Guidelines for Quality Implementation of Advance Care Planning

agency for integrated care

2025

PURPOSE

The Guidelines for Quality Implementation of Advance Care Planning (ACP) have been developed to inform interested organisations and their staff of the good practice principles, goals and quality indicators associated with implementing ACP in Singapore. They aim to promote a consistent and high-quality approach to ACP implementation regardless of care setting.

This guide is intended for individuals involved in the ACP programme including but not limited to leaders, organisational policy makers, practitioners, and administrators across different care settings such as acute, primary, community, social, and long-term care sectors.

Organisations are encouraged to progressively adopt and achieve these good practices outlined within these guidelines so as to benefit their clients and support Person-Centred Care.

ACKNOWLEDGEMENTS

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Section One

Introduction

1.1 What is Advance Care Planning?

Advance Care Planning (ACP) is an ongoing process of **planning and preparing** for future health and personal care. It includes conversations that communicate individuals' personal beliefs, values, and healthcare preferences to people important to them, as well as to their healthcare team.

Quality ACP ensures that this process is **person-centred, informed and guided**. In the event that the individual loses the capacity to make decisions or speak for themselves, the ACP will help the Nominated Healthcare Spokesperson(s) and healthcare team to act in their **best interests** and with relation to their prior expressed wishes.

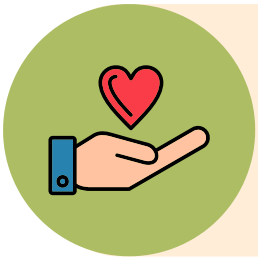
1.2 Objectives of ACP

The ACP process aims to assist individuals to:

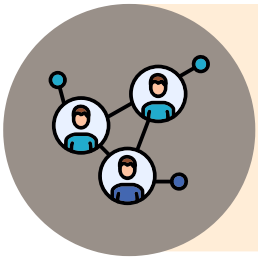
1. Understand their health condition, potential complications, and health management options (where relevant).
2. Reflect on personal values, define care priorities and management in relation to their values.
3. Communicate and document care preferences with family and healthcare teams that support care delivery.
4. Identify a Nominated Healthcare Spokesperson (NHS) that can support as a proxy in the event an individual loses mental capacity.

1.3 Benefits

Quality ACP has benefits for the individuals, their families, caregiver, and healthcare teams who care for them. Person-Centred Care (PCC) in ACP is a compassionate approach that respects each individual as a whole person. This approach:



Enhances quality of life: Aligns care with personal values, fosters dignity and well-being.

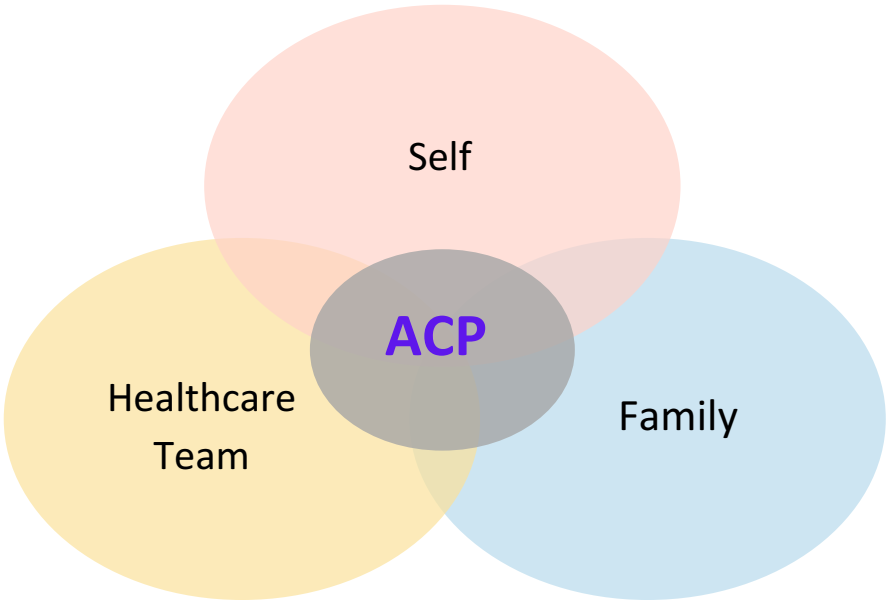


Strengthens trust: Builds stronger relationships between individuals, families, and healthcare providers.

Increases individual and family satisfaction: Reduces stress, helps individuals and their families be prepared for future decisions, and supports wishes to be respected.

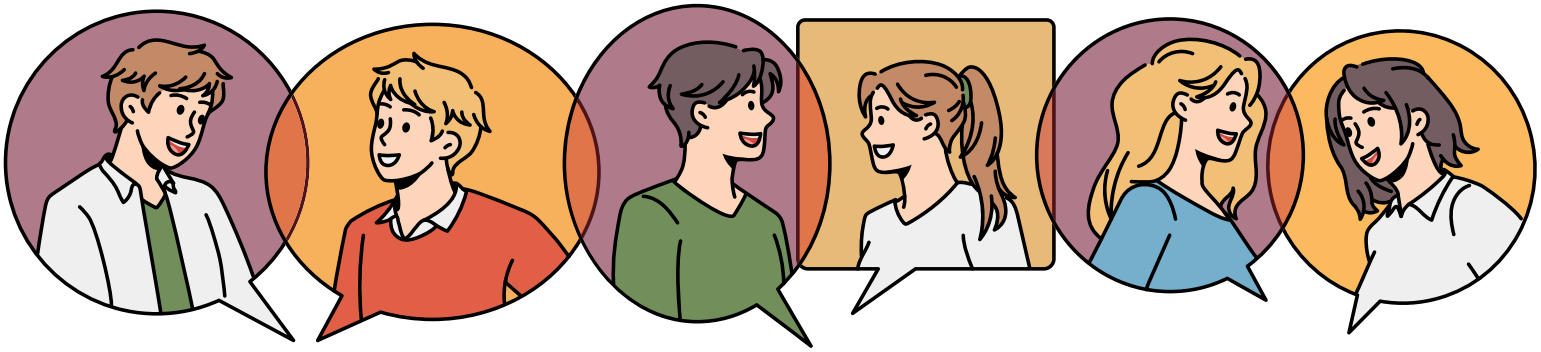
Figure 1. ACP outcomes to self, family and healthcare team

