

Advance Care Planning (ACP)

ACP Everybody
for ME

Advance Care Planning Conversations and Documentations

Values, Strength and Contentment

[These are important for me; that give my life meaning]

[At this stage of my life, these give me strength]

[These are situations that make me happy and content]

Preferences and Wishes

[These are worries that I concern me now]

[These are situations which I would want to avoid, if possible]

[This is why I'm writing this down]

Name of Patient
 ACP details available at
 Please Contact / Call
 Date of ACP

Name of Patient
 ACP details available at
 Please Contact / Call
 Date of ACP

I HAVE CHANGED MY MIND ? DATE:

I HAVE CHANGED MY MIND ? DATE:

DIRECTIONS ON ACP-POLST USE FOR CAREGIVERS / FAMILY MEMBERS / NEXT-OF-KIN	
<p>Keeping this ACP-POLST document</p> <ul style="list-style-type: none"> This POLST document is to be kept with the patient. Copies may be kept with medical records. Kindly ensure that this POLST document is always kept together with any medical notes or records that would normally accompany the patient, if they were to seek medical attention Keeping the ACP Card may assist in reminding all concerned about the availability of the ACP-POLST document. <p>Showing the ACP-POLST document</p> <ul style="list-style-type: none"> The POLST document must be shown to healthcare providers (paramedics, nurses, doctors, health aides) in order for the instructions to be carried out. However, treating doctors may determine that significant changes have occurred to the underlying circumstances to warrant renewed discussion with family members or next of kin. 	<p>Reviewing POLST</p> <ul style="list-style-type: none"> This POLST should be reviewed periodically <ul style="list-style-type: none"> when transferred to different care setting when there is substantial change in health status when patient treatment preferences change <p>Voiding POLST</p> <ul style="list-style-type: none"> A patient with capacity can, at any time, revoke POLST by any means that indicates intent to revoke. It is recommended to draw a line across all sections, writing VOID in large letters, signing and dating the VOID section. Any modifications require a new POLST. A surrogate decision-maker may request to modify the POLST based on known desires of the patient, or in the patient's best interests. POLST requests are persuasive in nature, but are not binding to healthcare providers.
ADVISORY FOR CAREGIVERS / FAMILY MEMBERS / NEXT-OF-KIN	
<p>When there is a significant deterioration of health status</p> <ul style="list-style-type: none"> This is time to communicate and express This is an appropriate time to update loved ones and reaffirm any care plans already made It is time to further any additional plans already discussed with healthcare providers or caregivers <p>Attend to Needs of the Patient, and Caregivers as well</p> <ul style="list-style-type: none"> The patient may have some increased needs that need attending to, which may require additional time and effort. It is important to recognise that caregivers will also have some needs; both physical, psychological or otherwise. 	<p>If the final hours are planned to be spent at home,</p> <ul style="list-style-type: none"> Preparations should be made in advance to avoid delays <ul style="list-style-type: none"> Recent letter from treating physician with terminal diagnosis and stated plan for home care <p>Procedures after a person as passed away at home</p> <ul style="list-style-type: none"> Take time to ... Prepare ... Inform ... Police ... Inappropriate to call the ambulance services or 999 to confirm that someone has passed away at home.
ADDITIONAL INFORMATION	
<p>Instructions</p> <ul style="list-style-type: none"> Subtext 	<p>Information</p> <ul style="list-style-type: none"> Additional

ADVANCE CARE PLAN (ACP)

Date	Patient's Full Name	MRN Number	NRI/C Number	Contact Details
Time	Mental Capacity of Patient <input type="checkbox"/> Fully Conscious, Alert, Understands, Communicates Fully <input type="checkbox"/> Anything other than the above	If Mental Capacity of Patient is not full capacity, family member / surrogate decision maker involved is (name / contact)		
Patient's Relevant Medical Information				
Doctor's comments (with Full Name and Signature at the End)				

PREFERENCES FOR LIFE SUSTAINING TREATMENTS (POLST)

This POLST form is filled by _____ [name of physician] being the treating physician for, and in accordance to the wishes of _____ [name of patient] following discussions agreed, in the presence of _____ [name of surrogate, next of kin, family] Dated _____ [Today's Date]

