Advanced Care Planning & Directives

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**Introduction**

Advance care planning refer to the advance discussions concerning patients healthcare with the healthcare staff. Advance care planning facilitates those who have the ability to take rational and benefitting decisions to reflect and recognise the significance and concern of their health status to develop goals, in order to prepare for the consequences in advance with the help of healthcare experts and family. Advance Care Planning (ACP) takes into account the psychological and social areas into consideration. ACP applies to everyone at any stage in life; however, it is specifically designed to target end-stage life and those terminally ill. It reassures planning amongst individuals to assign a representative to respond to their needs and preferences in a setting where they are unable to do it themselves appropriately (Robert A. Pealrman, 2014). ACP aims to accommodate to the needs of the patients who do not have the ability to appoint their physicians and reflect upon their choice of treatment. Advance care planning in adults develops the consistency of care with patients. It can help in building the communication between the patient and healthcare providers, trust, avail better medical satisfaction, reduction in patient anxiety and an increase in quality of life. Advance Care planning has gained more interest as the number of research, campaigns, books, awareness initiatives and law keep on contributing to it. A significant number of papers and research journals persisting to eliminate the gap and add quality to the process. Such initiatives have shown prolific results and have been recognised by the state appreciatively.

**Discussion**

The advance care planning revitalises the need to make rightful and well-informed decisions in a situation, unfortunately where one is unable and has lost the ability to undertake medical help. Advance care planning and directives work on the narrative of a substitute who takes the decision on the patient's behalf. Successful ACP initiatives do not only guarantee that the health care staff and patient communicate about their future medical considerations but also ensure that such records move along stages of care as they proceed along health care settings. (Hickman SE, 2005). The process is inclusive of an advance narrative document known as Advance Directive which keeps a record of the preferences, beliefs and values for their well being. The individual assigned the document is known as the surrogate decision maker (Advance Care Planning Australia). The document usually withholds the transfer of legal authority to take decisions on behalf of the patients' inability to make them, in a standardised format generally understood by healthcare staff. This also leads to more efficient and productive medical services. The goals of ACP are multi-dimensional mirroring upon autonomy exercised by the patient; to maximise the contribution to their health and to minimize the harm (Robert A. Pealrman, 2014). Advance Care Planning has received a considerably immense amount of optimistic response amongst adults. It has resulted in an increased understanding of patients wishes and reduced end life hospitalisation (Teno JM, 2007).

**Legal Framework in Victoria**

In Victoria, Advance Care Planning is a legally perceived notion of an individual's consensual record regarding their health care preferences. It is majorly categorised and provided to aged, life threatening situations, end-life/life- limiting conditions, in cognitive conditions and unforeseen occurrences. Victorian Parliament passed Medical Treatment Planning and Decisions Act in 2016 stating directives and making it an obligation for the individuals and healthcare providers (advance-care-planning, 2019). It further clarifies that the Advance Care is not a substitute for consent in regular treatment cases, a choice or a medium to attain reasonable and favourable healthcare with equitable resources amongst the public or an alternative for personal clinical services and engagements. The legislation on advance care planning is widely ensured around health care units and organisations through an efficient mode of strategy meeting the needs of local communities, their practices and learned informed empathetic health practitioners.

**Ethical Principles**

Ethical principles are the most central to advance care planning since they build and develop trustworthy ties with the adults to provide optimal health support to them. It brings individuals and those who are close to them and medical staff to discuss their future course of care. It should comprehensively include the needs and desires of the individual regarding health and medical care priorities. The individuals shall have access to understanding of the information they desire to know regarding their future course of care.Advance Care planning shall be updated as the over time as individuals life status and age change, in order to prepare for a particular strategy for medical treatments.

Moreover, significant decisions shall be in compliance with the Victorian law, healthcare expert and circumstances the individual is experiencing and lastly the most important ethical principle is to take into consideration and record the individual's values and beliefs when it comes to making decisions to healthcare providers. (Institute of Medicine. Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life, 2015)

**Benefits and Barriers**

Advance Care Planning provides the advantage of direction to the family and relative in accordance with taking informed healthcare decisions when it comes to the individual in reference. Moreover, it gives legitimate authority to the surrogate decision maker to uphold the individual's preferences. It lifts the burden of anxiety and moral misery from the substitute of not maintaining the desires of the individual (Elpern EH, 2005 ). It also minimises the fear and concerns of taken care of in time of need and treated with effective healthcare, particularly in end life situations. It further gives the individuals the option to die in a place of their choice Advance Care Planning also increases mortality rate significantly and help those with incognitive issues to plan their care and treatments before their condition deteriorates. Not only does the process ease the individuals and their families it also helps the healthcare providers to shift from curative care to palliative care controlling the symptoms than curing the illness, hence improving the quality of life (al, 2014). There are specific barriers to the advance care planning making it challenging to operate productively such as thinking and discussing the end stage of life by the individual or family members with the healthcare staff. Also, many people are not fully aware of the advance care planning and may not opt for it for better care in their end-life stages. And lastly, it is uncomprehendable by ACP to indulge in the unpredictability of the individual's situations is known (Johnson MJ, 2010.)

**Conclusions**

The advance care planning recognises the very importance of the decisions by the individual's health care needs mainly when they are unable to undertake them, themselves. They are facilitated by the healthcare organisations and legislation to bring the best to near life-ending stages or a comfortable experience with chronic illness through advance care directives. These documents outline the individual's choices, values and beliefs which are then accomplished by their surrogate decision makers. Although positive and successful results have emerged by effectively proceeding with programme however still more to be done to come to an arrangement with better end life experiences through individuals own consent and choices. The initiatives shall mark more significant change in accepting the reality of deterioration t with care and smooth journey onwards.

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