15th HKEC Online Symposium on Community Engagement:
End-of-life Care & Elderly Service Seminar (2 June 2021)

Advance Care Planning: Conception, Consultation and Conversation
預設照顧計劃：理念、諮詢、對話

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Conception

What is Advance Care Planning (ACP)?

ACP enables individuals to **reflect upon** the meanings & consequences of serious illness scenarios, to **define goals and preferences** for future medical treatment & care, to **discuss** these goals & preferences with family & healthcare providers, & to **record** and **review** these preferences if appropriate.

Think → **Talk** → **Text**

Rietjens JAC, Sudore RL, Connolly M, et al. Definition and recommendations for advance care planning: an international consensus supported by the European Association for Palliative Care. *Lancet Oncol*. 2017;18(9):e543-e551.

Who to be involved?

Framework

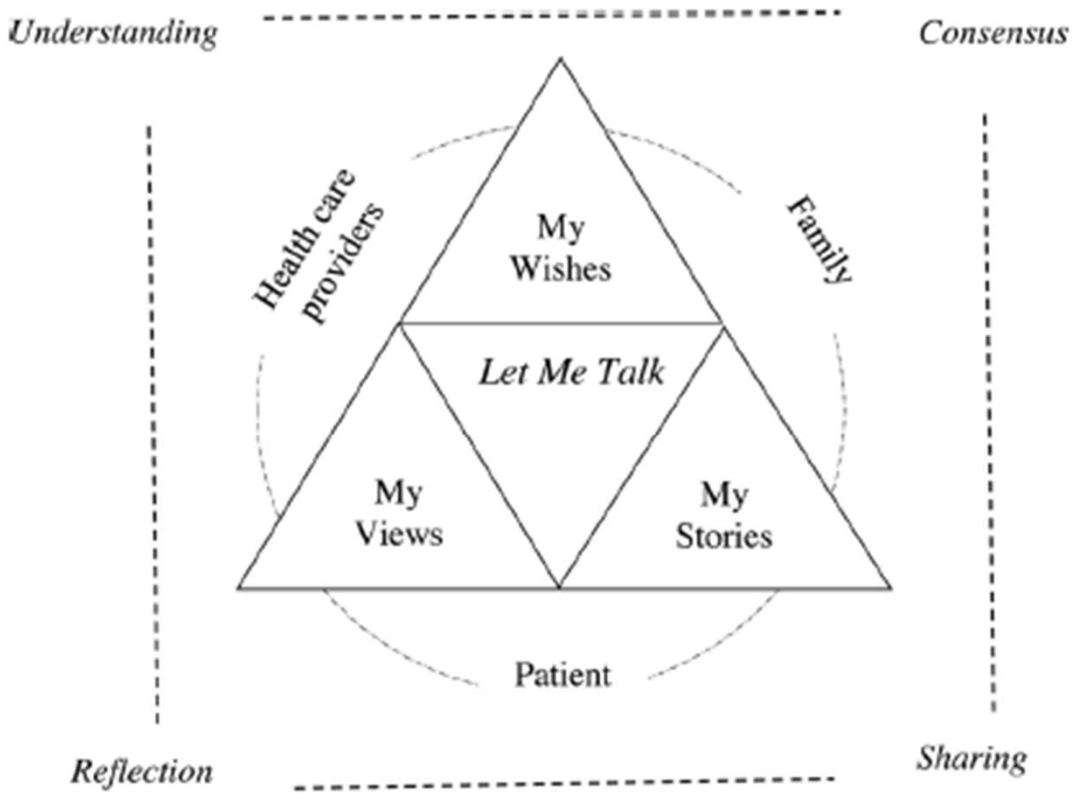


Fig. 1. Conceptual framework of the advance care planning programme.

Chan, H. Y. L. & Pang, S. M. C. (2010). Let Me Talk – an advance care planning programme for frail nursing home residents. *Journal of Clinical Nursing, 19,* 3073-3084.

