



Advance Care Planning Improvement Toolkit: Tasmania

2022

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Advance Care Planning Australia delivers national advance care planning leadership, advocacy, communications, support services, the advance care planning improvement toolkit, and education and information resources for consumers, the health and aged care workforce, and/or service providers. Our program is focused on improving advance care planning policy and systems, community awareness, understanding and uptake, workforce capability, and quality monitoring and evidence.

We promote a national collaborative approach to achieving excellence in advance care planning. We acknowledge the valuable advance care planning work being undertaken by others throughout Australia and internationally.

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Further information regarding this toolkit can be obtained by contacting Advance Care Planning Australia, phone 1300 208 582 or email admin@advancecareplanning.org.au. A copy of this toolkit is available at advancecareplanning.org.au.

Advance Care Planning Australia acknowledges the Traditional Custodians of the land and pay our respects to elders past, present and emerging. We celebrate, value, and include people of all backgrounds, genders, sexualities, cultures, bodies, and abilities.

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Disclaimer:

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Advance Care Planning Improvement Toolkit: Tasmania

The Advance Care Planning Improvement Toolkit ('ACPI Toolkit') has been implemented to support aged care and health service organisations to assess and improve the uptake and quality of advance care planning, ensuring more Australians have choice and control over their future treatment decisions.

Advance Care Planning Australia has developed the ACPI Toolkit following national consultation, a rapid literature review, systematic environmental scan and analysis of similar audit resources, adaption of the *Prevalence of Advance Care Planning Documentation in Australian Health and Residential Aged Care Services Study* ('Prevalence Study') resources, and evaluation.

The ACPI Toolkit is aligned with the Aged Care Quality Standards and the National Safety and Quality Health Service Standards. Due to the differences in law across the States and Territories, a toolkit has been designed for each jurisdiction. For organisations that have sites in multiple states and territories it is recommended that you use multiple toolkits.

Advance care planning in Australia

Advance care planning is concerned with ensuring more Australians have choice and control over their future treatment decisions. Currently, only an estimated 15% of Australians have documented their preferences for care in an Advance Care Directive.

Advance care planning is a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions.

Registered and non-registered health practitioners have a role in advance care planning and require capability to facilitate these conversations effectively. The National Quality Standards for aged care, general practice and health services all promote advance care planning.

National framework for advance care planning documents, 2021 (Page 4)

Advance Care Planning Australia (ACPA) has previously supported aged care and health service organisations to understand their advance care planning uptake as part of the national Prevalence Study.

The key findings from a national audit conducted in October 2018 – February 2019 include:

- Only 14% of older Australians had a statutory or common law advance care directive (ACD) for preferences of care and/or to appoint a substitute decision-maker. The prevalence across sectors was 6% in General Practice, 11% in hospitals, and 38% in residential aged care.
- When including non-ACD documentation (planning documents completed by a doctor or someone else), only 29% of older Australians had documentation to inform future medical treatment decisions and end-of-life care.
- For older Australians in residential aged care, 30% of documents were advance care plans completed by someone else (e.g., a family member or carer), with 65% of these including life-limiting instructions and only 25% indicating that a discussion took place with the person the instructions relate to.
- Low prevalence is complicated by poor document quality, with 27% of documents missing important quality identifiers such as full name, signature, document date, and/or witnessing.
- Having a discussion about advance care planning with anyone (including a clinician), made a person three times more likely to document an advance care directive.
- An analysis of the 62 participating organisations across 100 sites, found that only 18 organisations across 29 sites had a valid (in date and referring to correct legislation) advance care planning policy.
- Voluntary participation by 151 aged care and health service organisations demonstrated a commitment to advance care planning performance monitoring.

How to use the ACPI Toolkit

The ACPI Toolkit is a quality improvement resource designed to assess and improve the uptake and quality of advance care planning, ensuring people have choice and control over their future treatment decisions. This toolkit will also support organisations to monitor their progress against quality standards and generate an evidence base that can help drive quality improvement.

This toolkit provides information on how to prepare and conduct the audits, how to analyse and report information, the audit and survey tools, reporting templates, auditor guidance, and resources to support quality improvement for any areas of improvement identified.

The toolkit consists of three different areas of focus:

1. Advance care planning organisational systems
2. Advance care planning documents in health records
3. Advance care planning consumer experience

It is recommended that your organisation assesses and improves all three areas of focus. However, your organisation may wish to only focus on one area at a time. Annual auditing is recommended for best practice.

PLEASE NOTE:

ACPA strongly recommends you do not change any of the audit questions, as these have been developed following national consultation.

Using the same audit questions for your first and future audits also promotes consistent data collection for benchmarking and comparison, if required.

The ACPI Toolkit is most likely to be implemented by quality coordinators, nurses, care workers, allied health assistants or professionals, and/or students. These people will be referred to as the auditor(s) throughout this manual. An auditor should read this manual in full to ensure adequate knowledge of and a consistent approach to data collection.

How to prepare for the audit

The following section provides information on how to prepare for the audit(s). At the end of this section, a checklist will help you ensure all relevant tasks have been completed before beginning the audit(s).

Download audit tools

The three audit tools and their related reports are available in this document (see Appendix 1 and 2). These documents can also be requested in Word format or as a digital survey by contacting 1300 208 582.

Leadership, staff engagement and support

It is important that the implementation of the ACPI Toolkit is supported and endorsed by your organisation's executive, management and/or the relevant governance committee.

Your organisation should nominate an advance care planning leader(s) from the outset that will be responsible for advance care planning quality improvement.

All auditors and other relevant staff should be aware of the following before an audit begins:

- the ACPI Toolkit
- the role of the auditor(s)
- when the audits are taking place
- advance care planning quality improvement priorities for your organisation.

Ethics approval

Before the audit(s), determine whether ethics approval is required by your organisation. Generally, audits and surveys conducted solely for internal quality improvement will not require ethics approval, but research studies will.

Regardless of whether ethics approval is required, ethical practice and standards, including confidentiality and privacy, should be always upheld.

Auditor training and guidance

Auditor guidance is most relevant for the advance care planning health records audit to ensure reliable and comparable data collection. Auditors should ensure a comprehensive understanding of advance care planning documents and how to categorise documents identified during the audit.

For further information on auditor guidance, see Appendix 3.

Checklist: Preparing for the audit

Initiating the audit process

- Gain support/approval from all relevant leadership
 - Organisational executives, management and/or governance committee
 - Ethics committee (if required)
- Identify and engage ACP leadership and audit team
 - Organisational leaders responsible for advance care planning quality improvement
 - Audit team members

Identifying the work

- Determine which audits will be conducted
 - Organisational systems audit
 - Health record audit
 - Consumer experience audit
- Determine which organisational areas the audits will target
 - Entire organisation
 - Single site (if multiple sites exist)
 - Organisational unit/ward only

Coordinating resources for the audit

- Prepare the audit team
 - Ensure auditors receive appropriate training (if needed)
 - Ensure auditors are familiar with audit toolkit and resources
 - Ensure auditors are aware of quality improvement priorities
 - Allocate audit roles to auditors. If more than one audit is being conducted simultaneously, consider creating separate audit teams
- Prepare all the audit tools/resources
 - Access all relevant tools and templates prior to beginning the audit - templates available in toolkit and can be requested in Word format or digital survey
 - Ensure auditors have access to all relevant audit tools, templates, organisational systems and/or health records

Setting the audit schedule

- Develop and circulate a timeline
 - Set clear audit completion timeframes and deadlines for each task
 - Receive approval from appropriate leaders/committees for project time frames (if required)
 - Ensure audit team is aware of agreed deadlines

How to conduct the audits

The following table describes and summarises the audit data collection process.

