# *Advance Care Planning*

Oncology Social Work

*Adapted from The Project to Educate Physicians on End-of-life Care.*
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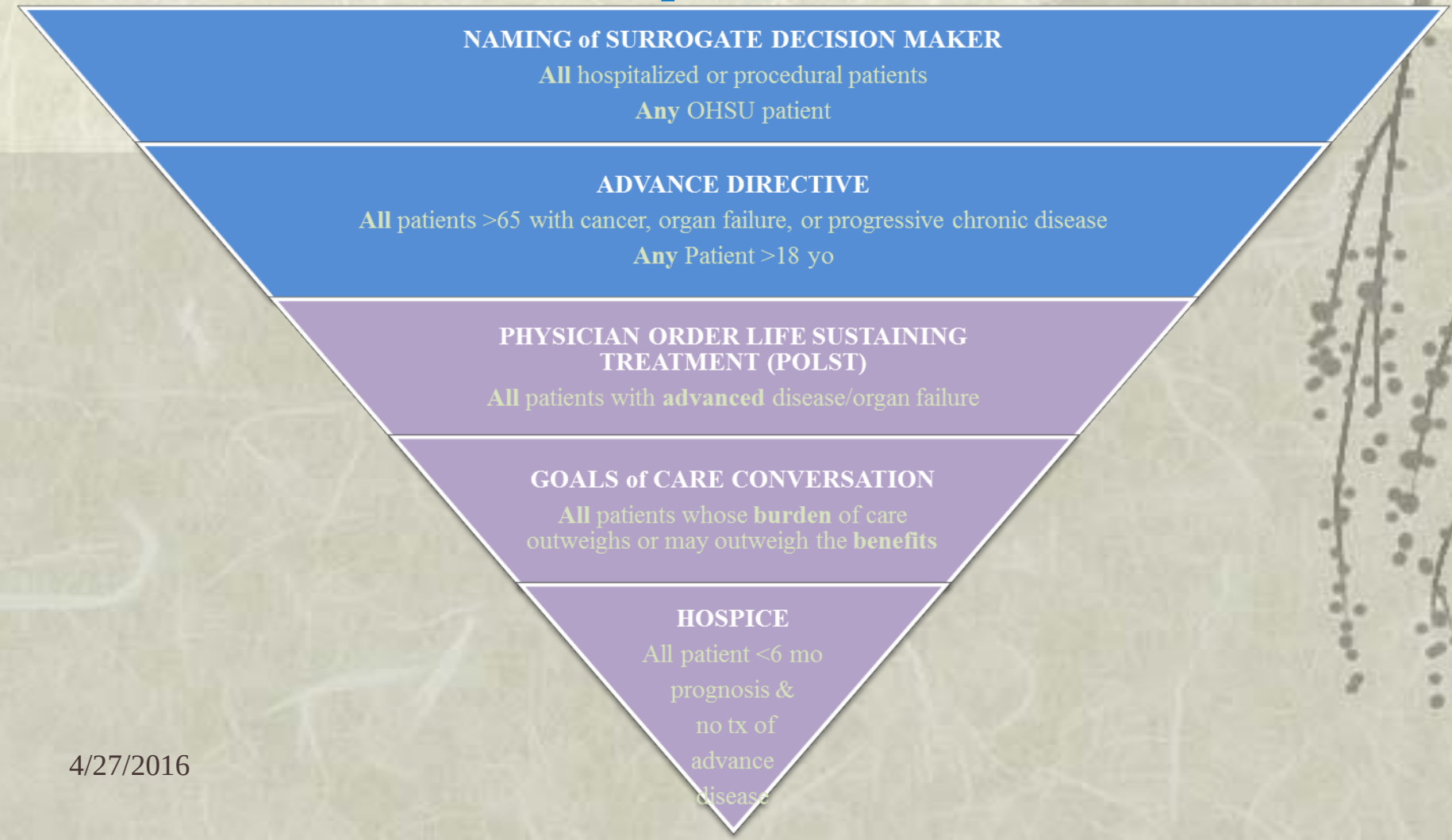
# Skillful Communication about Goals and Advance Care Planning Requires a Different Focus for Different Patient Populations



# *Why should you complete an advance directive?*

- Moving through this process for yourself can better equip you to have conversations with patients.
- Helps you think of questions to ask patients.
- Credibility– you can better advise people to do something if you've done it yourself.

*There are no right or wrong answers. It's the conversation that counts!*

- Consider your and your family's beliefs, customs and traditions, religious or spiritual beliefs you hold that influence your thoughts about life and your thinking about dying, if any.

- Think about any fears you hold regarding the end of your life.