Framework

Disease	anticipated progression and prognosis
Treatments	options available, benefits and risks
Patient's preferences and values	• expectation from treatments • preferences for treatment limits • preferences for personal care • personal goals to accomplish
Family members	• family values and concerns • views and preferences of parents for minors • patient's prior wish or preference for incompetent patients

(HA, 2019)

Barriers

What is "barrier"?
"An obstacle; or anything that prevents people from being together or understanding each other" (Cambridge Dictionary)

- Poor public awareness about ACP
- Limited consensus about ACP among healthcare providers
- Limited training/education about ACP for healthcare providers
- Not confident in the sensitive conversation

Breaking barriers

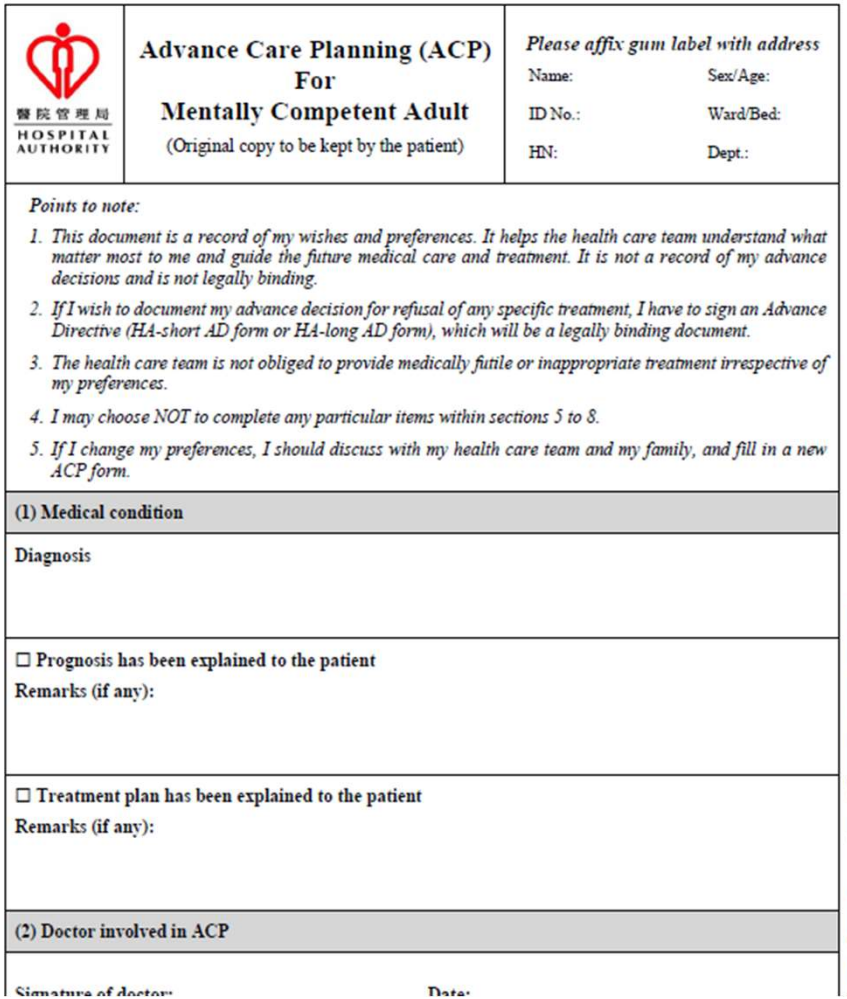
醫院管理局 HOSPITAL AUTHORITY	Patient Safety & Risk Management Department / Quality & Safety Division	Document No.	CEC-GE-9
		Issue Date	10 June 2019
	HA Guidelines on Advance Care Planning	Review Date	10 June 2022
		Approved By	HA CEC
		Page	Page 1 of 13

Helen Chan (NUR) is signed in

HA Guidelines on Advance Care Planning

Version	Effective Date
1	10 June 2019

ACP form for Mentally Competent Adult
ACP form for Mentally Incompetent Adult
ACP form for Minor



醫院管理局 HOSPITAL AUTHORITY

Advance Care Planning (ACP) For Mentally Competent Adult

(Original copy to be kept by the patient)

Please affix gum label with address

Name: Sex/Age:

ID No.: Ward/Bed:

HN: Dept.:

Points to note:

