Journey of Developing the National Programme in Advance Care Planning (ACP) in Singapore

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National ACP Steering Committee

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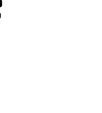
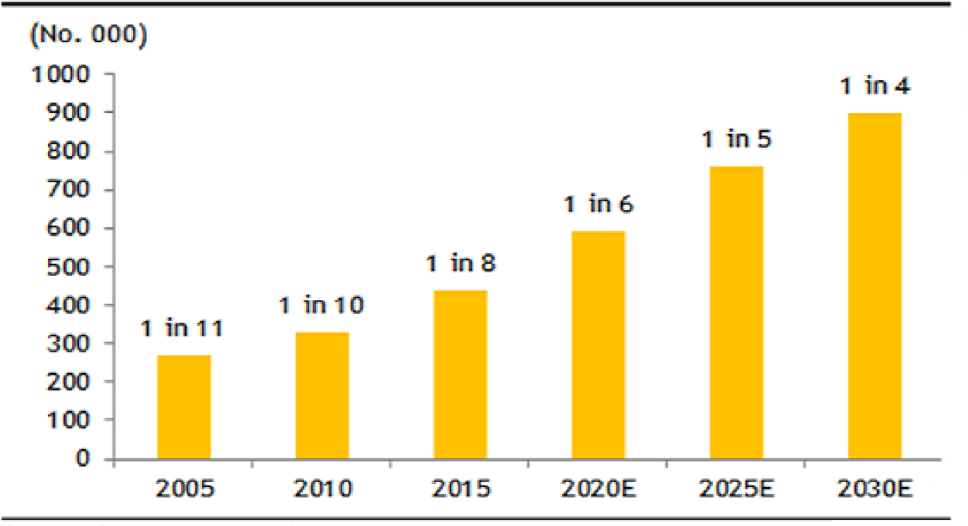
WHAT MATTERS TO YOU?

Quick Facts About Singapore

- Life expectancy 83.9 years





- ıis is

1.5 years longer than in 1990.

It is always too early until it is too late when it comes to ACP
Missed opportunities at engaging our patients and loved ones

Why do we need to plan ahead?

- Most of us will die from a chronic, progressive and ultimately fatal illness

- When the time comes to make important end-of-life decisions, approx. 50% of patients are not capable of participating in these decisions

- When healthcare professionals are uncertain about what decision to make, the default is to treat

- If caregivers have not spoken to a patient about end-of-life issues, they cannot reliably predict what the patient would have wanted

* Relatives & doctors don’t always get it right

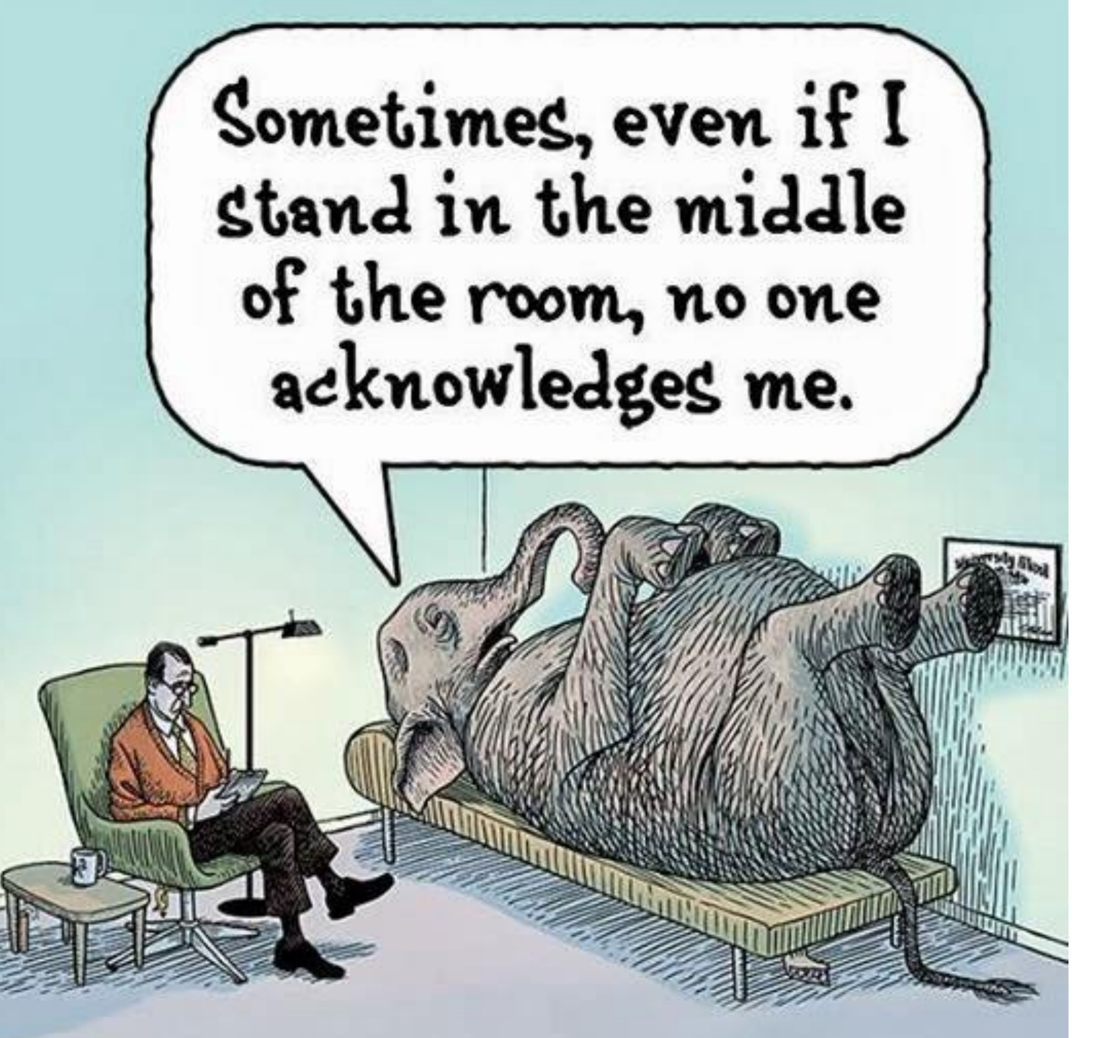
(2016, Singapore) Significant differences noted in their preferences on EOL care options among patients, relatives & health care professionals.

Ang Guat Cheng, Zhang Di, Jim Lim Kim Hwa. Differences in attitudes to end-of-life care among patients, relatives and healthcare professionals. S’pore Med J 2016; 57(1): 22-28

* Patients desire autonomy over EOL decisions

(2012, Singapore) Choice of ICU in EOL: concurrence is 20 out of 30 pairs of patient-surrogate. 80% of patients desired autonomy over their decision.

Foo ASC, Lee TW, Soh CR. Discrepancies in End-of-life Decisions Between Elderly Patients and Their Named Surrogates. Ann Acad Med S’pore 2012;41:141-53


Sometimes, even if I stand in the middle of the room, no one acknowledges me.

Coronavirus: GP Practice Asks Sickest Patients To Sign 'Do Not Resuscitate' Form

Surgery in south Wales apologises about letter advising on best way to limit "scarce ambulance resources".

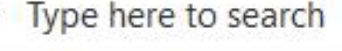
Ad covered content

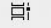
Not interested in this ad

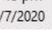
Seen this ad multiple times

Ad was inappropriate

Coronavirus has changed everything. Make sense of it all with the Waugh







ENG 10:13 pm 18/7/2020

The letter warns that, as hospitals are inundated with Covid-19 patients, those with serious conditions such as incurable cancer, motor neurone disease, and untreatable heart and lung conditions were "unlikely to be offered hospital admissions" and "certainly will not be offered a ventilator bed".

It goes on to ask the patients to complete the form as "scarce ambulance resources can be targeted to the young and fit who have a greater chance" of recovering from the virus.

Chris Elmore, the Labour MP for Ogmore, and Welsh Assembly Member Huw Irranca-Davies say they were "deeply concerned" on Monday when they were contacted by a number of "worried constituents" in "distress" over the GPs' plea.

