Advance Care Planning for Seniors with Renal Disease: Exploring and Honouring Choices… How can we make this happen? A Collaborative, Quality Approach…

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BACKGROUND/CONTEXT

Most renal patients have deteriorating health, despite dialysis, and often experience changes in their decision-making capacity. Thus, early planning is essential. Advance Care Planning (ACP) is a process whereby a capable adult talks over their beliefs, values and wishes for health care with their close family/friend(s) and health care providers in advance of when they may become incapable of such decisions.

Advance Care Planning may or may not include a(n):

- Advance Directive
- No CPR Physician Order
- Temporary Decision-Maker List
- Committee of Person or Representation Agreement

The BC Ministry of Health has produced *My Voice* handbooks which are Advance Care Planning Guides describing these components.

CLINICIAL ISSUE

ACP processes vary throughout Interior Health's Renal Services, are often limited, may not include adequate documentation and may not be communicated across healthcare settings. Changes to improve communication and patient-centered care are needed.

AIMS STATEMENT

The IH Renal ACP Pilot Project was developed:

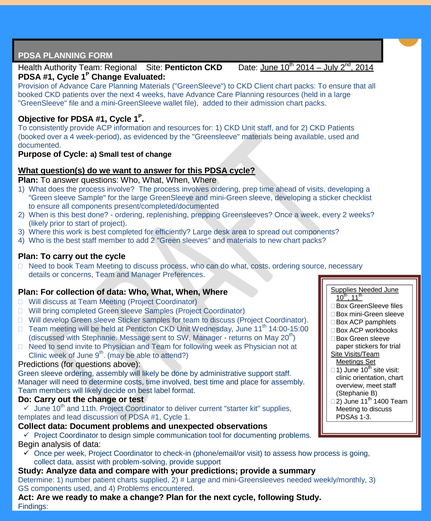
- To provide consistent ACP processes, education, discussion and documentation
- To honour patients' end-of-life wishes
- To improve patient-centered care

INTERVENTION

A Quality Model for Improvement approach was used with detailed Plan – Do – Study – Act (PDSA) cycles. Standardized resources were developed:

1. PDSA Planning Forms/Worksheets
2. ACP Participant Flowsheet
3. IH Renal ACP Prognostic Model Tool
4. ACP patient information packages
5. GP/Primary Care Provider Letters
6. Clerical and SW Material Resource/Source List
7. Patient Participant Survey

In the Penticton Chronic Kidney Disease Clinic, clinicians collaboratively selected high-priority patients for more thorough ACP, provided over three Social Worker sessions. The Nephrologist provided the patient with a prognostic discussion, for more informed decision-making, prior to the completion of ACP documents.



PDSA PLANNING FORM

Health Authority Team: Regional Site: **Penticton CKD** Date: June 10th 2014 – July 2nd, 2014

PDSA #1, Cycle 1st Change Evaluated:
Provision of Advance Care Planning Materials ("GreenSleeve") to CKD Client chart packs: To ensure that all booked CKD patients over the next 4 weeks, have Advance Care Planning resources (held in a large "GreenSleeve" file and a mini-GreenSleeve wallet file), added to their admission chart packs.

Objective for PDSA #1, Cycle 1st.
To consistently provide ACP information and resources for: 1) CKD Unit staff, and for 2) CKD Patients (booked over a 4 week-period), as evidenced by the "Greensleeve" materials being available, used and documented.
Purpose of Cycle: a) Small test of change

What question(s) do we want to answer for this PDSA cycle?
Plan: To answer questions: Who, What, When, Where
1) What does the process involve? The process involves ordering, prep time ahead of visits, developing a "Green sleeve Sample" for the large GreenSleeve and mini-Green sleeve, developing a sticker checklist to ensure all components present/completed/documented
2) When is this best done? - ordering, replenishing, prepping Greensleeves? Once a week, every 2 weeks? (likely prior to start of project).
3) Where this work is best completed for efficiently? Large desk area to spread out components?
4) Who is the best staff member to add 2 "Green sleeves" and materials to new chart packs?

Plan: To carry out the cycle
- Need to book Team Meeting to discuss process, who can do what, costs, ordering source, necessary details or concerns, Team and Manager Preferences.

Plan: For collection of data: Who, What, When, Where
- Will discuss at Team Meeting (Project Coordinator)
- Will bring completed Green sleeve Samples (Project Coordinator)
- Will develop Green sleeve Sticker samples for team to discuss (Project Coordinator).
- Team meeting will be held at Penticton CKD Unit Wednesday, June 11th 14:00-15:00 (discussed with Stephanie. Message sent to SW. Manager - returns on May 20th).
- Need to send invite to Physician and Team for following week as Physician not at Clinic week of June 9th. (may be able to attend?)

Predictions (for questions above):
Green sleeve ordering, assembly will likely be done by administrative support staff. Manager will need to determine costs, time involved, best time and place for assembly. Team members will likely decide on best label format.
Do: Carry out the change or test
- ✓ June 10th and 11th, Project Coordinator to deliver current "starter kit" supplies, templates and lead discussion of PDSA #1, Cycle 1.

Collect data: Document problems and unexpected observations
- ✓ Project Coordinator to design simple communication tool for documenting problems.