A	CARDIO-PULMONARY RESUSCITATION (CPR) - when the patient has no pulse, and is not breathing. (If otherwise, follow orders in B & C)
Check One	<input type="checkbox"/> CPR acceptable (Selecting this option requires the selection of Full Treatment in Section B) <input type="checkbox"/> CPR not acceptable (Selecting this option allows natural death that usually follows)

B	MEDICAL INTERVENTIONS - when the patient is found with a pulse and/or is breathing
Check One	<input type="checkbox"/> Full Treatment - primary goal of prolonging life by all medically effective means <i>In addition to treatment already described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation and cardioversion if indicated</i> <input type="checkbox"/> Trial of Full Treatment
	<input type="checkbox"/> Selective Treatment - goal of treating medical conditions while avoiding burdensome measures <i>In addition to treatment already described in Comfort Focused Treatment, non-interventional medical treatment as indicated. Do not intubate. May use non-invasive ventilation, generally avoiding ICU care.</i> <input type="checkbox"/> Transfer to Hospital only if comfort needs cannot be met in patient's current location
	<input type="checkbox"/> Comfort-Focused Treatment - primary goal of maximizing comfort <i>Relieve pain and suffering with medication by any route as needed, use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatment listed in Full and Selective Treatment, unless consistent with comfort goals</i> <input type="checkbox"/> Transfer to Hospice / Home if comfort needs can be met in those locations

CONTINUED NEXT PAGE

	Medical Interventions that would be considered <u>unacceptable</u> (eg tube feeding, dialysis etc)		
Outcome Hospitalization Interventions Location of Care Symptom Relief Nursing Care Others Others	PREFERRED PLAN OF CARE (condition-specific planned limits to medical interventions, as discussed and agreed with treating physicians) - <i>Signed and Stamped by Treating Physician at the End</i> -		
Prognosis Informing others Ambulance Home prep Hospitalization ? Prefer location Symptom Relief Care by ? Others Others	If significant changes in medical status occurs, these plans as stated shall apply (discussed with treating and palliative physicians) - <i>Signed and Stamped by Physician at the End</i> -		
X To VOID	VOID or CHANGE OF MIND - Please check / mark to indicate change of mind or void this copy of the POLST form.		
	Discussed with (check at least one) Name <input type="checkbox"/> Patient <input type="checkbox"/> Surrogate / Next of Kin / Family Member / Loved one <input type="checkbox"/> Healthcare Provider	Contact Details	Date (Mandatory)

Photocopies and faxes of signed POLST forms are valid. Healthcare providers may make copies for records.

DIRECTIONS FOR HEALTHCARE PROFESSIONALS	
<p>Completing ACP - POLST</p> <ul style="list-style-type: none"> This is generally meant for those with illness or frailty. Completing the POLST form is always voluntary. The POLST must be completed by a physician based on the medical condition and patient's preferences. POLST must be signed to be valid. <p>Using POLST</p> <ul style="list-style-type: none"> A POLST can be regarded as a professional communication of the patient's wishes from a fellow healthcare provider to another. Although not legally binding, most consider an ACP legally persuasive. As long as mental capacity is not in question, the most recent POLST replaces all previous orders. In situations where the POLST itself is incomplete or vague, some guidance may come from surrogate decision makers, family members or portions of the ACP which communicate the intentions of the patient. 	<p>Reviewing POLST</p> <ul style="list-style-type: none"> This POLST should be reviewed periodically <ul style="list-style-type: none"> when transferred to different care setting when there is substantial change in health status when patient treatment preferences change <p>Voiding POLST</p> <ul style="list-style-type: none"> A patient with capacity can, at any time, revoke POLST by any means that indicates intent to revoke. It is recommended to draw a line across all sections, writing VOID in large letters, signing and dating the VOID section. Any modifications require a new POLST. A surrogate decision-maker may request to modify the POLST based on known desires of the patient, or in the patient's best interests. ACP-POLST documents that are voided should be informed to healthcare providers, so that medical records that keep voided copies can be updated as void, and any new ACP-POLST documents are updated and kept.
FORM IS KEPT WITH PATIENT - SEND COPIES WHENEVER TRANSFERRED OR DISCHARGED	

Table 7.1: Practical approach on how to conduct ACP discussion in patients with chronic illness

