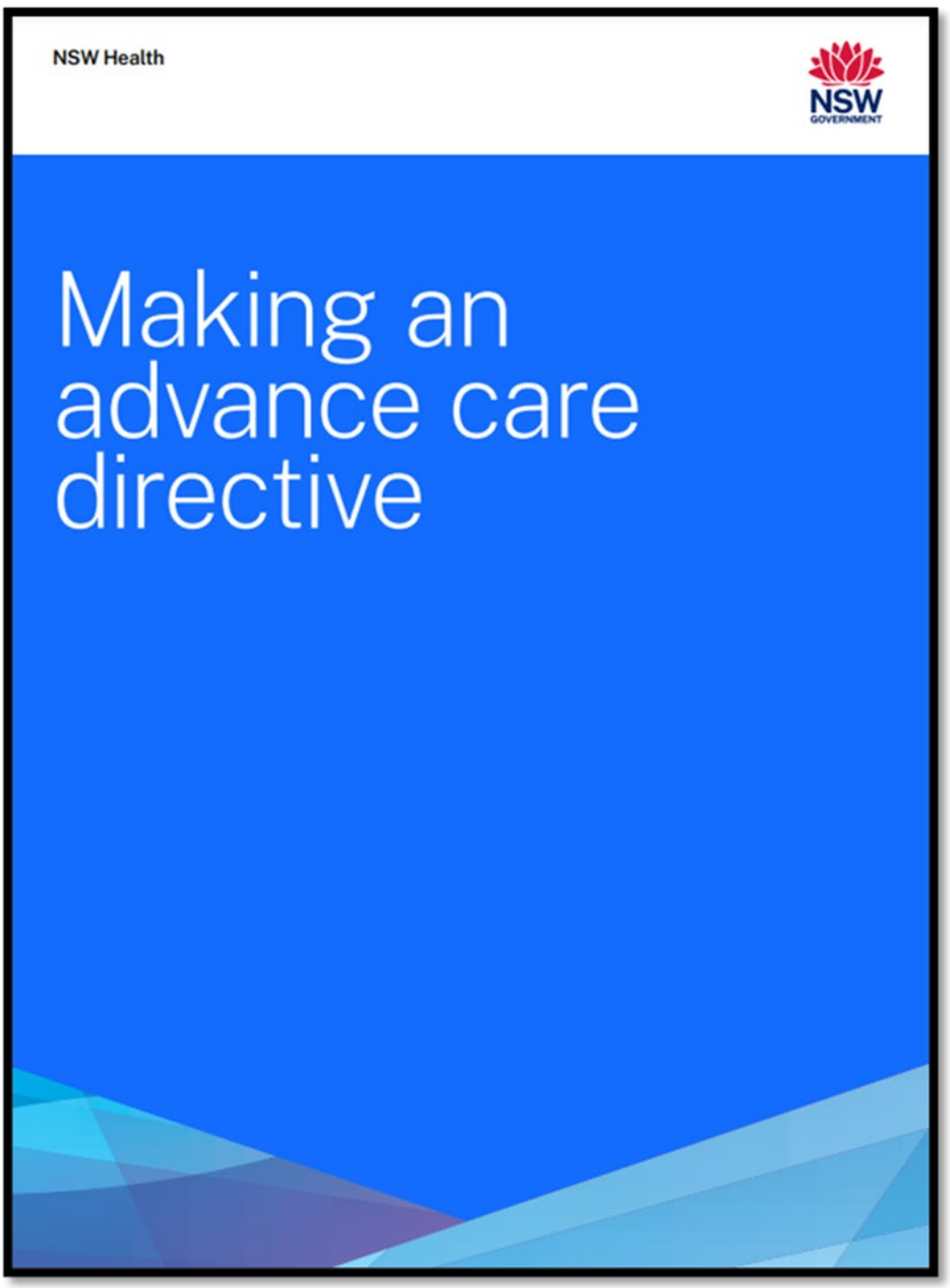
ADVANCE CARE PLANNING DOCUMENTS

ADVANCE CARE DIRECTIVE

- A document made by a person who has capacity
- Can include values, life goals and preferred outcomes
- Can include specific directions about care, including treatments person would like or refuse
- Identifies a substitute decision maker
- Advance Care Directives are legally binding and the preferences for health care documented must be followed
- An Advance Care Directive is only considered when the person does not have capacity

ADVANCE CARE PLAN

- A document created by someone on behalf of a person with diminished or no capacity
- Includes a person's belief's, values and preferences in relation to future care decisions
- Helpful in providing information for substitute decision makers and health professionals
- May guide care decisions
- Are not legally binding



ADVANCE CARE PLANNING DOCUMENTS

- Each state and territory has their own legislation around advance care planning
- In NSW there is no legislation around the document to be used for advance care directives or plans > therefore no expiry date
- NSW Government has created an Advance Care Directive document
- Advance Care Planning Australia have created an Advance Care Plan document for people who do not have decision making capacity

STORING ADVANCE CARE PLANNING DOCUMENTS

The person	Substitute decision maker
GP / Specialist	The Hospital > eMR
Residential Aged Care Facility	myhealthrecord.gov.au

Ask the patient/carer:

“DO YOU HAVE AN ADVANCE CARE DIRECTIVE OR ADVANCE CARE PLAN?”

“YES” - make a copy and give to clerical staff to have it uploaded to eMR.