FORM 1

MAKING OF ADVANCE MEDICAL DIRECTIVE

THE ADVANCE MEDICAL DIRECTIVE ACT 1996 [ACT 16 OF 1996, SECTION 3]

THE ADVANCE MEDICAL DIRECTIVE REGULATIONS 1997

PERSON MAKING THE ADVANCE MEDICAL DIRECTIVE

Name:

NRIC No.: - - Sex: Male Female (please tick)

Date of Birth: Day - Month - Year (must be at least 21 years of age)

Address:

Singapore

Office Telephone:

Home Telephone:

THE DIRECTIVE

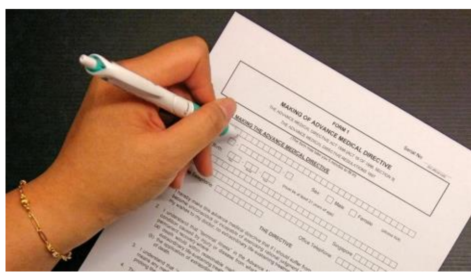
1. I hereby make this advance medical directive that if I should suffer from a terminal illness and if I should become unconscious or incapable of exercising rational judgment so that I am unable to communicate my wishes to my doctor, no extraordinary life-sustaining treatment should be applied or given to me.

2. I understand that "terminal illness" in the Advance Medical Directive Act 1996 means an incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery where -
   (a) death would within reasonable medical judgment be imminent regardless of the application of extraordinary life-sustaining treatment; and
   (b) the application of extraordinary life-sustaining treatment would only serve to postpone the moment of death.

3. I understand that "extraordinary life-sustaining treatment" in the Advance Medical Directive Act 1996 ... medical procedure or measure which, when administered to a terminally ill patient, will only ... but excludes palliative care.

File photo: MOH

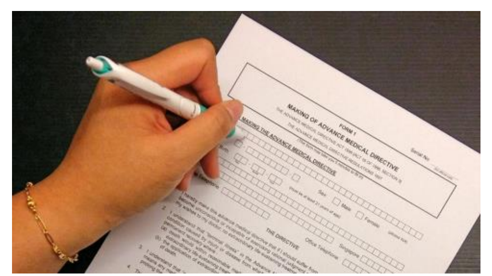
Advance Medical Directive / AMD



Credit: agewell.com.sg

- A legal document
- When you do not want your life to be artificially prolonged in the event you are unconscious, terminally ill and dying
- Form is signed in the presence of 2 witnesses, one of which must be a doctor

Advance Medical Directive / AMD



Credit: agewell.com.sg

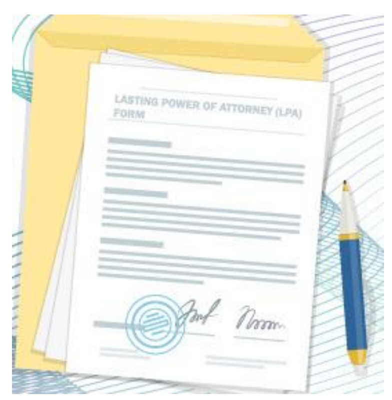
- The form only comes into effect when a patient is certified to be terminally ill by 3 individual doctors
- Doctors will not know that you have an AMD, unless you tell them
- An AMD can be made a GP clinic, polyclinic or hospital (form is found online)

Lasting Power of Attorney / LPA

Credit: msf.gov.sg

- A legal document
- When you (donor) want to legally appoint someone (donee) to help you make decisions on your behalf when you lose your mental capacity
- The appointed person can make decisions regarding your personal welfare and/or your financial matters

Lasting Power of Attorney / LPA



Credit: msf.gov.sg

- However if the decision is regarding life-sustaining treatment or treatment in preventing a serious deterioration of the donor, the final decision will be made by the doctor

- The form comes into effect when the donor loses mental capacity

Lasting Power of Attorney / LPA

Credit: msf.gov.sg

- Doctors will not know that you have nominated an LPA, unless you tell them

- The LPA form can be made by an accredited doctor, a lawyer or a psychiatrist (form is found online)

LPA Process

Advance Planning

Donor

Self (with mental capacity)

Self (without mental capacity)

In the best interest of donor

Makes LPA

- donor signs
- certificate issuer signs
- donee signs

Registers LPA

Office of the Public Guardian

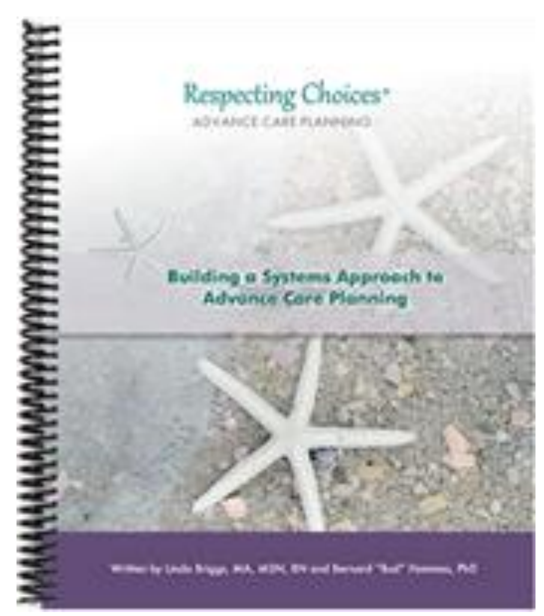
Donee

Help to make decisions on behalf of donor

Property and Affairs

Personal Welfare

History of Advance Care Planning in Singapore



2009
- National Healthcare Group End-of-life taskforce invited Respecting Choices (RC) Faculty from the Gundersen Health System, US to train a pool of ACP facilitators

2010
- Pilots started in Cardiology, Respiratory & Critical Care Medicine & Neurology

2011
- Agency for Integrated Care (AIC) bought the ACP license from Respecting
- Choices® (USA), adapted the ACP framework for Singapore.
- Branding of ACP as Living Matters, https://livingmatters.sg

2012
- With funding from AIC, various project teams in hospitals started its implementation, planning and development.

2017
- Embark on ACP 2.0 to develop and integrate ACP as part of care in all patients as well as healthy individuals.

National programme adapted from Respecting Choices model and renamed Living Matters

General ACP
Nominate **Healthcare Spokesperson** and consider when a serious neurological injury would change goals of treatment

Early onset & medically stable patients

Disease Specific (DSACP)
Determine what goals of treatment should be followed if complications result in “bad” outcomes

Patients with progressive, life-limiting illness, suffering frequent complications

Preferred Plan of Care (PPC)
Establish a specific plan of care expressed in the PPC form

Patients with <12 months prognosis / “No surprise” group

ACP documents are not legally-binding directives and are to be used as guides when the person loses mental capacity. Doctors can step in then to be the final decision-maker, bearing in mind the person’s best interests (includes views of loved ones, past and present wishes in the ACP, etc)

What is ACP?

ACP is **a voluntary process of communication** on future care preferences between an individual, his or her family and healthcare providers.

ACP describes the type of care the person would prefer, if he or she is to become very sick and unable to make healthcare decisions in the future.

The ACP process guides physicians, patients and their loved ones in making decisions based on the patients' values, beliefs, wishes and personal goals of care.

What ACP includes?

Who is ACP for?

ACP is suitable for everyone, in any stage of health, when he/she is ready to talk and plan for future healthcare.

When an individual makes his ACP preferences known, it saves his loved ones from having to make guesses about the type of care he may or may not want, should an unexpected medical emergency happen.

Benefits of ACP

- * **When approached sensitively, no evidence that ACP takes away hope.**
- More information earlier in the course of the ESRD focusing on the impact on daily life empowered patients: a key factor in sustaining patients' ability to hope.
- Sara N Davison, C. Simpson. Hope and advance care planning in patients with end
- stage renal disease: qualitative interview study. BMJ, 2006 Oct 28; 333(7574): 886.

Benefits of ACP

***ACP improves end of life care, and reduces stress, anxiety & depression in surviving relatives**

- Melbourne (2010), RCT (n=309)
- Of the 56 patients who died 6 mth later, EOL wishes were known in 86% (intervention group) vs 30% (control group).
- In the intervention group, surviving relatives had less stress, less anxiety & depression than the control group; and family satisfaction was higher.

Detering KM, Hancock AD, Reade MC, Silvester W.
The impact of advance care planning on EOL care in elderly patients: randomised controlled trial.
BMJ. 2010;340:c1345.

ACP National Office (Agency for Integrated Care)

Role of HQ ACP Office

Engagement

- Hospitals
- Community care providers
- Grassroots Civic groups
- Religious groups
- General public

Training & Education

- Facilitator training
- Advocacy training
- Certification
- Publicity and patient education

System Infrastructure

- Develop ACP IT system
- Maintain central registry of facilitators and instructors
- National ACP forms

Quality Improvement

- Track Programme KPIs
- Report progress to funders
- National standards & guidelines

Preferred Plan of Care (PPC)

This Advance Care Plan (ACP) captures and reflects, as far as possible, the patient's wishes regarding future healthcare if the patient lacks mental capacity to make his/her own healthcare decisions. The doctor will always act in the patient's best interests and everyone shall be treated with dignity and respect.

The PPC discussion is held for patients with advanced illness by a certified ACP Facilitator.