Care that is better aligned to one's values and preferences



With guidance from individual's expressed preferences, prior preparations can be made

Assurance and peace of mind. Less stress, conflicts and provides clarity for decision making



Section Two

Building an Organisational Culture for ACP

2.1 What is Organisational Culture?

Organisational culture refers to **the shared values, beliefs, norms and practices** that shape the social and psychological environment of an organisation. It **influences how employees interact, make decisions, and approach their work**, and is often described as "how things are done" within an organisation.

2.2 Leadership and Management

Effective leadership
Shapes culture, drives solutions, and fosters trust within teams.

Local champions
Drive ACP practices within the organisation.

Collaborative partnerships
Foster teamwork across disciplines and networks to enhance ACP implementation.

Culture of improvement
Emphasises continuous learning, quality improvement, and resource optimisation.

2.3 People, Diversity and Practice

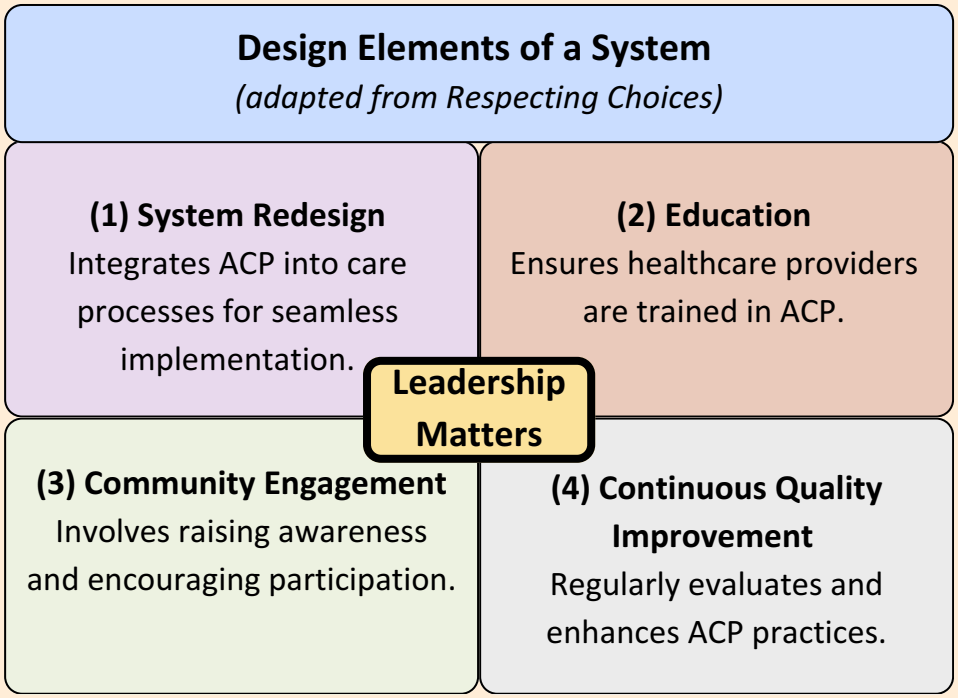
Empower Staff
Value and support staff to drive ACP innovation and growth.

Leverage on Diversity
Include diverse perspectives and foster creativity, resilience and effective problem-solving.

2.4 Systems approach

Having conversations and documentation are not sufficient. The ACP process is a complex and multi-dimensional intervention requiring a systems approach to ensure quality implementation of ACP.

Figure 2. Four pillars of systems approach to ACP originally by *Respecting Choices*



Section Three

Ethical and Legal Considerations in managing ACPs

3.1 Ethical Principles

Principle	Definition
 **Autonomy**	Autonomy refers to **an individual's right to make decisions** about their healthcare based on their own values, beliefs, and preferences. It emphasises respecting their choices, even when they lose mental capacity, and engaging in constructive conversations to ensure their wishes are understood and honoured.

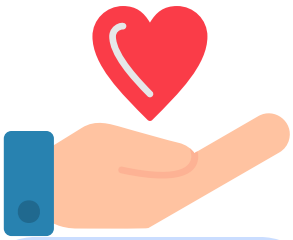
Example

An individual may choose not to receive aggressive treatment for their illness, expressing a preference for comfort care instead. The healthcare team **respects this choice**, even though some family members may disagree, by explaining the individual's wishes and ensuring that care aligns with their values.

Principle	Definition
 **Non-maleficence**	Non-maleficence refers to the **obligation to do no harm**. In the context of ACP, it means refraining from providing treatments that would cause more harm than good, such as withholding or withdrawing disproportionate treatments to allow natural death without hastening it.