“NO” - ask if they would like information about Advance Care Planning

Give a copy of the NSW Health ‘Advance Care Planning’ brochure

ACP SUGGESTED CONVERSATION STARTERS

"I like to talk to my patients about what they would want if they became more unwell. Have you ever thought about this?"

"You were quite unwell this last time you were in hospital.
If you were to be unwell like this again and you cannot talk for yourself, who are the doctors talking to?
Does that person know what you would want them to say?"

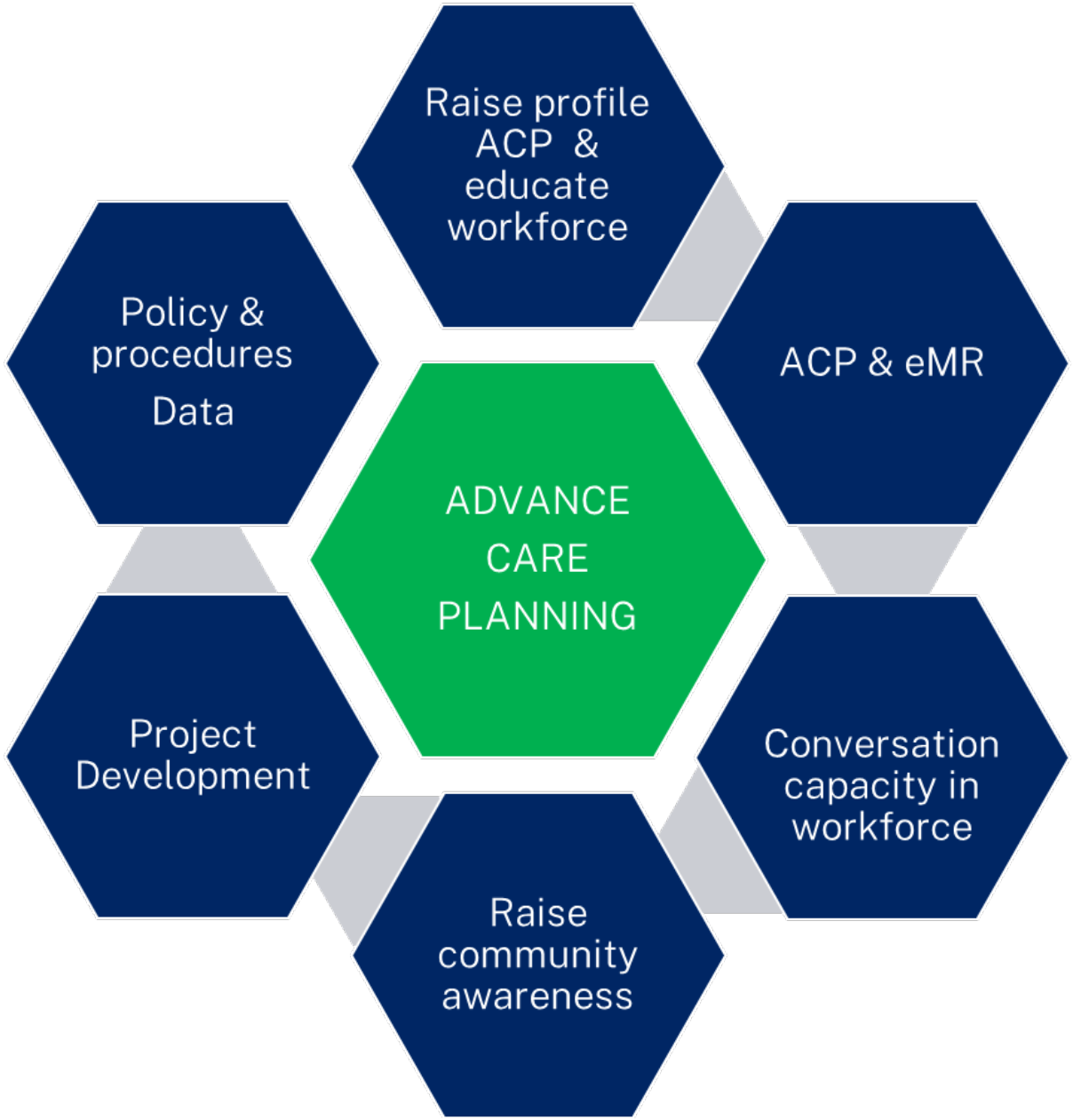
FOR CARERS
"As the main carer for your wife, have you considered what will happen with her if you were to become suddenly unwell?"

"You can have a say about what treatments you are willing to have and not to have"

"You can say who we are to listen to if you cannot speak for yourself"

"You can write this down so everyone knows what you want if you cannot say if yourself"

INITIAL FOCUS AREAS



RESOURCES

A nurse introduces her patient to advance care planning (ACPA video - 3min 28secs)
Nurse discusses ACP at chronic disease check-up
https://www.youtube.com/watch?v=w8xIlj6W8wA&t=114s

Advance care planning as part of routine care (ACPA video - 7min 20secs)
Nurse discusses ACP at chronic disease check-up > follows patient up with GP and physio home visit at deteriorates
https://www.youtube.com/watch?v=lEwfthRJlCI

Advance care planning in general practice
https://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-areas/advance-care-planning-in-general-practice

Advance care planning for Aboriginal and Torres Strait Islander peoples
https://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-for-aboriginal-and-torres-strait-islander-peoples

Advance care planning information in other languages
https://www.advancecareplanning.org.au/other-languages