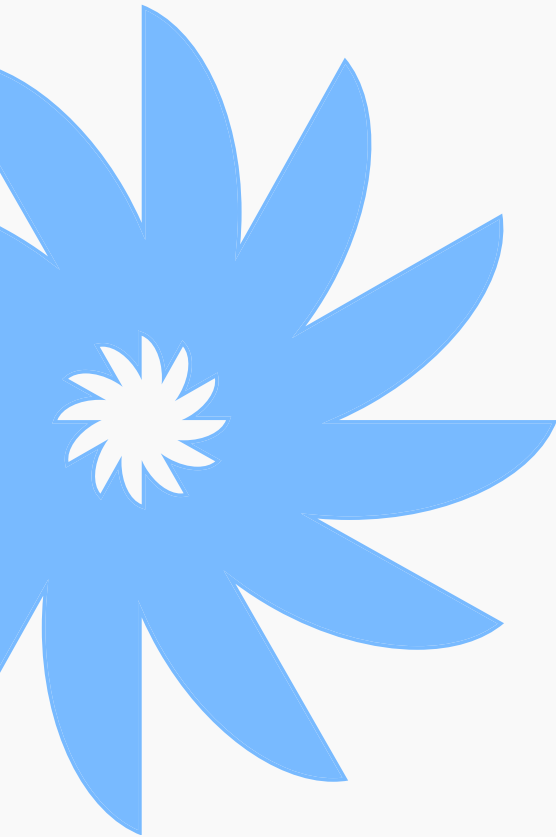


ADVANCE CARE PLANNING

A Toolkit for Empowerment

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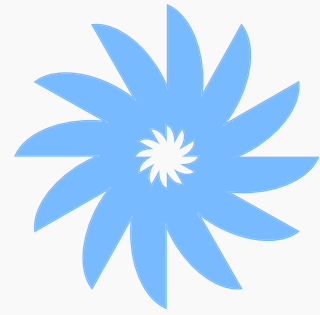
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Disclaimer

We aren't doctors, we're social workers. This guide is a tool to help enhance your knowledge about your options and support you in talking with your loved ones. This document is not meant to substitute for a conversation with a physician. Please ask your doctor if you need more clarification in making decisions for yourself or your loved one.

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Talking about Death



01



This can be a scary conversation.

Sometimes, families aren't ready to hear that their loved one is thinking about the end of their life. Sometimes the patient isn't ready, either!

This toolkit will provide information to help individuals understand their options for End of Life Care to support informed decision-making and self-determination, and make the process a little easier for everyone.

Talking about Death



Empowering patients to think about their own ACP

- Reflect on their own personal values
- Plan talks by working through a series of preferences covering care topics
- Identify who needs to know their wishes
- Keep conversations going over time.
Especially when health or life circumstances change!

Anticipatory Grief and ACP

What is anticipatory grief?

“When there is an awareness that a loss is coming, anticipatory grief is a form of mourning that can occur before the actual loss.” - Nancy Borstelmann, PhD, MPH, LCSW

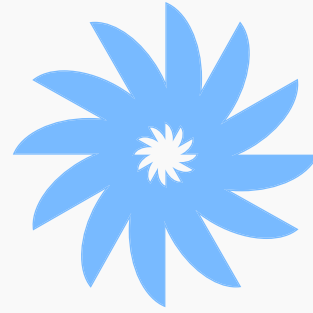
Why families might be avoidant

- Fear of facing what the prognosis might be
- Fear of facing life without their loved one
- Denial or guilt around the family member’s prognosis
- Confronting their own mortality!

Starting the conversation with family

- Set the Tone
- Initiate the Conversation
- Be Clear and Honest
- Listen to their Thoughts and Concerns
- Involve your Healthcare Provider
- Put it in Writing!

Types of ACP Documents



03

Advance Directive

An Advance Healthcare Directive is a set of written instructions expressing your wishes for medical treatment and end-of-life care, including organ and tissue donations. An Advance Healthcare Directive typically includes a Healthcare Power of Attorney and Living Will.

Living Will

A living will is a legal document that tells doctors how you want to be treated if you cannot make your own decisions about medical treatment. In a living will, you can say which common medical treatments or care you would want, which ones you would want to avoid, and under which conditions each of your choices applies. This is different than a will, which provides legal guidance about a person's estate — their property and financial assets — as well as care for a child or adult dependents, gifts, and end-of-life arrangements such as a funeral or memorial service and burial or cremation.

