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NEPEAN
BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
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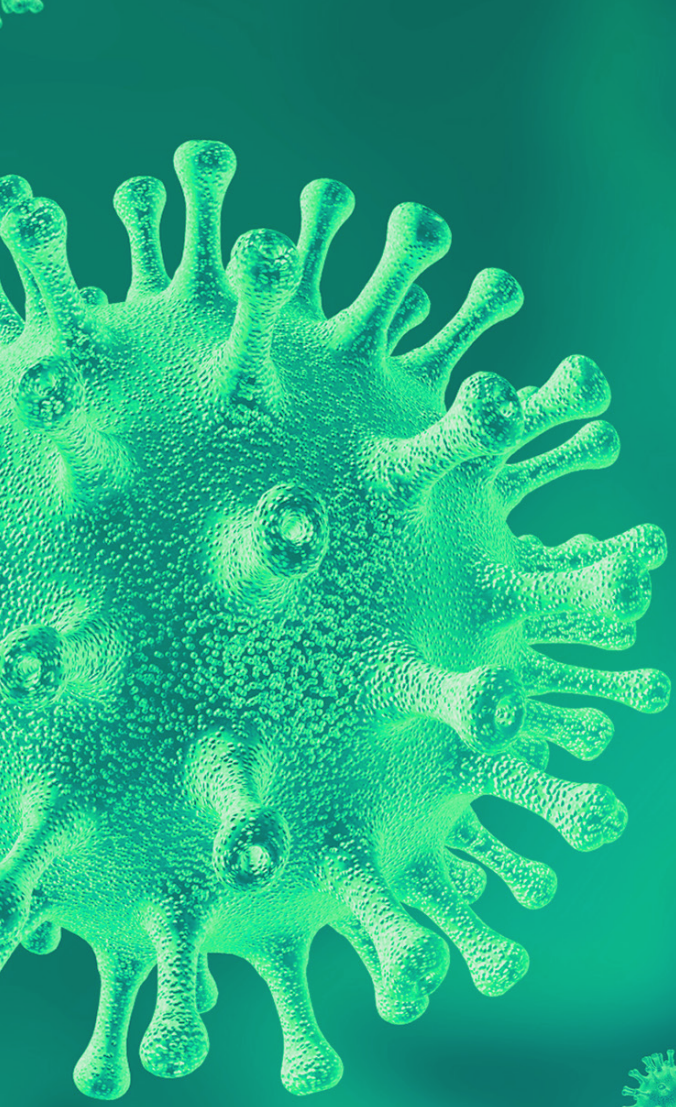
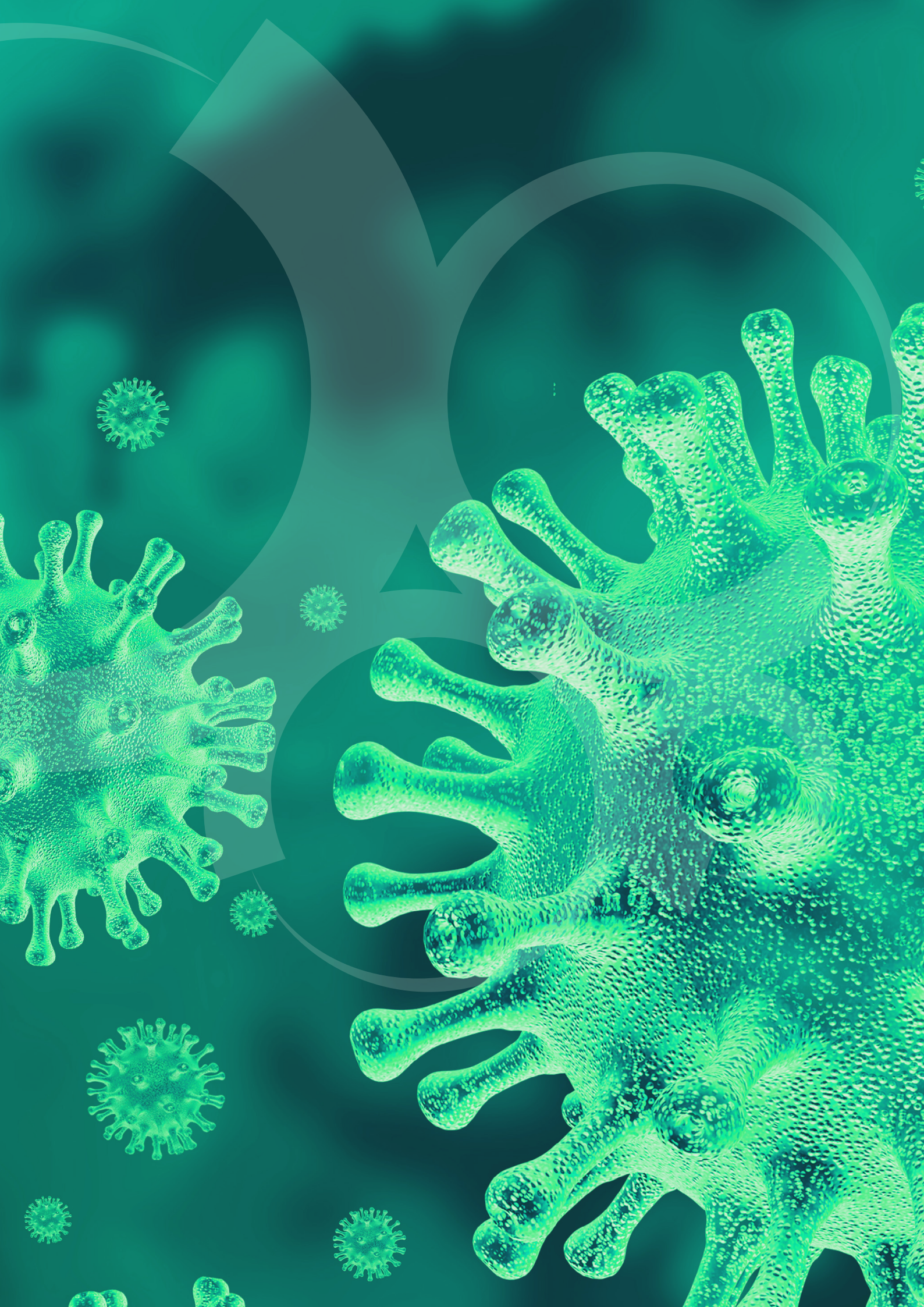
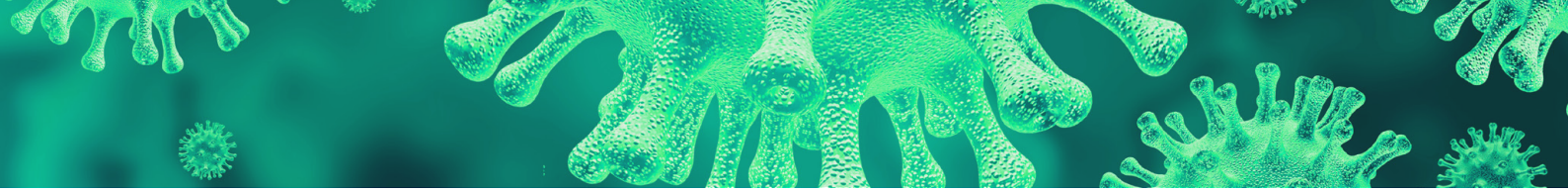


