

# Advance Care Plan for people who do not have capacity<sup>1</sup> to make health care decisions<sup>2</sup>

## Information sheet for Attorneys<sup>3</sup> (including guardians and nominated persons)

Advance care planning in Queensland is being promoted by the Respecting Patient Choices Program, which is about the promotion of autonomy and dignity. It is not concerned with, nor a promotion of, euthanasia or suicide. Rather it forms a part of the application of Good Medical Practice.

A person to whom this information applies has been assessed as not having the capacity to make their own decisions about their future medical care. If, while competent, that person appointed an enduring attorney for personal / health matters that attorney can, while the person lacks capacity, give views on consent or objection to health care treatment on behalf of the person. Alternatively, a statutory health attorney may give such views.

Advance care planning helps families, significant others and healthcare staff to discuss and plan future health care wishes for the person. This considers the person's current health and future treatment options as related to their beliefs, values and goals in life. It is important to include the person in these discussions *to the best of their ability*. A facilitator will be available to assist and guide you through the process.

If you, family members, carers or the appointed attorney are giving views for this person it is important to:

- Take into account what is in the person's best interests
- Take into account the person's previously and currently expressed wishes and values; and
- Involve any family and significant others within that discussion.

You may wish to record this process by completing an Advance Care Plan (see attached). This form will assist you to record the views that you give. A facilitator can assist you through this process.

Before completing an Advance Care Plan for the person, take time to read the following information. It is important that the person's values and beliefs are considered and reflected within that document.

**If the person has appointed an enduring attorney** for personal / health matters that attorney will now become the primary contact for the person's health care treatment. Please provide a copy of the Enduring Power of Attorney document to the facilitator who is assisting you. This will be held with an Advance Care Plan.

Take time to reflect on previous conversations with and values of the person to plan their future care in a way that they would have wanted if they were able to make health care decisions for themselves.

## Advance Care Planning

The process of advance care planning requires you to:

- **Understand** the person's current health condition and what medical decisions may need to be made in the future. If you are unclear about this, you should arrange to meet with the person's doctors who can ensure you understand this and answer all of your questions.
- **Reflect** on the person's values, beliefs and goals in life both now and before their illness progressed to its current state. It is important to plan the person's future care in a way that you feel they would have wanted if they were able to make decisions for themselves.
- **Discuss** the person's health condition and their values, beliefs and goals with each other, and finally...
- **Formulate a plan.** This plan can be documented on the attached 'Statement of Views'.

## The attached Statement of Views

You may wish to record the outcomes of your advance care planning discussions for the person regarding choices about their future medical treatment on the attached 'Statement of Views' form. It documents the choices and views you have expressed on behalf of the person, based on your knowledge of their wishes and discussions with other family members and significant others. It is not legally binding or directive, but is designed to inform the doctors of your understanding of the wishes of the person for their health care and treatment within the application of good medical practice.

**After completing the Statement of Views** the original remains with the person completing it and copies can be given to or discussed with:

- any alternate attorney
- the person's local doctor (GP)
- the person's family, carer or significant other
- the organisation where the documents have been completed for inclusion in the medical records
- other hospitals / clinics normally attended by the person (with a covering explanatory letter).

You may wish to give extra copies to others (eg. spiritual advisors). If an Enduring Power of Attorney for personal / health matters exists, a certified copy should be attached to the Statement of Views.

## What if a person regains their legal capacity?

A person who regains their legal capacity once more assumes responsibility for their health care decision-making. The attorney's power ceases.

## Ending an Enduring Power of Attorney (for personal / health matters)

An Enduring Power of Attorney document can be changed or revoked –

- By the person if they regain their legal capacity;
- By the resignation of the attorney. That attorney should inform the family members, significant others and the health care providers of this resignation.

## How can you change or revoke the Statement of Views?

The person who completes the Statement of Views can change or revoke the document by destroying it, requesting that it be destroyed or by completing a new document and informing the relevant people.

## Need further information?

If you need assistance in completing this document or would like more information please contact a Respecting Patient Choices Facilitator:

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

<sup>1</sup> As defined in the *Powers of Attorney Act 1998*: **capacity**, for a person or a matter, means the person is capable of (a) understanding the nature and effect of decisions about the matter; **and** (b) freely and voluntarily making decisions about the matter; **and** (c) communicating the decisions in some way. (These elements of definition are inclusive i.e. each of them must be present).

