醫院管理局 HOSPITAL AUTHORITY

登峰 QUALITY TIMES

Issue 37 | November 2019

Head Office Quality & Safety Division

The Hospital Authority Periodic Publication on Quality Improvement for Healthcare Professionals

Advance Care Planning (ACP) – Practical Considerations

*By **Department of Patient Safety and Risk Management,** HAHO*

Under HA setting, Advance Directive ("AD")/Advance Care Planning ("ACP") is widely used by clinical specialties such as palliative care (with oncology), geriatrics, paediatrics, internal medicine for patient with terminal or advance irreversible illness. In this issue, the focus of sharing is the application of the guidelines from a more practical perspective. Start by understanding the differences between ACP & AD, then the outcome, key considerations and Do's & Don'ts when applying the guidelines and forms. In closing, challenges and way forward in the form of Q&A will be shared.

In This Issue:

ACP vs AD

ACP is an overarching process of proactive communication regarding but not limited to end-of-life care. Through this process of communication, a patient with advanced progressive disease, together with his/her family members, health care team and caregivers can consider ahead of time what kind of care is appropriate when he/she can no longer make a decision. It also helps to prepare the patient and family emotionally, minimising their conflicts with the healthcare team/caregivers during future deterioration of the patient's condition.

AD is a tool used for advance care planning, which is a legal binding document. Using this tool, a patient can specify the treatment(s) that he/she is going to refuse in case he/she becomes mentally incapacitated to make decisions with disease progression. The key differences between an ACP and an AD are summarized below:

ACP	AD
1. A process of proactive communication	1. One of the tools during the ACP process
2. ACP form* are not legally binding	2. AD is legally binding under common law
3. ACP form document patient's wishes, values, and preferences for both medical & personal care	3. AD specify the medial treatment that patient refuse in case he/she becomes mentally incapacitated
4. During ACP, patient can opt out signing an AD	4. Sign an AD by itself

*ACP from serves as reference for healthcare team to make decisions and formulate individualized care plan for best interests of patient.

Key Considerations

When apply ACP clinically, the following key points and Do's and Don'ts should be noted by the clinical team:

1. The appropriate time for triggering discussion depends on the state of the disease as well as readiness of the patients and should not be initiated simply as a routine procedure.
2. ACP is more than just a process for signing an AD. ACP discussion is an on-going process that takes time and effort, and should not be handled as a simple one-off check list exercise.
3. Staff should have appropriate communication skill and knowledge of the subject.
4. Individual clinical unit/specialty may modify ACP form according to needs.
5. ACP guidelines should be used together with other related clinical ethics guidelines, together which stipulated the ethical framework from different aspects of making end-of-life decisions according to patient's best interest.

Do's	Don'ts
1. Assess patient's readiness	1. Done too early or too late
2. Respecting patient's autonomy	2. Take over to drive patient's decisions
3. Involve family members, health care team and caregivers during discussion	3. Attempt in absence of family members, especially for Mentally Incapacitated Patients (MIPs) & Minors
4. Consensus building informing the patient, minimizing conflicts with family members	4. Assume children /adults with impaired capacity cannot join the discussion
5. Review may be required as the patient's condition/ preference change	5. Handle as one-off checklist exercise

Outcome

Generally speaking, a series of ACP discussions may end up with (i) a signed AD (ii) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for non-hospitalized patients (if the patient falls into specified conditions) (iii) ACP forms that document the patients' values, beliefs, wishes and preference for personal care. Besides the AD, all the above statements on preferences for medical or personal care are not legally binding.

Challenges & Way Forward (Q&As)

Q 1: There is high government & public expectation that HA should do more work on AD/ACP, what had been done by HA?

A 1: HA had response through the promulgation of the ACP Guidelines, it helps to bring a positive message to the public that HA is moving forward towards this direction. Meanwhile, HA is participating in the Government led public consultation for AD legislation and relevant End-of-Life care (EOL). For this, a designated Task Force was set up in March 2019 to oversee the subject matter.

Press release to launch public consultation (Sep 2019) (Source of photo: Oriental Daily News)

Public consultation forums (Oct- Nov 2019)

Q 2: Two key challenges related to operational conflicts with external counterparts over the years (i) execution for DNACPR between HA and Fire Services Department and (ii) the handling of AD/ACP signed outside the HA. How to overcome?

