

Advanced Care Planning QI Quick Guide

The Queensland Government is encouraging patients and the community to discuss their health care wishes with their doctor.

Your patients may ask you about advance care planning in general or their Advance Health Directive, Enduring Power of Attorney, Statement of Choices or forms to revoke enduring documents. When undertaking 75-year old Health Assessments and or Chronic Disease Management Plans presents an ideal opportunity to initiate conversations with your patients on their health care wishes.

For Residents of RACF's. Routinely initiate ACP (Advanced Care Plan) discussions between senior nurses, patients and their decision-makers following: admission (ideally this should occur on or very soon after admission) after any major change in clinical status or recent acute hospitalisation, and at yearly intervals, or more frequently depending on deterioration of clinical status, including capacity.

Copies of advance care planning documents provided to the Office of Advance Care Planning will be clinically audited and uploaded to the patient's Queensland Health electronic hospital record, and can be accessed via the ACP Tracker in Health Provider Portal (The Viewer a secure web-based application enabling access to key patient information). Please see your [practice support officer](#) for further information.

The ACP Tracker is helping clinicians in Queensland health public hospitals, Queensland Ambulance Service and authorised GPs to provide quality end-of-life care.

What do I do if my patient asks about advance care planning?

1. Outline the process of advance care planning.
2. Provide the patient with the [Advance Care Planning brochure](#)
3. Suggest the patient complete their [Enduring Power of Attorney](#) to legally appoint their substitute decision maker(s).
4. Ask your patient to discuss their wishes and health care choices with their substitute decision maker(s), family and/or close friends.
5. Some patients may like to read the advance care planning forms ahead of time. Suggest your patient goes to the My Care, My Choices website to access the [advance care planning forms](#) online. You may choose to give the patient a copy of the Statement of Choices form (the Office of ACP can provide your practice with a supply of the Statement of Choices forms and brochures).

What do I do if my patient has completed a Statement of Choices?

1. Check the patient has read each section; discussed their preferences with their substitute decision maker(s), family and significant others; and written their choices on the correct form (Form A for people with decision-making capacity, Form B for people without decision-making capacity, or requiring supported decision-making).
2. Clarify any questions the patient may have about their decisions.
3. Have the patient (Form A) or substitute decision maker (Form B) sign and date the declaration in their completed Statement of Choices form.
4. Ensure the correct contact information is provided for their substitute decision maker(s).
5. Complete the Usual Doctor's Statement section (page 4 of 4).
6. Give the original document to the patient. Advise them to keep it in a safe but accessible place.
7. Keep a copy in your patient's file. Advise the patient to give photocopies to their substitute decision- maker(s) and/or family and close friends.
8. Send a copy of their completed Statement of Choices document to the address details on the form (bottom of page 4), or fax or email to the Office of Advance Care Planning, so it can be added into their secure Queensland Health electronic hospital record.

What do I do if my patient brings an Advance Health Directive (AHD) in to complete?

1. Discuss the person's medical history and views, explain any medical terms and clarify related queries that he/she may be unsure of.
2. Complete Section 5 Doctor involvement (p14) verifying:
 - a. You have discussed the document with the person.
 - b. In your opinion he/she was not suffering from any condition that would affect his/her capacity to understand the things necessary to make an AHD, and he/she understands the nature and effect of the health care described in the document as per document instructions.

- c. You are not:
 - i. The person witnessing the AHD.
 - ii. The person signing the AHD for the person.
 - iii. An attorney of the person.
 - iv. A relation of the person or of an attorney of the person
 - v. A beneficiary under the person's will.
3. Remind the person that:
 - a. Sections 8 (p19) and 9 (p20) of the form must be signed in front of an eligible witness (Justice of the Peace, Commissioner of Declarations, Lawyer or Notary Public).
 - b. Once complete, a copy of the AHD can be sent to the Office of Advance Care Planning, so it can be added into the person's secure Queensland Health electronic hospital record.

My Health Record

Encourage your patients to add their advance care plan to their My Health Record so it's available to the treating doctors if it's ever needed.

They can also store the names of people they have shared the advance care plan with.

Health Professional Education and Resources

[ELDAC](#) provides information, guidance, and resources to health professionals and aged care workers to support palliative care and advance care planning to improve the care of older Australians.

[Advance Care Planning Australia](#) is a national program that provides information and resources to individuals, care workers and healthcare professionals to improve this cooperation

[The Advance Project™](#) offers a range of learning options for GPs, general practice nurses and practice managers to develop their knowledge of, and skills in using, screening tools to support the provision of palliative care and advance care planning (ACP) in everyday general practice. These include eLearning modules and individual telementoring from an experienced palliative care nurse.