SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Advance Care Planning Documents - Uploading into the Patient Electronic Medical Record (eMR)
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/643
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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)	Cancer and Palliative Care Services 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.

Advance Care Planning Documents – Uploading into the Patient Electronic Medical Record (eMR)

SESLHDPR/643

1. POLICY STATEMENT

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

- an advance care plan / statement of values and wishes
- an advance care directive
- 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 the NSW Health 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

This unform 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.

3. DEFINITIONS

3.1. Advance Care Directive:

An Advance Care Directive (ACD) is a legally binding direction made by a patient with capacity, which describes their future preference for the medical treatment they do or do not wish to receive in the future, that will apply when the person loses capacity.

A valid Advance Care Directive must be respected.

An advance care directive is valid when:

- It has been made voluntarily by an adult with capacity
- is clear and unambiguous

- was intended to apply to the situation at hand.

3.2. Advance Care Plan:

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**.**

3.3. Guardianship document:

A person, 18 years of age or above, may appoint a guardian, or Enduring Guardian using the Guardianship Application from the NSW Civil & Administrative Tribunal (NCAT), or a form with the same features and effect.

Power of Attorney does not provide guardianship capacity.

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 refer to the NSW Health Consent to Medical and Healthcare Treatment Manual

4. RESPONSIBILITIES

4.1 All employees will

- Follow the processes set out in this procedure

4.2 AMO / Designated staff / Heads of Department will:

- Document advance care planning discussions within the electronic medical record
- Review and validate advance care planning documents.
- Arrange upload of advance care planning documents into eMR via Health Information / Records when valid and appropriate.
- Ensure junior medical staff are aware of clinical aspects (including ethic and legal) of the acceptance and use of advance care planning documents
- Follow the processes set out in this procedure for the revocation of advance care planning documents

4.3 Administrative employees will:

- Facilitate the scanning and emailing of advance care planning documents as instructed by clinical staff in line with this procedure.
- Provide clinicians with any advance care planning documents received directly from patients/clients.

4.4 Line Managers will:

- Ensure staff are aware of and monitor compliance with the procedure.
- Support staff to follow the procedure.

4.5 Designated health records staff will:

- Check appropriate email inboxes for advance care planning documents.
- Review received advance care planning documents as per this procedure.
- Import documents into eMR ensuring the document is against the correct patient/client, encounter, and document type.
- Check and add/update alerts when required.
- Revoke advance care planning documents as per this procedure when required.

4.6 Health Information Managers will:

- Allocate and oversee all processes associated with the importing of documents into the eMR.
- Ensure staff importing documents into eMR are adequately trained.
- Audit imports of documents as per this 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.

<u>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.</u>

To accept an advance care planning document for upload into the medical record it must be reviewed by SESLHD staff and assessed in consultation with the patient/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. They are also

responsible for ensuring junior medical staff are aware of clinical aspects (including ethical and legal) 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 or head of department.

The accepting staff member must follow the following steps:

1) If patient retains decision making capacity, check that the information in the document accords with their current wishes.
2) Confirm the document type and title is clear and correct (see definitions in Section 3).
3) The document is determined as valid for acceptance to the medical record (see definitions in Section 3).
4) The patient identification label is attached to the top right corner or four identifiers (name, MRN, DOB and sex) are clearly handwritten in header of each page of the document. If there is uncertainty about the identity of the patient or legibility of the handwritten details, the document will not be accepted.
5) The AMO / designated staff member / head of department's name and date of encounter is recorded in the header of front page or within the document.
6) 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).
   Available alerts are:
   - Advance Care Directive
   - Advance Care Plan
   - Appointment of Enduring Guardian
   - Guardianship Board
7) The approved document is scanned as a PDF and sent by email to the relevant health information / medical record unit or manager (See Section 6 below for email addresses).
8) The original document is returned to the patient.
9) Health information / medical record unit staff will then import the received document into eMR where it will be available to view under the advance care documents tab.