A 2: The HA Clinical Ethics Committee (CEC) started to explore development of electronic forms and enabling system functions to recognize ACP/AD signed outside HA. Also, HA had given specific views during the public consultation underway with regard to streamline more seamless AD/ACP services support with external counterparts including but not limited to both issues above. HA will closely follow the progress, take appropriate actions such as revision of relevant guidelines subject to the eventual AD legislation.

Q 3: Apparently, many frontlines are not aware of the AD/ACP development. How to tackle?

A 3: Similar to other corporate policies, promotion of AD/ACP in HA is challenging. It is possible that such promulgation may lead to staff sentiment that this would mean additional workload. To overcome this hurdle, we need to increase staff awareness. Communication had been enhanced in this respect through dissemination of information via operations circular and conduct briefing sessions. For progressive integration into more clinical departments/specialties less involved in AD/ACP, consideration for pace of adoption should focus on overall staff preparedness and readiness (mainly skill and communication). It is also important to promulgate the message to staff that workload should be reduced with appropriate ACP in the long term.

Q 4: A dilemma whether AD should cover relatively healthy patients and how should frontline staff handle when being asked?

A 4: HA does not preclude doctors from offering advice or assistance as work arrangement permits for communication with such patients. As usual practice, doctors will advise them to seek help from non-government organizations or private sector.

Editorial Comments

Advance care planning (ACP) is widely considered an essential step toward achieving end-of-life care that is consistent with the preferences of dying patients and their families. In this article, the author describes the ACP process, highlighting its difference from Advance Directive (AD), as well as a practical approach to increase its effective use. Current figures show that the number of AD and DNACPR are increasing in HA.

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Dust Barrier – Barrier More Than a Barrier

*By **Occupational Safety & Health Team,** Department of Quality & Safety, HKWC*

There is always some construction or renovation work in hospitals every day. Control of dust particles is an important element in all renovation projects. State-of-the-art technologies adopted in pathology laboratories require stringently maintained environmental conditions. To manage the dust particles that may pose adverse impacts other than infection control on the pathology services, an Infection Control Risk Assessment (ICRA) Dust Control Awareness Barrier has been introduced in Queen Mary Hospital (QMH) by the HKWC OSH Team. The barriers, with dust-repelling characteristic and fire resistant feature (National Fire Protection Association, NFPA 701), have been erected in both the Genomics and Haematology Laboratories (Fig. 1 & 2), which are in the immediate vicinity of the construction sites.


Fig 1.


Fig 2.

Full spectrum particle sizes (from PM1 to PM10) monitoring had been conducted before and during the whole renovation period. The effectiveness of the barriers was shown by the significant 3-fold reduction of measured environmental particle concentration to a range of 0.4 to 0.6 mg/m3, in the protected areas behind barriers, comparing to the unprotected area in the corridor and between doors and barriers (Fig. 3). The average particle concentration throughout the renovation period was similar to the pre-renovation baseline level.

