ADVANCE CARE PLANNING CONVERSATIONS – PROMPT SHEET

INTRODUCTION

Please remember that the conversation is the focus, not the filling out of the ACP document. The following prompts are designed to help ensure you offer opportunity to discuss all relevant topics; however you do not have to include everything in every conversation – each person will have different things they want to talk about. Be led by the resident's cues as much as possible. Please also refer to MODULE FIVE of the ACP Learning Resource as this also has useful information about what to include in the conversation.

1. EPOA details

CHECK all contact details and sight document if possible (tick box). If there is no EPOA then do not complete EPOA details. For the non-competent resident, if the information was collected from someone other than the EPOA then complete the relevant details.

2. What is important to you (or him/her?)

- Do you have any hopes? Dreams?
- Goals?
- What lifts your spirits?
- What makes life enjoyable/meaningful for you?
- What or whom do you hold dear?
- Do you have a religion or spiritual practices that are important to you?

3. If I am unable to communicate I would like my family to know the following

- Anything left unsaid to share with family?

4. When I am dying the following is important to me (to him/her)

- Place of death
- People you want present?
- Minister? Religious practices?
- Fears? Concerns?
- Past experiences of someone dying? (from their cues)
- Offer conversation about what to expect?

5. After death (how much this is discussed with depend on the person – be led by cues)

- Burial or cremation?
- Funeral?
- Funeral Directors?
- Special clothes you would like to be dressed in?
- Specific cultural practices that we may not be aware of?
- Family expectations? Do they know their preferences?

6. Other things

- Particular situations/circumstances that you would find unacceptable?
- Past experiences (e.g. distressing hospital experience, witnessing a traumatic death of a relative) if relevant

- Past grief experiences, if relevant
- Family tensions/conflict? (led by cues)

7. Specific Treatments

In order to complete this you will need to have an understanding of the person's health situation and the options available to them. You may need the input of the GP or NP – this can be arranged at a different time after the main conversation, if necessary. Different health/illness situations will require different information and will impact on the conversation.

Here are some general things to consider:

- If they become seriously ill what would their MAIN PRIORITY be?
  Let them tell you e.g. Recovery?
  Comfort?
  To be allowed to die?
  To remain in facility?
  To have family present? etc
- EXPLORE the above
- CLARIFY that they understand the implications
- CLARIFY the CIRCUMSTANCES they mean their preferences to apply
- SUMMARISE YOUR UNDERSTANDING ⇨ *'Have I got that right?'*
- START with OVERALL PRIORITIES for care and treatment THEN
- if appropriate, talk about SPECIFICS (e.g. infection, bleed) related to THEIR situation
- INFECTION: Avoid asking 'would you want antibiotics?' Refer to their OVERALL PRIORITIES and CLARIFY. E.g. *'from what you've said, am I right in thinking that if you got a (life-threatening) infection…?'*
- RESUSCITATION:
  - Have they discussed this previously?
  - Have they made a previous decision about this?
  - Have their preferences changed?

If you do not know enough about the medical issues or treatment options that might be available to them, involve GP or NP.

On the next page are some examples of how to write SPECIFIC TREATMENT AND CARE PREFERENCES.

If there are no specific preferences you do not have to complete this.

Use the resident's words if they make clinical sense; however you may need to interpret their words to make the directions meaningful to clinicians.

ADVANCE CARE PLANNING CONVERSATIONS – PROMPT SHEET

EXAMPLE SPECIFIC TREATMENT AND CARE PREFERENCES (IF ANY):

1. *This is someone who has an advancing malignancy who is expected to lose ability to speak and to swallow, and who has a fear of not being given food and fluid if he wants it.*

I WOULD / WOULD NOT WANT	IN THESE CIRCUMSTANCES
I WOULD want treatment for reversible conditions, for example antibiotics for an infection	If I have quality of life, or this is anticipated to return. Quality of life for me is being able to communicate, and to recognise my wife.
I would NOT want any treatment aimed at preserving or prolonging my life	If I no longer have quality of life (as defined above) and this is not expected to return.
I would NOT want any form of artificial fluids or nutrition	If I am no longer able to eat and drink by mouth and this is not reversible
I WOULD want to continue to be regularly offered food and fluids by mouth until I die	In all circumstances, including if there is a risk of choking or aspirating, in which case I accept the risk of developing a life threatening chest infection or of asphyxiating

2. *This is someone with end stage COPD with severe dyspnoea and anxiety who wants to die at the earliest possible opportunity and who fears dying gasping for breath – end of life sedation has been discussed with him.*

I WOULD / WOULD NOT WANT	IN THESE CIRCUMSTANCES
I would NOT want any interventions that will prolong or preserve my life, for example antibiotics for a chest infection	Under any circumstances, including if I am likely to die without treatment
I WOULD want medication and other interventions to treat pain and other symptoms, as a priority.	At all times as long as those treatments will not prolong or preserve my life, and even if those treatments may hasten my death
I WOULD want to be sedated to the point of being completely relaxed, and unconscious if necessary, at the end of my life	If my breathlessness, anxiety, pain or other symptoms cannot be successfully treated with other measures within 24 hours, even if this means my death may be hastened
I would NOT want artificial fluids or nutrition	Under any circumstances
I would NOT want to be transferred to hospital	For any reason – please give treatment here in the facility, including sedation if necessary

This document has been adapted from a document developed by Nelson Tasman Hospice.