Advance Care Planning Improvement Toolkit: Western Australia

2022

Advance Care Planning Australia

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Acknowledgements

Advance Care Planning Australia is funded by the Australian Government.

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. This initiative was informed by the *Prevalence of Advance Care Planning Documentation in Australian Health and Residential Aged Care Services Study*. The evaluation was undertaken with the support and advice of Dr Craig Sinclair (University of New South Wales) and Associate Professor Kim Devery and Dr Claire Hutchinson (Flinders University).

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: Western Australia

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 assess and improve 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 emailing admin@advancecareplanning.org.au.

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: ○ 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 in this toolkit).
- For *electronic data collection*, data can be collected using an online survey tool that allows for an Excel data extract (e.g., Survey Monkey).

For organisations with a Survey Monkey account, a copy of the audit tools on Survey Monkey can be provided by ACPA by emailing admin@advancecareplanning.org.au. Please use the subject heading *Survey Monkey: 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

- ☐ Decide on data collection method
  - ☐ Paper-based data collection
  - ☐ Electronic data collection
- ☐ Collect data using the ACPI toolkit audit and survey tools provided
  - ☐ Record data in appropriate data collection tool
  - ☐ Save all data files in an appropriate folder
  - ☐ De-identify all data once collected

Conduct data analysis

- ☐ Clean all data collected
  - ☐ Ensure all data points collected include a valid response type
  - ☐ FOR PAPER-BASED AUDITS ONLY: cross-check the accuracy of a random selection of paper-based audits against the data entered in Excel
- ☐ Assess the reliability of the data collection process
  - ☐ Ensure two auditors independently conduct the organisational systems and/or health record audit(s)
  - ☐ Compare findings of different auditors and review inconsistencies against guidance in this toolkit

Report audit results

- ☐ Produce report(s) for each audit conducted using templates provided in this toolkit
  - ☐ 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)
- ☐ Circulate report(s) to relevant parties
  - ☐ Organisational executives, management and/or governance committee(s)
  - ☐ Teams and individuals involved in advance care planning quality improvement, including external auditors assessing the organisation against national quality standards
  - ☐ 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	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) The committee should: ○ 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. 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
Advance care planning leadership	O2	Nominate an advance care planning leader(s)/champion(s) in your organisation to help implement any advance care planning activities. Make sure the advance care planning leader(s)/champion(s) can: ○ 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

Topic	Relevant question(s)	Recommended actions
		○ educate your workforce about advance care planning ○ 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. Advance Care Planning Australia offers Train the Trainer education that can provide the upskilling required to become an advance care planning leader.
Partnering with consumers	O3	Enable your organisation to support consumer partnerships in quality improvement initiatives. You may wish to: ○ 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 ○ use consumer focus groups. Ensure consumer feedback is communicated to a governance committee, where possible.
Policies	O4-O9	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. *Content* If your organisation has multiple sites, you must follow the law and policy in your particular state or territory. ○ Visit Advance Care Planning Australia's website for more information about advance

Topic	Relevant question(s)	Recommended actions
		care planning in your state or territory. You can use the policy checklist (Appendix 4) to assist with developing your policy. *Accessibility* To make sure your policies, procedures and protocols are accessible you may wish to: ○ 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 *Review of policies* Have a designated member and clinical governance committee responsible for the policy who ensures the policy: ○ reflects current law, policy, and best practice ○ covers the scope outlined in the policy checklist ○ has a review date to encourage periodic review When changes are made, communicate changes with your workforce by: ○ 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	To assist staff to navigate advance care planning conversations the following resources are useful: ○ Guidance for starting advance care planning conversations ○ Advance care planning – advanced communications module

Topic	Relevant question(s)	Recommended actions
		○ Dying to talk discussion starters Staff should encourage consumers to formally document their values and preferences in an Advance Health Directive and appoint an enduring guardian. Staff should record any values and preferences expressed to them during ACP conversations in the person's health record.
Recommended forms	O10-11 C6, C9	Have copies and promote the Western Australia's Advance Health Directive form and Enduring Power of Guardianship form. For Recommended forms please visit Advance Care Planning Australia's website or the Western Australian Government's website.
Identification of advance care planning documents	O12-14 HR (all questions) C3	*Identification of advance care planning documents* 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 Health Directive /Enduring Power of Guardianship (a legally binding document) or non legally binding advance care planning document like an advance care plan intended to guide care (e.g. Values and Preferences Form, Advance care plan for person with insufficient decision-making capacity). *Quality identifiers* Ensure there are systems in place so that before an Advance Heath Directive/ Enduring Power of Guardianship enters the health record, staff at your organisation can determine whether document formality requirements are satisfied.

