ACD/ACP Telephone prompts

Has there been a critical incident or unexpected deterioration of a resident?

STEP 1

Would transfer to hospital for further medical interventions or treatment be non-beneficial? Locate the resident's Advance Care Directive (ACD) or Advance Care Plan (ACP) and check the documented preferences.

If the ACP / ACD confirms that the resident wishes are below, **do not call an ambulance:**

- Focus is on maintaining dignity and comfort care.
- Not for resuscitation.
- Not for transfer to acute hospital.
- Not for any treatments to extend their life such as IV antibiotics, oral antibiotics or antivirals, blood products and IV fluids.
- Preferred place of care including at end of life is in residential aged care.

The resident's care needs can be provided in the residential care home, **proceed to step 2.**

STEP 2

Inform the Person Responsible (PR) of the change in the resident's condition (See over page for assistance in calling the PR).

Remind the family member of the resident's goals and wishes documented in the ACD/ ACP.

Reassure family that comfort measures will be implemented.

Contact (strike out non-applicable items and insert appropriate local contact teams within the Local Health District):

- General Practitioner (GP) / Nurse Practitioner (NP) to arrange review

or

- Insert appropriate local area Geriatric Rapid Assessment team and phone contact (such as BRACE /GRACE / Geriatric Flying Squad).

Team: _____ Ph: _____

Check availability of prescribed medications to optimise comfort including anticipatory EoL medications.

STEP 3

Request the GP / NP / Geriatric Rapid Assessment / Evaluation Team reviews and prescribes anticipatory medications.

Referral to the local Specialist Palliative Care Services for further advice around end-of-life medication management may be required.

Communications guide

Purpose: To avoid non-beneficial transfers to hospital from a RACF, and to assist RACF staff to effectively communicate when there has been a deterioration in a resident's condition.

The ISBAR framework is a standardised approach to communication. It stands for **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation.

I — **Hello my name is (*your name*), my role is (*your role*), I am calling from (*name of RACF*).**

S — **(*Resident's name*) condition has deteriorated as it was expected to at some stage.**

B — **We have looked at (*resident's name*) ACP/ACD which states (*read out points from the ACD/ACP*).**

A — **After our assessment we believe (*resident's name*) has:**

_____

_____

(RN to communicate their own assessment. For example, increased pain and discomfort, decreased level of consciousness etc.)

R — **We do not think it is appropriate to send (*resident's name*) to hospital at this stage and we think we should start an End-of-Life care pathway, focusing 100% on (*resident's name*) comfort and quality end of life care here in (*name of RACF*).**

Then followed with:

- **Do you understand that?**
- **Are you ok with that?**
- **Do you have any questions?**

- **Document** the conversation in the resident's medical record.
- **Commence** your RACH's end-of-life pathway including hourly monitoring and assessments.

Palliative Care New South Wales

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