Introducing Advance Care Planning (ACP)

Adapted from presentations by Jane Goodwin, Kate Grundy & Leigh Manson
Overview

• What is Advance Care Planning (ACP)?
• Why is ACP important?
• What does an Advance Care Plan look like and where might I find one?
• How and why might I start an ACP conversation?
• Where can I get more information about ACP?
• Questions
What is Advance Care Planning (ACP)?

ACP is a process of discussion & shared planning for future health care. It involves an individual, whanau & health care professionals.

ACP gives people the opportunity to develop and express their preferences for future care based on:

- Their values, beliefs, concerns, hopes & goals
- A better understanding of their current & likely future health
- The treatment & care options available

(ACP COOPERATIVE 2013)
What issues are discussed?

- Person’s understanding of their illness/prognosis
- Types of care/treatment that may be beneficial and/or available
- Personal preferences for future care/treatment
- Particular concerns, fears, wishes, goals, values or beliefs
- Religious, spiritual or other support
- Preferred place of care (and how this may affect the treatment options available)
Also....

• Family/whanau members or others that they would like to be involved in decisions about their care
  – appointing of an EPA
  – or “....is there an individual that you could nominate who would assist clinicians with decision-making if you were unable to do so in future? This would be a person who knows you well and understands what is important to you”

• Views and understanding about interventions that may be considered in an emergency
  – e.g. cardio-pulmonary resuscitation
  – e.g. Non invasive ventilation
Advance Care Planning

CONVERSATIONS
(Context)

ACP

AD

ACP = Advance Care Plan
AD = Advance Directive
Advance Directive:

An Advance directive is consent or refusal to specific treatment(s) offered in the future when the person does not have capacity.
Advance Directives

• Criteria for validity:

  – Person must have been competent when the AD was written

  – They must have been adequately informed

  – They must have been free of undue influence

  – The Advance Directive must have been intended to apply in the circumstances that have arisen
Just so you know...

I never want to live in a vegetative state, dependent on some machine.

If that ever happens, just unplug me, OK?

OK.

Hey!
Advance Directives

• An Advance Directive does not need to be in writing

• An Advance Directive only apply when a patient lacks capacity

• An Advanced Directive cannot require the provision of specific treatment
Advance Directives

A valid Advance Directive is legally binding

• The Code of Rights 7(5): Every consumer may use an advance directive in accordance with the common law.

• The Code of Rights 7(7): Every consumer has the right to refuse services and to withdraw consent to services. (In recognition of Section 11 of the New Zealand Bill of Rights Act 1990)
Advance Directives

In the absence of reasonable grounds to doubt validity, an Advance Directive should ordinarily be honoured.
**Advance Directives**

- In New Zealand an EPoA can not refuse any standard medical treatment or procedure intended to save life or prevent serious damage to health.

- An advance directive is therefore the best way for any individual to express their wish to refuse a particular treatment in the future (particularly if it is considered standard/potentially life-saving).
Decision Making Cascade: What happens when a person is no longer competent?

- Valid advance directive
- EPoA (cannot withhold standard life-sustaining treatment)
- Ascertainable preferences – apply patient preference
- Best interests - other suitable people
MoH guide for the health care workforce

- Standardised info about ACP principles and legislation
- Aims to promote consistency
- Will assist in the development of local policies, guidelines & training in ACP

Why is ACP important?

• Advance Care Planning encourages conversations about what is important for a person (Hudson & O’Connor, 2007).

• Helps a person achieve a sense of control as their illness progresses and death approaches (Lyon, 2007).

• Can positively enhance a patient’s hope in the face of progressive disease (Davison, 2006).

• Reduces fear and anxiety (Ditto et al., 2001).

• Increases understanding and comfort (Ditto et al., 2001).
Why is ACP important?

• Facilitates end of life wishes to be known and followed (Detering, Hancock, Reade, & Silvester, 2010).

• Reduces stress, anxiety and depression for family members when a patient dies (Detering et al., 2010).

• Improves patient and family satisfaction with overall care (Detering et al., 2010).

• Reduces time spent in hospital in the last year of life (Abel, Pring, Rich, Malik, & Verne, 2013).
What does an ACP look like?

MY ADVANCE CARE PLAN
(Page 1 of 4)

If you have had a chance to think about the care you want towards the end of your life, you may want to write your thoughts down. Use this plan to write down what you want health professionals, friends and family/whānau to know if you could no longer tell them yourself.

There is a section on medical treatments which is important to discuss with your doctor if possible, before you complete it.

This plan is for you and about you. Complete as much as you want. You can show it to anyone involved in your healthcare. You can add to it as often as you like and change your decisions at any time. Please take it to your doctor or nurses to discuss it and then you can both have copies. It can be forwarded through your doctor to others who may need it, with your consent.
What does an ACP look like?

**MY ADVANCE CARE PLAN**

I have had the chance to think about the health care I want, including towards the end of my life, and this plan represents my wishes. I would like the health professionals caring for me, and my family/whānau and friends to know these things when I can no longer speak for myself. For further information, see [www.healthinfo.org.nz/39484.htm](http://www.healthinfo.org.nz/39484.htm).

I am aware that this plan must be made by me, not for me. I can change or cancel it at any time, and am aware that it needs to be kept up to date.

