**QI Action Plan- \*add practice name\*   
Advance Care Planning Discussions**

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| **Ask-Do-Describe** | |
| **Why do we want to change?** | |
| **Gap** | Low number of advance care documents completed and sent to Office of Advance Care Planning (OACP) for patients, including for those who are high risk or have complex morbidities. |
| **Benefits** | Increase the opportunity to discuss end of life care wishes with patients undergoing health assessments. Aiming to reduce future inappropriate health interventions and hospitalisations and increasing the likelihood for patients to die in their place of choice. |
| **Evidence** | [RACGP](https://www.racgp.org.au/download/documents/Policies/Clinical/advancedcareplanning_positionstatement.pdf) position statement on ACP, suggests that General Practice is an important setting for initiating and promoting Advance Care Planning (ACP), as planning for future health care is best discussed with patients at the time when their health is stable. [QLD Health](https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688618/acp-guidelines.pdf) ACP Guidelines also suggests that ACP achieves successful outcomes reducing unnecessary and undesired interventions and treatments at the end of life, higher satisfaction with quality of care (increasing quality of life) and reduces unnecessary hospitalisations for patients at the end of life.[[1]](#footnote-2) |
| **What** do we want to change? | |
| **Topic** | Increased number of ACP discussions to initiate the completion of Advance Care documents for active patients of \*practice name\* during health assessment appointments.  \* [Advance Health Directive (AHD) form or Statement of Choices (SoC) form](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjGzKzRr8j6AhWR9zgGHcq7Bb8QFnoECA4QAQ&url=https%3A%2F%2Fmetrosouth.health.qld.gov.au%2Fsites%2Fdefault%2Ffiles%2Fsoc-qldhealth-form-a.pdf&usg=AOvVaw3F722JgMgGKIbNffFmxvyO) |
| **How much** do we want to change? | |
| **Baseline**  *Baseline data is your*  *your current performance.* | **Example:**  *The baseline will be unknown as ACP discussions are not able to be extracted from clinical information systems. This activity will ensure that during health assessments, patients are provided with the opportunity to discuss their future health care needs and to support completion of ACP documents.* |
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| **Target**  *Your target is the planned % result of the improvement. Target is the number of ACP discussions to be completed to meet your goal.* | Consider your sample size and how long it will take to initiate discussions and then complete advance care directives and to submit to OACP.  **Example:**   * *XX is the target number to be completed by XX* * *100% of patients that complete a 75-year-old health assessment will include ACP discussions. 50 health assessments will be completed over the next 6 months. Follow up appointments to be made for the patients that wish to proceed with completing ACP documentation.* |
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| **Sample**  *Sample is the number of patients who have had ACP discussions to meet your target.*  *Add your practice sample.* | *A list will need to be generated with individual names who are identified as most appropriate for ACP discussions (refer to ACP QI Toolkit for possible sample groups).*  ***Example:***  *Patients eligible for Health assessments over 75+.*  *This number could be determined from a Primary Sense report:*  *Health Assessments Report (Eligible and due) includes over 75 years old, Aboriginal and Torres Strait Islander and 40–49-year-old.*  *Consider narrowing down sample by:*   * *Focus on patients with higher complexity scores initially (ACG category 4-5). Specific age groups. e.g., 76–78-year-olds or patients who have just turned 75.* * *Offer patients with an existing appointment to book in for a health assessment appointment.* * *Focus on patients with a hospital risk score of 80% or more.* |
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| **Who** is involved in the change? | |
| **Contributors**  *Add names of the practice team involved* | **Practice Manager:**  **GPs:**  **Practice Nurses:**  **Receptionists:**  **GCPHN QI Project Officer:** |
| **When** are we making the change? | |
| **Deadlines**  *Add key dates here for this activity.* | **Baseline data report generated:**  **Implementation between (from/to):**  **Review meeting/s:**  **Final evaluation meeting:** |
| **How** are we going to change? | |
| **Implement**  *List some improvement strategies in order of implementation*  ***(see Appendix 1 for suggestions).*** | **1.**  **2.**  **3.** |