Topic	Relevant question(s)	Recommended actions
		If the document does not satisfy requirements: ○ 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	*Most up-to-date documentation* ○ upon arrival at your organisation, confirm with the consumer that any Advance Health Directive (or any other advance care planning document) you have access to is the most up to date version of the document. ○ 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 revoke or update the document (if possible) ○ Available in the health record ○ ensure your organisation's admission form identifies whether a consumer has an Advance Health Directive (or any other advance care planning document) and identifies who their person responsible or enduring guardian/person responsible is. ○ ensure copies of any identified documentation are included in the health record. *Readily accessible to clinicians* ○ incorporate information from the consumer's Advance Health 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.

Topic	Relevant question(s)	Recommended actions
		○ encourage consumers or their nominated and authorised representatives to upload advance care planning documents to My Health Record. *Review* ○ encourage consumers to review their Advance Health Directive(s) (or any other advance care planning document) annually or when circumstances change.
Consumer resources	O19-O22 C2, C11, C12	Have resources available to the consumer, their enduring guardian/person responsible, carer, and other loved ones in a variety of formats. *Information resources and support services* ○ ensure consumers have access to information from Advance Care Planning Australia, the Western Australian Department of Health, and the Western Australia Office of the Public Advocate. ○ 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	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. Ensure consumer centred care is inclusive of the person's enduring guardian/person responsible. Make sure resources that support the person responsible/enduring guardian are available. ○ Advance Care Planning Australia has information, a Support Service via 1300 208 582, and dedicated education module for substitute decision-makers (i.e., person responsible/ enduring guardian).

Topic	Relevant question(s)	Recommended actions
Clinical handover and transfer processes	O24-O25	Have advance care planning policy inclusive of clinical handover and transfer processes. *Clinical handover* ○ promote a clinical handover process inclusive of Advance Health 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. *Transfer processes* ○ 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.
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	Ensure resources are available to your staff. These resources may include: • Advance Care Planning Australia ○ 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 ○ WA Department of Health

Topic	Relevant question(s)	Recommended actions
		○ Advance care planning information ○ Advance Health Directive information ○ Health Professional Guide to Advance Care Planning in WA ○ End of Life Directions for Aged Care ○ 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 ○ 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
Trained advance care planning facilitator	O30	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. Advance Care Planning Australia's Train the Trainer Course provides this specialised training.
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
WA Department of Health advance care planning information for consumers including resources for culturally and linguistically diverse populations.	Palliative Care Education and Training Collaborative hub	My Health Record store and access advance care planning and goals of care guidelines
WA Department of Health advance care planning information for health professionals WA Department of Health Advance Health Directives information for health professionals WA Department of Health Advance Health Directives information for consumers	WA Health End-of-Life and Palliative Care Education and training framework	National Framework for Advance Care Planning Documents Policy checklist (appendix 4) Advance Health Directive information

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 1990* (WA))?

☐ 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 Western Australian Advance Health Directive form enabling consumers to document their preferences for care?

☐ Yes

☐ No

11. Does your organisation promote the use of the Western Australian recommended form(s) for enabling consumers to appoint an enduring guardian (i.e., Enduring Power of Guardianship form)?

☐ Yes

☐ No

12. Is there a process in place to identify whether a consumer has an Advance Health Directive / Enduring Power of Guardianship form (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 Health Directive / Enduring Power of Guardianship form (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 Health 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 guardian(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 1990* (WA))?
- ☐ 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 Health 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 an Advance Health Directive (or 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 Health Professionals Guide to Advance Care Planning in WA or similar)
- ☐ Advance Care Planning Learning modules (https://learning.advancecareplanning.org.au/) 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 Health 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 Health 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/carer 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 for preferences of care (i.e., Health Direction)

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

☐ Yes

☐ No

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

☐ Western Australia's recommended form

- ☐ Advance Health Directive (WA)

☐ Recommended forms from other states and territories

- ☐ Advance Care Directive (NSW)
- ☐ Advance Care Directive (SA)
- ☐ Advance Care Directive (Tas)
- ☐ Advance Care Directive (Vic)
- ☐ Advance Health Directive (Qld)
- ☐ 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)

☐ Values and Preference Form: Planning for my future care

☐ Statement of Choices

☐ Respecting Patient Choices Advance Care Plan

☐ My Values completed by the person

☐ ACP letter indicating treatment preferences

☐ Other (please specify) _____

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., Enduring Power of Guardianship)

17. Is there evidence of an Enduring Power of Guardianship completed by the consumer using a government recommended form?

☐ Yes

☐ No

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

☐ Western Australia's statutory form

- ☐ Enduring Power of Guardianship (WA)

☐ 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 Attorney (ACT)
- ☐ Instrument Appointing Enduring Guardian(s) (Tas)

☐ 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. Is at least one of the witnesses a registered medical practitioner and/or a person authorised by law to take a statutory declaration?

