Advance Care Planning
Policy and Procedure Example for Residential Aged Care

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V1A September 22\textsuperscript{nd} 2014

The intent of this document is to be aspirational rather than prescriptive. It was developed to complement the approach taken to Advance Care Planning in the best practice model ‘Residential Aged Care Palliative Approach Toolkit’ funded for national roll out by the Australian Government.

It is provided as an example of material content that a residential aged care provider can freely adapt to suit their needs for policy and procedure development or review. Consideration of a provider’s vision, mission and strategies to implement Advance Care Planning within the local context is encouraged. It is the author’s intention that this material may be used freely and might inspire the local development of user friendly internal resources for stakeholders at a facility level such as checklists, flow charts, letter templates, brochures and fact sheets. There are also many Advance Care Planning resources and form templates freely available. Advice on the implementation of Advance Care Planning and access to resources is freely available through the

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1. **INTRODUCTION**

1.1 The majority of residents entering **RACF NAME** are admitted because they have life-limiting incurable conditions or advanced chronic disease, age or frailty with functional decline. Given people entering residential care are increasingly frail, often highly dependent and with multiple co-morbidities it is reasonable to expect that residents are likely to experience a serious deterioration in health and die at some point during their tenure at **RACF NAME**. Residents have the right to receive care that is in alignment with their own values and wishes and to die with dignity.

1.2 Advance Care Planning is implemented at **RACF NAME** as one of the key processes within the best practice model of a ‘palliative approach in residential care’ framework. In this approach the focus of care is actively directed towards managing symptoms and increasing comfort and quality-of-life rather than curing disease where this is no longer a realistic goal. This emphasis on care is not restricted to the last days or weeks of life but applies throughout each resident’s remaining life journey.

1.3 Advance Care Planning has been demonstrated in randomised control trial of elderly patients to improve end of life care, patient and family satisfaction with care and to reduce stress, anxiety, and depression in surviving relatives.  

1.4 **RACF NAME** acknowledges Advance Care Planning as an important mechanism to ensure that each resident’s right to express preferences and make decisions about their own care is upheld and that their person responsible and family are encouraged to participate in the planning process.

1.5 **RACF NAME** seeks to provide a structured and systematic approach to Advance Care Planning in order to promote high quality, person-centred end-of-life care. Relevant expertise, oversight, clinical leadership and front line support for Advance Care Planning are provided through the involvement of senior clinical staff including Palliative Approach Link Nurses, Residential Service Managers, Directors of Nursing, Care Coordinators, ACP Portfolio Holders and General Practitioners.

2.0 **PURPOSE**

The aims of this policy are:

2.1 To define a framework and set of principles to follow regarding Advance Care Planning at **RACF Name**

2.2 To describe the procedures to be followed to ensure Advance Care Planning is applied in a consistent way

3.0 **DEFINITION OF TERMS**

**Advance Care Planning (ACP)**

The process of reflection, communication and documentation involved when an individual makes choices regarding preferred health care to guide future decision-making. Advance Care Planning is usually undertaken within a health or aged care setting with the assistance of a trained professional who facilitates exploration of the person’s values and preferences and reinforces respect for that person’s autonomy. Advance Care Planning allows a person to make decisions about preferred care and medical treatment in advance of a loss of decision-making capacity due to serious illness, injury, advanced frailty or disease. Where capacity is permanently impaired, it
enables the ‘person responsible’ to make well considered decisions in advance of a medical crisis or deteriorating condition affecting the person they represent.

ACP Portfolio Holder

A clinical care staff role assigned with the specific responsibility to champion Advance Care Planning and support its implementation according to facility policy and procedure.

Advance Care Plan

An Advance Care Plan is the written outcome of an Advance Care Planning discussion. Advance Care Plans are documents that record preferences about health and personal care and preferred health outcomes. They are prepared from the resident’s perspective to guide decisions about care made on their behalf. Advance Care Plans may be made by, with or for a resident depending on their capacity to make healthcare decisions. If made on behalf of an individual with permanently impaired capacity, they are formulated with the ‘person responsible’ who must draw on any previously expressed preferences and their close knowledge of the individual to make decisions in their best interests.

