SESLHD PROCEDURE COVER SHEET

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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.

Procedure for the Upload of Advanced Care Planning Documents into the Patient Electronic Medical Record

SESLHDPR/643

1. POLICY STATEMENT

The procedure relates to 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
iv. Ambulance NSW Adult Palliative Care Plan.

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 procedure aligns with the SESLHD End of Life Care Plan 2018 – 2020.

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).

2.1 An advance care directive is valid when:

i. It has been made voluntarily by a capable adult
ii. It is clear and unambiguous
iii. It extends to the circumstances at hand (this is applicability and is determined by the current clinical situation).

For further information see NSW Health Planning Ahead Tools.

Under the common law, a person with capacity cannot demand treatment be provided, and there is no obligation for clinicians to provide treatment that is futile or non-beneficial. This is also the case when a person lacks capacity. An advance care directive cannot require that futile treatment be given, and a person's substitute decision-maker cannot demand such

treatment. https://end-of-life.qut.edu.au/advance-directives/common-law-advance-directives/

3. RESPONSIBILITIES

3.1 All Employees will:

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

3.2 Line Managers will:

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

Support staff to follow the procedure.

3.3 District Managers / Service Managers will:

Support staff to follow the procedure.

4. 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 delegated member of a multidisciplinary team who has been designated by the Service Director.
See NSW Health, End of Life Decisions, the Law and Clinical Practice – Legal Resources for Health Professionals

4.1 All of the following steps must be followed:

4.1.1 The document is accepted as valid for acceptance into the medical record (see above) or the document is developed with the patient

4.1.2 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.

4.1.3 The **document type, AMO / designated staff members name and date accepted** - is recorded on the top of each document.

4.1.4 An **appropriate clinical alert** is entered in eMR as delegated by the medical officer or according to departmental practice and procedure. See Appendix 1- Using eMR to populate an advance care planning alert.

4.1.5 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.

4.1.6 The original is returned to the patient and a copy must be retained and filed into the paper health record behind the advance care planning documents divider until it has been uploaded electronically.

4.1.7 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.

5. 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

6. The process for the upload of the NSW Ambulance Adult Palliative Care Plan (APCP)

NSW Ambulance Adult Palliative Care Plans are instructions to NSW ambulance officers regarding medical treatments. The APCP are medical orders developed in consultation with the patient and/or person responsible. There is a space for family or carer to sign but this is not mandatory for competent patients**.**

6.1 All fields on the APCP must be completed and legible including;

- the patient identification details,
- the person responsible identification details,
- the medical orders, medical signature and date
- the **email address of the appropriate health information / medical record unit as indicated in Point 5 above.**

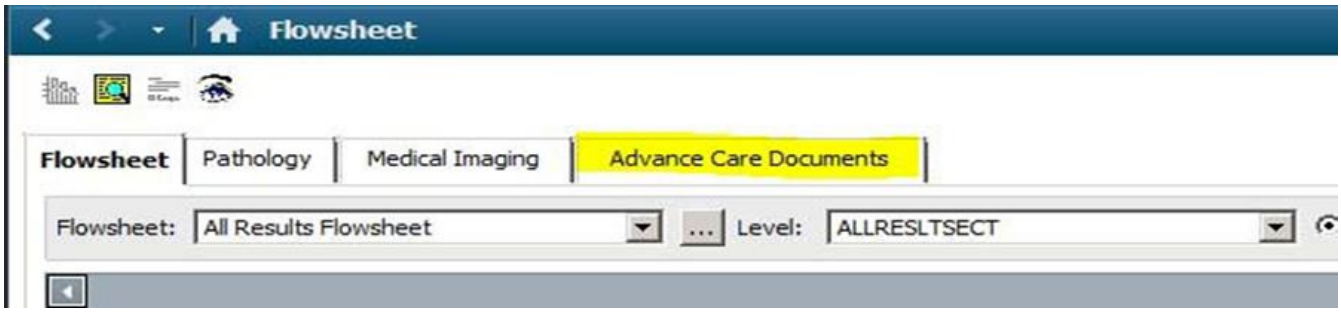
6.2 The completed form must be emailed to AMBULANCE-clinicalprotocolp1@health.nsw.gov.au for endorsement. If the information is unclear or incomplete the form may be returned to the author and will result in processing delays

6.3 An appropriate clinical alert is entered in eMR as delegated by the medical officer or according to departmental practice and procedure. See Appendix 1- Using eMR to populate an advance care planning alert.

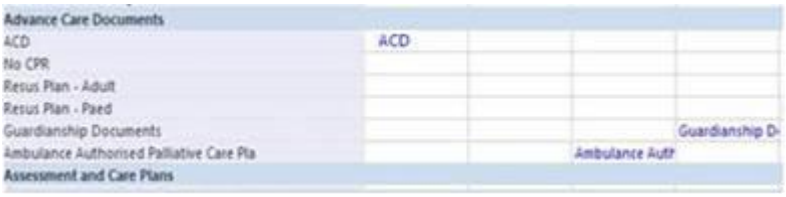
6.4 Upon receipt of the APCP form that has been endorsed by NSW Ambulance, the relevant site health information / medical record unit will import the form into the eMR system under the requested encounter date. For further information see NSW Ambulance Authorised Palliative Care Plans

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.



Advance Care Documents Screenshot



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

If a competent patient requests to revoke or make changes to the treatment options chosen on the form they need to notify a member of the treating clinical team.

Process for revoking advance care planning document/s:

8.1 Patient requests revocation or changes to the advance care planning document/s during discussions with their clinician.

8.2 The clinician will document the discussion in the healthcare record and write a physical revocation document-see Appendix 2 including the signature of the patient and doctor.

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

8.4 The clinician will create a new eMR Alert to reflect revocation of advance care planning document/s. See Appendix 1- Using eMR to populate an advance care planning alert.

8.5 Administration / clinical staff (as determined by department head) will scan and email revocation document to the health information / medical records unit email address (see Point 5 above).

8.6 The revocation document is returned to the patient and a copy must be retained and filed into the paper health record behind the advance care planning documents divider until it has been uploaded electronically.

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

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. AUDIT

Monthly auditing will be attended by health information / medical records unit management and presented to the SESLHD 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 GL2005_056 – Advance Care Directives (NSW) - Using
- NSW Health End of Life Decisions, the Law and Clinical Practice – Legal Resources for Health Professionals
- QUT End of Life Law in Australia
- NSW Government Planning Ahead Tools
- NSW Health PD2012_069 Health Care Records - Documentation and Management
- SESLHDPR/335 Clinical forms - creation and / or revision of
- SESLHDPR/292 Hybrid HealthCare Record

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.

APPENDIX 1 - Using eMR to populate an advance care planning 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. Ensure the patient has an open encounter request, if not generate a service request.
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 binoculars to the right of the 'Problem' option. Search for Advance Care Directive by typing the word 'advance'.
7. Click Advance Care Directive.
8. In the Alert notes section you must document the date of the ACD / ACP discussion to assist in locating the document type in the Advance Care Documents tab.

Appendix 2

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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