Example

An individual's ACP specifies not wanting life-sustaining treatment if they are terminally ill. The healthcare team **honours this decision**, ensuring that treatments are withdrawn in a way that allows a natural death, without hastening or prolonging the process.

Principle	Definition
 **Beneficence**	Beneficence is **acting in the most favourable way for an individual** by maximising benefits and minimising harm. It focuses on providing treatments that are most beneficial and respecting the individual's refusal of treatments that may cause unnecessary suffering or harm.

Example

An individual with terminal cancer refuses chemotherapy, even though it may extend their life. The healthcare team **respects the individual's decision**, clarifies any misunderstandings and **supports their choice**. They understand that forcing treatment against the individual's will would not be in their best interests.

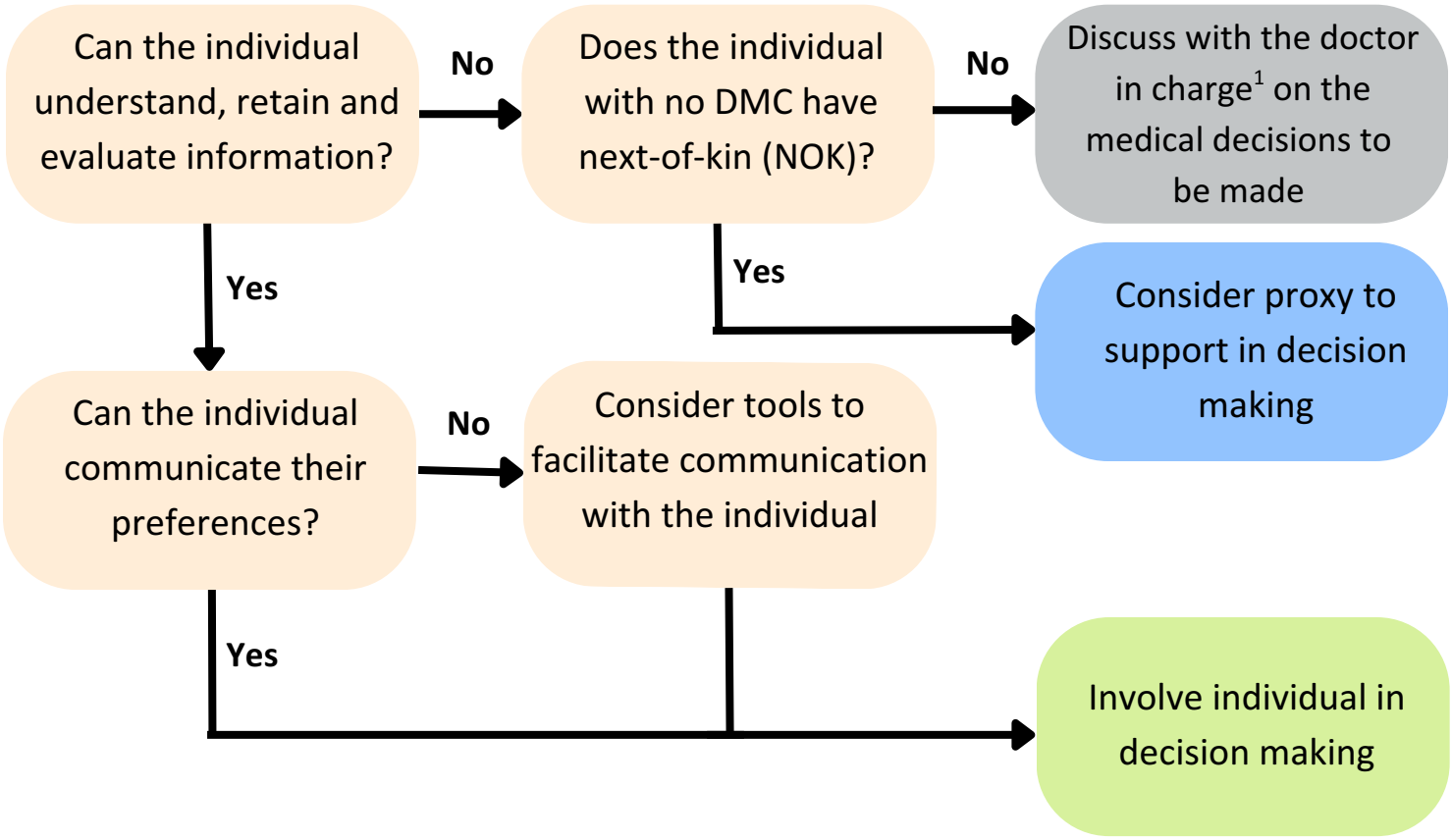
Principle	Definition
 **Best Interests**	The principle of best interests guides decision-making for individuals who lack mental capacity. It involves **acting in a way that aligns with the individual's values, preferences, and medical needs**, typically informed by their NHS or family members.

Example

If an individual becomes unable to communicate their wishes, the appointed NHS or family members may furnish **the relevant values and preferences** of the individual without mental capacity. This will enable **substituted judgement** and allow the healthcare team to consider the individual's preferences for care and treatment in the decision-making process.

3.2 Assessing an Individual's Decision-Making Capacity (DMC)

Figure 3. DMC assessment workflow



Note: In situations lacking clarity on the individual's decision-making capacity, ground staff may consult with care team members or seek a doctor's assessment for guidance and further advice.

[1]Please refer to the role of a doctor under Section 5: Roles of Healthcare Staff in ACP Implementation.

