Procedure

Advance care planning			
Document ID:	**Version number:**	**Revision date:**	**Approval authority:**
PR-CLN-900133	1	18-Jan-2018	Refer to section 6.2
Key words:	Advance care planning, AHD, EPOA, adult resuscitation plan, end of life, EOL		

Table of contents

Affirmation

This governance document is consistent with Mater's Mission, Vision and Values.

1 Introduction

1.1 Purpose

This procedure outlines the process to assist patients and substitute decision-makers engage in advance care planning (ACP).

1.2 Scope and context

This procedure applies to all Mater Health staff who are involved in ACP processes and discussions.

1.3 Governing policy

Document ID	Document title
PY-CLN-900034	Recognising and responding to clinical deterioration

2 Procedure requirements

2.1 Advance care planning (ACP)

a. Advance care planning (ACP) is a process that increases the opportunity for patients to contemplate and discuss with family, friends and doctors their preferences for future healthcare.
b. By documenting their preferences in an advance care plan, patients let family, friends and healthcare professionals know what their future health care preferences are if at some time in the future they are unable to make or communicate their decisions.
c. ACP is entirely voluntary. The patient has a number of different documents available to record ACP decisions – see Appendix 1 Documents available for advance care plan discussion.
    i. A patient can change their mind and their plans (and legal documents) at any time while they have capacity.
    ii. There are multiple ACP forms that are available for a patient to document their values and preferences e.g. Statement of Choices, Respecting Patient Choices, My Values.
        i. The preferred form in use at Mater is the Statement of Choices form.
d. ACP discussions can commence at any time, but become much more important as people approach the end of life (see triggers section 2.2)
e. Advance care plans shall be revisited and reassessed as required and particularly if there has been a change in the patient's health condition.
f. Before initiating ACP discussions:
    i. Confirm if the patient has any of the following:
        - Queensland Civil and Administrative Tribunal (QCAT) appointed substitute decision-maker.
        - Advance Health Directive (AHD)
        - Enduring Power of Attorney (EPOA)
    i. Patients transferred from aged care facilities discuss with Aged care facility/family and check documentation that usually accompanies patient when transferred.
    ii. Clinical staff can also check on QH viewer by logging into Verdi and going to external portal tab to check if ACP documents are available.
g. Refer also to Advance Health Directives, Enduring Power of Attorney and Office of Adult Guardian Documentation.

2.2 Who should be offered ACP

a. ACP conversations should be a routine part of every interaction with a health care provider and should occur as part of a person's ongoing healthcare plan. Better outcomes are achieved when ACP is introduced early rather than in response to a decline in health condition or a crisis situation.
b. A patient or family member may initiate a discussion of ACP or may ask about current and future treatment goals which could provide the opportunity for a conversation about their preferences and wishes for end of life care.

c. Triggers for ACP conversations can include:
    i. Age greater than 70 years.
    ii. Hospital inpatients at risk of dying in the next 12 months.
    iii. Any patient with a diagnosis of a life limiting illness e.g.
        - cancer, dementia, COPD/emphysema, congestive heart failure, chronic kidney disease, Parkinson's disease, and frailty.
        - Meets criteria from Supportive and Palliative Care Indicators Tool (SPICT) – see page 4 of Adult resuscitation plan (ARP) form.
    iv. Any patient that experiences a significant deterioration in an ongoing medical condition
    v. Any patient who is newly admitted to a Residential Aged Care Facility.

2.3 Who initiates the ACP process

a. ACP is not the province of one group of healthcare workers – it is a shared responsibility.
b. Staff who have an ongoing relationship with the patient are well placed to initiate ACP conversations.
c. It is important that the staff member is comfortable in the role, is able to answer questions and form a trusting relationship with the patient.
d. For difficult and complex patients refer to registrar or consultant for discussion of prognosis and treatment options and consider calling palliative care specialist for advice.
e. The person initiating the conversation will ideally assist the patient to complete the process but can also engage support from other staff such as social work to facilitate completion.
f. Whichever staff member takes on the role the information must be shared with the team and the discussion documented in the patient's health record.