Advance Care Directive (ACD)

An Advance Care Directive is the written Advance Care Plan of a competent person recognised by common law or authorised by legislation. In Victoria, correctly using a legislated form from the Medical Treatment Act allows an individual to make binding directions to limit treatment (Refusal of Treatment Certificate - Competent Person) and to formally appoint a preferred substitute decision maker for medical treatment decisions (Enduring Power of Attorney - Medical Treatment).

Agent  A term for a person appointed as an Enduring Power of Attorney for Medical Treatment

Capacity

A term used to describe the mental ability of a person to make a decision which may have legal consequences. There is a presumption of capacity, that is, the law assumes that adults have decision-making capacity unless it can be demonstrated otherwise. Capacity is not global but is decision or situation specific. Decision-making capacity is assessable and involves considering the person’s ability to make a decision and comprehend its implications. Capacity may be temporary, partial or fluctuate therefore a person’s degree of decision-making capacity is assessed at the time any significant decision is required. In relation to a specific decision a person with capacity is able to:

- Understand information relevant to a decision
- Retain that information long enough to process it
- Process and weigh up the information (evaluate the pros and cons)
- Make a choice and comprehend the main consequences of that decision
- Communicate their decision

Competence

A legal term used to describe when an adult is mentally able to execute a document with legal effect, being able to demonstrate sufficient soundness of mind to comprehend the general nature and effect of the instrument at
the time of signing it. Competence is recognised internationally and in common law as a requirement for completing a legal document such as an Enduring Power of Attorney.

**End of Life (EOL)**

The interval of a person’s life from onset of a progressive state of decline due to age-related frailty, chronic disease or life-limiting illness until their death; that is, the period of time marked by disease, impairment and disability that progressively worsens until death.

**Life Prolonging Treatment**

Medical treatment that may extend the duration of life or delay death without providing a cure and involves the use of any clinical procedure, medical device or drug that requires the skill, knowledge or expertise of a registered health practitioner. Such treatments may have a high risk of being burdensome when administered at End of Life. Examples include insertion of feeding tubes, major surgery, renal dialysis, intravenous infusions, mechanical ventilation, cardiopulmonary resuscitation and intensive care interventions.

**Location of Care Preferences**

Preferences about the physical environment and setting where the resident would prefer to receive medical and non-medical care including whether they wish to be transferred to an acute care hospital for invasive medical interventions in the event of a serious deterioration in health.

**Medical Enduring Power of Attorney (MEPOA)**

A person appointed as the agent in an EPOA (Medical Treatment) instrument (form) whose power commences when the donor (resident) loses capacity to make medical treatment decisions

**Medical Care Preferences**

The type of medical treatment that a resident would prefer to have or forego, based on their own values and choices; or those preferences communicated by the ‘person responsible’ on the resident’s behalf based on their intimate knowledge of the resident’s values or previously expressed wishes and the resident’s best interests.

**Non-medical Care Preferences**

Choices expressed by a resident or their Substitute Decision Maker, regarding personal care and support measures that would assist in providing personal comfort, particularly if nearing death. For example; specific measures to uphold dignity or address spiritual, religious and cultural needs; specific preferences regarding physical environment, rituals, favourite food or fluids, music to play, the presence of family and friends.

**Palliative Approach**

A palliative approach aims to improve the quality of life for residents with life-limiting conditions and their families by reducing their suffering through early identification, assessment and treatment of pain, physical, cultural, psychological, social and spiritual needs. Importantly, this form of palliative care is not restricted to the last days or weeks of a resident’s life but is applied to the entire period of their remaining lifetime.
Person Responsible

The adult responsible (as defined in the Guardianship & Administration Act 1986 Victoria) for the health care decisions (consenting or withholding consent to medical treatment) of a patient (resident) who has lost the capacity to make their own health care decisions. The ‘Person Responsible’ means the first person on the list in order of hierarchy, who in the circumstances is available and willing and able to make a medical or dental treatment decision on behalf of the patient (resident). See Appendix 1 for the list.

Substitute Decision-Maker (SDM)

The individual (Medical EPOA or Guardian) appointed by the resident when competent for the purpose of making substitute decisions to accept, withhold consent or refuse (only Medical EPOA legally authorised to refuse) medical treatment on the resident’s behalf if capacity becomes impaired. In the absence of an appointment then the SDM is determined by the Victorian law as set out in section 37 of the Guardianship and Administration Act 1986 hierarchical list of the ‘person responsible’ (see Person Responsible).

