Advance Care Planning (ACP)

預設照顧計劃

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- Birth, age, sickness and death are unavoidable
- Life is uncertain; death is certain
- Most of us are not well prepare for death
- Most of death happened in hosptals

History of ACP in USA

- The concept of advance care planning emerged in the 1960s and 1970s
- In 1990, the U.S. Congress passed the Patient Self-Determination Act
- In 2015, the Institute of Medicine (now the National Academy of Medicine) released a report titled "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life."

Barriers to good end-of-life care planning

- The natural reluctance of patients, families, and clinicians to explore death and dying;
- A fragmented health care system that can make the discussion of end-of-life preferences “someone else's problem”;
- Poor-quality communication in the conversations that are held, often in hurried or crisis situations; and
- Inadequate structural supports for advance care planning, including clinician training, payment, and record keeping.
- 90 percent of Americans know they should have a conversation about what they want at the end of life, yet only 30 percent have done so. 2013.

History of ACP in UK

- In 2004, National End of Life Care Programme
- In 2005, Advance Decisions and Lasting Power of Attorney for Health and Welfare (LPA): The Mental Capacity Act 2005. Amended in 2019.
- In 2007, The Five Priorities for Care: The UK's National Institute for Health and Clinical Excellence (NICE)
- In 2020, Universal Principles for Advance Care Planning. NHS England

Universal Principles for Advance Care Planning

1. The person is central to developing and agreeing their advance care plan including deciding who else should be involved in the process.
2. The person has personalised conversations about their future care focused on what matters to them and their needs.
3. The person agrees the outcomes of their advance care planning conversation through a shared decision making process in partnership with relevant professionals.
4. The person has a shareable advance care plan which records what matters to them, and their preferences and decisions about future care and treatment.
5. The person has the opportunity, and is encouraged, to review and revise their advance care plan.
6. Anyone involved in advance care planning is able to speak up if they feel that these universal principles are not being followed.

History of ACP in Hong Kong

- In 2002, HA Guidelines on Life-sustaining Treatment in the Terminally Ill. Revised in 2020
- In 2019, HA Guidelines on Advance Care Planning
- In 2010, Guidance for HA Clinicians on Advance Directives in Adults. Revised 2020

International Consensus Definition of ACP

- Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.
- The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illnesses.

Definition of advance directive (預設醫療指示)

- An advance directive is a document that allows you to specify your preferences for medical care if you are unable to make or communicate your own decisions.
- Two main types:
  1. Living will: it states which treatments you want or do not want in certain situations i.e. resuscitation or life support
  2. Durable power of attorney for health care. It names a person who can make health care decisions for you when you cannot.
- Recognized under common law in HK for adults aged 18 and above.

Medical intervention for sudden health deterioration

- Life-sustaining treatments:
  - Cardiopulmonary resuscitation, ventilation, blood products, pacemaker, vasopressors, antibiotics
  - Artificial nutrition and hydration
- Palliative Care, place of death
- Organ donation, body donation for cadaveric dissection in Medical school
- Types of funeral
  - Cremation: sea burial, garden burial, crematorium
  - Land burial

Palliative Care - WHO

- Palliative care is an approach that improves the quality of life of patients (adults and children) and their families
- Who are facing problems associated with life-threatening illness.
- It can be provided along with curative treatment.
- It prevents and relieves suffering through
  - early identification
  - correct assessment
  - treatment of pain
  - and other problems, whether physical, psychosocial or spiritual

Hospice care

- For patients with serious illness who is approaching the end of life.
- The Illness is not responding to medical treatment aiming to cure or slow the disease’s progress.
- Similar to palliative care, a multi-disciplinary team off comprehensive medical, emotional and spiritual supports.

Problems arise from unexpected deterioration / death

1. Do not know the preferred treatment: resuscitation, life support
2. Family disagreement: tension, conflicts, legal action
3. Emotional distress
4. Medical team management difficulties

Benefits of ACP to the person

- The person can consider, explore and share with others who, and what, matters most to them in life and how this might change were they to become less well. Many people feel more confident that they have gained more control of their own lives through doing this.
- The person should be able to expect to receive care and treatment which is more in keeping with what matters to them, as far as can be achieved, especially towards the end of their lives. This can include engaging with palliative care, and also connecting them to other services and support they may need to live well for as long as possible.
- The person can better understand which medical interventions may not work in their specific circumstances.
- The person can be more confident that what matters most to them will be known and taken into account as part of treatment decisions in the event of an unexpected emergency situation or should they become unable to fully participate in decision making.

Benefits to families, carers and those important to the person

- Families, carers and those important to the person will be more content and confident in knowing that the person had ownership of the process and was able to make what matters most to them known while the person had capacity to do so.
- Families, carers and those important to the person will be less likely to have to contribute to decisions on behalf of the person without the person's needs and preferences being explored earlier.

Benefits to health and care staff

- Able to deliver better personalised care more confidently if, or when, the person becomes too ill to make decisions or speak for themselves. This is based on an understanding of the person's goals, priorities and values documented through advance statements, and guided by legally binding ADRTs or LPAs for Health and Welfare where these exist.
- Greater enjoyment in their work with more insight into the person's views and preferences.
- Reduced risk of doing something that the person would not want or delivering care in a way they would not wish.
- Improved communication and clarity about treatment decisions and reduced potential for conflict or misunderstanding between care teams.

Benefits to health and care services and system

- Service improvements across the system can be informed by better understanding of people's preferences and priorities, recognising and addressing the diverse needs of individuals and communities.
- Better outcomes and better mental health for the person and health and care workers when an advance care plan is in place.
- More effective and efficient use of resources in delivering person-centred care in preferred locations.