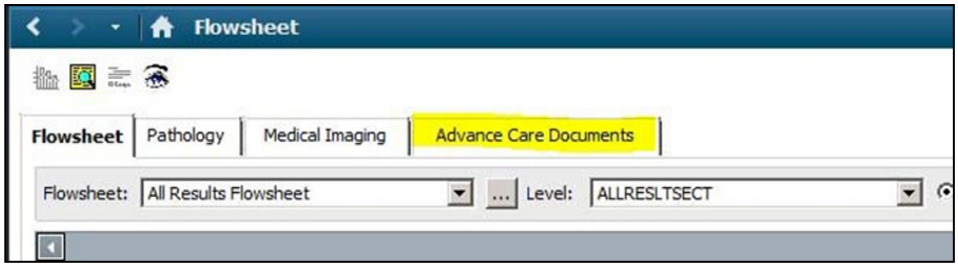
   Relevant note types for importing are:
   - Advance Care Directive
   - Advance Care Plan
   - Guardian/Court Orders

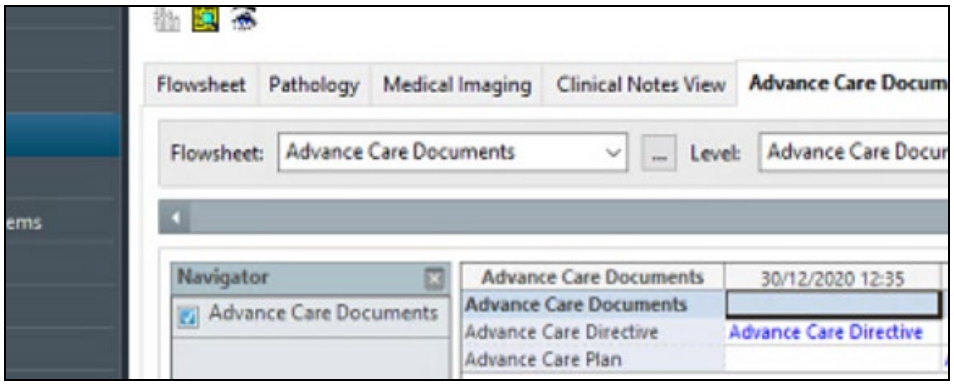
6. HEALTH INFORMATION / MEDICAL RECORDS EMAIL ADDRESSES BY SITE

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
PaCH	SESLHD-AdvanceCare-PaCH@health.nsw.gov.au

7. WHERE TO FIND ADVANCE CARE PLANNING DOCUMENTS

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





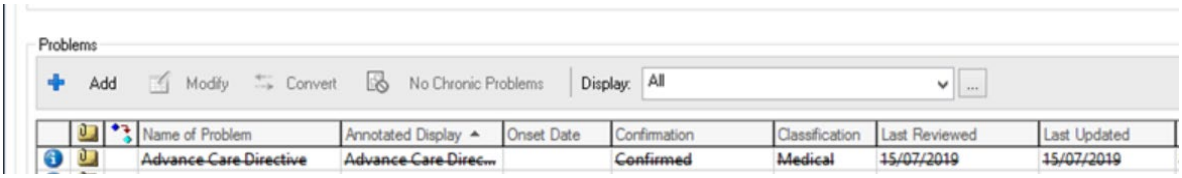
8. REVOKING ADVANCE CARE PLANNING DOCUMENTS THAT HAVE BEEN UPLOADED TO EMR

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

1) Patient requests to rescind or make changes to the advance care planning document that has been uploaded to eMR during discussions with their clinician.
2) The clinician will document the discussion in the healthcare record and complete the “Revocation of Advance Care Planning Document” (Appendix 3). This

document must include the signature of the patient and doctor.

3) The clinician will cancel the Alert in eMR so it appears as below. Refer to SESLHD eMR Quick Reference Guide – Add, Modify or Cancel Alerts for guidance on this process.



4) Administration / clinical staff (as determined by department head) will scan and email the "Revocation of Advance Care Planning Document" to the site health information / medical records unit email address (Refer to Section 6).

5) Health information / medical record unit staff will "in error" the advance care planning document according to the information on the revocation document (See Appendix 4 for a guide).

6) Clinical staff will rule a diagonal line through any hard copies of the rescinded advance care planning document with the clinician's 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.

9. DOCUMENTATION

- NSW Health - Making an Advance Care Directive (Booklet and Form)
- SESLHD Advance Care Directive Form (Same contents of form within NSW Health – Making an Advance Care Directive)
- SESLHD Statement of Values and Wishes Form
- NCAT Guardianship Application

10. GOVERNANCE

Regular quarterly auditing will be attended by the SESLHD Medical Record Managers and presented to the:

- Facility End of Life Committee,
- SESLHD Palliative Care Committee, and
- Health Records and Medico-Legal Committee.

