SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Upload of Advance Care Planning Documents into the Patient Electronic Medical Record (eMR)
TYPE OF DOCUMENT	Procedure
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LEVEL OF EVIDENCE	National Standards for Safety and Quality in Healthcare: Standard 5 - Comprehensive Care
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records & Medico-Legal Committee and Palliative Care Stream
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FUNCTIONAL GROUP(S)	Records Management – Health
KEY TERMS	Electronic Medical Record, upload, Advance Care Planning process, Advance Care Directive, Advance Care Plan, Guardianship Documents, NSW Ambulance Service Authorised Adult Palliative Care Plan
SUMMARY	The procedure provides guidance for SESLHD staff on the process of the receipt and upload of Advance Care Planning documents into the Electronic Medical Record.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Upload of Advance Care Planning Documents into the Patient Electronic Medical Record

SESLHDPR/643

1. POLICY STATEMENT

This procedure will describe the receipt, upload and Alert notification of the following documents into the advance care documents tab of the eMR system:

i. an advance care plan
ii. an advance care directive
iii. a guardianship document

The procedure for the upload of advance care planning documents into the eMR must be followed when SESLHD staff are made aware of the existence of advance care planning documents as per NSW Ministry of Health IB2020_010 - Consent to Medical and Healthcare Treatment Manual *'If a patient presents with an [valid] Advance Care Directive or other document that refuses treatment, a copy of the document should be made and placed on the patient's medical record'*.

2. BACKGROUND

A uniform process of accepting advance care planning documents into the eMR has been developed.

The process has been established to ensure timely access to advance care planning documents by the treating team, at the time of end of life treatment. If a treating clinician is not aware of the patient's advance care planning documents at the time of end of life treatment, there is a risk of inappropriate treatment being delivered to the patient.

Use of advance care planning documents must occur within the legal framework provided. The NSW Supreme Court has ruled that a valid advance care directive must be respected, as an extension of a person's right to determine their own medical treatment as determined in the following cases:

- Hunter New England Area Health Service v A [2009] NSWSC 761 (6 August 2009)
- Re JS [2014] NSWSC 302 (14 March 2014).

Medical Practitioners and other Health Practitioners are under no obligation to provide treatments that in their reasonable opinion are futile, that is treatment that is unreasonable, offering negligible prospect of benefit to the patient[1]

3. DEFINITIONS

Advance Care Directive:

An Advance Care Directive (ACD) is a legally binding direction made by a patient with capacity, which describes a patient's future preference for the medical treatment they do or do not wish to have in the future, that will **apply when the person loses capacity**[1]
A valid Advance Care Directive must be respected.

3.1 An advance care directive is valid[1] when:

- It has been made voluntarily by an adult with capacity
- is clear and unambiguous
- was intended to apply to the situation at hand.

Advance Care Plan[2]:
An Advance Care Plan can be made by the individual or together with people that they trust and/or are important to them. Where the individual is not able to make decisions, the Advance Care Plan can be made by their family/carer with a health practitioner. An advance care plan is not a legal document and the information in an Advance Care Plan is used to **guide care.**

Guardianship document[2]:
A person, 18 years of age or above, may appoint a guardian, or Enduring Guardian using the prescribed form from the Guardianship Division of NCAT, or a form with the same features and effect.
An appointment only has effect during a period in which the person needs a guardian (when the person does not have capacity).
The decisions that an Enduring Guardian may make on behalf of the person are specified in the document appointing the person. The person appointing the Enduring Guardian may limit the decisions that they can make. **Health Practitioners should ask to review the appointment document to ensure that the Enduring Guardian has the power to make decisions in relation to medical and dental treatment.** Where there is a guardian appointed (enduring or appointed by NCAT) and that guardian has authority to consent to medical and dental treatment, only the guardian can perform that function. .

For further information see
Consent to Medical and Healthcare Treatment Manual

4. RESPONSIBILITIES

4.1 All Employees will:

Ensure compliance with the procedure. This includes their responsibilities as per the process described below.

4.2 Line Managers will:

Ensure staff are aware of and monitor compliance with the procedure.

Support staff to follow the procedure.