2.4 Substitute decision making

a. A substitute decision-maker(s) can be appointed formally through:
    i. an order of the QCAT (as a Guardian) or
    ii. an advance health directive (as a health attorney); or
    iii. an enduring power of attorney (as a personal attorney and/or financial attorney).
b. If a patient has not appointed a substitute decision-maker(s) and their capacity is impaired, the law automatically grants power to somebody to make health decisions for them. This is called a statutory health attorney. No documentation is completed for this role. By law, a statutory health attorney is the first, in listed order, of the following people who is readily available and culturally appropriate to act:
    i. a spouse or de facto partner, if the relationship is close and continuing
    ii. a person who is responsible for care of the patient (but not a paid carer) over the age of 18
    iii. a person who is a close friend or relative (but not a paid carer) who is over the age of 18. If there is no one who meets the criteria for this, the law will recognise the Public Guardian as the statutory health attorney.
    iv. a substitute decision-maker only comes into effect if a patient is unable to communicate decisions for themselves.
c. Refer to Adult Resuscitation plan (ARP), section 5 Capacity Assessment and identification of substitute decision-maker listed in order of priority.

2.5 ACP discussions

a. A patient has a right to determine who they do or don't want to be involved in discussions. In situations where the patient does not have capacity the discussion will occur with the substitute decision-maker.
b. There is no set format for ACP discussions but it is important that sufficient time is available and the person prompting the discussion is sensitive to the emotional context and the level of understanding the patient/substitute decision-maker has about the issues being discussed.
c. Providing information about the person's condition and prognosis and possible future scenarios can lead to discussion of treatment options that may need to be considered including the benefits and burdens of various options.
d. Everyone has their own view of what "quality of life" means to them. Understanding the core values of the patient can help guide others in situations where they have to make decisions on behalf of the patient.
e. Discussion of what is most important to the patient as they get closer to end of life can be helpful in identifying healthcare treatment that the patient may wish to avoid or levels of functioning that they

would find intolerable may be identified, along with any specific treatments or interventions that they would consider burdensome or intrusive.

f. Staff initiating ACP discussion and/or assisting a patient/substitute decision-maker to complete the "Statement of Choices" form should document that the discussion has occurred and that the forms have been distributed in the patient's health record.

2.6 Management of advance care planning documents

2.6.1 Legal advance care plan documents

a. Advance Health Directive and /or Enduring Power of Attorney are legal documents and can only be completed by an adult patient who has capacity.
   i. AHD, EPOA or QCAT orders will be forwarded to "Privacy Coordinator – Information Privacy Office" to ensure documents are properly stored and recorded in the patient's health record.

b. Refer to Work instructions for AHD, EPOA and OAG documentation to ensure documents are properly stored and recorded in the patient's health record.

2.6.2 Patient documentation of health choices and distribution of completed documents

a. The preferred form at Mater is the "*Statement of Choices*" form which can be completed by:
   i. a patient who has capacity (Form A)
   ii. or their substitute decision-maker when they know the patient's values and life goals to inform decision making (Form B)
   iii. the form records wishes, values and beliefs to help guide those making decisions on behalf of the patient
   iv. Once the patient or substitute decision-maker completes the statement of choices a medical officer is to review and sign the statement of choices form
      - At Mater forms must be signed by a Consultant or registrar
   v. When a patient or their substitute decision-maker presents a completed Statement of Choices form A or B to staff, the staff member shall confirm how the document has been disseminated and document in patient's health record:
      - Provided to family, friends, GP and treating hospital.
      - Sent to acp@health.qld.gov.au
      - Provided to other healthcare professionals
   vi. When a completed Statement of Choices form is presented to Mater staff or when Mater staff assist the patient /substitute decision-maker to complete a Statement of Choices form it is to be labelled with patient label and sent for scanning into the patient's health record.

b. If the patient has not already done so or is having difficulty with sending the form email any "*Statement of Choices*" forms completed at Mater to acp@health.qld.gov.au
   i. By sending the form to the ACP office the SOC form can then be uploaded to The Viewer we are ensuring the SOC form is made accessible across health sectors.
   ii. Refer to Appendix 3 Steps for submitting Statement of Choices form to ACP office.

c. To ensure patient wishes regarding resuscitation and end of life are upheld following discharge from hospital and to facilitate completion of advance care plan with relevant primary care providers if appropriate:
   i. Copies of completed Adult resuscitation plans (ARP) will be provided to the patient (or their substitute decision-maker).
   ii. Faxed or scanned by hospital staff to care provider (e.g. general practitioner [GP]/residential aged care facility).
   iii. Documentation of the development of an ACP will be included in the discharge summary.

