Ask

Early and ongoing conversations

OPPORTUNITIES

- Serious Illness Conversation guides and tools
- "Surprise question" trigger
- "Speak Up" Advance Care Planning tools

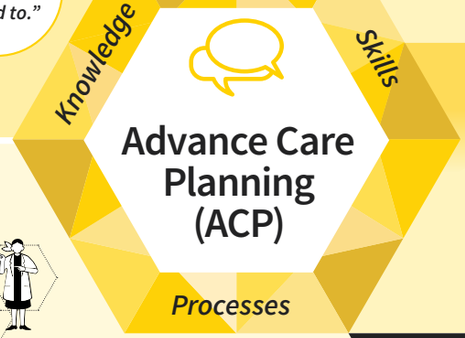
GAPS

- Lack of **SKILLS**, proficiency and time
- Not clear who to involve in **CONVERSATIONS**
- Limited understanding about **DISEASE TRAJECTORY** and end-of-life prognosis

"Conversations are critical, but consider the extra paperwork burden on frontline staff."

"We needed information about what to expect, what our choices were and what was available sooner rather than half-way through or at the end."

"Knowing what my sister wanted was important. As much as we didn't want to talk about it, we needed to."



Share

Understand and continually communicate wishes

OPPORTUNITIES

- Culturally sensitive conversations
- Advance Care Planning Frameworks

"We knew what we wanted, but we didn't know how to make everyone else know."

"It is so important that staff can differentiate between their beliefs and the client's wishes."

"They listened to me. They understood–I knew what my husband wanted. If they didn't understand, they asked. We all agreed."

GAPS

- **CHANGES** in patients' wishes not shared
- Varied **ACCESS** and **USE** of tools and documentation
- Lack of **SHARING** between care settings and providers

Respond

Decisions are reflected in care plans and legal papers

OPPORTUNITIES

- Communities of practice
- Palliative care teams and networks programs
- Collaborative assess, treat & refer process

"My sister's ACP was simple—she wanted to be at home with her family around her—not in hospital, not in a swirl of chaos in an emergency department."

"It is not just physical needs. It's also strategies to preserve my dignity, quality of life and a plan to meet my spiritual needs – this is often neglected."

"The plan was well thought out and in theory was a good plan. The execution and delivery on the plan were what fell short."

GAPS

- Minimal **ACCOUNTABILITY** and tracking systems
- Varied understanding of **LEGAL** and **ETHICAL** obligations
- Lack of **PROCESSES** to include decisions into care planning

INCLUSION OF ADVANCE CARE PLANS INTO CARE DELIVERY

Advance care planning is an ongoing process of making decisions about the care an individual wants to receive if they become unable to speak for themselves.

This Experience Map is a visual representation of opportunities and gaps shared by subject matter experts, patients and caregivers in translating advance care wishes into the planning and delivery of home care. Experiences were identified through a stakeholder workshop, telephone interviews and online surveys. Input was validated through an E-Delphi survey with a panel of experts.

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