St George and Sutherland Hospitals Department of Nephrology Recommendations on Advance Care Planning

1. It is both advisable and appropriate to initiate advance care planning with patients with ESRD

2. Those discussions should be initiated by the Nephrologist. Other members of the Renal team could participate.

3. Advance Care Planning should be initiated in :

(a) all competent patients aged 65 years and above, **and**
(b) all competent patients, irrespective of age, who fulfil one or more of the following criteria :

- The Nephrologist would not be surprised if the patient were to die in the next 12 months.
- Two or more significant co-morbidities
- Poor functional status
- Chronic malnutrition.
- Poor quality of life

4. The decision on the timing of these discussions lies within the discretion of the Nephrologist. Recommended times would be :

- (a) As soon as the patient is identified with criteria listed in Point 3.
- (b) Pre-Dialysis discussions
- (c) Significant sentinel events.

5. Where possible, ACP discussions should include the patient's family.

6. Where possible, these discussions should also include the Renal Social Worker.

7. The content of the discussion and any documentation should include :

- Information on the nature of ESRD, prognosis and quality of life.

- Selecting a substitute decision maker

- Exploring expectations, goals of care and values

- An indication as to what circumstances the patient would wish that dialysis and all other active treatment cease and a purely palliative approach commence. This process may continue over many conversations

8. That all ACP discussions are documented. That any ACP documentation is universally available through all relevant sites within the department and the hospital.

Dear Doctor,

In patients with a serious illness an advance care planning process is recommended. Today we initiated an Advance Care Plan for :

Name :

whom we found competent to make this plan.

Date :

Meeting attended by :

Nephrologist :

On Dialysis or Conservative pathway:

If on dialysis the mode of Dialysis :

Plan

If I were to become ill and unable to make medical decisions for myself I would nominate the following person to be my Substitute Decision maker :

If I were to have a serious life-threatening and irreversible illness and be unable to make medical decisions for myself I would/would not want :

1. Ventilation
2. Inotropes
3. Cardio-pulmonary resuscitation
4. Continuation of my dialysis

Other discussions and or decisions :

Signature of patient

Signature of Nephrologist

A copy of this plan will be given to the patient, sent to you, the patient's General Practitioner, kept in the patient's clinical file and be available electronically to all doctors in St George and Sutherland Hospitals. Ideally this Plan shall be reviewed every year.