Welcome to the first newsletter of the Office of Advance Care Planning for 2018! We hope you had a wonderful Christmas and were able to enjoy a refreshing break with family and friends.

This New Year brings new opportunities and this newsletter provides an update on some of the Office’s recent initiatives which include the introduction of the Statement of Choices v5.0, the implementation of the ACP Tracker; and the commencement of a pilot involving review and uploading of AHD, EPOA and other revocation documents.

We want this newsletter to be valuable to you so please share your feedback and suggestions to enable future newsletters to be relevant to you.

Statement of Choices: version 5.0

On behalf of The Office of Advance Care Planning, we would like to express our sincere thanks to the many stakeholders involved in the development of the new and improved version 5.0 of the Statement of Choices (SoC). This included consultation and collaboration with consumers, health professionals from acute, community and residential sectors and legal stakeholders.

There has been extensive positive feedback from clinical users of the v5.0 SoC regarding the modifications to content and format, in particular, an improved understanding of each section on the form and the rich content of the individual’s Personal Values. Please continue to send us your feedback from clinical users, patients and their families.

You can get interactive and PDF versions of Statement of Choices v5.0 by visiting the My Care My Choices website at: www.mycaremychoices.com.au

If you are not yet using version 5.0 of the SoC and would like printed documents to be sent to you, please contact the Office of Advance Care Planning.

The Office of ACP helps Queenslanders plan and share their healthcare wishes.

- Provides information and resources about ACP
- Shares health care wishes with doctors involved in care (via The Viewer)
- Connects you to ACP services in your local area

New resources:

Click on the following links for handouts to help guide completion of the SoC.

- Tips for completing Form A
- Tips for completing Form B
- Guide for health professionals using the SoC

SoCs on The Viewer

There are now over 8000 Statement of Choices documents which can be accessed by authorised Queensland Health clinicians, Queensland ambulance service and general practitioners (GPs) via The Viewer.

GPs who would like to have access to The Viewer can contact the Health Portal Provider team at Queensland Health on 1300 478 439 or via email at: connectingqld@health.qld.gov.au to register.
Please encourage acute, residential and community services in your region to send copies of all completed Statement of Choices documents to you (as per local protocols) or directly to the Office of ACP so we can review and then upload them to patient records in The Viewer.

Send completed SoCs to the Office via:
- Email: acp@health.qld.gov.au or
- Fax: 1300 008 227 (new fax number!)

**Advance Care Planning Tracker now available on The Viewer**

The new Advance Care Planning Tracker (ACP Tracker) was officially launched in The Viewer on 2 January 2018.

This is the first state-wide centralised system that allows a patient’s advance care planning history to be accessed and updated across Hospital and Health Services.

The ACP Tracker, accessed through The Viewer, contains patients’ advance care planning interactions with Queensland Health and Mater Hospital staff, as well as advance care planning documents uploaded by the Office of Advance Care Planning or from CIMHA.

New advance care planning interactions with clinical staff can be directly entered into the ACP Tracker. Click on the purple ACP icon in a patient’s record on The Viewer to launch the ACP Tracker.

The ACP Tracker will improve efficiencies for staff and enhance patient-centred care with an increased clinical awareness of advance care planning interactions and documents from around Queensland. Clinical users of ACP Tracker have already commented upon its ease of use and the value of real-time updating of ACP activity.

**Want more information about ACP Tracker?**

For further information and training opportunities
- contact the Office of ACP
- view QHEPS (if you work in Queensland Health - includes a test environment)

**Pilot: upload of other ACP documents**

The Office of ACP in partnership with Metro South Health (MSH) and Central Queensland Hospital and Health Service (CQHHS) has commenced a pilot to review and upload Advance Health Directive (AHD), Enduring Power of Attorney (EPOA) and related revocation documents to The Viewer.

If successful, this pilot can be expanded across the state and offer a mechanism to enable direct access to these documents through the ACP Tracker to further support person-centred care.

It is envisaged an evaluation of this pilot will be completed by March 2018.

**End-of-Life Care for Residential Aged Care: information & resources**

A website with information and resources to support end-of-life care in residential aged care facilities has been developed as part of a partnership project between Brisbane South PHN and Metro South Health.

This work has focused on determining residents' values, wishes and preferences and best clinical practice at end of life including advance care planning. For more information go to: www.eolcareracf.com.au or contact Mia Taylen-Smith on Mia.Taylen-Smith@health.qld.gov.au.

