Palliative Care Project Plans

In 2015-16, the GRPCC offered quality improvement grants to local Health Services to undertake projects that would directly improve the delivery of palliative care to clients living with life limiting illnesses in Gippsland.

To create some sustainability to the investment in these grants, the GRPCC is offering these project plans and accompanying documents and proforma to assist other services to develop their own implementation plans for palliative care activities.
These plans are free for you to download, but in the instance that they are used, we would appreciate you notifying us, and acknowledging the GRPCC (use the feedback tab on GRPCC front page www.grpcc.com.au).

We have endeavoured to ensure that health services have been de identified in these documents, without removing information that may be pertinent to the plan.

Original project plan

NAME OF PROJECT	Advance Care Planning- an organisational approach
BACKGROUND	(*Health Service*) identified a need to have a more coordinated approach in the process of advance care planning, following the review of processes against the Advanced Care Planning: have the conversation strategy for Victorian Health Services 2014-18 that was released by the Department of Health and Human Services (DHHS). In the 2015-16 Statement of Priorities, (*Health Service*) is required to : • "Implement an organisation-wide approach to advance care planning including a system for identifying, documenting, and/or receiving advance care plans in partnership with patients, carers and substitute decision makers so that people's wishes for future care can be activated when medical decisions need to be made…" • A coordinated organisational approach is required to review current policies and procedures, educational opportunities for staff, set up an auditing process and reporting structure to successfully meet the DHHS requirements
AIM	(*Health Service*) aims to form a multidisciplinary project team who will work together to implement the Advanced Care Planning: having the conversation strategy for Victorian Health Services 2014-2018
Target Group	Nurses working in acute and aged care, palliative care workers, district nurses, social workers who work with patients, residents and clients of (*Health Service*)

OBJECTIVE	MEASURES	OUTCOMES
• Implement an education program for clinical staff, with a competency successfully completed by 25% of clinical staff by *(date/timeframe).* • Develop and implement an alert system for advance care planning (ACP) that is consistent across the (*Health Service*) by *(date/timeframe).* • Develop KPI's and an auditing process that will provide quarterly reports \to the Clinical Practice committee that will direct practice improvements and target future education planning by *(date/timeframe).* as evidenced by the Clinical Practice Committee agenda and minutes • That 100% of patient, resident and client information tools will include a question on the presence of an ACP by *(date/timeframe).*	• Monthly progress reports to Clinical Practice Committee • Staff competency assessment reports from learning platform • KPI audit reports to monitor implementation and progress	• Increase in the number of patients, residents and clients with an ACP • Improved alert process for identifying patients, residents and clients with ACP • Increase in the number of clinical staff competent to "have the conversation" with patients, residents and clients, and to assist in the development of an ACP. • Improving monitoring processes for (*Health Service*) that will inform future education requirements and service improvements.

METHODOLOGY
• Multidisciplinary working party to be formed and project lead to be appointed • Organisational audit to determine current status in relation to ACP • Develop education strategy for immediate and ongoing education of staff • Develop KPIs and auditing schedule for ongoing monitoring of ACP. • Report ACP KPIs to appropriate clinical committees.

