Nurse-led ACP clinics in general practice

What: Nurse-led advance care planning (ACP) clinic in general practice

Why/rationale: to support patients to document their ACP.

Who: General practice, Capital & Coast DHB

Benefits/value added:

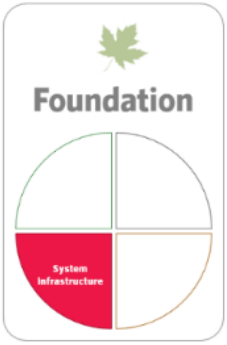
- Patients are able to talk about what matters to them and plan for their future.
- Dedicated time is available to support ACP conversations within the practice.
- Patients are supported to complete plans.
- Advance care plans are documented and available.

Risks/challenges:

- Establishing 'buy in' from the practice to re-direct long term condition (or other) funding.
- Selection of appropriate patients.
- IT challenges in formatting advance care plans.
- Clinicians do not recognise the opportunities or cues for introducing ACP.
- Succession planning if the 'dedicated' ACP nurse leaves the practice.
- Initial training/confidence building.

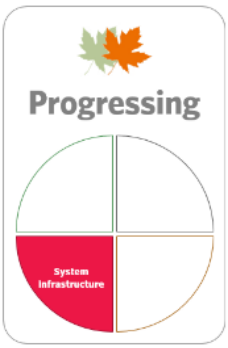
Steps: How this looked on the ground

Foundation



1. Nurse practitioner initially took the lead on ACP from 2015 (key is to have a strong clinical champion) and has since mentored another nurse to be the ACP lead
2. GPs and nurses agreed in their clinical governance meeting the desire to raise ACP with more patients and enable them to complete ACPs.
3. All RNs and GPs completed the ACP eLearning.
4. ACP educational talks were given at two large retirement villages in the area.
5. Some long term condition funds were set aside to enable (a finite number of) half an hour nurse ACP visits (free to the patient).

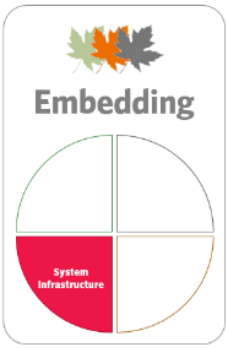
Progressing



1. The GP introduced and explained ACP, gave the patient an ACP resource pack and asked them to go home to look at the materials and consider their thoughts.
2. The GP asked the patient to make a further appointment with the practice nurse to discuss and document their ACP.

3. The GP sent the lead ACP nurse a task to invite the patient in for an ACP appointment.
4. The lead ACP nurse contacted the patient and booked the appointment.
5. ACP was discussed, completed and signed off during the ACP appointment.
6. The completed document was scanned into the practice management system.
7. An ‘ACP completed’ read code was placed for the patient (ticked as long term).

Embedding



1. Six-monthly review to check on utilisation of clinic.
2. Monitoring of read codes.
3. Establishing a system for review of ACPs.

Outcomes to date:

- Many more ACPs discussed and coded.
- GPs and practice nurses recognising cues to initiate discussion.

Future opportunities:

- Establish dedicated weekly slot for nurse led clinic.
- Weave ACP into year of care for Health Care Home.