Patient's Particulars	
Name:	
NRIC / ID No:	
Gender:	
Date of Birth:	
Institution/ Programme Name:	
Place of Documentation:	
Date of Session:	

This plan is based on discussion(s) with *(Select all appropriate options)*

- ☐ Patient
- ☐ 1st Substitute Decision-maker
- ☐ 2nd Substitute Decision-maker

☐ This discussion was held with the patient's substitute decision-maker because the patient lacks mental capacity to make his/her own healthcare decisions due to ______________________________
(please state reason, e.g brain tumour, advanced dementia)

A Cardiopulmonary Resuscitation (CPR):
(When the patient is in cardiopulmonary arrest and is not breathing or has no pulse)

- ☐ To proceed with CPR / attempt resuscitation.
- ☐ DO NOT attempt CPR (allow natural death).

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

B Medical Intervention Guidelines:
(When the patient has a pulse and is breathing)

☐ **COMFORT MEASURES ONLY**
Patient is to be treated with dignity and respect. Reasonable measures are made to offer food and fluids. Medications, oxygen and other measures may be used as needed for comfort. Do not intubate. These measures may be used where the patient resides. Consider transfer only if comfort needs cannot be met in current location.

☐ **LIMITED ADDITIONAL INTERVENTION**
Includes care described above. To initiate limited trial of treatment. May include oral/intravenous medications. Continue with comfort measures if there is no clinical improvement. Do not use endotracheal intubation or long-term life support measures. May consider non-invasive ventilation support. Transfer to hospital if indicated. Avoid transfer to intensive care unit.

☐ **FULL TREATMENT**
Includes care described above. May consider intubation, mechanical ventilation, and cardioversion. Management may include transfer to intensive care if indicated. These measures are subject to the assessment and decisions of the hospital care team.

Additional Care Preferences (e.g. dialysis, artificially administered nutrition, use of antibiotics, blood transfusions etc):

C Preferred place of medical treatment and care in event of deterioration

- ☐ Remain in my own home / nursing home / hospice / hospital *(please select one)*
- ☐ Trial of treatment in own home / nursing home / hospice before considering transfer to hospital *(please select one)*
- ☐ Transfer to hospital
- ☐ Others (transfer to hospice, etc) ______________________________
- ☐ No Preference

D Preferred Place of Death in event of deterioration

☐ Nursing Home	☐ Acute Hospital	☐ No Preference
☐ Own Home	☐ Inpatient Hospice	

D Other important notes *(for e.g what living well means to the patient)*

Patient's Particulars:	1st Substitute Decision-maker:	2nd Substitute Decision-maker:
Name:	Name:	Name:
NRIC No:	Relationship:	Relationship:
Signature & Date:	Contact No:	Contact No:
	Signature & Date:	Signature & Date:

Facilitator:	Physician-in-charge
Name:	Name:
Last 4 digits of NRIC:	MCR No:
Signature & Date:	Signature & Date:

Personal Data Protection Act (PDPA) – Client Consent
I understand that the information contained in this ACP document will be stored in hard copy and/or soft copy by this/my organisation using reasonable security measures to ensure that my information is only accessed for legitimate reasons by this/my organisation staff members and transmitted to external healthcare providers caring for me.

Directions For Healthcare Professionals

When completing the "Preferred Plan of Care" document:

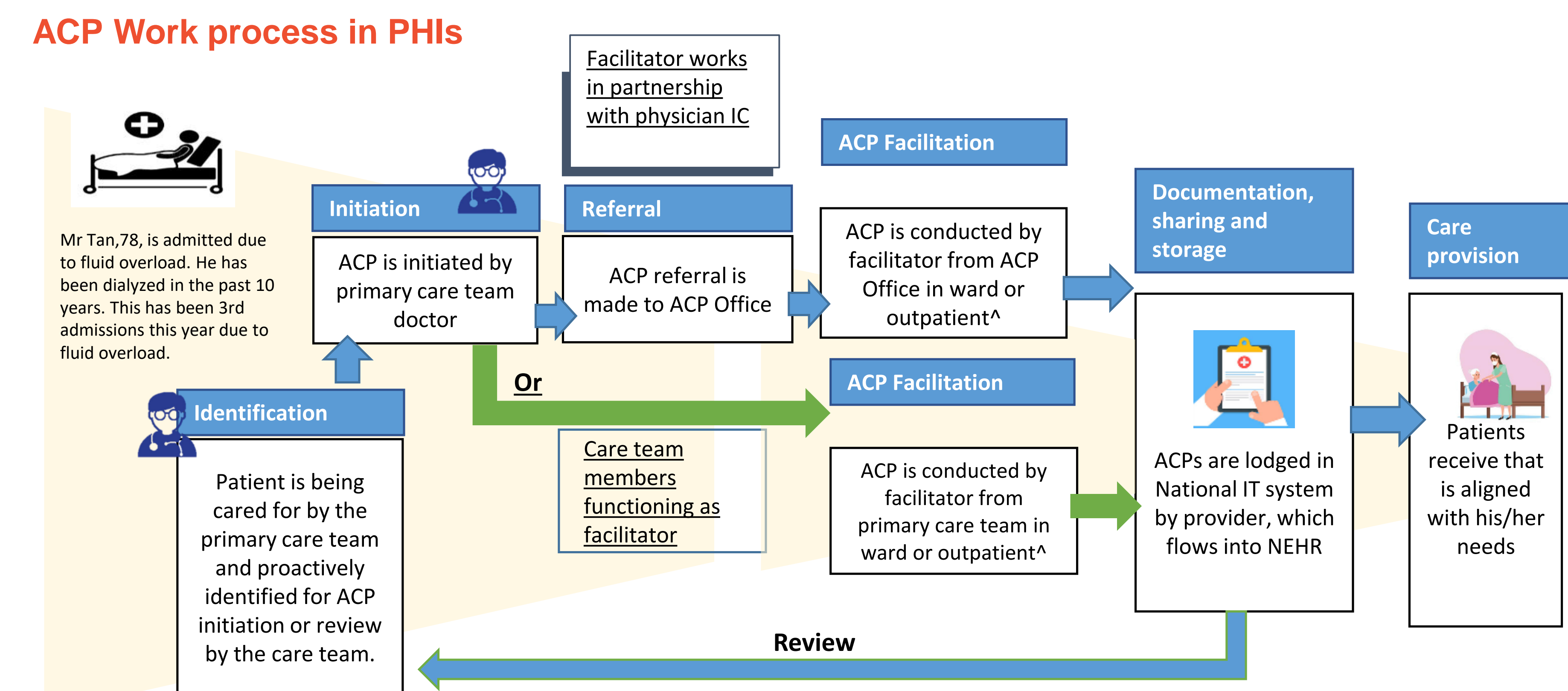
- Any incomplete section of the Preferred Plan of Care form will require physician's discretion, as indicated.
- Tick ☑ all relevant boxes in the form.
- Photocopies and faxes of signed Preferred Plan of Care are valid.
- Place this document at the front of the patient's case notes during each hospitalization.
- This document serves to guide and not dictate medical treatment.
- The patient may verbally change his/her preferences.
- Contact the facilitator or physician-in-charge for any queries.

Review of the Preferred Plan of Care

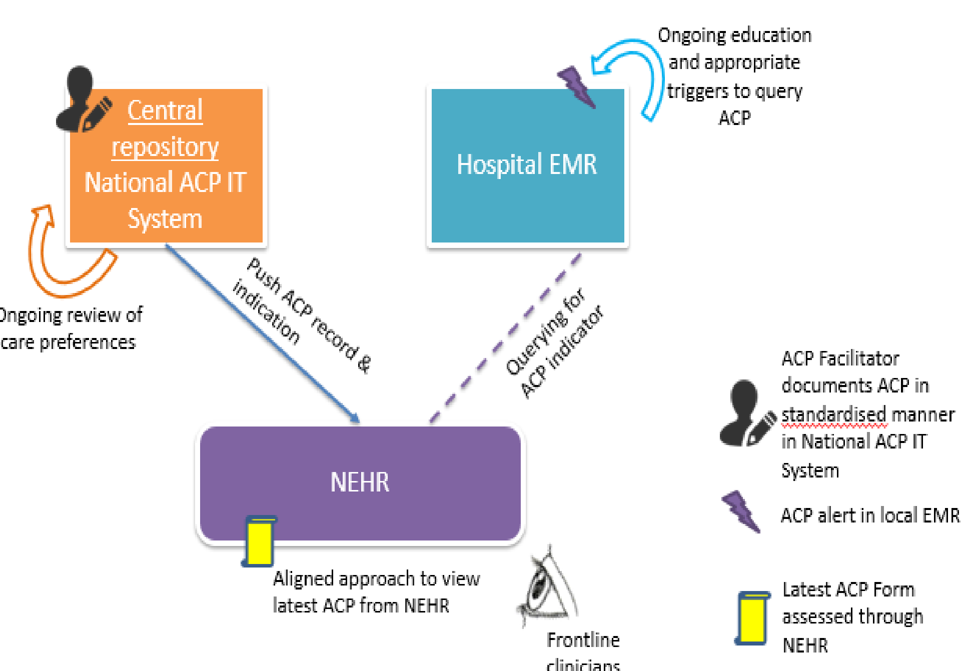
Preferred Plan of Care should be reviewed if:

- The patient is transferred from one care setting or care level to another, or
- There is substantial change in the patient's health status, or
- The patient's treatment preferences change.

