

our voice  
tō tātou reo

Advance  
Care  
Planning

**ACP, ADs, DNR, Goals of  
Care, SICG, ...  
Making it all make sense**

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SICG national trainer



# Overview

- **Definitions of the various tools**
  - **The conversations**
  - **Legalities**
- **Touchpoints and integration of tools**
- **Documentation**



# Definition – Advance Care Planning

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

ACP gives people the opportunity to develop & 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)



# Definition – Advance Care PLAN

- **A record of the individual's values, beliefs, goals, preferences, fears, understanding of their current and likely future health**
- **It may include one or more Advance Directives**
- **There is a national document**



# ACP legal standing

- **The Code of Health and Disability Consumers' Rights (the Code) promotes patient choice and autonomy in planning and receiving health care.**
- **ACP is consistent with this approach and facilitates clinical decision making and the provision of health care services that respect the rights and preferences of individuals.**
- **The Code has legal status as a regulation made under the Health and Disability Commissioner Act.**

# Definition – Advance Directives

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

**A resuscitation decision made by the individual is an example of an AD**

**They cannot be made on behalf of another person.**

**Valid Advance Directives are legally binding.**

**Also may be known as a Living Will**



# Advance Directives - legalities

## Criteria for validity:

- Person must have been competent when AD created
- They must have been adequately informed
- They must have been free of undue influence
- It must have been intended to apply in the presenting circumstances

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



# Medical treatment decisions

**Decisions made by Physicians / Nurse Practitioners about medical treatments**

**Based on the patient's values, goals, preferences if known AND on what is medically appropriate**

- **Medical DNR order**
- **OtTeR form**
- **POLST form**
- **Ceiling of Care form**

**etc**





# Medical Treatment decisions - legalities

- **ALL medical decisions should take into account the person's preferences, values and so on.**
- **They should ALWAYS be in line with any valid Advance Directives the person may have made**

# Goals of Care

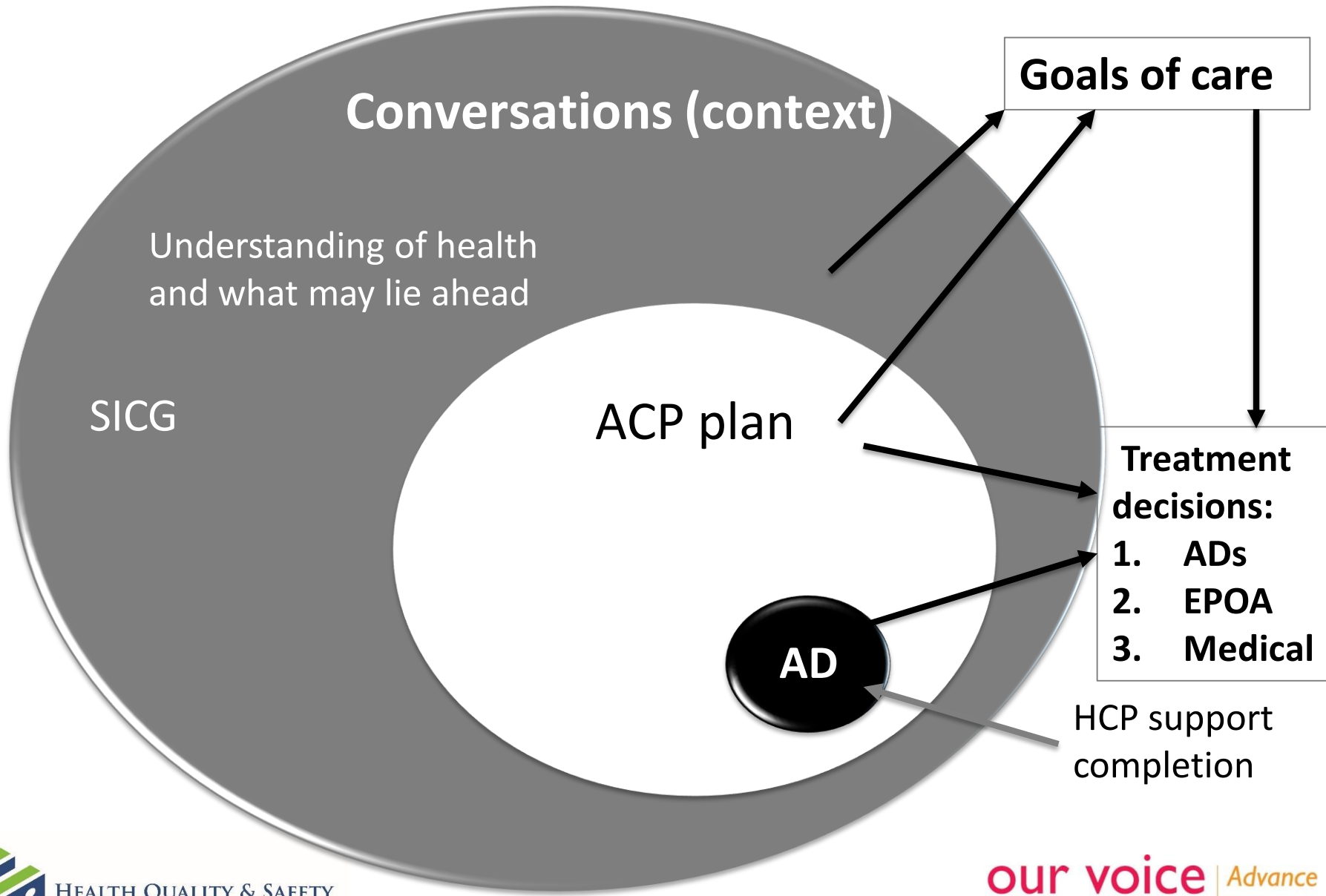
- Usually refers to the overall approach to care and treatment in specific circumstances
- Decided in collaboration with the healthcare team and patient/family and whānau based on:
  - Goals, values and preferences of the patient (ACP)
  - What is medically appropriate in presenting circumstance
- Treatment options are considered based on the overall goals of care
- Goals of care are documented in many different ways, on various different forms



