**CPD activity: mini-audit of advance care planning and Advance Health Directives**

**Time to complete:** 6 hours; **CPD type:** measuring outcomes (MO)

* **To complete as a group** – upload via GP-led activity on [myCPD](https://mycpd.racgp.org.au/) select **Log** > **GP-led activity**.
* **To complete as an individual** – [use this pre-filled quick log](https://mycpd.racgp.org.au/log?logName=Mini-audit+of+advance+care+planning+and+Advance+Health+Directives&mo_hours=6&notes=I+completed+the+WA+Department+of+Health+Mini-audit+of+advance+care+planning+and+Advance+Health+Directives.++%0A%0AUPLOAD+the+completed+template+%28please+do+not+include+any+patient+identifying+information%29.%0A%28OPTIONAL%29+note+your+main+take+away+from+the+mini+audit%3A) and upload template

**Identification of need:** Advance care planning (ACP) is a voluntary process of planning for future health and personal care whereby the person’s values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions. An Advance Health Directive (AHD) is a statutory form to record a person’s treatment decisions in WA, as prescribed by the *Guardianship and Administration Act 1990*. There is currently low uptake of AHDs across Australia, including WA. Increased uptake of ACP and completion of AHDs is expected to reduce the disparity between treatment preferences and delivered care.

This mini-audit can be used to review whether opportunities to introduce ACP or AHD conversations into consultations, assessments and care plans are being adequately undertaken and recorded, and to help you to identify actions the practice team can collectively take to increase effective ACP and AHD conversations.

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| **Mini-audit item** | **Resources/ advice** | **Response** |
| Select a sample of at least 5 adult patients per participating GP from any of the following cohorts of patients seen in the last 6 months:* 75 years and older Health Assessment (item 701, 703, 705, 707)
* GP Management Plans and/ or Team Care Arrangements, or reviews (or equivalent) (item 721, 723, 732)
* Aboriginal and Torres Strait Islander peoples' Health Assessment (Item 715, 228)
* Nurse chronic disease management consultation items (10997)
* diagnosis of, or change in, a chronic or life-limiting illness or disease that could result in loss of capacity
* recent hospital admission, especially if unplanned
* if you would not be surprised if the person died within 12 months
* if there were changes in care arrangements (e.g. admission to a residential aged care facility)
* someone applying for care assistance (e.g. Aged Care Assessment Team (ACAT) assessment or the National Disability Insurance Scheme (NDIS))
 | *Note: Do not put any patient identifying details when completing this form, as this form will need to be uploaded with your quick log.** Refer to best practice:
	+ [Health Professional Guide to ACP in WA](https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/End-of-Life/ACP/ACP-Guide.pdf)
	+ [RACGP Standards for general practices 5th edition](https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/5th%20edition/Standards-for-general-practice-5th-edition.pdf).
		- Criterion C7.1 – Content of patient health records
		- Criterion GP2.1 – Continuous and comprehensive care
* Other tools:
	+ [SPICT](http://www.spict.org.uk)TM
 | **Cohort type(s):** Click here to enter text.**Total number of patients in cohort (if known, otherwise mark N/A):**Click here to enter text.**Number of patients selected for mini-audit:** Click to enter text.**If a group activity, names of participating GPs:**Click here to enter text. |
| Of the patients that could have benefited from advance care planning, with how many was advance care planning offered/raised? | Consider where advance care planning conversations are documented in your practice software, such as in Health assessment forms, GP Management Plans and/ or Team Care Arrangements, or reviews, clinical notes or incoming correspondence.  | **Number of patients where there is evidence that ACP was offered/raised:** Click here to enter text. |
| Was the patient asked if they have an existing advance care planning document? | Advance care planning documents can include:* Advance Health Directive (AHD)
* Enduring Power of Guardianship
* Values and Preferences Form
* Advance Care Plan for Person with Insufficient Decision-Making Capacity
* Other written document containing values, preference or treatment decisions
 | **Number of patients where there is evidence they were asked if they had an ACP document:**Click here to enter text. |
| If it was recorded that the patient has an Advance Health Directive or other advance care planning document, is a copy of the document on file? | Consider where in your clinical software advance care planning documents are recorded and if they are located in a consistent place. Please note, My Health Record should only be accessed in the provision of care to patients not for the purpose of audits only. | **Number of patients who have the presence of an ACP document recorded:** Click to enter text.**Number of patients who have a copy of their document(s) on file:**Click here to enter text. |
| Review the management of each of the patients identified. What steps do I plan to take for quality improvement for these patients?  | If the patient did not undertake ACP, what are the opportunities to offer take home information about ACP and arrange a future appointment to discuss? If the patient commenced ACP, assess if: * there appears to be anything that wasn’t covered that should be
* the patient’s clinical condition has changed warranting another ACP conversation.

Set up a recall or follow up at next appointment as appropriate.Refer to the [Advance Care Planning HealthPathway](https://wa.communityhealthpathways.org/39484.htm).Refer to [ACP and supporting MBS items factsheet](https://www.practiceassist.com.au/PracticeAssist/media/ResourceLibrary/Medicare%20Benefits%20Schedule/Advance-Care-Planning-Fact-Sheet-V2-01072021.pdf). | **Number of patients recalled for a further ACP discussion:**Click here to enter text.**Number of patients identified for follow up ACP discussions at next appointment:**Click here to enter text. |
| What steps do I plan to take for quality improvement at a practice level? Consider further discussions with practice about opportunities to routinely offer ACP, ask patients about ACP documents and record these in clinical software in a consistent way. Consider extension to a full audit this year by repeating the steps after a suitable period or a follow up mini audit next year to assess if ACP has improved and to sustain progress. | **Document discussions held:**Click here to enter text.**Your plan/actions agreed:**Click here to enter text. |