☐ Yes

☐ No

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

☐ Yes

☐ No

28. If **YES**, do these limitations or conditions conflict with preferences contained in the consumer's Advance Health Directive?

☐ Yes

☐ No

☐ The person does not have preferences documented in an Advance Health 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 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) form (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 (e.g., Goals of Patient Care in WA)
- ☐ 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 Health 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 Health 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 Health Directive

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

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ N/A - Already had an Advance Health 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/person responsible) during your stay?

- ☐ Yes
- ☐ No
- ☐ Unsure

8. Were you encouraged to appoint an enduring guardian?

- ☐ 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 Health Directive form		
Correct Enduring Power of Guardianship 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/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 Health 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:

1. [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
2. [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
3. [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 Health Directive when they have capacity to do so. Advance Health 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 Health 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 Health Directive) and **[XX%]** an advance care directive – appointment of a substitute decision-maker (i.e., Enduring Power of Guardianship). 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 non-statutory / common law documents completed by the person that indicated preferences for care was **[XX%].**

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 14% 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:

1. [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
2. [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
3. [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 Health Directive on admission				
Asked to update document if needed				
Encouraged to complete Advance Health Directive				
Given the required form(s)				
Encouraged to appoint an enduring guardian/person responsible				
Given the required Enduring Power of Guardianship 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:

1. [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
2. [Define improvement required; action(s) to be taken; timeframe; department or person responsible]
3. [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 – Western Australia

