Advance Care Planning in the Community

The HARP Experience

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19 November 2015
The Plan

• Decision to implement Advance Care Planning into the HARP model of care

• Train four ACP facilitators within the program to support all clients of the program and assist with ACPs for other community programs as able

• Thoughts (or dreams!) of a senior clinician to mentor the ACP facilitators, market the availability of ACP facilitation via HARP, monitor the quality of the ACPs and facilitate a quarterly meeting with the ACP facilitators as peer supervision and support.
Progress

- Four ACP facilitators trained – two now working in other programs

- Three more ACP facilitators trained this month – total of five now

- Many ACP conversations held with HARP clients – not all of which have gone the distance of a developed ACP

- However, seed planted regarding the idea and even if no ACP, MEPOAs have often been put in place

- A modest number of ACPs have been completed
Many difficulties have been experienced:

- General public awareness is low – some clients initially find the subject confronting
- Ability to word the instructions well is difficult when new to ACP facilitation
- Difficult for nurses and social workers to answer some questions regarding the medical implications of decisions and expected quality of life post some medical events
- GP willingness to sign ACPs is not always high
- Follow up for certified copies of documents
- Guarantee that the ACP will be followed in all circumstances cannot be given
- Difficulty of who can follow up at times of change to medical condition and/or at 12 months has not been solved
Issues identified

• How to begin the conversation

• Appointment of a MEPOA

• Formalisation of the ACP

• Awareness of others that an ACP is in place for the patient

• Follow up to update the ACP
Positive Experiences

• Ability to spend time in client’s home environment to discuss their wishes

• Assists future planning around MEPOA

• Clients have expressed relief that they have been able to express their wishes formally in a document

• Supports a positive discussion with the GP

• Some GPs have been very proactive and supportive of the process
Planned Improvements

- Senior Social Work Clinician to mentor ACP facilitators within community programs of the health service
- Quarterly ACP facilitator group supervision/mentoring sessions
- Work with Primary Care to increase awareness and understanding of the process
- Peer review of quality of ACPs to provide feedback to facilitators
- Senior Social Work Clinician to assist to monitor quality of completed ACPs
Thank you.

We hope to see a time where all of our clients are offered the opportunity to have the conversation and have a say in their end of life care. We hope yours do too.