At the end of this section, a checklist will help you ensure all relevant tasks have been completed before finalising the audit(s).

Table 1. Summary of methods

Advance care planning organisational systems audit	
Audit description	Assesses what systems are in place to facilitate advance care planning such as leadership, governance, policies, workforce capability, and risk management.
Eligibility criteria	An aged care or health service organisation that might include multiple sites.
Audit requirements	The auditor must have access to information about the organisation and its systems to collect data.
Advance care planning documents in health records audit	
Audit description	Assesses the prevalence, type, and quality of advance care planning documents.
Eligibility criteria	A health record of a person who: <ul style="list-style-type: none"> • is ≥18 years of age; and • has been admitted for ≥48 hours to the aged care or health service organisation. The ACP document must be in English.
Audit requirements	The auditor must have access to the patient/client health records (paper and/or electronic). A minimum of 30 randomly selected health records should be audited. Attempt to locate relevant ACP documentation within 15 minutes of opening the record. Record the time taken to locate the ACP document using a stopwatch / device. Once timer is stopped, collect relevant data from the record for the audit. If no ACP document is located within 15 minutes of opening the record, document a failure to locate ACP document within the 15-minute timeframe. See Appendix 3 for guidance.
Advance care planning consumer experience survey	
Audit description	Assesses the consumer's experience of advance care planning at your organisation.
Eligibility criteria	A person with capacity to complete the survey with or without the support of their enduring guardian (e.g., a carer) or a health professional.
Audit requirements	The auditor (or someone else in your organisation) distributes the survey to a sample of those who meet the eligibility criteria. The survey should be voluntary. Willingness to complete the survey implies consent.

Collect data

The ACPI Toolkit collects a range of data. Data collection should remain consistent across aged care and hospital service organisations to enable and promote benchmarking and comparison.

In some circumstances, your organisation may choose to share the results of the audit with external stakeholders. Regardless of whether these results will remain internal or be provided to external stakeholders, accuracy and transparency in data analysis and reporting, as well as version tracking, is vital to good record management.

Ensure at least two auditors are independently conducting the organisational systems or health record audit to allow for reliability assessments during data analysis.

The ACPI Toolkit audit and survey tools must be used for data collection.

Before commencing, your organisation will need to decide whether data collection will be paper-based or done electronically.

- For *paper-based data collection*, enter data into an Excel document (template available from Advance Care Planning Australia).
- For *electronic data collection*, data can be collected using an online survey tool that allows for an Excel data extract (e.g., SurveyMonkey™).

For organisations with a SurveyMonkey™ account, a copy of the audit tools on SurveyMonkey™ can be provided by ACPA by phoning 1300 208 582. Please use the subject heading *SurveyMonkey™: ACPI Toolkit* and indicate your state and which audit tool(s) you want access to in the body of the email.

Analyse data

Best practice auditing should include data cleaning and assessments of data quality and reliability.

All data should be de-identified before any analysis is conducted.

Data cleaning may include checking the accuracy of a random selection of paper-based audits against the data entered into Excel.

Reliability of data collection can be checked by two auditors independently conducting the organisational systems or health record audit, comparing findings, and reviewing inconsistencies against this toolkit guidance.

Produce reports

Organisations should report key ACPI Toolkit findings and improvement priorities using the recommended reporting templates. These templates are available in this document and versions in Word format and SurveyMonkey™ are available on request. Data will most commonly be reported as percentages and findings described.

Reporting should be provided to the relevant clinical governance committee(s) and shared with those involved in advance care planning quality improvement, including external auditors assessing the organisation against the national quality standards.

Identify improvement priorities

An important part of reporting is the identification of areas for improvement, at either the organisational, advance care planning document, and/or consumer experience level.

The advance care planning actions and resources section may provide relevant priority activities to address areas for advance care planning improvement.

Your organisation, governance committee or team may wish to assess the implementation of improvement priorities and commit to ongoing performance monitoring.

Checklist: Conducting the audit

Collect data	
<input type="checkbox"/>	Decide on data collection method
<input type="checkbox"/>	Paper-based data collection
<input type="checkbox"/>	Electronic data collection
<input type="checkbox"/>	Collect data using the ACPI toolkit audit and survey tools provided
<input type="checkbox"/>	Record data in appropriate data collection tool
<input type="checkbox"/>	Save all data files in an appropriate folder
<input type="checkbox"/>	De-identify all data once collected
Conduct data analysis	
<input type="checkbox"/>	Clean all data collected
<input type="checkbox"/>	Ensure all data points collected include a valid response type
<input type="checkbox"/>	FOR PAPER-BASED AUDITS ONLY: cross-check the accuracy of a random selection of paper-based audits against the data entered in Excel
<input type="checkbox"/>	Assess the reliability of the data collection process
<input type="checkbox"/>	Ensure two auditors independently conduct the organisational systems and/or health record audit(s)
<input type="checkbox"/>	Compare findings of different auditors and review inconsistencies against guidance in this toolkit
Report audit results	
<input type="checkbox"/>	Produce report(s) for each audit conducted using templates provided in this toolkit
<input type="checkbox"/>	Save all data and reports in an appropriate folder with clear document names that identify the year of the audit (e.g., Organisational Systems Audit Results 2022 V1.0)
<input type="checkbox"/>	Circulate report(s) to relevant parties
<input type="checkbox"/>	Organisational executives, management and/or governance committee(s)
<input type="checkbox"/>	Teams and individuals involved in advance care planning quality improvement, including external auditors assessing the organisation against national quality standards
<input type="checkbox"/>	Ethics team (if required)



Copies of the report(s) should be kept digitally for comparison against any future audits

**continued on next page*

Identify and action improvement priorities

- Identify and prioritise poor performance areas using the resources available in the toolkit
 - Identify areas needing improvement at the organisational level
 - Identify areas needing improvement at the advance care planning document level
 - Identify areas needing improvement at the consumer experience level
 - Once a list of all areas requiring improvement has been developed, assign priority rankings to each task (e.g., low, medium, high priority)
- Develop and action a plan for addressing improvement priorities
 - Use the actions and resources section of the toolkit to develop relevant priority activities to address areas of improvement
 - Provide the action plan to management, governance committee and/or audit team for feedback and/or approval
 - Schedule review of the action plan and next audit as required. (Your organisation may wish to commit to ongoing performance monitoring to promote continuing advance care planning quality improvement.)

Advance care planning actions and resources

In Tables 2 and 3 you will find additional advance care planning information and resources related to the audit toolkit.

Recommended actions and information are available for specific questions within the audit tool, identified by the first letter (O= organisational systems audit tool, HR= health records audit tool, and C= consumer survey tool) and number corresponding to the question in the audit tool.

