

Advance Care Planning

Advance Care Planning (ACP)

Advance care planning is a process of documenting your health care service wishes for your health care team so that in the event you are no longer capable of making independent choices, your care preferences will be respected. Advance care planning is important for residents, families and health care providers as it assists in avoiding crisis-based decisions and avoids unwanted treatments.

Advance Directive (AD)

An advance directive (AD) is a legal form used to inform your health care provider and loved ones of your wishes regarding medical and mental health care. Advance directives will guide their decisions regarding treatments if you are not able to speak for yourself. An advance directive protects your right to make your own medically related decisions and provides comfort knowing that that your wishes for future medical care will be respected.

Proactive Care Planning

Clinicians should proactively assist individuals at risk for complications related to comorbid medical conditions to express their wishes for care in the event they are unable. Nursing home residents may choose to stay at “home” with known staff versus being hospitalized.

If the resident has decisional capacity, ask that their health care agent/family be involved in the discussion by video or phone if visitation is restricted. If the resident refuses do not include invite them to participate.

Key Elements in Conversations:

- Resident willingness to talk
- Resident preferences for information
- Resident understanding of their illness
- Resident preferences for family disclosure and/or decision-making
- Personal life goals, including upcoming milestones
- Fears and anxieties
- Identify what would be an unacceptable state of health/function vs tradeoffs they are willing to accept
- Recognize that residents have the right to change their mind at a future date
- Explore emotional and spiritual factors
- Share mutual trust and willingness to listen

Conversations:

- Review any current advance health care decisions, POLST or other treatment preferences
- Determine if there is a health care agent/proxy and offer to include them in the conversation/decision making process

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This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.

- These are difficult discussions for everyone.

Invitation

- Is it okay if we talk about what's important to you and how medical conditions might affect you, so we can be sure to provide you with the care you want.
- This conversation can help your family and help us, your health care team, if that ever happens.
- Have you chosen a person to make decisions for you if you are unable to speak for yourself? Who is it? Are you confident they will respect your wishes?
- What do you know about your medical conditions, and do you have any questions about it that I can help you get answers to?
- Tell me about any of your medical conditions and how they affect you.

Goal Clarification

- What are your most important goals if your health declines?
- What are your biggest fears about the future?
- What are some things that you can do now that you can't imagine living without in the future?
- Does your family know about these values? This is a hard subject, but it is best to talk to them.

Summarize

- Acknowledge emotion, allow for silence
- Thank you for having this hard conversation
- What I am hearing you say is that what's most important to you is _____, and that if you couldn't _____, you would not want to live that way. Is that right?
 - "What I am hearing you say is that what is most important to you is staying out of the hospital and that if you weren't able to breathe on your own, you would not want to live that way even for a short period, even if there might be a chance you could get off of it, is that right?"
- Based on that and based on your condition, I would recommend _____ because _____.
 - "So based on that and based on your congestive heart failure, I would recommend that we just treat you in place here and give you all the support we can, make sure we have medication to keep you comfortable and if you do get sick we will be ready for it and we will take the best care of you that we possibly can."
- I hope things don't get worse, but I am glad we talked about this while everything is ok
- We will do everything we can to make sure you get the care you want to receive, and I will make sure orders are written to reflect that
- Is there someone else you'd like me to tell about our conversation?
- **I care about you. We will walk this path together. We want you to have it your way.**

Immediately following conversation:

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1. Modify physician orders/create “Advanced Health Care Decisions” form as appropriate. Give copy to the healthcare agent if applicable.
2. For those who prefer not to be hospitalized, explore plans of care to provide aggressive symptom management in their desired care location. Make arrangements/referrals as appropriate.
3. If the resident gives permission, update their healthcare agent or other loved ones, if not present during conversation.
4. Document conversation and decisions in the medical record.
5. Communicate decisions to the IDT and staff responsible for the care of the resident.
6. Ensure that facility protocol for identifying code status is updated and audit for ongoing compliance (i.e., MAR, stickers on doorframes, etc.)

<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf>

<https://order.nia.nih.gov/sites/default/files/2023-04/nia-advance-care-planning.pdf>

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