Power of Attorney

A “Durable Power of Attorney for Healthcare” is a legal document that appoints a trusted person as your Healthcare Proxy, meaning that they are allowed to make medical decisions on your behalf if you are incapacitated and cannot speak for yourself. While the Living Will outlines specific treatments you do or do not want, the healthcare POA simply authorizes another person to make the decisions on your behalf, which allows for some flexibility.

Types of ACP Documents

Healthcare Proxy

A healthcare proxy is also known as a representative, medical surrogate, or agent. This is a person who can make health care decisions for you if something happens and you are unable to communicate these wishes yourself. They work closely with your health care team to ensure that your care and treatment preferences are followed. Having a proxy is especially helpful in the event of unexpected situations like a stroke or car accident. To name a health care proxy, you can use an advance directive called the durable power of attorney for health care, also known as POA.

POLST


POLST stands for Pennsylvania Orders for Life-Sustaining Treatment, but is also known as Physician Order for Life-Sustaining Treatment in other states. This document is often printed on bright pink paper. It is a simple form meant to indicate quickly and clearly what treatments a patient does and does not want. It includes the option to decide whether the patient would like:

1. CPR
2. Intubation
3. Antibiotics or
4. Artificial Nutrition and Hydration

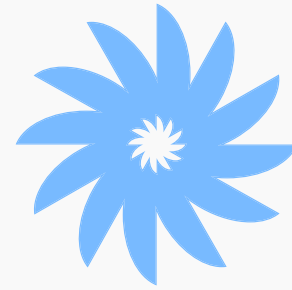
It also includes a summary of goals. This document is discussed with a physician, physician's assistant, or nurse practitioner, who then signs it. A copy is usually made for the patient's medical chart, and the original pink form is kept by the patient and typically displayed on the fridge or somewhere that is easy for emergency medical technicians to find.

Example POLST

05

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED To follow these orders, an EMS provider must have an order from his/her medical command physician												
 <p>pennsylvania DEPARTMENT OF HEALTH</p>	<p>Pennsylvania Orders for Life- Sustaining Treatment (POLST)</p>	Last Name										
		First/Middle Initial										
		Date of Birth										
<p>FIRST follow these orders, THEN contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.</p>												
<p>A Check One</p>	<p>CARDIOPULMONARY RESUSCITATION (CPR): Person has <u>no</u> pulse <u>and</u> is <u>not</u> breathing.</p> <p><input type="checkbox"/> CPR/Attempt Resuscitation <input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C and D.</p>											
	<p>B Check One</p>	<p>MEDICAL INTERVENTIONS: Person has pulse <u>and/or</u> is breathing.</p> <p><input type="checkbox"/> COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. <i>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</i></p> <p><input type="checkbox"/> LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <i>Transfer to hospital if indicated. Avoid intensive care if possible.</i></p> <p><input type="checkbox"/> FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i></p> <p>Additional Orders _____</p>										
<p>C Check One</p>		<p>ANTIBIOTICS:</p> <p><input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms.</p> <p><input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs, with comfort as goal</p> <p><input type="checkbox"/> Use antibiotics if life can be prolonged</p> <p>Additional Orders _____</p>	<p>D Check One</p> <p>ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION: Always offer food and liquids by mouth if feasible</p> <p><input type="checkbox"/> No hydration and artificial nutrition by tube.</p> <p><input type="checkbox"/> Trial period of artificial hydration and nutrition by tube.</p> <p><input type="checkbox"/> Long-term artificial hydration and nutrition by tube.</p> <p>Additional Orders _____</p>									
				<p>E Check One</p> <p>SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:</p> <table border="1"> <tr> <td> <p>Discussed with</p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Health Care Agent</p> <p><input type="checkbox"/> Health Care Representative</p> <p><input type="checkbox"/> Court-Appointed Guardian</p> <p><input type="checkbox"/> Other:</p> </td> <td> <p>Patient Goals/Medical Condition:</p> </td> </tr> </table> <p>By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.</p> <table border="1"> <tr> <td>Physician /PA/CRNP Printed Name:</td> <td>Physician /PA/CRNP Phone Number</td> </tr> <tr> <td>Physician/PA/CRNP Signature (Required):</td> <td>DATE</td> </tr> <tr> <td colspan="2">Signature of Patient or Surrogate</td> </tr> <tr> <td>Signature (required)</td> <td>Name (print)</td> <td>Relationship (write "self" if patient)</td> </tr> </table>		<p>Discussed with</p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Health Care Agent</p> <p><input type="checkbox"/> Health Care Representative</p> <p><input type="checkbox"/> Court-Appointed Guardian</p> <p><input type="checkbox"/> Other:</p>	<p>Patient Goals/Medical Condition:</p>	Physician /PA/CRNP Printed Name:	Physician /PA/CRNP Phone Number	Physician/PA/CRNP Signature (Required):	DATE	Signature of Patient or Surrogate
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Physician/PA/CRNP Signature (Required):	DATE											
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Signature (required)	Name (print)	Relationship (write "self" if patient)										