1. *This document is a record of my wishes and preferences. It helps the health care team understand what matter most to me and guide the future medical care and treatment. It is not a record of my advance decisions and is not legally binding.*
2. *If I wish to document my advance decision for refusal of any specific treatment, I have to sign an Advance Directive (HA-short AD form or HA-long AD form), which will be a legally binding document.*
3. *The health care team is not obliged to provide medically futile or inappropriate treatment irrespective of my preferences.*
4. *I may choose NOT to complete any particular items within sections 5 to 8.*
5. *If I change my preferences, I should discuss with my health care team and my family, and fill in a new ACP form.*

(1) Medical condition

Diagnosis

☐ **Prognosis has been explained to the patient**

Remarks (if any):

☐ **Treatment plan has been explained to the patient**

Remarks (if any):

(2) Doctor involved in ACP

Signature of doctor: **Date:**

Advance Care Planning (ACP) for Mentally Com

Updated 20 Jan 2020

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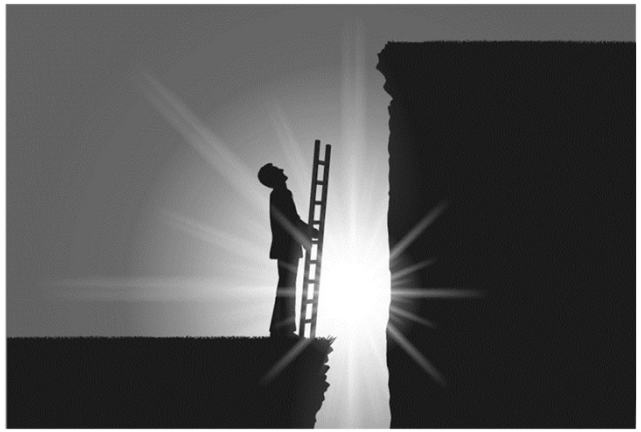
Faculty of Medicine The Chinese University of Hong Kong

Challenges ahead

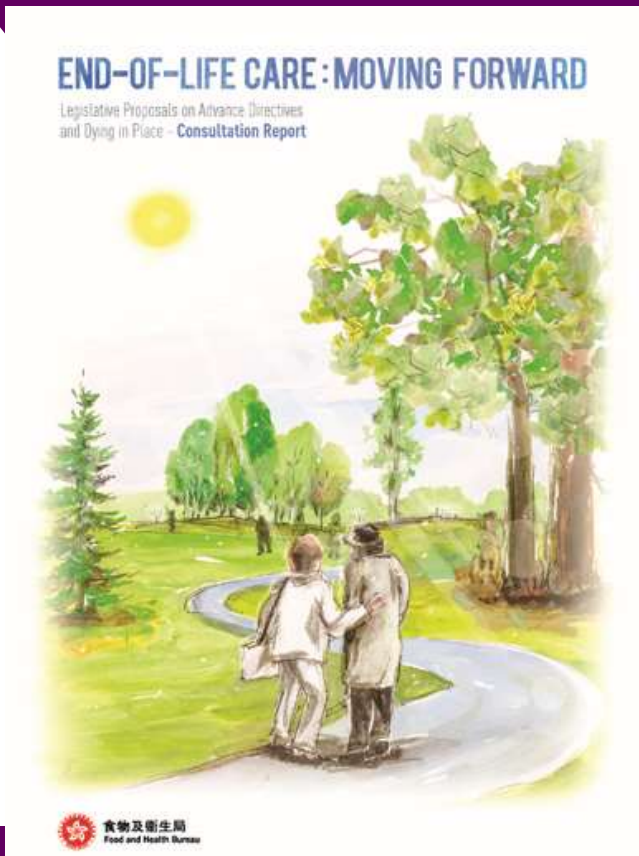
What is "challenge"?
"(the situation of being faced with) something that needs great mental or physical effort in order to be done successfully and therefore tests a person's ability" *(Cambridge Dictionary)*

- Unclear roles and responsibilities
- Concerns about legal liability
- Documentation and archive



Consultation

Public Consultation on End-of-life Care: Legislative Proposals on Advance Directives and Dying in Place, 2019 – 2020



