Advance Care Planning Australia

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Instruction Guide

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.

What is advance care planning?

A process of planning for future health care, for a time when the person is no longer able to make their own health care decisions. It relates to a person's future health care and medical treatments. It may include conversations about treatments they would or would not like to receive if they become seriously ill or injured. It includes identifying the person they want to make these decisions and how they want those decisions to be made. It has many benefits for the person (care aligned with preferences), loved ones and treating clinicians.

When should this form be completed?

This form should only be completed if the person no longer has sufficient decision-making capacity to make or communicate their medical treatment decisions. This form is available for use in all Australian states and territories, however the Australian Capital Territory, Queensland, and Victoria have existing recommended forms, see Table 1.

This form is not intended to replace or revoke a legally-binding advance care directive. If the person does have decision-making capacity, they should consider completing an advance care directive. The voluntary completion of an advance care directive, when the person still has decision-making capacity, is preferable over the completion of an advance care plan[1]. The relevant advance care directive form from each state and territory is available at:
www.advancecareplanning.org.au/create-your-plan

Who should complete this form?

This form should be completed by a person's recognised substitute decision-maker(s), assigned to the role by law or appointed by the person to make medical treatment decisions, see Table 2. They should have a close and continuing relationship with the person. It is intended that this form will assist substitute decision-makers and the treating team to make medical treatment decisions that align with the decisions the person would have made in the same circumstances. This information can be used in aged care, community, or hospital settings.

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How to complete this form?

This form allows you to provide information about the values and preferences relating to future medical treatment for a person who has lost the capacity to make their own decisions. The information provided in this form should be guided by the person's past choices and decisions, and any previously expressed values and preferences. When completing this form, you should consider what decisions the person would have made in these circumstances, if they had the decision-making capacity to do so.

When completing this form, the following **guiding principles** should be used:

- When considering the person's values, think about how they like to live their life, what they enjoy doing, and what matters most to them, taking into account things they have said or done in the past.
- Any previously expressed preferences or choices made relating to healthcare, medical treatment, or life prolonging treatments[2], and type or location of care should be regarded.
- Any previously expressed views the person made about acceptable or unacceptable health outcomes should be taken into account.
- Consideration should be given to any observations made in relation to the person including how they make decisions and what their priorities and interests are.

How should this form be used?

Before relying on this form, the person's clinicians should consider their legal obligations relating to consent of medical treatment decisions in the state or territory that they practice in. They should be sure that the person does, at the time that decisions must be made, lack the capacity to make those decisions.

Where possible, the responsible clinicians should ascertain, the most up-to-date advance care directive for preferences for care and/or appointment of a substitute decision-maker. The clinician should also ensure that the person completing this form is the most appropriate substitute decision-maker if no-one has been appointed.

The identities of the person(s) filling out this form on behalf of the person with insufficient decision-making capacity to complete an advance care directive should be assessed carefully. Anyone relying on this form should be confident that the person(s) who completed this form truly represented the person's values and preferences.

How should this form be stored and shared?

Copies of the advance care plan should be shared with the person's substitute decision-maker(s), aged care, community or hospital provider, treating clinicians, General Practitioner and/or stored in My Health Record.

Who to contact for further information?

Advance Care Planning Australia
National Advance Care Planning Support Service: 1300 208 582
www.advancecareplanning.org.au

Table 1. Existing Advance Care Plans

State/Territory	Document name
Australian Capital Territory	Advance Care Plan Statement of Choices (No Legal Capacity)
Queensland	Statement of Choices Form B
Victoria	What I understand to be the person's preferences and values

Table 2. Title of legally-binding Advance Care Directives by state and territory

State/Territory	Advance Care Directive - preferences for Care	Advance Care Directive – appointment of a substitute decision-maker
Australian Capital Territory	Health Direction	Enduring Power of Attorney
New South Wales	Advance Care Directive	Appointment of Enduring Guardian
Northern Territory	Advance Personal Plan	Advance Personal Plan
Queensland	Advance Health Directive	Advance Health Directive/ Enduring Power of Attorney
South Australia	Advance Care Directive	Advance Care Directive
Tasmania	Advance Care Directive	Instrument Appointing Enduring Guardian(s)
Victoria	Advance Care Directive	Appointment of a Medical Treatment Decision Maker
Western Australia	Advance Health Directive	Enduring Power of Guardianship

Note: In the absence of a substitute decision-maker appointment by the person, state and territory law assigns this role via a hierarchy, with the exception of Northern Territory.