Medical Interventions



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CPR

CPR stands for cardiopulmonary resuscitation. “Cardio” means heart and “pulmonary” means lungs. CPR includes tilting the patient’s head back to open the airway, giving chest compressions, and giving rescue breaths. It is important to know that CPR is a very intense process that can break ribs, especially in older adults.

Intubation

Intubation is a medical procedure where a flexible plastic tube is inserted through the mouth into the trachea to keep the airway open and deliver oxygen to the lungs. It is often connected to a ventilator, which breathes for the patient when they cannot.

Defibrillation

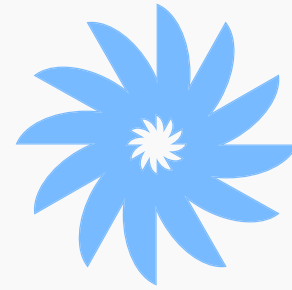
Defibrillation is what you might know as shocking the heart back into rhythm. Pads placed on the chest deliver a powerful electric current to depolarize the heart muscle and restore a normal rhythm.

Nutrition / Hydration

Nutrition and hydration can be provided to a patient through a couple of different avenues.

- N-G or N-J tube: a nasogastric tube is a thin tube that passes through the nose and down to the stomach. The N-J tube goes past the stomach, into the part of the intestines called the jejunum
- PEG tube: a feeding tube that is inserted through the abdomen directly into the stomach
- TPN: stands for Total Parenteral Nutrition, which is when all nutrients are given directly into the bloodstream, passing the digestive system entirely

DNR / DNI / AND



07



DNR

Do Not Resuscitate

This order specifically addresses interventions to restart a person's heart. If you have a DNR, it means that medical staff will NOT perform CPR or defibrillation (shocks) if the individual's heart stops beating. It does NOT mean "do not treat;" medications or pain management could still be given to the patient. A DNR is a legally binding document that is signed by a physician.

AND

Allow Natural Death

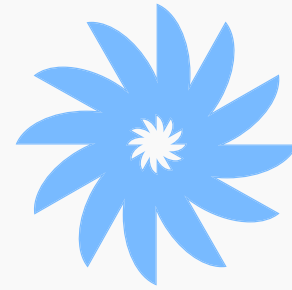
This term is used at some hospitals as an alternative to DNR/DNI. An AND order is used to ensure that only comfort measures are taken. This includes making the patient DNR/DNI, but also stops artificial hydration or nutrients that would prolong the dying process without adding to quality of life.

DNI

Do Not Intubate

This order specifically addresses the life sustaining intervention of intubation. It means that medical staff are NOT to insert a breathing tube to then be placed on a ventilator (breathing machine). A DNI still allows for potential chest compressions or heart medications.

Conversation Starters



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I need your help with future planning.

I have been thinking about what I'd want if I ever got really sick. I don't want to leave you guessing and stuck making a decision. Can we talk about it? // I want to help make sure that if you ever get sick we give you the care that you want and nothing you don't want. Can we talk about it?

Would you be my decision maker?

If there ever comes a time where I am unable to speak for myself and make my wants and needs known, I'd want someone I trust to speak for me. Would you be willing to be that person?

I want to make sure you know my wishes if I'm ever too sick to speak for myself.

It would mean a lot to me if you knew what I wanted for my care. Can I share that with you?

I saw something on the news that got me thinking ...

Something made me realize we've never talked about this. What would happen if something happened to me that a decision around life sustaining treatments needed to be made and I was incapacitated? I think it's time we talk. // We've never really talked about what medical treatment you might want if you couldn't speak for yourself. Can you help me know how to best advocate for you in that situation?



Allegheny County
Living Will and
Healthcare POA



Conversation
Guide PDF



The Order of the
Good Death:
End of Life Planning



The Conversation
Project

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