RACF COVID-19 Outbreak:

'Statement of Wishes' Process for the Nepean Blue Mountains Region





RACF COVID-19 Outbreak: Statement of Wishes Process for the Nepean Blue Mountains Region

Wentworth Healthcare (provider of the Nepean Blue Mountains Primary Health Network) wish to acknowledge the significant contribution in the development of these resources from Three Tree Lodge Residential Aged Care Facility, local General Practitioners and the Supportive & Palliative Care Team at the NBM Local Health District.

This package is designed to provide a set of template documents to support General Practitioners (GP) and Residential Aged Care Facilities (RACFs) to have a conversation with residents and their families about their wishes during the COVID-19 pandemic. The primary purpose of the documents is to support GPs and RACFs to engage in conversations with residents and/or their substitute decision maker/s (SDM) to address any worries they may have if they tested positive for COVID-19. In addition the material can be used to confirm that the wishes outlined in a resident's existing Advance Care Directive/Plan are consistent with the care and treatment they would want to receive if they were to become very unwell as a result of COVID-19.

These resources will be made available to RACFs in the Nepean Blue Mountains region however, they will need to be considered in the context of national and state frameworks in place at the time of an outbreak.

Important considerations when using these templates:

- If using an existing Advance Care Directive/Plan which is comprehensive and up-to-date and includes considerations in the event of an outbreak of COVID-19 in the RACF this supporting material may not be required.
- If there are specific issues the general practitioner or RACF would like discussed, this may be useful to assist in updating the residents Advance Care Directive/Plan.
- For a new resident to the facility without an Advance Care Directive/Plan in place, these templates will provide an opportunity to clarify the resident's goals of care in creating their Advance Care Directive/Plan, incorporating their treatment wishes in a COVID-19 environment.

Please note: The completion of the Statement of Wishes document does not replace a resident's existing Advance Care Directive/Plan, however is deemed an adjunct to this documentation.

The following supporting material are provided within this package:

1. **Letter to GPs re Advance Care Directive/Plan and COVID-19**
2. **COVID-19 Advance Care Directive/Plan – Letter to Residents**
3. **COVID-19 Advance Care Directive/Plan – Letter to Substitute Decision Maker**
4. **RACF Statement of Wishes COVID-19 Flowchart**
5. **Statement of Wishes – COVID-19**
6. **Advance Care Directive/Plan COVID-19 Discussion Resource GP RACF**

Attachment 1:

Letter to GPs re Advance Care Directive and COVID-19

(…insert name of aged care service or print on letterhead…)

(…insert date…)

(…insert mailing address or email…)

Dear *(…insert name of general practitioner…)*

Preparing for COVID-19 in Aged Care Facilities

So far in Australia, most aged care facilities have been able to prevent COVID-19 outbreaks from occurring. This has been as a result of combined community and government response to the pandemic, as well as the actions taken by facilities to minimise risk.

Where facilities have experienced an outbreak, the outcome has sometimes been swift and devastating. As in the general community, aged care facilities remain at risk of an outbreak until such time as a vaccine is produced and/or effective treatment options become available.

How can general practitioners (GPs) act to ensure aged care facilities are best prepared to manage if an outbreak was to occur?

Currently the most important intervention involves advance care planning and conversations with residents and/or substitute decision makers (SDM), where applicable. This is not about creating a new advance care directive as these have generally already been documented for most residents. It involves GPs discussing with residents and/or SDMs what their wishes would be in the event of them acquiring a COVID-19 infection.

The advantages of such an approach would be that the wishes of residents can be clearly documented before such an outbreak occurs and with representatives of the aged care facility also being involved. These conversations would include the likelihood of survival of elderly residents with multiple co-morbidities in the event of complicated or serious COVID-19 infection. Resident's wishes such as the transfer to hospital, ICU admission and interventions such as intubation and CPR, if desired, could be explored in the context that such decisions may be overridden by state health authorities in any event. Levels of care available at the aged care facility and the local hospital could be clarified, which may help residents themselves to modify their expectations and ultimately be more prepared if the situation arises.

A three (3) step process, as attached could be considered by GPs.

1. Residents and/or SDMs be provided with documentation to consider the key questions and issues as outlined above.
2. GPs arrange a consultation with the resident and/or SDMs to gauge their general attitudes and preferences and ascertain whether these are clear and whether they present further issues to be explored.
3. A joint meeting be arranged with each resident and/or SDM and a representative of the aged care facility to finalise the process and to document the resident or their substitute decision maker/s worries and wishes.

A variation of the above process could be undertaken. Some of the conversations will be straightforward and others more complex. Ultimately it will be beneficial to all parties to have these conversations ahead of any potential outbreak. Learnings from previous outbreaks in Australia demonstrate that opportunity is lost or becomes more complicated when a team of completely new staff, including medical officers are required to care for unwell residents. Additionally, if a resident is admitted to hospital, the documentation from the conversation could be used to guide their care.

Attachment 2:

COVID-19 Advance Care Directive – Letter to Residents

(…insert name of aged care service or print on letterhead…)

(…insert date…)

(…insert name of resident…)

(…insert address…)

Dear *(…insert name of resident…)*

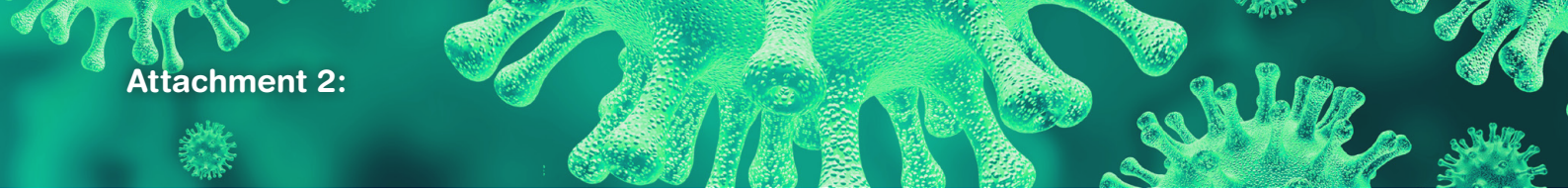
A review of your clinical records indicate that you have previously provided us with a copy of your Advance Care Directive that outlines your choices and preferences for your future care and treatment, including your wishes for care at the end of your life.