4.3 District Managers / Service Managers will:

Support staff to follow the procedure.

5. PROCEDURE

An advance care planning document may be provided by a patient, their family, their person responsible, or their enduring guardian, at outpatient, outreach appointments, community consultation or during admission. All discussions regarding advance care planning must be contemporaneously documented in the progress notes of eMR.

All advance care planning documents must be assessed as valid prior to acceptance by the clinician and prior to upload into eMR.

The applicability of the advance care planning document/s must be assessed at the time it becomes relevant i.e. if/when a patient is unwell and/or not able to communicate their wishes.

In order to accept an advance care planning document into the medical record it must be reviewed by SESLHD staff and assessed in consultation with the patient or person responsible and the AMO (Consultant). This includes checking if the documents are still current with the patient's wishes. The AMO (Consultant) must be advised and take responsibility for the acceptance of these documents. The AMO (Consultant) is responsible for ensuring junior medical staff are aware of clinical (including ethical and legal) aspects of the acceptance and use of advance care planning documents. In areas where the patient does not have an AMO e.g. Community Health, a document may be accepted by a member of a multidisciplinary team who has been designated by the Service Director.

5.1 All of the following steps must be followed:

5.1.1 "If patient retains decision making capacity, check that the information in the document accords with their current wishes"

5.1.1 Confirm the document type and title is clear and correct - **see definitions**.

5.1.2 The document is determined as valid for acceptance to the medical record (see 3.1 above).

5.1.3 The patient identification label is attached to the top right corner or four identifiers (name, MRN, DOB and sex) clearly handwritten in header of each page of the advance care planning document. If there is uncertainty about the identity of the patient or legibility of the handwritten details, the document will not be accepted.

5.1.4 The **AMO / designated staff members name and date of encounter** - is recorded in the header of front page or within the document.

5.1.5 An **appropriate clinical alert** is entered in eMR as delegated by the medical officer or according to departmental practice and procedure. See Appendix 2- Using eMR to populate an advance care planning alert.

5.1.6 The approved document is scanned as a PDF by administrative / clinical staff as determined by department head and sent by email (see Point 5 below) to the relevant health information / medical record unit.

5.1.7 The original document is returned to the patient.

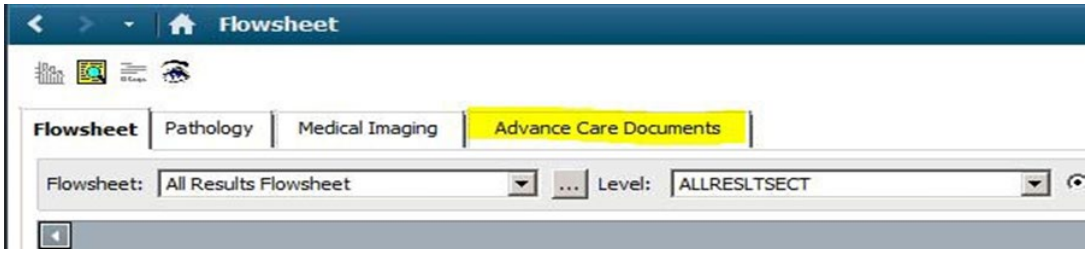
5.1.8 Health information / medical record unit staff will then import the emailed document to the advance care documents tab in eMR under the requested encounter date.

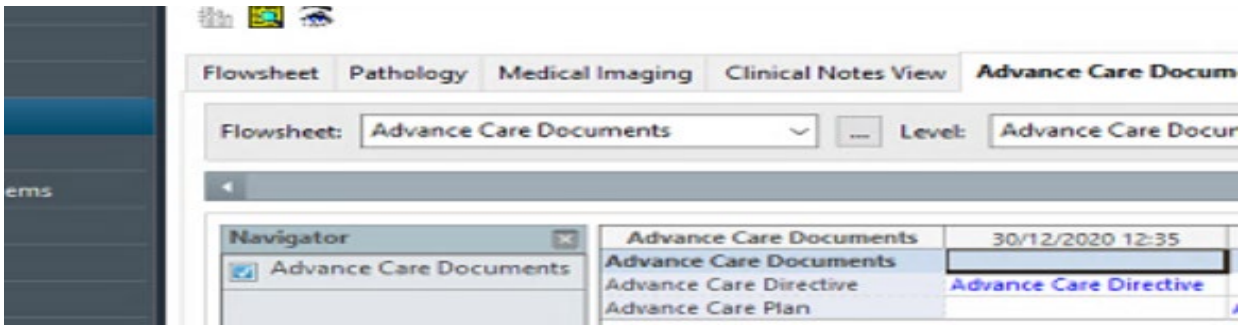
6. Health information / medical records unit email addresses

