Advance Care Planning Australia

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FACTSHEET FOR
HEALTH PROFESSIONALS

What is advance care planning?

Advance care planning involves shared planning for a person's future health care needs. It is voluntary and iterative.

Benefits of advance care planning

- It helps to ensure people receive care that is consistent with their wishes and preferences.
- It improves end-of-life care, satisfaction with the care provided[1] and communication with health professionals.[2]
- Families and carers of people who have done advance care planning experience less moral distress.[3] It may reduce non-beneficial as well as unwanted treatments and interventions[4].

Who should be involved in advance care planning?

All health and aged care professionals can play a role in advance care planning. It may involve:

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

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

When should advance care planning be introduced?

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

Better outcomes are experienced when advance care planning is introduced early as part of ongoing care. When an advance care planning conversation is initiated, the person should be medically stable, comfortable, and ideally accompanied by their substitute decision-maker(s), family or carer.

Triggers for advance care planning conversations can include:

- if you would not be surprised if the person were to die within twelve months
- a 75+ health assessment
- when there is a diagnosis of a life-limiting illness or organ failure indicating a poor prognosis
- when there is a diagnosis of early dementia or disease which could result in loss of capacity
- if there are changes in care arrangements (e.g. admission to a residential aged care facility)
- when a person or family member asks about current or future treatment goals.

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

How can health professionals help with advance care planning?

Be open

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

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Be open (continued)

Substitute decision-makers should be:

- available
- over the age of 18 years
- prepared to advocate and make decisions clearly and confidently on a person's behalf when talking to doctors, other health professionals and family members if needed.

Be ready

- Undertake training in advance care planning to increase knowledge and improve skills.
- Ask about the person's wishes and preferences regarding their health care options.
- Become familiar with advance care planning documents and legal requirements.

Be heard

- Discuss with other relevant health professionals, family, friends and/or carers.
- Encourage people to appoint a substitute decision maker.
- Encourage people to write an advance care directive or use a form relevant to their state/territory. See **advancecareplanning.org.au**.
- Encourage them to review their advance care directive every year or if there is a change in their health or personal situation.
- Encourage them to make their advance care planning documents available if needed.

References

1. Brazil K, Carter G, Cardwell C, Clarke M, Hudson P, Froggatt K, McLaughlin D, Passmore, P, & Kernohan WG (2018). Effectiveness of advance care planning with family carers in dementia nursing homes: a paired cluster randomized controlled trial. Palliative medicine, 32(3), 603-612. https://doi.org/10.1177/026921631772241
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3. McMahan RD, Tellez I, & Sudore RL. (2021). Deconstructing the complexities of advance care planning outcomes: what do we know and where do we go? A scoping review. Journal of the American Geriatrics Society, 69(1), 234-244. https://doi.org/10.1111/jgs.16801
4. Brinkman-Stoppelenburg A, Rietjens JA, & van der Heide A. (2014). The effects of advance care planning on end-of-life care: a systematic review. Palliative medicine, 28(8), 1000–1025. https://doi.org/10.1177/0269216314526272

The law and advance care planning

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

Where should advance care planning documents be kept?

Advance care planning documents may be kept with the:

- person
- substitute decision-maker(s)
- GP/local doctor
- specialist(s)
- provider of specialist care such as aged or disability services
- hospital.

Encourage and support people to store their advance care planning documents on available free national and jurisdictional digital platforms that are readily accessible by clinicians when needed like My Health Record nationally or The Viewer, Queensland.

Conversation starters

- I try to talk to all my patients about how they would want to be cared for if they become more unwell or were suddenly unable to make their own health care decisions. Have you ever thought about this?
- I am pleased to see you recovering from your recent illness. If you became very sick again, have you thought about the treatment outcomes that you would or would not want?

For more examples, visit the conversation starter page at **advancecareplanning.org.au**

Where can I get more information?

Advance Care Planning Australia™

advancecareplanning.org.au

National Advance Care Planning Support Service™ : 1300 208 582

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