**Accessible transcript**

**Advance care planning overview**

Audio

(Relaxed music plays) Advance care planning is a process. In New Zealand, advance care planning is a process. The focus is on understanding what is important now and in the future.

**Visual**

**Black text on a white screen reads ‘Advance care planning is a process’. In the top right corner is a logo which reads ‘Health Quality & Safety Commission New Zealand Kupu Taurangi Hauora o Aotearoa’. The blue and green company logo comprises of three thin square blocks with white circles of differing sizes within them. In the bottom left corner is a logo which reads ‘our voice tō tātou reo, advance care planning’.**

Audio

The process of exploring your hopes, goals, worries and care preferences by thinking, talking and sharing what matters most to you and your whānau. Understanding what the future might hold for you and your health, what care and treatments are available — you know, your options. Using that to support care and treatment planning and decision-making. We have a number of tools to support people, their whānau and the members of their health care team during this process. Firstly, an advance care plan. This records the person's hopes, goals, worries and treatment preferences and may also include advance directives. You know, advance directives are a consent or refusal to specific treatments that may or may not be offered in the future when the person is unable to communicate their consent or refusal. The next tool is the serious illness conversation guide. This is a guide to support health care staff to talk about advance care planning with seriously ill people.

**Visual**

**A graphic is slowly revealed piece by piece, on a white screen. The heading reads ‘Advance care planning, a process of thinking, talking and planning for future healthcare and end of life’. Another heading appears which reads ‘Think, talk, plan, share, use. Hopes, goals, worries, preferences of person & whānau’. On the left a smaller heading reads ‘tools to support the process’. A black square appears with the words ‘My advance care plan’ inside. Beside that is the text ‘Advance care plan (ACPLAN), records person’s voice & preferences (inc. advance directives’. On the right a black square appears with a grid pattern drawn within. The top row is filled in blue and the remaining five rows are filled in green. Text beside the box reads ‘Serious illness conversation guide (SICG), guide to support talking to seriously ill person & whānau’. At the bottom left of the screen is the advance care planning logo and at the bottom right is the Health Quality & Safety Commission logo.**

Audio

You can see it's a scaffolding or structure with conversation prompts. It guides the clinician through setting up the conversation, seeking permission, checking the person's understanding of their health and what may be ahead, sharing a prognosis and then exploring the person's priorities, worries and what gets them through the tough times, their critical abilities and what they're willing to go through for more time. And then closing the conversation with a recommendation and affirmation that the clinician will do everything he or she can to ensure the person gets the best care possible.

**Visual**

**A copy of the Serious Illness Conversation Guide is shown on a white background. The words ‘Aotearoa serious illness conversation guide’ appear in the top left of the screen. The document is set out as a table with five rows and two columns; the left-hand column is shaded in light green, the right-hand column is shaded in light blue.** **At the bottom left of the screen is the advance care planning logo.**

Audio

The next tool is shared goals of care. The shared goals of care principles and forms support advance care planning during a hospital admission or during the time a person is in an aged residential care facility. Shared goals of care are when clinicians, patients, families and whānau explore the patient's values, the care and treatment options available and agree the goal of care for the current admission, and if the patient deteriorates. The shared goals of care principles provide guidance to health care providers on developing and supporting a shared goals of care approach and outlines what is required for shared goals of care discussions with adult patients, their families and whānau.

**Visual**

**The illustration headed ‘advance care planning’ returns to the screen. Beneath the original illustration is a hand-drawn image of two overlapping pieces of paper. The text beside them reads ‘Shared goals of care (SCOG), records goals of care for this admission’. At the bottom left of the screen is the advance care planning logo and at the bottom right is the Health Quality & Safety Commission logo.**

Audio

The shared goals of care form supports the discussion with prompts and space to document the discussion on the one side; on the flip side is where the shared goals of care plan is documented — the goals that will inform the care and treatment decisions should the person deteriorate.

**Visual**

**A copy of the Shared goals of care plan is shown on a white background. There are two pages. The words ‘Share goals of care – in hospital’ appear in the top left of the screen.**

Audio

There are a number of other tools to support the advance care planning process, including Te Waka Kakarauri, Whenua ki te Whenua, Te Ara Whakapiri and many others that can be found on the advance care planning website — www.myacp.org.nz. Let's now look at how these come together.

**Visual**

**The illustration headed ‘advance care planning’ returns to the screen. Beneath the illustration is a dotted outline of two overlapping pages. Beside them text reads ‘Other tools, tools to support thinking, talking & recording preferences.**

Audio

The advance care plan and advance care planning ideally starts early, before a serious illness. It should then inform any subsequent serious illness conversation guide conversation. The information gathered in the serious illness conversation guide-supported conversation should be recorded and added to the advance care plan. The serious illness conversation guide supports shared goals of care discussions. The key points of that conversation are recorded on a shared goals of care form and inform the recommendation or goal of care for the specific hospital or aged residential care admission. The advance care plan and planning should inform that shared goals of care conversation. On discharge, the information and recommendations might prompt a review of the advance care plan.