Reference

1. National framework for advance care planning documents. 2021. Australian Government, Department of Health.
2. Advance Care Planning Australia. Life prolonging treatments. 2021. Available: www.advancecareplanning.org.au/understand-advance-care-planning/life-prolonging-treatments

Disclaimer

This publication is general in nature and people should seek appropriate professional advice about their specific circumstances, including advance care planning legislation and policy in their state or territory.

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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

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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.

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

UR Number:

Surname:

Given name(s):

Date of birth: (dd/mm/yyyy)

Question 3

Additional contributor to this document, if applicable

Full name:

Relationship to the person:

Address:

Phone number:

This person is a 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 be listed above as the person completing this document.

Question 4

Does the person have an advance care directive? (see Table 2 of the Instruction Guide)

☐ Yes (please attach copy to this form) ☐ No ☐ Unknown

If you answered yes, was the person's advance care directive considered when completing this form?

☐ Yes

☐ No Please provide reasons:

Question 5

The person's main health conditions (list all relevant conditions)

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UR Number:	
Surname:	
Given name(s):	
Date of birth: (dd/mm/yyyy)	

Question 6

The person's values (as I best understand them)

I believe the things that are <u>most important</u> to this person are:

(Note: consider the guiding principles and the person's desire for independence, social connections, emotional well-being, functional mobility, and participation in activities. An example statement might be 'they would like to be able to have meaningful interactions with family and loved ones such as conversations, eating together, and celebrating special occasions').

I believe the things that would be <u>unacceptable health outcomes</u> to this person are:

(Note: consider the guiding principles and their desired functional requirements, emotional well-being, and willingness to receive medical interventions. An example statement might be 'being fully dependent on care and unable to interact with family and loved ones').

I believe the things that would be <u>acceptable health outcomes</u> for this person are:

(Note: consider the guiding principles and their desired functional requirements, emotional well-being, and willingness to receive medical interventions. An example statement might be 'living with equipment and support for the activities of daily living; being dependent on care if they can interact with family and loved ones').

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Date of birth: (dd/mm/yyyy)	

Question 6 continued

I believe the things that this person is hoping to do now and in the future are:

(Note: consider the guiding principles and their desire for independence, social connections, emotional well-being, functional mobility, and participation in activities. An example statement might be 'live in their own home with support of family and paid carers; read novels or the paper daily').

Other values that are important to know about this person

Question 7

The person's treatment preferences (as I best understand them)

If this person became very unwell with either an expected or unexpected deterioration with no hope of an acceptable outcome, the following statement best represents their views: (tick one box only)

(Note: Life prolonging treatment includes but is not limited to Cardiopulmonary Resuscitation (CPR), artificial ventilation, tube feeding, surgery, oral or intravenous antibiotics and/or dialysis.)

- ☐ Living as long as possible is their major goal no matter the outcome **OR**
- ☐ They would want life prolonging treatment that may extend their life, but not if it is likely to result in an unacceptable health outcome **OR**
- ☐ They would not want life prolonging treatment that may extend their life **OR**
- ☐ Not sure

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Surname:	
Given name(s):	
Date of birth: (dd/mm/yyyy)	

Question 7 continued

Are there any life prolonging or particular treatments that the person would not want to receive?

I believe if this person is nearing death, they would like the following to be considered.
(Example: place of death, presence of family or loved ones, music, religious, cultural or spiritual support).

Additional notes

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UR Number:

Surname:

Given name(s):

Date of birth: (dd/mm/yyyy)

Question 8

Please tick all to indicate your understanding of the following statements.

- ☐ I am of the reasonable belief that a person for whom this form applies does not have decision-making capacity to make medical treatment decisions.
- ☐ I understand that this document does not provide legally-binding consent to, or refusal of treatment but may be used to guide substitute decision-makers and clinicians to make medical treatment decisions.
- ☐ I understand that if the person does have an advance care directive, the values and preferences expressed in a valid advance care directive will be respected, if their medical treatment decisions are clinically indicated and appropriate.
- ☐ I understand that this person may still receive care for symptoms such as pain and to alleviate suffering regardless of the values or preferences stated in this form and that an advance care directive or advance care plan cannot refuse such measures.
- ☐ I understand that I am documenting this person's values and preferences honestly, to the best of my knowledge and without intent to cause harm.
- ☐ I understand this form should be reviewed if the persons condition changes, can be cancelled or changed whenever needed.

Signing

Legally recognised substitute decision-maker

By signing this form, I confirm this is an accurate record of this person's values and preferences as I understand them at the time of completing this form.

Full name:

Signature:

Date: (dd/mm/yyyy)

The person's treating doctor or registered health professional

By signing this form, I certify to the best of my knowledge the person completing this form is an appropriate person to represent the values and preferences of the person with insufficient decision-making capacity.

Full name:

Signature:

Date: (dd/mm/yyyy)