<sup>2</sup> As defined in the *Powers of Attorney Act 1998*: **health care**, of a principal, is care or treatment of, or a service or a procedure for, the principal (a) to diagnose, maintain, or treat the principal's physical or mental condition; and (b) carried out by, or under the direction or supervision of, a health provider; and includes withholding or withdrawal of a *life-sustaining measure* for the principal if the commencement or continuation of the measure for the principal would be inconsistent with good medical practice; and a *life-sustaining measure* is health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation. Without limiting this definition each of the following is a *life-sustaining measure* (a) cardiopulmonary resuscitation; (b) assisted ventilation; (c) artificial nutrition and hydration; however a blood transfusion is not a *life-sustaining measure*.

<sup>3</sup> As defined in the *Powers of Attorney Act 1998*: **attorney** means (a) an attorney under a power of attorney, enduring power of attorney or advance health directive; or (b) a statutory health attorney.

<sup>4</sup> As defined in the *Powers of Attorney Act 1998*: **good medical practice** is good medical practice for the medical profession in Australia having regard to (a) the recognised medical standards, practices and procedures of the medical profession in Australia; and (b) the recognised ethical standards of the medical profession in Australia.

# Statement of Views

## Future health care wishes

*(given on behalf of people who do not have capacity to make health care decisions)*

|   |
|---|
| Name: _____                             |
| Address: _____<br>_____                 |
| Date of birth: _____                    |
| Affix Identification Label if available |

This document relates to the following person: \_\_\_\_\_  
of address: \_\_\_\_\_

I understand that he/she has been assessed as not having capacity to make an Enduring Power of Attorney (for personal / health matters), or to make independent health care decisions.

I give my views based on their best interests, taking into account their wishes, the wishes of family members and significant others, and the benefits and burdens of health care treatment. I request that the stated choices recorded below are respected by health professionals now, and in the future as part of the application of good medical practice.

*Please note: The statement is not a legally binding directive to health professionals.*

**A. CPR (Cardiopulmonary Resuscitation)** *Tick the box that you honestly and reasonably believe that the person would have marked for themselves.*

The person would want to have CPR if it is medically appropriate

OR

The person would not want to have CPR at all.

**B. Life Prolonging Treatments** *Tick the box that you honestly and reasonably believe that the person would have marked for themselves.*

eg. breathing machine (ventilator), kidney machine (dialysis), feeding tube.

The person would want treatment in order to prolong their life as long as possible.

OR

The person would only want to have life prolonging treatments if there were the probability of a reasonable outcome. A reasonable out come means:

\_\_\_\_\_

OR

The person would not want to receive life prolonging treatments at all. If life prolonging treatment has been commenced I honestly and reasonably believe that the person would have requested that it be discontinued. The person would have wanted to be allowed to die naturally, in comfort, with dignity and without pain or distress.

**C. Good Medical Practices** *Circle the option(s) that you honestly and reasonably believe that the person would have selected for themselves.*

eg. major operation, intravenous fluids, blood transfusion, antibiotics, other: \_\_\_\_\_

Circumstances in which the person would not want to have life-prolonging treatments include:

\_\_\_\_\_

This person's current medical condition includes:

\_\_\_\_\_

EPOA / Guardian / nominated person appointed has an understanding of health conditions / prognosis

(tick appropriate box):  Yes /  No

**Other requests with regard to health care** *eg. Such as circumstances in which you honestly and reasonably believe that the person would not want a particular treatment.*

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**Other points that are important**

*If the person had other end of life wishes (eg. organ or body donation) you may wish to attach any documentation to this plan. NB. it is the next-of-kin / family that consent to organ donation.*

I ask that doctors include the following persons in health care decisions if there is time.

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If the person is nearing death, I want the following (list things that would be important to them, including spiritual / cultural preferences):

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Signed by: \_\_\_\_\_

Date: \_\_\_\_\_

Attorney / Guardian / Nominated person appointed  
(please circle your relationship with the subject)

**Other persons present at discussion and formulation of this plan:**

| Name  | Relationship |
|-------|--------------|
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |
| _____ | _____        |

**Doctor's review of the plan**

Doctor's name: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_

Date: \_\_\_\_\_

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# Advance Care Plan – Contact Information

Name: \_\_\_\_\_  
(or identity label)

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Attorney / Guardian / Nominated person appointed** (please circle to identify which role)

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home

Mobile

Work

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_

**Attorney / Guardian / Nominated person appointed** (please circle to identify which role)

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home

Mobile

Work

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_

**The Advance Care Plan includes the following documents:**

Statement of Views Yes / No

Enduring Power of Attorney Yes / No  
(personal / health matters)

Acute Resuscitation Plan Yes / No

The original of the Advance Care Plan is held by: \_\_\_\_\_

Recommendation for review (if applicable):  12 monthly

**The Advance Care Plan has also been given to:**  
(complete as many lines as applicable)

1. \_\_\_\_\_ 3. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

7. \_\_\_\_\_ 8. \_\_\_\_\_