2.6.3 Medical documentation of advance care plan discussion

a. With regards to ACP discussions, the following information should be documented in the chart:
   i. Who was present for the discussion.
   ii. Whether the patient has capacity.
   iii. Who the substitute decision-maker is/would be (see section 2.4).
   iv. Patient values and wishes regarding future care (see section 2.5d and e).
   v. Previously completed ACP documents, whether these have been sighted, and how they have been distributed (see section 2.1.f).

b. The Adult resuscitation plan (ARP) is a health care plan made by health care providers in the context of the patient's known goals, values and wishes and what the health care provider considers to be "good medical practice' (ARP form CF-IID-001935). With regards to ARP discussions, in addition to the above points, the following should also be documented both in the patient's health record and on the ARP form:
    i. Goals of care.
    ii. Beneficial and non-beneficial treatments especially with reference to cardiopulmonary resuscitation (CPR).
    iii. Any disagreement between health care providers and patient / substitute decision-maker regarding the above and measures taken to rectify this.
c. A new ARP form is required for each patient when the patient's condition changes, such that will lead to a change in treatment limitations, or every 12 months, whichever is sooner.
d. Any ACP documents completed by Mater staff, including the statement of choices (SOC) form, AHD, and ARP, must be signed by a Consultant or Registrar and discussions recorded in the patient's health record.
e. Resuscitation plans:
    i. Completed at another health care facility remain valid until reviewed by admitting team / VMO at the earliest opportunity after admission. (e.g. Mater Private Hospital Redland [MPHR] patients admitted from Redland Public Hospital [RPH]).
    ii. A Resuscitation plan may be partially completed on admission and a new plan completed when ACP discussion with patient and / or substitute decision-maker completed and patient's values and wishes known and documented.
f. If there is significant change in a patient's condition and the ARP form needs to be cancelled the medical officer is to:
    i. Strike through the front and back pages, write "VOID"
    ii. Print name and designation of medical officer revoking plan then sign and date ARP form.

2.6.4 ARP form and scanned record

a. Completed ARP forms will be scanned and viewable in the scanned record via Verdi under the Alerts tab and will be viewable at all times.
b. Clinical staff are to print in colour valid ARP form (e.g. valid for 12 months) from scanned record when patient readmitted.
c. On discharge reprinted ARP forms will be managed as follows:
    i. Reprinted ARP forms with no annotations will be discarded and not sent to scan centre.
    ii. Reprinted ARP forms with annotations (e.g. cancelled plans) to remain in current attendance record (CAR) and sent to scan centre.

2.6.5 Clinical alerts

a. Clinical staff involved in the advance care plan discussion will be responsible for identifying that the following alerts are applicable to a patient and documenting on alerts page in (CAR):
    i. Advance care planning – no end date required.
    ii. Adult resuscitation plan form – when form completed (signed by medical officer and valid by ticking appropriate box (section 7 Clinical Authorisation).
b. Administration staff will activate alerts in iPM for ACP by ticking appropriate boxes as follows:
    i. Advance Health Directive - when AHD document presented to staff.
    ii. Enduring Power of Attorney - when EPOA document presented to staff.
    iii. Advance care planning – refer to Patient alert procedure.
    iv. Adult resuscitation plan form – when valid ARP form completed and end date documented as per form.
c. Ensure copies of forms are held in CAR for an inpatient and sent to scan centre post discharge to be scanned into Verdi.
d. Scanned AHD/ARP/ EPOA/SOC forms are filed in Verdi under the alerts tab.

