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**ACP2026**

# Participants Guidelines for Zoom Webinar

- No screenshots, pictures or recordings are to be taken during the session without the permission of the speaker.

- If you face any technical issues, please use the Chat function to communicate with the admin team.

# **Advance Care Planning (ACP):**
# A Communication Tool for Delivering Care Aligned with Patients' Values

1 September 2026, 2 – 3pm

# Programme Outline

| Segment | Duration |
|---|---|
| Introduction and Updates on ACP Landscape | 20 mins |
| Eliciting Patients' Values through ACP | 20 mins |
| Q&A Session with Panelists | 20 mins |
| **Total** | 60 mins |

# Opening Address

# Ms Wong Wai Min

## Designation

- Deputy Director, End of Life Support, Sector Planning Division, Agency for Integrated Care

# Introduction and Updates on ACP Landscape

# What is Advance Care Planning?

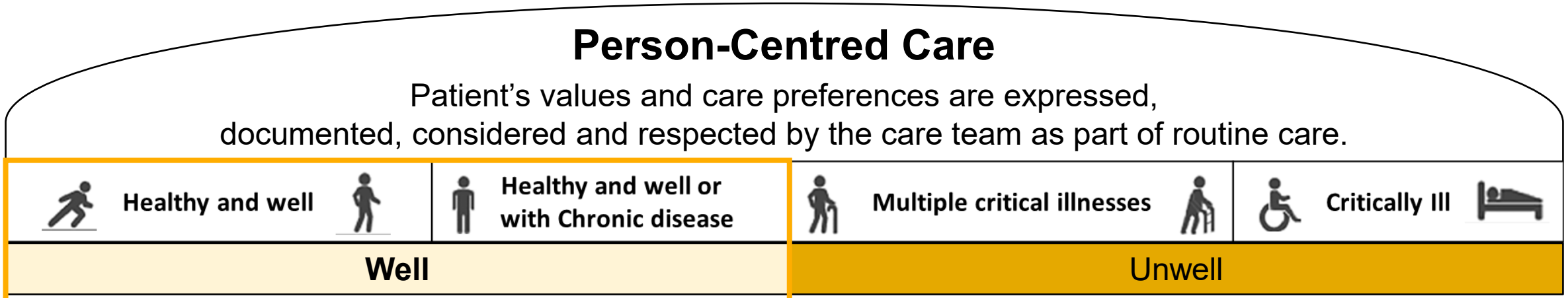
**Advance Care Planning (ACP)** is an **ongoing process** of planning and preparing for future health and personal care.

1. Includes conversations that communicate the patient's
   - Personal beliefs
   - Values
   - Healthcare preferences

   to people important to them, as well as to their healthcare team.

2. If the patient loses the capacity to make decisions or speak for themselves, the ACP will help the Nominated Healthcare Spokesperson(s) (NHS) and healthcare team to act in their **best interests** and with relation to their prior expressed wishes.

# Advance Care Planning allows individuals' values and care preferences to be documented to inform the care team of the care they wish to receive.

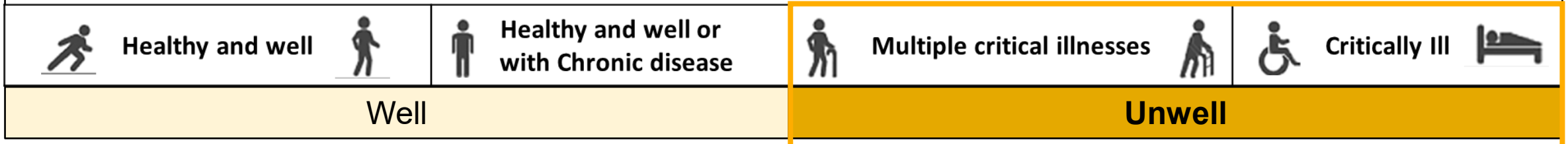



The **General ACP** is a tool for healthcare professionals and facilitators to **engage in early conversations** with the well population about their values and care preferences as part of person-centred care.

# Advance Care Planning allows individuals' values and care preferences to be documented to inform the care team of the care they wish to receive.

## Person-Centred Care

Patient's values and care preferences are expressed, documented, considered and respected by the care team as part of routine care.