Benefits to society

- Opportunity to promote living well and to improve quality of conversations and understanding about health, illness, death and dying.

Who should be making ACP

- People with chronic conditions or progressive life limiting illness, e.g. dementia, frailty, kidney, heart or liver failure, lung disease, progressive neurological conditions, incurable cancer
- People with declining functional status, increased burden of illness or persistent physical or mental health symptoms
- People facing key transitions in their health and care needs, e.g. multiple hospital admissions, shifts in focus of treatment to a more palliative intent, moving into a care home, etc.
- People facing major surgery or high-risk treatments, e.g. bone marrow transplant
- People facing acute life-threatening conditions which may not be fully reversible

ACP process cycle

1. Think
2. Discuss
3. Documentation
4. Share
5. Review

ACP process - Think

- Start by thinking about what medical care you would like in the future if, for some reason, you could not make these decisions at the time. Base these desires on your personal beliefs and values. Some common questions to think about include:
  - *Would I want to live if I couldn't use my arms or legs?*
  - *Would I want to have invasive ventilation to help me breathe? If so, for how long?*
  - *Would I want to have a feeding tube if I couldn't eat? If so, for how long?*
  - *Would I want to have palliative care? Who would I like to be a part of my palliative care team? Where would I want my care to take place?*
  - *Where would I like to pass away? Who would I want with me? Would I want to die in a hospital or at home?*
  - *Would I want to be resuscitated if I went into cardiac arrest?*
  - *Would I like to donate my organs after my death?*

ACP process - Discuss

- Discuss your wishes with your family and doctors. This is important both so that you have emotional support during the planning process and so that those around you are all aware of your wishes and preferences.
- Formalised your planning into an **advanced care directive**. An advanced care directive is a legally recognised document that by law must be respected and followed by your health practitioners and medical treatment decision-makers.

ACP process - Documentation

- Formalized your planning into an **advanced directive**. An advanced directive is a legally recognized document that by common law must be respected and followed by your health practitioners and medical treatment decision-makers.

HA ACP Form for mentally competent adult

- Medical conditions: diagnosis and prognosis
- Doctor involved
- Other healthcare professionals involved
- Family members involved
- Patient's value, beliefs and wishes
- Designated family member for future consultation
- Patient's preference for personal care
- Patient's preferred place of death. Own home, aged home, hospital
- Patient's decision for life sustaining treatment
- Patient's decision for advance directive and/or DNACPR

ACP process - Share

- Give your advanced care directors to others. Always keep an original copy of yourself but also provide copies to your doctor, family, medical decision maker and the hospital that you most often use. This ensures that the wishes you have outlined in the document will be found and actioned.

ACP process - Review

- Regularly review your advanced care plan so that it stays current to your values, beliefs and wishes.
- Common reasons to review your plan include:
  - Being hospitalised for a deterioration in a chronic illness
  - Being diagnosed with a new chronic or life-limiting illness
  - Having a change in family dynamics or relationships that may change who you would like to be your medical decision maker
- Share any changes you make with your family, doctor and medical decision maker, and provide them with a new updated copy of your advanced care directive with the included changes.

Guardianship Board

- The intention to apply for guardianship is to ask the Guardianship Board
- to appoint someone to become a guardian for another person.
- The Board may give the guardian the legal power to make important decisions relating to personal circumstances for such adults about his/her place of residence or consenting to his/her medical or dental treatment.
- The guardian may also be given legal power to manage a limited amount of that person's money, which currently is a maximum of HK$20,000 per month.
- There is no need to apply for guardianship for emergency medical treatment

Guardianship Application – Medical Conditions

7. I am of opinion that this person is suffering from: **[Please tick]**

- ☐ a) mental illness, Please specify **diagnosis**:
  - ☐ schizophrenia;
  - ☐ delusional disorder
  - ☐ Alzheimer's disease;
  - ☐ vascular dementia;
  - ☐ mixed-type dementia;
  - ☐ others: please specify: _____
- ☐ b) a state of arrested or incomplete development of mind, which amounts to a significant impairment of intelligence and social functioning, which is associated with abnormally aggressive or seriously irresponsible conduct;
- ☐ c) psychopathic disorder;
- ☐ d) other disorder or disability of mind which does not amount to mental handicap:
  - ☐ CVA (Cerebral Vascular Accident / haemorrhage)
  - ☐ acquired brain injury;
  - ☐ a stroke causing some cognitive deficits;
  - ☐ PVS (Persistent Vegetative State);
  - ☐ Comatose / semi-comatose;
  - ☐ others: please specify: _____
- ☐ e) mental handicap (developmental delay).

Guardianship Application - Time

Online Calculator

Time requirements for supporting medical reports:

1. The Application Form (Form 1) with two medical reports must be received and accepted by the Secretariat **within 14 days** of the last examination of the second doctor.
2. Applicant must ensure that they have seen the Subject **within 14 days** of the application date as required by law and confirm it in the application form. Otherwise, the application will be invalid even though the supporting medical reports complied with the following dates.
3. At least one examination must be carried out by an Approved doctor.

Date of last examination of Approved doctor [View Sample]	2024/01/22
Date of last examination of registered medical practitioner [View Sample]	2024/01/22

Calculate

Guardianship Application - Urgent

- Urgent hearing
- Emergency guardianship order
  - Emergency medical treatment does not require emergency guardianship order

Enduring powers of attorney

- A legal instrument which allows its donor (i.e. the person who wishes to give his/her power of attorney to someone)
- While he/she is still mentally capable
- To appoint attorney(s) to take care of the donor's financial matters
- In the event that he/she subsequently becomes mentally incapacitated.

General power of attorney

- It will cease to be effective if the donor becomes mentally incapacitated

End