PHOTOCOPIES OF THIS FORM ARE TO ACCOMPANY THE PATIENT UPON TRANSFER OR DISCHARGE



^Option for outpatient include tele-ACP and physical session



1. "ACP" alert is currently in place in following hospital EMRs
   - EPIC
   - CPSS2
   - SCM (KTPH/Singhealth)

2. Only the latest ACP i.e. active form is sent to NEHR. System manages the forms through versioning and when a new form is published, old form will be automatically archived without the need of withdrawal. Form withdrawal is only allowed for consent withdrawal and major data entry issue. Once a form is withdrawn, the old form will not be made active automatically. Facilitator will need to review and ensure the preferences are current before publishing a new ACP.

3. In the event that frontline clinicians require discussion worksheet information for the corresponding ACP Form presented in NEHR, the discussion worksheet information is retrievable by certified facilitator (with access to National ACP IT System) of the organisation.

Barriers to Communication in ACP

1. Patient / Family factors

- Anxiety, denial
- Desire to spare patient / protective family members
- Low health literacy

2. Physician factors

- Prognostic uncertainty
- Reluctance to disclose a dire prognosis, ‘too early’,
- fear of diminishing hope
- Inadequate communication skills, own emotional distress, lack of training for EOL conversations
- Perceived low health literacy of patient
- Lack of time

Barriers to Communication in ACP

3. System factors

- Life-sustaining care is the default
- Fragmented institutional systems for end-of-life care (eg. must resuscitate if collapse…)
- Quality of ACP documents may vary, inconsistent across care settings Ambiguity about who is responsible

Ethical Considerations

1. Respect for Autonomy:

-> does not mean allowing unguided choices regarding medical treatment. It is important that physicians provide the **necessary information** to enhance the person's **decision-making ability**.

2. Patient's Best Interests:

-> guided by the ethical principles of **beneficence (doing good)** and **non maleficence (doing no harm)**.

-> **shared decision-making** approach is preferred among patient, family and healthcare professionals.

3. Withholding & withdrawing treatment

-> medical team can withhold or withdraw treatment that is **incompatible** with the patient's wishes, or when the **treatment burden outweighs its benefits.**

-> **time-limited trial of treatment** may be started and eventually withdrawn when treatment proves ineffective.

Jonsen's Four Box Approach

<table>
<tr>
<td>Medical Indication

Medical problem (acute, chronic, emergent)
Goals of treatment
Treatment options and alternatives
Likely success of treatment</td>
<td>Patient preferences

Informed of risks
Understand benefits
Patient has decisional capacity?
Preferences
Surrogates
ACP</td>
</tr>
<tr>
<td>Quality of life

Baseline functionality
Current lifestyle and independence
Expected time of recovery
Possible deficits resulting from treatment</td>
<td>Contextual features

Family
Conflicts of interest
Personal interests
Financial interests
Professional biases</td>
</tr>
</table>

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Notes from the Editor

Advance Directives/Care Planning: Clear, Simple, and Wrong

R. Sean Morrison, MD, Senior Associate Editor

"For every complex problem there is an answer that is clear, simple, and wrong."
—H.L. Mencken

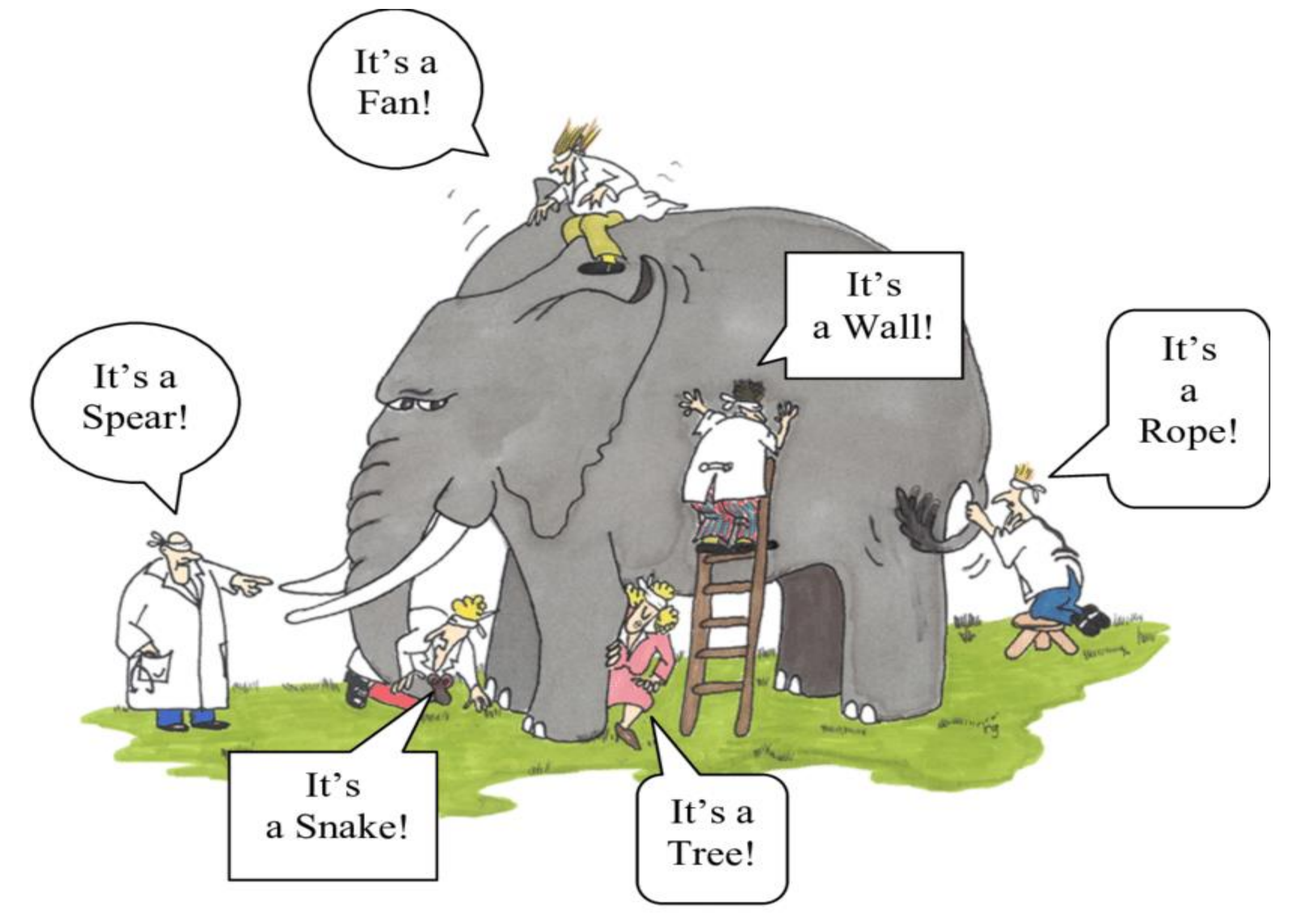
- Jimenez et al. State of advance care planning research: A descriptive overview of systematic reviews. Palliative and Supportive Care, 1–11. https://doi.org/10.1017/S1478951518000500

- Result. Eighty systematic reviews, covering 1,662 single articles
- Significance of results. Despite the surge of ACP research, there are major knowledge gaps about ACP initiation, timeliness, optimal content, and impact because of the **low quality and fragmentation of the available evidence.** Research has mostly focused on discrete aspects within ACP instead of using a holistic evaluative approach that takes into account its intricate working mechanisms, the effects of systems and contexts, and the impacts on multilevel stakeholders. **Higher quality studies and innovative interventions are needed to develop effective ACP programs and address research gaps**

*Morrison et al. What's Wrong With Advance Care Planning? *JAMA.* 2021;326(16):1575-1576.

Advance care planning (ACP) has emerged during the last 30 years as a potential response to the problem of low-value end-of-life care.

