our voice
tō tātou reo

Advance Care Planning

ACP, ADs, DNR, Goals of Care, SICG, …

Making it all make sense

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ACP Facilitator, national trainer

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.**

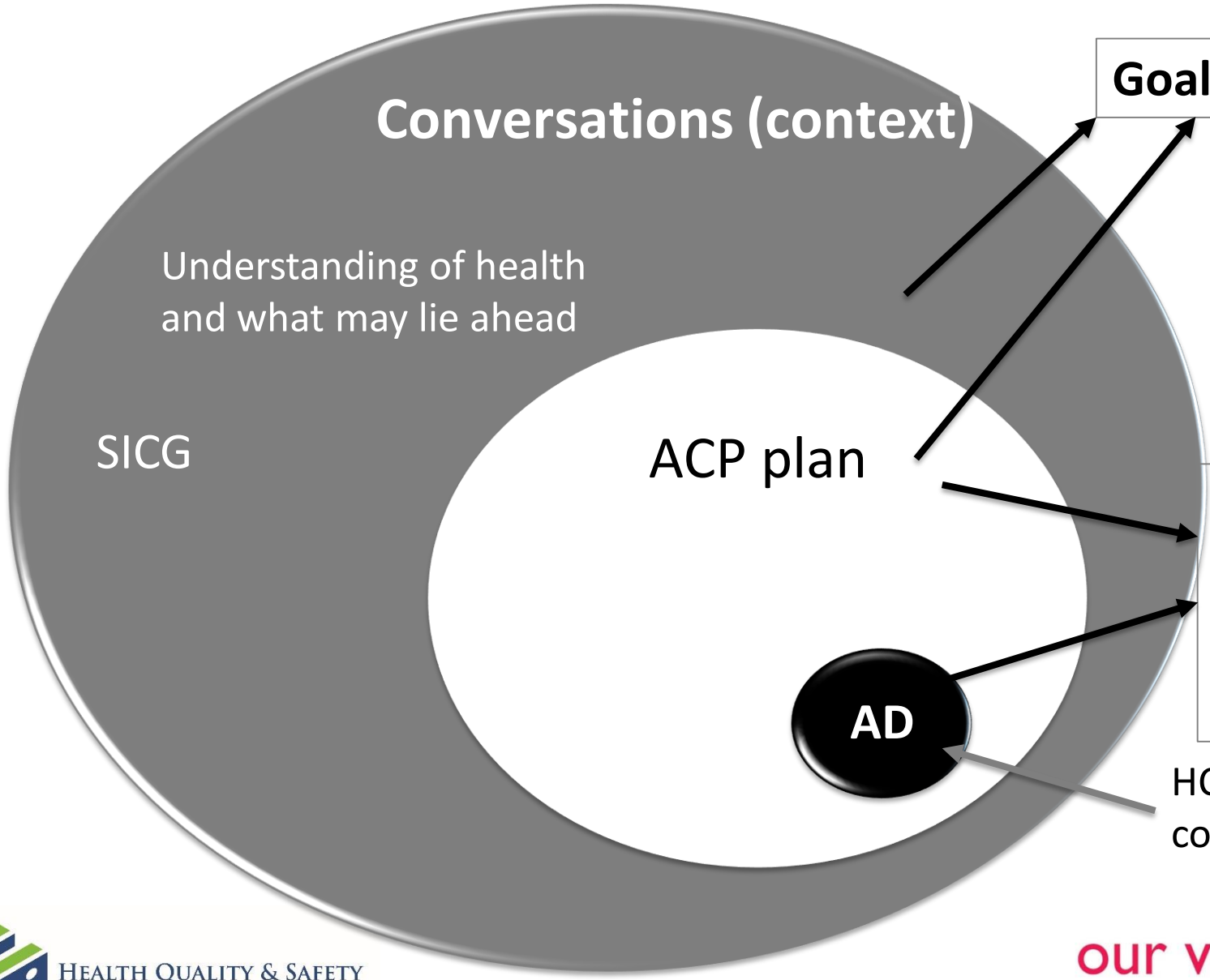
- **They should ALWAYS be in line with any valid Advance Directives the person may have made**

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

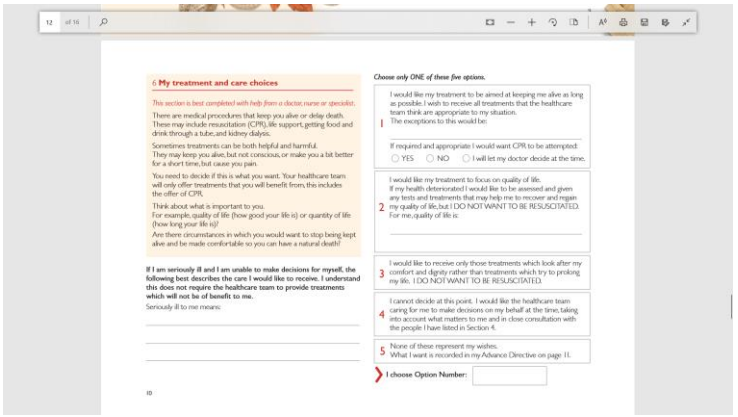
- **A guide (or prompt sheet) to help clinicians navigate a conversation about goals and preferences in the context of serious illness**
  - **Set-up (why you're wanting to have the conversation)**
  - **Assess (understanding; how much detail they want)**
  - **Share (prognosis / what might be ahead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