3.3 The Law and ACP in Singapore

Common Law System: Singapore's legal system includes statutes (laws passed by Parliament) and judge-made law (court decisions). Statutes override court decisions.

Advance Medical Directive Act (AMDA): Allow individuals to refuse extraordinary life-sustaining treatment if terminally ill and unconscious. In such cases, the AMDA taking precedence over ACP.

ACP is Not Legally Binding: ACP forms provide guidance on decision-making and are not legally enforceable. While the final decision on treatment for individuals who lack capacity rests with healthcare providers, following the Mental Capacity Act (MCA), the individual's preferences for care and treatment will be considered in the decision-making process.

Best Interests: Decisions for individuals without capacity must prioritise their best interests, considering their values, wishes, and input from loved ones.

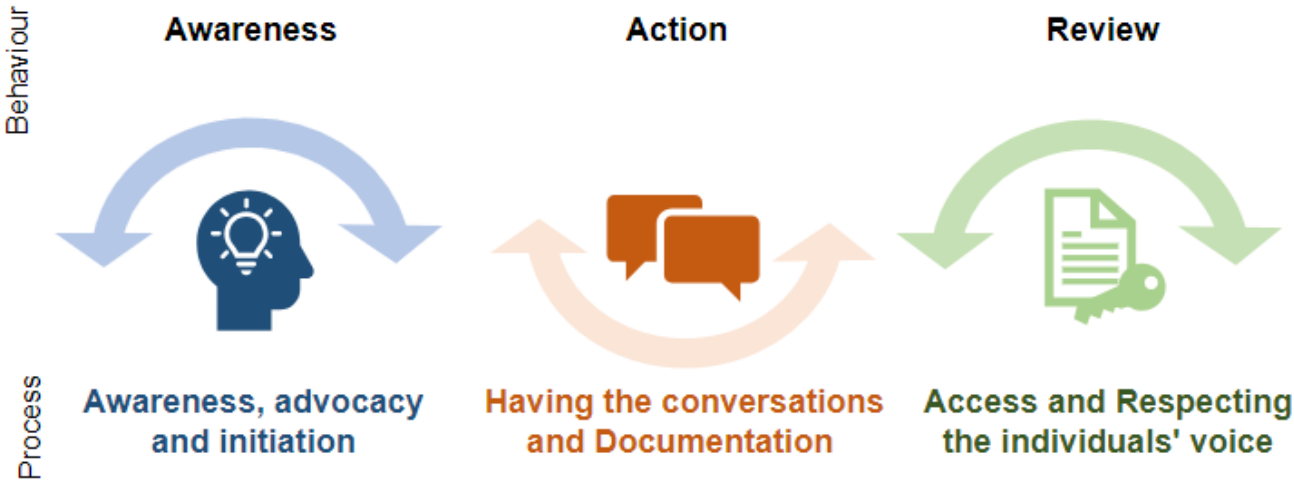
Note: In situations lacking clarity, ground staff may consult senior leadership, ACP clinical leads or institutional ethics committees within their organisations for further advice and guidance.

Section Four

Quality ACP Implementation

4.1 Quality ACP Implementation

Figure 4. ACP Process Framework

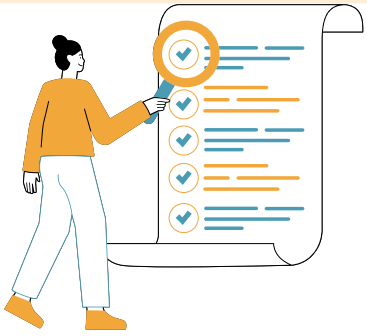


Awareness	Introduction of ACP

The National ACP Portal can be used to verify if an individual has an existing ACP across other care settings. Healthcare staff can introduce ACP to individuals and their next-of-kin (NOK) as part of routine care. The ACP discussion can be deferred by the individual or their NOK at any time.

Awareness	Identifying Individuals Suitable for Discussion

ACP facilitators should be well-prepared, ensuring they have the necessary training and knowledge to explain what ACP is and how it differs from related topics like Advance Medical Directive (AMD) and Lasting Power of Attorney (LPA). It is important to understand the individual's medical condition, social background, and family dynamics before initiating the conversation, with team collaboration when needed.



Action	ACP Conversation

ACP facilitators should involve the individual, their caregivers, NHS and loved ones in discussions to explore values and medical care preferences. The facilitator should create a supportive environment where everyone can clarify misconceptions, set common goals, and ensure that the family understands and supports the individual's decisions.

Action	ACP Documentation

ACP facilitators must ensure all information is clearly recorded on ACP forms, and signatures from individuals and their NHS are strongly encouraged. The most recent ACP documents should be uploaded to the National ACP Portal for portability and shared with healthcare professionals across the relevant settings.

Review	ACP Review

ACP reviews should take place when an individual's health condition changes, post-hospitalisation, or if the individual changes their mind. Any new decisions must replace the old ACP form and uploaded to the National ACP Portal, and the previous form should be voided and archived.

Section Five

Roles of Healthcare Staff in ACP Implementation

5.1 Functional Roles in ACP Implementation

Table 1. Functional Roles

S/N	Functional Role	Description of Role
1	ACP Lead	• Engage senior management and colleagues to gain support for ACP. • Implement ACP processes and workflows (e.g., referral criteria). • Monitor and evaluate quality indicators. • Identify resources and develop a team of ACP advocates, educators, facilitators, and administrators.
2	ACP Advocate	• Advocate for ACP within the organisation, to individuals, and the public.
3	ACP Educator	• Mentor and train healthcare teams to ensure competency in ACP facilitation and implementation.
4	ACP Facilitator	• Assess individual suitability and readiness for ACP discussions. • Respond to ACP related queries. • Conduct ACP reviews.