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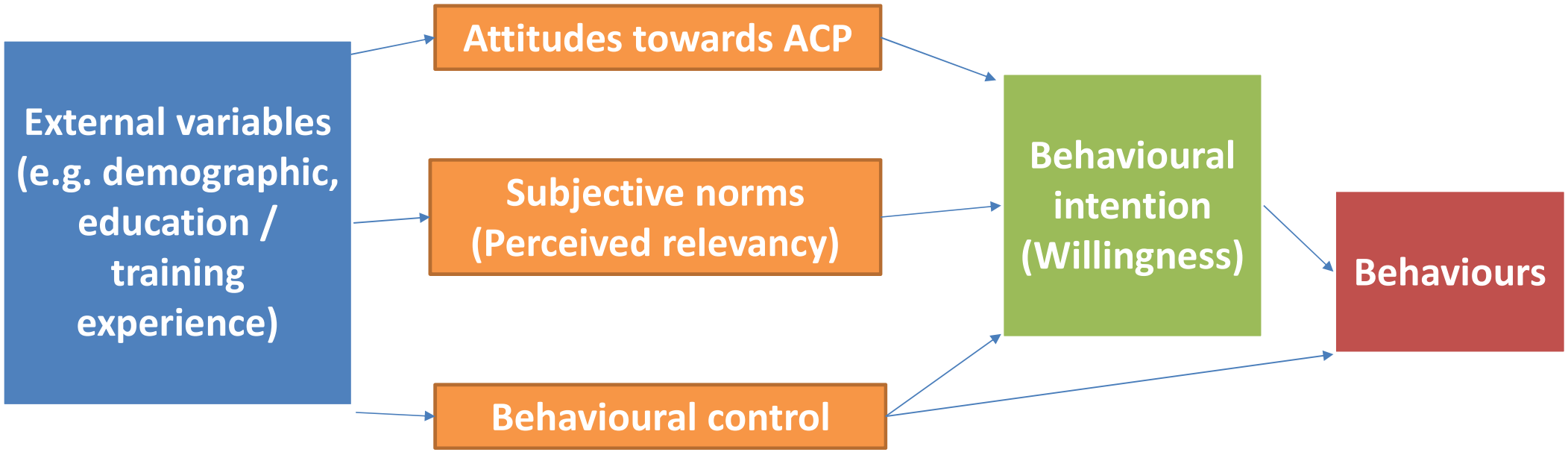
Key issues related to ACP in the report

- **No limitation on the health condition** for mentally competent adults to make an advance directives voluntarily
- Need to **raise public awareness** towards ACP, especially those with advanced illness
- Dedicated **training and education** should be rendered to the healthcare providers
- **Revocation of advance directives
  - No witness is required for a written revocation
  - For verbal revocation, at least 1 witness is needed. A second witness is required if the verbal revocation is made by a single family member or carer

Shall We Talk?

Adapted from Theory of Planned Behaviours (Ajzen, 1985)



Chan et al. Association between training experience and readiness for advance care planning among healthcare professionals: A cross sectional study. BMC Medical Education. 2020, 20, https://doi.org/10.1186/s12909-020-02347-3

Conversation

Principles

Person-centredness

- Follow client's agenda

Let the person talk

- Expression of worry and fears is therapeutic

Focus on the PROCESS rather than the outcomes only

NOT to finish in one go

Post-discharge ACP

- ↑ dyadic congruence regarding various end-of-life care preferences
- ↑ documentation

Contents lists available at ScienceDirect

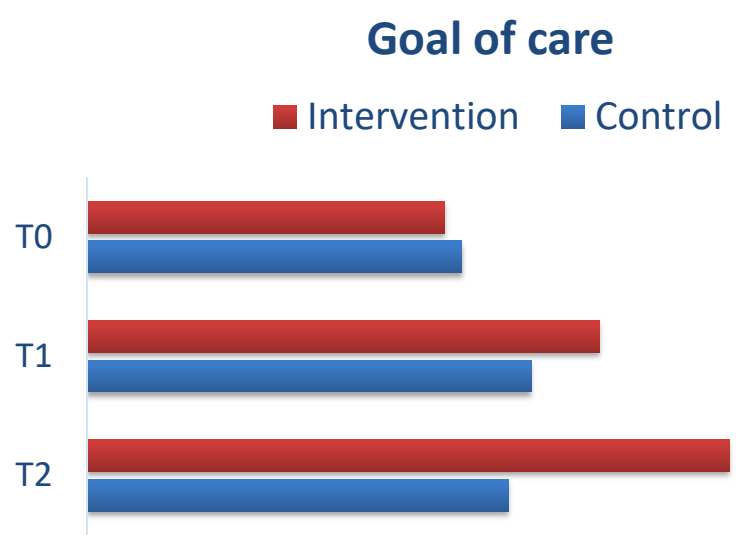
International Journal of Nursing Studies