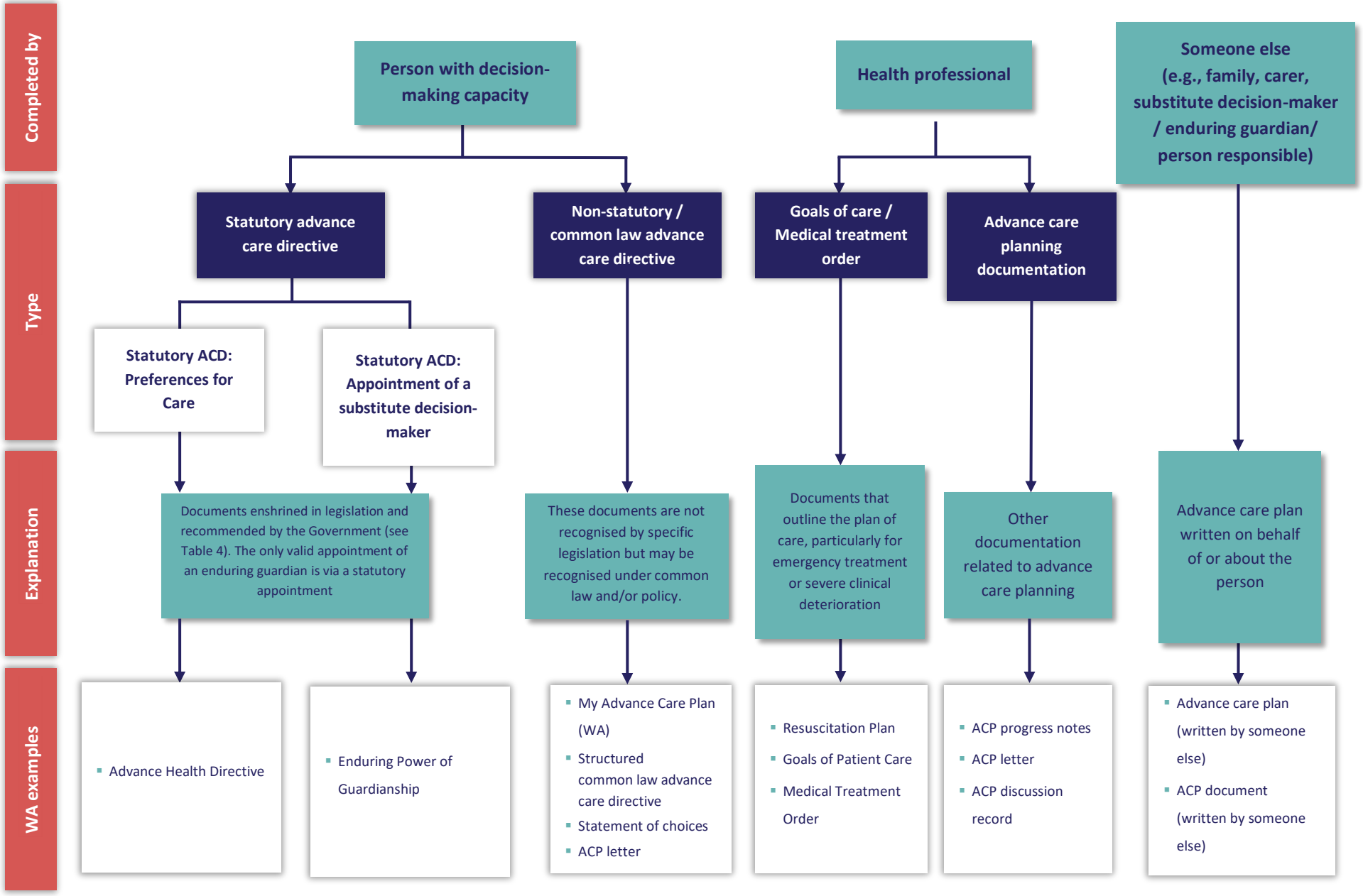


Table 4. Statutory advance care directives used in Australia

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 *(prior to 1 July 2014)*	Advance Personal Plan – Substitute Decision-Maker Appointment Enduring Power of Attorney *(prior to 17 March 2014)*
Queensland	Advance Health Directive	Enduring Power of Attorney Advance Health Directive
South Australia	Advance Care Directive Anticipatory Direction *(prior to 1 July 2014)*	Advance Care Directive - Substitute Decision-Maker Appointment Medical Power of Attorney *(prior to 1 July 2014*) Enduring Power of Guardianship *(prior to 1 July 2014*)
Tasmania	Advance Care Directive	Enduring Guardianship
Victoria	Advance care directive for adults made under the *Medical Treatment Planning and Decisions Act 2016* (Part 2 and/or Part 3) *(from 12 March 2018*) Refusal of Treatment Certificate (Competent) *(prior to 12 March 2018*) *See note* *	Appointment of Medical Treatment Decision Maker *(from 12 March 2018*) Enduring Power of Attorney (Medical Treatment) *(prior to 12 March 2018*) Enduring Power of Guardianship *(prior to 12 March 2018*) Enduring Power of Attorney (Personal Matters) *(prior to 12 March 2018*)
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 Health Directive

Under current Western Australia's advance care planning legislation, an adult can make an Advance Health 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 Health Directive)

Figure 2. Advance Health Directive

Government of Western Australia
Department of Health

XY310580

Advance Health Directive

This form is for people who want to make an Advance Health Directive in Western Australia.

To make an Advance Health Directive, you must be 18 years or older and have full legal capacity. Your Advance Health Directive is about your future treatment. It will only come into effect if you are unable to make reasonable judgements or decisions at a time when you require treatment.

Part 4 marked with this symbol, contains your treatment decisions. If you choose not to make any treatment decisions in Part 4, then the document is not considered a valid Advance Health Directive under the *Guardianship and Administration Act 1990*.

Please tick the box below to indicate that by making this Advance Health Directive you revoke all prior Advance Health Directives completed by you.

☐ In making this Advance Health Directive, I revoke all prior Advance Health Directives made by me.

This form includes instructions to help you complete your Advance Health Directive. For more information on how to complete the form and to see examples, please read the *A Guide to Making an Advance Health Directive in Western Australia*.

Before you make your Advance Health Directive, you are encouraged to seek medical and/or legal advice, and to discuss your decisions with family and close friends. It is important that people close to you know that you have made an Advance Health Directive and where to find it. Once you complete your Advance Health Directive, it is recommended that you:

- store the original in a safe and accessible place
- tell your close family and friends that you have made an Advance Health Directive and where to find it
- upload a copy of your Advance Health Directive to My Health Record – this will ensure that your Advance Health Directive is available to your treating doctors if it is needed
- give a copy of your Advance Health Directive to health professionals regularly involved in your healthcare (for example, your General Practitioner (GP), a hospital you attend regularly, and/or other health professionals involved in your care).

If English is not your first language, you may choose to engage a translator. Western Australian Institute of Translators and Interpreters (WAITI) and National Accreditation Authority for Translators and Interpreters (NAATI) have online directories which list qualified and credentialed translators able to assist you.

MR00H Advance Health Directive

Advance Health Directive | 1

Quality Identifiers

To be valid an Advance Health Directive needs to be:

- in a form (or substantially in the form) prescribed by the regulations.
- signed by its maker or by another person in the presence of, and at the direction of, its maker.

The signature needs to be witnessed by 2 persons (in the presence of each other and the person making the appointment) in accordance with the witnessing requirements, described below.

What are the witnessing requirements?