Terminal Care

Care provided to a dying resident who is experiencing the last hours, days or final weeks of life.

4.0 POLICY PRINCIPLES

4.1 At RACF Name information about Advance Care Planning will be provided to residents and their family pre-admission so that they can understand its’ purpose and expect to be approached about it as part of routine care. Discussions about preferred care will be initiated early on in a resident’s tenure at RACF Name to avoid imposing the burden of crisis decision-making on a resident’s family or representative. Making requests for urgent end of life decisions late in a resident’s illness or during a foreseeable deterioration in condition when their capacity for participation is likely to be most compromised is to be avoided by conducting timely and iterative Advance Care Planning discussions.

4.2 At RACF Name four key domains of preferences will be explored with residents and their chosen representatives and family during the Advance Care Planning process with the mutual understanding that these wishes will be followed during any period of incapacity as a result of deteriorating mental or physical health. These are: preferred substitute decision-maker; medical treatment preferences; non-medical or supportive care preferences and location of care preferences.

4.3 Advance Care Planning discussions in regard to medical care preferences are to focus on the goals of care for the resident, their general views about the acceptability of life prolonging treatment and any circumstances or treatments they strongly wish to avoid. If relevant discussion points about specific treatments are raised and require exploration, residents and substitute decision-makers should not be expected to make any decisions in advance without affording them sufficient time to access suitable information about the benefits and burdens of such treatments, alternative options and likely outcomes with a suitably qualified health professional such as a their GP, medical specialist or senior nurse.

4.4 The purpose of Advance Care Planning is to aid decision-making if the resident loses capacity to make or communicate decisions about their medical treatments and care due to advanced illness, frailty or disease.

Disclaimer: This document is intended as an educational sample of an ACP Policy and Procedure suitable for use in an aged care facility.
Where the resident is able to make reasoned decisions their current views take precedence over any documented plan. Advance Care Plans will only be activated and used to guide an appropriate course of care for a resident when they become unable to communicate their wishes regarding preferred health care and medical treatments. They do not replace discussion with a resident who has the capacity to make their own decisions about whether they consent or not to the available medical treatment and care on offer to them. Furthermore at the time residents and their chosen representatives and family formulate any Advance Care Plan at RACF they are to be informed about the facility’s regular review process and that they are free to change or revoke the Advance Care Plan whenever they wish to.

4.5 Given the inevitability of death and the close proximity that many residents will be to the end of their lives, Advance Care Planning consultations with the resident, their chosen representative and family will include open discussion about death and dying. Every effort is to be made to ascertain a resident’s preferred care if nearing death including specific emotional, social, cultural, spiritual and religious care at that time. This is to be done in a sensitive way, engaging residents to the extent that they are comfortable.

4.6 RACF Name acknowledges that the key purpose and priority of ACP is to facilitate meaningful discussions between residents, their substitute decision makers and health providers so that the resident’s wishes and preference for future care can be accommodated. At RACF residents and their substitute decision makers will never be asked or expected to complete ACP forms without guidance and assistance.

4.7 Advance Care Planning involves skilful communication about health care and specific documentation. At RACF Name this is always to be initiated by an appropriately trained facilitator with relevant knowledge to assist the resident or their substitute decision maker with the process of discussing and documenting care preferences. This will usually be a registered nurse ready to involve other members of the aged care team as necessary (e.g. GP) to enable informed choices by the resident/SDM. RACF Name will ensure that such clinical staff have access to ACP training and are supported in these duties by the designated Palliative Approach Link Nurse and the ACP Portfolio Holders assigned to each unit.

4.8 RACF Name aims to offer all residents and their substitute decision-makers the opportunity to participate in the Advance Care Planning process. However, it is acknowledged that some may decline this offer and this is to be regarded as a valid choice. Advance Care Planning should be viewed as an entirely voluntary undertaking at all stages of the process and staff must not attempt to coerce or unduly influence participation in it.

