

Preferred Plan of Care

Advance Care Planning Discussion Guide

Adapted from Respecting Choices®

Things to note:

- ❖ The PPC ACP Discussion Guide is a structured guide with examples and prompts that facilitators may use to assist in conducting PPC ACP conversations.
- ❖ For proxy-completed ACP, you may want to replace “you” and “your” with “patient’s name” or “his/her” as appropriate.

Critical information should be documented on the ACP form. Supplementary information may be documented and uploaded onto the ACP IT system as attachments. Information uploaded as attachments will not flow into the National Electronic Health Record (NEHR).

Before starting the ACP Discussion, facilitators should:

- ❖ Get to know the patient and Nominated Healthcare Spokesperson(s) (NHS) first
 - “What did you use to work as?”
 - “What are your hobbies?”
- ❖ Set up the conversation
 - Introduce the purpose and benefits of ACP
 - “ACP is a process of discussion between you and your healthcare providers to get to know you better to help prepare for the future. We want to take into account your preferences for care.”
 - Ask for permission
 - “With your permission, I hope that we can talk more about your values and healthcare preferences that would help guide the medical team in times of emergency.”

Interview Guide

Section A: Understanding of Medical Condition, Values and Goals of Care

A1. Explore General Understanding of Health Status

- ❖ Elicit understanding of medical conditions, functional status, complications & prognosis if known
 - “Can you share with me what you know about your medical conditions?”
 - “Tell me how your medical condition has changed over the years... and over the past 1 year.”
 - “How have these conditions affected your physical activities over the years... and over the past 1 year?”
 - “What else have your doctors said about your treatment?”
 - “Has the doctor shared what may happen with your illness in the future?”
 - If the patient has further enquiries, facilitators can encourage the patient to clarify with their physician(s)
 - “You seem to have questions about your condition. We will write these down for you to discuss with your doctor, nurse or other healthcare provider.”
 - Explore understanding of potential complications with patient or NHS
- ❖ “As you know, you have an illness that makes it difficult to predict when a complication may occur and decisions may have to be made on your behalf.”
 - “Do you know what complications may occur?” (Provide information only if appropriate)
- ❖ Explore experiences in sick role/ healthcare utilization
 - “Have you had experiences where family or friends became seriously ill and decisions about care had to be made? What did you learn from those experiences?”
 - “Tell me more about your recent visits to the hospital (or when you were sick, how you managed, who you sought help from) ... share with me your experiences and what you learnt.”

A2. Patient’s Priorities and Concerns

- ❖ “What does living well mean to you? (e.g. to be independent, to be mentally aware etc.)”
 - “What is important and meaningful for you to live well?”
 - “What gives your life meaning?”

Examples of living well		
Spending quality time with family and friends	Practising my faith	Enjoying my hobbies (e.g. exercising, reading, music, television, travelling)
Being independent in my daily life	Eating well	Volunteering

❖ “What are your biggest concerns (e.g. pain, finances, being a burden)?”

- “Are there issues that concern you or worries that are affecting your life or health?”
- “What does suffering look like to you as your health deteriorates? How would we know that you are suffering?”

Examples of fears/ worries		
Not able to manage my pain well	Not able to think independently	Not able to communicate
Being a physical burden on loved ones	Being an emotional burden on loved ones	Being a financial burden on loved ones
Being on life support for a long time	Not able to care for my loved ones	Not able to say a proper goodbye to my family

- “What helps you when you face serious challenges in life?”
- “Do you have people you can turn to for support when encountering serious challenges (e.g. religious group, interest group, support group, family and friends etc.)? How do they support you?”

Examples of coping strategies/ resources		
Having support of family members	Engaging in leisure activities	Participating in religious activities

❖ “What matters most to me/the patient? (e.g. functions and abilities that are important to me/the patient etc.)”

- “What are the most important priorities/goals/hopes/wishes now based on your current condition and function?”
- (if relevant): “What would the most important priorities/goals/hopes/wishes be if your health deteriorates?”

Examples	Elaboration of consideration/ preferences
Pain management	Preference regarding how medication is administered or specific procedures to avoid.
Functions and ability	Important function e.g. walking, talking, eating, thinking, communicating. Ability to perform different activities of daily living (ADLs) e.g. bathing, toileting, leisure engagement
Companionship and emotional support	Preferences regarding visits from loved ones or specific types of emotional support.
Personal hygiene	Preferences regarding how you are bathed, particular grooming processes and products or frequency of oral care.
Cultural and spiritual needs	Cultural, religious, and spiritual considerations.
Personal comfort items	Specific personal items or comforts such as favourite blankets, music, or personal mementoes.