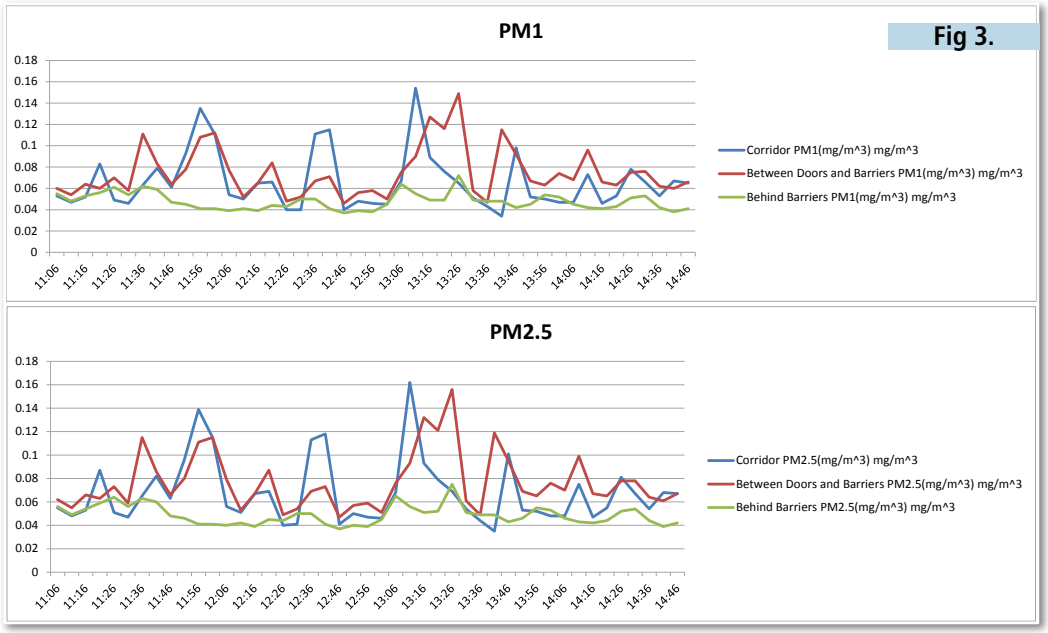

Fig 3.

With the science behind the simple act of dust containment, this measure maintains a healthy environment during renovation and would be useful to other clinical areas as well.

Editorial Comments

Effective control of dust particles is essential in creating maintained environmental conditions in hospitals, especially in construction or renovation work areas. This barrier in QMH provides a measure for effective dust containment that not only can benefit staff in hospitals but also patients in clinical areas.

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CLUSTER SHARING

Enhancing Nursing Documentation with a DAR Marker in NDH

New Territories East Cluster

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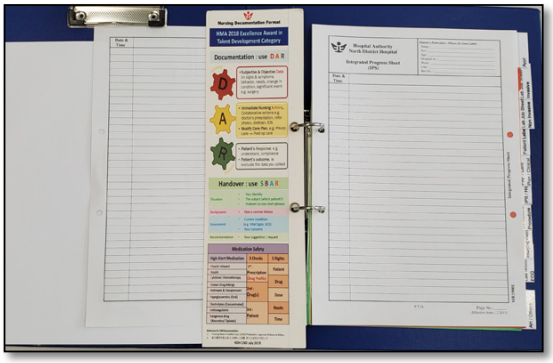
Good nursing documentation reflects nurses' judgement and outcome of care. It not only enhances the role of nurses, but also allows multidisciplinary communication and collaboration in the delivery of patient care.

With the support of top nursing management, a workgroup has been formed with link nurses from different specialties aiming at enhancing nursing care plan and documentation. In 2016, the Workgroup has further developed a Data-Action-Response (DAR) Marker which was put into each patient folder to remind colleagues to assess patients' condition (Data); provide nursing care and collaborative actions (Action), and also evaluate patients' outcomes (Response). Common assessment tools are included in the DAR Marker, such as Glasgow coma scale, fall risk, pressure injury risk, pain assessment, muscle power grading and modified functional ambulation classification.

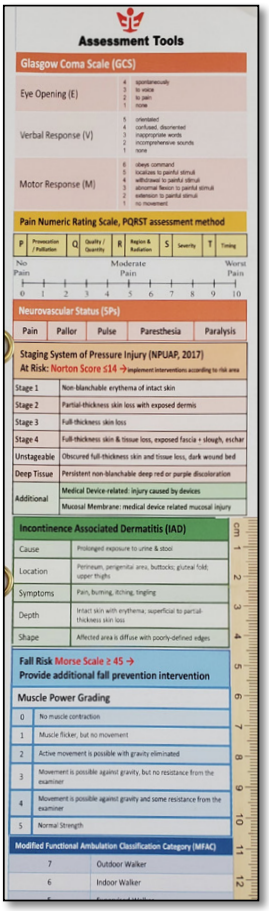
In order to foster staff engagement, promotion road show, forums, interactive training workshops had been organized for promulgation with positive feedback. In 2017, a retrospective audit on documentation of 812 nursing entries got the overall compliance rate of over 84% in the items of regular assessment, appropriate action and record of progress/response. The hard work of the workgroup has been recognized with an Excellence Award in Talent Development Project of Hospital Management Awards 2018.

In 2019, the DAR marker has been further revised with the involvement of frontline nursing staff and tailor-made for the other six NTEC hospitals as a useful reference tool for nursing documentation.

NDH Workgroup members



DAR Marker front page



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Editorial Comments

This eye-catching and creative design of Data-Action-Response (DAR) Marker not only could remind nursing staff to make more comprehensive clinical documentation, but also give easy references of the up-to-date assessment tools. With the good evaluation results reported, other clusters may consider adopting similar tool for better clinical documentation.

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