However, the scientific data do not support this assumption. **ACP does not improve end-of-life care, nor does its documentation serve as a reliable and valid quality indicator of an end-of-life discussion.**

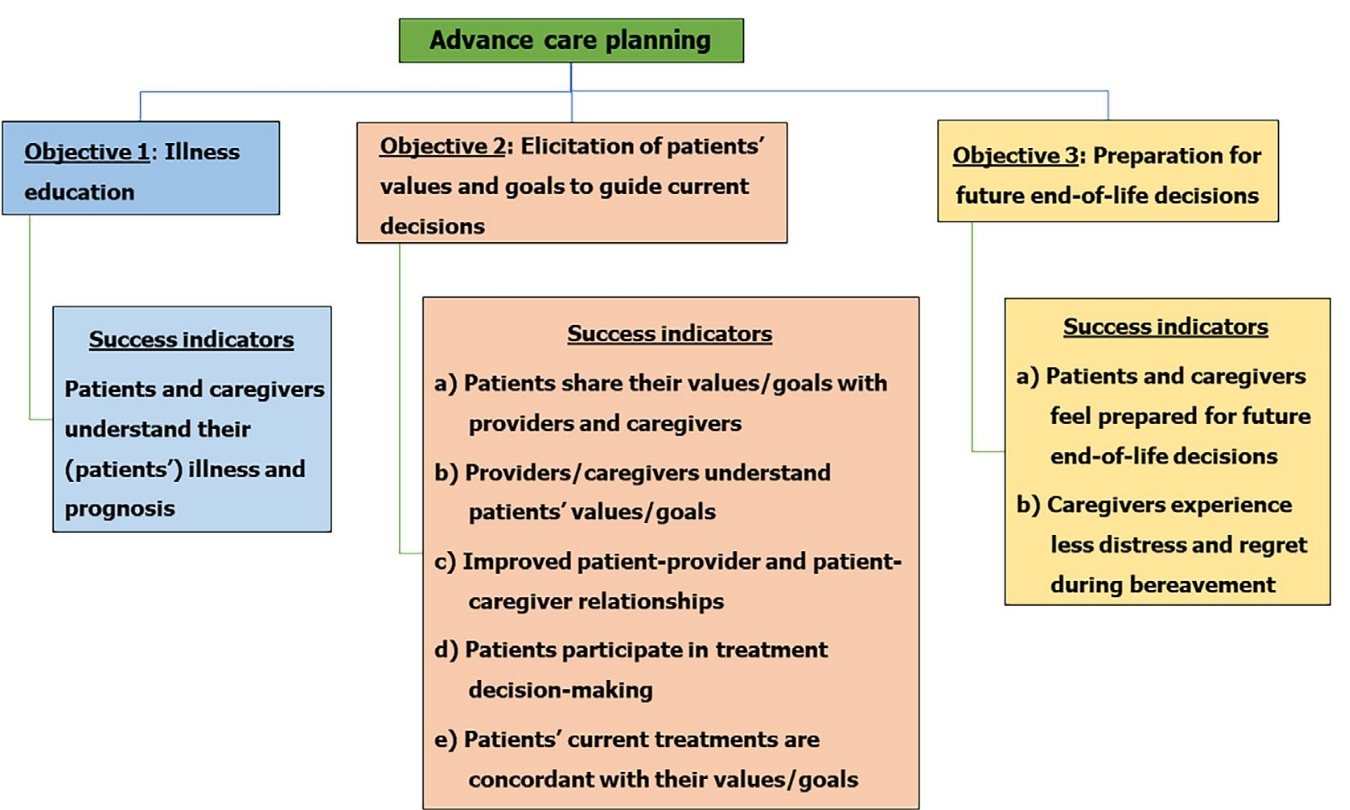

It's a Fan!
It's a Spear!
It's a Wall!
It's a Rope!
It's a Snake!
It's a Tree!

COMMENTARY

Advance care planning: It is time to rethink our goals

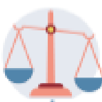
Chetna Malhotra MD, Lien Centre for Palliative Care, Program in Health Services and Systems Research, Duke-NUS Medical School, Singapore, Singapore

Journal of the **American Geriatrics Society**

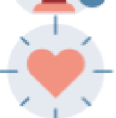


Person's values and beliefs, concerns and fears

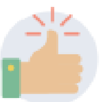
Options that are reasonable



Weigh benefits versus potential burden of treatment



Empathy by acknowledgement and affirmation



Recommend based on patient's best interest

Scan for the Goals of Care Conversations Guide

EARLY CONVERSATIONS, **BETTER** CARE

	Serious Illness Conversation Guide (adapted from Ariadne Labs*)
Set Up the conversation	*"How are you feeling today?* *I would like to talk together about what's happening with your health and what matters to you. Is this ok with you?* *"I am afraid that I might forget something. Is it OK with you if I use this guide and take notes during our talk?*
Assess understanding and information preferences	*"What have your doctors told you about your illness/ current condition?"* *"How much information about your health/illness/condition would you like to know?"*
Share prognosis	*"This is my understanding of where things are at right now…"* *Uncertain: "I'm worried that that your health could change quickly, and I think it is important to prepare for that possibility."* *Time (for doctors only): "I wish we were not in this situation, but I am worried that time may be as short as ……. (Express as a range, e.g., days to weeks, weeks to months, months to a year)"* *Function: "I hope that this is not the case, but I'm worried that this may be the best you will feel, and things might get worse with time."*
Explore key topics	*Priorities/ Goals: "If your health gets worse, what are your most important goals?"* *Fears/ Worries: "What are your biggest worries?"* *Sources of strengths: "What gives you strength as you think about the future?"/ "What gives you strength to go through the hard times?"* *Critical abilities: "What activities bring joy and meaning to your life?" (early in trajectory) "What abilities are so important for you that you can't imagine living without them?" (late in trajectory)* *Trade-offs: "If your health gets worse, how much are you willing to go through for the possibility of living longer?" (May need to give some context and examples)* *Family: "Is your family aware about what is important to you?"*
Close the conversation **Recommendation**	*"I've heard you say that _______ is important to you."* *"Keeping that in mind, and what we know about your illness, I recommend that we _______. This will help us make sure that your care reflects what's important to you."* *"How does this plan sound to you?"* *"If you think of anything else later, we can revisit this conversation another time."*

Art of Engagement

Death denying culture

Nudge

What is Advance Care Planning

Advance Care Planning (ACP) is the process of planning for your future health and personal care. Having ACP conversations with your loved ones allows you to:

- Share your personal values and beliefs
- Explore how your values and beliefs affect your healthcare preferences in difficult medical situations
- Think about who among your loved ones can be your voice if you become very ill one day

Have you experienced the death or near death of a loved one? What have you learnt from that experience?

It's ok if you don't have a personal experience. You can draw examples from the following:

- Newspaper articles and TV news stories
- Books and magazines
- Scenarios from movies and TV shows

....

....

....

....

....

The categories and examples that follow are meant to guide you. You can select more than one option in each category, or come up with your own responses.

What are the most important aspects about your well-being?

My Physical Well-Being

- Being able to walk and move around by myself
- Being able to feed, bathe and dress myself
- Being able to talk to and be close to my loved ones
- **Others:**

....

My Mental Well-Being

- Being able to make my own decisions
- Being able to talk to and understand the people around me
- Being aware of who or where I am
- **Others:**

....

My Emotional Well-Being

- Being able to contribute to society
- Being able to live a life that is meaningful
- Being able to feel the love and concern of others
- **Others:**

....

Your responses in this section can help your loved ones and doctors understand how best to care for you should you become very ill one day.

Credit: Agency for Integrated Care

My Care Wishes

Now that you have considered the things that give your life meaning, think about how you would like to be cared for if you can no longer enjoy any of these things.

My greatest fears and worries about having a serious illness are...

TIP Being honest and open about your fears and worries can help your loved ones better understand your care wishes.

- ◯ Pain
- ◯ No one to care for me
- ◯ Causing worry to my family
- ◯ Financial burden
- ◯ Not being able to move around on my own
- ◯ No freedom to do what I want
- ◯ Others: ....

Picture yourself in each scenario and select the bubble ◯ that best reflects how you feel. There is no right or wrong answer and it is perfectly fine to change your mind later on.

If I am seriously ill and cannot speak, move around or make my own decisions one day...

This is exactly how I feel	*This is how I feel sometimes*	*I'm not sure how I feel about this*	*This is how I feel sometimes*	*This is exactly how I feel*
◯	◯	◯	◯	◯
My loved ones and doctors can make care decisions for me based on what they think is best.				My loved ones and doctors should think about what I would want for myself before making any decisions on my behalf.

Credit: Agency for Integrated Care

TIP The clearer you are about your preferences, the easier it will be for your loved ones should they ever need to make these decisions on your behalf.

If I have an injury or illness, and my doctors believe that I would have a low chance of recovery...

