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ACP the “Unique Way”

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There are currently 4368 patients on renal replacement therapy in my country and of this 1822 patients are on RRT within the city’s greater region. The city is divided into 3 district health boards (DHB), one District Health Board (WDHB) in the north, one District Health Board (CMDHB) in the south and one in the centre. The central DHB provides renal replacement therapy for 13.5% (or 589 patients) of country’s nephrology population with 340 patients on dialysis and 249 transplanted patients. Fifteen percent of country’s dialysis population (or 401 patients) die each year of which 96 are from patients who withdraw from dialysis.

It has been well recognized that patients on haemodialysis and their families want to discuss Advance Care Plans (ACP) with their health care providers in order for them to have positive outcomes (Goff et al, 2015).

In 2014, the Renal Service at Auckland District Health Board (ADHB) recognised the importance of Advance Care Planning on the lives of their patient population. This was promoted during a ‘Conversation that Counts Day’ activity. However, due to poor staff engagement, there was little improvement in the number of completed advanced care plans. Initially there was only 1 nephrologist and 2 nurses that had completed the level 2 ACP training and the author (who was the Haemodialysis charge nurse) was on ADHB’s ACP Working Group.

Intervention. Lack of progress was raised at a Management meeting and it was decided that Advance Care Planning was to become a Key Performance Indicator (KPI) and was launched at a Monthly Renal Education meeting. In order to achieve this, education sessions were to be held for the staff and flip cards specifically related to the renal patient population were available for staff to use. A further 4 nurses and 2 nephrologists were identified to attend the level 2 ACP training. In the first month 60 ACPs were completed but dropped to 13 after 5 months this was due to some nurses struggling with having conversations with their patients on ACP and also there were delays to some of the nurses who were to complete the ACP. Following further staff education and training the entire service has had an average of 133 ACPs completed per month since July 2015.

Results. Completed advanced care plans are then scanned to the organization’s patient data storage. This then appears on the patient’s system as a “Clinical Alert” so that when patients are admitted staff are aware when patients present in the emergency department that they have an ACP. A random audit of 10 Incentre patient’s clinical notes is done weekly looking for completed ACPs with a target of 70%.

Improvement has been made in the Incentre and nephrology (pre-dialysis) patients and there has been increasing engagement within the renal transplant service over the past 6 months.

Discussion. It has been 2 years since the implementation was started and progress has been good in all areas except self-care and home therapies. There are plans to expand into this area with further education for the staff and identifying at least 2 nurses to complete the level 2 ACP training.

In conjunction with another organization we have been running a Communication Skills Course every 6 months over the past 2 years. This course is designed for staff to gain skills in having difficult conversations with their patients. Funding is supplied for 10 staff to attend the 3-day course.

Management support and engagement has been the key to the success of this initiative.

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