Responsibility and Directives

There is a change to the items in Advance Directives.

Assessment Type	Advance Directives item location
Long term Care Facilities Assessment	P2
Home Care Assessment	O2
Palliative Care Assessment	N2

Intent

Has the person had the opportunity to consider their own advance care plan and to be supported to talk about and document their goals, hopes, worries and preferences, including any advanced directives.

Definition

To determine whether the person has recorded their goals, hopes, worries and personal preferences and how that has informed their care and treatment planning now and in the future. An advance care plan is a dynamic document and should be updated as the person's circumstances change, or if they refine their thinking about their preferences as their health deteriorates. This may include updating advance directives if any.

Advance Care Planning Discussions Started

Definition

Advanced care planning is a process of discussion and shared planning for healthcare now and in the future. It involves an individual, family and healthcare professionals. It gives people the opportunity to develop and express their preferences for their care based on:

- their values, beliefs, concerns, hopes and goals
- a better understanding of their current and likely future health
- the treatment and care options available to them

Coding

0. Not started – person has had no conversations about what matters most to them (hopes, values, goals, and worries) and how that might impact on their current and future healthcare preferences.

1. Started - person has had conversations about what matters most to them (hopes, values, goals and worries) and how that might impact on their current and future healthcare preferences

Example

Advance Care Plan Documented

Definition

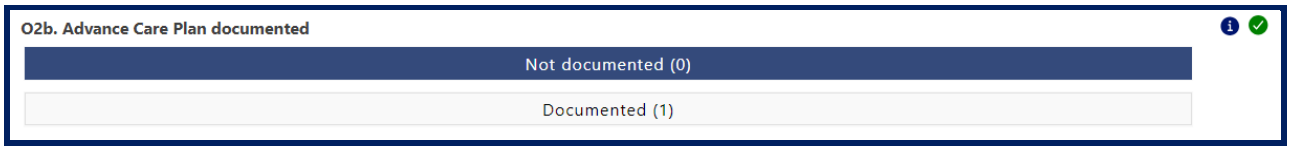
An **advance care plan** documents what matters most to the person, their preferences and wishes including, for example who will speak on their behalf if they were unable to make decisions, where and how they are cared for and any preferences for care and treatments as they approach the end of their lives.

Coding

0. Not documented - the person's hopes, goals, and preferences have not been recorded anywhere that is accessible to their whānau or health care team.

1. Documented - the person's hopes, goals, and preferences have been recorded somewhere that is accessible to their whānau or health care team.

Example



Advance Directive Documented

Definition

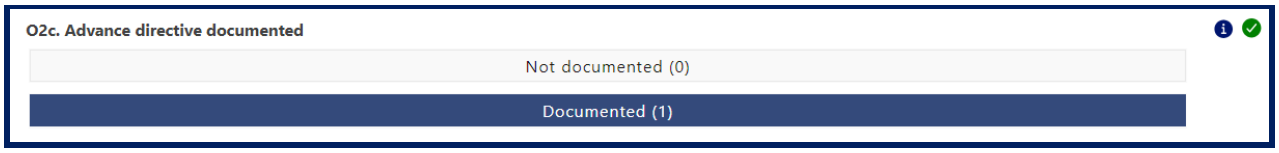
An **advance directive** is consent or refusal of a specific treatment that may or may not be offered when the person is no longer able to speak for themselves. Consent or refusal for an advance directive is often included in advance care plans. Advance directives can be verbal and do not need to be written down, signed nor dated.

Coding

0. Not documented - the consent or refusal, verbal or written, of a specific treatment that may or may not be offered when the person is no longer able to speak for themselves, has not been recorded.

1. Documented - the consent or refusal of a specific treatment that may or may not be offered when the person is no longer able to speak for themselves, has been recorded somewhere that is accessible to their whānau or healthcare team.

Example



For help with completing assessments, click the 'i' icon in the interRAI assessment software to access 'Section Help' information.