S/N	Functional Role	Description of Role
5	ACP Administrator or Coordinator	• Support ACP facilitators with administrative tasks and coordination with individuals and their caregivers.
6	Doctor	• Assist ACP facilitators in identifying care issues and priorities. • Clarify patient concerns and care options. • Provide clinical information, discuss prognosis and make appropriate treatment recommendations. • Deliver care based on individual's expressed values and best interests.

Note: These roles are not mutually exclusive and may overlap in practice.

Section Six

Quality Indicators

6.1 Key Principles for Indicator Selection

The indicators are intended to guide the work of ACP advocates, facilitators, clinical staff, and managerial staff.

6.2 Organisational Goals for ACP

Different organisations may have varying priorities based on their stage of ACP implementation. To ensure progress, it is essential to set short, medium, and long-term goals and use indicators to track progress. New organisations may focus on developing **human resources and workflows**, while matured ones may simultaneously seek to **improve the ACP process and outcomes** and **creating a sustainable ACP structure**.

6.3 Types of Indicators

To assess ACP quality, indicators should cover three key areas: structure, process, and outcome. **Structure** refers to the resources, policies, and facilities for ACP. **Process** involves activities related to ACP (e.g., awareness, action, review phases). **Outcome** evaluates the effectiveness of ACP in achieving its goals. Organisations should prioritise indicators based on their monitoring goals and the feasibility of data collection.

6.4 List of Suggested Quality Indicators

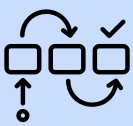
STRUCTURE

Human Resources

- **Trained Workforce:** Number of active versus inactive facilitators.
- **Confident and ACP-Ready Workforce:** Percentage of trained staff confident in conducting ACP conversations.
- **Staff Satisfaction and Engagement:** Level of satisfaction and engagement among facilitators and frontline staff.

Incentivisation and Support Structure

- **Staff Recognition:** Inclusion of ACP advocacy, engagement and facilitation in staff performance recognition



ACP Workflows

- **Institutional Workflows:** Clear roles and standardised workflows for screening, identifying, and facilitating ACP.
- **Audit and Quality Framework:** Presence of an audit framework for ACP processes.

PROCESS

Awareness, Advocacy, and Initiation

- **Public Awareness:** Level of public interest and engagement in ACP.
- **ACP Adoption:** Adoption rate by individuals, families, and healthcare teams.

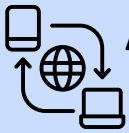
Having the Conversation

- **Successful Conversations:** Number of uploaded and ongoing ACP discussions.
- **Quality of Conversations:** Assessing individuals' understanding of health status, elicitation of individuals' values, fostering trust, clarity of care goals, and identification of NHS.

Documentation

- **Documentation Clarity and Adequacy:** Timely and clear documentation of ACP discussions, care goals, and appointed NHS.

PROCESS



Accessing ACP Information

- **Timely Access:** Feasibility of accessing ACP information at point of care for informed decision-making.

Overall Efficiency

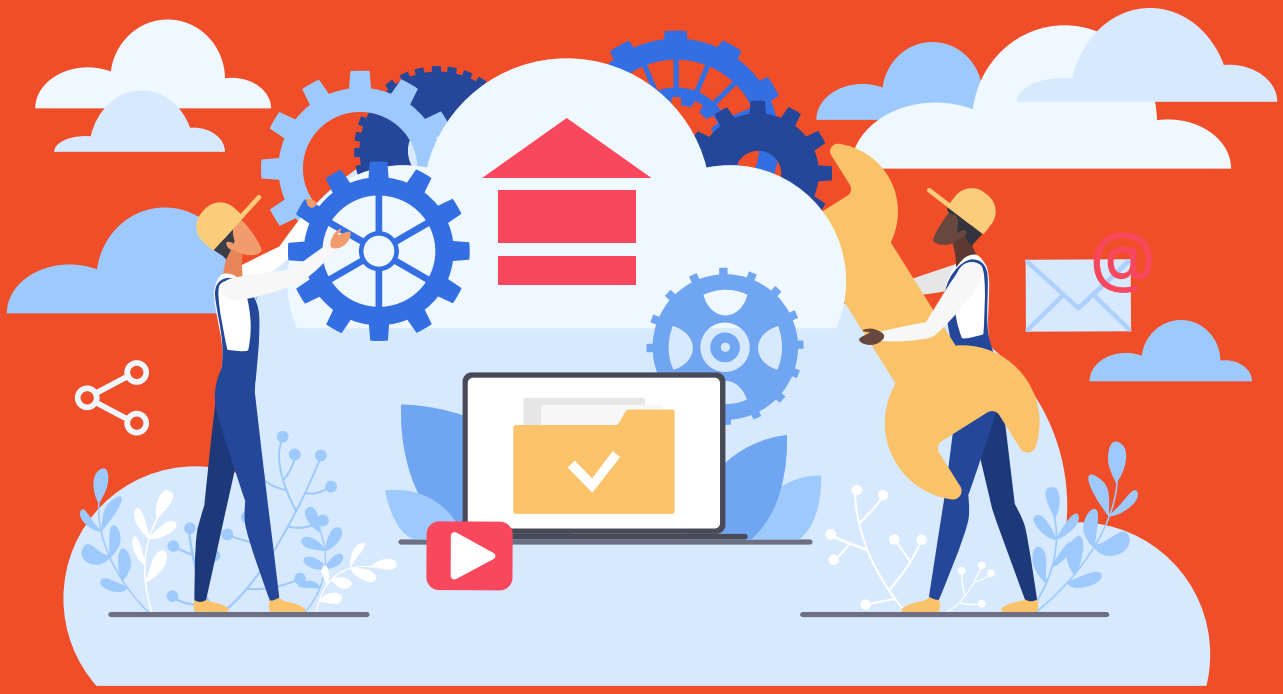
- **Efficiency:** Evaluation of ACP implementation outcomes versus operational costs.

