Advance Care Planning Australia
An Australian Government initiative

IMPROVING ADVANCED CARE PLANNING COMPLETION IN A DIALYSIS UNIT THROUGH COLLABORATION WITH THE ACP TEAM

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1 INTRODUCTION TO ADVANCE CARE PLANNING (ACP)

Advance care planning is a way for you to have a say about your future health care.

It involves thinking about, talking about and documenting your values, goals and preferences for the type of care you would or would not want if you became unable to make decisions or communicate.

It helps ensure the right care for you, by the right people, at the right time.



It's not just for end of life care.
It's for any future health event.

WHY ADVANCE CARE PLANNING IS IMPORTANT FOR NURSING PRACTICE



As nurses, we are often at the forefront of supporting patients and families through some of life's most critical moments. Advance care planning (ACP) enables us to deliver person-centred, respectful, and appropriate care that aligns with the individual's values and wishes.

EMPOWERS NURSING PRACTICE

- Enables nurses to support patients to express their healthcare preferences early.
- Facilitates proactive, informed conversations about care choices, treatment limits and goals.



REDUCES STRESS AND CONFLICT FOR ALL

- Reduces uncertainty and moral distress for nurses when care is aligned with the patient's wishes.
- Minimises conflict and emotional burden for families, who are supported by clear documentation and discussions.



IMPROVES QUALITY OF CARE

- Supports delivery of care that is consistent with the person's values, beliefs and goals.
- Reduces unwanted or non-beneficial interventions and supports appropriate use of healthcare resources.



Advance care planning: simple today, better tomorrow

Your conversations today shape the care of tomorrow.

Advance care planning is a core component of safe, high-quality, person-centred care. Together, we can ensure every person's wishes are known, respected and acted upon.

Ask. **Listen.** **Document.**

Your conversations today shape the care of tomorrow.

IT'S AS SIMPLE AS 1, 2, 3

1 in 10

Australians have an advance care directive.



90%

of Australians say it's important to plan for future care.

An advance care directive

outlines your care choices in advance.

It helps your loved ones and healthcare team

make decisions that reflect your wishes.

Start the conversation. Learn more in the time that's right for you.

** Source: Advance Care Planning Australia National poll 2024*

ADVANCE CARE PLANNING AND ADVANCE CARE DIRECTIVES

EMPOWERING NURSES TO SUPPORT INFORMED CHOICES AND RESPECTED WISHES

WHAT IS AN ADVANCE CARE DIRECTIVE?

- A legal document where you outline your medical treatment preferences and appoint a substitute decision-maker.
- Can include specific instructions for different situations, like life support or palliative care.



KEY DIFFERENCES BETWEEN ACP AND DIRECTIVES

ADVANCE CARE PLANNING

The ongoing process of discussing and planning your healthcare.

VS

ADVANCE CARE DIRECTIVE

A formal document that records your healthcare wishes and is legally binding.

Both are essential and work together to ensure your wishes are known, understood and respected.

WHEN ADVANCE CARE PLANNING TAKES EFFECT

Ensuring your wishes guide your care when you can't

ACTIVATION CONDITIONS

ACP and Advance Care Directives become active when you are no longer able to make or communicate decisions yourself.

This can happen due to:

- Serious illness
- Severe mental incapacity
- Serious injury
- Other circumstances that impact decision-making capacity

A registered health practitioner determines you lack decision-making capacity.

ROLE OF SUBSTITUTE DECISION-MAKERS

If you've nominated someone, they will make decisions based on your preferences when you can't.

These decisions are legally binding as long as they align with your documented wishes.

Their role is to:

- Make healthcare decisions in your best interests
- Follow your known wishes and values
- Work with the healthcare team
- Advocate for the care you would want

Strengthening Advanced Care Planning (ACP) in the Dialysis Unit

Empowering patients. Driving person-centred, purpose-driven care.

