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Jockey Club End-of-Life Community Care Project

把握時間
與晚期認知障礙症院友
訂定晚晴心願

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同心 同步 同進 RIDING HIGH TOGETHER

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JCECC-End of Life in RCHE Project (2016-18)

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83% of the residents joined the project

are diagnosed with Dementia

All of them had comorbidity of other illness, like stroke, organ failure, cancer DM, Hypertension

Why ACP discussion is important?

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- **enable better planning and provision of care aligned with the needs and preferences** of patients & their caregivers.

- Evidence from literature:

  doctor are more likely to give **appropriate treatment** according to **patient's preference** (family as advocate)

  if

  ACP has been discussed and documented

Principles of ACP discussion

- Should instigate ACP only if the process is considered beneficial to the patient
- The process must be voluntary
- Must approach the discussion sensitively
- Dialogue over a period of time
- The contents of the discussion should be determined by the patient
- Staff need appropriate knowledge & communication skill
- Confidentiality must be respected

Why family involved

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- Work together to make decisions, **building consensus** in determining the best course of treatment for individuals

- Family may **bring a valuable, yet different perspective to the process of care planning & death**

- Family participation in care and decision making may also provide families with **a feeling of purpose and closeness to the patient**

- Shown to improve **effectiveness of ACP**

Research- ACP in Chinese patients from various countries

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Recent SR of 16 studies, including 7 from HK, suggests many but not all Chinese patients are open to discussing end of life issues in the form of ACP:

- ACP needs to be **tailored to each patient** individually taking culture into consideration

- A **family decision-making model** may be more appropriate rather than focusing on individuality

Lee MC et al. Journal of Hospice & Palliative Nursing 2014;16:75-85

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Steps for ACP discussion

1. **Exploration - Assess the patient's (family) readiness to discuss the topic**
2. **Communications**
3. **Notifications**
4. **Documentation**
5. **Regular review**

(*Capacity, care planning and advance care planning in life limiting illness*, 2011, section 5.2)

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Exploration

Be sensitive

patient's (family) readiness- cues Vs avoidance

Provide adequate information

- Current **health /disease status**
- **Prognosis**
- the types of **care or treatment** that are available and **their benefits, harms and risks**

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Exploration

Explore preferences, wishes, beliefs, values and feelings about:

- **illness and prognosis**
- **personal goals** or aspirations **for care**
- the **treatment option**

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Exploration

Intention, wish, belief , value, feelings:

- types of **decisions** that may need to be made about

- **Life-sustaining treatments**
- **Place to care**
- **Who to care**
- **Funeral arrangement…**

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Communication

Effective Communication

- clear delivery of information
- allow pauses to allow absorption of information
- listen attentively-patient & family, consensus/conflict?
- check understanding

- **Be Supportive**

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Notification

- Explain the purpose of the ACP
- Lead for concrete plans in the ACP process
- Explore the issues to be discussed, e.g. DNACPR
- Make sure the patient (family) understand the plan clearly, Double checking if necessary
- Make preferences/choices clear to family

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Documentation & Filing

Document the conclusion of the discussion in the medical records

Complete the AD form & DNACPR form for non-hospitalized patient

Assign a family member to be the key person for future if possible

Keep AD form & **DNACPR form for non-hospitalized patient** in patient's medical file

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Regular review

- Regular review, especially, in the Final Days
- DNACPR form for non-hospitalized patient review for every 6 months

References

Advance Care Planning e-learning course.
http://www.rpctraining.com.au/