Respecting the Individual's Voice

- **Satisfaction:** Overall satisfaction of individuals, NHS, and healthcare teams with the ACP process.
- **Caregiver Experience:** Level of caregiver distress and bereavement experience.

Section Seven

ACP IT Infrastructure & System Support



7.1 Publishing ACP in the National ACP Portal

Trained ACP facilitators and administrators should ensure current and ongoing access to the National ACP portal.

Lodging Documents: ACP facilitators must upload individuals' ACP documents to the national portal for cross-setting access.

Step 1

Explanation to Individuals:

- Inform individuals that their ACP documents will be shared across health and social care settings.
- Assure that only authorised professionals can access their documents, similar to electronic health records.

Step 2

Obtain Assent:

- Get agreement from individuals or their spokesperson(s) that the ACP aligns with their wishes and that the ACP can be shared across care settings in compliance with current data protection laws.

Step 3

Timely Publication:

- Completed forms should be published as soon as possible to ensure prompt sharing with other institutions.
- Give a copy of the completed ACP form to the individual and their NHS.

Section Eight

References

1. ‘Advance Care Planning: Aged Care Implementation Guide’; Advance Care Planning Australia (2021)

2. ‘Advance Care Planning Framework’; Cheshire & Merseyside Palliative and End of Life Care Network (2015)

3. ‘Recommendations for the Promotion of Advance Care Planning: End-of-Life Issues Subcommittee consensus statement’; Japan Geriatrics Society (2020)

ACP Objectives and Benefits

Table 2. Elaboration on ACP Objectives and Benefits

Objectives of Advance Care Planning	ACP aims to assist individuals to: • Understand their illness, potential medical complications and treatment options. • Understand the options for future medical care, in relation to their current health condition. • Consider the benefits and consequences of current and future medical treatments. • Reflect on their personal values, beliefs and goals of care. • Identify their wishes and/or preferences toward future care. • Discuss their medical condition(s) and preferences with caregivers and healthcare providers; and • Identify a nominated healthcare spokesperson (NHS).

Benefits	ACP has benefits for the individual, their caregivers, and other people who care for them. Some of these benefits are: • Improved and appropriate care, including end-of-life care. • Increased likelihood that the individual's preferences are known and respected. • Improved psychological outcomes for surviving relatives. • Reduced stress and anxiety for caregivers and NH personnel in making decisions. • Fewer inappropriate transfers from nursing homes (NHs) to hospital. • Higher personnel satisfaction for those caring for individuals of NHs; and • Respect for individual's right to self-determination and autonomy. Adapted from 'Advance Care Planning: Aged Care Implementation Guide', Australia, 2021

Tools to facilitate Preferred Plan of Care (PPC) conversation

Examples of tools that help care teams facilitate PPC conversation

A. Serious Illness Conversation Guide (SICG)

The Serious Illness Conversation Guide (SICG) is developed by palliative care experts at Ariadne Labs and acts as a framework to support discussions between clinicians, patients, and their families about their illness understanding, information preferences, prognosis, key topics (i.e., goals, fears, worries, critical abilities, family involvement, etc.), and clinician recommendations. SIC are guided by a person-centred approach and they provide structure for clinicians to find out what is important to the patient and use this to inform values-based shared decision making and goal-concordant care.

Serious Illness Conversation Guide (locally adapted)*

Table 3. SICG

Set Up the conversation	*"How are you feeling today?"* *"Is it okay if we talk together about your condition?"* *"I will be using a guide and taking notes during our talk in case I forget something." (Use if appropriate)*
Assess Understanding and information preferences	*"What have you been told about your condition?"* *"What would you like to know about your condition?"*
Share Prognosis (Use only if appropriate)	*"I would like to tell/inform/share with you my understanding of where things are right now with your condition – is that okay?"* **Uncertain:** *"I hope that you will stay as well as possible for a long time and we will work towards that. It is also possible that your health could change quickly. I think it is important that we prepare for that possibility."* **Time (for doctors only):** *"I wish this was not the case. It is also possible that time may be as short as ____ (express as a range, e.g. days to weeks, weeks to months, months to a year)."* **Function:** *"I hope you will feel as well as possible for a long time, and we will work towards that. It is also possible that your _____ (eg: strength/ energy-level/ alertness/ abilities to do daily activities) may be affected."*
Explore Values	**Priorities (now):** *"What are your most important priorities now?"* **Priorities (future)**: *"If your health gets worse, what are your most important priorities?"* **Worries:** *"What are your biggest worries?"* **Sources of strengths**: *"What gives you strength living with your condition?"* **Critical abilities:** *(early in trajectory): "What activities bring joy and meaning to your life?"* **Critical abilities:** *(late in trajectory): Given your condition, what activities would you like to continue doing?"* **Trade-offs:** *"If your condition gets worse, how much more treatment/ interventions are you willing to go through for the possibility of living longer?" (give egs : ICU/ dialysis/surgery/ feeding tubes/ more tests etc)* **Family/ Social Support:** *"Are people closest to you aware of what is important to you?"*
Close conversation **Recommend**	*"I've heard you say that _____is important to you."* *"Keeping that in mind, and what we know about your condition, let's make the best of this situation."* *"I recommend that we _____."* *"This will help us make sure that your treatment/ care plans reflect what's important to you."* *"Is this plan ok to you?"If you think of anything else later, we can revisit this conversation another time."*

B. SPIKES

SPIKES stands for Setting, Perception, Invitation, Knowledge, Emotions, and Strategy and Summary. SPIKES protocol has provided a systematic way to discuss bad news with the patients.

