What is advance care planning?

Advance care planning allows health professionals 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 formal, written Advance Care Plan, to help ensure the person's wishes are respected.

Advance care planning is only used when the person loses capacity to make or express their wishes.

Benefits of advance care planning

Advance care planning benefits the person, their family, carers, 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)
- For healthcare professionals and organisations, it reduces futile transfers to acute care and unwanted interventions. (2)

Who should be involved in advance care planning?

Advance care planning requires a team effort. It should involve doctors, nurses, allied health professionals and, most importantly, the person, their substitute decision-maker(s) and/or family.

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 healthcare plan.

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

When the conversation is initiated, the person should be medically stable, comfortable and ideally accompanied by their substitute decision-maker(s) or a family member.

Triggers for advance care planning conversations can include:

- when a person or family member asks about current or future treatment goals
- at a 75+ health assessment
- when an older person receives their annual flu vaccination
- when there is a diagnosis of a metastatic malignancy or end organ failure indicating a poor prognosis
- 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 'surprise' question)
- if there are changes in care arrangements (e.g. admission to a residential aged care facility).

Other triggers 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 requirements relevant to your state/territory.
- Encourage people to think about their beliefs, values and preferences regarding their current and future healthcare.

Advance Care Planning Australia

Explain that they will need to select a substitute decision-maker(s). This should be someone who is not a paid carer or healthcare provider.

- They will need to be:
- Available (live in the same city or region)
- Over the age of 18
- Prepared to advocate clearly and confidently on your 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.
- Talk about their beliefs, values, attitudes and life goals regarding healthcare treatment options.

Be heard

- Discuss with other relevant healthcare professionals, family and/or carers.
- Encourage people 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'.

In some states and territories, some documents (e.g. refusal of health care, refusal of treatment) are legally binding, and if a health professional ignores them they may face sanction.

Where should Advance Care Plans be kept?

Advance Care Plans may be stored with:

- the person
- the substitute decision-maker(s)
- the GP/local doctor
- the specialist(s)
- the residential aged care home
- 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.

(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

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