Advance Care Planning Webinar 2026 – Responses to Submitted Questions

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Please contact the National ACP Office (acp@aic.sg) for further enquiries.

1	**ACP Facilitation**
1.1	Are all doctors able to facilitate Advance Care Plan (ACP) and Preferred Plan of Care (PPC) discussions, including conducting PPC discussions via telephone?
	Doctors may conduct ACP/ PPC facilitation via tele-consultation if they are certified ACP/ PPC facilitators.
2	**ACP Documentation**
2.1	Should a patient's previously completed Advance Medical Directive (AMD) be documented in the ACP discussion notes if it is declared by the patient or family?
	Yes. If the patient or family indicates that an AMD has been previously completed, this may be documented as part of the ACP discussion notes. The information recorded in the ACP serves as an indication that an AMD has been made, but it does not replace formal verification with the Registrar of Advance Medical Directives. If a doctor assessed that the patient is terminally ill, the doctor is required to check the patient's AMD status with the Registrar.
2.2	Can a PPC discussion still be conducted if a patient does not meet the surprise question criteria?
	The surprise question* is one of the key considerations used to identify patients who may benefit from a PPC conversation. However, it should not be used as the sole criterion for determining PPC eligibility. Clinical judgement should also consider the patient's overall health condition, disease trajectory, functional status, frequency of hospitalisations or complications, and care needs. If the patient has a progressive life-limiting illness or complex care needs that would benefit from advance care planning discussions, a PPC conversation may still be appropriate even if the surprise question criterion is not met. ** "Would you be surprised if the person were to die within the next 12 months?"*
2.3	Can a Microsoft Word version of the ACP-PPC form be provided to facilitate documentation, given feedback that the PDF version may be challenging to complete due to formatting and space constraints?
	The revamped General ACP and PPC forms (Microsoft Word version) are available for download on the AIC website at https://www.aic.sg/Partners/ACP-Resources.
2.4	How should facilitators manage situations where a patient wishes to include extensive details in their ACP, resulting in less concise documentation?
	The ACP documentation should capture a patient's values, goals and preferences accurately, while remaining concise and clinically useful. If a patient shares extensive details, the facilitator should simplify the facilitation process through clear and succinct documentation of patient's values, goals and care preferences, rather than lengthy narrative write-ups. This helps ensure that the ACP remains accurate, while also facilitating easy and quick retrieval of information for

	frontline healthcare professionals (e.g. Emergency Department staff, SCDF, etc.) to facilitate care that is concordant with the patient's wishes. As the published ACP form is the document that is shared via National Electronic Health Records (NEHR) system for clinicians' reference and via myLegacy for clients, it is important that all critical information and key principles expressed arising from the ACP conversation are documented within the published ACP form itself, and facilitators may instead upload supplementary materials.
2.5	With the enhanced PPC form requiring family/next-of-kin (NOK) and physician signatures, is a PPC considered complete if one or more of these signatures are not obtained?
	To ensure a complete ACP for publication, it is mandatory to obtain patient and/or Nominated Healthcare Spokesperson (NHS) consent prior to publication of ACP to allow them to verify the accuracy of the information documented, acknowledge their respective roles and preferences, and minimise the risk of downstream disagreements or requests for amendments after publication. Patient and/or NHS consent may be documented through the following approaches: • Explicit consent as physical signatures obtained on hardcopy ACP form • Implicit consent as declaration by facilitator (i.e. documentation of proxy consent obtained by the facilitator on behalf of the patient and/or NHS where physical signatures could not be obtained). However, such declaration should be made only after best efforts to obtain their signatures fail. It is best practice to obtain the physician's signature as an acknowledgement of the ACP completed to support goal-concordant care. If the facilitator is unable to obtain the physician's signature, the facilitator would need to document the reasons for no signature (i.e. physician not on-site) before proceeding to publish the form. Facilitators are encouraged to follow-up and obtain the physician's signature to update on the ACP IT system.
2.6	Can signatures or thumbprints be obtained from the patient or NHS before the PPC documentation is fully completed?
	No. The PPC documentation should be completed before the patient and/or NHS signs or provides a thumbprint. The signature or thumbprint signifies that the patient and/or NHS have reviewed the documented PPC and agrees that it accurately reflects the discussion, values, goals, and care preferences that were expressed during the conversation. Obtaining signatures before the documentation is completed may result in the patient or NHS endorsing information that has not yet been recorded or reviewed. Facilitators should therefore complete the documentation, review the contents with the resident and/or NHS, address any clarifications, and then obtain the required signatures or thumbprints.