journal homepage: www.elsevier.com/locate/ijns

Effects of a nurse-led post-discharge advance care planning programme for community-dwelling patients nearing the end of life and their family members: A randomised controlled trial

Helen Yue-Lai Chan[a,*], Jeffrey Sheung-Ching Ng[b], Kin-Sang Chan[b], Po-Shan Ko[b], Doris Yin-Ping Leung[c], Diana Tze-Fan Lee[a]

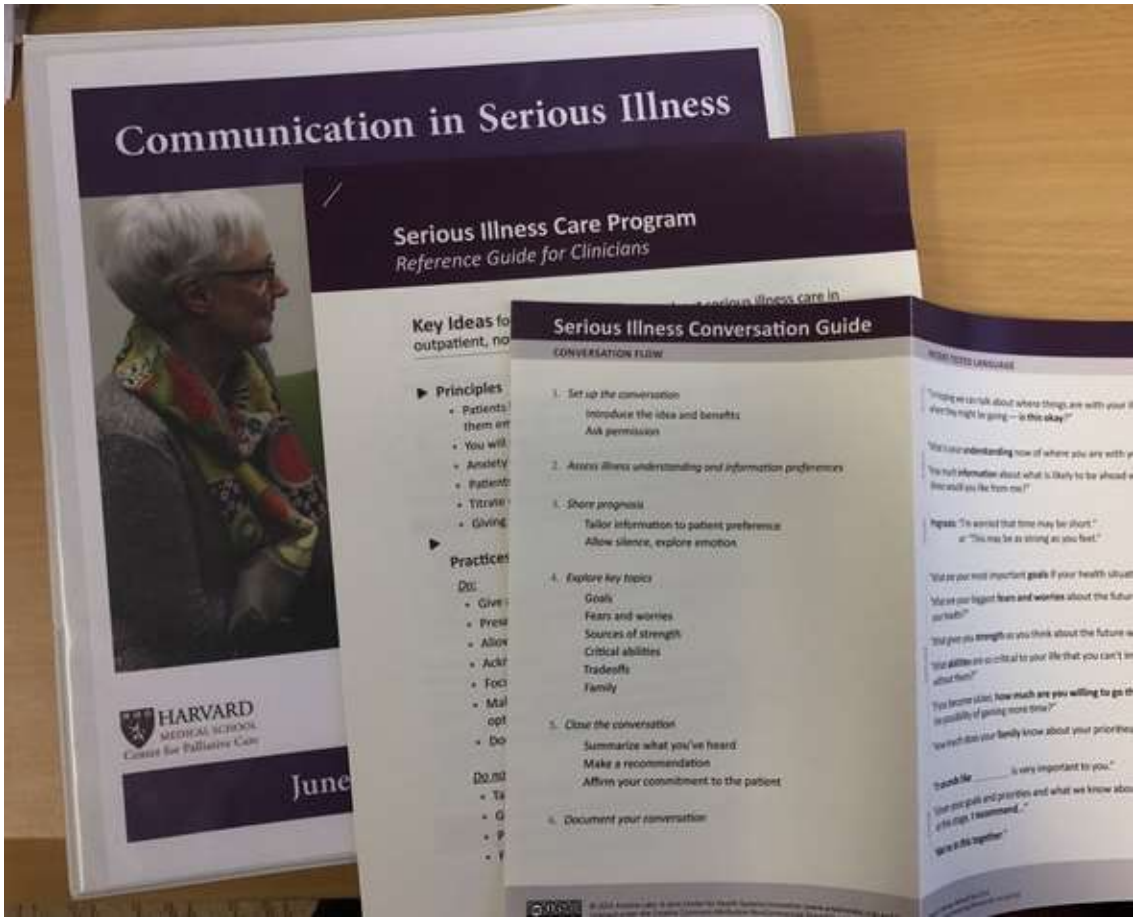
[a] The Nethersole School of Nursing, T
[b] Haven of Hope Hospital, Hong Kon
[c] School of Nursing, The Hong Kong