This is exactly how I feel	*This is how I feel sometimes*	*I'm not sure how I feel about this*	*This is how I feel sometimes*	*This is exactly how I feel*
◯	◯	◯	◯	◯
I want to live for as long as possible. Continue trying all medical treatments, even if my chance of recovery is low.				I want to go peacefully and naturally when the time comes. I cannot imagine using a machine to stay alive.

Being able to take care of myself (for example, bathing, eating, moving around) is...

This is exactly how I feel	*This is how I feel sometimes*	*I'm not sure how I feel about this*	*This is how I feel sometimes*	*This is exactly how I feel*
◯	◯	◯	◯	◯
Not that important. I do not mind being helped by someone else if that means I can live longer.				Very important. I need to be independent, even if that means a shorter life.

ACP Ethics Webinar 2021_EDM.pdf - Adobe Acrobat Reader DC

PROGRAMME

Advance Care Planning Ethics Webinar

Challenges & Dilemmas in Honouring Advance Care Planning: Are We Giving False Promises?

Consultant (General Medicine),
Tan Tock Seng Hospital

Speaker:

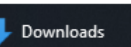
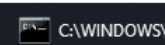
Dr Eunice Chua Shumin

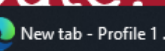
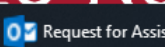
Dr Chua is a Consultant wit
General Medicine. She serves
for Advance Care Planning in T
(TTSH), and is a member of th
Committee & the TTSH Ad
Advisory Committee.

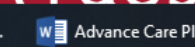
Date: 23 Nov 2021 (Tues)

20 - 26 NOVEMBER 2021

TIME OF YOUR LIFE X LIFESTYLE



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Misconception in ACP

Misconception	Reality
ACP is a conversation about death.	ACP is an ongoing discussion about your healthcare preferences. It encourages you and your loved ones to discuss and understand your values, beliefs and wishes.
ACP is only for the elderly and sick.	ACP is for everyone. Healthy individuals, young adults, working professionals and retired seniors are encouraged to discuss about the type of healthcare they prefer.
ACP is to withdraw life-sustaining treatment.	ACP is a discussion about your healthcare preferences. You may indicate your preference is to withdraw active treatment, or receive other treatment where clinically appropriate.
ACP means the medical team has given up on me.	ACP helps the medical team to understand your wishes and deliver the type of healthcare and services that align with your care preferences.

Factsheet – CPR, Ventilation

Understanding Cardiopulmonary resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) may be done if a person stops breathing and/or has no pulse. It can include:

1. Breathing into your mouth and pressing onto your chest to restart your heart's pumping action
2. Electrical shock and drugs to try and start your heart
3. Inserting a tube to help you breath

Does CPR works?
CPR may be successful (i.e bring back normal function of the heart or lungs) if

- You are healthy with no significant chronic medical illness
- CPR is done within a few minutes when your heart or lungs stops working

CPR may not work if

- You have chronic medical problems such as underlying heart or lung disease.
- You have an illness that is terminal
- You are very old and frail.

What are the chances of surviving after a CPR?
Some studies have shown that if you are in the hospital and get CPR, you have a 17% chance of having a successful CPR and leaving the hospital alive. If you are older, weak and have underlying medical conditions, chances of having a successful CPR is less than 3%.

The outcomes of CPR

- There may be rib fractures from CPR
- There may be permanent brain damage
- There will usually be a need to be on a breathing machine
- Care in the Intensive Care Unit (ICU) is usually required

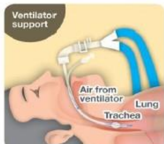
You may want to consult your doctor to find out more.

Understanding Mechanical Ventilation (MV)

What is Mechanical Ventilation?
Mechanical ventilation is the use of a machine to assist in breathing. There are 2 types of mechanical ventilation: Invasive and Non-Invasive Ventilation (NIV).

What is Invasive Ventilation?
Invasive ventilation involves a tube that goes into your windpipe. It is connected to a machine that takes over the work of breathing. It will not be possible to eat or speak during this time. Therefore, tube feeding will be required. Medicine can be given for pain or distress. This can only be carried out in the Intensive Care Unit.

What is Non-Invasive Ventilation (NIV)?
NIV is given through a tight-fitting mask. It may be an alternative to invasive ventilation for some conditions. The tight fitting mask may hurt the skin. Air may leak into the stomach and cause discomfort. It may be difficult to eat or speak.



Will Mechanical Ventilation work?

Mechanical ventilation or NIV may work best if:

- Your condition may be improved
- Your condition is acute and a short period on a ventilator may be helpful

Mechanical ventilation or NIV may not work if:

- Your condition is chronic and progressive.
- Your condition is irreversible and terminal.
- Your condition is so severe that the ventilator is unable to assist the body to function normally.

What if Mechanical Ventilation doesn't work?

You will need to think about what you want to do if mechanical ventilation does not work. What if your condition gets worse? What if you cannot think or talk? Will you want to stop the ventilator if these things happen?

Talk to your doctor and family about what you would want them to do.

Factsheet on Tube Feeding

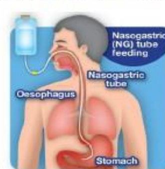
Understanding Tube Feeding

If you are unable to swallow safely or take in enough food or water for your daily needs, you may want to consider an alternative way of feeding such as tube feeding. The decision for tube feeding, however, depends on your medical condition, your personal values, and, its benefits need to be weighed against its harm.

What is tube feeding?

Tube feeding is an alternative route of feeding by inserting a tube either

- Through the nose into your stomach (nasogastric tube - NG) or,
- Through the skin of your stomach (percutaneous endoscopic gastrostomy- PEG)
- Nutritional supplements are given through the tube to help meet your nutritional needs.



How can tube feeding help?

Depending on your medical condition, you may be tube-fed for a short period until you are safe to swallow again, or for an indefinite period.

What are the problems of tube feeding?

- Discomfort due to the insertion or from the tube itself
- Hand restrains may be needed to prevent accidental pulling of the tube
- Chest infection due to the possibility of feeds entering the lungs instead
- Swelling of the body may occur if the supplements cannot be absorbed as the body function shuts down.

You may want to consult your doctor/ speech therapist /dietitian to find out more.

Warning: The facts provided here are for educational purposes. Please consult your doctor for treatment specific questions. Please do not disseminate, distribute, or use this factsheet without permission.