Conversations (context)
Understanding of health and what may lie ahead
SICG
ACP plan
AD
Goals of care
Treatment decisions:
1. ADs
2. EPOA
3. Medical
HCP support completion

Documentation

- **Advance Care Plan**

- **Advance Directives (section 6)**



- **Ensure document is easily retrievable when it is needed**

Documentation cont.

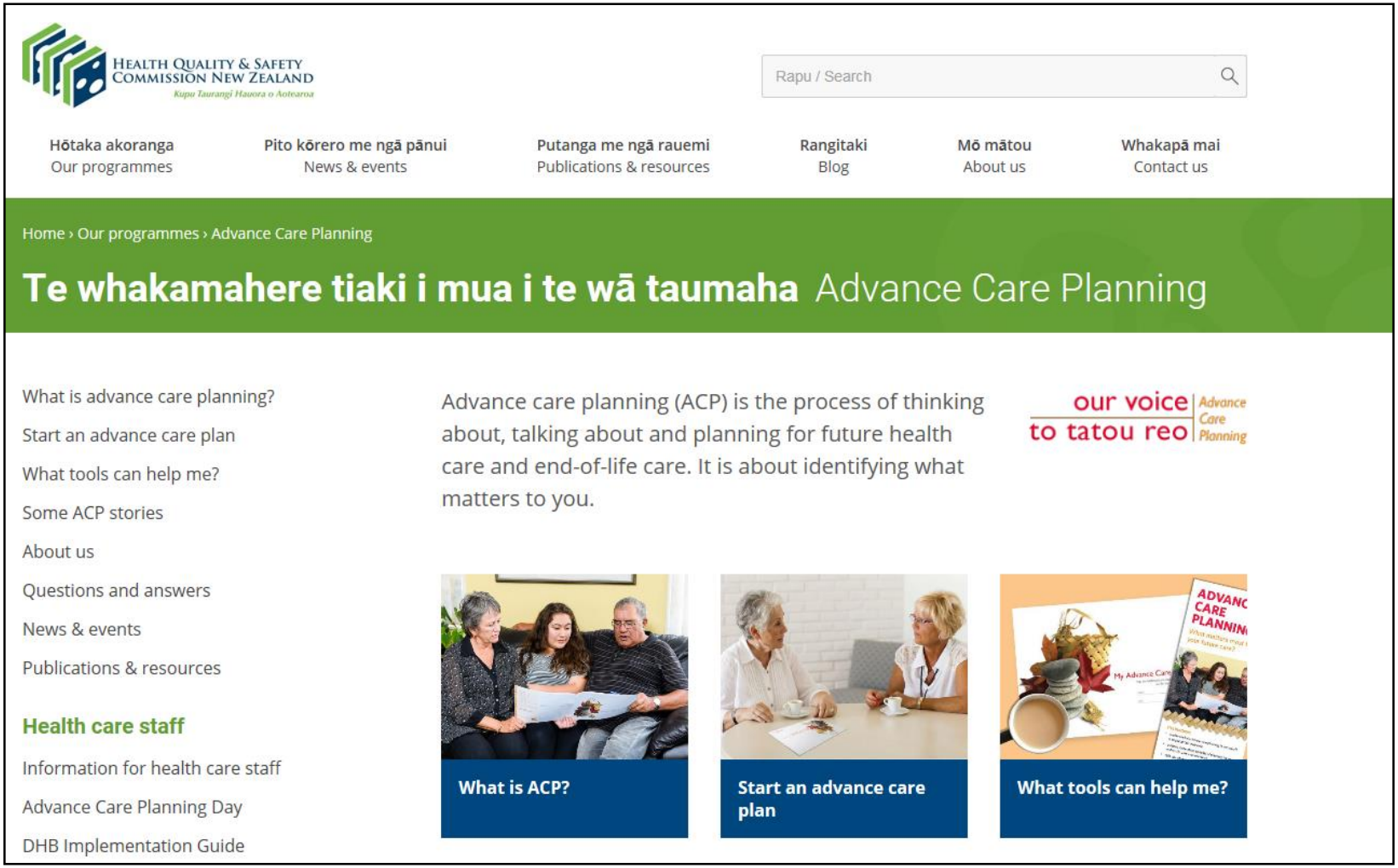
- **Serious Illness Conversation Guide (SICG)**
  - **No formalised documentation yet – may be developed nationally**
  - **Consider typing up the discussion using the SICG framework, for clinical record and patient?**
  - **Consider supporting patient to enter relevant aspects into the ACP**
  - **Consider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



www.myacp.org.nz

Level One ACP Training Package

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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