2.7 Referral and escalation process

a. Referrals can be made to Social Work to assist in ACP conversations with patients/substitute decision-maker/s and to assist with completion of ACP documents.

b. For difficult and complex patients refer to registrar or consultant for discussion of prognosis and treatment options and consider calling palliative care specialist for advice.
c. In cases where the patient does not have capacity and there is ongoing disagreement with the substitute decision-maker then an escalation process should be followed such as:
    i. obtaining a second opinion,
    ii. referring to clinical ethics committee,
    iii. referring to hospital medical legal team for advice.

2.8 Patient information on completing advanced care plan forms

a. Metro South "My Care My Choices- Advance Care Planning" website has helpful information www.mycaremychoices.com.au
    i. Advance care planning brochure which is available in other languages https://metrosouth.health.qld.gov.au/acp/resources
    ii. Hardcopies of Statement of Choices form is available through social work department or
    iii. Online at www.mycaremychoices.com.au
b. Barwon Health "My Values" website has helpful information and the ability to complete your profile on line
    i. https://www.myvalues.org.au/
c. Queensland Health – Care at the End of Life
    i. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life
d. Palliative Care Queensland
    i. https://palliativecareqld.org.au/

2.9 Measuring ACP

a. A structured approach to patient and service level review is undertaken within each clinical stream to ensure end of life care and advance care planning is reviewed to identify opportunities to manage clinical variation where it exists.
b. System measures have been revised to track and monitor end of life care through the hospital incident reporting system.
