Advance Care Planning and COVID-19

Advance Care Planning (ACP) is a process which involves planning for future health and personal care, whereby a person can state their values and wishes and appoint a Medical Treatment Decision Maker to make decisions on their behalf when they are no longer able.

Staff can refer to and obtain support from the ACP Coordinator, Amy Tarrant, via PFM, telephone (5454 6386), email (acp@bendigohealhtorg.au) or online meetings.

ACP in 3 Steps:

- Appoint Another: People can appoint another person (**Medical Treatment Decision Maker**) to act on their behalf when they cannot speak for themselves.
- Chat and communicate: People can chat and communicate their wishes with their family, GP and treating specialists, ensuring everyone involved understands what is most valued and what the person's wishes are for future treatment.
- Put it on paper: People can complete an **Advance Care Directive (ACD)**, which includes values, beliefs and instructions for medical treatment. People can share this document with everyone involved, upload it to My Health Record and provide it for their medical record.

During the COVID-19 pandemic, conversations about ACP may come up more frequently. Here are some ways Advance Care Planning Australia suggest opening up this conversation.

- ✓ You mentioned concern for what might happen if you got the virus. Would you like to talk about this?
- ✓ How are you going with your isolation? What do you think would happen if you got COVID-19?
- ✓ Because of your severe lung (heart/ kidney/ cancer etc.) disease you are more likely to get really sick if you got the virus. Have you thought about this?
- ✓ Can we talk about your future health care and any preferences you have?

Bendigo Health staff must ensure they are able to:

- Locate ACP documents –Advance Care Plan, Advance Care Directive or Medical Treatment Decision Maker (previously Medical Power of Attorney) Finding ACP documents in patient DMR
- Confirm the Medical Treatment Decision Maker, particularly for when the person is unable to make decisions &/or consent to treatment. Review at ACP Intranet page
- Adhere to any Instructional Directives as a legal requirement (e.g. not for CPR, not for intubation) and recording them in Patient Flow Manager (PFM)
- Incorporate ACP information into all handovers.

Developed by A.Tarrant, Quality and C.Eyres, CLAD, May 2020

References

Advance Care Planning Australia. (2020). For health and care workers. Retrieved from https://www.advancecareplanning.org.au

Advance Care Planning Australia. (2020). For health and care workers. Beginning the conversation. Retrieved from https://www.advancecareplanning.org.au/for-health-and-care-workers/beginning-the-conversation#/

Australian Commission on Safety and Quality in Health Care. National Consensus Statement: essential elements for safe and high quality end-of-life care. Sydney: ACSQHC, 2015.

Hayes, B., Fabri, AM., Coperchini, M., Parker, R. & Austin-Crowe, Z. (2017). Health and death literacy and cultural diversity: insights from hospital-employed interpreters. British Medical Journal Supportive & Palliative Care. doi:10.1136/bmjspcare-2016-001225

PROMPT (2018). *Advanced care planning protocol* (EN0002834 v1.0). Bendigo, Victoria: Bendigo Health.

State of Victoria, Department of Health & Human Services. (2020). Advance care planning. Retrieved from https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning

State of Victoria, Department of Health & Human Services. (2020). Initiating advance care planning. Retrieved from https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-initiating