❖ Do a summary of discussion before moving on to treatment decisions.

Section B: Goals of Medical Care
Choosing the Nominated Healthcare Spokesperson (NHS) ❖ “With a progressive life-limiting illness, it can be difficult to predict when a serious complication may happen, and you may become very sick. It is important to appoint someone to be your voice/ spokesperson to express your thoughts and who can follow through on the things that have been discussed. Do you have such a person who meets the following criteria:” • Is this person willing?

- Is this person able to discuss your preferences, values and goals?
 - Is this person willing to follow your preferences?
 - Is this person able to make decisions under stressful situations?
- ❖ If the NHS is present, reiterate the need for knowledge of the patient's wishes, being agreeable to the role, being available, and being able to act on wishes, especially during crisis time to get everybody on the same boat.

B1. Explore understanding of CPR

"The next situation I'd like to talk with you about is whether you would want CPR attempted if your heart or breathing were to stop. This is a decision that people often make without understanding all the facts. My hope is that you can make an informed choice. So first, I'd like to ask you a few questions."

- ❖ Explore understanding:
 - "Can you share with me your understanding of CPR?"
- ❖ Explore understanding of benefits and burdens of CPR:
 - "Well, there are definite risks involved. Would you like to know what they are? – share outcomes of CPR"
 - If the patient thinks the success rate of CPR is high: "People often think that CPR is more successful at restarting the heart and breathing than it really is. The success of CPR is lower for those with serious illness."
- ❖ Explore goals of treatment:
 - "What would your goals for CPR be? If your heart or breathing suddenly stops, what do you hope the care team will do?"
- ❖ If patient has further enquiries on CPR, facilitators can encourage the patient to clarify with their physician(s).
 - "You may wish to talk to your doctor at your next appointment."

B2. Explore preferred medical intervention

"As an individual with _____ (illness), there may come a time when you may become very sick from progression of illness or serious complications. We would like to explore your goals of care in such a situation.

- ❖ Explain each option
- ❖ Assist in selecting the option that meets the patient's goals
- ❖ Inform that medical intervention provided (including CPR) will be subject to the assessment and decision of the care team in discussion with the NHS in the best interests of the patient

Goals of care	Prioritise comfort	Additional interventions	Prioritise life extension
Definition	Patient is to be treated with dignity and respect. Reasonable measures are made to offer food and fluids. Medications, oxygen and other measures may be used as needed for comfort. Do not intubate. These measures may be used where the patient resides. Consider transfer only if comfort needs cannot be met in current location. and allow them to pass away naturally.	<i>Includes care described to the left</i> To initiate limited trial of treatment. May include oral/intravenous medications. Do not use endotracheal intubation or long-term life support measures. May consider non-invasive ventilation support. Transfer to hospital if indicated. Avoid transfer to intensive care unit and continue with comfort measures if there is no clinical improvement.	<i>Includes care described to the left</i> May consider intubation, mechanical ventilation, and cardioversion. Management may include transfer to intensive care if indicated. These measures are subject to the assessment and decisions of the hospital care team
Additional considerations to explore and	• "What are your motivations and hopes for prioritising comfort?"	• "What are your motivations and hopes for these interventions when you become very sick?"	• "What are your motivations and hopes for these

to document under "Other Preferences"		• "What would be some scenarios that your goals of care would change? For example, prolonged duration of intervention, low chances of recovery, complications, discomfort or burden on family"	interventions when you become very sick?" • "What would be some scenarios that your goals of care would change? For example, prolonged duration of intervention, low chances of recovery, complications, discomfort or burden on family"
Explore other preferences	"Would you consider dialysis, artificially administered nutrition, use of antibiotics, or blood transfusion as a treatment option for yourself?" (discuss if relevant) ❖ If the patient has further enquiries, facilitators can encourage the patient to clarify with their physician(s).		

Section C and D: Exploring Preferred Place of Medical Treatment and Care, and Preferred Place of Death in Event of Deterioration

Step 1: Establish the context of deterioration with serious illness:

In Event of Deterioration	Establish Context
Preferred place of medical treatment and care (PPOC)	• "If a life-threatening condition occurs, would you consider initial treatment at the current care site? If there is no improvement, would you want to return to the hospital?" • "Can you share with me where your preferred place of medical treatment and care would be in the event of deterioration?"
Preferred place of death (PPOD)	• "If the medical team shares that you may have only 2-3 days left to live, where would you want your last moments to be?"

