The Power of Innovation

A health care system to meet our needs

NSW Health Symposium Oct 2012

Advanced Care Planning in the Ballina Renal Service: Empowering Patients

Introduction

The Ballina Haemodialysis Unit is a 7-chair satellite facility providing 84 dialysis treatments weekly.

The majority of our patients are aged 70 years or older with comorbidities including diabetes, cardiac, cardiovascular and haematological conditions.

With the use of Advanced Care Planning (ACP) / Advance Care Directives (ACD) we gave our 28 patients a voice in their ongoing medical management and at critical life threatening times when they are unable to advocate for themselves.

With careful planning, this project has been accepted by the staff and patients alike and is sustainable as part of our core business

Aim

Our project aimed to have 80% of our patients with up-to-date ACDs; easily accessible in their medical charts including their electronic medical records (eMR).

Method

Notification and on going discussion with interdisciplinary stake holders (nephrologist, social worker, CNC, CNE)

Needs assessment of Nursing staff indicated a knowledge deficit concerning the process and aims of ACP and ACDs.

The nurses identified potential staff, patient and carer barriers to ACP and ACD process. The information gathered acknowledged that the current ACD form was not user-friendly.

Having identified and acknowledged staff concerns, education program were developed.

Sessions included relevant evidence based best practice pre reading, interactive role play, concept mapping and familiarisation with the approved ACD document.

Primary Nursing Teams were formalised and patients were assigned to individual teams.

Nurse initiated consultation with assigned patients prior to patient led final development and introduction of ACD document and package for patient and carer review and completion.

Results

ACDs provide medical and nursing staff clear direction during medical emergency situations.

ACP/ACDs have saved valuable resources, time and money within our health service by eliminating unwanted costly life prolonging treatments.

Patients and careers have direct input in future medical interventions.

ACDs are being implemented during the pre-dialysis stage, co-ordinated by our Renal Social Worker.

ACDs are reviewed as patient directed or six monthly with the patients and the primary nurses.

All stakeholders continue to be actively involved in the ACP/ACD process.

Programs continue to evolve covering the cultural, spiritual and psychosocial needs of all participants

New ACD forms have been developed utilising the expertise of local Palliative Care Unit.

Unit nurses and patients have ownership of project.

Patients have confidently utilised the ACP/ACD process to withdraw from active treatment. ACP/ACDs have not only empowered patients and their carers but also assisted health professionals in their supportive role.

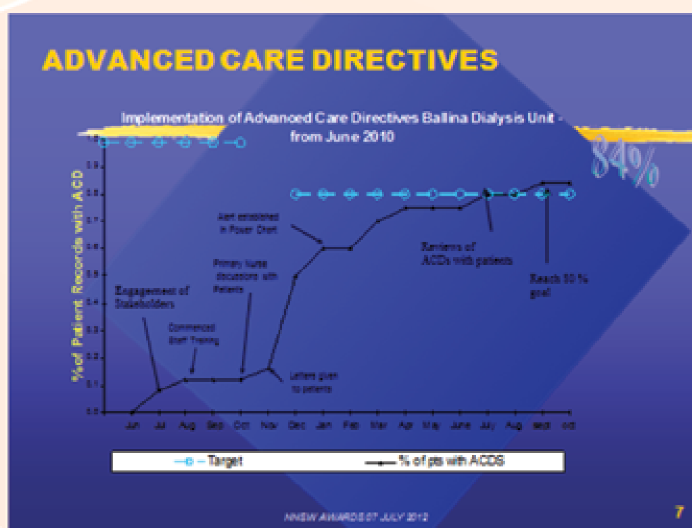
Conclusion

The Renal Unit patients, careers and multidisciplinary team have successfully worked in partnership to implement ACPs/ACDs as a standard component of patient care.

The patient and careers have been empowered to make informed decisions regarding end of life medical management.

Importantly we have supported and enabled the staff to initiate ACP/ACDs for the benefit of the patients and their careers.

Key element in the success of the project has been the existence of a trusting therapeutic relationship between the patient and the primary nurse.



Key Message

Our project:

- Has introduced Advance Care Directives (ACD) for our patients
- Has empowered the patient and family to make an informed decision regarding end-of-life medical management
- The process has been self directed by patient
- Leads to the effective, timely and judicious use of health care resources

3

Acknowledgements

Model Of Care Project 2010

NNSWLHD

Southern Cross University

Health
Northern NSW
Local Health District