**Visual**

**An illustration appears on a white screen with the heading ‘Advance care planning, a process of thinking, talking and planning for future healthcare and end of life’. A hand-drawn** **image of a doctor talking to a patient and their whānau is in the middle. Around the outside are two layers of arrows, the inside layer points clockwise and the outside layer points anti-clockwise. At the top of the circle are the words ‘advance care plan (ACPLAN), at the bottom right are the words ‘serious illness conversation guide’ and at the bottom left are the words ‘shared goals of care’. At the bottom left of the screen is the advance care planning logo and at the bottom right is the Health Quality & Safety Commission logo.**

Audio

Let's now look at how this plays out over time.

Imagine advance care planning as a set of overlapping sound waves that expand and contract over time. The relevance and the level of advance care planning activity for a person and their whānau expands and contracts over time, triggered often by life events — like when you update your will or when someone you love or care for becomes unwell, or you might move house or need increasing support with your daily activities, or you start struggling with your short-term memory — and health events — like, I don't know, a visit to the GP; diagnosis of a chronic or life-limiting illness; a health complication, like a fall. And in between times, a person and their family might spend no or little time thinking or talking about advance care planning. And as it expands and contracts, the person will use their advance care plan to support their thinking, talking, planning and sharing.

**Visual**

**An illustration appears on a white screen with the heading ‘Advance care planning, a process of thinking, talking and planning for future healthcare and end of life’. Drawn below is an illustration of overlapping soundwaves in green, grey and orange, which stretches across the screen.**

Audio

Let's now look at this from the perspective of interactions with the health care system, when what matters most to the person and their whānau — their preferences — are discussed and used to plan ahead and to inform care and treatment. These can be times where advance care planning can be supported — for example, when talking about support in the community or, generally, with a GP; maybe when the person lands up in hospital or as their health deteriorates; if they potentially lose capacity, and particularly in those last weeks, days, and as they die.

**Visual**

**The illustration of soundwaves reappears on a white background. Illustrated figures appear at intervals along the length of the soundwave, indicating the different times where advance care planning can be supported.**

Audio

These are all opportunities for advance care planning, using what matters most to the person to inform their care. Now let's look at how various tools that support advance care planning might be used. The advance care plan is relevant and should be added to, used and reviewed throughout the process. It should inform discussions with the GP, on admission, during admission, whilst receiving care in the community or in aged residential care.

**Visual**

**The illustration of soundwaves reappears on a white background. The illustrated figures are all in place along the length of the soundwave, indicating the different times where advance care planning can be supported.**

Audio

So, for example, during a GP visit, the GP or practice nurse might refer to it. Or if the person has become seriously ill, they might use the serious illness conversation guide to support that conversation. On admission to hospital or an aged residential care facility, the health care team will want to determine the direction of care and agree shared goals of care, should the person deteriorate. This should start with reference to any advance care plans and documented conversations. The clinician might use the serious illness conversation guide to help structure the conversation and should then capture any shared goals of care or treatment decisions that result. And on discharge, any new information should be shared with the GP to prompt an advance care planning review and care plan in the community. If the person loses capacity, the advance care plan and any documented conversations or discussions should inform the treatment and care planning and provision. And as a person is dying, we should honour the person and their whānau's wishes by using the information we know about the person's preferences — what matters most to them — to provide care and treatment that best matches that.

**Visual**

**The illustration of soundwaves reappears on a white background. The illustrated figures are all in place along the length of the soundwave, indicating the different times where advance care planning can be supported. Questions and goals appear above the soundwaves inside small, black bubbles and flags.**

Audio

So, to wrap up — advance care planning is a process of discussion and shared planning for future health care. It involves an individual, their whānau and health care professionals. Advance care planning gives people the opportunity to develop and express their preferences for future care based on their values, beliefs, concerns, hopes and goals, a better understanding of their current and likely future health, and the treatment and care options available. It is our responsibility to ensure that each and every one of us supports the process and uses the information that people share with us. Ma tini, ma mano, ka rapa te whai; by many, by thousands, the work will be accomplished. Unity is strength. Ngā mihi.

**Visual**

**A complex illustration is shown on screen inside a green bubble. It shows the full soundwave illustration as well as the advance care plan, shared goals of care, Serious Illness Conversation Guide and other tools graphics from earlier in the video, beneath the green bubble.** **At the bottom left of the screen is the advance care planning logo.**

Audio

(Relaxed music plays)