The **Preferred Plan of Care (PPC)** expands on General ACP conversations for individuals with **progressive life-limiting illness, suffering frequent complications** to communicate care goals. It also enables Nominated Healthcare Spokesperson (NHS) to speak on behalf of the patient.

# Advance Care Planning in Practice: A Case Study of Mdm Tan*

## *We did every thing, but did we do the right things?*

**Any resemblance to actual events or persons, living or dead, is purely coincidental.*

**Mdm Tan**
**74yo**

- Diagnosed with Alzheimer's disease 7 years ago; has diabetes
- Values quality of life over length, tells second daughter she wants to be surrounded by family at home her time comes
- Chairbound


- Poor intake, more lethargic and drowsy, becomes increasing dependent and difficult to rouse
- One morning, daughter notices Mdm Tan to be feverish, breathing rapidly and unresponsive

- Daughter calls 995
- Brought to ED, assessed to have sepsis
- No prior knowledge of values/wishes, IV antibiotics and fluid resuscitation initiated
- Admitted into hospital
- Mdm Tan visibly distressed
- SPO2 drops, medical team considers transfer to high dependency ward

Daughter

I know mum would not want this, but I'm the only one she told…

Son

"Everything must be done."

Transferred to high dependency ward and eventually passes on there

Mdm Tan

No concordance with wishes/ care goals

Daughter

Sorry mum, I feel like I failed you…

Son

Mum, did I make you suffer more?

# Advance Care Planning in Practice: A Case Study of Mdm Tan*

***We might not have done every thing, but we did the right things.***

**Any resemblance to actual events or persons, living or dead, is purely coincidental.*

**Mdm Tan**
**74yo**

- Diagnosed with Alzheimer's disease 7 years ago; has diabetes
- Values quality of life over length, tells second daughter she wants to be surrounded by family at home her time comes
- Chairbound

- Dr initiates ACP at point of diagnosis as part of care pathway
- Mdm Tan shares her values and wishes with children present
- Referred to home care services


- Poor intake, more lethargic and drowsy, becomes increasing dependent and difficult to rouse
- One morning, daughter notices Mdm Tan to be feverish, breathing rapidly and unresponsive

- Daughter calls home care service provider
- Medical team is aware of comfort-focused goals of care
- Oral antibiotics for symptom relief; anticipatory medications prescribed for management at home

Daughter

I'm glad I don't have to deal with the stress of going to the hospital.

Son

I'm sad, but I think this is for the better.

Continues to be managed at home, and eventually passes on at home, surrounded by loved ones

Mdm Tan

Passed on at home in concordance with wishes

Daughter

We are glad that we got to fulfil your wishes to pass on at home, the way you said you wanted.