Kata-Kata Kita poster.pdf - Adobe Acrobat Reader DC
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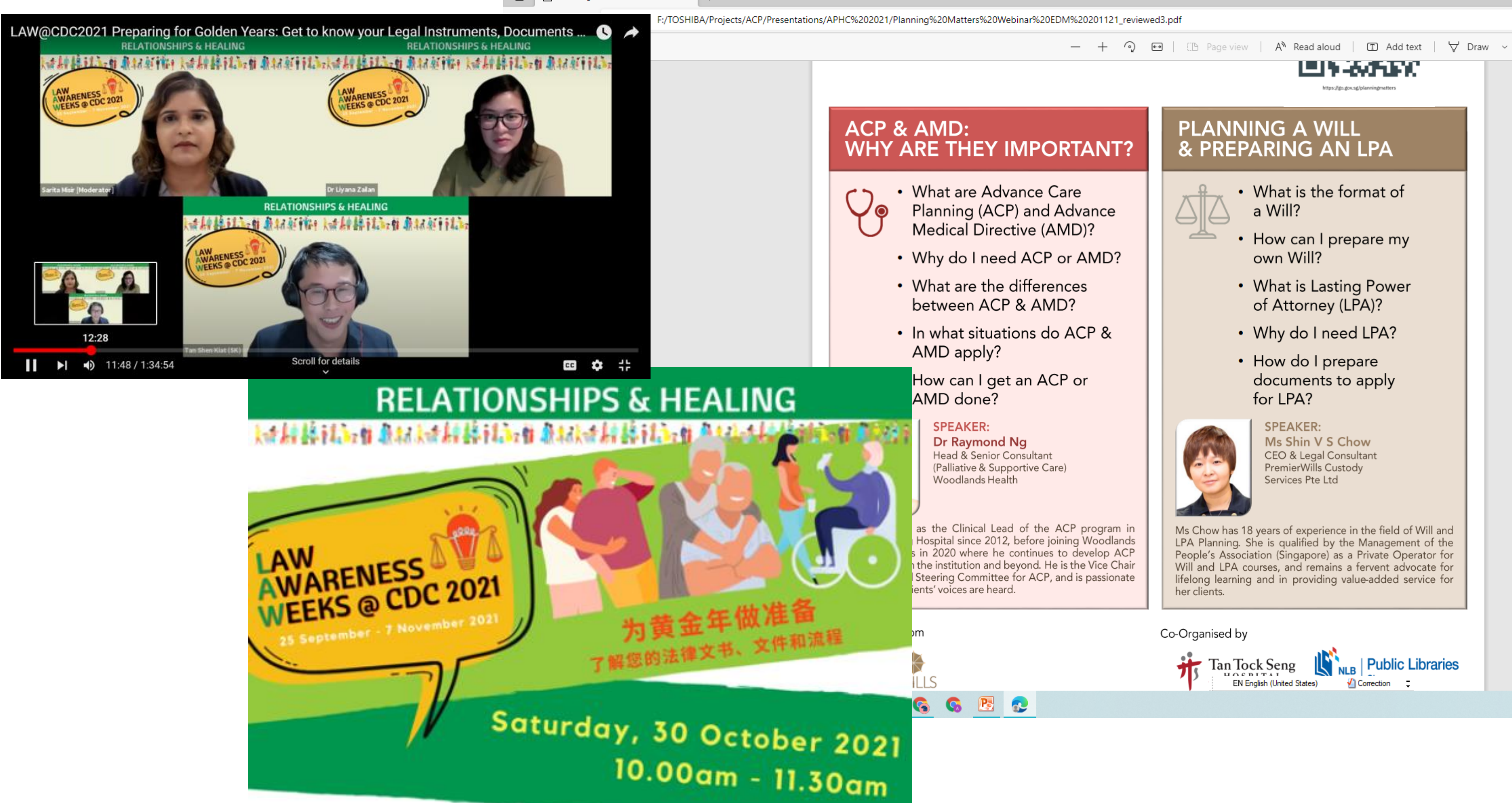
LAW@CDC2021 Preparing for Golden Years: Get to know your Legal Instruments, Documents ...
RELATIONSHIPS & HEALING
Sarita Misr [Moderator]
Dr Liyana Zailan
Tan Shen Kiat (SK)
12:28
11:48 / 1:34:54
Scroll for details
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Page view
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ACP & AMD:
WHY ARE THEY IMPORTANT?
What are Advance Care Planning (ACP) and Advance Medical Directive (AMD)?
Why do I need ACP or AMD?
What are the differences between ACP & AMD?
In what situations do ACP & AMD apply?
How can I get an ACP or AMD done?
SPEAKER:
Dr Raymond Ng
Head & Senior Consultant
(Palliative & Supportive Care)
Woodlands Health
as the Clinical Lead of the ACP program in Hospital since 2012, before joining Woodlands in 2020 where he continues to develop ACP the institution and beyond. He is the Vice Chair Steering Committee for ACP, and is passionate ients' voices are heard.
PLANNING A WILL
& PREPARING AN LPA
What is the format of a Will?
How can I prepare my own Will?
What is Lasting Power of Attorney (LPA)?
Why do I need LPA?
How do I prepare documents to apply for LPA?
SPEAKER:
Ms Shin V S Chow
CEO & Legal Consultant
PremierWills Custody
Services Pte Ltd
Ms Chow has 18 years of experience in the field of Will and LPA Planning. She is qualified by the Management of the People's Association (Singapore) as a Private Operator for Will and LPA courses, and remains a fervent advocate for lifelong learning and in providing value-added service for her clients.
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LAW AWARENESS WEEKS @ CDC 2021
25 September - 7 November 2021
为黄金年做准备
了解您的法律文书、文件和流程
Saturday, 30 October 2021
10.00am - 11.30am
COMMUNITY DEVELOPMENT COUNCIL

ACP CLAN:
CONTINUOUS LEARNING AND NETWORKING

Compassion and Emotional Competency in Advance Care Planning

This workshop aims to provide participants with an overview of the conceptual and empirical foundations of compassion in clinical work, with an emphasis on nurturing self-compassion through the core principles of mindful awareness, kindness presence, and common humanity. Participants will get a chance to examine their personal experiences of work-related stress while discovering new insights to overcoming these challenges through an experiential mindfulness practice and breakout room discussion on compassionate self-care.

Learning Objectives

- To discuss the conceptual and empirical foundations of compassion and self-compassion
- To explore compassionate practices for building resilience and emotional competency in ACP
- To examine experience of work-related stress and ways to engage in compassionate self-care

Details

7 December 2021 (Tuesday)

Speaker

Prof Andy Hau Yan HO

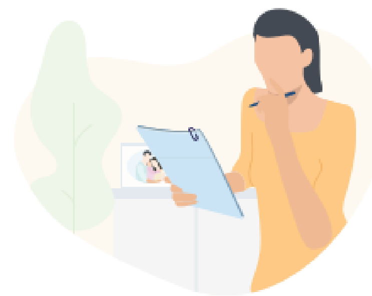
Associate Professor of Psychology and Medicine, Nanyang Technological University

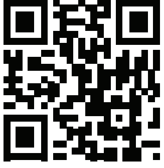
Deputy Director of Research, Palliative Care Centre

The pandemic has been an impetus for change

What can I do on My legacy?

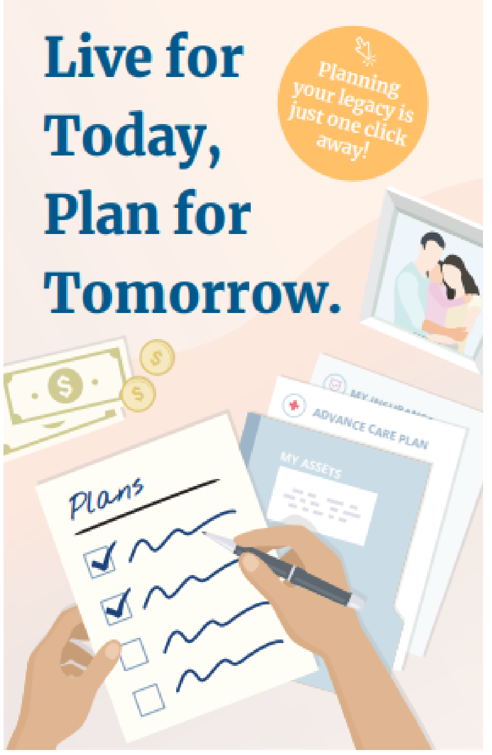
- Organise and plan your will, lasting power of attorney, advance care plan, CPF nomination and funeral wishes
- Upload and store your documents safely in one place for secure and easy access
- Share important information with people you trust
- Understand what you need for end of life care





Find out more at **mylegacy.gov.sg**

Live for Today, Plan for Tomorrow.



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You've saved up for a rainy day

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You've even thought about when 'enough is enough'

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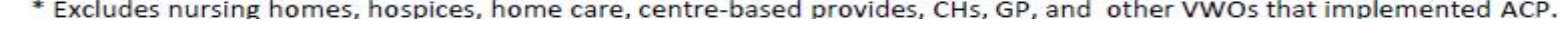
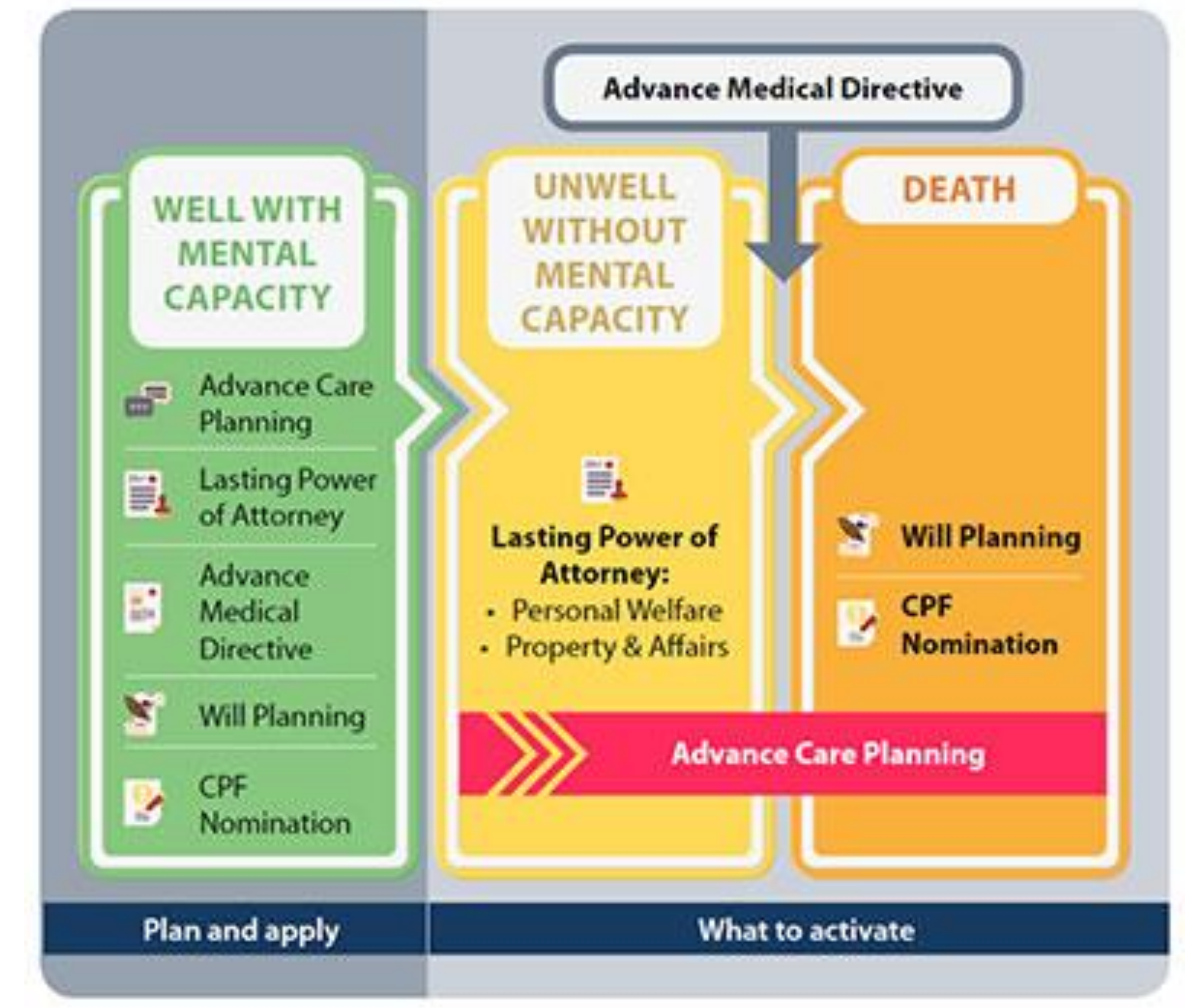
For more information