Table 2. Advance care planning actions to support improvement

Topic	Relevant question(s)	Recommended actions
Clinical governance	O1	<p>Establish a clinical governance committee dedicated to advance care planning or incorporate advance care planning as part of a broader committee. (e.g., End-of-life and palliative care)</p> <p>The committee should:</p> <ul style="list-style-type: none"> • have terms of reference (covering membership, purpose, responsibilities, meeting frequency, reporting requirements) • meet regularly • review requirements of relevant national standards and results of audits and surveys; set and endorse improvement priorities and actions; and monitor and report outcomes • be responsible for organisational advance care planning policy. <p>For more information about implementing key clinical governance processes see the Australian Commission on Safety and Quality in Health Care's National Model Clinical Governance Framework</p>
Advance care planning leadership	O2	<p>Nominate an advance care planning leader(s)/champion(s) in your organisation to help implement any advance care planning activities.</p> <p>Make sure the advance care planning leader(s)/champion(s) can:</p> <ul style="list-style-type: none"> • understand the importance and requirements of advance care planning including relevant laws, policy, national standards, and consumer experience • effectively communicate and advocate for advance care planning • educate your workforce about advance care planning

Topic	Relevant question(s)	Recommended actions
		<ul style="list-style-type: none"> • act as a resource for staff, consumers, enduring guardian/person responsible and consumers' loved ones • coordinate and champion advance care planning quality improvement activities • monitor the delivery of advance care planning by your workforce and report on your findings. <p>Advance Care Planning Australia offers Train the Trainer education that can provide the upskilling required to become an advance care planning leader.</p>
Partnering with consumers	O3	<p>Enable your organisation to support consumer partnerships in quality improvement initiatives.</p> <p>You may wish to:</p> <ul style="list-style-type: none"> • use the advance care planning consumer survey to obtain feedback from consumers about your organisation • use the organisation's existing consumer reference group e.g., Community Advisory Committee • use an informal mechanism such as a suggestion box or web-based anonymous feedback form • utilise consumer focus groups. <p>Ensure consumer feedback is communicated to a governance committee, where possible.</p>
Policies	O4-O9	<p>Ensure you have policies, procedures, and protocols in place in relation to advance care planning that are up-to-date and comply with the current law and policy.</p> <p><i>Content</i></p> <p>If your organisation has multiple sites, you must follow the law and policy in your particular state or territory.</p> <ul style="list-style-type: none"> • Visit Advance Care Planning Australia's website for more information about advance care planning in your state or territory • You can use the policy checklist (Appendix 4) to assist with developing your policy <p><i>Accessibility</i></p> <p>To make sure your policies, procedures and protocols are accessible you may wish to:</p>

Topic	Relevant question(s)	Recommended actions
		<ul style="list-style-type: none"> • ensure the policy is in an organisation-wide policy repository and is easy to find to prevent being overlooked • promote its availability to relevant staff and their responsibilities at induction, during continuing professional development, and when reviewing outcomes of audits and surveys • promote consumer and community access to this policy due to its relevance in promoting their choice and control over future medical treatment decisions. <p><i>Review of policies</i></p> <p>Have a designated member and clinical governance committee responsible for the policy who ensures the policy:</p> <ul style="list-style-type: none"> • reflects current law, policy, and best practice • covers the scope outlined in the policy checklist • has a review date to encourage periodic review. <p>When changes are made, communicate changes with your workforce by:</p> <ul style="list-style-type: none"> • offering resources and training on any new/amended documents • notifying staff members in meetings • sending communications to workforce (e.g., emails, department newsletter).
Advance care planning conversations	O16 C5, C8, C10	<p>To assist staff to navigate advance care planning conversations the following resources are useful:</p> <ul style="list-style-type: none"> • Guidance for starting advance care planning conversations • Advance care planning – advanced communications module • Dying to talk discussion starters <p>Staff should encourage consumers to formally document their values and preferences in an Advance Care Directive and appoint an enduring guardian on an Instrument Appointing Enduring Guardian form.</p> <p>Staff should record any values and preferences expressed to them during ACP conversations in the person’s health record.</p>

Topic	Relevant question(s)	Recommended actions
Recommended forms	O10-11 C6, C9	Have copies and promote Tasmania’s Advance Care Directive form and Instrument Appointing Enduring Guardian(s). For recommended forms please visit Advance Care Planning Australia’s website or the Tasmanian Government’s website .
Identification of advance care planning documents	O12-14 HR (all questions) C3	<p><i>Identification of advance care planning documents</i></p> <p>Ensure when a consumer enters your organisation your admission process and/or form asks the consumer (or enduring guardian/person responsible) about the existence of any advance care planning documents. A copy of all the relevant advance care planning documents should be made available and entered into the health record. Documents should be identified as either an Advance Care Directive, Instrument Appointing Enduring Guardian (a legally binding document) or non-legally binding advance care planning document like an advance care plan intended to guide care.</p> <p><i>Quality identifiers</i></p> <p>Ensure there are systems in place so that before an Advance Care Directive, Instrument Appointing Enduring Guardian(s) enters the health record, staff at your organisation can determine whether document formality requirements are satisfied.</p> <p>If the document does not satisfy requirements:</p> <ul style="list-style-type: none"> • in the case that the consumer has decision-making capacity, then the document should be amended or revoked (and have a new document completed and entered into the health record) • in the event the document originated in another organisation, notify the organisation of this fact • In the case the consumer has lost decision-making capacity, the preferences expressed may be used as a guide only and may not be legally binding.
Storage, accessibility, and review processes	O15, O17-18 C4	<p><i>Most up-to-date documentation</i></p> <ul style="list-style-type: none"> • upon arrival at your organisation, confirm with the consumer that any Advance Care Directive (or any other advance care planning document) you have access to is the most up to date version of the document.

Topic	Relevant question(s)	Recommended actions
		<ul style="list-style-type: none"> • communicate the current values and preferences documented to ensure they are still reflective of the person’s current values and preferences. If they are not, give the consumer the opportunity to update the document. <p><i>Available in the health record</i></p> <ul style="list-style-type: none"> • ensure your organisation’s admission form identifies whether a consumer has an Advance Care Directive (or any other advance care planning document) and identifies who their enduring guardian/person responsible is. • ensure copies of any identified documentation are included in the health record. <p><i>Readily accessible to clinicians</i></p> <ul style="list-style-type: none"> • incorporate information from the consumer’s Advance Care Directive (or any other advance care planning document) into a goals of care form (or similar), palliative care plan, and/or comprehensive care plan. • ensure any advance care planning documents made during the consumer’s admission are made available to other parts of the organisation, the consumer’s GP, and any other health organisation they attend. • encourage consumers or their nominated and authorised representatives to upload advance care planning documents to My Health Record <p><i>Review</i></p> <ul style="list-style-type: none"> • encourage consumers to review their Advance Care Directive(s) (or any other advance care planning document) annually or when circumstances change.
Consumer resources	O19-O22 C2, C11, C12	<p>Have resources available to the consumer, their enduring guardian/ person responsible, carer, and other loved ones in a variety of formats.</p> <p><i>Information resources and support services</i></p> <ul style="list-style-type: none"> • ensure consumers have access to information from Advance Care Planning Australia and the Tasmanian Government.

Topic	Relevant question(s)	Recommended actions
		<ul style="list-style-type: none"> ensure your organisation makes culturally sensitive resources available to relevant consumers Advance Care Planning Australia offers a number of bilingual resources in 18 different languages and culturally sensitive learning modules. Palliative Care Australia offers a learning resource for conducting end-of-life conversations with Aboriginal and Torres Strait Islander People. ELDAC offers resources for the LGBTIQ+ population.
Involving the enduring guardian/person responsible	C7 O23	<p>Use an admission form to identify if an enduring guardian has been appointed. If not, identify the consumer's person responsible by the hierarchy within the law and document this.</p> <p>Ensure consumer centred care is inclusive of the person's enduring guardian/person responsible.</p> <p>Make sure resources that support the enduring guardian/person responsible are available.</p> <ul style="list-style-type: none"> Advance Care Planning Australia has information, a Support Service via 1300 208 582, and dedicated education module for substitute decision-makers (i.e., enduring guardian/ person responsible).
Clinical handover and transfer processes	O24-O25	<p>Have advance care planning policy inclusive of clinical handover and transfer processes.</p> <p><i>Clinical handover</i></p> <ul style="list-style-type: none"> promote a clinical handover process inclusive of Advance Care Directive preferences if the consumer is deteriorating or being assessed for significant treatment, and is at risk of having insufficient decision-making capacity ensure the most up-to-date and relevant information is communicated and necessary documents are made available ensure staff understand their responsibilities. <p><i>Transfer processes</i></p> <ul style="list-style-type: none"> ensure transfer of consumer care between service providers and providers of transportation (e.g., ambulance officers) includes the transfer of advance care planning documents as this clinical information is intended for this use.