# SERIOUS ILLNESS CONVERSATION GUIDE

- **A guide (or prompt sheet) to help clinicians navigate a conversation about goals and preferences in the context of serious illness**
  - **Set-up (why you're wanting to have the conversation)**
  - **Assess (understanding; how much detail they want)**
  - **Share (prognosis / what might be ahead for them)**
  - **Explore (priorities, fears, strengths, preferences if health declines, family awareness)**
  - **Close**





# Documentation

- Advance Care Plan



- Advance Directives (section 6)

The image is a screenshot of a digital form titled "6 My treatment and care choices". The form is displayed in a browser window. The text on the form includes: "This section is best completed with help from a doctor, nurse or specialist. There are medical procedures that keep you alive or delay death. These may include resuscitation (CPR), life support, getting food and drink through a tube and kidney dialysis. Sometimes treatments can be both helpful and harmful. They may keep you alive, but not conscious, or make you a bit better for a short time, but cause you pain. You need to decide if this is what you want. Your healthcare team will only offer treatments that you will benefit from, this includes the offer of CPR. Think about what is important to you. For example, quality of life (how good your life is) or quantity of life (how long your life is). Are there circumstances in which you would want to stop being kept alive and be made comfortable so you can have a natural death?" Below this text, there are several numbered options for the user to choose from, each with a "YES" or "NO" radio button. The options are: 1. "I would like my treatment to be aimed at keeping me alive as long as possible. I wish to receive all treatments that the healthcare team think are appropriate to my situation. The exceptions to this would be: If required and appropriate I would want CPR to be attempted. YES NO I will let my doctor decide at the time." 2. "I would like my treatment to focus on quality of life. If my health deteriorates I would like to be assessed and given any tests and treatments that may help me to recover and enjoy my quality of life, but I DO NOT WANT TO BE RESUSCITATED. For me, quality of life is: \_\_\_\_\_" 3. "I would like to receive only those treatments which look after my comfort and dignity rather than treatments which try to prolong my life. I DO NOT WANT TO BE RESUSCITATED." 4. "I cannot decide at this point. I would like the healthcare team caring for me to make decisions on my behalf at the time, taking into account what matters to me and in close consultation with the people I have listed in Section 4." 5. "None of these represent my wishes. What I want is recorded in my Advance Directive on page 11." At the bottom of the form, there is a field labeled "I choose Option Number:" with a dropdown menu.

- Ensure document is easily retrievable when it is needed



# Documentation cont.

- **Serious Illness Conversation Guide (SICG)**
  - No formalised documentation yet – may be developed nationally
  - Consider typing up the discussion using the SICG framework, for clinical record and patient?
  - Consider supporting patient to enter relevant aspects into the ACP
  - Consider supporting patient to document ADs based on the conversation



# Goals of care and medical decisions

- **Document the conversation!**
- **Forms and documentation requirements will differ between organisations – follow your organisational policies and procedures**
- **Make sure it is visible / easily retrievable!**
- **Ensure ACP / ADs are kept with such decisions**
  
- **Consider influencing decisions about national / regional consistency with documentation**



# Where can we all go for more information?

**HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND**  
*Kupu Taurangi Hauora o Aotearoa*

Rapu / Search

Hōtaka akoranga  
Our programmes

Pito kōrero me ngā pānui  
News & events

Putanga me ngā rauemi  
Publications & resources

Rangitaki  
Blog

Mō mātou  
About us

Whakapā mai  
Contact us

Home > Our programmes > Advance Care Planning

## Te whakamahere tiaki i mua i te wā taumaha Advance Care Planning

What is advance care planning?  
Start an advance care plan  
What tools can help me?  
Some ACP stories  
About us  
Questions and answers  
News & events  
Publications & resources

**Health care staff**  
Information for health care staff  
Advance Care Planning Day  
DHB Implementation Guide

Advance care planning (ACP) is the process of thinking about, talking about and planning for future health care and end-of-life care. It is about identifying what matters to you.

**our voice to tatou reo** Advance Care Planning

**What is ACP?**

**Start an advance care plan**

**What tools can help me?**

[www.myacp.org.nz](http://www.myacp.org.nz)



# Level One ACP Training Package

[www.myacp.org.nz](http://www.myacp.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



### 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](#)

# Face to face national training

- **ACP L1A one day workshop**
- **SICG 3-hour training**
- **Train-the-trainer opportunities for both**



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!



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