DecisionAssist
Palliative Care and Advance Care Planning for Aged Care

Advance Care Planning in general practice

The Advance Care Planning (ACP) Conversation: A 5 Step General Practice Guide

The ACP conversation can be broken down into five parts. These parts overlap and may occur in the conversation in different order.

Note: a person with limited decision making capacity should be included in the conversation, to the extent that they can, without distress.

TOPIC	CONTENT	CONVERSATION STARTERS and USEFUL PHRASES
STEP 1 **Introducing the topic**	Introduce the topic Offer the option of having someone else present Explore the patient's previous experience of end of life decision making (may already have formed ideas about what they want or don't want for themselves)	I try to talk to all my patients about what they would want if they become more unwell and could not talk. Have you ever thought about this? I am pleased to see you recovering from your recent illness. If you became very sick again, have you thought about the treatment that you would want or not want? Have you ever thought about your wishes regarding your future medical care? Some people have thought about what they want and document their wishes in an advance care directive. Do you have an advance care directive? Would you like to complete one? It's often easier to talk through tough decisions when there isn't a crisis.
STEP 2 **Who will speak for you?** **Appointing a Substitute Decision Maker (SDM)**	Explain the role of a SDM Help identify a SDM Explain how to appoint a SDM Offer to include SDM in conversations	If something should happen to you and you were unable to talk for yourself, who would you want me to speak to, to help make these decisions? Do you like to make medical decisions, or do you prefer your family to decide for you?* Would this person know what you would want? Would they be willing and able to make decisions on your behalf if you are too sick to do so? Have you spoken to this person who will make these decisions for you? Now that you have decided who that person would be, would you like to appoint him/her on a legal document to ensure that he/she is approached to make the decisions for you?

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TOPIC	CONTENT	CONVERSATION STARTERS and USEFUL PHRASES
STEP 3 **Goals, values and beliefs** **Individual quality of life, priorities and goals of care**	Keep questions broad Explore goals, values including cultural and religious values Discover what the patient would consider an acceptable/ unacceptable outcome	Many people have goals and values that influence their decisions, including decisions about their healthcare. I would like to find out your goals and the things you most value in life. For some the goal may be to prolong life no matter what; for others aiming for quality of life. What do you hope for most for the future? What is your biggest concern at the moment or for the future? What is most important to you, or to be able to do? What does it mean to you to live well or what makes your life worth living? What things are important for you to be able to enjoy your life? What do you consider an acceptable outcome after recovery from a serious illness (eg ability to talk, to recognise family, to walk, to go to the toilet or feed yourself)? On the other hand is there anything you would find completely unacceptable and make life not worth living (e.g. being unable to talk / walk/eat or recognise family)? Do you have religious, spiritual or cultural beliefs that you would like the doctors to know about if you are very sick?* Are there important things for me to know about how you/your family view illness?* Think about your preferences regarding where you live, which activities you enjoy, who are the people most important to you. Where would you prefer to be cared for if you are nearing the end of life?

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TOPIC	CONTENT	CONVERSATION STARTERS and USEFUL PHRASES
STEP 4 **Care and treatment preferences**	Explore understanding of medical conditions, prognosis and possible treatments Establish whether there are any treatments the person would not wish to have either now or in the future Discuss the concept of a natural death and of palliative care	Do you feel you have a good understanding of your current health problems/situation and what can be done to help you/your treatment options? What further information do you need? It is good to hope for the best but, if things did not go according to plan, have you thought about what to do then? Some people like to know about everything that is going on with them and what may happen in the future, others prefer not to know too many details. What do you prefer? Are there medical treatments you have experienced or seen others experience that have concerned you or that you would not want? Given what you have told us, at what point (if any) during your illness would you consider stopping treatments and changing the focus of care to comfort care?

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TOPIC	CONTENT	CONVERSATION STARTERS and USEFUL PHRASES
STEP 5 **Concluding the conversation**	Clarify and summarise Suggest documenting wishes Advise speaking to family or SDM and giving copy of documented wishes Remind that the advance care directive may be updated at any time	Do you have any other questions or concerns? Can we go through what we have discussed? This has helped me to understand your values and goals. Have you talked to anyone else about these issues? It would be helpful to think about what we have spoken about today so we can talk some more at your next visit. If there are changes in your life, in your health, or in your priorities in the future, we should talk about this again. I think that it would be good to: • have another discussion • read through this information, talk about it with your family or SDM and come back to see me and please bring your SDM with you so that they are part of the discussion • arrange for my practice nurse to talk to you about this in more detail • have a look at this form, called an advance care directive,, discuss with your family and bring it back to me and we can fill it out together. We will need a half hour appointment. When we have completed these documents you should give copies to your family/SDM and send a copy to the hospital that you attend.

** These are key phrases to use when exploring the beliefs of people from culturally or linguistically diverse (CALD) backgrounds.*

References:

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2) Department of Health Victoria (2014). *Advance care planning: have the conversation, A strategy for Victorian health services 2014-2018.*

3) RACGP 'Silver Book' National Taskforce. (2006). Silver Book (4th ed.) *Medical care of older persons in residential aged care facilities (4th edition, Funded by the Australian Government Department of Health and Ageing.* http://www.racgp.org.au/your-practice/guidelines/silverbook/ (Accessed July 2015)

4) Clark, K., & Phillips, J. (2010). *End of life care: the importance of culture and ethnicity.* Australian family physician, 39(4), 210.