Topic	Relevant question(s)	Recommended actions
Assessing compliance	O26-O27	Promote death audits to assess whether treatment was provided in accordance with values and preferences documented in any advance care planning document to assess concordance.
Assessing staff understanding and confidence	O28	Use Advance Care Planning Australia’s capability framework and self-assessment tool to assess current skills levels and help to identify education opportunities to upskill.
Promoting resources to your staff	O29	<p>Ensure resources are available to your staff.</p> <p>These resources may include:</p> <ul style="list-style-type: none"> • Advance Care Planning Australia <ul style="list-style-type: none"> • Advance Care Planning Australia’s website • Advance Care Planning Support Service - 1300 208 582 (available 9am – 5pm (AEST) Monday to Friday) • Advance Care Planning Australia’s referral service • End of Life Directions for Aged Care <ul style="list-style-type: none"> • Advance Care Planning in Residential Aged Care • Advance Care Planning in Home Care • Advance Care Planning Primary Care • Queensland University of Technology End of Life Law <ul style="list-style-type: none"> • Resources on advance care directives • Resources on treatment decisions • Dementia Australia’s advance care planning information for health professionals • Advance Care Planning Australia’s Learning Modules • Tasmanian Government’s advance care planning resources
Trained advance care planning facilitator	O30	<p>At least some of your staff should have undertaken specialised training in advance care planning to help deliver advance care planning education within the organisation.</p> <p>Advance Care Planning Australia’s Train the Trainer Course provides this specialised training.</p>

Topic	Relevant question(s)	Recommended actions
Continuing professional development	O31	Promote staff at your organisation to complete Advance Care Planning Australia's learning modules or the organisation's local advance care planning training annually or when changes occur to law or forms to ensure advance care planning capability.
Risk management	O32-33	Consider adding items relevant to advance care planning to your organisation's incident management and investigation system. The audit tool provides a list of potential items to include.

Table 3. Advance care planning resources

Resources		
Information	Education	Other
advancecareplanning.org.au for advance care planning information and forms	ACPA Learning hub for modules	Advance care planning aged care implementation guide
ACPA National Advance Care Planning Support Service – 9am to 5pm (AEST) Monday to Friday on 1300 208 582	ACPA webinar training courses for participants and Train the Trainer	Aged care continuous improvement cycle
ACPA other languages hub for bilingual resources in 18 languages	ACPA YouTube videos including how to have advance care planning conversations	End of Life Decisions for Aged Care resources
ACPA's referral service	End of Life Law for Clinicians courses	My Health Record consumer resources
Tasmanian Government's Advance Care Planning resources	Palliative Care Education and Training Collaborative hub	My Health Record store and access advance care planning and goals of care guidelines
TAS Advance care planning forms		National Framework for Advance Care Planning Documents
		Policy checklist (Appendix 4)

Appendix 1: Audit Tools

Advance care planning organisational systems audit tool

This audit should only need to be completed once per year for single site organisations or multi-site organisations with central policies, processes, and governance. For other multi-site organisations, across multiple states and territories, multiple surveys may be required.

Date Completed: _____

Audit Completed by: _____

Leadership and governance

1. Is there a governance committee responsible for advance care planning within your organisation?

Yes

No

2. Is there an advance care planning champion or a clinical lead who can oversee the performance monitoring and improvement of advance care planning processes?

Yes

No

3. Are there systems in place to engage consumers in your organisation's advance care planning governance and planning to support organisational redesign?

Yes

No

Policies

4. Is there a policy, procedure and/or protocol in relation to advance care planning that can be easily accessed by staff?

Yes

No

5. Does the policy, procedure and/or protocol reference the most current advance care planning legislation (i.e., *Guardianship and Administration Act 1995 (Tas)*)?

Yes

No

6. Is the policy, procedure and/or protocol in date? For example, not past its review due date.

Yes

No

7. Has the policy been assessed according to the policy checklist (see Appendix 4)?

Yes

No

8. If **YES**, please list any gaps identified:

9. When changes are made to the organisation's advance care planning policy, are such changes communicated to the workforce?

Yes

No

Person-centred care

10. Does your organisation promote the use of the Tasmanian Advance Care Directive form enabling consumers to document their preferences for care?

Yes

No

11. Does your organisation promote the use of the Tasmanian form(s) for enabling consumers to appoint an enduring guardian (i.e., Instrument Appointing Enduring Guardian(s))?

Yes

No

12. Is there a process in place to identify whether a consumer has an Advance Care Directive, Instrument Appointing Enduring Guardian(s) (or other advance care planning documents) upon admission into the health service?

Yes

No

13. Is there a process in place to identify whether the consumer's Advance Care Directive, Instrument Appointing Enduring Guardian(s) (or other advance care planning documents) entering the health record contains quality identifiers (e.g., person identification, signing and witnessing requirements)?

Yes

No

14. Is there a process in place to check the consumer's My Health Record for advance care planning information?

Yes

No

15. Are there processes in place to ensure the consumer's Advance Care Directive or any other advance care planning document is:

- the most up-to-date documentation of the person's values and preferences?
- available in the health record?
- readily accessible to clinicians involved in providing care to the consumers?
- accessible in all areas where care is provided, including emergency situations?

16. Are there staff who have had advance care planning training available to discuss the consumer's values and preferences upon admission and/or during their time in your organisation?

- Yes
- No

17. Is there a process in place to ensure that a consumer's values and preferences are reviewed at regular times during their care?

- Yes
- No

18. If **YES**, how frequently does this occur?

19. Do consumers have access to information and resources about advance care planning?

- Yes
- No

20. Do the consumers' families, carers, and enduring guardians(s)/ person responsible have access to information and resources about advance care planning?

- Yes
- No

21. Do the information and resources available

- acknowledge cultural diversity in advance care planning?
- acknowledge LGBTIQ+ needs in advance care planning?
- acknowledge disability needs in advance care planning?
- reflect the current advance care planning legislation (i.e., *Guardianship and Administration Act 1995* (Tas))
- exist in a variety of formats to meet different consumers' needs (e.g., different media, low literacy 'Easy Read' versions, multiple languages)?
- the organisation does not have information or resources

22. Please list the information and resources currently available.

23. Is there a process in place to ensure that the consumer's enduring guardian/person responsible meets with the responsible clinical team to discuss the person's values and preferences and their future role in decision-making?

Yes

No

24. During clinical handover, are there processes in place to ensure that the consumer's goals and preferences are made known to inform care decisions?

Yes

No

25. If the consumer is transferred to another health service, are there processes in place to ensure any Advance Care Directive (or other advance care planning document) is provided to inform medical treatment decisions at any stage of the transfer?

Yes

No

26. Is there a process in place to assess whether a consumer's Advance Care Directive (or any other advance care planning document) was followed (e.g., death audit)?

Yes

No

27. If you answered **YES** to the above question, please specify the mechanism:

Workforce capability

28. Are there processes in place to assess staff understanding and confidence in advance care planning?

Yes

No

29. Which of the following are promoted and made available to your staff?

National Advance Care Planning Support Service 1300 208 582

Advance Care Planning Australia's referral service

Information resources (Advance care planning in aged care guide, ELDAC resources or similar)

[Advance Care Planning Learning modules](#) or local online training

Face-to-face training

Other _____

None of the above

30. Does your organisation have a trained advance care planning facilitator (e.g., someone who has completed Advance Care Planning Australia's (ACPA) [Train the Trainer](#) course or similar)?