Site / Facility	Email address
Prince of Wales Hospital and Royal Hospital for Women	SESLHD-AdvanceCare-POW_RHW@health.nsw.gov.au
St George Hospital	SESLHD-AdvanceCare-SGH@health.nsw.gov.au
Sydney / Sydney Eye Hospital	SESLHD-AdvanceCare-SSEH@health.nsw.gov.au
The Sutherland Hospital	SESLHD-AdvanceCare-TSH@health.nsw.gov.au
War Memorial Hospital	SESLHD-AdvanceCare-WMH@health.nsw.gov.au
Calvary Health Care Kogarah	SESLHD-AdvanceCare-CAL@health.nsw.gov.au

7. Where do I find advance care planning documents?

Once scanned and uploaded via the health information / medical record unit, the document will then be viewed in the eMR flow sheet tab called advance care documents.





8. Revoking advance care planning document/s that have been uploaded into the eMR

If a competent patient requests to revoke or make changes to the treatment options chosen in the advance care planning document this process must be followed;

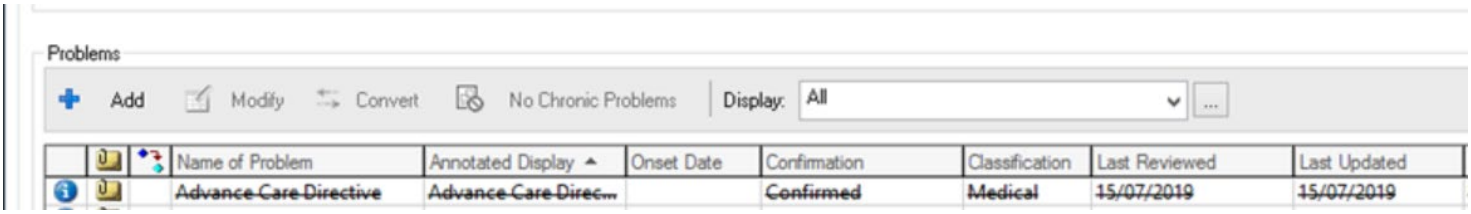
Process for revoking advance care planning document/s:

8.1 Patient requests to rescind or make changes to the advance care planning document in eMR during discussions with their clinician.

8.2 The clinician will document the discussion in the healthcare record and will complete the Revocation document-see Appendix 3 including the signature of the patient and doctor.

8.3 The document type, AMO and encounter date is recorded on top of the Revocation document.

8.4 The clinician will cancel the Alert in eMR so it appears as below. Refer to Alerts QRG for guidance on this process.



8.5 Administration / clinical staff (as determined by department head) will scan and email the copy of the revocation document-see Appendix 3 to the site health information / medical records unit email address (see Point 5 above). Health information / medical record unit staff will in error* the advance care planning document according to the information on the revocation document.

8.6 Clinical staff will rule a diagonal line through any hard copies of the rescinded advance care planning document with the clinicians name signature and date on the line. The patient is given a copy of both the rescinded advance care planning document and the revocation document. Copies of both must be retained and filed into the paper health record.

*Needs to be referred the relevant staff responsible to undertake the fix of the error as per the procedure Single Document Capture (SDC): Troubleshooting and Data Fixes for Errors. Locate document in the eMR, in error the document ensuring relevant reason is entered in the comment: i.e. patient has requested revocation of the advance care planning document

9. DOCUMENTATION

- NSW Health - Making an Advance Care Directive - booklet and form
- SESLHD Advance Care Directive form (same as MoH ACD form)
- SESLHD Statement of Values and Wishes Form

10. GOVERNANCE

Monthly auditing will be attended by the SESLHD Medical Record Managers/Upload working group and presented to the

- facility End of Life Committee
- the SESLHD Palliative Care Committee
- and the Health Records and Medico-Legal Committee to:

- monitor numbers of documents uploaded
- ensure documents are uploaded to right patient, right record, and the appropriate eMR clinical alert has been included
- monitor staff documentation compliance in the clinical record.

