Implementation of Advanced Care Planning
within the Renal Service of the North Coast Area Health Service

Advanced Care Directives Renal Services Network ‘Models of Care’
Project Report

Northern New South Wales Local Health Network, Ballina Renal Unit

Executive Summary

Empowerment of the patient and family to make an informed decision regarding end of life medical management and the effective, timely and judicious use of health care resources were the issues addressed by this project.

Following two serious incidents, the Ballina Renal Unit nursing staff identified timely implementation of Advanced Care Directives including accessible medical record documentation as a high need priority for their Unit and stated the need for 100% of patients to have advanced care planning in place. The project team then undertook a process of information gathering, consultation and liaison with major stakeholders; education and In-service with Renal Unit nursing staff and the dissemination of information to patients under the Team Leader direction and supervision occurred between August 2010 to December 2010.

The anticipated challenges of the spiritual, cultural and social beliefs of individual Renal Unit patients were acknowledged and managed with appropriate sensitivity. The cultural belief system identified by the 20% of Aboriginal or Torres Strait Islanders Renal Unit patients presented a significant barrier to achieving 100% implementation of Advanced Care Directives.

Ballina Renal Unit patient compliance to date is 60% with 8% utilising Advanced Care Directives to withdraw from treatment.

The project recommendations are that the Advanced Care Planning (ACP) should be initiated during pre-dialysis consultation workup including the use of “Taking Care of Business: Planning Ahead in Aboriginal and Torres Strait Islander communities” program to meet a target of 100% Advanced Care Directive (ACD) documentation.
Introduction

In 2009 two incidents occurred with patients of the Ballina Renal Unit whereby staff failed to meet the patients’ end of life requests because of lack of prior knowledge of their Advance Care Directives (ACD). These incidents highlighted the need for ACDs and appropriate medical records, and this led to the development of a project to implement ACDs as a standard component of the model of care for this unit. ACDs are designed to empower patients and give them a choice of their health wishes while they are still competent for future medical care needed. According to the NSW Health policy established in 2004, ACD’s are to be present in the patient’s medical records for moments when the patient is unable to make decisions for them.

ACDs are to be a standard component of patient care, however review of patient records in the Ballina Renal unit identified that 0% of patients had an ACD on the front of their dialysis patients chart.

Aim

Our project aimed to have 80% of our patients with advanced care directives in the progress notes which are up-to-date, easily accessible in their charts and with electronic alerts on Powerchart indicating that they have an ACD in place. Target date was 15 December 2010.

The nursing staff of the Ballina Renal Unit identified several factors influencing the implementation of the Model of Care Project. Staff expressed a lack of confidence, in general, in their ability to initiate a discussion regarding life style choices within a dialysis framework which focused on death and dying. They also expressed a need for medical record ACD documentation in emergency situations.

Method

The following activities took place prior to planning action

- Ballina Renal Unit nurses discussed aims of Advanced Care Directive planning.
- Ballina Renal Unit nurses identified staff barriers to ACD.
- Ballina Renal Unit nurses identified potential patient and carer barriers to ACD.
- Team adapted ACD form used within the area health service for use with Renal Patients
- Developed cover letter explaining rationale for use of individual ACDs

Having identified and acknowledged staff concerns, an education program was developed to address these issues. Structured in-service sessions were provided utilising the expertise of the renal unit social worker, the palliative care and renal unit clinical nurse specialists (CNSs), and the project coordinator. These sessions included relevant evidence based best practice pre reading, interactive role play, mind and concept mapping and familiarisation with the approved ACD document. Sessions were enhanced through ongoing evaluations and staff feedback. The process was adaptable, flexible and responsive.

Primary Nursing Teams were created and patients assigned to individual teams. A learning package was given to all team members prior to attending the scheduled in-services. Primary Nurses opened the discussions with their assigned patients prior to introduction of ACD package. Primary Nurses were available for frank and open discussions concerning ACP.

Due to the sensitive nature of ACP and ACDs it was important in the initial stages to make sure all nurses were familiar with the appropriate terminology and the medical legal implication associated with the project. It also offered a forum for the expression of individual personnel views and belief and to give all participants a chance to understand and respect others belief systems. It offered a
chance to identify beliefs of both of patient and staff that would interfere with their ability to participate in the project effectively. It was a very gradual, time-consuming process if an appropriate outcome for the patient was to be achieved. It was necessary to have a solid foundation before we could initiate the project so as to appear confident when assisting patient in making life and death choices in their medical care.

The renal unit patients' attitudes to the ACD discussions varied. The decision-making process was heavily influenced by the patient's cultural, psychosocial and spiritual needs. Some patients self-initiated discussions but the majority required nursing staff conversation to initiate the ACD end goals. Patients were able to talk to the staff about topics such as death and dying, future goals, and factors influencing their decisions. Renal unit patients were empowered to make an informed decision regarding their ACD.

Cultural changes that have taken place revolve around the transparent exchange of views and ideas between nursing staff and nursing staff and the patients. There has been a creation of respectful open communication amongst all participants. There also exists a greater understanding and respect for peoples cultural, social and religious beliefs and how they shape a person's decision making process.

Results

Advanced Care Directives have been introduced as a standard component of the model of care in the Ballina Renal Unit.

Renal Social workers have commenced initiating ACDs ACP during pre-renal replacement therapy assessment work up. New ACD forms have been developed with assistance from Palliative Care Unit and 100% of all permanent nursing staff have participated in the in-service programs related to ACD and ACP.

We presently have 60% of all inpatients who attend haemodialysis treatment at Ballina Hospital with ACD’s both on their medical records and on their EMRs. (See Graph)
Discussion

ACD’s give the patients a voice in their ongoing medical management and at critical life threatening times when they are unable to advocate for themselves. The patient’s right to die and to have a death with dignity is enabled. We believe that ACDs can save valuable resources, time and money within our health service by eliminating unnecessary costly life prolonging treatments if requested by the patients.

However it was found that staff have difficulty approaching the patients on these very sensitive and challenging issues, and require considerable training to empower them to support their patients’ advanced care planning.

The Area Renal Educator needs to develop a standardised education program for all renal staff in North Coast Area Health Service for Advance Care Planning and the Advanced Care Directive to give them the appropriate tools to implement ACP within the renal units.

A copy of the ACD should be easily accessible in the patients’ medical records.

Recommendations for Director of Nursing

- Advanced Care Planning (ACP) should be initiated prior to the need for dialysis i.e. at the time of pre-renal replacement therapy interviews.

- All dialysis patients should utilise Advanced Care Directives to assist their future medical wishes.

- An electronic medical record (EMR) alert should be established for Advanced Care Directive.

These recommendations are in accordance with North Coast Area Health Services policy on Advance Care Planning and Substitute Decision making, document ID:NC-AREA-POL-NC-AREA-POL-3485-08, 24th June 08

Conclusion

Patient, family, carers and the Renal Unit multidisciplinary team have successfully worked in partnership within the model of care project to implement ACDs as a standard component of patient care in the Ballina Renal Unit. So far the unit has achieved a 60% compliance rate of ACDs present on patients’ charts and EMR alerts.

The Renal Unit would like to see Advanced Care Planning initiated during pre-dialysis consultation workup including the use of “Taking Care of Business: Planning Ahead in Aboriginal and Torres Strait Islander communities”. Introducing ACDs and ACPs at the pre-dialysis consultation stage should improve Ballina Renal Unit’s patients’ compliance to 100%.
References (Bibliography)

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