Yes

No

31. Are there processes in place to ensure staff receive continuing professional development in relation to advance care planning?

Yes

No

Risk management

32. Does your organisation have a reportable event system to investigate failures relating to advance care planning?

Yes

No

33. If **YES**, what types of incidents are reported?

Missing, inadequate or illegible Advance Care Directive (or other advance care planning documents)

Communication inadequate or failed between clinicians

Communication inadequate or failed between enduring guardian/person responsible/family/ carer and clinicians

Consumer incorrectly identified

Enduring guardian/person responsible contact delayed or not attempted

Advance Care Directive (or other advance care planning document) not followed or used (e.g., treatment provided that was refused).

Planned treatment option unavailable

Disputes between clinicians

Disputes between enduring guardian/person responsible/family/carers and clinicians

Advance care planning documents in health records audit tool

Prior to using this audit tool, auditors should be familiar with this manual including Appendix 3 Health Record Audit Guidance. It is important that data and information is collected in a consistent way across aged care and health service organisations to promote benchmarking and comparison.

Date Completed: _____

Audit Completed by: _____

Person-completed documents

Statutory advance care directive indicating preferences of care (i.e., Advance Care Directive)

1. Is there evidence of an Advance Care Directive completed by the consumer?

Yes

No

2. If **YES**, what form(s) are used? (Tick all that apply)

Tasmania's recommended form

Advance Care Directive (Tas)

Recommended forms from other states and territories

Advance Care Directive (NSW)

Advance Care Directive (SA)

Advance Care Directive (VIC)

Advance Health Directive (QLD)

Advance Health Directive (WA)

Health Direction (ACT)

Advance Personal Plan (NT)

3. Is the document dated?

Yes

No

4. What details does the form contain about the consumer? (Tick all that apply)

Full name

Date of birth

Address

5. Is the document signed by the consumer?

Yes

No

6. Is the document signed by an eligible person at the consumer's direction? e.g., if the consumer has a physical disability that means they cannot sign the form

- Yes
- No
- Question not applicable

7. Is the document witnessed by two people?

- Yes
- No

8. Is at least one of the witnesses a person authorised by law to take statutory declarations?

- Yes
- No

9. Does the document specify the person's treatment preferences?

- Yes
- No

10. If YES, what treatment preferences are recorded?

- Wants all life-prolonging treatment
- Only wants some life-prolonging treatment
- Does not want life-prolonging treatment
- Person wants to delegate decisions to another person (e.g., enduring guardian/person responsible)
- Unable to determine
- Other (please specify) _____
- Non-statutory / common law advance care directive indicating preferences for care

11. Is there any evidence of other types of person-completed documents which include preferences for care? (Tick any that apply)

Other structured common law advance care directive forms

- Statement of Choices
- Respecting Patient Choices Advance Care Plan
- My Values completed by the person
- Letter indicating treatment preferences
- Other (please specify): _____

Recommended forms from other states and territories

- Advance Care Directive (NSW)

- Advance Care Directive (SA)
- Health Direction (ACT)
- Advance Care Directive (Vic)
- Advance Health Directive (Qld)
- Advance Health Directive (WA)
- Advance Personal Plan (NT)

12. Is the document dated?

- Yes
- No

13. What details does the form contain about the consumer? (Tick all that apply)

- Full name
- Date of birth
- Address

14. Is the document signed by the consumer?

- Yes
- No

15. Is the document witnessed?

- Yes
- No

16. If there was evidence of other types of person-completed documents, did this document express a preference for refusal of treatment?

- Yes
- No

Statutory advance care directive - appointment of a substitute decision-maker (i.e., Instrument Appointing Enduring Guardian)

17. Is there evidence of an Instrument Appointing Enduring Guardian completed by the consumer using a government recommended form?

- Yes
- No

18. If **YES**, what form(s) are used? (Tick any that apply)

- Tasmania statutory form
 - Instrument Appointing Enduring Guardian(s) (Tas)
- Statutory document from another state/territory:

- Advance Care Directive (SA)
- Advance Health Directive / Enduring Power of Attorney (Qld)
- Advance Personal Plan (NT)
- Appointment of Enduring Guardian (NSW)
- Appointment of a medical treatment decision maker (VIC)
- Enduring Power of Guardianship (WA)
- Enduring Power of Attorney (ACT)

Other (please specify) _____

19. Is the document dated?

- Yes
- No

20. What details does the form contain about the consumer? (Tick all that apply)

- Full name
- Date of birth
- Address

21. What details of each enduring guardian does the form contain? (Tick all that apply)

- Full name
- Date of birth
- Address
- Phone number

22. Is the document signed by the consumer?

- Yes
- No

The following question applies if the document is NOT signed by the consumer.

23. Is the document signed by an eligible person at the consumer's direction? e.g., if the consumer has a physical disability that means they cannot sign the form

- Yes
- No
- Question not applicable

24. Has the appointed person signed to indicate their acceptance of the enduring guardian appointment?

- Yes
- No

25. Is the document witnessed by two people?

- Yes
- No

26. Are the witnesses eligible witnesses?

- Yes
- No

27. Have there been any conditions put on the enduring guardian?

- Yes
- No

28. If **YES**, do these conditions conflict with specified in the consumer's Advance Care Directive?

- Yes
- No
- The person does not have preferences documented in an Advance Care Directive

Documents completed by someone else

29. Is there evidence of an advance care plan for someone without sufficient decision-making capacity completed by someone else, e.g., family, carer, enduring guardian/person responsible?

- Yes
- No

30. If **YES**, what form(s) are used? (Tick all that apply)

- Advance care plan applicable to TAS completed on behalf of someone with insufficient capacity
 - Advance care plan for a person with insufficient decision-making capacity (ACPA)
 - Other (please specify) _____
- Advance care plans from another state/territory:
 - Statement of Choices, Advance Care Planning Form B (Qld)
 - Advance Care Plan Statement of Choices, No Legal Capacity (ACT)
 - What I understand to be the person's preferences and values form (VIC)
 - Statement of Choices, no capacity (VIC)
 - Refusal of Treatment Certificate, incompetent person (VIC, prior to March 2018)
 - Other (please specify) _____

31. Is the document dated?

- Yes
- No

32. Is the form completed and signed by the person's enduring guardian/person responsible?

Yes

No

Other types of advance care planning documents completed by health professionals

33. Are there any other documents present that indicate the consumer's values and preferences, completed by someone other than the consumer?

Yes

Goals of Care plan

Comprehensive care plan

Medical order or resuscitation plan

ACP letter by a health professional

ACP discussion record

Terminal Care Wishes

Other (please specify) _____

No

Advance care planning consumer experience survey

This survey should be completed by a consumer (a person currently admitted or receiving services from a health service or aged care), and the questions are framed this way. If the consumer is unable to do so, someone else such as their enduring guardian/person responsible or health professional, can support them to complete it. The questions should be answered from the consumer's perspective.

Note: Advance care planning allows you to plan for your future medical treatment decisions, for a time when you might not be able to make your own decisions. The process involves conversations about your values and treatment preferences, considering what is acceptable or unacceptable outcomes to you. It may result in you completing an Advance Care Directive about your values and preferences for treatment and/or appointing an enduring guardian to make decisions for you.

Date: _____

1. Are you the consumer?

Yes

No

If **NO**, what is your relationship with the consumer?