Son

# A framework that would help guide how we may practice and integrate ACP in our daily work.

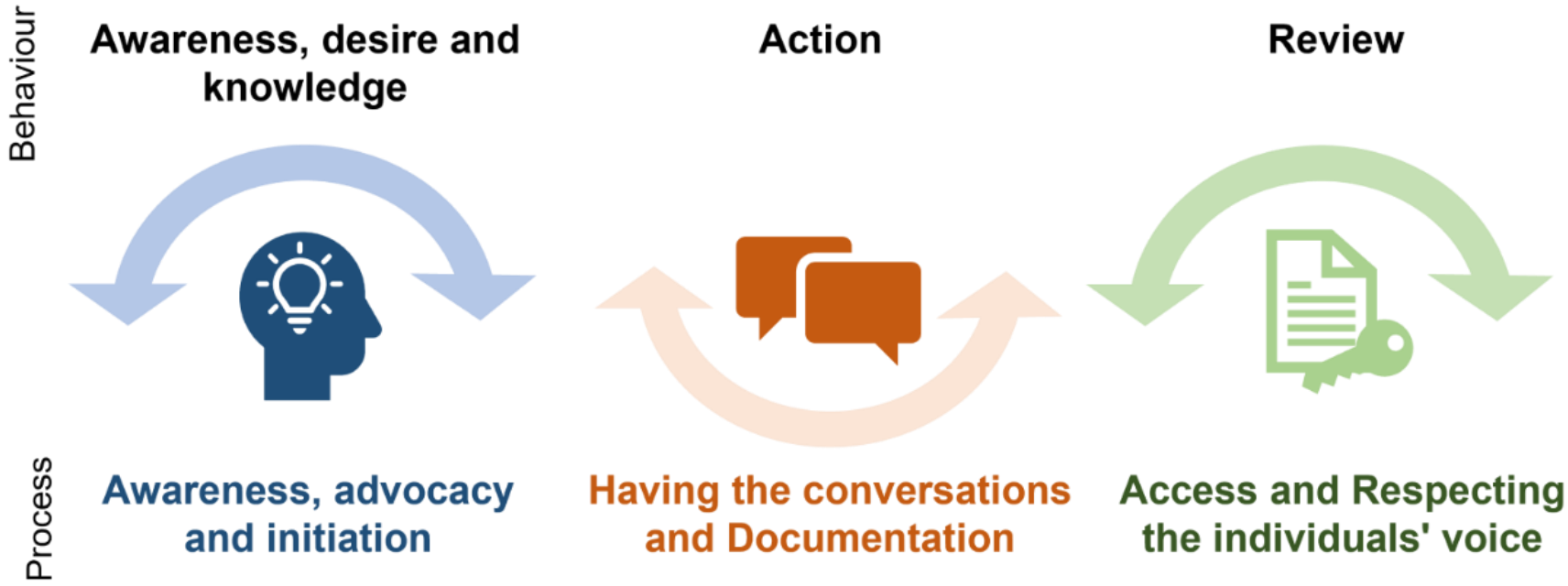



Figure: **ACP Process Framework**

*Extracted from Guidelines for Quality Implementation of Advance Care Planning*


# There have been efforts to increase awareness, access and adoption for Advance Care Planning nationally.

## Awareness

1

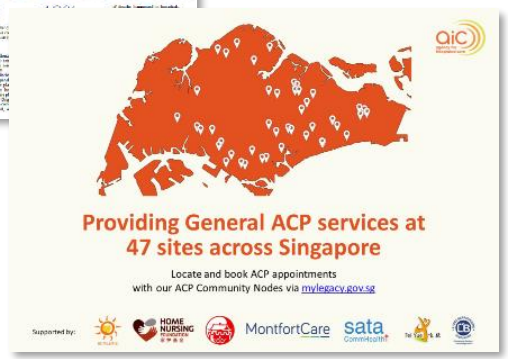

2

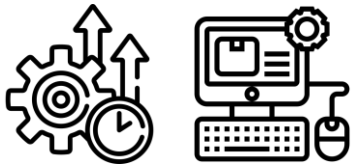

3


4


## Access


New digital tool launched to encourage advance care planning



Process improvement and service expansion

## Adoption

**116,105**

Total ACP forms ever published

**59,750**

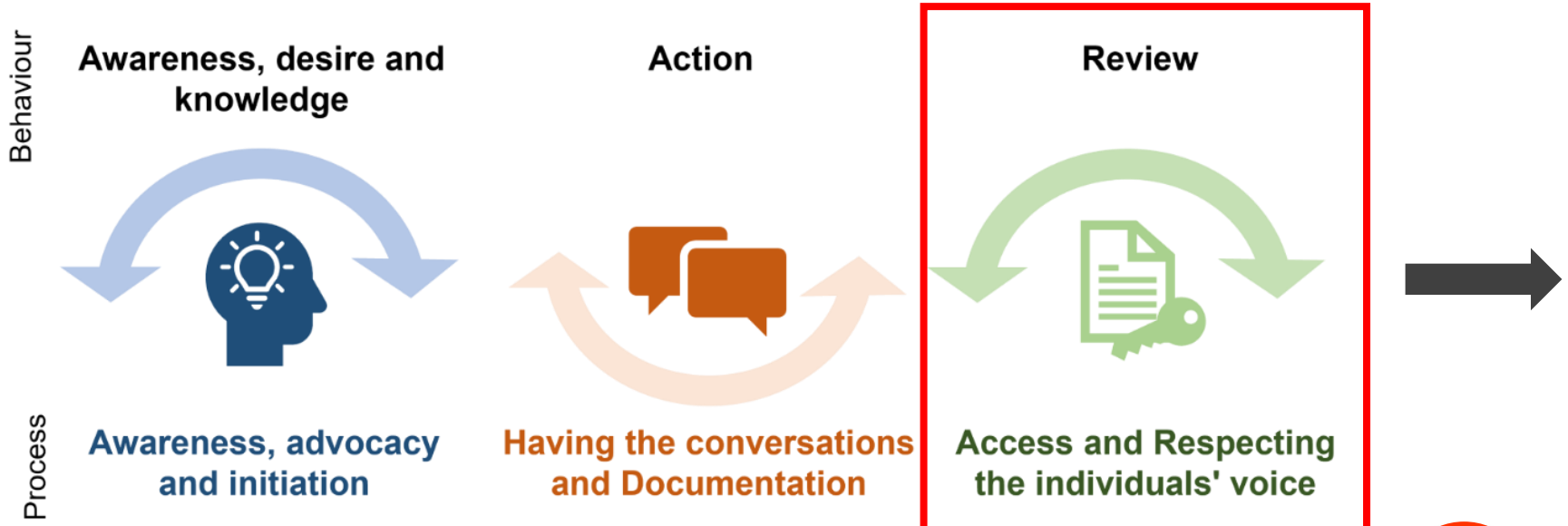
Total PPC forms ever published (**51%** of all ACP forms)