Begin analysis of data:
- ✓ Once per week, Project Coordinator to check-in (phone/email/or visit) to assess how process is going, collect data, assist with problem-solving, provide support

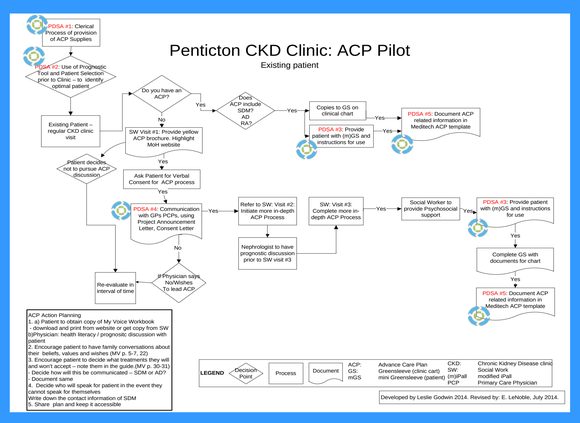
Study: Analyze data and compare with your predictions; provide a summary
Determine: 1) number patient charts supplied, 2) # Large and mini-Greensleeves needed weekly/monthly, 3) GS components used, and 4) Problems encountered.
Act: Are we ready to make a change? Plan for the next cycle, following Study.
Findings:

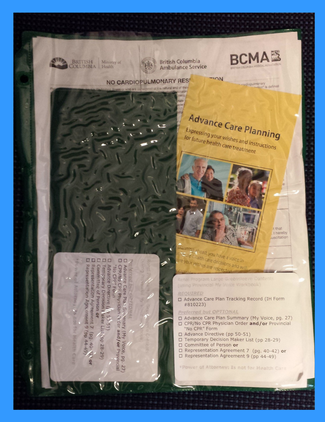
Supplies Needed June 10th - 11th
- Box GreenSleeve files
- Box mini-Green sleeve
- Box ACP pamphlets
- Box ACP workbooks
- Box Green sleeve paper stickers for trial

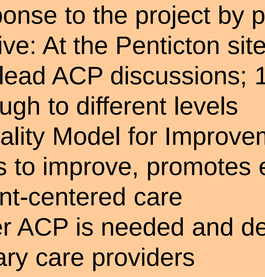
Site Visits/Team Meetings Set
- 1) June 10th site visit: clinic orientation, chart overview, meet staff (Stephanie B)
- 2) June 11th 1400 Team Meeting to discuss PDSAs 1-3.

MEASUREMENT

Typical patient progression through each clinic was analyzed with detailed PDSA cycles for key components: 1) Provision of ACP supplies, 2) Use of a Prognostic Model/Patient Selection Tool, 3) Use of mini-Green Sleeves, 4) Communication with Primary Care Providers, 5) Documentation.
Each PDSA cycle then was revised when learning occurred, to become the next PDSA cycle on that particular component. An ACP Participant Flow Sheet allowed tracking and measurement of processes and data.







Renal ACP Project: Penticton Chronic Kidney Disease Clinic (non-dialysis patients)

Multidisciplinary Team: **Patients/Clients, SWs, RNs, Nephrologists, GPs, NUCs, Managers**

CHALLENGES/LESSONS LEARNED

Challenges included:

- coordinating screening time
- patient transportation difficulties
- on-going clerical requirements.
- booking Nephrologist prognostic discussions

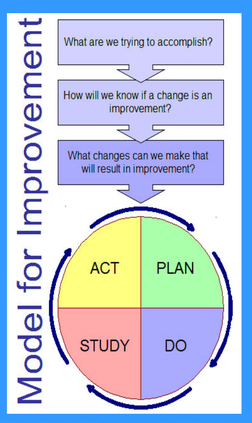
Lessons learned involved process improvements, related to:

- preparation of information packages
- clerical duties
- use of screening/selection tool
- staff knowledge of ACP
- determination of time required for ACP work

We also learned that in some cases, patients initially keen, may not be ready to document an AD; staff should be prepared to review again

RESULTS

- Standardization of ACP processes and tools reduced clerical and Social Worker time, once processes became familiar
- Response to the project by physicians and patients was positive: At the Penticton site, 13/15 physicians requested clinic staff lead ACP discussions; 12/15 patients agreed to participate, although to different levels
- A Quality Model for Improvement approach for ACP highlights areas to improve, promotes efficiencies and helps reinforce patient-centered care
- Better ACP is needed and desired by patients, clinicians and primary care providers



NEXT STEPS

- ✓ Results/lessons learned can be incorporated into the future Phases of the ACP Pilot Project (Kelowna Peritoneal Dialysis Clinic, Rutland Hemodialysis Unit, Kootenays and Kamloops sites)
- ➢ Project needs support in terms of time requirements, clear staff roles, responsibilities and expectations
- ➢ Need to keep addressing sustainability; ACP work with patients is not "extra" - needs to continue post-project!
- ➢ Next sites to be determined, following site reviews and debriefing
- ➢ Full ACP roll-out throughout Renal Program planned for Summer 2015.

ACP Participant Flowsheet: GP Consent, Patient Consent, Visits, Use of Tracking Record, ACP Materials, ACP Components, Documentation, ACP Priority Indicators Site: _____

Patient/ Clinic Date	Letters sent	Age/Sex	Yes by GP	No by pt.	No by GP	Completed with GP	1st SW Apt	Tracking Record	2nd SW Apt	Neph Apt	3rd SW Apt	GS/AD/RA on Chart	mGS with pt.	Meditech Charting	Priority Indicators