2. Had you heard of advance care planning prior to completing this survey today?

Yes

No

Unsure

3. Were you asked whether you had an Advance Care Directive (or any other advance care planning document) when you were admitted into the health service or care facility?

Yes

No

Unsure

4. If you had some type of advance care planning document when entering the health service or care facility, were you asked if you want or need to update the document?

Yes

No

Unsure

N/A - Did not have an Advance Care Directive

5. If you did not have some type of advance care planning document, were you encouraged to document your preferences in an Advance Care Directive?

- Yes
- No
- Unsure
- N/A - Already had an Advance Care Directive.

6. If **YES**, did the health service or care facility give you the required form?

- Yes
- No
- Unsure
- N/A - Question does not apply

7. Were you asked to identify your substitute decision-maker for medical decisions (e.g., enduring guardian / personal responsible) during your stay?

- Yes
- No
- Unsure

8. Were you encouraged to appoint an enduring guardian in an Instrument Appointing Enduring Guardian form?

- Yes
- No
- Unsure
- N/A - Have already appointed an enduring guardian, or do not need to
- N/A - an enduring guardian cannot be appointed as the person has lost decision-making capacity

9. If **YES**, did the health service or care facility give you the required form?

- Yes
- No
- Unsure
- N/A - Question does not apply

10. Have you had an advance care planning conversation during your stay?

- Yes
- No
- Unsure

11. Were you given a resource about advance care planning?

Yes

Please specify if known _____

No

Unsure

12. If **YES**, was the resource easy to understand?

Yes

Somewhat (please provide further detail)

No (please provide further detail)

13. Do you have any suggestions about how to improve your access to or understanding of advance care planning?

Appendix 2: Reporting tools

The findings of the audits and survey should be made available to the relevant organisational governance committee and team. Organisations may already have reporting templates for use.

The following templates are provided as examples of how the data and information could be reported to support the identification of advance care planning improvement priorities. MS Word versions of the templates are available via request to Advance Care Planning Australia and can be adapted for local use.

This section includes resources to assist with strategies and activities to support advance care planning quality improvement.

Advance care planning organisational systems report

Introduction

The Advance Care Planning Improvement Toolkit, a nationally endorsed quality improvement resource, was implemented in [MONTH YEAR] to assess advance care planning organisational systems.

Advance care planning organisational systems are believed to promote better consumer choice and control over future medical treatment decisions. This is an important aspect of quality care and recognised within national quality standards.

Findings

The following information demonstrates the advance care planning organisational system results.

Leadership and governance	Yes	No
Governance committee		
Advance Care Planning Champion / Clinical Lead		
Consumer engagement		

Score ___ /3

Policies	Yes	No
Easily accessible		
Policy in compliance with most recent advance care planning legislation		
Policy in date		
Satisfies the policy content checklist		
Processes in place to communicate changes in policy to the workforce		

Score ___ /5

Person-centred care	Yes	No
Correct Advance Care Directive form		
Correct Instrument for Appointing Enduring Guardian(s) form		
Systems to identify advance care planning documents on admission		
System to ensure documents contain quality identifiers		
Systems are in place to ensure that advance care planning documents are stored, available in health record and readily accessible at the point of care and any place where care is provided		
Trained staff to discuss consumer's values and preferences		

Systems in place to facilitate review of values and preferences		
Consumers have access to information and resources about advance care planning		
Consumer families, carers, and enduring guardian(s)/person responsible have access to information and resources about advance care planning		
Resources are culturally sensitive, reflect current legislation and are in a variety of forms		
Process enabling an enduring guardian/person responsible to meet with the responsible clinical team		
Clinical handover processes that ensure goals and preferences are made known		
Process in place to assess whether an Advance Care Directive was followed		

Score ___ /13

Workforce capability	Yes	No
Assessment of staff confidence in advance care planning		
Promotion of national advance care planning support service, information resources, learning modules and face to face training		
Train the Trainer		
Continuing professional development		

Score ___ /4

Risk management

There **[is or is not]** a reportable event system available.

The following reportable items are missing from the current reportable event system **[insert here, if applicable]**

Recommendations

The following advance care planning improvements and actions are recommended / proposed:

- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]

Advance care planning documents in health records report

Introduction

The Advance Care Planning Improvement Toolkit, a nationally endorsed quality improvement resource, was implemented in [MONTH YEAR] to assess the prevalence and quality of advance care planning documents in health records. This is an important aspect of quality care and recognised within national quality standards.

Advance care planning is a process of planning for future health and personal care, whereby the person's values and preferences are made known. Although conversations themselves are useful, ideally advance care planning results in the voluntary completion of an advance care directive to enable consumer choice and control over future medical treatment decisions.

Preferably, consumers should complete an Advance Care Directive when they have capacity to do so. Advance Care Directives are an important part of advance care planning because they provide information and support for enduring guardians/the person responsible, clinicians and caregivers who may need to consider and advocate for the person's expressed preferences at a time when the person is unable to make or communicate their decisions.

An advance care plan may also be completed on behalf of the person by someone else close to the person, such as a family member, carer, or enduring guardian/person responsible, when a person lacks decision-making capacity to make an Advance Care Directive. An advance care plan may inform care but is not a legally binding document.

Other documentation that can inform future medical treatment decisions, is completed by medical practitioners, and includes do not resuscitate orders or goals of care documents.

This audit examined the prevalence and quality of the different types of advance care planning documents.

Findings

A total of [X] health records were audited at [organisation and site name]. The audit identified an overall prevalence of [XX%] for advance care directives, documents completed by the person. This included a prevalence of [XX%] for an advance care directive – preferences for care (i.e., Advance Care Directive) and [XX%] an advance care directive – appointment of a substitute decision-maker (i.e., Enduring Guardian). Of these documents, [XX%] included all quality identifiers such as full names, date of birth, address, signing by the person, document date, and witnessing. [XX%] of the advance care directive – preferences for care included refusal of life prolonging treatment.

The prevalence of documents completed by someone else was [XX%] for an advance care plan completed by someone else such as a family member, carer, or enduring guardian/person responsible and [XX%] for planning documents completed by a health professional.

Overall, [XX%] had some type of planning document available in the health record to support future medical treatment decision-making.

In comparison, only an estimated 15% of Australians have documented their preferences for care in an Advance Care Directive. The national research project *Prevalence of Advance Care Planning Documentation in Australian Health and Residential Aged Care Services* found only 14% of older Australians 65+ years had an advance care directive for preferences of care and/or to appoint a substitute decision-maker. The prevalence across sectors was 11% in hospitals and 38% in residential aged care. For older Australians in residential aged care, 30% of documents were advance care plans

completed by someone else (e.g., a family member, carer, or substitute decision-maker), the rate was preferably lower in hospitals at 3%. There was a 10% prevalence of planning documentation completed by a health professional. Overall, only 29% of older Australians had documentation to inform future medical treatment decisions and end-of-life care. Notably, the prevalence reported from this study was ultimately low and the organisation should aim to record a greater prevalence.

Recommendations

The following advance care planning improvements and actions are recommended / proposed:

- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]

Advance care planning consumer experience survey report

Introduction

The Advance Care Planning Improvement Toolkit, a nationally endorsed quality improvement resource, was implemented in [MONTH YEAR] to assess consumer advance care planning experience. This is an important aspect of quality care and recognised within national quality standards.

Findings

A total of [X] advance care planning consumer experience surveys were completed and [X] were completed by the consumer themselves and [X] were completed with support. [XX%] report that they had not heard of advance care planning prior to this survey.