**Your ACP Stories**

The following stories (de-identified) provide valuable and practical examples of how to have ACP discussions in clinical practice.
An ACP story by Carey-Ann Tanner (CNC-ACP Royal Brisbane & Women’s Hospital)

I had the pleasure to have met a gentleman from Japan who had been in Australia for quite some time. He was estranged from his family except for one son who lived nearby. This gentleman was a haemodialysis patient and also had quite a few co-morbidities associated with renal disease. He did not eat well and was not able to look after himself as well as he used to. He was having increasing hospital admissions due to his complications on haemodialysis and the doctors needed to have a conversation about the longevity of his dialysis. An interpreter was booked with the team and I was asked to come along and talk about his thoughts on ACP and his wishes for the future. After the team had been in, and touched on ACP, they introduced the interpreter and I and we sat and had a long chat about his family, his career and his thoughts on haemodialysis.

Amongst the sadness associated with being estranged from his family, he stated he would like his son to know his wishes and to have more contact with him. He did not want any life prolonging treatments but did still want to stay on dialysis at this time. He also wanted classical music to be played at his end of life.

I asked him for permission to share this with his son and he stated yes. I rang his son and explained the Statement of Choices (SoC Form A) and that his Dad would like him to have a copy. Through this process his son came to see his Dad and was more involved in his health care in hospital.

This gentleman was looking forward to going home, but unfortunately after a long admission and many complications from haemodialysis, he spent his last days in hospital with us. On the weekend this gentleman passed away, the palliative care team knew he had a SoC and reminded the staff on the ward of its whereabouts. The nurses on the ward were able to provide classical music for him and his son was also with him at his end of life.

When I think of this gentleman, I hope the contact with his son gave him some happiness and peace, not just for him but for his son as well😊

An ACP story by Sabrina Palham (CNC-ACP Logan Hospital)

The Social Worker at Beaudesert Hospital rang me, saying the husband of a woman with Lewy Body Dementia was requesting a facilitated conversation so he would have a document to give to the Nursing Home when his wife arrived at the end of the week.

I stood at the entrance of the four-bed bay and raised my eye-brows in the direction of a spry 60-something man sitting at the bedside of a woman who looked twice his age. He squeezed her hand and walked over to me. I introduced myself. “Call me Miles”, he said, “and that is my ‘Lilli’. If you call her Marillia, she’ll growl at you. Lilli was deformed by contractures and had a far-away look in her deep-set eyes; cloudy blue in a pallid, rigid face.

“How would you like to do this?” I asked, referring to how much Miles thought Lilli would like to be involved in the facilitated discussion and documentation of her future health care wishes. “Ask her yourself”, he said simply. I asked her. Lilli spoke with evenly paced deliberately chosen words. “You ask him” she countered. “He thinks he knows me. We’ll see.” A smile of sorts. Lilli was able to broadly respond to questions when asked, but did not initiate conversations, nor was orientated to time and place. Her cognition screening indicating the appropriateness of using a Form B Statement of Choices.

Initially, Miles asked me to first speak with him separately, so we went away to a quiet place down the corridor. Miles began; a nervous rush of words. I started to write contact details and demographics onto the Form B. He spoke of the woman she was – a music teacher; a musician herself – stopped playing jazz piano with her jamming mates nearly four years ago – the first undeniable sign of her dementia.

Miles said the hard question was not what she loved, but what gives her life joy now. He struggled. “Music still, I think, although sometimes it makes her worse!” Other small, small things like her own clothes and some foods, chocolate mousse topping the bill of late. “NO to a feeding tube, that’s for sure!”

And NO to any other life prolonging measures, it seemed. “When we go back to her, ask her outright; she won’t flinch. When this bloody disease started she cried, for days on end and she only calmed down when I promised I would not let her linger. Any chance she has to get out of her body, she’ll take it”. So we took the completed form back and went through it section by section with Lilli. Mostly she approved, she even laughed. Or at least I think the guttural cough-like sound expressed merriment. Miles certainly laughed; and I did, out of sheer relief. We got to: When the person is nearing death, I believe they would want (including spiritual/cultural preferences), Lilli stopped me reading by interjecting. “I bet he said I would want to be listening to Jazz music! He is wrong. Jazz is not for dying.”

“Play me the Blues”