Approach	Example of key Phrases and issues to discuss
<p>Step 1:</p> <p>Introducing ACP and assessing readiness for discussion</p> <p>(This should be done after a conversation on the disease process and possible prognosis)</p>	<ul style="list-style-type: none"> ● “Given our earlier discussion, I wonder if you have any concerns, especially about your future care?” ● “Some patients find it useful to have a discussion about how they would want to be cared for in the future in case there is a time when they become too unwell to speak. Do you think you would find something like that useful?”
<p>Step 2:</p> <p>Assess values, strength and contentment</p> <p>(This allows decision makers to understand a person’s possible choices better)</p>	<ul style="list-style-type: none"> ● “Perhaps we can start by just thinking about what gives you meaning in life?” ● Prompt person to think of a) relationships b) meaningful activities c) religion/beliefs d) past memories ● “Think of a time in your life when you were down or having a lot of difficulties, what gave you strength to go on at that time?”
<p>Step 3:</p> <p>Assess preferences and wishes</p> <p>(Ask about 1. Worries and concerns 2. Situations to avoid)</p>	<ul style="list-style-type: none"> ● “Given the fact that you have such an illness, are there any fears or worries you have in particular?” ● “What do you feel is most important to you at this point in your life?” ● Prompt person to consider: a) symptoms and comfort issues b) important events c) social/financial concerns d) family issues ● “In terms of your future care, if at some point you were very unwell to a point you were unconscious, are there any situations or particular procedures you would want to avoid?” ● Prompt with examples: Tube feeding, dialysis, invasive ventilation etc ● In general, this section could be filled up by the patient themselves once they understand what to reflect upon as it may be quite personal in nature.
<p>Step 4:</p> <p>Discuss preferences for life sustaining treatments in acute medical events. (POLST)</p> <p>Part A & B (this follows further from discussion about situations to avoid)</p>	<ul style="list-style-type: none"> ● “So, if your illness were to get worse to a point where your heart became so weak to a point where it stopped beating, would you want doctors to attempt resuscitation/CPR?” ● “If you were to become more unwell to a point where you were unconscious and you are brought to hospital, would you want the doctors to do everything they can to make you survive even if your quality of life may be poor?” ● If a person does not want full treatment then explore if they are open to selective treatments with examples of IV antibiotics, IV fluids, non-invasive ventilation etc. (as you describe examples,

	<p>if patient says no this can be recorded as unacceptable interventions.</p> <ul style="list-style-type: none"> ● If a person says they want comfort measures only, then confirm that they would want minimum interventions including reducing injections and blood taking and only accept measures that provide comfort. ● Finally, “are there any other interventions that you would consider unacceptable if you were very sick to a point where you could not speak” (generally if a person is unsure if they would find an intervention unacceptable you should not document it as such.
<p>Step 5:</p> <ul style="list-style-type: none"> ● Preferred plan of care 	<ul style="list-style-type: none"> ● This section is meant to address care plans for the individual patient based on the unique circumstances of their health condition e.g. Discussion on ICD deactivation in cardiac disease or PEG feeding in motor neuron disease etc. ● Basically, this section outlines some broad goals of care and requires the clinician to discuss relevant issues that are commonly anticipated in a particular disease process. ● Towards the end of this discussion would be to explicitly ask about preferred place of care and possibly death if very ill eg. “If you were very ill and unconscious with slim chances of recovery, where would you prefer to be cared for? At home, hospital or nursing home ● “And if you were facing your last moments of life, where would you prefer to be as you pass on?”
<p>Step 6:</p> <p>Naming a surrogate decision maker</p>	<ul style="list-style-type: none"> ● “While we have discussed quite a bit about your preferences, it is impossible to discuss every possibility that may occur in the future so it may be necessary for your doctors to still discuss your health matters with a family member or a close friend of yours who is able to speak on your behalf in case you are unable to do so yourself. Can you think of who you would like to be that person to speak on your behalf?” ● “And in case this person is unable to be reached at the time, can you think of a second person you would like to nominate to speak on your behalf?”
<p>Step 7:</p> <p>Wrapping up</p>	<ul style="list-style-type: none"> ● “So, I have recorded our discussion here so that you can also let your family know about this and remember that this is merely a conversation about how you feel and it is not something that MUST be followed at all times. People change their minds all the time and situations are never exactly as we imagine it. What is important is that we have had this conversation and you have an idea now of how you feel.”