2.7	What should be done if the physician declines to sign the PPC form because the patient does not meet the surprise question criteria?
	It is best practice to obtain the physician's signature as an acknowledgement of the ACP completed to support goal-concordant care. If a doctor declines to sign the PPC, the facilitator should seek to understand the clinical rationale and discuss whether another form of ACP, such as General ACP, may be more appropriate. A PPC should only be completed and endorsed in accordance with the prevailing clinical and governance requirements.
2.8	How should unpublished ACP/ PPC records completed using the previous form be managed following the launch of the new system, and is re-consent required before publication?
	Facilitators are required to migrate the information from the unpublished ACP/ PPC records that were documented on the old forms to the refreshed PPC form. They will then need to inform the patient about the changes in the revised PPC form and revisit the PPC discussion with them/ NOK and to seek their consent to complete the PPC form before publication. From 1 September 2026, all facilitators are required to document and publish the refreshed PPC form.
2.9	Can a patient complete and submit a PPC online without facilitation by a healthcare professional?
	At present, only General ACP can be completed independently via myACP. PPC must be conducted with a certified PPC facilitator as it involves in-depth discussions with the patient and/ or next-of-kin to understand the disease trajectory, establish goals of care, and develop treatment plans that can be reviewed as the patient deteriorates.
3	**Patient Management**
3.1	If a patient has no or fluctuating mental capacity due to medical conditions such as dementia or schizophrenia, should a General ACP or PPC be completed?
	The decision on whether to complete a General ACP and PPC should not be based solely on the patient's mental capacity. The patient's medical history, prognosis and care needs should be considered when determining the most appropriate care approach. Not all patients with a diagnosis of schizophrenia or dementia lack mental capacity. A patient with early-stage dementia or a patient with schizophrenia on treatment may have mental capacity. When a patient is assessed to have no mental capacity, this should be clearly documented. The facilitator should note the details of the doctor's assessment, i.e. duration of incapacity (permanent or temporary) and what decision the patient was assessed for. In the context of ACP discussions, the assessment of the patient's mental capacity should be for decisions on care and treatment. If the lack of mental capacity is temporary, the ACP discussion should be deferred until capacity returns.

	If there is no mental capacity and it is deemed permanent, consent for the ACP should be obtained from the NHS as the proxy or LPA donee, where applicable.
3.2	If the patient does not have mental capacity and does not have a NOK, is the patient eligible for PPC?
	If the patient does not have mental capacity and has no next-of-kin, it will be challenging to establish the person's values, goals and preferences. There is also no NOK who can be the nominated healthcare spokesperson. Thus, the patient is ineligible for either General ACP or PPC. The clinical team will instead establish the goals and extent of care based on best interest.
3.3	If an unconscious patient with an existing ACP is presented at the Emergency Department, how would the doctor use the patient's ACP to guide care decisions?
	The doctor will consider the patient's current medical condition and whether the situation is reversible. For example, if the unconsciousness is caused by a temporary and treatable condition, such as a medication side effect, treatment will focus on recovery. For patients with serious or advanced illnesses, the medical team will refer to the patient's ACP (or PPC) to understand their care preferences, such as whether they prioritise life-prolonging treatment, additional medical interventions, or comfort-focused care. These preferences will be considered alongside the patient's clinical condition to guide treatment decisions. The healthcare team will also engage the patient's family to ensure they understand the patient's wishes and the proposed care plan. Awareness and recognition of ACP in A&E settings have increased, and healthcare professionals strive to honour documented care preferences whenever possible.
3.4	How can non-clinical ACP facilitators effectively support discussions on treatment preferences when they are not trained to provide medical advice on medical interventions?
	Non-medically trained facilitators are not expected to provide medical advice or recommend specific treatments. The facilitator's primary role is to discuss with patients/clients to facilitate their understanding of their condition and align their preferences for treatment based on their goals and values. When questions arise on the patient's condition and treatment, the facilitator may guide the patient to their physician to address those queries. For cases where detailed discussion on medical interventions is required, facilitators are advised to involve or seek support from the treating physician during the ACP conversation to ensure the individual receives accurate and appropriate information.
3.5	Can a patient appoint a family member residing overseas as their primary NHS, and are there any eligibility requirements for overseas appointees?
	Yes. A patient may nominate a foreigner to be the NHS, provided that the nominee is 21 years old and above, understands the client's wishes, is willing to act on those wishes, and can be contacted when required. An NHS does not need to be a Singapore Citizen, or Permanent Resident. Patient may appoint anyone they trust to speak on their behalf, including family members or close friends.