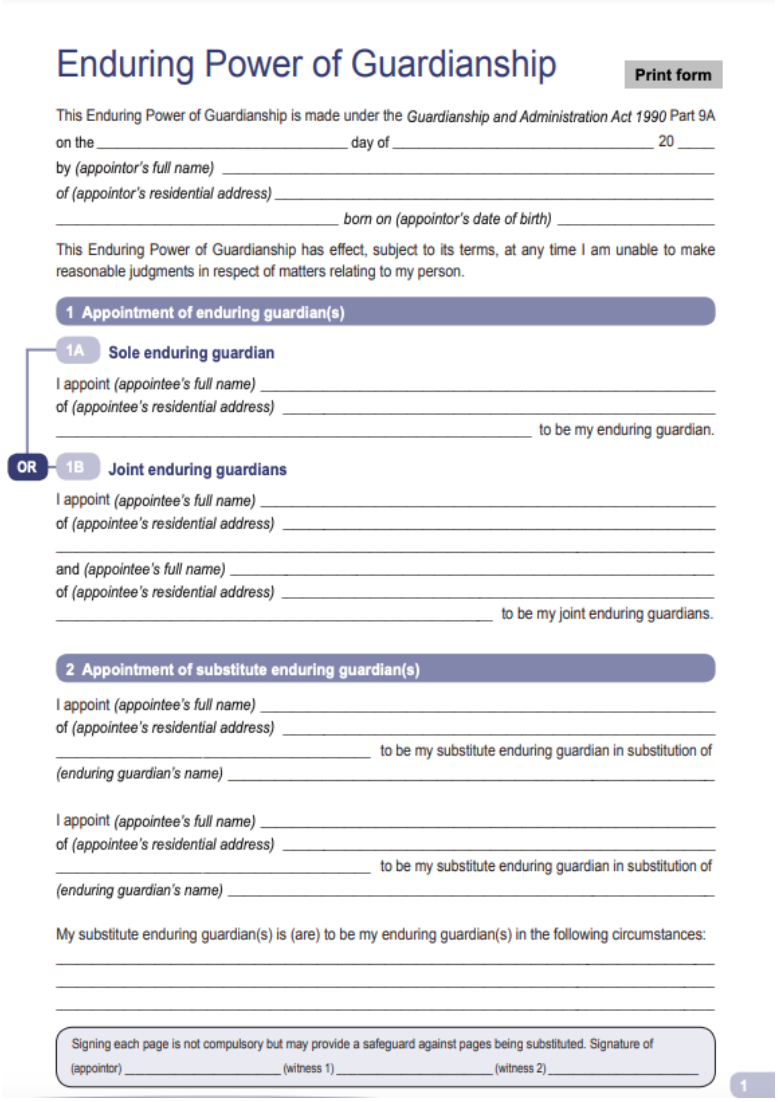
To be eligible, both of the witnesses must be authorised by law to take declarations, or one witness must be authorised by law to take declarations and the other witness must be an adult who is not the person (or someone signing on their behalf).

The person making the Advance Health Directive is encouraged to seek medical and legal advice, but the validity of the Advance Health Directive will not be impacted by failure to do so.

Statutory advance care directive – appointment of a substitute decision-maker (Enduring Power of Guardianship)

In Western Australia, a person is able to appoint an enduring guardian to make healthcare decisions on the person's behalf when a person no longer has decision-making capacity under an Enduring Power of Guardianship.

Figure 3. Enduring Power of Guardianship



Enduring Power of Guardianship

Print form

This Enduring Power of Guardianship is made under the *Guardianship and Administration Act 1990* Part 9A
on the _____ day of _____ 20 ____
by *(appointor's full name)* _____
of (appointor's residential address) _____
_____ *born on (appointor's date of birth)* _____

This Enduring Power of Guardianship has effect, subject to its terms, at any time I am unable to make reasonable judgments in respect of matters relating to my person.

1 Appointment of enduring guardian(s)

1A Sole enduring guardian

I appoint *(appointee's full name)* _____
of *(appointee's residential address)* _____
_____ to be my enduring guardian.

OR

1B Joint enduring guardians

I appoint *(appointee's full name)* _____
of *(appointee's residential address)* _____
_____
and *(appointee's full name)* _____
of *(appointee's residential address)* _____
_____ to be my joint enduring guardians.

2 Appointment of substitute enduring guardian(s)

I appoint *(appointee's full name)* _____
of *(appointee's residential address)* _____
_____ to be my substitute enduring guardian in substitution of
(enduring guardian's name) _____

I appoint *(appointee's full name)* _____
of *(appointee's residential address)* _____
_____ to be my substitute enduring guardian in substitution of
(enduring guardian's name) _____

My substitute enduring guardian(s) is (are) to be my enduring guardian(s) in the following circumstances:
_____
_____
_____

Signing each page is not compulsory but may provide a safeguard against pages being substituted. Signature of
(appointor) _____ (witness 1) _____ (witness 2) _____

1

Quality Identifiers

To appoint an enduring guardian:

- The Enduring Power of Guardianship needs to be a form (or substantially) in the form prescribed.