c. System measures are reported at the End of Life working party who reports to the Acute Deterioration and End of Life Care Committee.

3 Definitions

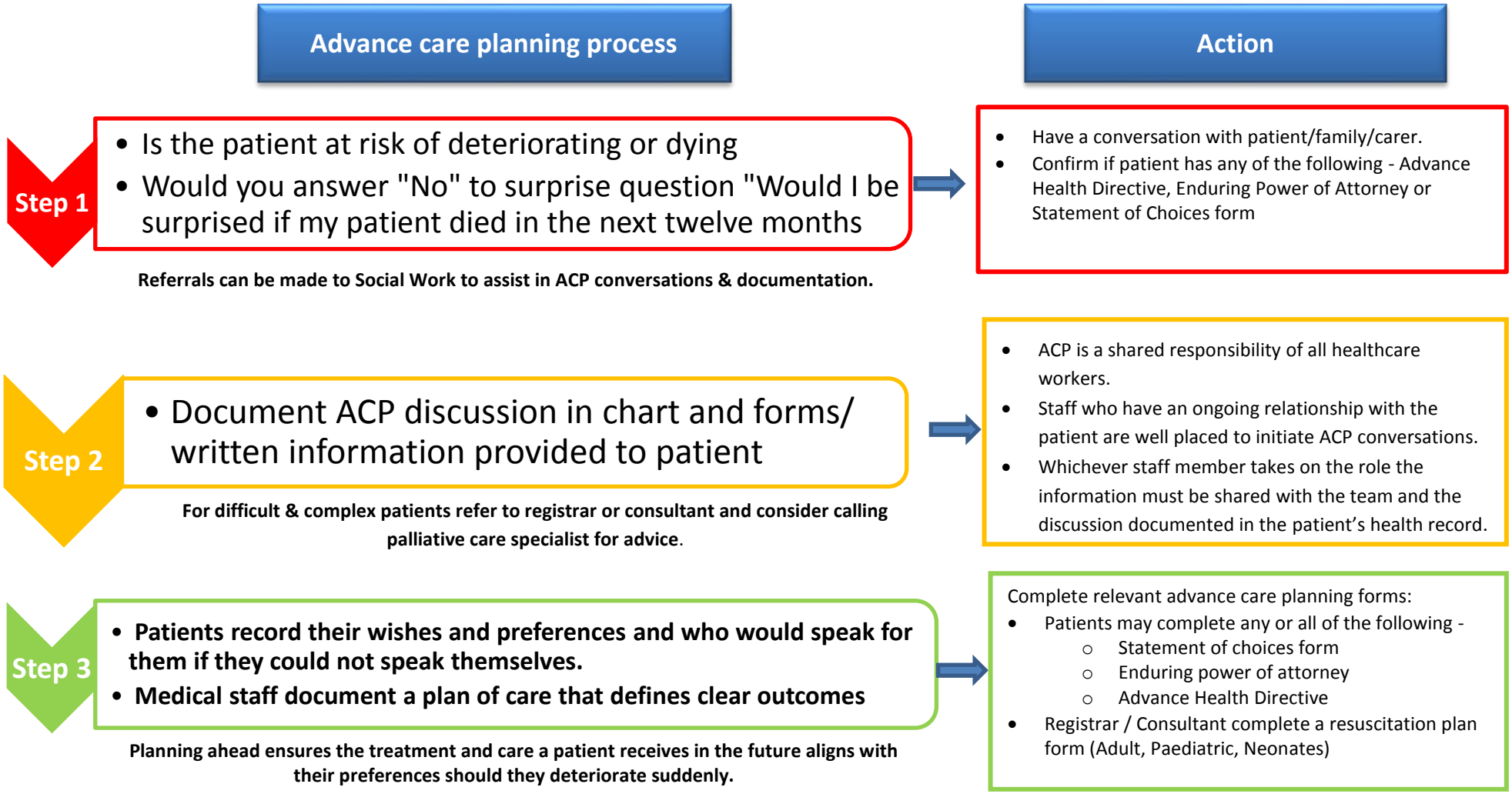
Term	Definition
Advance Health Directive	An Advance Health Directive (AHD) is a legal document by which a person may give directions about health matters, provide information about those directions, appoint persons to exercise power for health matters and provide terms about exercising the power.
Enduring Power of Attorney	An Enduring Power of Attorney (EPOA) is a legal document by which a person may (a) authorise 1 or more other persons who are eligible attorneys to do anything in relation to 1 or more financial matters or personal matters, or both, for the principal that the principal could lawfully do by an attorney if the principal had capacity for the matter when the power is exercised; and (b) provide terms or information about exercising the power.
Office of Adult Guardian (OAG)	The role of the Adult Guardian is to protect the rights and interests of adults who are unable to make decisions for themselves and who have not appointed an Attorney or made an Advanced Health Directive.
QCAT	Queensland Civil and Administrative Tribunal
Statement of Choices	Form that documents a patients' health care values and preferences. Understanding the core values of a person can assist those who have to make decisions on their behalf should they be unable to voice their preferences.
Substitute decision-maker	A person appointed or identified by law to make substitute decisions on behalf of a person whose decision-making capacity is impaired. [7]
The Viewer	The Viewer is a read-only web-based application which sources key patient information from a number of existing Queensland Health enterprise clinical and administrative systems. Uploading a SoC to The Viewer enables clinicians in Queensland Health hospitals and GPs access to the person's SoC.

