

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 wishes, if the person ever becomes seriously ill and unable to communicate for themselves.

Ideally, advance care planning will result in a written Advance Care Plan, to help ensure the person's wishes are respected.

Advance care planning is only called upon if the person loses the ability to make or express their wishes.

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, attitudes and preferences.
- It improves end-of-life care along with person and family satisfaction. (1)
- Families of people who have done advance care planning experience less anxiety, depression and stress and are more satisfied with care. (1)

MAKING HEALTHCARE DECISIONS FOR OTHERS CAN BE DIFFICULT. AN ADVANCE CARE PLAN CAN GIVE PEACE OF MIND AND COMFORT AS PREFERENCES ARE CLEAR, UNDERSTOOD AND RESPECTED.

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 wishes
- The family raises concerns
- Their close family and friends
- Their substitute decision-maker(s)
- Carers
- Aged care professionals, nurses, doctors and other healthcare 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 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:

- The person raises concerns
- The family raises concerns
- 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).

How can an aged care professional 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).

Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

They will need to be:

- Available (ideally live in the same city or region) or readily contactable
- Over the age of 18
- Prepared to advocate clearly and confidently on 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, attitudes 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 Plan or use a form relevant to their state/territory law. For state/territory links, see advancecareplanning.org.au.
- Encourage them to keep the Advance Care Plan safe, and store it appropriately (see below).
- Encourage them to review their Advance Care Plan every year or if there is a change in their health or personal situation.

The law and advance care planning

Different states and territories in Australia have different laws regarding advance care planning. There are also (national) common law decisions in advance care planning.

See advancecareplanning.org.au for information.

Depending on the state/territory:

- A substitute decision-maker may be legally appointed as an 'agent', 'guardian', 'enduring guardian' or 'enduring power of attorney'
- An Advance Care Plan may also be called an 'advance care directive' or an 'advance health directive' and may include a 'refusal of treatment certificate'.

Where should Advance Care Plans be kept?

Advance Care Plans may be stored at one or many of the following:

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

Where can I get more information?

Advance Care Planning Australia:

WWW.ADVANCECAREPLANNING.ORG.AU

NATIONAL ADVISORY HELPLINE: 1300 208 582

Reference

(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.

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This publication only provides a general summary of the subject matter covered. People should seek professional advice about their specific circumstances. ACPA is not liable for any errors or omission in this publication.