4.9 Advance Care Planning discussions must involve the capable and willing resident. If the resident’s capacity to understand the nature of the discussion is impaired, the person identified as their substitute decision-maker is to be identified and asked to participate. It is desirable that the resident’s GP and other relevant health providers are involved in discussions and this is to be invited and encouraged. ACP discussions will not be a single event but iterated at designated intervals and triggers for review (see procedure guidelines).

4.10 The resident and their chosen representatives and family involved will have all ACP discussions conducted with due regard to maintaining their privacy and they are to be informed about the confidentiality and safekeeping of any documents completed. It should be explained that Advance Care Plans may need to be
provided to external health providers such as on transfer to hospital so that if relevant circumstances arise their express wishes can be known and respected.

4.11 Many residents admitted to RACF are likely to have some degree of cognitive impairment and may not possess sufficient capacity to make an Advance Care Plan. In such cases diligent effort must be made to harness the resident’s residual capacity to ascertain any views they may have on preferred care. In these circumstances the substitute decision-maker is to be afforded the opportunity to be involved to a greater degree. They should be encouraged to participate in thoughtful and considered discussions about care decisions concerning the resident and supported to incorporate the resident’s known preferences and personal participation to the degree that the resident is able and wishes to be involved.

4.12 Residents admitted to RACF who permanently lack the capacity to make or communicate decisions have the right to have any pre-existing documented preferences filed in their health record and taken into account when planning provision of care. Such documents may include a nominated substitute decision maker such as an agent and any written document of health care choices authored and signed by the resident, whether in an informal format such as a letter or a more formal format such as an Advance Care Directive. It is unethical to allow the express wishes of a resident to be overridden by health providers or family members and any previous wishes documented by the resident are to be respected and upheld whenever applicable.

5.0 PROCEDURE / GUIDELINE

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<thead>
<tr>
<th>Key care point</th>
<th>Process</th>
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<tbody>
<tr>
<td>1. Pre-admission / initial orientation interview</td>
<td>1.1 Identify if resident made a pre-existing appointment of a preferred substitute decision-maker as their MEPOA (agent) or Enduring Guardian: make request to sight and copy the original or certified copy of the document to keep in the resident’s file.</td>
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<td>1.2 File same if available at the time of interview in the front of the resident’s health record behind the designated section divider.</td>
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<td></td>
<td>1.3 If no resident-appointed agent or Guardian (with Health care powers), identify the listed ‘person responsible’ (see Appendix 1) with the resident/representative using the Office of Public Advocate (OPA) fact sheet ‘Medical/Dental Treatment for Patients who cannot Consent’ to clarify who the legal substitute decision-maker is for such decisions. Ensure relevant contact details are obtained and recorded on (insert NR name/#)</td>
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<td></td>
<td>1.4 Identify if the resident has previously made an Advance Care Plan / Advance Care Directive. Request and file document per 1.1 and 1.2.</td>
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|  | 1.5 Use prior points as stepping stones to now briefly introduce the Advance Care Planning process and how discussions about current and future care needs and preferences are key to providing good care to the
### Policy Name: **Advance Care Planning**

<table>
<thead>
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<th>Policy Number</th>
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#### Executive Sponsor/Approved by:
Residential Services Manager

#### Section:
Residential Services: Clinical Care

**Date Created/Revised:** September 22nd 2014  
**Reviewed:** September 25th 2017

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**1.6** Inform resident / representative that all new residents are provided a care planning case conference within 4-6 weeks of admission. Inform them that the resident-appointed SDM and any other nominated family are encouraged to participate. Alert them to expect an invitation letter with questionnaire to arrange and prepare for this meeting.

**1.7** Provide **ACP Brochure** to reinforce this verbal information.

**1.8** Offer **OPA Fact Sheet ‘Enduring Power of Attorney (Medical Treatment)’** if resident appears competent and has not appointed one but might like to.

**1.9** Offer **OPA Fact Sheet ‘Advice for Agents (Medical)’** to the Medical EPOA if present to support clarity re their role.

**10.** Point out concise information about ACP in the Palliative Approach section of the **RACF Name Resident Handbook**.

**11.** Document brief points regarding this discussion in the ACP Discussion Record (insert NR name/#) so follow up staff will know key points discussed and any outstanding documents to be obtained at admission.

