

ADVANCE CARE PLAN (NON-COMPETENT PERSON) **INFORMATION SHEET**

Your family member/friend has been assessed as being unable to make independent decisions about their own medical care and therefore regarded as non-competent, or not having legal capacity.

This may not exclude them from saying what they do and don't want for themselves. They may assist you in completing an advance care plan on their behalf, based on their wishes.

Advance care planning is a process for making and writing down future health care wishes. It is normally undertaken by competent people, with support from their family and doctor.

If a person is no longer competent, then their family, particularly the Person Responsible, are able to undertake advance care planning on the person's behalf. This ensures that the person only receives treatment that the person would want and is in the person's best interests.

The process of advance care planning considers the person's current state of health, their beliefs, values and goals in life and their future treatment options. It is important when completing an advance care plan on behalf of your family member/friend that you include them, where possible, in these discussions to the best of their ability. A health professional trained in advance care planning is available to guide you through the process.

Pre-Existing Advance Care Planning Documents:

1. A previously appointed Medical Enduring Power of Attorney (MEPOA)

If the person has previously appointed a MEPOA (referred to as an agent) the agent will now become the primary decision maker for medical treatment on behalf of the non-competent person. A copy of the Medical Enduring Power of Attorney document should become a part of this advance care plan.

2. A previously completed Refusal of Treatment Certificate (RTC)

The person may have completed a RTC while still competent. If the RTC is valid for the current illness then the person's refusal of specified treatments, or all treatments, is legally binding and cannot be overridden by the doctors or others.

3. A Previously Completed Advance Care Plan/Directive or document

The person may have previously completed an Advance Care Plan/Directive or similar written document expressing their wishes about future medical treatment that they would or would not want. Doctors and decision-makers must take the documented wishes into account when making decisions about medical treatment. You may wish to review previously completed documents to reflect current circumstances.

What advance care planning can be done for a non-competent person?

If the person had previously appointed a MEPOA:

That agent (usually a family member or close friend) is able to complete a RTC on the person's behalf. As a legally binding document, the RTC can ensure that the person does not receive unwanted medical treatment or investigation that is related to their current condition. By law, a RTC cannot be used to withhold palliative care (the relief of pain and suffering).

If a MEPOA has not previously been appointed:

The person's medical decision maker, known as the "Person Responsible", is identified from a standard list defined by Victorian legislation. The Person Responsible can consent, or withhold consent, to medical treatment offered by the doctor, but they cannot complete a Refusal of Treatment Certificate.

Writing down other wishes for future medical care:

As the Person Responsible (the MEPOA, if one exists) you may choose to record the wishes of the non-competent person on a SOC. In completing a SOC, and documenting health care wishes, it is important to:

- Take into account the person's previous (and current) health care wishes
- Take into account what is in the person's best interest (including the benefits and the burdens of possible treatment)
- Involve discussion with family and significant others
- Discuss these wishes with their doctor(s)

What if a person regains their legal capacity (their competence)?

A person who regains their legal capacity is once again responsible for their medical decision-making. The agent's power ceases while the person remains competent.

Changing or cancelling advance care planning documents(s)

You might want to change or cancel the advance care planning document(s) in the future if there is a change in the person's medical condition. You can change or cancel these documents by drawing a line across the document, writing void on it and signing and dating it. These documents can also be revoked by the completion of new document(s). The most recently dated document overrides the older document. To revoke the RTC, it is advisable to also fill in the cancellation section of the existing certificate. It is also important to inform the important family members and their doctors of the changes and provide them with copies of the new documents.

How to do advance care planning for a non-competent person:

1. Think about what their beliefs, values and goals would be at this time
2. Involve family and significant others in advance care planning discussions
3. Talk with their doctor(s) about their current and future state of health and how this may impact on what they would regard as an acceptable outcome
4. Document their wishes in an Advance Care Plan/Directive
5. These documents will need to be witnessed by their doctor.
6. Give copies of this document to all relevant people who care for your family member including their doctor(s), aged care facility, family members, and the hospital

Need further information?

Detailed information and help is available for all aspects of advance care planning.

Ask to speak to your Advance Care Planning facilitator at your health service.

Phone Advance Care Planning facilitator at _____ on: _____

More information is also available from:

www.advancetcareplanning.org.au

www.publicadvocate.vic.gov.au

www.health.vic.gov.au

Or call the Office of the Public Advocate on 1300 309 337

ADVANCE CARE PLAN/DIRECTIVE FOR THE NON-COMPETENT PERSON (Victoria)

SITE
LOGO

A record of future health care wishes

This document relates to the following person: _____

of _____

(*person's address*)

- 1) I understand that he/she has been assessed as not having legal capacity to appoint a Medical Enduring Power of Attorney or make medical decisions independently.
- 2) This person has the current health problems*:

- 3) This document has been explained to me and I understand its importance and purpose. I may complete all or part of this document. It is a guide and will be taken into account when determining future medical treatment* for this person.
- 4) I request that this person's wishes, beliefs and values on which these decisions are based, are respected. I have written on this form the things that they value most in life, and other things that may help their doctors and other decision makers.
- 5) I understand that doctors will only provide treatment that might be medically beneficial. I also understand that, irrespective of any decisions by the doctor about CPR and life prolonging treatment, he/she will continue to be cared for, including care to relieve pain and alleviate any suffering.

A

CPR (Cardiopulmonary Resuscitation) *Initial appropriate box*

It has been explained to me by Dr _____ that he/she would not benefit from attempted CPR and I understand and accept this.

OR

I would like CPR attempted on him/her if it might be medically beneficial.

OR

I do NOT want CPR for him/her even if the doctors think it could be beneficial.

AND

B

Life Prolonging Treatments *Initial appropriate box*

e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube, surgery

I would like life prolonging treatment for him/her in order to prolong their life as long as possible

OR

I would like life prolonging treatments for him/her only if the doctors expect a reasonable outcome. By reasonable outcome I mean: _____

OR

I do NOT want life prolonging treatments for him/her at all. If life prolonging treatment has been commenced on him/her I request that it be discontinued and that he/she receive palliative care.

* If you are the MEPOA for the above named person, you may choose to complete a Refusal of Treatment Certificate. Refer to Information Sheet.

The things that he/she most values are: (eg. independence, enjoyable activities, family and friends):

Future state(s) of health that he/she would find unacceptable:

Specific treatments I believe he/she would NOT want:

Other things I would like known about him/her which may help with future medical decisions:

If he/she is nearing death I would like the following (for example, music, spiritual care, customs or cultural beliefs met, family members present):

I have hereby made choices based on the best interests of _____
(insert non-competent person's name), taking into account their wishes, the wishes of family members and significant others, and the benefits and burdens of treatment. I request that the stated choices recorded are respected by health professionals, now and in the future.

Name _____

Signature _____ Date _____

Relationship to person _____ MEPOA/Person Responsible

I, Dr _____ believe that _____
(Registered Medical Practitioner) (MEPOA/ person responsible name)

is acting in the best interests of and on behalf of the person stated above. The MEPOA/Person Responsible understands the importance and implications of this document.

Doctor's signature _____ Date _____

The contents of this Advance Care Plan/Directive have also been discussed with:

Name: _____
Relationship: _____
Signature: _____
Date: _____

Name: _____
Relationship: _____
Signature: _____
Date: _____