Tool

Effects of a Structured Advance Care Planning Guide among Patients with Advanced Illness in Hospital Care Settings: A Stepped-wedge Cluster Randomised Controlled Trial.

Supported by Health and Medical Research Fund, Food and Health Bureau



Innovative approaches

Micro-movies

http://acpe.cuhk.edu.hk

To illustrate dilemmas in end-of-life care

- Family disputes, guilt and shame, anger and hostility
- Based on real patients' stories

→ Highlight the importance of early and frank communication

  - Respect for patients' autonomy
  - Revisit the goal of care

Game approach

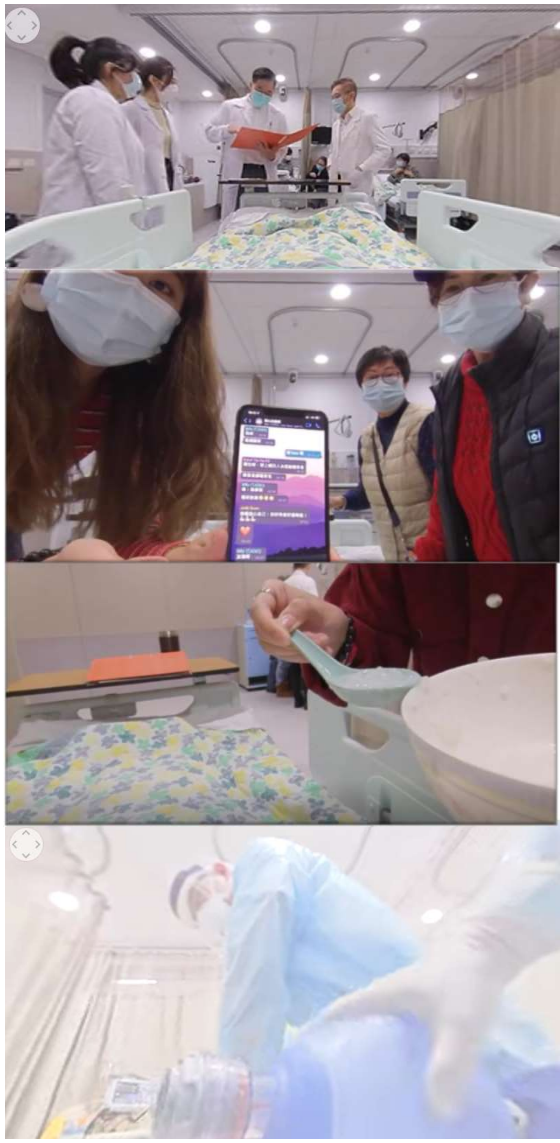
To introduce and facilitate ACP in a relaxing atmosphere

- Card game
- Board game
  - Culturally specific
  - Co-developed with stakeholders

Liu L, Zhao YY, Yang C, & Chan HYL. Gamification for promoting advance care planning: A mixed-method systematic review and meta-analysis. Palliative Medicine, 2021, https://doi.org/10.1177/02692163211005343

Immersive Virtual Reality

- To promote experiential and reflective learning of end-of-life care
  - How the patient might feel?
  - What would be their major concern?



Supported by Teaching Development and Language Enhancement for 2019-22 Triennium, University Grant Scheme

Expand beyond cancer diagnosis

ACP for Early Dementia

Supported by Health and Medical Research Fund
Enquiry: 楊小姐 9522 3112

Way forward

To overcome challenges, we need concerted effort

- Public education
- Professional training
- Organisational support
- Government policy

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40th Anniversary 四十週年

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Thank you!

"Our ultimate goal, after all, is not a good death but a good life to the very end"
(Being Mortal)