

## Meeting Comprehensive Care Standard Action 5.17

The **Comprehensive Care at the End of Life** actions are new to the National Safety and Quality Health Care Standards and include these actions:



### 5.17: The health service organisation has processes to ensure that current advance care plans:

**a. Can be received from patients**

**b. Are documented in the patient's healthcare record**

Consider accessing the **End-of-Life Essentials** module: *Planning End-of-Life Care - Goals of Care* which highlights that "Health care leaders have described a 'freeway' to ICU or the default 'fix it' mode of Australian hospitals, which is not necessarily the best place or care for older patients with advanced progressive illnesses". There is more information here about what this means in relation to Advance Care Plans.

Advance Care Planning Australia has information on *Advance Care Planning* which they describe as "the process of planning for your future health care. It relates to health care you would or would not like to receive if you were to become seriously ill or injured and are unable to communicate your preferences or make decisions. This often relates to the care you receive at the end of your life". One way to achieve this is for clinicians to discuss the patient's values and preferences with them to determine shared goals of care.

Also explore the **End-of-Life Essentials** module: *Patient-Centred Communication and Shared Decision-Making* which highlights that establishing goals of care via shared decision-making is the basis of patient-centred care and, along with communication, is a very important concept in end-of-life care. These processes can be enabled via a family meeting, with choices and wishes formally documented via an Advance Care Plan noted in the healthcare record.

Access the **new End-of-Life Essentials** module: *Meeting the Standards* and *Toolkit* to learn more about what you can do to deliver high quality end-of-life care and prepare the organisation for accreditation, including:

- **Leadership** - ensures clear policies and strategic direction (aligning with jurisdiction) that drives ACP quality.
- **Workforce capability** - ensuring that the knowledge, skills and competence to enable staff to partner with patients and/or their substitute decision makers to implement ACP.
- **Communication** - enable timely and appropriate communication. Do staff know how to compassionately ask a patient about ACP and where to document plans or directives?
- **Evaluation and audit** - to monitor quality and safety and to identify areas of need within the organisation. Audit of compliance and noncompliance of advanced care plans is valuable, along with policies, actions, and documentation of advance care plans. How will you know whether certain changes lead to an improvement in end-of-life care? What changes about managing advance care plans will drive improvement?

### **EOLE** **insight:**

Staff require a level of comfort and confidence regarding asking a patient or person responsible about an advance care plan. Consider how staff training happens regarding asking about and reviewing advance care plans.

