Advance Care Planning: Decisions Matter for Memory Loss Patients and Their Families

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Queen’s Clinically Integrated Physician Network
What Is Advance Care Planning?

- An opportunity to address wishes, preferences, fears and range of choices when one becomes very ill
- An opportunity to weigh the benefits and burdens of future healthcare decisions
- A way to translate wishes and preferences into legal documents
- To understand this is a process, journey meant to be revisited and shared
Empowers the individual to have their voice heard

Their “voice” will only diminish over time as they lose insight into their disease

Dementia is filled with losses of personhood (identity)

Avoids “unwanted care” or “usual care” which are costly financially but costly in terms of suffering for patient and family members
Starting the Conversation

- “Helps make sure your voice is heard and you are cared for in the way you want”
- “Decisions are best considered before a crisis, and your decisions can always be changed
- “Gift to those you love, making sure they are not burdened making decisions for you in times of uncertainty”
Explore “Living Well”

- What things are most important to you, bring you joy, make life worth living?
- What fears or worries about your health keep you up at night?
- In difficult times, where do you turn for strength?
- What does “do everything” mean to you?
- What would an unacceptable outcome of CPR look like for you?
Elicit their Perspective

- What are you expecting?
- What is most important in your life right now?
- What are you hoping for?
- What do you hope to avoid?
- What do you think will happen?
- What are you afraid will happen?
- What would make the quality of your life unacceptable?”
Help me understand what he was like before he got sick. What was most important to him?

Has he ever said anything about how he would want to be treated if he could no longer make decisions for himself?

What would he say in this situation?

Tell me what you understand about feeding tubes? About CPR?
Resources

**A Guide to Advance Care Planning: Making Life Decisions**

**Your Advance Directive for Future Health Care**

**Hawaii Pacific Health**

**A FREE Advance Care Planning Event**

**Kokua Ma - Hawaii’s Hospice and Palliative Care Organization**

**Questions about CPR**

**Tube Feeding**

**What is POLST?**

**Advance Care Planning Clinic**

**Queen’s Clinically Integrated Physician Network**

**Consider Encouraging Your Patients to Attend:**

- They are over 75 years old and have no advance care plan
- They have a chronic, long-term illness
- They have a serious, life-limiting condition

There is no cost to attend. Clinics are held at the Queen’s Physicians Office Building II.

**Mondays: 1 p.m. - 3 p.m.**

**Thursdays: 10 a.m. - 12 p.m.**

**Fridays: 10 a.m. - 12 p.m.**

For more information or referrals to Advance Care Planning Clinic, call 808-491-1735 or fax to 808-491-4052.
AHCD – Selecting a Health Care Agent

- Speaks as if they were speaking for you – even if they disagree
- Assures your wishes are carried out
- Can make a judgment call if no directive exists
- Not have to be family members
What is POLST?

- Provider Orders for Life-Sustaining Treatment
- Order completed with physician or advance practice nurse practitioner.
- Order that can be followed by emergency medical services (EMS)
- Provides direction for healthcare providers during serious illness.
- Is designed to follow patient and remain active at different points in the health care system.
Diagram of POLST
Medical Interventions

CPR

Comfort Measures

Limited Interventions

Full Treatment*

DNAR
# Advance Health Care Directive vs. POLST

<table>
<thead>
<tr>
<th>Advance Directives</th>
<th>POLST</th>
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<tbody>
<tr>
<td>For anyone 18 years or older</td>
<td>Persons at any age with serious illness</td>
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<tr>
<td>Identifies wishes for <strong>future</strong> healthcare</td>
<td>Indicates decisions about <strong>current</strong> treatments</td>
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<tr>
<td>Appoints a health care representative</td>
<td>Legally authorized representative can be noted</td>
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<tr>
<td>Does not translate into orders for EMS personnel</td>
<td>Actionable orders</td>
</tr>
<tr>
<td>CPR/DNR not addressed</td>
<td>CPR/DNR order</td>
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Where Does POLST Fit In?

Advance Care Planning Continuum

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness (*at any age*)

Complete a POLST Form

Treatment Wishes Honored
“Ain’t the Way to Die”
Advance Care Planning (ACP) Workshop
Gain skills on starting and leading
ACP Conversations

Nursing Contact Hours 7.41
Social Worker CE Units
Free Class held at Queen’s Conference Center