Stage 1

Key Performance Indicator	Next Quarter Objectives
Institute an organisation wide advance care planning policy that is endorsed by executive and clinical leaders	
Work towards creating alert systems for advance care plans and provide access-related documentation	Advance care planning resources (e.g. storage sleeves and discussion record cards) are available in key clinical areas
(*Health Service*) use quality audits to inform and improve advance care planning systems	Develop measurable KPI's to be audited. Add to organisational audit plan Executive and clinical leaders receive and respond to results of advance care planning quality audits through appropriate committee
Establish mechanisms that support the mutual recognition of advance care plans developed in other settings or services	Advance care plans included in communication templates between health services and other care providers, including identification of the substitute decision maker
Inform advance care planning practice through review of activity, quality and patient experience data	Advance care planning included as a parameter in an assessment of outcomes including - mortality and morbidity review reports - patient experience - routine data collection
Shape advance care planning practice with available evidence (*Health Service*) establish implementation plans for advance care planning that is based on evidence	That 100% of patient, resident and client information tools will include a question on the presence of an advanced care plan in 3/12
Staff are informed and educated about their role through - position descriptions - induction programs - access to training programs - mentoring and support	Position descriptions describe role in advance care planning Induction programs include advance care planning Mentoring is identified in health service implementation plan Implementation of an education program for clinical staff, with a competency successfully completed by 25% of clinical staff by *(date/timeframe)* as measured by Learning platform reports Development of ongoing educational strategy
Provide clients with opportunities to discuss and record their wishes and preferences at clearly identified points in their care	Number and percentage of people with an advance care plan Client information collected includes identification of the substitute decision maker

Final Report

KPI's	Previous Quarter Outcomes	End of Project Activity Status
Establish mechanisms that support the mutual recognition of advance care plans developed in other settings or services.	• ACP template created. Local medical centres have reviewed it and belief it is user friendly. • Template taken to Health Information Committee for approval • Meetings held with local medical centres. Clinics now have a greater understanding of what (*Health Service*) do once they receive an ACP. • All clinics provided with ACP project officer contact details. Meetings held with RACFs, Primary Health Services and acute ward NUM's to discuss what ACP is and to open lines of communication.	• All departments have been advised to remove any old versions from stock. • All departments aware of how to order forms • All GP clinics have finalised copy of ACP form that is compatible with their software. • Form to complete trial in *(date/timeframe).* • No issues have been raised to date.
Accurate recording and filing of ACP including creating alert systems.	• Agreed to store hard copy of ACP in green pocket at the very front of all medical records (acute, community and residential). • Ward Clarks and medical records staff will enter ACP as an alert onto iPM. Emergency directions will be transcribed into the comments section as a fast access point (to reduce errors occurring whilst waiting for paper based file)	• All ward clerks and appropriate admin staff have been train in how to record ACP electronically and the correct location to store ACP in paper-based histories.
Inform ACP practice through review of activity, quality and patient experience data	• No data collection or quality activities were being undertaken regarding ACP prior to project. • Quality audit tools obtained • iPM can now collect data regarding patients admitted with an ACP.	• Auditing plan created with guidance from Quality Manager. • Auditing plan identifies staff responsible for undertaking/collating audit data and where it is to be presented.
Staff are informed and educated about their role through - position descriptions - induction programs - access to training programs - mentoring and support	• Review of available online training completed. Current online course 8hrs in duration. • Online education package is in progress to be available to all staff via (*Health Service*) learning site. • Contact made with Human Resources to ensure all PD's have information regarding ACP.	• Current PD template meets needs for ACP • Presentation created to be presented by *(role title)* in orientation

KPI's	Previous Quarter Outcomes	End of Project Activity Status

Provide clients with opportunities to discuss and record their wishes and preferences at clearly identified points in their care	• Information gathering has taken place.
	  ○ Social work currently undertaking this in an ad-hoc manner
	  ○ Palliative care team discussing and providing information to all their consumers
	  ○ Discussed during admission to residential care
	• GP clinics request
	  ○ If consumer has an ACP template and is ready to complete then to book a long appointment with GP
	• If consumer wishes to have further discussions regarding ACP and may not be ready for finalise plan then to book an appointment with a practice nurse.
		• ACP question now on admission form. With supporting flowchart.
		• Social work department to provide ongoing support.

Institute an organisation wide advance care planning policy that is endorsed by executive and clinical leaders	• Policy was created and available on intranet • Reviewed policy at start of project. Currently meeting needs however ongoing review required.	• Policy has been updated and sent to Clinical Practice Committee for review and approval.


ACP Flowchart.docx


Auditing Plan.docx