OUR APPROACH

- **Partnership:** Dialysis staff member with ACP portfolio partnered with the ACP team

- In-service education by the ACP team

- Introduced what ACP is to patients
- ACP champion read each question and explained the importance of this values directive

- One-on-one training by the ACP team for the ACP champion

- Direct engagement with patients
- Private room (dialysis unit's isolation room) booked for each patient during dialysis
- More accessible; reduced need for separate appointments

MANAGER SUPPORT MADE A DIFFERENCE

- Support to complete ACP champion portfolio
- Provided paper days to support completion of ACP documents and discussions

Renal Dialysis Champions

Empowering patients through Advance Care Planning (ACP)

01 LEARN & PREPARE

- Provide ACP introduction
- Brochure, Getting started Book

Goal:
Build knowledge and confidence in ACP

02 ENGAGE & CONNECT

- Seek consent to have a conversation about ACP
- Coordinate time to have a discussion
- Send referral to ACP service if preferred

Goal:
Start the conversation and build trust

03 PREPARE & GUIDE

- Prepare documents
- Explain to patient process for document completion/witnessing
- If patient declines document completion, complete ACP discussion record in SMR legal tab

Goal:
Support informed decision-making

04 DOCUMENT & FOLLOW UP

- Complete ACP discussion record
- Update Alerts in EMR for ACP discussion
- Update Unit database on Sharepoint
- Notify ACP service of completion of documents/discussion via e-mail

Goal:
Ensure documentation and continuity of care

Every conversation matters. Every choice counts. | *Together, we champion patient-centered care.*

CHALLENGES AND HOW WE OVERCAME THEM

Patient reluctance to discuss end-of-life preferences

WHAT WE DID

- Patients were given time to think about the documents
- Simple words were used to have the follow up conversation
- Pros and cons discussed

Managing GP witness requirement

WHAT WE DID

- Involved renal registrars to witness
- Involved renal consultants to witness

Language barriers

WHAT WE DID

- Used phone translators to support conversations
- Used in-person translators when available

WHAT WE ACHIEVED

- Successfully enhanced ACP completion
- Promoted proactive end-of-life care
- Empowered patients and families

FUTURE FOCUS

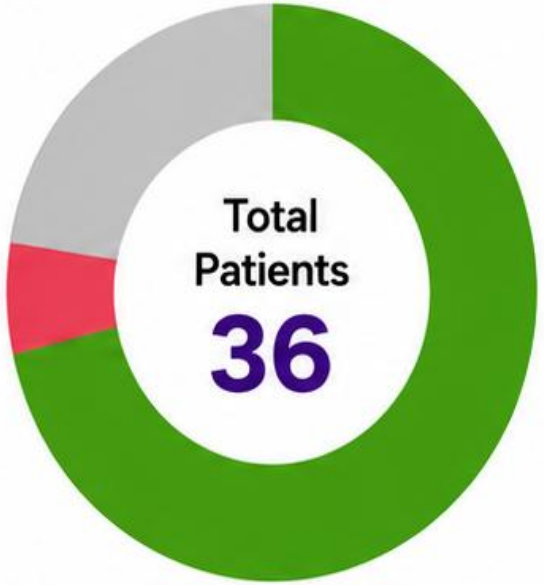
- Continued follow-ups
- Increased translator involvement
- Strengthened patient education and support

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Empowering patients. Driving person-centred, purpose-driven care.

OUTCOMES

ACP COMPLETION OUTCOMES (Total Patients = 36)



26 (72.2%)
Completed ACP
Patients with completed ACP documents

2 (5.6%)
Refused
- Patient refuses to talk about future planning
- Patient too young (23yo) and feeling anxious to talk about this topic

8 (22.2%)
Yet to Complete
Ongoing discussions / follow-ups

KEY IMPACT



of patients have completed ACP

26 out of 36

Over **8x** increase in ACP completion!

QUESTIONS?

Thank you for your time and commitment to person-centred care.

Together, we can ensure every person's wishes are known, respected and acted upon.

