ADVANCE CARE PLANNING POLICY

RATIONALE / KUPU WHAKATAKI:

The purpose of this policy is to provide a definition of advance care planning (ACP) and a series of policy statements that support the process of ACP within the Northland DHB service provision.

DEFINITION / KAUPAPA: What is Advance Care Planning?

ACP is a process of discussion and shared planning for future health care needs of the patient/client. The process is a reflection of society's desire to respect personal autonomy whilst also holding to the traditional medical values of beneficence (the moral obligation to act for the benefit of others) and non-maleficence (the obligation not to inflict harm on others – Beauchamp & Childress 2011).

An advance care plan is an articulation of wishes, preferences and personal goals relevant to all current and future care needs for an individual. An advance care plan is not intended to be used only to direct future medical treatments and procedures when the person loses capacity to make their own decisions (becomes incompetent). It can and should be used, however, to inform decision making in the current situation along with other measures such as discussions with the individuals (and their families) regarding their treatment and care management and end of life care planning. It may involve the appointment of an enduring power of attorney (EPA).

Who is responsible for executing advance care planning?

Advance Care Plans are patient tools. They are used to assist in the planning of future care needs for patients. All health care workers involved in the personal and clinical care and management of the patients, including but not limited to physicians, surgeons, doctors, registered nurses, social workers, other allied health staff and senior personal care assistants in hospitals, community health workers within primary health care, aged residential care facilities, hospitals and hospice settings; should offer patients the opportunity to have meaningful conversations about their future care and management.

Who is responsible for the enforcement of the ACP policy?

Northland DHB is required as part of the regional accord to provide advance care planning to ensure patients/clients who receive health care services also receive advance care planning opportunities. All NDHB funded organisations shall ensure that their organisation has a policy on ACP and that there is a documented process by which they will record which patients have been offered ACP opportunities and monitor and report the progress of the ACP process.

All health workers shall undertake the on-line training of the basic and level 1 competency for ACP. Health professionals involved in the clinical care and treatment of patients/clients shall be required to attend the ACP level 2 competency course. Priority will be given but not limited to those clinicians involved in the delivery of Care Plus programmes.

POLICY STATEMENT / TOHU WHAKAPUMAU:

1. The Health & Disability Commissioner Act 1994 outlines the right of a competent person to be involved in decisions about their medical treatment and care. This is also supported by the Code of Health and Disability Services Consumers Rights 1996 (The Code of Rights). In addition, this code also recognises that people have the legal right to use an advance directive in accordance with the common law Right 7(5).
2. All patients receiving health care services from the Northland DHB or by its contracted suppliers are entitled to enter into discussions with an appropriately trained health professional to discuss their preferences, values and wishes of current and future health care needs.
3. Advance care planning conversations should be included as a part of the clinical practice for all patients who have been diagnosed with a long term condition. Conversations can occur in the community setting either in the home, at the doctor's surgery or nurse's clinic, at an Aged Residential Facility or at Hospice. An ACP can be updated during a consultation with hospital specialists whilst attending outpatient clinics.
4. The patient has the right to understand how the health professional will use the information provided, how the information will be stored by the organisation, how and who will access the information and how the organisation will respond to changes the patient may make from time to time. The Health Professional should at all times ensure that the information provided by the patient is secured and does not breach the client/health professional duty of care, Privacy Act and confidentiality obligations.
5. Advance care plans are patient tools used to assist in the planning of future care needs however they are voluntary and are not legally binding.
6. It is imperative that the patient/client is not under stress or crisis or under duress when developing their ACP.
7. Advance care planning is voluntary. A patient has the right to decline any conversation regarding their future health care preferences, needs and wishes.
8. Should the wishes of the patient/client be expressed formerly (in writing) then the health professional should seek permission to record the expressed wishes either in the patient's notes or to seek a copy of their ACP for use at that particularly time only.
9. An ACP will remain in the possession of the patient/client and updated by the patient. At all times prior to providing care and treatment, health professionals need to ask the patient/client if they have had an opportunity to discuss their wishes and preferences for future health care. Health professionals need to ensure that they are familiar with the preferences, values and wishes of the patient/client and incorporate them into their care and treatment practice.
10. Copies of advance care plans (or information) may be provided to health professionals with the consent of the patient. If the ACP is provided for use by the health professional, then this shall be noted and with the patient's permission provided with the referral to another service involved in the patient's care. It should be noted that the patients may at any time up date their plan. Health professionals should ensure that the patient/client's wishes are still current and that any changes resulting in a pending treatment are noted.
11. All organisations funded by Northland DHB who have health professionals attend the ACP Level 2 Training are required to report the progress of ACP conversations (commenced and completed) with their patients/clients on a quarterly basis to the ACP Programme Support Administrator.