Table 4. 6 Steps of SPIKES

Step 1: S – **Setting** up the interview	Medical professionals should ensure a conducive setting for discussion with the patient on his or her condition. E.g., book an interview room for privacy, involve patient's significant others, make connection with the patient, and manage time constraints and interruptions.
Step 2: P – Assessing the patient's **perception**	Check the patient's perception of his or her medical situation. Before the clinician discuss the medical findings, he/she uses open-ended questions to create a reasonably accurate picture of how the patient perceives the medical situation —what it is and whether it is serious or not.
Step 3: I – Obtaining the patient's **invitation**	While some patients may express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not / are not ready to know the full details. Always seek the patient's invitation to hear more information and updates

Step 4: K – Giving **knowledge** and information to the patient	Impart knowledge to the patient in a clear and understandable way. 1) Start at the level of comprehension and vocabulary of the patient. 2) Try to use nontechnical words such as “spread” instead of “metastasised”. 3) Avoid excessive bluntness. 4) Give information in small chunks and check periodically on patient's understanding.
Step 5: E – Addressing the patient’s **emotion** with empathic responses	Address the patient’s emotions by being empathetic in words and actions. 1) Observe patient’s emotion. This may be tearfulness, a look of sadness, silence, or shock. 2) Identify the emotion experienced by the patient by naming it to oneself. If a patient appears sad but is silent, use open questions to query the patient as to what they are thinking or feeling. 3) Allow the patient to identify the reason for their emotion. 4) Let the patient know that you have connected the emotion with the reason for the emotion by making a connecting statement.
Step 6: S – **Strategy** and **Summary**	Summarise the discussion and strategise. Patients who have a clear plan are less likely to feel anxious and uncertain.

Resources:

SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer - Baile - 2000 - The Oncologist - Wiley Online Library

Key Differences between Advance Care Plan (ACP), Advance Medical Directive (AMD) and Lasting Power of Attorney (LPA)

Table 5. Differences between ACP, AMD and LPA

	ACP	AMD	LPA
Legal stature	Document that records your medical treatment and health care preferences	Legal document. Backed by Advance Medical Directive Act. Stating that you do not want any extraordinary life-sustaining treatment to prolong your life if one is terminally ill and unconscious.	Legal document. Backed by Mental Capacity Act. Voluntarily appoint one or more donee(s) to make decisions / act on your behalf if mental capacity is lost.
Process	Conversations with trained ACP facilitator and NHS(s).	Form signed in the joint presence of a doctor and a witness who must not stand to gain from your death	Determine if using LPA Form 1 or 2. Get it certified by a Certificate Issuer (lawyer/doctor)
Costs	Check with institution regarding charge.	No cost for AMD per se. GP consultation fees may apply	Form is free. Certificate issuer fee is chargeable. There is also an Office of Public Guardian (OPG) application fee
Scope	Healthcare treatment and preferences	Instructs doctor that you do not want any artificial means of prolonging life if you are terminally ill and unconscious.	Specify: (a) Property and financial matters, and/or (b) Personal welfare, including health care decisions
Involvement of loved ones	Select up to 2 Nominated Healthcare Spokesperson(s).	None	Appoint 1 or more Donee(s).

Annex A

Advance Care Planning for Residents in Residential Care (Nursing Homes)

Annex A.1

Enhanced Nursing Home Standards (ENHS)

1.1 Nursing home requirements under the Enhanced Nursing Home Standards (ENHS) and Nursing Home Licensing Terms and Conditions

In 2014, Enhanced Nursing Home Standards (ENHS) was introduced to review existing NH standards and identify gaps and redefine baseline standards and outcomes for good NH care. ENHS strives to achieve clarity and simplicity so that NHs can easily understand the requirements on standards of care.

A section on ACP has been included in the NH Licensing Terms and Conditions (LTCs) as below:

Advance Care Planning

The licensee shall ensure a system in place to identify residents who may be approaching the end of life. For these residents, the nursing home shall:

a) Conduct an Advance Care Planning (ACP) discussion with the resident or family/representative(s):

b) Develop a plan in accordance with the resident's care preference(s) when he/she is nearing the end of life, and

c) Record and store the resident's care preferences and care plans.

When a resident is approaching the end of life, the nursing home shall be guided by the expressed care preferences of the resident as much as possible to manage his/her care appropriately.

Where variations from the ACP may be in the best interest of the resident, the nursing home may provide care, treatment, or referral as needed while consulting and informing the resident and/or family representative(s) appropriately.

The nursing home shall keep the family/representative(s) informed of the resident's condition.

For audit and learning purposes, the nursing home shall conduct an after-death review of residents who pass on in the nursing home.

