Advance care planning: have the conversation

Module 6: Review – When to revisit the conversation

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Healthcare settings: GP practice, hospital, aged care

Target skills: communication skills, confidence, knowing your role

Time: 10 mins

6.1 Review

A review of an advance care plan can be undertaken at any time. It is encouraged and important because people refine their goals for treatment and care during the course of their lives and their illnesses (Michael et al. 2013). An up to date advance care plan also makes it easier for doctors to assess its validity.

A review may be initiated by the patient or could be prompted by you at key times in the patient's illness trajectory, including the following situations:

- At annual reviews such as health assessments or CDM reviews
- Patient has been hospitalised for a severe progressive illness
- There has been a change in the patient's condition, or the patient experiences an unstable phase of an illness
- Patient says they want to refuse life-sustaining treatment
- Patient or family enquire about palliative care
- There has been a medical decision not to provide certain interventions
- Patient is marginalised in the community or may be likely to face discrimination
- Patient is isolated and vulnerable
- Patient has specific cultural needs or beliefs
- Patient has differing opinions, values or beliefs to their family members

The plan should be reviewed with the patient, their substitute decision maker, their family and relevant doctors involved in the patient's care.

6.2 A 10 step guide to reviewing an advance care plan

1. Be prepared
2. Re-introduce the potential outcomes of advance care planning if the patient has not appointed a substitute decision maker or documented their advance care plan.
3. Clarify the patient's current health status
4. Discuss the patient's fears and expectations and, if applicable, identify any gaps in the patient's understanding of their condition.
5. Discuss the patient's quality of life priorities and goals of care
6. Where no substitute decision maker has been appointed, encourage the patient to appoint one – it may be useful to identify the substitute decision maker from the person responsible hierarchy. This can often be a surprise to a patient and they may wish to choose a different substitute decision maker by appointing a medical enduring power of attorney. Where a substitute decision maker has been appointed, encourage the patient to confirm or review their choice of substitute decision maker, as circumstances may have changed.
7. Encourage the patient to write it down into a new advance care planning document, so that it is clearly distinguishable from the previous advance care plan.
8. Confirm the patient's understanding of the revised plan and emphasise the importance of future review and ongoing conversations.
9. Record the conversation as outlined in Module 5. Where no changes are made to an existing ACP after it has been reviewed, ensure that the reviewed plan is dated and signed by the patient. If a clinician is involved in the review they may sign that they witnessed the review. This will make it clear that this ACP has been reviewed and is still valid. Also be sure to consider electronic or other storage of ACPs in your healthcare setting. Ensure that outdated ACPs are marked appropriately and that treating staff can easily identify the most recent version.
10. Encourage the patient to provide a copy of the reviewed advance care plan to their substitute decision maker, family members (if appropriate), general practitioner, other treating doctors, ambulance service, district nurse and their local hospital.