# *Important links*

- Oregon Health Decisions

http://www.oregon.gov/DCBS/Insurance/shiba/Documents/advance_directive_form.pdf

- Conversation Project
  http://theconversationproject.org/starter-kit/intro/

# *What are Advance Directives?*

- An Advance Directive allows you to document your wishes concerning medical treatments at the end of life
- Before your Advance Directive can guide medical decisions, two physicians must determine that you are unable to make medical decisions yourself
- Until that time, you are the one making the decision

# *Advance Directives*

- Allows you to decide what medical care you would want if you are unable to speak for yourself
- Allows you to appoint a health care power of attorney to speak for you, if you are unable to speak for yourself
- Helps loved ones to know what your wishes are

# *Advance Directives: Important things to know*

- You do not need an attorney to prepare ADs
- Advance Directives are legally valid throughout the US, however most States have their own documents
- Advance Directives do not expire unless you complete a new one
- Advance Directives should reflect YOUR values

# *Appointing a Health Care Representative*

- A healthcare Power of Attorney or Representative is someone you designate to make medical decisions for you if at some future time you are unable to make decisions yourself
- Your Representative can be a family member or friend, but should be someone who knows you well and whom you trust

# *Your Health Care Representative*

- Should be someone who knows your wishes about medical treatment and who is willing to take responsibility to ensure your wishes are followed

- Ideally should be someone who is not afraid to ask questions of the health care providers in order to get information needed to make decisions

# *Your Health Care Representative*

- Not everyone is comfortable accepting this sort of responsibility, therefore an honest discussion with that person should occur

- If they accept, talk with them about your end-of-life wishes, and complete the document, the Durable Power of Attorney (included in the Advance Directives).

# *Oregon*

- In Oregon, the Health Care Decisions Act allows an individual to preauthorize health care representatives to allow the natural dying process if he or she is medically confirmed to be in one of the conditions described in his or her health care instructions.

# *I have completed the documents: now what ?*

- Make copies for:
  - Your healthcare representative
  - Your doctor(s)
  - Your family

# *Why should I have an Advance Directive?*

- “I have a 2 year old”
- “ I am a white-water kayaker”
- “I climb mountains”
- “I drive a car”
- “ I cross the street”
- “ I am mortal, and life has risks”
- “I want to help my family, should something happen”

# *Patient Barriers to Completion of Advance Directives*

- Belief that physicians should initiate discussions
- Procrastination
- Apathy
- Belief that family should decide
- Family would be upset by the planning process
- Fear of burdening family members
- Discomfort with the topic

# *Physician Barriers to Advance Care Planning*

- Belief that patients should initiate discussions.
- Discomfort with the topic.
- Time constraints.
- Lack of knowledge about AD's.
- Negative attitude.

(Morrison et al, Arch Intern Med, 1994)

# *What is a POLST?*

- A POLST is a Physician Order for Life Sustaining Treatment
- It outlines the kinds of measures to be administered should a patient have an acute event
- As a physician order, it guides Emergency Rescue personnel as to the level of intervention
- www.polst.org  OR Epolst on the EPIC header

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

# Physician Orders
## for Life-Sustaining Treatment (POLST)

**First** follow these orders, **then** contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

First Name/ Middle Initial

Date of Birth

**A** *Check One*

**CARDIOPULMONARY RESUSCITATION (CPR):** **Person has no pulse and is not breathing.**

☐ Resuscitate/CPR ☐ Do Not Attempt Resuscitation (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

**B** *Check One*

**MEDICAL INTERVENTIONS:** **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care.*

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

*Additional Orders*: _____

**C** *Check One*

**ANTIBIOTICS**

☐ No antibiotics. Use other measures to relieve symptoms.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ Use antibiotics if life can be prolonged.

*Additional Orders*: _____

**D** *Check One*

**ARTIFICIALLY ADMINISTERED NUTRITION:** **Always offer food by mouth if feasible.**

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Additional Orders*: _____

**E**

**SUMMARY OF MEDICAL CONDITION AND SIGNATURES**

**Discussed with:**
☐ Patient
☐ Parent of Minor
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Other: _____

**Summary of Medical Condition**

**Print Physician/ Nurse Practitioner Name**

MD/DO/NP Phone Number

Office Use Only

**Physician/ NP Signature** (mandatory)

Date

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

# *Who Needs a POLST?*

- Primarily people who are seriously ill and who may experience a critical event.

- It will ensure that emergency personnel, and loved ones, will make decisions that are consistent with the patient's wishes.

# *How can we all help?*

- Being informed about Advance Care Planning
- Have you completed your own Advance Directives?
- Being aware of resources within the clinical setting, should the patient/family request them
- Not being afraid to talk about it

# *Johns Hopkins*
# *"Palliative Care Temporary Tattoo"*

- 1. What is your understanding of your situation?
- 2. How do you like to get medical information?
- 3. What is important to you?
- 4. What are you hoping for?
- 5. Have you thought about a time when you could be sicker ... Advance Directives or POLST

# *Ultimately…*

- It's about listening, and being present.
- You don't have to have all the answers for patients, just conveying that what they're saying is important and valid.
- Bottom line – patients are in charge of their own medical care and level of intervention.
- Patients deserve focus on quality of life.

# *Bibliography*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