Annex A.2

Nursing Home Resident Segmentation

2.1 Nursing Home Resident Segmentation

While managing large groups of residents with differing levels of urgency for ACP, it is prudent for care providers to identify and prioritise the needs of residents at risk of serious health deterioration. Residents may be triaged in the following manner:

Type of ACP to conduct: Preferred Plan of Care (PPC)

High Needs
(Residents who are critically unwell and may pass away within 12 months)

Residents may present with advanced and/or complex conditions or diseases, with unstable symptoms or exacerbations associated with worsening health and poor function.

Moderate Needs
(Residents who have declining health and advancing disease but may not pass away within 12 months)

Residents have decreasing performance in daily activities and may have advancing disease or are frail but are not so severely sick or at risk of passing away soon. Athough these residents may not be seriously ill, exacerbations of their conditions may cause a serious deterioration in their health.

Type of ACP to conduct: General ACP

Low Needs
(Residents who are generally well with well managed chronic disease)

Residents may require supervision in care but may not have advanced chronic diseases. They may present with disability or other conditions such as brain injury due to trauma but are in a stable condition. They and/or their NHS are motivated to have their ACP completed.

Annex A.3

Safeguards for ACP by Proxy

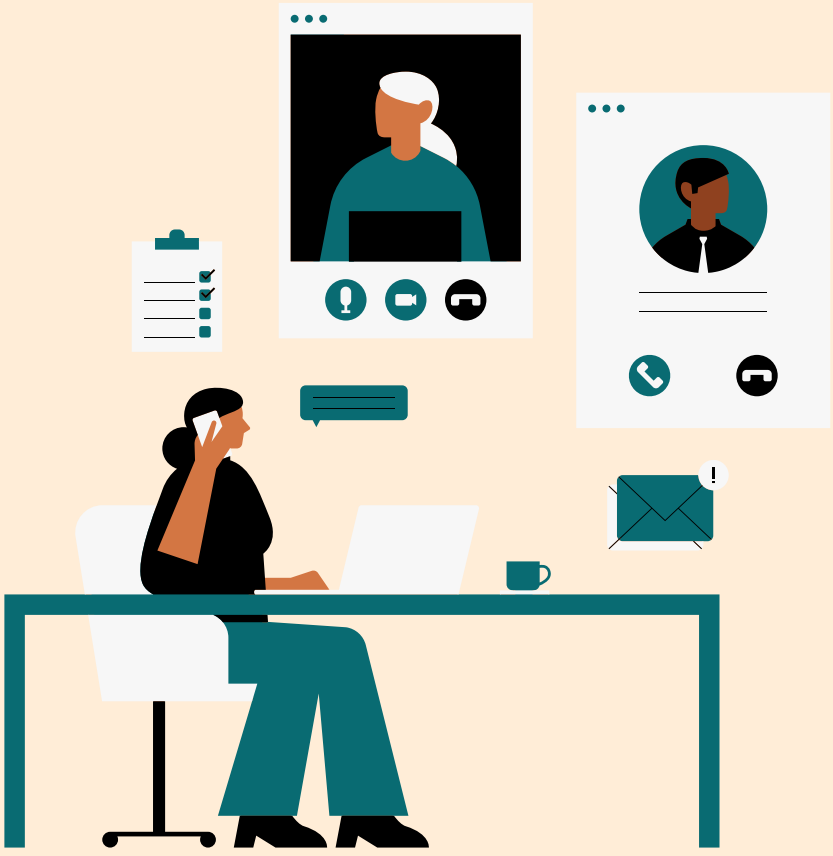
3.1 Safeguards for ACP by Proxy

The main safeguard to ensure appropriate conduct of ACP by proxy is to document a clear rationale as to why the Preferred Plan of Care (PPC) is being done for the resident without decision-making capacity (DMC), with the following considerations:

a) NH Residents

i. Assess if the resident has decision-making capacity based on the guidelines from the Mental Capacity Act. Refer to 3.2 of the main guide, Figure 3, DMC assessment workflow.

ii. When in doubt, discuss with the other care team members. Assessment by a qualified doctor may be needed.



b) Nominated Healthcare Spokesperson (NHS)

The NHS should be someone close to and understands the resident well. For example, the NHS could be someone who has lived with the resident for a long time, or someone who accompanies the resident for appointments.

The NHS could also be the main caregiver and someone whom the resident will turn to if he or she has a problem, or a legal deputy if one has been assigned.

The proposed steps are outlined below.

1. NHs can hold a conference with all the caregivers and next-of-kin (NOK) to determine who can be the NHS, so that conflicts and disagreements can be minimised.

2. After the NHS has been identified, determine that the NHS understands and respects the resident's values and preferences.

Note:

1. NH care team and NHS should act in the best interest of the resident.
2. NH care team and NHS should include the resident's known values and preferences, or substituted judgement, to guide their discussions with the care team.

3. NHs can conduct ACP by proxy with NHS.

3.2 Case Study - Family Members in Conflict

Mr Lim

- 77 years old
- Recently discharged from hospital for pneumonia
- Third admission in 6 months
- Advanced dementia, unable to make decision for self
- Bed bound, recommended for tube feeding, unable to care for self

I do not agree for tube feeding as I wish for Dad to live comfortably without the discomfort of a feeding tube.

I want the tube feeding for Dad as I wish for my Dad to live and be able to receive more nutrition.

1. The siblings have differing views on how to manage their father's condition.
2. NH care team may hold a family conference with the siblings to understand their concerns and priorities and to align care recommendations with the resident's best interest.
3. Knowing who the NHS is can help to minimise the conflicts and disagreements among the family members.

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Information updated as of April 2025