4 Appendixes

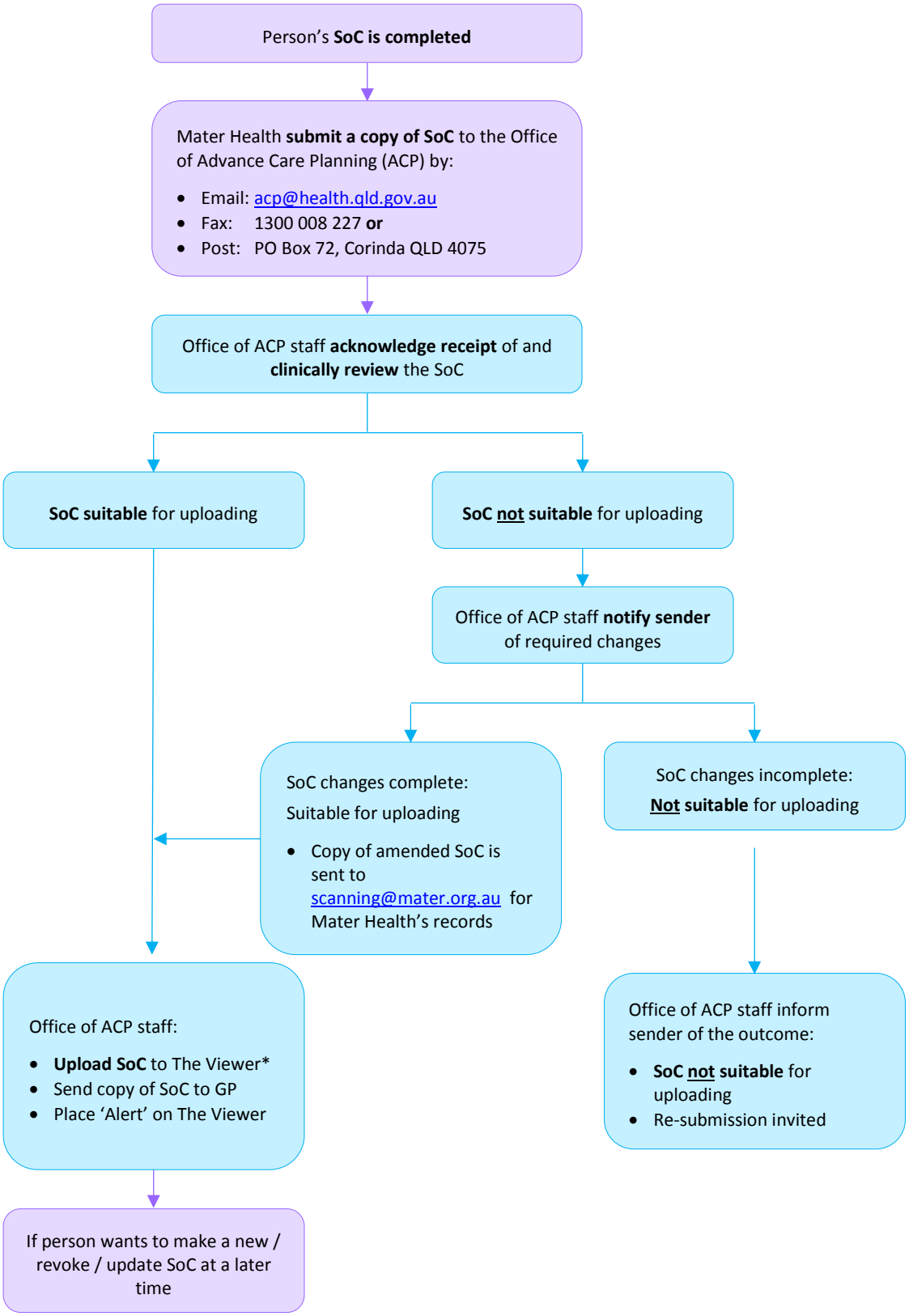
4.1 Appendix one: Documents available to record advance care plan discussion

Document	Advance Health Directive	Enduring Power of attorney	Statement of Choices	Resuscitation Plan
Type	Legal document	Legal document	Statement of the patient's health choices/wishes	Medical document
Purpose	Directs substitute decision-maker/s and doctors about your wishes and preferences for medical treatments Used to direct management plan in specific health circumstances Option to appoint substitute decision-maker/s for health matters	Appoints substitute decision-maker/s for health and/or financial matters	Supports ACP conversations Used to guide care management plan	Supports ACP conversations and documents what the health care provider considers to be "good medical practice".
Use of documents	Used across Queensland Is activated when adult has impaired capacity for decision-making about health matters Choices documented in an advance health directive will override an enduring power of attorney and Statement of Choices	Used across Queensland Used when adult has impaired capacity Used to nominate a substitute decision-maker/s who has power to make decisions about personal (health)/financial matters Does not override advance health directive	Used in some Health facilities, residential aged care facilities, and general practice. Used to guide medical and personal care management plan	Used across Queensland Mater has resuscitation plans for: Adults, Paediatrics and Neonates
Completion	Completed by adult with capacity	Completed by adult with capacity	Completed by adult with capacity (FORM A); or Completed by the substitute decision-maker for an adult without capacity (Form B)	Completed by medical officer in the context of the patients known goals, values and wishes
Authorisation	Signed by adult, and Must be signed by doctor, and Must be witnessed by justice of the peace/commissioner for declarations	Signed by adult, and Signed by substitute decision-maker/s accepting role, and Must be witnessed by justice of the peace/ commissioner for declarations	Signed by adult and/or substitute decision-maker, and a healthcare professional (preferably doctor)	Signed by Consultant or registrar
Forms	Available online at: www.justice.qld.gov.au	Available online at: www.justice.qld.gov.au	Available online at: www.mycaremychoices.com.au	Available as hardcopy on clinical wards
Completed forms	Refer to Work instructions for AHD, EPOA and OAG documentation Scanned forms held in Verdi under Alerts tab.	Refer to Work instructions for AHD, EPOA and OAG documentation Scanned forms held in Verdi under Alerts tab.	Held as part of patient's CAR. Completed forms emailed to acp@health.qld.gov.au if not already done so by patient. Scanned forms held in Verdi under Alerts tab.	Completed forms held as part of patient's CAR. Scanned forms held in Verdi under Alerts tab.
Alerts	Advance Health Directive Refer to Patient Alerts Procedure	Enduring Power of Attorney Refer to Patient Alerts Procedure	ACP – Statement of Choices Form A ACP – Statement of Choices Form B Refer to Patient Alerts Procedure	Advance care planning – Adult resuscitation plan form Refer to Patient Alerts Procedure