As you would be aware, over the past few months many people in Australia and around the world have become ill with COVID-19, the illness caused by a newly discovered coronavirus. Many people who have become unwell with COVID-19 experience cold and flu symptoms and recover fully on their own. However, some people, especially those who are older and/or have chronic health conditions, have become seriously ill and some have died.

Unlike conditions such as heart disease, cancer and dementia that may take years to reach a serious stage, COVID-19 can cause people to become suddenly and seriously unwell requiring intensive treatment. Unfortunately for many older people and/or those with chronic health conditions, the intensive medical treatments used to treat people with COVID-19 are not always effective and may not ensure your survival or enable you to get back the quality of life you had before the illness.

We appreciate this may be difficult to think and talk about. We would like to be able have a conversation with you about any concerns you may have about COVID-19 and to support you as you consider what care and treatment you would want if you became seriously ill from COVID-19. These are hard questions to answer. While we understand you have already documented your wishes and preferences for future care and treatment and these will remain unchanged until you advise otherwise, you may not have considered these in relation to becoming unwell as a result of a COVID-19 infection.

We would encourage you to speak with *(…insert title and/or name of senior clinician in the aged care service…)* to arrange a discussion with you, your general medical practitioner *(…insert name of general medical practitioner…)* and a member of our clinical team to discuss any questions, thoughts and concerns you may have. We would like to understand your worries and wishes and confirm the care and treatment that is right for you if you became seriously ill from COVID-19. You may wish to have a family member or a trusted friend to participate in the discussion.



Attachment 2:

We have provided some questions below that may assist you, your family member or trusted friend with your decision making. We would encourage you to make some notes so we can discuss your thoughts and any concerns you may have at this time when we meet with you.

1. At this time, what are you most worried about?

2. If you tested positive to COVID-19 what would you be most worried about?

3. If you became seriously ill with COVID19?

    a) what would be most important to you?

    b) what would you find helpful while you were unwell?

    c) Would you want treatment aimed at comfort and care which is consistent with your existing Advance Care Directive or treatment aimed at prolonging your life?

4. Have you appointed a person/s (substitute decision maker) who can act on your behalf and make decisions about your care and treatment if you are unable to speak or make decisions for yourself?

5. Have you spoken to your substitute decision maker and or family or trusted friend about what you may want if you become seriously ill with COVID-19?

Thank you for taking the time to read this letter and giving consideration to your care and treatment if you tested positive to COVID-19. Please contact *(…insert title and/or name of senior clinician in the aged care service…)* on *(…insert telephone number…)* to arrange our discussion with you or if you have any questions in relation to the contents of this letter.

Yours sincerely

(…insert name…)

(…insert title…)

Attachment 3: COVID-19 Advance Care Directive – Letter to Substitute Decision Makers

(…insert name of aged care service or print on letterhead…)

(…insert date…)

(…insert name of substitute decision maker…)

(…insert address…)

Dear *(…insert name of substitute decision maker…)*

We are writing to you as our records indicate that you are the nominated decision maker for *(…insert residents full name…)*

A review of the clinical records of the resident indicate that you have previously provided us with a copy of the Advance Care Directive/Plan for the resident that outlines the choices and preferences for future care and treatment, including wishes for care at the end of their life.

As you would be aware, over the past few months many people in Australia and around the world have become ill with COVID-19, the illness caused by a newly discovered coronavirus. Many people who have become unwell with COVID-19 experience cold and flu symptoms and recover fully on their own. However, some people, especially those who are older and/or have chronic health conditions, have become seriously ill and some have died.