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### 2. At Admission (first week)

**Key expected outcomes:**
- Confirm SDM
- Arrange case conference
- Enable resident/SDM preparation

**2.1** Confirm the resident’s ‘person responsible’ substitute decision-maker (SDM) according to list and obtain outstanding documents if this has not been completed at pre-admission/orientation interview.

**2.2** The designated nurse responsible for care plan arrangements is to reinforce that the ACP process of discussion enables facility to provide the best high quality person-centred care to the resident.

**2.3** Arrange meeting time for 4-6 weeks from admission and issue standard ‘Invitation and Family Questionnaire’ to set up advance care planning discussion as part of case conference appointment. Invite GP via standard fax and advise relevant members of aged care team of date/time/details.

**2.4** Provide facility Factsheet on ‘ACP and the Palliative Approach’ to resident where applicable and post with invitation to substitute decision-maker/family re purpose, benefits and what to expect in the process of discussion and documentation.

**2.5** Enable capable resident to ask questions about the meeting.
2.6 Offer SDM booklet to read “Affirming Life What is a Palliative Approach? A guide for family & friends with loved ones in aged care”.

3. Six weeks from admission

Key expected outcomes:
- Discuss resident’s preferences
- Liaise with GP for input to ACP and relevant orders
- Ensure documentation of resident’s preferences on relevant MR forms
- Utilise ACP Discussion Record to track discussions
- Disseminate ACP documents to relevant stakeholders
- Enter alert re completed ACP

3.1 Having allowed for a settling in period of 4-6 weeks:
Conduct ACP discussion as part of routine nurse led palliative approach case conference with the resident/SDM and aged care team members to establish, in the event of serious deterioration in resident’s condition, preferences from four key domains. A summary of discussions, topics covered and individuals involved is to be documented by the senior nurse for future reference in the ACP Discussion Record (insert MR name/#).

Note: If a resident/SDM declines to attend the case conference meeting or to discuss preferences, then it is equally important to document this response. It is important to validate any feelings expressed, not show disappointment or disapproval and to respect that such discussions can be confronting and participation is voluntary. A more receptive state of readiness may present later and the senior nurse can check on this once the resident is more settled in. A subsequent offer is to be made at 3 months from admission or any time the resident/SDM gives verbal cues that they are ready to talk.

3.1.1 Preferred SDM
If the resident is competent to appoint their preferred SDM as Medical EPOA the senior nurse is to facilitate correct completion of the form and check resident’s understanding of same per Appendix 2. Give the agent the original form and make copies to give the resident and to file in the resident’s health record behind the designated divider.

3.1.2 Medical care preferences
Ensure medical treatment preferences are communicated to the GP for further discussion and incorporation into medical treatment plans and orders. Facilitate correct completion of the Advance Care Plan form (insert MR name/#) with the SDM or Advance Care Directive form (insert MR name/#) to be signed by the resident.

3.1.3 Non-medical care preferences
If resident/SDM does not wish to document their wishes in a formal way using facility forms then ensure these preferences are documented in the ACP Discussion Record (insert MR name/#) where they can be easily accessed during terminal care and commencement on Residential Aged Care End of Life Care Pathway [Palliative Care Pathway] (insert MR name).
3.1.4 **Location of care preferences**

Ensure there is an agreed plan regarding transfer to acute care hospital in the event of serious deterioration and that this is documented as per 3.1.3.

3.2 If in doubt about resident’s capacity to understand or sign a Medical EPOA or Advance Care Directive, senior nurse or care coordinator is to liaise with GP for opinion regarding resident’s capacity and to provide any medical information needed by the resident/SDM to make relevant decisions.

3.3 Assist resident/substitute decision-maker to document the resident’s preferences using applicable ACP form/s *(insert MR name/#)*

3.4 Consult and liaise closely with the resident’s GP to support GP role in Advance Care Planning responsibilities:

a) determine expected prognosis and trajectory (per section 4.)

b) assess capacity if resident’s competence is in question

c) act as the signatory witness to resident signing any Medical EPOA or Advance Care Directive form/s

d) facilitate comprehensive medical assessment completed by the GP with plan for appropriate medical care in line with resident’s goals for care

e) write medical orders necessary to action the Advance Care Plan/Directive e.g. medication orders for comfort or a NFCPR order

3.5 Provide copies of any signed Advance Care Planning documents to SDM, nominated family stakeholders and care providers e.g. GP +/- medical specialist or regularly attended clinic and ensure signed copies are filed in the resident’s health record behind the designated divider.