Step 2: Facilitate discussion to the facilitator's best abilities based on ALL options EXCEPT "Not Decided"

If patient has reservations on PPOC/PPOD:

- ❖ Explore reasons for why the patient is unable to indicate preferred place and underlying considerations.
- ❖ If applicable, address these reasons to enable decision-making (e.g. providing more information on the different options, addressing misconceptions, allowing time for clarification, making referral as needed).
- ❖ Provide the option of "Not Decided" only after the facilitator's best attempt to explore and clarify the PPOC/PPOD.

Step 3 (Applicable for patient who is "not decided" for PPOC/PPOD):

- ❖ Explore and document considerations for "Not decided" under the free text field next to the "Not decided" option:
 - Reason why patient is not able to decide on their PPOC/ PPOD at this point, the underlying considerations and what will help the patient decide (if any).
 - What does the patient wish to highlight to family and/or medical team (if any), e.g. avoid hospital.

Step 4: Ensure NHS is agreeable and aligned with patient's decisions

- ❖ Provide opportunities for NHS to seek further clarification with the patient (if any)
- ❖ Ensure the patient and NHS understand the role of NHS when patient is "not decided" on PPOC/PPOD (select as applicable)

Step 5: Share importance of indicating PPOC/PPOD and encourage periodic review of ACP with changes in life stages or health status

- ❖ Recognise that PPOC/PPOD is a dynamic discussion that may fluctuate throughout the disease trajectory.

- ❖ Encourage regular reviews and refer for appropriate support to enable PPOC/PPOD to be actualised when the time comes.

Section E: Other Important Notes

- ❖ Include any important notes which could not be documented in the above fields, for example:
 - Decisions recorded in other legacy planning tools made e.g. LPA, Will, CPF nomination
 - Funeral plans
 - Concerns raised by the patient and/or NHS
 - Follow-up plans

Administrative Requirements For Publication of PPC

- ❖ Seek consent from the patient and/or Nominated Health Care Spokesperson(s)
 - ACP should only be published if consent is obtained from the patient and/or NHS (if applicable).

Profile of Patient and NHS		Has NHS		No NHS
		Patient's consent and signature	NHS's consent and signature	Patient's consent and signature
Age ≥ 21	Has Mental Capacity	✓	✓	✓
	Lacks Mental Making Capacity	X	✓ PPC will be valid with NHS's consent and signature	Not eligible for PPC Rationale: For patients without decision-making capacity, NHS is required to function as the proxy to communicate the patient's values, wishes and care preferences.
Age < 21	Lacks Mental Capacity	X		
	Has Evolving Mental Capacity	✓ Obtain consent to seek concurrence of the ACP discussed. X Signature is not required from the patient as they are aged < 21.		

Legend: ✓ Required ; X Not Required

- ❖ Facilitators are encouraged as best practice to obtain the full suite of signatures (either physical or digital) of those required to their best abilities.
 - If unable to obtain the signatures of those required, facilitators should document the reasons and tick the checkbox "Declaration by Facilitator"

- ❖ Seek acknowledgement from physician-in-charge:

Steps Upon Completion of the PPC Form					
1	Facilitators to inform the physician (e.g. referring physician) of the completed PPC form as soon as possible.				
2	Facilitators to input physician's name (mandatory field) and MCR number (mandatory field) into the completed PPC form.				
3	Facilitators to obtain signature (physical or digital) from the physician for the completed PPC form to the best of their abilities. Intent for physician's signature is to acknowledge that the PPC form has been completed.				
	<table> <tr> <th>Scenarios</th><th>Next Steps</th></tr> <tr> <td>If signature obtained</td><td> • Proceed to input physician's signature and publish ACP </td></tr> </table>	Scenarios	Next Steps	If signature obtained	• Proceed to input physician's signature and publish ACP
Scenarios	Next Steps				
If signature obtained	• Proceed to input physician's signature and publish ACP				

		If unable to obtain signature • Document the reasons for no signature (e.g. physician not on site) • Proceed to publish the form in a timely manner • Encouraged to follow up and obtain the physician's signature to update on the ACP IT System	
❖ Summary & follow-up plan: • Summarise main points on living well, fears/suffering • Reiterate role of NHS • Update significant others on the outcomes of the discussions • Reassure the patient and their loved ones that the ACP may be reviewed and changed at any point in time and encourage continued discussion • Encourage the patient to clarify with their physician(s) if they have further enquiries and make additional referrals, if needed and applicable			