

Advance care planning: have the conversation

Module 3: Develop – When to have the conversation



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Advance care planning: have the conversation

Module 3: Develop – When to have the conversation

Healthcare settings: GP practice, hospital, aged care

Target skills: Confidence, knowing your role

Time: 15 mins

3.1 Aim: Advance care planning conversations

Advance care planning conversations with patients should avoid focusing initially on medical interventions (e.g. cardiopulmonary resuscitation, intubation) but rather determine the patient's values, goals and preferences.

For example, discussions may be focused on what matters most to the patient:

- preserve mental activity
- minimise suffering
- avoid undignified states
- avoid an unacceptable functional status. (Scott et al. 2013)
- prolong life (e.g. to enable the patient to go on a planned holiday or attend an important event)

Ideally advance care planning discussions will take place when the patient is medically stable, thinking clearly and comfortable. The conversation may be held at any point in the patient health trajectory, and does not have to relate to a specific condition. However, these discussions frequently take place in the context of serious medical illness. Advance care planning conversations are not intended to be completed all in one go. They should be developed, built upon and reviewed over time.

Advance care planning discussions need to involve the patient to the best of their ability and take into account their capacity to make their own care and treatment decisions.

The plan should be discussed between the patient, their medical treatment decision maker, their family (if appropriate) and relevant doctors involved in the patient's care.

For patients with intellectual disabilities and patients with mental health conditions, it is particularly important to include the appointed medical treatment decision maker and other support people in advance care planning discussions.

3.2 When to have the conversation: In general practice

The following triggers are excerpts from the Department of Health 2014; Keon-Cohen 2013; Scott et al. 2013; and Clayton et al. 2007.

Triggers

Relevant to patients at the following stage:

✓ no disease

- Patient indicates they would like to talk about their future care and treatment
- Patient attends an appointment for a flu shot
- Patient indicates that they have drafted a will
- Patient inquires about registering for organ donation
- Patient is marginalised in the community or may be likely to face discrimination
- Patient is isolated and vulnerable
- Patient has specific cultural needs or beliefs
- Patient has differing opinions, values or beliefs to their family members
- Patient is a new parent (and may be considering guardianship issues if something should happen to both parents)
- Patient has experienced the death of a loved one
- Patient is due for 45-49 year old health assessment
- Patient is due for 40-49 year old diabetes risk assessment
- Patient is due for 75+ year old health assessment

Relevant to patients at the following stage:

✓ early chronic disease

- Patient visits GP
- Patient is diagnosed with life-limiting conditions
- Patient is registered in psychiatric patient programs
- Patient commences the use of home support services
- Patient's health is poor (e.g. limitations in self-care, multiple hospitalisations)

Relevant to patients at the following stage:

✓ **chronic disease**

- During development of a Chronic Disease Management Plan
- At key points in the patient's illness trajectory (such as after hospitalisation)
- As a routine part of the care for key groups with chronic progressive disease, patients approaching the end of life, and patients who are managing multiple co-morbidities
- Patient experiences loss of response to, or complications from, disease-specific treatments

Relevant to patients at the following stages:

✓ **advanced disease**

✓ **end of life**

- Disease-specific indicators predict a poor prognosis (e.g. advanced organ failure, advanced dementia, disabling neurological conditions, progressive malignancies)
- Where it is clear that the patient has a life-limiting advanced progressive illness
- If the doctor would not be surprised if the patient died within 6-12 months



3.3 When to have the conversation: In the hospital

Triggers

Relevant to patients at the following stage:

✓ no disease

- Patient indicates they would like to talk about their future care and treatment
- Patient is registered in psychiatric patient programs
- Patient is marginalised in the community or may be likely to face discrimination
- Patient is isolated and vulnerable
- Patient has specific cultural needs or beliefs
- Patient has differing opinions, values or beliefs to their family members

Relevant to patients at the following stage:

✓ early chronic disease

- New diagnosis of life-threatening conditions
- Admission to a health service for a diagnostic procedure
- Admission to a health service for an acute illness related to an emerging chronic condition

Relevant to patients at the following stage:

✓ chronic disease

- As a routine part of the care for key groups with chronic progressive disease, people approaching the end of life, and people who are managing multiple co-morbidities
- Pre-admission for high-risk surgery
- If there are requests or expectations that are inconsistent with clinical judgement
- If disease-specific treatment is not working or there are complications from this treatment that limit its effectiveness
- Relapse of a chronic and progressive condition

Relevant to patients at the following stages:

✓ advanced disease

✓ end of life

- When there is a change in the condition or a perception of change (by patients, caregivers or clinical staff)
- When a patient experiences an unstable phase of an illness
- Severe, irreversible deterioration in the patient's health status
- Referral to acute services
- Referral to specialist palliative care services
- Failure of treatment and/or rapid deterioration

3.4 When to have the conversation: In the aged care facility

Triggers

Relevant to patients at the following stage:

✓ no disease

- When a patient indicates that they would like to talk about their future care and treatment
- When a new resident is admitted to a nursing home or aged care facility – every new patient should have an ACP discussion
- When a resident inquires about making a will, obtaining a seniors card and disability support pension applications
- Patient is marginalised in the community or may be likely to face discrimination
- Patient is isolated and vulnerable
- Patient has specific cultural needs or beliefs
- Patient has differing opinions, values or beliefs to their family members

Relevant to patients at the following stage:

✓ early chronic disease

- New diagnoses of life-limiting conditions
- By doctors at key points in the patient's illness trajectory (such as after hospitalisation)

Relevant to patients at the following stage:

✓ chronic disease

- At key points in the patient's illness trajectory (such as after hospitalisation)
- As a routine part of the care for key groups with chronic progressive disease, people approaching the end of life, and people who are managing multiple co-morbidities
- When a resident is transferred to hospital for treatment for an acute episode

Relevant to patients at the following stage:

✓ advanced disease

✓ end of life

- Severe, irreversible deterioration in the patient's health status
- When there is a change in condition, or a perception of change (by patients, caregivers or clinical staff)