Auditing will consist of:

- monitoring numbers of documents uploaded,
- ensuring documents are uploaded to right patient and right record,
- checking whether an appropriate eMR clinical alert has been added,
- monitoring staff documentation compliance in the clinical record.

11. REFERENCES

11.1 SESLHD eMR Quick Reference Guides: PowerChart Resources - All Documents

- SESLHD eMR Quick Reference Guide – Add, Modify or Cancel Alerts
- SESLHD eMR Quick Reference Guide – Single Document Capture (SDC): Importing
- SESLHD eMR Quick Reference Guide – Single Document Capture (SDC): Troubleshooting and Data Fixes for Errors

11.2 SESLHD Procedures

- SESLHDGL/077 - Advance Care Planning
- SESLHDPR/292 - Hybrid HealthCare Record
- SESLHDPR/513 - Management of Documentation Import Requests for the Electronic Medical Record (Manual and System Integrations)

11.3 NSW Health Policies, Procedures, and Guidelines

- NSW Health Consent to Medical and Healthcare Treatment Manual (2024)
- NSW Health Website: Advance Care Planning - Information for health professionals
- NSW Health Guideline GL2021_004 - End of Life Care and Decision-making
- NSW Health Policy Directive PD2012_069 - Health Care Records - Documentation and Management

11.4 External

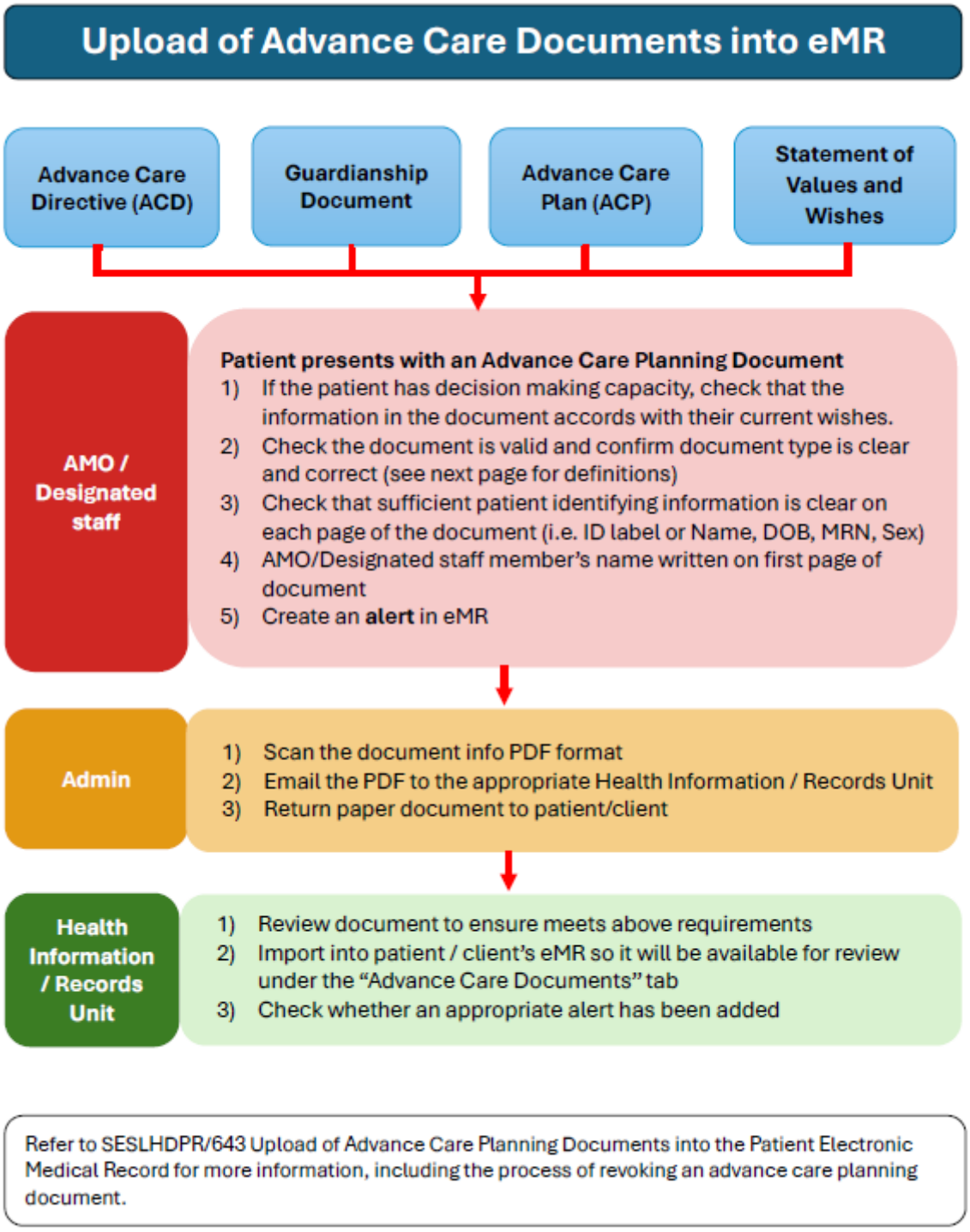
- Australian Commission on Safety and Quality in Healthcare: Delivering and supporting comprehensive end-of-life care: a user guide (2021)

12. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
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.
August 2023	4.5	Minor update to eMR note types
20 February 2025	4.6	Minor update to staff responsibilities, auditing requirements, and addition of revoking appendix and “Head of Department” to be allowed to approve an advance care document for upload.

APPENDIX 1: Upload of advance care planning documents in the patients eMR Flowchart



Upload of Advance Care Documents into eMR

Patient Documents

- Guardianship (Enduring or other such as Tribunal)
- Advance Care Directive (ACD) – If valid, more authoritative
- Advance Care Plan – used to guide care

Person Responsible (P/R):
May complete an Advance Care Plan or Statement of Values and Wishes on behalf of a person who lacks capacity outlining general values and preferences

May inform

Medical Orders

- Resuscitation Plan (Adult)
- Terminal Care / End of Life Care Plan

Definitions / Intent

Advance Care Directive (ACD)
An advance care directive (ACD) is a legally binding direction made by a patient with capacity, which describes a patient's preference for the medical treatment they do or do not wish to have in the future, that will apply when the patient no longer has capacity.

An ACD must be determined valid – i.e. that it has been made voluntarily by an adult with capacity, is clear and unambiguous, was intended to apply to the situation at hand. Seek advice if unsure.

Enduring (or other) Guardianship Appointment
Legal appointment which instructs healthcare staff who to speak with / gain consent from when a person is incompetent.

Check "directions" to ensure authority has been given for medical / dental treatment decisions.

Advance Care Plan / Statement of Wishes and Values
May be made by the individual or together with people that they trust and/or are important to them.

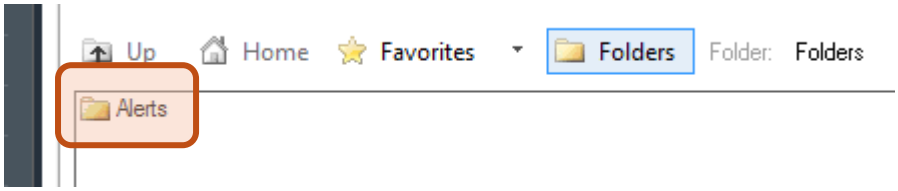
Where an individual is not able to make decisions, the ACP can be made by their family/carer with a health practitioner.
An ACP is not a legal document, and the information is to be used to guide care.

For more information:
- SESLHDPR/643 Upload of Advance Care Planning Documents into the Patient Electronic Medical Record
- SESLHDGL/077 – Advance Care Planning

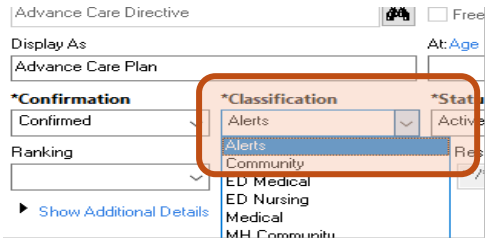
For advice contact:
- AMO
- Palliative Care Team – Page team on duty
- Advance Care Planning CNC if available
- Health Information Manager

APPENDIX 2: Adding an advance care alert in eMR

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 term. Appropriate alerts are:
   - Advance Care Directive
   - Advance Care Plan
   - Appointment of Enduring Guardian
   - Guardianship Board



7. Ensure the Classification is set to "Alerts".



8. In the comments section document any additional information (such as "Advance Care Document sent to Medical Records for importing to eMR").
9. Click ok to finalise.

Appendix 3: "Revocation of Advance Care Planning Document" Form

Patient Details: _____

ID label or names, DOB, and sex

Date: _____

DD/MM/YYYY

Department/Service: _____

The patient has requested to revoke his/her advance care planning document.
The corresponding Alert has been removed.