Unlike conditions such as heart disease, cancer and dementia that may take years to reach a serious stage, COVID-19 can cause people to become suddenly and seriously unwell and requiring intensive treatment. Unfortunately for many older people and/or those with chronic health conditions, the intensive medical treatments used to treat people with COVID-19 are not always effective and may not ensure the person's survival or enable them to get back the quality of life they had before the illness.

We appreciate this may be difficult to think and talk about. We would like to be able to have a conversation with you about any concerns you may have about COVID-19 and to support you as you consider what care and treatment you would want for the resident if they became seriously ill from coronavirus. These are hard questions to answer. While we understand you have already documented the wishes and preferences for future care and treatment and these will remain unchanged until you advise otherwise, you may not have considered these in relation to the resident becoming unwell as a result of COVID-19 infection.

Attachment 3:

We would like to arrange a discussion with you, the resident, their general medical practitioner *(…insert name of general medical practitioner…)* and member of our clinical team to discuss any questions, thoughts and concerns you may have. We would like, based on your understanding of the resident's previous wishes and preferences, to know what action you would like to take if they became seriously ill from COVID-19.

We have provided some questions below that may assist you with your decision making and you may wish to talk with the resident when considering these questions. We would encourage you to make some notes so we can discuss your thoughts and any concerns you may have at this time when we meet with you.

1. At this time, what are you most worried about as the substitute decision maker for the resident?

2. If the resident tested positive to COVID-19 what would you be most worried about?

3. If the resident became seriously ill with COVID-19

    a) what do you think would be most important to the resident?

    b) what do you believe the resident would find helpful while they were unwell?

    c) would you want the resident to receive treatment aimed at care and comfort which is consistent with their existing Advance Care Directive/Plan or treatment aimed at prolonging life?

4. Have you spoken with other significant people in the resident's life about what you believe the resident would want if they become seriously ill with COVID-19?

Thank you for taking the time to read this letter and give consideration to the care and treatment of the resident if they test positive to COVID-19.

Please contact *(…insert title and/or name of senior clinician in the aged care service…)* on *(…insert telephone number…)* to arrange our discussion with you or if you have any questions in relation to the contents of this letter.

Yours sincerely

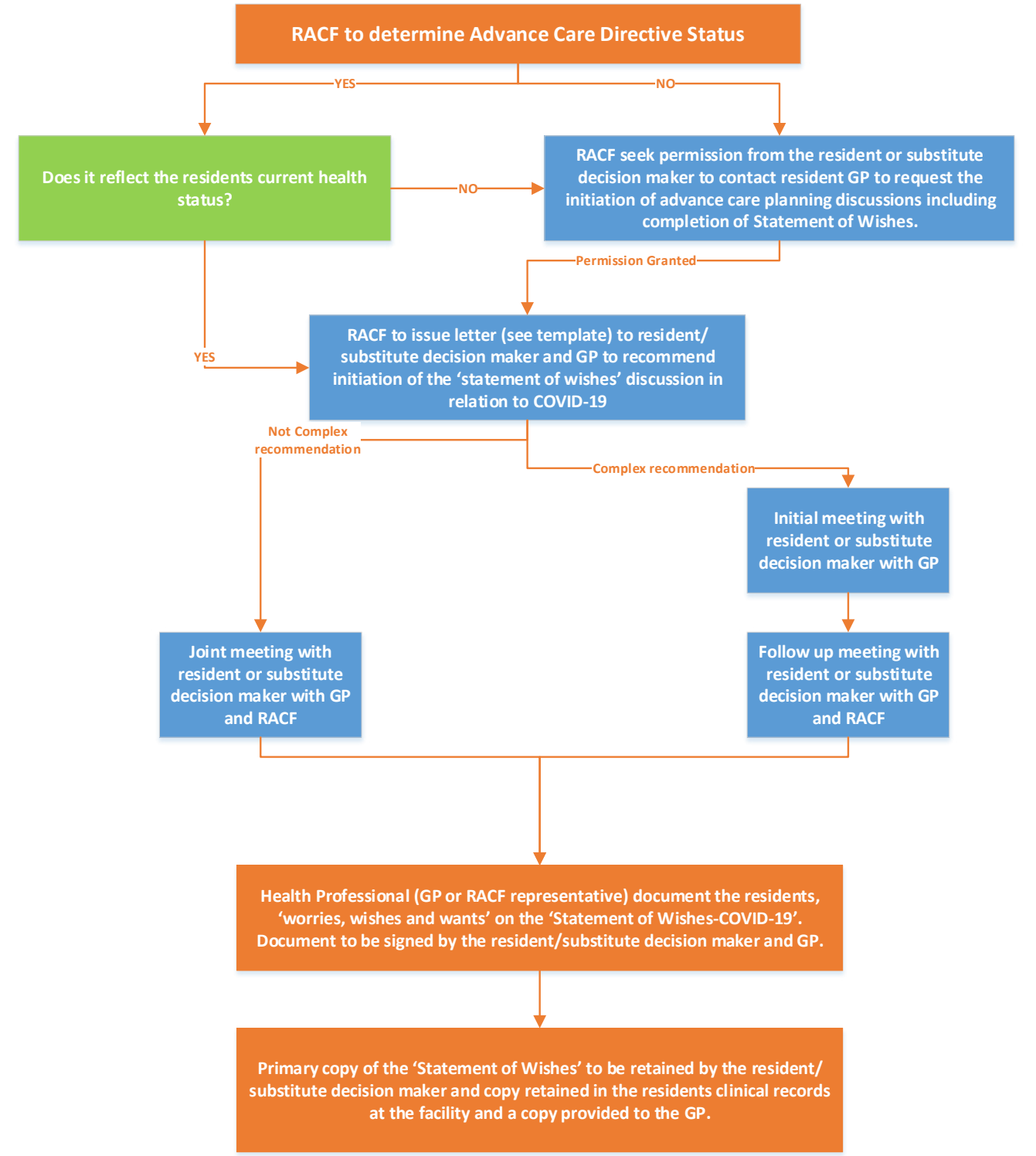
(…insert name…)