Table 1. Consumer experience with advance care planning processes

	Number of responses (%)			
	Yes	No	Unsure	N/A
Asked about Advance Care Directive on admission				
Asked to update document if needed				
Encouraged to complete an Advance Care Directive				
Given the required form(s)				
Encouraged to appoint an enduring guardian				
Given the required Instrument Appointing an Enduring Guardian form				
Advance care planning conversation				
Given an ACP resource				
The resource was easy to understand				

Consumers provided the following suggestions for improvement:

- [insert verbatim comment or describe themes]
- [insert verbatim comment or describe themes]

Recommendations

The following advance care planning improvements and actions are recommended / proposed:

- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
- [Define improvement required; action(s) to be taken; timeframe; department or person responsible]

Appendix 3: Health record audit guidance

The advance care planning health record audit requires the auditor(s) to have robust knowledge of advance care planning and the types of advance care planning documents and formalities requirements. This could be achieved by completing the ACPA Learning modules 1 to 4, being familiar with this ACPI Toolkit manual including this Appendix and testing the audit toolkits prior to rollout.

The audit examines the prevalence, type of, quality and availability at the point of care of advance care planning documents at your organisation. An overview of the various types of advance care planning documents can be found in the flowchart (Figure 1) on the next page.

This guidance is intended to assist you to complete the audit and understand the types of advance care planning documents.

Figure 1. Documentation flowchart – Tasmania

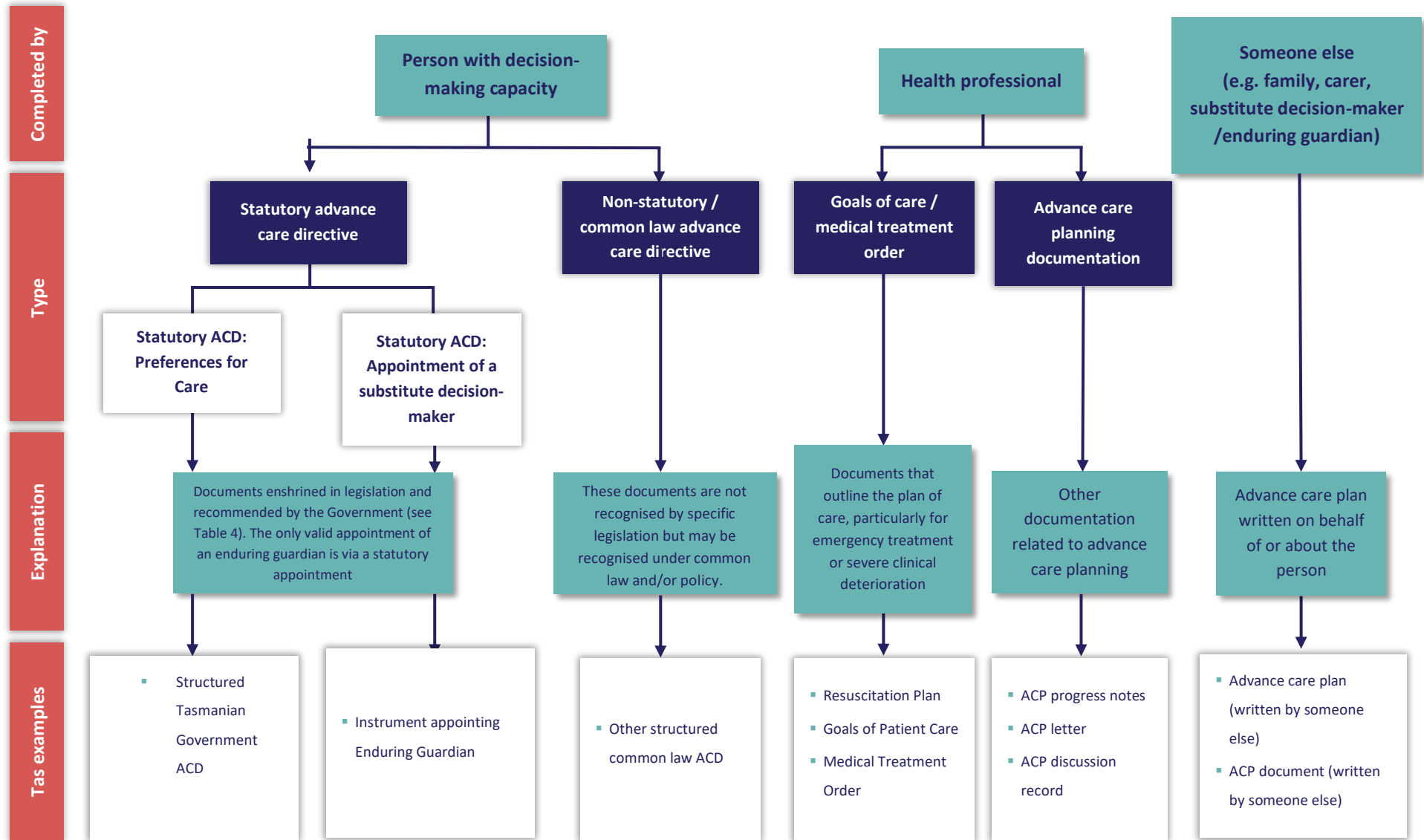


Table 4. Statutory advance care directives used in Australia

Jurisdiction	Statutory advance care directive: preferences for care	Statutory advance care directive: appointment of a substitute decision-maker
Australian Capital Territory	Health Direction	Enduring Power of Attorney (Healthcare Matters)
New South Wales	Advance Care Directive (common law advance care directive)	Appointment of Enduring Guardian
Northern Territory	Advance Personal Plan Direction under Natural Death Act <i>(prior to 1 July 2014)</i>	Advance Personal Plan – Substitute Decision-Maker Appointment Enduring Power of Attorney <i>(prior to 17 March 2014)</i>
Queensland	Advance Health Directive	Enduring Power of Attorney Advance Health Directive
South Australia	Advance Care Directive Anticipatory Direction <i>(prior to 1 July 2014)</i>	Advance Care Directive - Substitute Decision-Maker Appointment Medical Power of Attorney <i>(prior to 1 July 2014)</i> Enduring Power of Guardianship <i>(prior to 1 July 2014)</i>
Tasmania	Advance Care Directive	Enduring Guardianship
Victoria	Advance care directive for adults made under the <i>Medical Treatment Planning and Decisions Act 2016</i> (Part 2 and/or Part 3) <i>(from 12 March 2018)</i> Refusal of Treatment Certificate (Competent) <i>(prior to 12 March 2018)</i> <i>See note *</i>	Appointment of Medical Treatment Decision Maker <i>(from 12 March 2018)</i> Enduring Power of Attorney (Medical Treatment) <i>(prior to 12 March 2018)</i> Enduring Power of Guardianship <i>(prior to 12 March 2018)</i> Enduring Power of Attorney (Personal Matters) <i>(prior to 12 March 2018)</i>
Western Australia	Advance Health Directive	Enduring Power of Guardianship

Note: * Under previous Victorian legislation (*Medical Treatment Act 1988*), the Refusal of Treatment Certificate (Non-competent) was also an authorised statutory advance care directive. However, there is no provision in the current Victorian legislation for statutory advance care directives written on behalf of non-competent people. Therefore, for the purposes of this audit, the Refusal of Treatment Certificate (Non-competent) is considered advance care planning documentation completed by someone else.

Documentation completed by the person – Advance Care Directive

Under the current Tasmanian legislation, an adult can make an Advance Care Directive to refuse, or require the withdrawal of, medical treatment generally or a particular kind of medical treatment.