	However, facilitators should advise the patient to consider the practicality of appointing an NHS who is based overseas. Accessibility to the NHS during emergencies and promptness of communication with the healthcare team due to differing time zones or connectivity may be limiting factors.
3.6	How should facilitators explain the value of ACP to individuals and families when an LPA has already been completed?
	An LPA and ACP serve different but complementary purposes. An LPA allows an individual (the donor) to appoint one or more trusted individuals (the donees) to make decisions on their behalf if they lose mental capacity. The appointed donee(s) can be appointed to act on either personal welfare matters; or property and affairs matters; or both. An ACP, on the other hand, documents the person's values, healthcare goals, and care preferences. The nominated spokesperson will reference these values, goals and preference to guide the healthcare team in decision making for the person when mental capacity is lost. Even when an LPA is in place, the donee may not always know the person's wishes in specific healthcare situations. ACP provides guidance to family members, donees, and healthcare professionals by making the person's preferences known in advance. ACP can therefore support the donee in making decisions that are more consistent with the person's values and wishes. Having both an LPA and ACP helps ensure that there is clarity about what decisions can be made, who will make decisions and what considerations should guide those decisions.
3.7	How should care decisions be managed when a patient has lost mental capacity, particularly if an existing ACP differs from the views of family members or the NHS?
	When a patient has lost mental capacity, patient's previously expressed or known wishes, values, goals and preferences should guide care decisions. Ideally this information should have been documented in the ACP. When there is an existing documented ACP, the healthcare team can use it to guide decision-making in consultation with the NHS and family. The NHS and family should represent the patient's wishes, not substitute their own preferences. An ACP that is documented when a patient has mental capacity cannot be changed later by the NHS or family after the patient has lost mental capacity. If there are disagreements among the family and/or NHS on the patient's preferences in the ACP, the healthcare team will engage with all parties to understand their concerns and work towards honouring the patient's wishes based on the principle of best interests. In the absence of a valid, documented ACP, the healthcare team will consult the family and loved ones to establish the patient's likely wishes and if appropriate, use the information to make decisions in the patient's best interests.