(…insert title…)

Attachment 4:

Statement of Wishes COVID-19 Flowchart

Advance Care Directive, Statement of Wishes COVID-19 Flowchart



Supporting Documentation:

- Letter template to Residents/Substitute Decision Makers
- Letter template to GPs
- Statement of Wishes document to be completed
- COVID-19 discussion resource document

Attachment 5:

Statement of Wishes – COVID-19

(…insert name of aged care service or print on letterhead…)

STATEMENT OF WISHES – COVID-19	Please complete the following:
	Clinical Record No:
	SURNAME:
	Given Name:
	Date of Birth:
	Room No.: Admission Date:

This document has been developed to provide guidance for the future care and treatment of a resident who tests positive to COVID-19. The statement should be read in conjunction with the resident's existing Advance Care Directive/Plan.

PEOPLE INVOLVED IN DEVELOPING THIS STATEMENT:

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

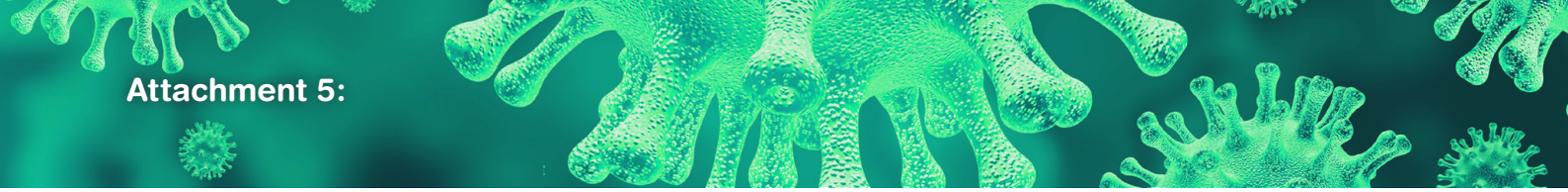
WORRIES, WANTS AND WISHES:

1. At this time the resident/substitute decision maker are most worried about:

_____

_____

_____



Attachment 5:

2. The resident and/or their substitute decision maker understand that the following health conditions mean that they are at an increased risk of serious illness or death from COVID-19.

3. If the resident was to test positive with COVID-19 they are worried about *(for example: how unwell could I became if tested positive with COVID-19, what treatment and care options are available, where I would be able to receive my care and treatment preferences)*

4. If the resident becomes seriously ill with COVID-19 then the following are most important to the resident: *(for example: to have contact with my family, the listen to my music, to have my cultural and spiritual practices supported, to have my symptoms managed)*

5. If the resident tested positive for COVID-19 they would want:

☐ treatment aimed at comfort and care which is consistent with their existing Advance Care Plan/Directive

☐ treatment aimed at prolonging life

NAMES AND SIGNATURES OF THOSE INVOLVED IN PREPARING THIS STATEMENT

Name resident: _____

Substitute decision maker: _____

Signature: _____

Date: _____

Name of medical practitioner: _____

Signature: _____

Date: _____

Once completed, file in Resident's Clinical Records.

