ACP hospital alert and recording system

What: Developing an electronic ACP documentation process for the hospital

Why/rationale: Allow clinicians to find previous ACP discussions and ACP plans in hospital records.

Who: Auckland DHB

Benefits/value added:

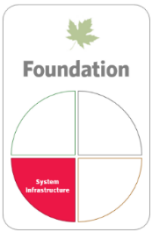
- Saves clinical time in the emergency department (ED) because clinicians can access advance care plans and confirm the details with families and whānau.
- Helps clinicians find records of previous conversations so they can pick up conversations instead of having to re-initiate them.
- Advises the clinicians of the patient's goals of care, which they can then follow.
- Families and whānau have information when difficult decisions need to be made at a stressful time.

Risks/challenges:

- Alert fatigue – there are so many alerts on the system none are paid any attention.
- Ensuring clinicians can easily find and use an advance care plan.
- Clinicians cannot find the information they require.
- Getting advance care plans into the hospital records from general practice.

Steps: How this looked on the ground

Foundation



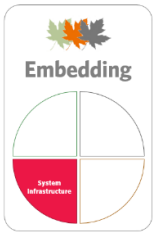
1. Identified the need to bring attention to advance care plans in the vast volume of clinical records in the hospital system. ED clinicians were overwhelmed by information that needs to be drawn from various record systems.
2. Obtained agreement from the clinical steering group of Auckland DHB's Concord Improvement Programme to look for ways to bring advance care plans to the surface of recorded information.
3. All paper-based hospital records at the DHB are scanned using a barcode referencing system for filing the scanned records. This includes the alert form (see example).
4. A process flow diagram was used to create a shared understanding of the steps required to raise an ACP alert and file an advance care plan in the record so it can be easily retrieved.
5. The forms committee was approached for approval to add ACP to the Auckland DHB alert form. Approval was given.
6. The form change was designed. The process of raising an ACP alert and storing the advance care plan was agreed with the IT and records departments.

7. The advance care plan and alert form are stored together in the alerts section of the hospital record. This helps clinicians easily find information related to the alert.
8. An intranet page was created about ACP with links to the ACP template and the alert form.
9. A change communication plan was used to think through who needed to be informed of the change and how they would be communicated with. This included communication in the Auckland DHB staff newsletter, grand rounds, information sessions in the ED and information sessions and emails to all staff trained in ACP.
10. By using barcoded forms for conversation records and advance care plans, the ACP facilitator can monitor the number of ACP conversations and plans.

Progressing

1. Identified the need to include advance care plans created in the community in the hospital record system.
2. Agreed a process to have advance care plan created by GPs scanned into the hospital record. The GP faxes the plan to the Auckland DHB ACP facilitator, who completes the alert form, attaches the plan, and sends both to the records department for processing and scanning.
3. Communicated the new process to all GP practices. An A4 poster with key information including the fax number was sent out to GPs for them to display in clinic areas. See example – Poster – ACP plans into hospital record.

Embedding



Every year as part of Conversations that Count Day (now Advance Care Planning Day), an ACP resource pack is sent out to GPs, including the A4 poster about how they can get advance care plans into the hospital record.

Outcomes to date:

Number of advance care plans on record.

Future opportunities:

Auckland DHB's solution is not ideal, but it was the best that could be done in 2012 using a complex record system that was in the process of being redesigned for a Northern region electronic health record.

Ideally, what matters to a person and their preferences and choices would be at the core of a record system so all care and treatments are designed with patients to meet those patients' needs.

Note: This example does not include the additional development of an e-shared care record within the Northern region. This allows GP practices and clinicians in secondary services to capture a person's advance care plan directly into a web-based electronic health record that is available to the patient and their wider health care team.

Similar examples from others:

- Bay of Plenty DHB
- Waitemata DHB
- Counties Manukau Health
- Northland DHB.

See also: Electronic ACP progress note (not yet ready at guide testing stage; ref resource 30)