3.8	How should an ACP or PPC be used to guide care decisions when a patient has lost mental capacity, has no Nominated Healthcare Spokesperson (NHS), and the ACP/PPC was completed without family involvement?
	If a patient has completed an ACP without a NOK present and subsequently loses mental capacity without a nominated NHS, the ACP should still be used to guide care decisions. This is based on the consideration that the patient's care preferences documented in the ACP were expressed while they had decision-making capacity. However, it is important to note that the while the medical care team will take into consideration the patient's care preferences documented in the ACP, the team also retains the right to decide what may be the most appropriate treatment for a patient, alternatives available and risks concerned.
3.9	How can facilitators adapt ACP discussions for individuals who may have difficulty articulating their values and preferences due to limited health literacy or communication challenges?
	Facilitators should ask open-ended questions to help encourage patients to share more of their stories. For example, they may try asking the following questions: • "What" question – Gather facts: What are your interests? • "How" question – Focus on process/ feelings: How are you feeling today? How was your hospital stay? • "Why" question – Find out reasons/ meanings: What makes you feel anxious? (asking “why” question may put a person on the defensive. If too many “why” questions are asked, the person may feel attacked/ judged.) • "Could" question – A choice of being open or closed: Could you give an example? When patient expresses emotions, facilitators should name and acknowledge the patient's emotions (e.g. I see that you are feeling happy) and pace the conversation appropriately. Creating a safe and unhurried environment will help to encourage the patient to share more.
3.10	What is the purpose of ACP/ PPC for patients who lack mental capacity, given that care decisions are made by their NOK on their behalf?
	The purpose of ACP/ PPC is to document and communicate the patient's wishes, values, goals, and care preferences while the patient still has decision-making capacity. It can guide future care should the patient lose the ability to make decisions at a later stage. If a patient no longer has mental capacity and has not completed a PPC, the NOK may be consulted to help the healthcare team understand the patient's values and likely wishes. Input from multiple NOKs is likely to provide more insight than those of one NOK. This may help provide some guidance on the patient's preferences that can enable decision-making that is aligned with the patient's wishes. However, the facilitator is advised to assess whether the NOK is projecting his/her own values into those of the patient. If so, it should be documented as such so that

	healthcare teams can further assess how much weight the PPC should hold in the decision-making process.
4	**ACP Training**
4.1	Under the new ACP IT System, can a facilitator be trained in both General ACP and PPC be assigned the role of ACP Coordinator for reporting purposes?
	Yes, ACP Coordinator role is granted to trained ACP Facilitators who are certified to conduct both types of ACP (General and PPC) for patients. In addition, they are able to withdraw forms at the institutional level (e.g. in the event of consent withdrawal) and access reports that contain ACP information of all the patients whom their institution encounters.
4.2	Can facilitators who have not completed the refreshed PPC training continue to facilitate ACP discussions?
	PPC-certified facilitators who have not completed the refreshed PPC e-learning training may seek assistance from their Executive Officer (EO) to be nominated for the current e-learning extension cycle. The current extension cycle ended on 30 September 2026. Facilitators who successfully complete the refreshed PPC training within the stipulated timeline may retain their PPC certification status. Failure to complete the refreshed PPC training by the end of the extension cycle will result in the facilitator's PPC certification status lapsing, and they will no longer be authorised to conduct PPC conversations.
4.3	What is the difference between ACP and PPC?
	A General ACP is intended for generally healthy individuals, as well as those with stable chronic conditions, to discuss and document their values and healthcare preferences. However, a PPC is intended for individuals with progressive life-limiting illness, those who are suffering frequent complications, or for those who would answer "no" to surprise question (“Would you be surprised if the person were to die within the next 12 months?”) to communicate their values and healthcare preferences.
4.4	If ACP is not legally binding, does it mean that it is not a legal document?
	ACP is not a legal document and is not legally binding. It serves as a record of an individual's values, healthcare goals, and care preferences to guide family members and healthcare professionals when the individual is unable to make or communicate decisions. However, healthcare providers will take the ACP into consideration when making care decisions that are in the individual's best interests.
4.5	If an individual has appointed an organisation as their Donee under a Lasting Power of Attorney (LPA), can the same organisation be appointed as their NHS, and how should this be recorded in the ACP IT System?
	No. An NHS must be an individual aged 21 years or above whom the client trusts to communicate and help interpret their healthcare wishes if they lose decision-making capacity. Clients may appoint up to two NHSes.