Advance Care Planning COVID-19 Discussion Resource: RACF & GPs

INFORMATION FOR CLINICIANS	
Advance Care Planning Australia Resources - COVID-19	
Resources to assist GPs discussing Advance Care Planning with their patients in the context of COVID-19 including a conversation starter for clinicians. Links to COVID-19 specific webinars for both GPs and for planning in aged care.	https://www.advancecareplanning.org.au/docs/default-source/acpa-resource-library/acpa-fact-sheets/conversation-starters-for-health-aged-care-and-general-practice-workforce.pdf https://www.advancecareplanning.org.au/for-health-and-care-workers/covid-19-web#/
The Advance Project	
Practical, evidence-based toolkit and a training package in initiating advance care planning and palliative care.	https://www.theadvanceproject.com.au/
Nepean Blue Mountains HealthPathways	
COVID-19 Preparation of Residential Aged Care Facility (RACF) Residents [for GPs] – Preparation to: Ensure all patients have an updated Advance Care Directive (which includes COVID specific management preferences)	https://nbm.communityhealthpathways.org/745539.htm Username/password per LGA: PENRITH – hppenrith| hpppassword BLUE MOUNTAINS – hpbluemount|hpbmpassword HAWKESBURY – hphawkesbury | hphpassword LITHGOW – hplithgow | hplpassword
ELDAC – End of Life Directions for Aged Care	
ELDAC COVID-19 Webinar Series – What Age Care Providers Need to Know About Older Australians and End of Life Care	https://www.eldac.com.au/tabid/5999/Default.aspx
End of Life Essentials Resources	
Video - Critical Conversations Video COVID-19	https://vimeo.com/412149077
Pallium Canada Webinar	
"Essential Conversations: Utilizing Advance Care Planning & Serious Illness Tools During COVID-19 and Throughout the Patient Journey" COVID-19 conversation with the Serious Conversations and "*3W's Framework*" 20min mark (approx.10 min). ''*Wish, Worry, Wonder*'' – Framework	https://www.youtube.com/watch?v=6D89fNdQz7E&feature=youtu.be http://conversationsofalifetime.org/wp-content/uploads/2019/11/N-U-R-S-E-S-card.pdf
Ariande Labs COVID-19 Response Toolkit (Canada)	
COVID-19 Conversation Guide for Outpatient Care	https://covid19.ariadnelabs.org/serious-illness-care-program-covid-19-response-toolkit/
CALMER guidelines card	
COVID as starting place for Advance Planning	https://images.app.goo.gl/hQQSX13K85ocboaA9 Copy and Paste link into browser
INFORMATION FOR CONSUMERS	
Included in these resources is a conversation starter for individuals, families and loved ones.	https://www.advancecareplanning.org.au/docs/default-source/acpa-resource-library/acpa-fact-sheets/conversation-starters-for-individuals-families-and-loved-ones.pdf

NSW Health – Making an Advance Care Directive
https://www.health.nsw.gov.au/patients/acp/Publications/acd-form-info-book.pdf

Key Definitions

Substitute Decision Maker

A substitute decision-maker is a person who makes a health care decision for a person who has lost capacity. The substitute decision-maker stands in the shoes of the person to make the decision about health care. Generally the substitute decision-maker's decision has the same legal effect as if the person had capacity and made the decision themselves. A substitute decision-maker will not need to make the decision if the person without capacity has an Advance Care Directive that applies to the situation.

A person who has capacity can plan for a later time when they may lose capacity by appointing someone to be their substitute decision-maker. This is done by completing a formal document. The document used is different in all states and territories.[1]

Advance Care Planning

Advance care planning is a process where a person discusses their values and healthcare preferences with their family, friends and healthcare team. The goal is to provide clear and documented preferences about a person's future medical treatment. It is essential to person-centred care and is an ongoing process.[2]