[1] Legacy Planning Campaign
[2] ACP Pushcart at KTPH organised between April 2025 to December 2025 (Credit: KTPH)
[3] ACP Awareness Talk at Live Well Leave Well 2024 (Credit: CGH and SHC)
[4] NUH Showcase on “Empowering Living Well & Leaving Well” exhibition on 21 March 2025 (Credit: NUHS)

# To improve the Advance Care Planning process, some changes have been made based on ground feedback.


| Feedback Received | Changes Made |
|---|---|
| ACP conversations are not naturally conclusive and many ACPs were drafted but left unpublished, resulting in wishes expressed but not captured | **[PPC form]** Added “Not decided” option under “preferred place of medical treatment and care/ death in event of deterioration”<br><br>**[IT system]** Changed requirements for signatures and declaration to allow ACPs to be published while the conversation continues |
| Too many forms and worksheets, hard to know which to use/ refer to | **[PPC form]** Integrate following into single PPC form<br>1. Disease Specific (DS) ACP and Children and Young Person (CYP) ACP<br>2. PPC Discussion Worksheet |
| Facilitator must create an additional ACP record in order to update NEHR on typo edits | **[IT system]** Facilitators will not need to create an additional ACP record when they:<br>• Update patient’s bio-data<br>• Make edits for typos or update physician’s signature for published ACPs |

# Healthcare professionals play a critical role in delivering goal-concordant care, making the ACP come to life.


**OUTCOME**

**Goal-concordant care**

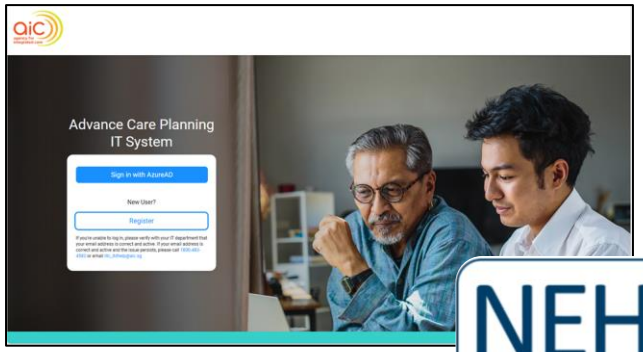
*Delivering care aligned with patients' values*

CRITICAL ROLE

**Healthcare Professionals**

*Review it and act on it*

*Access ACPs via NEHR or ACP IT system*




NEHR
National Electronic Health Record Singapore

# A quick poll to get a sense of our understanding on the use of ACP.

1. ACP is legally binding, and is equal to advance directives like the Advance Medical Directive (AMD). True or false?

2. Mr A has mental capacity and is able to communicate their wishes. In his PPC, he indicated “DO NOT attempt CPR”. Before he goes for any operation/procedures, the DNR order must be reversed. True or false?

# A quick poll to get a sense of our understanding on the use of ACP.

1. ACP is legally binding, and is equal to advance directives like the Advance Medical Directive (AMD). True or false?

   False. ACP is not legally binding. ACP forms provide guidance on decision-making and are not legally enforceable. While the final decision on treatment for individuals who lack capacity rests with healthcare providers, following the Mental Capacity Act (MCA), the individual's preferences for care and treatment will be considered in the decision-making process.