- Signed by the person making the appointment, or by another person in the presence of, and at the direction of, the appointer.

The signature needs to be witnessed by 2 persons (in the presence of each other and the person making the appointment) in accordance with the witnessing requirements, described below.

What are the witnessing requirements?

To be eligible, both of the witnesses must be authorised by law to take declarations or one witness must be authorised by law to take declarations and the other witness must be an adult who is not the person (or someone signing on their behalf) and not a prospective 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 on the person.

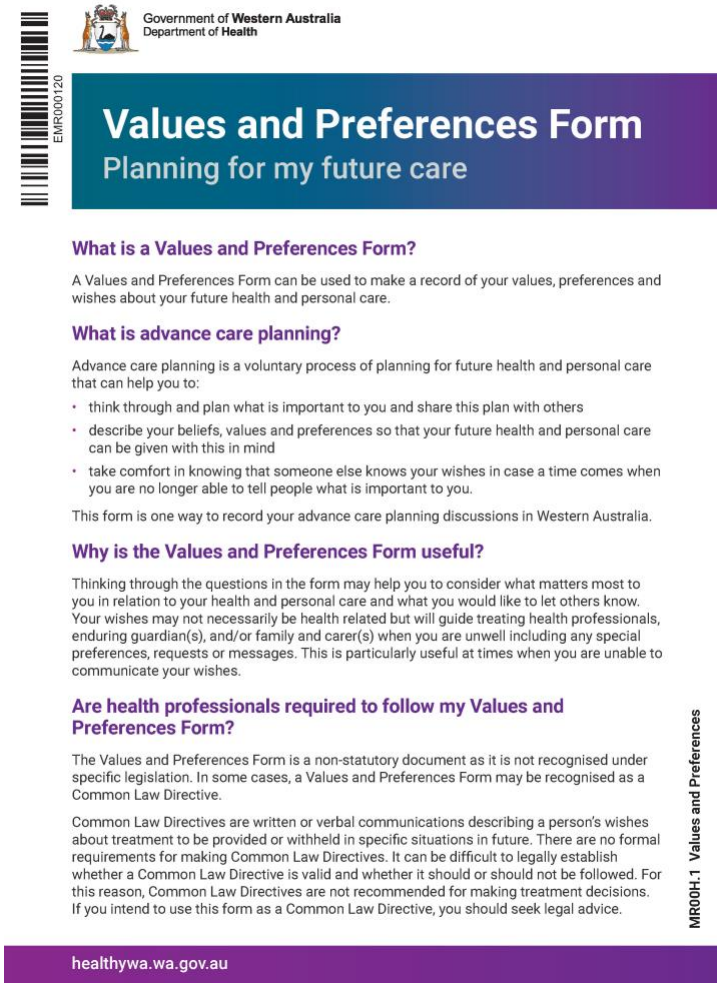
The person responsible is determined by a hierarchy and will be the person's nearest relative in order of priority of the following relatives who have reached 18 years of age:

(a) spouse or de factor partner
(b) child
(c) parent
(d) sibling

Non-statutory / common law document indicating preferences for care

The WA Department of Health has developed the Values and Preference Form: Planning for my future care. A Values and Preferences Form is a statement of a person's values, preferences and wishes in relation to their future health and care. Wishes may not necessarily be health-related but will guide treating health professionals, enduring guardian(s), family members and carer(s) in how a person wishes to be treated, including any special preferences, requests or messages. In some cases, this may be considered a valid Common Law Directive – although this is not the recommended format to make treatment decisions.

Figure 4. Values and Preferences Form: Planning for my future care



Government of Western Australia
Department of Health

EMR000120

Values and Preferences Form

Planning for my future care

What is a Values and Preferences Form?

A Values and Preferences Form can be used to make a record of your values, preferences and wishes about your future health and personal care.

What is advance care planning?

Advance care planning is a voluntary process of planning for future health and personal care that can help you to:

- think through and plan what is important to you and share this plan with others
- describe your beliefs, values and preferences so that your future health and personal care can be given with this in mind
- take comfort in knowing that someone else knows your wishes in case a time comes when you are no longer able to tell people what is important to you.

This form is one way to record your advance care planning discussions in Western Australia.

Why is the Values and Preferences Form useful?

Thinking through the questions in the form may help you to consider what matters most to you in relation to your health and personal care and what you would like to let others know. Your wishes may not necessarily be health related but will guide treating health professionals, enduring guardian(s), and/or family and carer(s) when you are unwell including any special preferences, requests or messages. This is particularly useful at times when you are unable to communicate your wishes.

Are health professionals required to follow my Values and Preferences Form?