ACP Directory in AIC

https://www.aic.sg/care-services/acp-directory



Better Health. With You.



Credit: Agency for Integrated Care

Overseas ACP frameworks

Content covered	Australian National Framework for ACP Documents (2021)	ACP - A guide for the New Zealand Healthcare Workforce (2021)	National Health Service ACP Framework (2015)	ACP in Canada - A Pan-Canadian Framework (2020)
Glossary of terms	✓	✓	✓	✓
Definition/Concept of ACP	✓	✓	✓	✓
Purpose of framework	✓	✓	✓ *Explicitly stated populations excluded in coverage of framework (e.g. CYP, advanced dementia)	✓ *Structured as vision, mission, goals and long term national roadmap (including 10 year national goal)
Structure of framework	**How ACP conversation should be conducted:** • Structured as 3 iterative stages: 1. Having ACP conversation 2. Making an ACP document 3. Accessing and enacting an ACP	**How ACP conversation should be conducted:** • Structured as 5 steps: 1. Value of ACP 2. Deciding when to have conversation 3. Explaining the process and getting started 4. Involving the right people 5. Documenting discussions	**How ACP should be implemented by providers:** • Adapted from Respecting Choices Framework • Structured as 4 sections: engagement, education, system infrastructure, quality improvement)	**How ACP should be implemented by providers:** • Structured as priority actions at national, regional and local level • 4 sections: Extend partnership network, build supportive systems, engage and educate all stakeholders, measure Impact)
Barriers to ACP implementation	✓	✓	✓	✓
Ethical considerations	✓	✓		✓
Legal considerations	✓	✓	✓	✓
Quality indicators	✓	✓		✓
Special populations		✓ *Populations covered: MCI, intellectually/ visually/hearing/ physically/ speech impairments		✓ *Populations covered: Underserved communities

ACP Quality Implementation Workgroup

WORLD CAFÉ June 2023

Behaviour change	**Awareness, desire and knowledge**		**Action**		**Review**
Main processes	**Awareness and advocacy**	**Identification by care team for ACP *based on the defined criteria***	**Having the conversations**	**Documentation**	**Accessing and honouring**

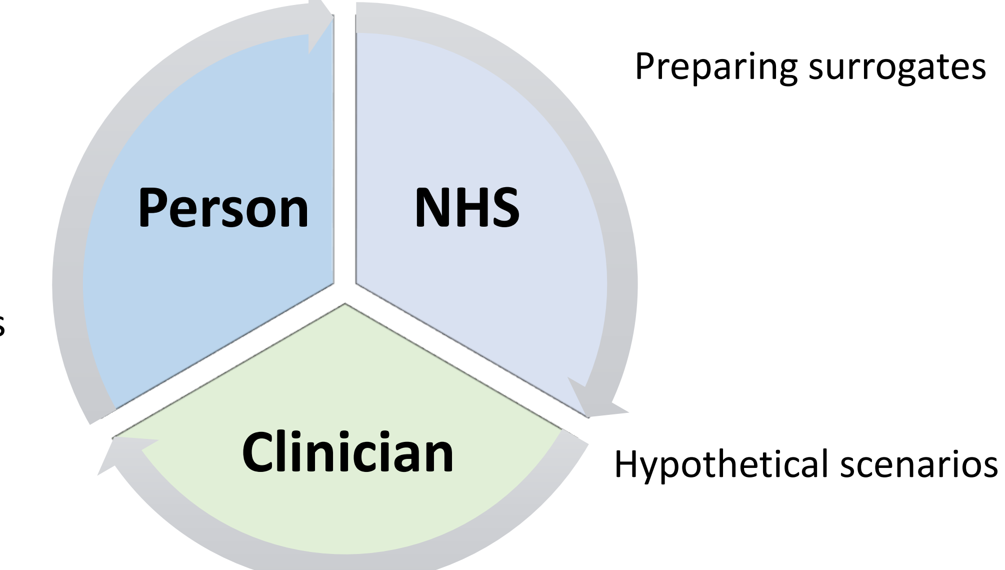
RESTRICTED, NON-SENSITIVE

Focus on the conversation not the form, the process not the product

Anticipatory care planning for serious illness, not just death and dying

Relevant for EVERYONE, not just the elderly and sick

Iterative Cycle of Conversations and Care Planning



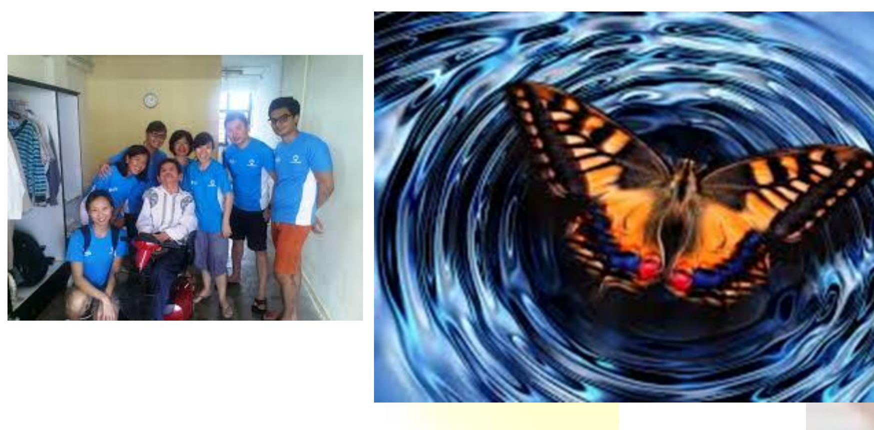
Preparing surrogates

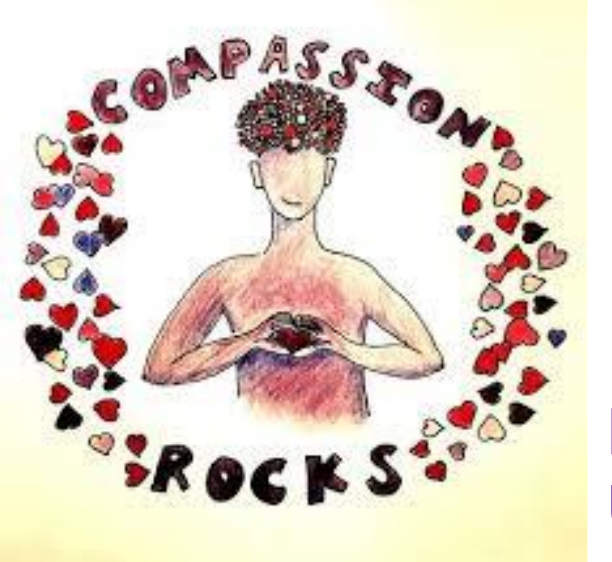
Start conversations early

Hypothetical scenarios

Values history

Make Best Interest Recommendations





Remembering the heart of ACP : Understanding what matters to the person

TALKING ABOUT END-OF-LIFE CHOICES IS DIFFICULT, THERE NEVER SEEMS TO BE A GOOD TIME ….

BUT WE DO NOT HAVE TO WAIT FOR A CRISIS BEFORE HAVING THE CONVERSATION

Leave
LIVE
WELL