	While an individual may have appointed a company (e.g. a professional trust company) as a Donee under a LPA, this does not automatically qualify the company to be appointed as an NHS. The role of an NHS is intended for a person who knows the individual's values, beliefs and healthcare preferences and can communicate these to the healthcare team. Since a company cannot be an NHS, there is no requirement to capture a Unique Entity Number (UEN) for NHS documentation purposes.
4.6	Can facilitators trained in PPC also conduct General ACP discussions?
	Staff who are certified as facilitators for both General ACP and PPC may conduct General ACP conversations. Organisations should verify their staff's certification and credentialling status before assigning them to facilitate either a General ACP or PPC discussion. This helps ensure that conversations are conducted by appropriately trained and authorised facilitators in accordance with organisational policies and governance requirements.
5	**ACP IT System**
5.1	If a patient wishes to add or amend information after the ACP has already been signed and published, should this be considered an ACP review?
	Yes. This would be considered an ACP review, as the patient is making a change to the contents of a completed and signed ACP.
5.2	Can other ACP users view an ACP record that has been saved as a draft, or are records only visible after publication in the new ACP System?
	All facilitators can view the patient's draft. Please proceed to ACP form tab and click on view form. If the ACP draft was created by a user from a different organisation, you will not be able to edit it. Should you face difficulty viewing the patient's draft, please contact the respective helpdesk with patient OID, your ACP role, your organisation and email address for further investigations. • For PHI users, please contact: IT.servicedesk@synapxe.sg • For Non-PHI users, please contact: iltc_itdhelp@aic.sg
5.3	Can the email address of an NHS be edited after an ACP has been published, or is re-publication required?
	Please ensure patient, NHS information and consent are collected before publishing as these information cannot be edited thereafter. Should there be a need to make an edit, please have an Institutional Admin or ACP Coordinator to withdraw the ACP. The facilitator can then proceed to create a new form with the correct details thereafter.
5.4	Who is responsible for adding ACP e-services to an organisation's Corppass account?
	If your organisation is required to onboard the ACP IT system to Corppass, please proceed with the following: • EOs should contact your organisation's Corppass Administrator • Corppass Administrators should: a. Add ACPS e-service to your organisation b. Create or update user accounts in Corppass c. Assign ACPS e-service to your organisation's ACP IT system users

	Please refer to the "Set Up, Assign & Manage User's Digital Service Access" guide available here for more info. For new Corppass users in your organisation: You will receive an email from Corppass to activate your Corppass account For existing Corppass users in your organisation: No action required. Your Corppass Administrator will link your Corppass Account to ACP IT system.
5.5	Who is responsible for updating a patient's status (e.g., deceased) in the ACP IT System?
	Currently, facilitators can update the patient's death status. We are reviewing this workflow in hopes of reducing the need for manual updates and will update if there are any changes.
5.6	How can supporting documents be uploaded to the ACP IT System, and what should be done if Corppass access has not been activated?
	If your organisation is not onboarded to Corppass, EOs and users cannot login to ACP IT system. Visit https://www.corppass.gov.sg/portal/admin-application to onboard your organisation to Corppass to maintain access to ACP IT system.
5.7	Can PPC records completed using a previous version of the PPC form be uploaded into the new ACP System, or must they be re-documented using the new form?
	If the PPC was completed using the previous version of the form outside of the ACP IT system, it cannot be uploaded into the new system. The PPC will need to be documented using the new PPC form in the revamped ACP IT system.
5.8	What should be done if a user encounters a message indicating that the individual is not registered with NEHR when attempting to register them in the ACP System?
	If the patient is not registered or opt-out from NEHR, we are not able to retrieve the patient's information from NEHR. As such, you may consider keying in the patient's bio data manually. However, should this occur for every patient, please drop an email to iltc_itdhelp@aic.sg together with the full screenshot (that includes timestamp and error message), and password protected patient details for further investigations.
5.9	Does an ACP/PPC facilitator who supports multiple care settings within the same organisation (e.g., Nursing Home, Home Care, and Senior Care Centre) need to be registered separately for each setting in the ACP System?
	Please confirm your current deployment terms with your employer. • If you have been seconded to a non-PHI as a staff (e.g. hospital staff seconded to community hospice provider to deliver palliative care services), you should be provided with a Corppass account from the non-PHI to log ACPs under their organisation. Additionally, ensure that the non-PHI is onboarded in the ACP IT system. • If you are serving the clients as a PHI staff and just providing place-based care (e.g. conducting ACPs for PHI clients in the AAC), you should be using your PHI email to log ACPs under your organisation account.