# A quick poll to get a sense of our understanding on the use of ACP.

2. Mr A has mental capacity and is able to communicate their wishes. In his PPC, he indicated "DO NOT attempt CPR". Before he goes for any operation/procedures, the DNR order must be reversed. True or false?

   False. There is no legal or ethical mandate to reverse DNR order before an operation or procedure. The medical team in charge of the patient should consult the procedurist and anaesthetist with regard to the procedure and its anaesthetic risks and as a team, **engage the patient in a process of shared decision making** as to the perioperative extent of care. The discussion includes:

   - the risk versus benefits of the procedure including potential reversal of DNR;
   - the risks versus benefits of resuscitative procedures that may be associated with the procedure;
   - limited trials of resuscitative treatments; and
   - what are acceptable and unacceptable outcomes to patient as well as patient's goals of care.

# Dr Norhisham Main

## Designations

- Head of Division & Senior Consultant, Division of Supportive Care & Palliative Medicine, Ng Teng Fong General Hospital
- Chair, ACP Training & Curriculum Workgroup

# Eliciting Patients' Values through ACP


# What can ACP do, what is it for?

When does ACP/PPC come into effect?

- When patient does not have mental capacity or cannot communicate their wishes any more
- When patient has mental capacity and can communicate their wishes, **conversations with patient and NOK takes precedence over the ACP.**

General ACP and PPC are communication tools to facilitate conversations.

- Even when the ACP/PPC is completed, the conversation does not end.
- General ACP and PPC standardise communication and documentation across organisations and settings.
- A completed ACP/PPC form should be reviewed in instances such as:

| Review ACP… | Review PPC… |
|---|---|
| • At every new decade of life<br>• At every significant life stage or milestone (e.g. marriage)<br>• After a significant medical diagnosis<br>• After a significant change in daily functioning (e.g. activities of daily living) | • When current health condition deteriorates<br>• When frequency of complications increases<br>• After a significant change in daily functioning (e.g. activities of daily living) |

# ACP/PPC must be easy to use, when it is needed.


## General guidelines for documentation

**Succinct** and not too lengthy

Contain **sufficient** information for clinician to make decisions

- Elicit and highlight key values and care preferences

Should **not be too vague** (e.g. “burden”, “suffering”) – clarifications should be made to define these terms

- Do not use uncommon abbreviation or short-forms
- Provide full term in brackets for the first time

# Example – Good Documentation

- ✅ Succinct and not too lengthy
- ✅ Elicits and highlight key values and care preferences
- ✅ Not vague


| A2 | Patient's priorities and concerns |
|---|---|
| | i. What does living well mean to me/the patient? (e.g., to be independent, to be mentally aware etc.)<br>• Enjoys gardening, cooking for family, and travelling.<br>• Had a fulfilled life and current priority is spending time with family.<br><br>ii. What are my/the patient's biggest concerns (e.g., pain, finances, being a burden)?<br>• Well accustomed to the routine of dialysis, and has confidence coping for stressful situations.<br>• Worried about becoming dependent on others for daily activities and burdening her family with physical caregiving. Also worried about losing mental capacity and not being able to express her needs and thoughts.<br>• Coping mechanism: The support of family and friends, personal beliefs that challenges are part of life and they help her to grow as a person.<br><br>iii. What matters most to me/the patient? (e.g., functions and abilities that are important to me/the patient etc)<br>• Wishes to be able to continue her daily routine for as long as she can.<br>• When her health deteriorates, patient would value being able to express her needs and wants, communicate and spend time with her family. |

# Example – Poor Documentation



| A2 | Patient's priorities and concerns |
|---|---|
| | i. What does living well mean to me/the patient? (e.g., to be independent, to be mentally aware etc.)<br>• Independence is very important to me. Able to self-care and move around.<br><br>ii. What are my/the patient's biggest concerns (e.g., pain, finances, being a burden)?<br>• Fear of discomfort that is caused by medications. Immobility is considered suffering to me.<br><br>iii. What matters most to me/the patient? (e.g., functions and abilities that are important to me/the patient etc)<br>• If unable to care for myself, do not mind going to nursing home. Pain management is important. Unable to accept tube feeding and dialysis. Do not prolong my life with artificial life support system. |

Key value: patient prioritises independence

But how can it be better?

