# What is advance care planning?

**Advance care planning allows health professionals to understand and respect a person's healthcare preferences, if the person ever becomes seriously ill and unable to communicate for themselves.**

Ideally, advance care planning will result in a written Advance Care Directive (values and/or instructional), to help ensure the person's preferences are respected.

An Advance Care Directive is only used when the person loses capacity to make or express their preferences.

## Benefits of advance care planning

Advance care planning benefits the person, their family, carers, health professionals and associated organisations.

- It helps to ensure people receive care that is consistent with their beliefs, values and preferences.
- It improves end-of-life care, and person and family satisfaction with care.[1]
- Families of people who have done advance care planning experience less anxiety, depression and stress and are more satisfied with care received.[1]
- For healthcare professionals and organisations, it reduces non-beneficial transfers to acute care and unwanted interventions.[2]

## Who should be involved in advance care planning?

Advance care planning requires a team effort. It should involve:

- the person who is considering their future health and personal care preferences
- their close family and friends
- their substitute decision-maker(s)
- carers
- aged care workers, nurses, doctors and other healthcare professionals.

Organisations can also support the process by having good policies and guidelines and by making current information available.

## When should advance care planning be introduced?

Advance care planning conversations should be routine and occur as part of a person's ongoing health care plan.

Better outcomes are experienced when advance care planning is introduced early as part of ongoing care rather than in reaction to a decline in condition or a crisis situation.

When the advance care planning conversation is initiated, the person should be medically stable, comfortable and ideally accompanied by their substitute decision-maker(s), and/or a family/carer.

Triggers for advance care planning conversations can include:

- when a person or family member asks about current or future treatment goals
- at a 75+ health assessment
- when an older person receives their annual flu vaccination
- when there is a diagnosis of a metastatic malignancy or end organ failure indicating a poor prognosis
- when there is a diagnosis of early dementia or a disease which could result in loss of capacity
- if you would not be surprised if the person died within twelve months
- if there are changes in care arrangements (e.g. admission to a residential aged care facility).

Other triggers for initiating this conversation can be found at advancecareplanning.org.au.

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# Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

FACTSHEET FOR HEALTHCARE PROFESSIONALS

## How can health professionals help with advance care planning?

### Be open

- Find out more about advance care planning and the requirements relevant to your state/territory.
- Encourage people to think and talk about their beliefs, values and preferences regarding their current and future health care.
- Explain that they may like to select a substitute decision-maker(s). This should be someone who is not a paid carer or healthcare provider.

Ideally, they will need to be:

- available (live in the same city or region) or readily contactable
- over the age of 18
- prepared to advocate and make decisions clearly and confidently on a person's behalf when talking to doctors, other health professionals and family members if needed.

### Be ready

- Undertake training in advance care planning to increase knowledge and improve skills.
- Talk about the person's beliefs, values and life goals regarding health care options.

### Be heard

- Discuss with other relevant healthcare professionals, family, friends and/or carers.
- Encourage people to write an Advance Care Directive or use a form relevant to their state/territory law. See advancecareplanning.org.au.
- Encourage them to keep the Advance Care Directive safe, and store it appropriately.
- Encourage them to review their Advance Care Directive every year or if there is a change in their health or personal situation.

## The law and advance care planning

Health professionals are obliged to review and consider documents. Different states and territories in Australia have different laws regarding advance care planning. There are also common law decisions in advance care planning. See advancecareplanning.org.au for information.

Depending on the state/territory:

- A substitute decision-maker may be legally appointed as an Attorney, Enduring Guardian, Decision-Maker or Medical Treatment Decision-Maker.
- An Advance Care Directive may also be called an Advance Health Directive, Health Direction or Advance Personal Plan.

## Where should Advance Care Directives be kept?

Advance Care Directives may be stored with:

- the person
- the substitute decision-maker(s)
- the GP/local doctor
- the specialist(s)
- the residential aged care home
- the hospital
- myagedcare.gov.au.

Encourage and help people to store them in 'My Health Record' at myhealthrecord.gov.au.

## Conversation starters

- I try to talk to all my patients about what they would want if they become more unwell. Have you ever thought about this?
- I am pleased to see you recovering from your recent illness. If you became very sick again, have you thought about the treatment that you would want or not want?

## Where can I get more information?

Advance Care Planning Australia

advancecareplanning.org.au

National Advisory Service: 1300 208 582

learning.advancecareplanning.org.au

## References


1 Detering, KM, Hancock, AD, Reade, MC, Silvester, W 2010, 'The impact of advance care planning on end of life care in elderly patients: randomised controlled trial', British Medical Journal, 340: c1345.doi:10.1136.

2 Brinkman-Stoppelenburg A, Rietjens JA, van der Heide A. The effects of advance care planning on end-of-life care: a systematic review. Palliat Med 2014; 28: 1000–1025.



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