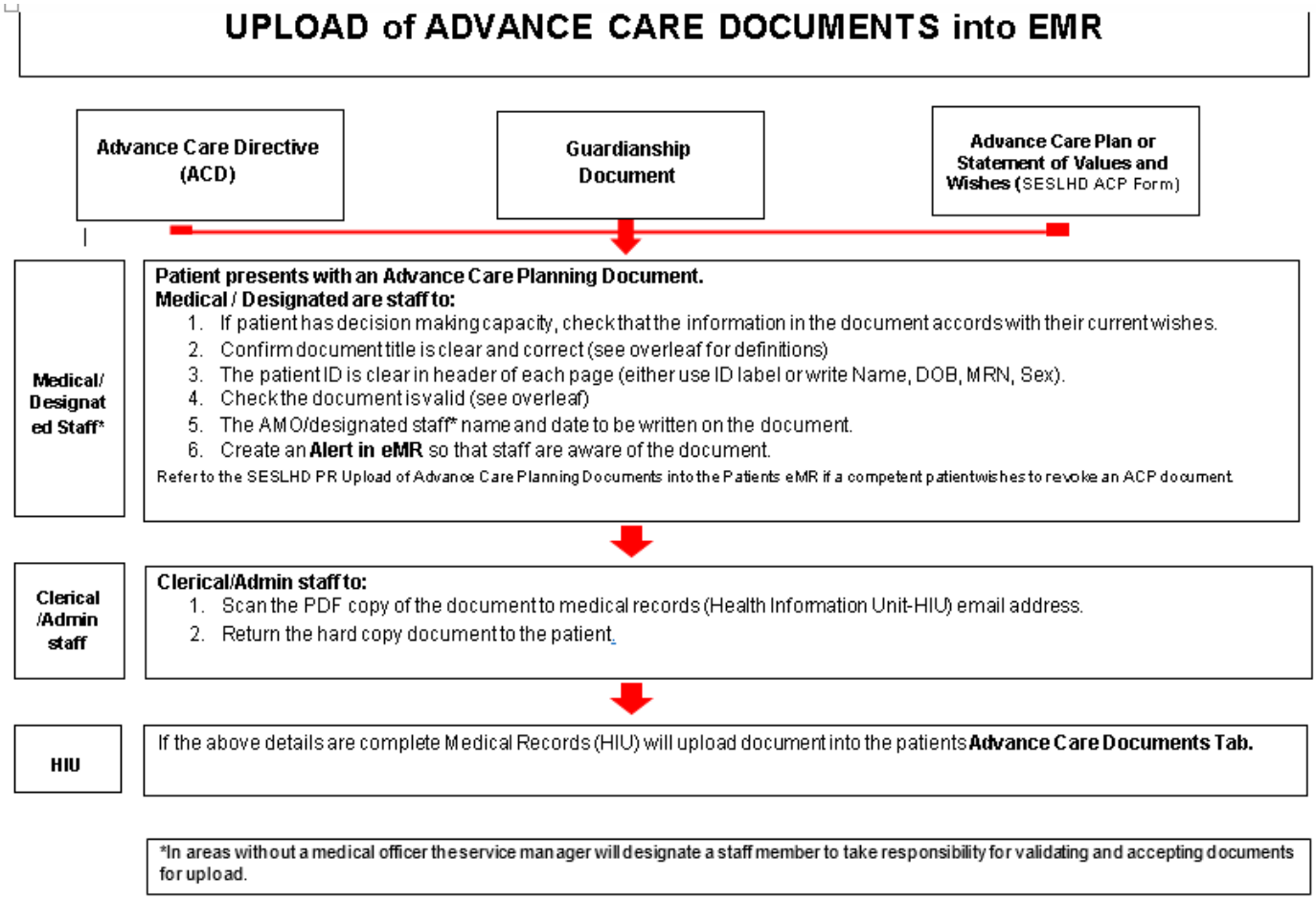
11. REFERENCES

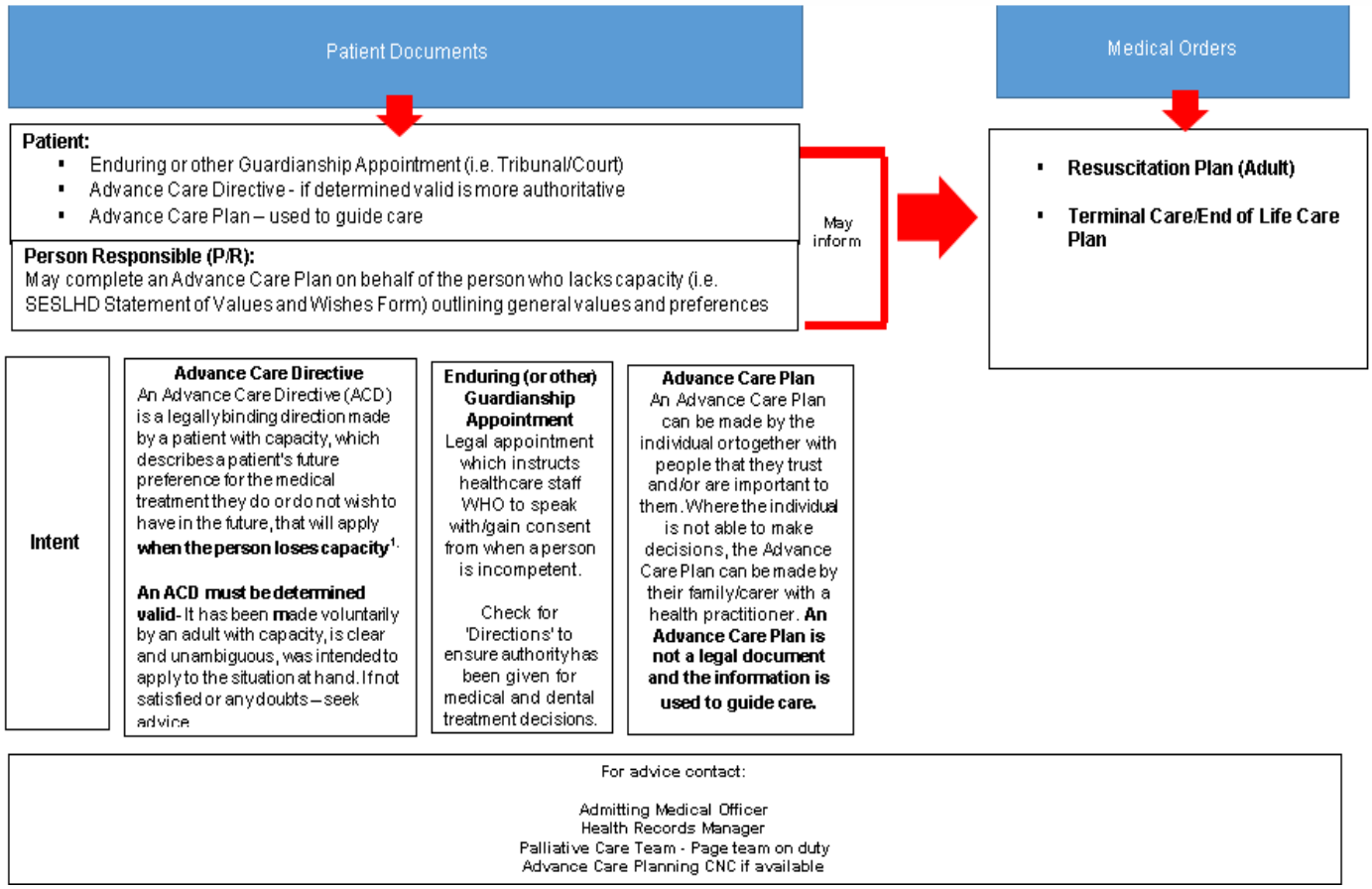
- NSW Health IB2020_010 - Consent to Medical and Healthcare Treatment Manual
- NSW Health GL 2021_004 - End of Life Care and Decision-making
- NSW Health End of Life Decisions, the Law and Clinical Practice – Legal Resources for Health Professionals
- Australian Commission on Safety and Quality in Healthcare (2021) Delivering and Supporting Comprehensive End of Life Care: a user guide
- NSW Ministry of Health Policy Directive PD2012_069 - Health Care Records - Documentation and Management
- SESLHDPR/335 - Clinical forms - creation and / or revision of
- SESLHDPR/292 - Hybrid HealthCare Record
- SESLHD eMR Quick Reference Guide – Add, Modify or Cancel