Document name: _____

AMO/Designated staff member/Head of Department: _____

Encounter Date: _____

Patient signature	**Drs signature**
----------	----------
---------- (name printed)	---------- (name printed)

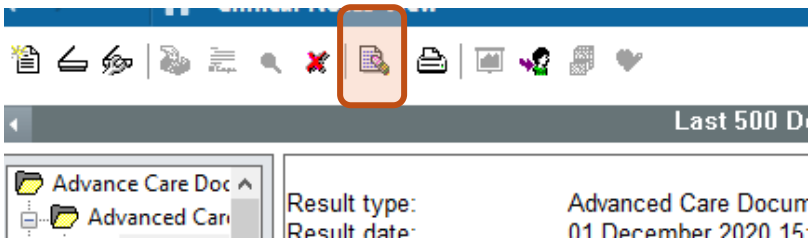
District Executive Unit
Locked Mail Bag 21
TAREN POINT NSW 2229

P. (02) 9540 7756 F. (02) 9540 8757
E. SESLHD-Mail@health.nsw.gov.au

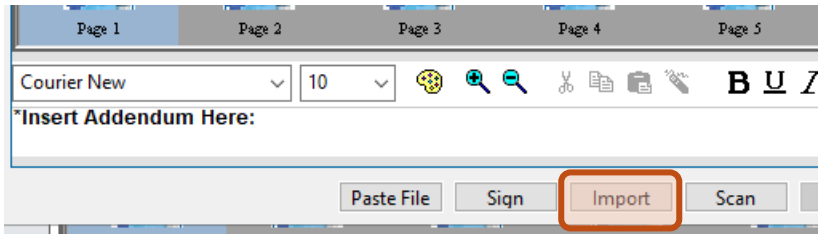
Appendix 4: Guide to "In error" an advance care planning document in eMR due to revocation

1. Locate the required advance care planning document in Flowsheet, Clinical Notes View, or Documentation and open it.

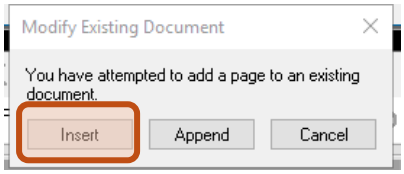
2. Add the "Revocation of Advance Care Planning Document Form" to the existing document by clicking the "Modify" icon



3. A "Modify Document" window should open. In this window, click "Import" at the bottom of the page.

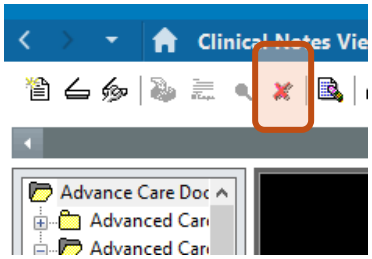


4. A "Modify Existing Document" box will appear. Select the "Insert" option to place the new document in front of the others.

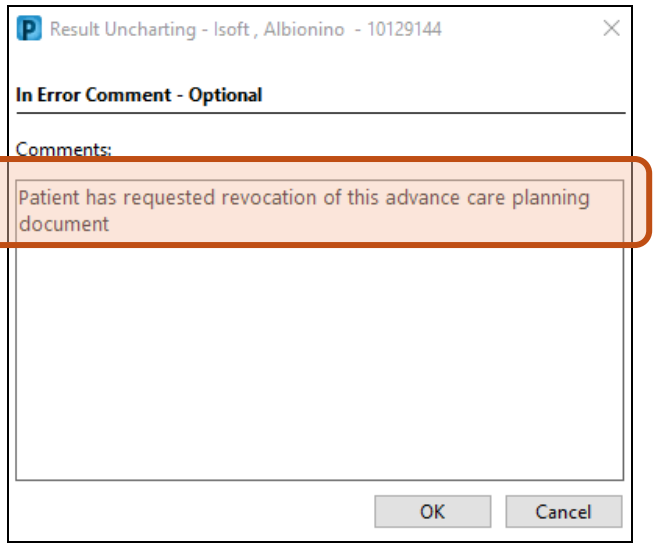


5. Continue with import and sign off as per regular Single Document Capture (SDC) procedure.

6. Now the entire document must be marked "In error". With the required document still open, click on the "In error" icon



7. A “Result Uncharting” comment box will pop-up. In the comments note that the patient has requested revocation of this advance care planning document and click “OK”



8. Document should now appear as “In error”