

What is advance care planning?

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

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

An Advance Care Directive is only called upon if the person loses the ability to make or express their preferences.

Benefits of advance care planning

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

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



Who should be involved in advance care planning?

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

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

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

See Advance Care Planning Implementation Guide for Aged Care.

When should advance care planning be introduced?

Advance care planning can be a routine conversation when caring for an older person. It is important to also encourage conversations with their family/carers and care team.

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

Where possible, people should be medically stable, comfortable and ideally accompanied by their substitute decision-maker(s) and/or family/carer.

Other triggers to discuss advance care planning include when:

- a person or family member asks about current or future treatment goals
- there is a change in the person's health or capability
- there is a change in their living situation (e.g. when they move into a residential aged care home)
- when there is a diagnosis of early dementia or a disease which could result in loss of capacity
- if you would not be surprised if the person died within twelve months

The law and advance care planning

Different states and territories in Australia have different laws regarding advance care planning. There are also some common law decisions regarding advance care planning. See advancecareplanning.org.au for information.

Depending on the state/territory:

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

How can aged care workers help with advance care planning?

Be open

- Find out more about advance care planning and the requirements of your organisation in your state/territory.
- Be open to engage with people who want to discuss their beliefs, values and preferences regarding their current and future health and personal care.
- Explain why they may like to select a substitute decision-maker(s).

Substitute decision-makers need to be:

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

Be ready

- Undertake training in advance care planning to improve your knowledge and skills.
- Talk with your client about their beliefs, values and preferences regarding health and personal care outcomes.

Be heard

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

Where should Advance Care Directives be kept?

Advance Care Directives may be stored in one or many places, including:

- at home with the person
- with the substitute decision-maker(s)
- with the GP/local doctor/specialist
- aged care service provider records
- hospital
- myagedcare.gov.au.

Encourage clients to store them in their 'My Health Record' at myhealthrecord.gov.au.

Conversation starters

- What does a good day look like to you?
- If something should happen to you and you were unable to speak for yourself, who would you want us to talk to, to help make decisions?
- Do you like to make medical decisions, or do you prefer your family to decide for you?

Where can I get more information?

Advance Care Planning Australia

- advancecareplanning.org.au
- National Advisory Service: 1300 208 582
- learning.advancecareplanning.org.au

References

- 1 Detering, KM, Hancock, AD, Reade, MC, Silvester, W 2010, 'The impact of advance care planning on end of life care in elderly patients: randomised controlled trial', *British Medical Journal*, 340: c1345.doi:10.1136.
- 2 Brinkman-Stoppelenburg A, Rietjens JA, van der Heide A. The effects of advance care planning on end-of-life care: a systematic review. *Palliat Med* 2014; 28: 1000-1025.