The Values and Preferences Form is a non-statutory document as it is not recognised under specific legislation. In some cases, a Values and Preferences Form may be recognised as a Common Law Directive.

Common Law Directives are written or verbal communications describing a person's wishes about treatment to be provided or withheld in specific situations in future. There are no formal requirements for making Common Law Directives. It can be difficult to legally establish whether a Common Law Directive is valid and whether it should or should not be followed. For this reason, Common Law Directives are not recommended for making treatment decisions. If you intend to use this form as a Common Law Directive, you should seek legal advice.

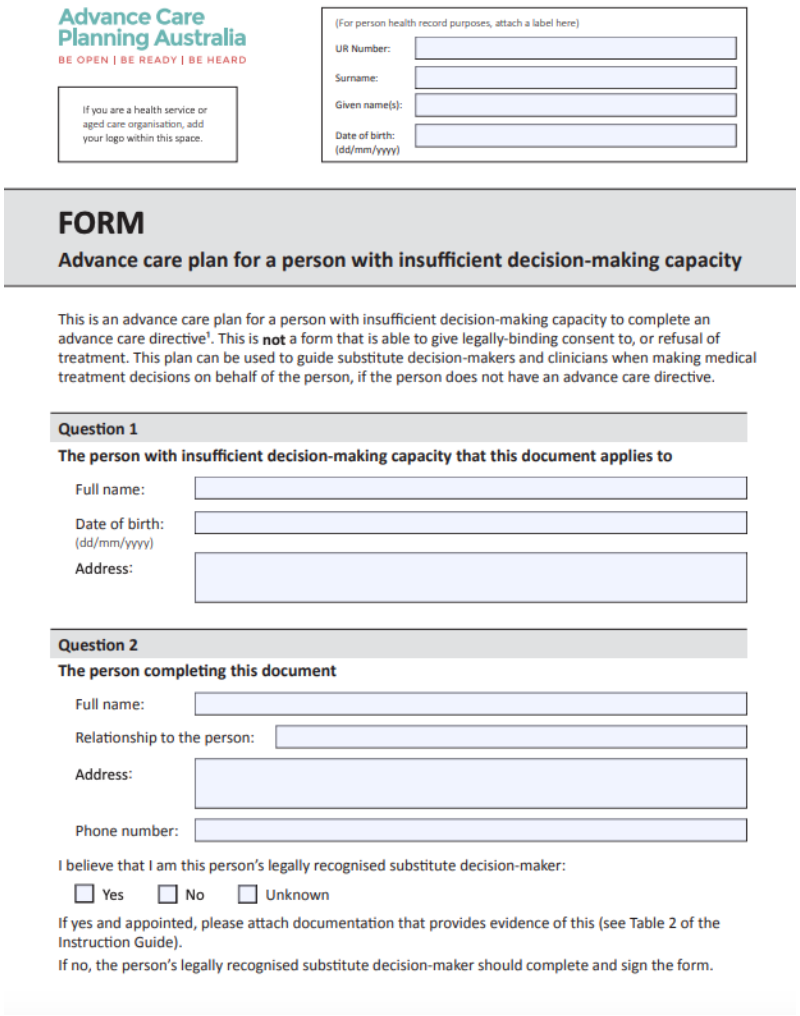
MR00H.1 Values and Preferences

healthywa.wa.gov.au

Documentation completed by someone else

Although the statutory Advance Health Directive or Enduring Power of Guardianship documents 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 5 is an example of an advance care plan that may be used by any state or territory.

Figure 5. Advance care plan for a person with insufficient decision-making capacity



Advance Care Planning Australia
BE OPEN | BE READY | BE HEARD

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 directive[1]. 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.