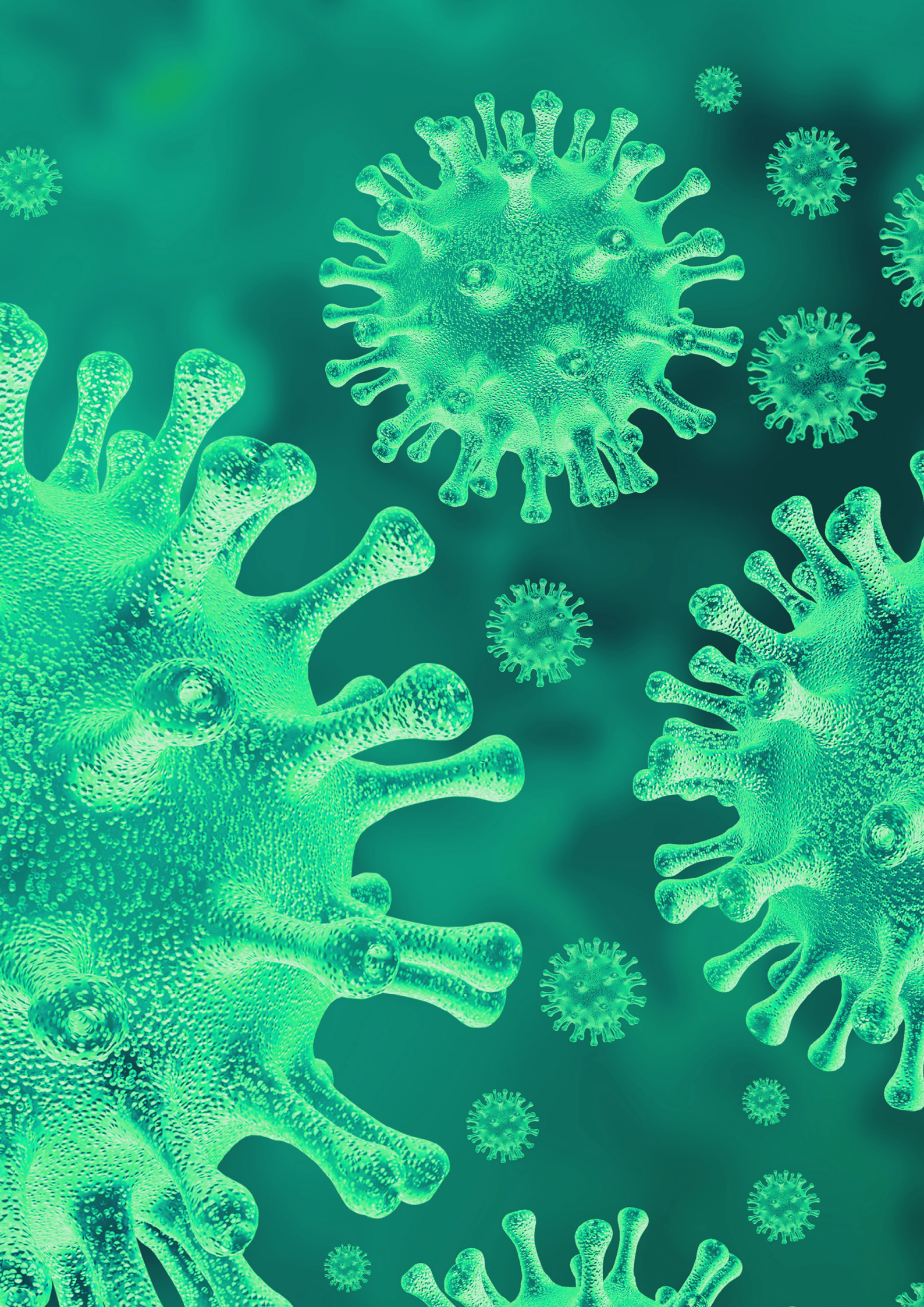
Advance Care Plan

An advance care plan is a document to tell your doctors or family about how you want to be treated if you can no longer speak for yourself or make your own decisions. They are sometimes called a 'living will'.[3]

Advance Care Directive

An Advance Care Directive is sometimes known as a living will. It is written by the person themselves. An Advance Care Directive is a written record of their preferences for future care. The Directive can record a person's values, life goals and preferred outcomes, or directions about care and treatments. Advance Care Directives can also formally appoint a substitute decision-maker. Advance Care Directives differ between states and territories. Some state governments have specific forms that you can use. An Advance Care Directive may also be called an Advance Health Directive, Health Direction or Advance Personal Plan.[2]

1. https://www.eldac.com.au/
2. https://www.advancecareplanning.org.au/
3. https://www.myhealthrecord.gov.au/



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