12. REVISION AND APPROVAL HISTORY

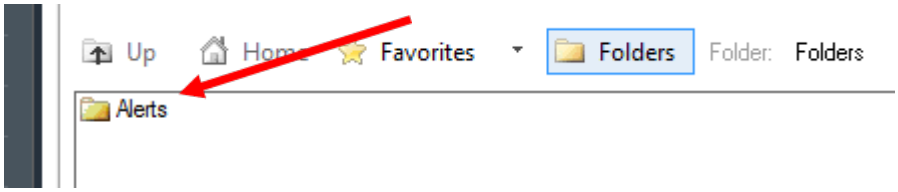
Date	Revision No.	Author and Approval
February 2019	Draft	Initial Draft. Draft for Comment period
May 2019	Draft	Final draft approved by Executive Sponsor.
May 2019	Draft	Processed by Executive Services prior to submission to Clinical and Quality Council.
May 2019	1	Approved at May 2019 Clinical and Quality Council Meeting for publishing. Published by Executive Services.
February 2020	2	Minor review approved by Executive Sponsor. Changes include the addition of Appendix 2 and minor terminology changes to Section 4. Processed by Executive Services prior to publishing.
July 2021	3	Major review: addition of flowchart in appendix 1; removal of detail related to NSW Ambulance Palliative Care Plan (APCP); wording changes.
August 2021	3	Draft for Comment period.
September 2021	4	Feedback incorporated. Approved by Executive Sponsor. For approval by Clinical and Quality Council.
November 2021	4	Approved at October Clinical and Quality Council meeting.

APPENDIX 1- Upload of Advance Care Planning Documents in the Patients Electronic Medical Record Flowchart

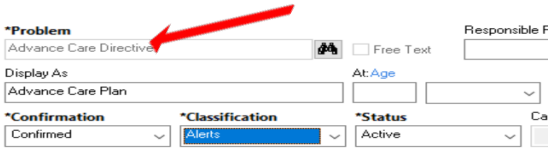




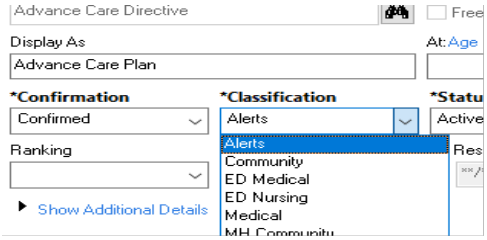
APPENDIX 2 - Using eMR to populate an advance care planning document Alert

1. Open eMR and search using the patients MRN to find the patient.
2. Double check that the patient, demographics and information is correct.
3. Select the appropriate encounter
4. From the task bar on the left hand side, click on 'Diagnosis, Alerts and Problems'
5. Under the heading 'Problem' click 'Add'
6. Click on the Alerts folder in the lower part of screen and select the appropriate title in i.e. Advance Care Directive, Guardianship document.
7. 

8. **If the correct title is not available in the Alerts folder free text the document title in 'DISPLAY AS' so the correct title display**



9. Ensure the Classification is set at Alerts.



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10. In the Alert comments section you can document any additional information.
11. Click ok to finalise.

Appendix 3 - Revocation of Advance Care Planning Document

Place ID label here: **Date:** **Dept:**

The patient has requested to revoke his/her Advance Care Planning document. The corresponding Alert has been removed.

Document name:

Patient signature **Drs signature**

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---------- (name printed) ---------- (name printed)

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