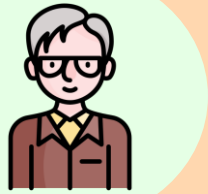
# As part of routine care, it is important for us as healthcare professionals and facilitators to review ACPs and establish alignment.


| | |
|---|---|
| **C** | Clarify prior discussions and documentations of patient's values and care preferences |
| **A** | Approach the nominated healthcare spokesperson (NHS) to provide patient-centered care |
| **R** | Review ACP regularly, especially after significant health or life changes |
| **E** | Establish alignment between the patient's updated wishes and care preferences with the ACP |

# Navigating Patient's Care Preferences

Case 1

**How should the healthcare team proceed?**



**Patient A**
**55-Year-Old Male**

| | |
|---|---|
| **Patient Profile** | Diabetic nephropathy, advised to consider dialysis but deferred decision as he still felt well |
| **ACP Status** | ACP completed with prioritisation on comfort |
| **Current Presentation** | • Presented to the ED with sepsis, hypotension and acute chronic renal failure, fluid overload<br>• Patient is still communicative despite being ill<br>• Doctors conflicted on plans due to prioritisation of comfort in completed ACP |

# Navigating Patient's Care Preferences

Case 2

**How should the healthcare team proceed?**

**Patient B**
**70-Year-Old Female**

| | |
|---|---|
| **Patient Profile** | Recently diagnosed neurodegenerative condition |
| **ACP Status** | ACP not yet completed, but patient has expressed interest in completing ACP. |
| **Current Presentation** | • Her only child wants his opinions to be considered in the ACP<br>• He finds ACP discussion a waste of time if only patient's preferences are documented |

# Q&A Session with Panelists

# Q&A Panel

**Dr Norhisham Main**

- Head of Division & Senior Consultant, Division of Supportive Care & Palliative Medicine, Ng Teng Fong General Hospital
- Chair, ACP Training & Curriculum Workgroup

**Ms Wong Wai Min**

- Deputy Director, End of Life Support, Sector Planning Division, Agency for Integrated Care

*Moderated by*
**Mr Adwin Ho**

- Senior Manager, End of Life Support, Sector Planning Division, Agency for Integrated Care

# If you have any questions during the Q&A session, please post them in the Pigeonhole.

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**ACP2026**

# Save the Date – 30 and 31 October 2026

## National Celebration of Seniors (NCOS) 2026

### Live Well | Age Well | Plan Well

- **Event Dates:**

  30 October 2026 (Friday), and

  31 October 2026 (Saturday)

- **Time:** 10am to 8pm
- **Venue:** Toa Payoh HDB Hub
- **Guest of Honor (30 October):** Mr Tan Kiat How, Senior Minister of State, Ministry of Health

## What you can expect

Hear from subject experts at talks and panel discussion, as they share practical guidance on legacy planning

Find out more about legacy planning tools (e.g. Lasting Power of Attorney, Advance Care Planning, CPF nominations) at interactive booths

On-site support to assist on legacy planning tools

# Resource – Guidelines for Quality Implementation of Advance Care Planning

- The Guidelines for Quality Implementation of ACP provide essential principles, quality indicators and good practices to organisations who are helping their clients adopt ACP as part of care planning.

- The guidelines are designed with visual elements to enhance readability and user understanding. We welcome you to download an e-copy and share with your colleagues today! 😊


**Please scan the QR code above to download an e-copy, or visit https://for.sg/aqiguidelines**

# Thank you for your participation!

For further enquiries:

| | |
|---|---|
| General enquiries on Advance Care Planning (ACP) or ACP training | Please contact the office-in-charge of ACP within your organisation |
| Enquiries related to myACP or the refreshed Preferred Plan of Care (PPC) form | Please contact ACP National Office at acp@aic.sg |

Presentation slides and recording of webinar will be shared via email provided during registration

# We would love to hear from you!

Help us improve future webinars by filling up this short feedback form (< 2 mins)


**https://for.sg/yvoqou**

# Thank you!