4.2 Appendix two: Advance care planning flowchart



4.3 Appendix three: Steps for submitting Statement of Choices form to ACP Office



* The Viewer is a read-only web-based application which sources key patient information from a number of existing Queensland Health enterprise clinical and administrative systems. Uploading a SoC to The Viewer enables clinicians in Queensland Health hospitals to have direct access to the person's SoC.

5 Documents related to this procedure

Mater documents

Document type	Document ID	Document Title
Policy	PY-IID-1000016	Information Privacy Policy
	PY-CLN-900034	Recognising and responding to clinical deterioration
Procedure	PR-IID-100035	Patient alerts procedure
Work Instruction	WI-IID-100021	Advance Health Directives, Enduring Power of Attorney and Office of Adult Guardian Documentation
Clinical Form	CF-IID-001935	Adult resuscitation plan form
	CF-IID-000502	Paediatric acute resuscitation plan form
	CF-IID-000446	Recommended Resuscitation Plan
Other	CF-IID-002043	Advance Care Planning - Statement of Choices (FORM A)
	CF-IID-002044	Advance Care Planning - Statement of Choices (FORM B)

External documents

1	Powers of Attorney Act http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PowersofAttA98.pdf
2	Advance Health Directive Form http://www.justice.qld.gov.au/__data/assets/pdf_file/0007/15982/advance-health-directive.pdf
3	Enduring Power of Attorney Form: Long http://www.justice.qld.gov.au/__data/assets/pdf_file/0008/15983/enduring-power-attorney-long-form.pdf Short http://www.justice.qld.gov.au/__data/assets/pdf_file/0004/15970/enduring-power-attorney-short-form.pdf
4	General Information http://www.justice.qld.gov.au/justice-services/guardianship
5	Queensland Civil & Administrative Tribunal http://www.qcat.qld.gov.au/
6	Australian Commission on Safety and Quality in Healthcare. Safety and quality improvement guide standard 9: recognising and responding to clinical deterioration in acute health care. Commonwealth of Australia. 2012 Oct
7	Australian Commission on Safety and Quality in Healthcare. National Consensus Statement: essential elements for safe and high-quality end-of- life care. Sydney:ACSQHC, 2015
8	Department of Health. Implementation plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, Australian Government, Canberra, 2015.
9	Australian Commission on Safety and Quality in Healthcare. Safety and quality improvement guide standard 2: partnering with consumers. Commonwealth of Australia. 2012 Oct

6 Document controls

6.1 Document revision history

Version	Release date	Description	Risk-rated review date
1	18-Jan-2018	Version 1 published on the Mater Document Centre	Jan-2021

6.2 Document review and approval

Name Person/committee	**Position** If applicable	**Function** Owner/author/review/approve
Clare Morgan	Chief Medical Officer	Document owner
Michelle Daly	Director Social work & Psychology	Document author
Diana Moore	Clinical Safety & Quality Partner	Document author
End of life care working party	Key stakeholder/s consulted	Review
Jo Richards	Medicolegal Lawyer	Review/approve
Acute Deterioration and End of Life Care Committee		Approve
Key approvers as per DocReview		Approve