**NB: RACF Name** should ensure that document’s completed using an electronic software format e.g. *iCare*, can be printed out for signing by the resident / SDM and same filed in the resident’s health record. This is necessary for the document to be considered valid and used by another service provider (e.g. public hospital if transferred for acute care).

3.6 Place ACP sticker *(RACF insert the colour or alternative method)* on spine of health record folder to alert all care staff that resident has an Advance Care Plan to be referred to in the event of a serious deterioration in health.

3.7 Advise resident and SDM about when the plan will be reviewed according to resident’s estimated Trajectory (see section 4. below) and who to approach if more information or a non-scheduled review is desired.

### 4. Trajectory Specific Case Conference and Advance Care Plan Reviews

Following completion of initial palliative approach case conference:

4.1 Schedule follow up nurse-led case conference and care plan review
## Key expected outcomes:
- Identify resident’s Trajectory
  - **Trajectory A**: \( >\frac{6}{12} \)
  - **OR**
  - **Trajectory B**: \( <\frac{6}{12} \)
  - **OR**
  - **Trajectory C**: \( <\frac{1}{7} \)
- Schedule and conduct ACP Review in line with trajectory
- Deliver terminal palliative care in alignment with resident’s express wishes per the Advance Care Plan

4.1.1 **Trajectory A: Expected Prognosis greater than 6 months**
Conduct annual case conference with resident/SDM - review the Advance Care Plan and provide 6 monthly follow up review of it and all care plans.

4.1.2 **Trajectory B: Expected Prognosis less than 6 months**
Conduct 6 monthly review of the Advance Care Plan with resident/SDM and monthly review of all care plans.

4.1.3 **Trajectory C: Expected Prognosis less than one week**
Conduct review of resident’s Advance Care Plan along with all other care plans and commence *Residential Aged Care End of Life Care Pathway* (insert MR name/#). Activate the Advance Care Plan and incorporate resident’s requests into the terminal care provided.

4.2 Issue an ‘Invitation and Family Questionnaire’ to resident/SDM and nominated family prior to any scheduled follow up palliative approach case conference in order to focus the discussion on key areas of concern for resident/SDM/family.

## 5. Resident deteriorates in health or experiences a major threat to health event or medical crisis and is unable to communicate wishes

### Key expected outcomes:
- Medical advice is sought to ensure resident’s condition is adequately assessed and terms of resident’s Advance Care Plan are applied appropriately.
- Advance Care Plans / Directives are respected and followed when applicable

### Senior Nurse on duty is to:
5.1 Check resident’s health record for any pre-existing medical orders that apply to the current clinical situation and circumstances.

5.2 Check resident’s health record for any specific wishes or preferred care outlined in the Advance Care Plan that can be applied to the resident’s current clinical situation and circumstances.

5.3 Phone the resident’s GP or locum service, residential-in-reach team physician or local public hospital Emergency Department Admitting Officer for medical advice to support decisions as necessary if no orders in place to support resident’s care appropriately.

5.4 Communicate to any medical practitioner (including locums) or paramedic the wishes of the resident per any pre-existing documented Advance Care Directive signed by the resident or intent to follow agreed action per any Advance Care Plan signed by the SDM on behalf of the resident.

5.5 Check file for the legal SDM and telephone to advise of the emerging situation, any medical advice or orders received and applicability of the terms of the ACP with intent to follow if relevant and applicable.

5.6 If transfer of the resident to a hospital is necessary, copy ACP documents signed by the resident/SDM and ensure these are sent with the transfer form (insert MR name/#).
5.7 Where Trajectory C is confirmed discuss the resident’s trajectory with the SDM and nominated family to allow preparation for resident’s death and provide the Palliative Approach Toolkit 9) EOL Care Pathway information brochure “Understanding the Dying Process”.

