Top Tips

Advance Care Planning (ACP)

1

Where do I find an existing ACP in patient records?

Login to MCP / Add NHI for Patient Search / Click Alerts / Access plan

2

How do I Identify suitable patients for ACP conversations?

ACP conversations are appropriate for all capable and competent adults, regardless of age or health status. Everyone admitted to the hospital should be given an opportunity to talk about health care wishes regarding medical treatments.

These conversations are particularly important in the following scenarios: advanced chronic disease, life limiting illness, resident of aged care facility, new diagnosis, at risk of losing mental competence, has no-one to act on their behalf, recurrent hospital admissions.

Remember to document ACP conversations.

3

Starting an ACP conversation?

There are many ways to start the conversation. Ideally it is best to start when a person is well and at home. However, while in hospital ACP conversations can be initiated by asking if they have heard about ACP and proceed to introduce the book. Encourage the person to talk with their family and healthcare team. ACP Project Manager is available to support, assist and follow up, **See Top Tip 9.**

4

What information is available for the person/ family/ whānau to support them?

There are hard copies of Whenua ki te Whenua. This book provides a series of thoughts and questions to think about and support ACP conversations. The Advance Care Plan is the next step that provides a space to document your thoughts and decisions. Online resources are also available, **see Top Tip 9**

5

Where can I get Whenua ki te Whenua and an Advance Care Plan?

Hospital reception, ward lounges and corridors will have these resources available. Please contact the Project Manager if area requires replenishing, **see Top Tip 9.**

6

How will the GP know we have initiated or completed an ACP?

Complete a Discharge letter or Transfer of care and document that ACP conversation was initiated and follow up is required. Please notify the Project Manager to follow up, **See Top Tip 9.**

7

Other important documents to include with ACP?

- ✓ Enduring Power of Attorney
- ✓ Living Will
- ✓ Advance Directives
- ✓ Shared Goals of Care (when applicable)
- ✓ Just Incase Plans (when applicable)

8

Where can I access further ACP training or information?

Level 1 : My Menu – My Training – Te Whariki a Toi – ACP modules

Level 1a: My Menu – Training Calendar – Book Me

View ACP page for more information and to see videos

9

Who can help?

Anyone who has completed the Level 1 and 1a ACP training and able or confident to support colleagues.

Or contact the ACP Project Manager: For more online resources please see the ACP page under Innovation & Improvement.

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tō tātou reo advance care planning

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