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ADVANCED CARE PLANNING

- **Advanced Care Planning** is a process that gives you the opportunity to plan for health care preferences with the older person, their family/whanau and the health care team. It is a way to ensure that the wishes of the older person and their family/whanau have been thoroughly articulated and are part of the care plan.
- **It is an ongoing process that should be discussed and updated on a regular basis.** It does not have to be a legalised formal process, but rather part of the care. Review should be carried out any time there is a change in the resident's status or at least annually.
- **All discussions and decisions must be documented** including the date, all personnel involved in the discussion and their status/role.

LET ME DECIDE TOOL
For ADVANCED CARE PLANNING

INITIATE THE ADVANCED CARE PLANNING DISCUSSION

Initiate the discussion about care preferences at the time of admission.

Find out and follow your facility's protocol for these discussions.

Special considerations for residents no longer able to make their wishes known:

- Is there a designated **EPOA for Personal Care and Welfare** (see pg 4 for more information)?
- Is there a copy of the EPOA document (check signature, date etc.)?
- Has the EPOA been activated?
- EPOA cannot make decisions regarding end of life and can only provide guidance regarding what the resident's wishes were. End of life treatment is ultimately a medical decision.
- Document who the EPOA is in the Advanced Care Planning documentation

Is there an existing Advanced Care Plan? Discuss if all aspects are still valid and place it in the resident's chart.

MAKE SURE THAT WISHES ARE CLEARLY ARTICULATED & DOCUMENTED

Avoid using terms such as "no heroic measures" but instead help older persons and their family/whanau to articulate with clarity care wishes, particularly regarding CPR, feeding and treatment.

UNDER WHAT CONDITIONS WOULD THE ADVANCED CARE PLAN BE ACTIVATED?

DOCUMENT CPR STATUS

Discuss with the person and/or their family/whanau the following:

CPR – Use cardiac massage with mouth to mouth breathing; may also include intravenous lines, electric shocks to the heart (defibrillators), tubes in the throat to lungs (endotracheal tubes)

OR

NO **CPR** – Make no attempt to resuscitate.
Allow natural death and do not prolong the dying phase.

FEEDING – DISCUSS THE FOLLOWING OPTIONS

Basic: spoon-fed with regular diet. Give all fluids by mouth that can be tolerated but make no attempt to feed by special diets, intravenous fluids or tubes.

Supplemental: give supplements or special diets e.g. high calorie, fat or protein supplements.

Intravenous: give nutrients e.g. water, salt, carbohydrates, protein and fat by intravenous infusions.

Nasogastric tube – a soft plastic tube passed through the nose or mouth into the stomach.
Gastrostomy tube – (known also as PEG tube: percutaneous endoscopic gastrostomy tube) a soft plastic tube passed directly into the stomach through the skin over the abdomen.

GO TO LEVEL OF CARE DISCUSSION NEXT PAGE

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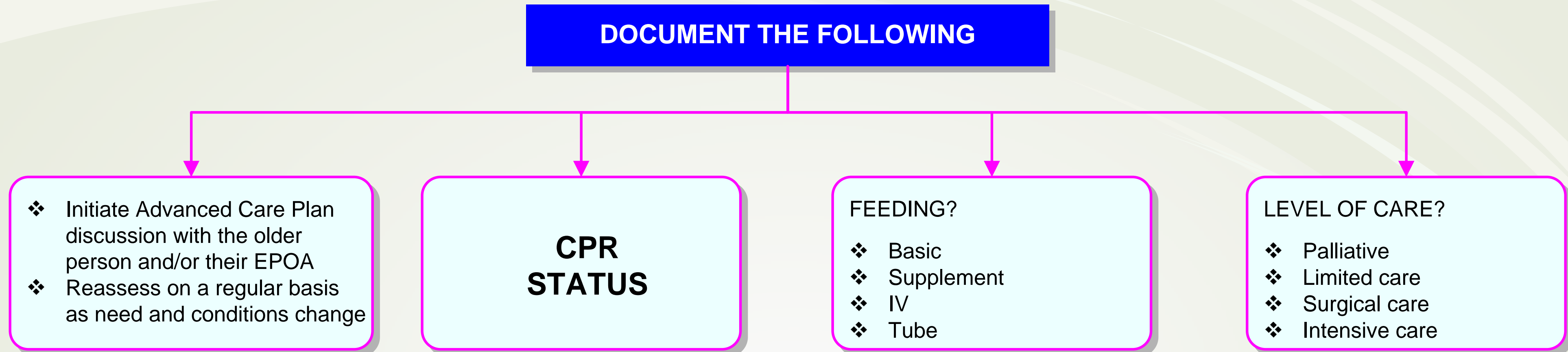
ADVANCED CARE PLANNING DISCUSSION

Assist the older person and/or their designated EPOA for Personal Care and Welfare to decide what level of care would preserve their quality of life and dignity.



Level of Care Definitions

PALLIATIVE CARE:

- Keep me warm, dry and pain free.
- Do not transfer to hospital unless absolutely necessary.
- Only give measures that enhance comfort or minimise pain e.g. morphine for pain.
- Subcutaneous line started only if it improves comfort e.g. for dehydration.
- No x-rays, blood tests or antibiotics unless they are given to improve comfort.

SURGICAL CARE (Includes Limited):

- Transfer to acute care hospital (where patient may be evaluated).
- Emergency surgery if necessary.
- Do not admit to Intensive Care Unit.
- Do not ventilate (except during and after surgery e.g. tube down throat and connected with machine).

LIMITED CARE (includes Palliative):

- May or may not transfer to hospital.
- Intravenous therapy may be appropriate.
- Antibiotics should be used sparingly.
- A trial of appropriate drugs may be used.
- No invasive procedures e.g. surgery.
- Do not transfer to Intensive Care Unit.

INTENSIVE CARE (includes Surgical):

- Transfer to acute care hospital without hesitation.
- Admit to Intensive Care Unit if necessary.
- Ventilate me if necessary.
- Insert central line e.g. main arteries for fluids when other veins collapse.
- Provide surgery, biopsies, all life support systems and transplant surgery.
- Do everything possible to maintain life.

All discussions and decisions must be documented including the date, all personnel involved in the discussion and their status/role