6. Resident returns from non-elective hospitalisation following an acute deterioration in health OR New medical diagnosis of life-limiting illness OR Resident requests limitation of medical treatment

Key expected outcomes:
- Liaison with GP
- Conduct a non-scheduled Advance Care Plan Review with resident / SDM
- Facilitate a Refusal of Treatment Certificate where appropriate

6.1 Senior nurse-led liaison with GP is conducted to review:
- resident’s hospital discharge summary
- significant change in health and medical treatment plan for new condition / diagnosis
- reassessment of resident’s estimated prognosis and palliative approach trajectory

6.2 Any of these events is to trigger an unscheduled discussion with review of Advance Care Plan with resident/SDM. A new or update to pre-existing Advance Care Planning documents may be necessary including complete re-write on new form for clarity if significant changes from previous wishes expressed by resident/SDM.

6.3 Where a competent resident or the agent of a non-competent resident wishes to refuse specific treatment or treatment in general to ensure that the resident’s wishes are documented in the strongest possible terms and/or in a legally binding manner, information about the Refusal of Treatment Certificate is to be supplied. The OPA Factsheet Refusal of Medical Treatment is to be provided and the GP informed so that an appointment can be arranged for follow up to facilitate discussion and if appropriate completion of form (insert MR name/#) (see Appendix - Forms).

5. RELATED POLICIES/GUIDELINES

Insert name of relevant policy / procedure documents for cross reference e.g. Palliative Care Procedures Assessment and Care Planning Policy, Choice and Decision Making Policy. These should be reviewed to cross reference to Advance Care Planning Policy where applicable.

6. QUALITY ASSURANCE / KEY PERFORMANCE INDICATOR

The following measures of performance will be evaluated by audit of every resident’s file after death and reports of performance fed back to staff on a minimum bi-annual basis for review of practice and continuous quality improvement of processes.

1) Every resident / SDM will be offered an opportunity to discuss resident preferences and goals for care through the palliative approach case conference process and have these communicated to the aged care team in a clearly documented format.

2) The resident’s documented wishes and preferences for medical treatment and comfort care will be respected and followed at EOL.

Disclaimer: This document is intended as an educational sample of an ACP Policy and Procedure suitable for use in an aged care facility.
7. REFERENCES


   1. *Medical Treatment Act 1988 (Victoria)*
   2. *Guardianship and Administration Act 1986 (Victoria)*

8) National Health and Medical Research Council’s Guidelines for a Palliative Approach in Residential Aged Care (May 2006)


10) Standards and Guidelines for Residential Aged Care Services Manual (See Appendix 4 for most relevant)
Appendix 1

Person Responsible List

The adult responsible (as defined in the Guardianship & Administration Act 1986 Victoria) for the health care decisions (consenting or withholding consent to medical treatment) of a patient (resident) who has lost the capacity to make their own health care decisions. The ‘Person Responsible’ means the first person on the list below in order of hierarchy, who in the circumstances is available and willing and able to make a medical or dental treatment decision on behalf of the patient (resident).

1. An agent - appointed by the patient under Enduring Power of Attorney (Medical Treatment)
2. A person - appointed by VCAT to make decisions about the proposed treatment
3. A Guardian - appointed by VCAT with health care powers
4. An Enduring Guardian - appointed by the patient with health care powers
5. A person - appointed by the patient in writing to make decisions about medical and dental treatment including the proposed treatment
6. The patient’s spouse or domestic partner with whom the patient has a close and continuing relationship
7. The patient’s primary carer, including carers in receipt of a Centrelink Carer’s payment but excluding paid carers or service providers
8. The patient’s nearest relative over the age of 18, which means (in order of preference):
   a. Son or daughter
   b. Father or mother
   c. Brother or sister (including adopted persons and ‘step’ relationships)
   d. Grandfather or grandmother
   e. Grandson or granddaughter
   f. Uncle or aunt
   g. Nephew or niece

Note: Where there are two relatives in the same position (for example, a brother & sister) the elder will be the person responsible
Appendix 2 Facilitating resident completion of an (EPOA Medical Treatment)
Enduring Power of Attorney (Medical Treatment) of Schedule 2 Section 5A (2) of the Medical Treatment Act 1988.