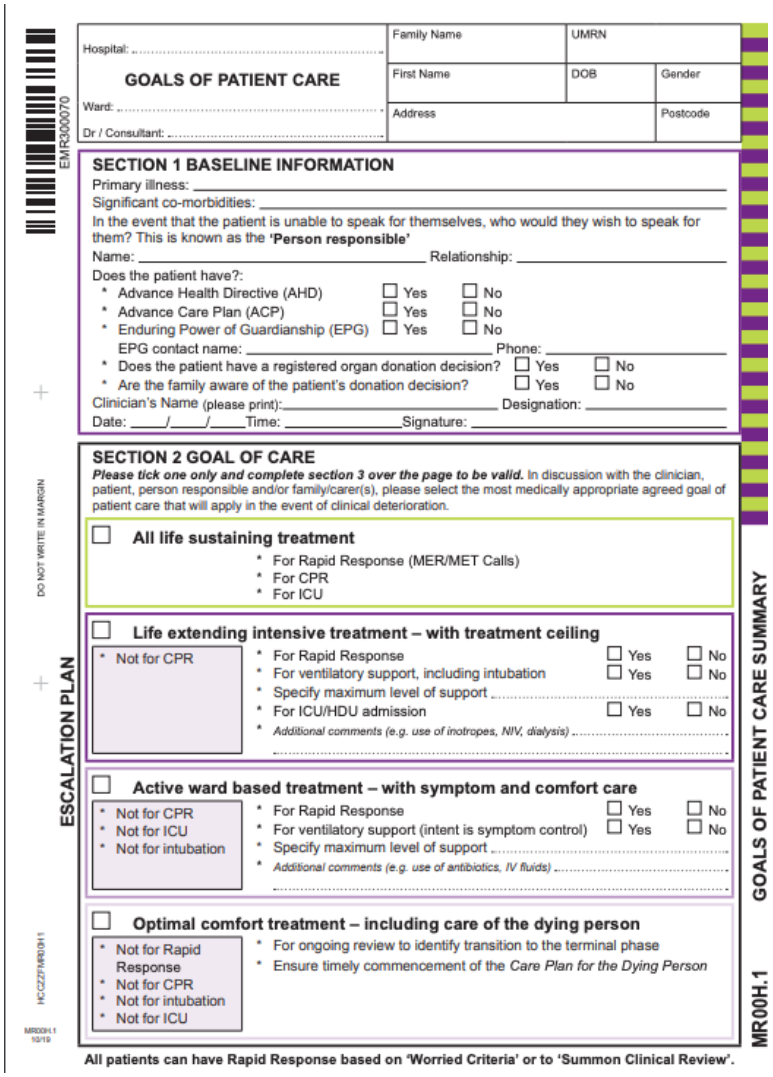
Documentation completed by health professionals.

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 (e.g., Goals of Patient Care (see Figure 6))
- 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).

Figure 6. Goals of Patient Care (WA)



EMR300070

Hospital: .....
Ward: .....
Dr / Consultant: .....

GOALS OF PATIENT CARE

Family Name	UMRN	
First Name	DOB	Gender
Address		Postcode

SECTION 1 BASELINE INFORMATION

Primary illness: _____
Significant co-morbidities: _____
In the event that the patient is unable to speak for themselves, who would they wish to speak for them? This is known as the **'Person responsible'**
Name: _____ Relationship: _____
Does the patient have?:
* Advance Health Directive (AHD) ☐ Yes ☐ No
* Advance Care Plan (ACP) ☐ Yes ☐ No
* Enduring Power of Guardianship (EPG) ☐ Yes ☐ No
EPG contact name: _____ Phone: _____
* Does the patient have a registered organ donation decision? ☐ Yes ☐ No
* Are the family aware of the patient's donation decision? ☐ Yes ☐ No
Clinician's Name (please print):_____ Designation: _____
Date: ____/____/____Time: _____Signature: _____

SECTION 2 GOAL OF CARE

Please tick one only and complete section 3 over the page to be valid. In discussion with the clinician, patient, person responsible and/or family/carer(s), please select the most medically appropriate agreed goal of patient care that will apply in the event of clinical deterioration.

☐ **All life sustaining treatment**
* For Rapid Response (MER/MET Calls)
* For CPR
* For ICU

☐ **Life extending intensive treatment – with treatment ceiling**
* Not for CPR
* For Rapid Response ☐ Yes ☐ No
* For ventilatory support, including intubation ☐ Yes ☐ No
* Specify maximum level of support .....
* For ICU/HDU admission ☐ Yes ☐ No
* *Additional comments (e.g. use of inotropes, NIV, dialysis)* .....

☐ **Active ward based treatment – with symptom and comfort care**
* Not for CPR
* Not for ICU
* Not for intubation
* For Rapid Response ☐ Yes ☐ No
* For ventilatory support (intent is symptom control) ☐ Yes ☐ No
* Specify maximum level of support .....
* *Additional comments (e.g. use of antibiotics, IV fluids)* .....

☐ **Optimal comfort treatment – including care of the dying person**
* Not for Rapid Response
* Not for CPR
* Not for intubation
* Not for ICU
* For ongoing review to identify transition to the terminal phase
* Ensure timely commencement of the *Care Plan for the Dying Person*

All patients can have Rapid Response based on 'Worried Criteria' or to 'Summon Clinical Review'.

DO NOT WRITE IN MARGIN

ESCALATION PLAN

GOALS OF PATIENT CARE SUMMARY

MR00H.1

HCGZ27MR0911

MR00H.1 10/19

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 guardian, 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 Health Directive	
	My Advance Care Plan	
	Consent	
	Decision-making capacity	
	Enduring guardian/person responsible	
	Impaired decision-making capacity	
	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	