1. Staff need to understand the terminology “Advance Directive”
   - This is a jargon word that many may find hard to remember.
   - Staff may understand the concept but fail to understand the words “Advanced Directive”
   - The HH Learning Guide Poster may assist staff understand this complex issue ongoing.

2. Staff need to understand that documented Advance Directives are VOLUNTARY. We have a “duty of care” so EVERYONE is looked after to set standards and to the best of our ability.

3. This is a complex subject and it may be useful to generate discussion around how many in Residential Care are seen as competent to make advance directives by the time they are admitted?

4. Advance Directives must be free of coercion [pressure] from family and cannot be made on behalf of a resident by family.
   - Only the resident themselves can make an Advance Directive
   - Anyone making an Advance Directive must be competent to do so.
   - A person’s own doctor, who has known them for sufficient time, may endorse competency or other recognised clinician [not RN’s, Managers, or family].

5. Forward Planning
   - Ideally each of us decides upon “Power of Attorney” & makes “Advance Directives” before we are too frail to do so.
   - We need to realise that in practice this does not happen.

Trainers Instructions: Read the Problem Based Learning Exercise, below, to the group. Ask each trainee what would be the most important thing if this happened to them. [This is the learning part for each person]. Staff can discuss their own “Advance Directives” or write them as an assessment of knowledge. Sometimes a lively discussion enhances the learning experience.

Good trainers will cover each of the areas shown in the Trainers Resource Poster and give trainees the opportunity to consider their own beliefs. Trainees may have parents or others they care about who cannot speak for themselves and welcome sharing personal experience.

PBL Learning Opportunity for Care Givers & RN's

1. You are an old lady.
2. FUTURE: You will have a stroke NEXT WEEK and be unable to talk properly.
3. No one will understand you and you will not be able walk without help.
4. Your sister-in-law is mean and you NEVER liked her since she tricked your father out of $20,000. She’s the LAST person you want to see and you don’t want her to know ANYTHING!
5. You cannot change the future .... but...
6. You have TODAY to make an ADVANCE DIRECTIVE to tell EVERYONE looking after you [in the future] your wishes [if you cannot speak for yourself].

Either document or discuss among the group what their personal wishes would be.
PROBLEM BASED LEARNING EXERCISE

Please Imagine this is your last chance to tell people how you would like to be treated.

Give yourself a name: _____________________________

**Sorry but you can no longer walk without help or talk [so that others understand you]**

I would like you to take instruction from my existing Advanced Care Plan dated ____________ at another place of residence. [You don't have one]

Regarding certain visitors or family members:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Palliative Care: I want to remain at THIS Rest Home if at all possible. I believe that you will keep me comfortable & pain free. I do not want x-rays, blood tests or external specialist appointments for diagnostic purposes.

I do not want antibiotics should I get a pneumonia. [This is a serious decision]

I do NOT want surgery or blood transfusions [This is a serious decision]

Feeding Infections: [Decision about prolonging life]

☐ Basic only - spoon fed with a regular soft diet. Fluids given by mouth but no attempt at tube feeding or into the tissues fluids.

☐ No feeding by tubes in any way either into nose, mouth or directly into the stomach.

☐ No intravenous fluids or nutrients [saline / protein or fats]

Key People to advise in the event of an emergency [IMPORTANT INFORMATION]

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Resuscitation: [VITAL PERSONAL DECISION NEEDING GP ENDOREMENT]
Please make no attempt at Resuscitation - I feel that I am now in the final stages of my life and wish die in a peaceful and dignified manner.
Please note ONLY the a resident themselves may initiate and choose this option [no one can request this for them] and they must have doctor endorsement as to competence to sign.

Signed competent to make this decision: ___________________________ Date: __________
PRINT: GP Name & No:
NOTE: By default, if this is not requested, in the event of collapse you will be assisted to maintain airways and an ambulance will be called, unless it is agreed with doctor family and staff that cares are now terminal. In this case family and staff will sit with you and make all effort to keep you comfortable and at peace.

Note: if you cannot speak for yourself GP's are good at making the right decision where people are obviously terminal and resuscitation would be “inappropriate”.

It's a really good idea for GP's to document this clearly to guide everyone!

Burial instructions: [PERSONAL DECISION: this may be VERY important. E.g. Maori NEVER want to be cremated but rather return to Papatuanuku [Earth mother].
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Signed: ___________________________ Designation: _______________________ Date: __________
Trainer: ___________________________ Designation: _______________________ Date: __________

This training is aimed at enhancing Resident Care and understanding.

Staff who have concerns about Advance Directives or Resident Wishes should talk to Team Leaders or managers.

Purchase this tool from the Resource Library