Advance treatment planning | Te whakamahere ā-mua i te whakamaimoatanga

Understanding the process

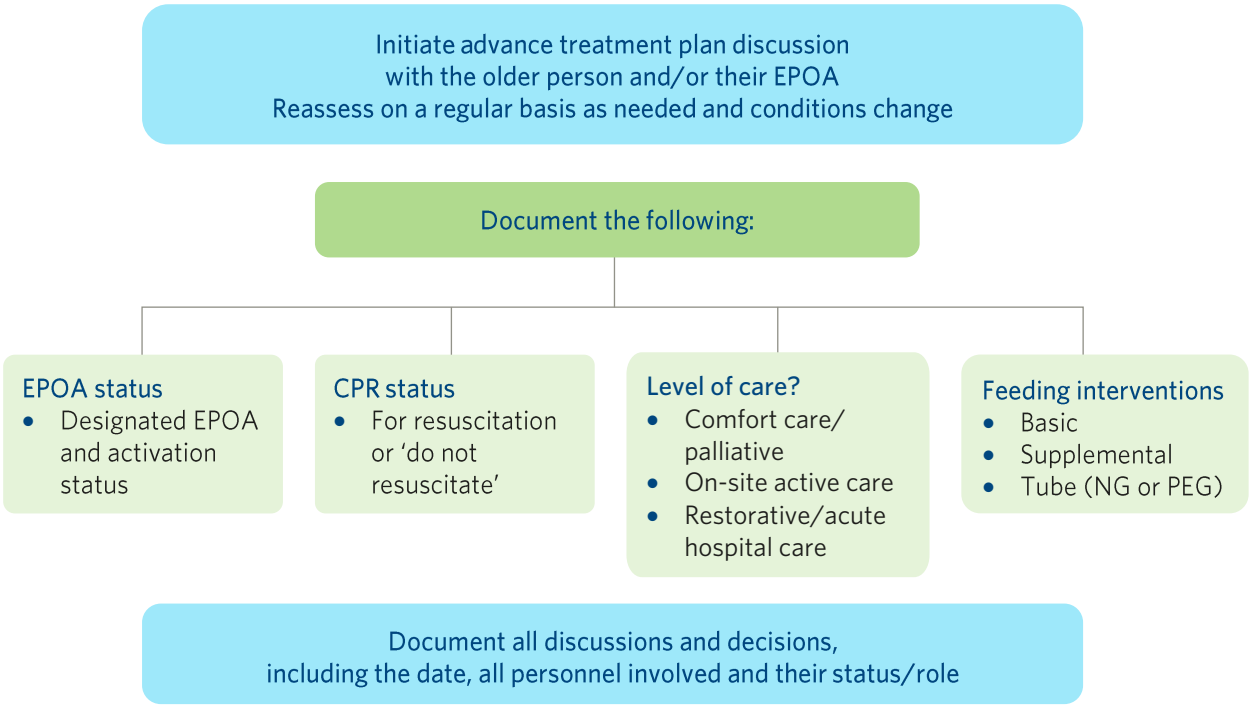
Advance treatment planning/shared goals of care is a process that gives you the opportunity to plan for health care preferences with the older person, their family/whānau and the health care team. It is a way to capture the wishes of the older person and their family/whānau in the care plan.

It is an ongoing process that should be discussed and updated on a regular basis. It does not have to be a legalised formal process but rather part of the care. Review should be carried out any time there is a change in the resident's status or at least annually.

All discussions and decisions must be documented, including the date, all personnel involved in the discussion and their status/role.

Please direct residents and family/whānau to *My Advance Care Plan and Guide* (www.hqsc.govt.nz/our-programmes/advance-care-planning/publications-and-resources/publication/3212) for more information about personal advance care planning.

Modified *Let me decide tool* for advance treatment planning (adapted from Molloy et al 2000)



Level of care definitions

Comfort care (includes palliative care)

- Do not transfer to hospital unless absolutely necessary (unless for traumatic injury).
- Keep the person warm, dry and pain free.
- Only give measures that enhance comfort or minimise pain.
- Subcutaneous line started only if it improves comfort.
- No X-rays, blood tests or antibiotics unless they are given to improve comfort.
- Care aimed at comfort measures rather than preserving life.

On-site active care

- May or may not transfer to hospital.
- Intravenous therapy may be appropriate.
- Antibiotics should be used sparingly.
- A trial of appropriate drugs may be used.
- No invasive procedures, eg, surgery (unless for traumatic injury).
- Treatment aimed at reducing further health decline as well as enhancing comfort.

Restorative/acute hospital care (includes surgical)

- Transfer to acute care hospital if treatment cannot be provided on site.
- Emergency surgery may be appropriate.
- Treatment aimed at preserving life as well as enhancing comfort.

An editable shared goals of care template can be downloaded here:
www.hqsc.govt.nz/our-programmes/talking-covid/publications-and-resources/publication/4003.

Initiate the advance treatment planning discussion

Initiate the discussion about care preferences at the time of admission. Find out and follow your facility's protocol for these discussions.

Special considerations need to be made for residents no longer able to make their wishes known.

Document EPOA status

- Is there a designated EPOA for personal care and welfare?
- Document who the EPOA is in the advance treatment planning document.
- Is there a copy of the EPOA document? If so, check signature, date, etc.
- Has the EPOA been activated?
- The EPOA cannot make decisions regarding end of life and can only provide guidance regarding the resident's wishes. End-of-life treatment is ultimately a medical decision.

Document CPR status

Discuss with the older person and/or their family/whānau the following:

- CPR: use cardiac massage with breathing; may also include intravenous lines, electric shocks to the heart (defibrillators), tubes in the throat to lungs (endotracheal tubes) OR
- NO CPR: make no attempt to resuscitate. Allow natural death and do not prolong the dying phase.

Document level/goals of care

Is there an existing advance treatment plan? Discuss if all aspects are still valid and place it in the resident's chart. Under what conditions would the advance treatment plan be activated? See page 2 for level of care definitions.

Document feeding options

Discuss with the older person and/or their family/whānau the following options:

- Basic: spoon-feed with regular diet; give all fluids by mouth that can be tolerated but make no attempt to feed by special diets, intravenous fluids or tubes
- Supplemental: give supplements or special diets, eg, high-calorie, fat or protein supplements
- Nasogastric tube: a soft plastic tube passed through the nose or mouth into the stomach
- Gastrostomy tube: (known also as a PEG (percutaneous endoscopic gastrostomy) tube); a soft plastic tube passed directly into the stomach through the skin over the abdomen.

Make sure that wishes are clearly articulated and documented. Avoid using terms such as 'no heroic measures' but instead help older people and their families/whānau clearly articulate their care wishes, particularly regarding CPR, feeding and treatment. Discuss level of care and goals of care (examples on previous page).

Bibliography | Te rārangi pukapuka

Advance treatment planning

Molloy DW, Russo R, Stiller A. 2000. How to Implement the "Let Me Decide" Advance Health and Personal Care Directive Program. *Journal of Clinical Outcomes Management* 7(9): 41–7.

See the full range of frailty care guides here.