I am aware that Part B should be written in conjunction with a trusted health professional.

I understand that within the Canterbury Region this plan can be made available to all health professionals who are involved, or become involved, in my care.

**PART A**

- [ ] I have not appointed an Enduring Power of Attorney for personal care and welfare.
- [ ] My appointed Enduring Power of Attorney for personal care and welfare is:
  - First Name(s) __________________ Last Name __________________
  - Relationship __________________
  - Address __________________
  - Home Phone __________________ Daytime Phone ________ Mobile ________

- [ ] I would like the following people contacted by health professionals when decisions are made about my care / treatment. These people know me well and understand what is important to me:
  - First Name(s) __________________ Last Name __________________
  - Relationship __________________ Phone __________________
  - Address __________________
  - First Name(s) __________________ Last Name __________________
  - Relationship __________________ Phone __________________
  - Address __________________
  - First Name(s) __________________ Last Name __________________
  - Relationship __________________ Phone __________________
  - Address __________________

I have made a Will: [ ] Yes, [ ] No
**How do I know if a patient has an ACP?**

<table>
<thead>
<tr>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRP1660</strong></td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>Mobile</td>
</tr>
<tr>
<td>Address</td>
</tr>
</tbody>
</table>

**Patient Notes**

- No additional notes

**CCMS Collaborative Care**

- A Collaborative Care Record is available: [View]
- An Advance Care Plan is available: [View]
- No Acute Plan is available: [Create]

**Patient GP Information**

- No GP Information available

**National Medical Warnings**

NATIONAL Medical Warnings, may NOT include local information, please check your Local Patient Management Systems.

Unable to display NHI Medical Warnings for patient PRP1650. Failed to connect to the NHI database.
Who is ACP for?
Who is ACP for?

• ACP conversations are for everyone.

• How we initiate and explore an ACP conversations will be different depending on the situation (for example, someone who is well vs. someone facing inoperable cancer).
Triggers

• Someone asks you about ACP
• Someone has change in health status
• Someone asks you about Palliation
• Or they ask you about a reduction in the intensity of their treatment
Triggers

• You can answer “Yes” to these 4 questions?
  – Is the patient seriously ill?
  – Is the patient’s condition not improving?
  – Will the condition worsen?
  – Will the condition cause death?

• The Surprise Question:
  “Would I be surprised if this patient died in the next 12 months?”

• Consider the “trajectory” of their illness
Illness Trajectories

**Proposed Trajectories of Dying**

**Sudden Death**
- High Function
- Time
- Death

**Terminal Illness**
- High Function
- Time
- Death

**Organ Failure**
- High Function
- Time
- Death

**Frailty**
- High Function
- Time
- Death

*Figure 1.* Trajectories of dying. Reproduced with permission of Blackwell Publishing (Lunney JR, Lynne J, Hogan C. Profiles of older Medicare decedents. *JAGS.* 2002;50:1108-1112).
How to get started

Someone Well:

“I was wondering if you and your partner have had any conversations about what you’d want if there was a sudden health crisis or emergency...?”

Someone with a new diagnosis:

“I know you have a lot going on at the moment and your new diagnosis has probably made you think about and consider all sorts of possibilities for your future. I wonder if you might like to talk to me about what things are important to you?”
How to get started

Someone with Chronic Illness:

“Have you thought about what might happen if things don’t go so well during your next admission/treatment? How would you like us to care for you?”

Someone with an End Stage Condition:

“Now would be a good time for me to know more about what’s important to you about your treatment and care going forward…”
Tips

- Make sure patient is ready (their agenda not yours)
- Be prepared – have all the information you need
- Create the right environment
- Make sure the right people are there
- Avoid leaving the conversation until the need for decisions is urgent
- Don’t make assumptions based on culture, religion, age, gender, disability etc
- Use empathy and good communication skills
Where can I get more information about ACP?

www.advancecareplanning.org.nz
Level One ACP Training Package
www.advancecareplanning.org.nz

Resources
Here are some tools that you may find useful to help you have Advance Care Planning conversations with your patients.

Documents | eLearning | Useful Links
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1. Considering Advance Care Planning
   An interactive module which will guide you through the full Advance Care Planning process.
   Open Now

2. Talking about Advance Care Planning
   An interactive module which helps to prepare you for having Advance Care Planning conversations with your patients.
   Open Now

3. Changing Outcomes
   An interactive module which helps you understand how healthcare decisions are made when a patient can't speak for themselves.
   Open Now

4. Clarifying Advance Care Planning Process
   An interactive module which helps you clarify the policy and procedures for your organisation.
   Open Now

our voice to tātou reo Advance Care Planning
My Advance Care Plan

• Have you done your own Advance Care Plan?!
  – What is most important to me?
  – What are my greatest fears?
  – What choices would I make for myself?
CONVERSATIONS THAT COUNT DAY

16 APRIL IS CONVERSATIONS THAT COUNT AWARENESS DAY
ACP gives us the opportunity to:

Help people understand what the future might hold...

so **they** can be better prepared...

and **we** can be better informed to make decisions in their best interests
Questions?
Talking about sex won’t make you pregnant, and talking about death won’t make you dead.