| **STOP: The next section is to be completed after implementation has already commenced.** | |
| **Monitor**  *A minimum of one QI*  *activity review /touchpoint is required.*  *You can include multiple reviews/touchpoints – list by date.* | **Review 1 - Date:**  *What is working/not working?*  *Has there been a change in your performance? If not, why not?* |
| **STOP: The next section is to be completed at the end/closure of activity.** | |
| **How much** did we change? | |
| **Performance**  *Question: Did you*  *achieve your target?*  *If not, reflect on why not* | **Example:**   * *Number of active patients eligible for a 75+ health assessment that have completed ACP discussions.* * *Number of active patients eligible for a 45-49 health assessment that have completed ACP discussions.* * *Number of active patients eligible for an Aboriginal and Torres Strait Islander Health Assessment that have completed ACP discussions.* |
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| **Worthwhile**  *Was the effort to complete the improvement activity worth the outcome?*  *Did the team value the improvement activity?* | **Example:**   * *We believe the effort to complete the activity* ***was worthwhile*** *as we increased the number of patients who had discussions about ACP and returned to complete ACP documentation.*   ***OR***   * *We believe this activity* ***was not worth*** *the effort required, as we did not significantly increase the number of patients with an ACP.* |
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| **Learn**  *What lessons learnt*  *could you use for other improvement activities?*  *What worked well, what could have been changed or improved?* | **Example:**   * *The consumer Planning Your Future Today Booklet was helpful to provide the patient, in conjunction with referring to other support services such as GC Health to create ACP documents.* |
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| **What next?** | |
| **Sustain**  *Implement new processes and systems into business as usual - which parts of this activity, if any, will you incorporate into business as usual at your practice?* | **Example:**   * *Nurses/Doctors will continue to add in reminders for patients for patients having a health assessment to receive a copy of Planning Your Future Today Booklet and discuss ACP.* |
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| **Monitor**  *Review target measure quarterly and initiate corrective measures as required.* | **Example:** *Review target measure quarterly and initiate corrective measures as required.* |
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| **Appendix 1 – Potential solutions** | |
| ***Review suggested implementation strategies listed below. You do not have to implement all options that are brainstormed/listed.***   * PM to implement a process for new patients to add in reminders to ensure ACP is discussed when health assessments are completed (new patient questionnaire). * Receptionist to generate a report from Primary Sense to identify target patients. For example, using Primary Sense Patients with high complexity (4 and 5) or Health Assessment reports. * Staff to add a reminder for patients to be provided ACP consumer resources and discussion with GP and/or nurse for ACP. * Some clinical software systems have a field to record when ACP documents are completed. Ensure a team member is responsible for adding this as part of the process. * Potential ways to increase the number of patients with an ACP for patients may include:   + practice webpage, newsletter, and social media pages   + ACP Consumer Resource [Planning Your Future Today Resources](https://gcphn.org.au/community/advance-care-planning/advance-care-planning/)- print or request a hard copies from GCPHN for the waiting room.   + Practice phone out of hours and on hold messages to promote ACP.   + Refer patients who require additional support to Gold Coast Health Clinical Nurse Consultant ACP clinic via [Smart Referrals.](https://www.health.qld.gov.au/clinical-practice/innovation/smart-referrals)   + Monitor participation using excel spreadsheet and/or Primary Sense. * *Note: The health assessment template includes a list of activities and investigations, and there may not be time to complete all Advance Care Planning activities during this assessment (including recording details of any existing documents. So, it is suggested that staff start the conversation and* [*provide information about advance care planning*](https://metrosouth.health.qld.gov.au/acp/acp-resources)*). It is an opportunity to offer printed information and organise a follow up consultation.* | |

1. [↑](#footnote-ref-2)