Statutory advance care directive – preferences for care (i.e., Advance Care Directive)

Tasmania has a prescribed form for written health directions, see Figure 2.

Figure 2. Advance Care Directive

The image shows the top portion of a form titled "ADVANCE CARE DIRECTIVE (TASMANIA)" from the Tasmanian Government. The form includes instructions on how to use it, a list of items that can be included in the directive, and a section for personal details. The "Section 1. My Values, and Preferences" section is partially visible, listing several bullet points for consideration.

Tasmanian Government

ADVANCE CARE DIRECTIVE (TASMANIA)

Making an Advance Care Directive (ACD) allows you to set out, or guide, what health care and treatment you wish to receive in the future if you lose the ability to make and communicate such preferences and decisions yourself.

You can include in your ACD:

1. Information about your values or preferences, which can guide a person making a decision about your health care; and
2. Specific treatments you refuse and in what circumstances.

To make an ACD you must have the ability to make decisions about your future health care and understand the consequences of making the ACD.

It is recommended that you discuss your future health concerns and treatments with your doctor or a health professional and discuss your wishes with significant people in your life such as your family, your enduring guardian and anyone else who is close to you.

Please also read the accompanying ACD Information Sheet before completing this form.

This form is compliant with the provisions of the *Guardianship and Administration Act 1995* (the Act). The Act provides for penalties for those who by dishonesty, or undue influence, induce another person to give an ACD or include a provision in an ACD that you do not want.

This is the ACD for YOU - the person making the directive

Print Name _____ Date of Birth ____/____/____

Address _____

Section 1. My Values, and Preferences

The values, and preferences you express here can guide a person making a decision about your health care. For example, you can include information about the following:

- What is important to me for my health care
- What gives me quality of life and makes my life worth living
- What is important to me if I am nearing death, including my preferred places of care and place to die
- What health outcomes I regard as acceptable
- Any reasons for refusing certain treatment (for example, cultural or religious beliefs)

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Statutory advance care directive – appointment of a substitute decision-maker (Instrument Appointing Enduring Guardian(s))

Figure 3. Instrument Appointing Enduring Guardian(s)

Guardianship and Administration
Act 1995
Form 1 (Section 32)

Instrument Appointing Enduring Guardian(s) For Tasmania

Section 1: Your details

Write your name, address, occupation and date of birth here.
Occupation examples:
Carpenter; Retiree;
Home duties

I, (your full name): _____
Of (your address): _____

Occupation: _____
Date of birth: _____
Phone No.: _____

Section 2: Choosing your guardian(s)

Write your guardian's details here.
If you only want to appoint one person as your guardian, complete this section, then go to Section 3. If you want to appoint joint guardians, write the first guardian's details here.

Appoint (guardian's name): _____
Of (guardian's address): _____

Phone No.: _____
Guardian's occupation: _____
to be my guardian.

Optional section:

I also appoint (joint guardian's name): _____
Of (joint guardian's address): _____

Phone No.: _____
Joint guardian's occupation: _____
to be my guardian.

Section 3: Choose your alternative guardian (Optional)

Optional section:
If you want to appoint an **alternative guardian in case one of your guardians cannot assume the role**, write your alternative guardian's details here. If you do not wish to appoint an alternative guardian, go to Section 4 now.

In the event that my guardian (or one of my joint guardians) becomes incapable or unavailable to exercise this appointment, I appoint

(Alternative guardian's name): _____
Of (alternative guardian's address): _____

Phone No.: _____
Alternative guardian's occupation: _____

Quality Identifiers

To be legally binding:

- The appointment must be in the approved form
- Each enduring guardian signs to confirm their appointment
- There are two eligible attesting witnesses who have witnessed the appointment in the presence of the person and the enduring guardian(s) appointed
- The form is registered with the Guardianship and Administration Board.

Who is an eligible witness?

To be an eligible witness, the witness must not be a relative or the person's enduring guardian.

When no enduring guardian is appointed

In the absence of an enduring guardian appointed by the person or a guardian appointed by the tribunal, the person responsible will be responsible for making decisions on behalf of the person.

The person responsible is determined by a hierarchy and will be the person's nearest relative in order of priority of the following relatives who have reached 18 years of age:

- (a) spouse¹
- (b) person having the care of the other person
- (c) close friend or relative of the other person²


¹ Cannot be under guardianship and must have a close and continuing relationship with that person.

² Cannot be a person receiving remuneration (not including carer's pension) for caring services.

Documentation completed by someone else

Although Tasmania's Advance Care Directive and Instrument Appointing Enduring Guardian(s) forms completed by an adult with decision-making capacity are preferable, it is recognised that other types of advance care planning documents may be available that are indicative of the consumer's values and preferences. These documents may be useful to health practitioners and the person responsible/enduring guardians when making medical treatment decisions on behalf of the person. These documents will be produced on behalf of a person who does not have sufficient decision-making capacity and may include the person's enduring guardian, person responsible, carer and/or other loved ones and referred to as advance care plans. Figure 4 is an example of an advance care plan that may be used by any state or territory.

Figure 4. Advance care plan for a person with insufficient decision-making capacity



If you are a health service or aged care organisation, add your logo within this space.

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

FORM

Advance care plan for a person with insufficient decision-making capacity

This is an advance care plan for a person with insufficient decision-making capacity to complete an advance care directive¹. This is **not** a form that is able to give legally-binding consent to, or refusal of treatment. This plan can be used to guide substitute decision-makers and clinicians when making medical treatment decisions on behalf of the person, if the person does not have an advance care directive.

Question 1

The person with insufficient decision-making capacity that this document applies to

Full name:

Date of birth:
(dd/mm/yyyy)

Address:

Question 2

The person completing this document

Full name:

Relationship to the person:

Address:

Phone number:

I believe that I am this person's legally recognised substitute decision-maker:

Yes No Unknown

If yes and appointed, please attach documentation that provides evidence of this (see Table 2 of the Instruction Guide).

If no, the person's legally recognised substitute decision-maker should complete and sign the form.

If a person is transitioning care between states and territories, they may have an advance care plan from another jurisdiction.

Documentation completed by health professionals.

These documents are completed on behalf of the consumer by a health professional, usually the consumer's treating medical practitioner.

Examples of these documents include:

- Goals of care form
- Medical order that describes the resuscitation and/or need for transfer
- An advance care planning discussion record
- ACP letter by a health professional
- Comprehensive care plan
- Notes related to advance care planning (e.g., progress notes).

Appendix 4: Policy checklist

Policy checklist	Item content	Yes / No
Administrative details	Date came into effect/ approved	
	Date of last review	
	Date of next review	
Introduction	Clear statement of intent about the purpose of the policy	
	Objectives of the policy	
	Desired outcomes of the policy	
	Indication of the staff the policy applies to	
Advance care planning content	Clear explanation of advance care planning as a voluntary process	
	Identification of current relevant law and policy	
	Clear explanation of when and how an advance care planning document is created, stored, accessed, and activated	
	Clear explanation of the ACP document formalities	
	Roles in the advance care planning process (including the consumer, enduring guardians(s)/ person responsible, the consumer's loved ones, and treating/care team.	
	Clinical handover / transfer processes (internal and external)	
	Storage of advance care planning documents (including the role of My Health Record)	
Definitions	Advance care planning	
	Advance Care Directive	
	Advance care plan	
	Consent	
	Decision-making capacity	
	Impaired decision-making capacity	
	Enduring guardian/person responsible	
	Substituted judgement, if relevant	
Culturally sensitive / underserved populations	Reference to engaging with consumers from diverse backgrounds including culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander populations	
	Reference to engaging with consumers who are LGBTIQ+ or people with disability	