Three parties must be present at the same time to sign the document.
1) The donor of the power (your resident)
2) One ordinary witness - does not require any particular qualification under the law and can be any competent adult who is confident to witness that the donor of the power is of sound mind but excludes the agent or alternate agent who cannot witness their own appointment. At RACF Name this is only to be a senior nurse
3) One authorised witness who can by law take statutory declarations and who is prepared to affirm the capacity of the donor to appoint a Medical Power of Attorney. A patient’s regular GP is ideally placed to be the authorised witness given that the ongoing therapeutic relationship places the doctor in a unique position to identify any problems relating to their patient’s ability to understand, retain and process information relevant to this decision. At RACF Name the authorised witness is to be the resident’s GP.

What it means to witness that a resident has the capacity to appoint a Medical EPOA

When you sign as a witness, you are confirming that your resident is of sound mind and understands the importance of the document at the time of signing it. You are witnessing they are mentally capable of choosing and appointing a person to be their medical agent and they understand the general nature and effect of the power they are donating to them. They should be able to tell you things like:

1. What sort of power the medical agent will have
2. What sort of decisions the medical agent will have the authority to make
3. When the medical agent will have the authority to exercise that power
4. The effects the medical agent’s decision could have on them
5. How they may cancel or change the arrangement in the future

The following questions provide a guide to checking on the capacity of a resident to appoint an agent:

<table>
<thead>
<tr>
<th>Question</th>
<th>Expected Answer (in general terms)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who are you appointing as your Medical Enduring Power of Attorney?</td>
<td>The name of the agent and the alternate “back up” agent if appointing one.</td>
</tr>
<tr>
<td>What sort of powers are you giving to them?</td>
<td>The power to make decisions about my medical treatment.</td>
</tr>
<tr>
<td>What type of medical decisions will they be able to make?</td>
<td>To decide whether to agree to treatment or refuse treatment on my behalf.</td>
</tr>
<tr>
<td>What is the most serious thing that could happen if they decide to refuse medical treatment?</td>
<td>I could die / pass away.</td>
</tr>
<tr>
<td>When will they be able to make these decisions?</td>
<td>Only when I can’t make my own decisions.</td>
</tr>
<tr>
<td>If you want to change or cancel your Medical Power of Attorney, what do you need to do?</td>
<td>I need to tell my agent and others with copies that I’m cancelling it and ask them to destroy the document. I can cancel it in writing too. If I make a new appointment that will automatically cancel any previous versions.</td>
</tr>
</tbody>
</table>

It is useful for the GP to record a note in the resident’s medical file that there were no concerns about their patient’s capacity to understand the general nature and effect of signing the document (in case this is ever brought into question in the future)
Appendix 3  RACF can insert ACP Forms and Templates e.g. Invitation and Family Questionnaire (see below), Refusal of Treatment Certificate, Medical EPOA, Advance Care Plan/Directive

**Invitation and family questionnaire**

**Palliative care case conference**

**Important information**

A palliative care case conference has been organised for:

- **Resident's name:**
- **Date:**
- **Time:**
- **Location:**

Your facility contact for this case conference is:

- **Staff member's name:**
- **Telephone:**

Please read through this brochure. It answers some frequently asked questions about palliative care and specifically palliative care case conferences.

It also provides a section for you to write down any questions or issues you wish to have addressed at the case conference.
REFUSAL OF TREATMENT CERTIFICATE
COMPETENT PERSON

SCHEDULE 1
Medical Treatment Act 1988
Sections 3, 5 (2)

We certify that we are satisfied -

(a) that ................................................................. (name or patient)
   has clearly expressed or indicated a decision, in relation to a current condition, to refuse -
   ★ medical treatment generally;
   or
   ★ medical treatment, being .................................................................
   .................................................................
   .................................................................
   .................................................................
   .................................................................
   .................................................................
   .................................................................
   (specify particular kind of medical treatment)
(b) that the patient’s decision is made voluntarily and without inducement or compulsion;
(c) that the patient has been informed about the nature of his/her current condition to an extent which
   is reasonably sufficient to enable him/her to make a decision about whether or not to refuse
   medical treatment generally or of a particular kind (as the case requires) and that he/she has
   appeared to understand that information; and
(d) that the patient is of sound mind and has attained the age of 18 years.

Signed................................................................. Print Name: ..............................................Dated:.............
(Registered Medical Practitioner)

Signed................................................................. Print Name: ..............................................Dated:.............
(Another Person)

Patient's current condition

The patient's current condition is .................................................................

.................................................................

.................................................................

( describe condition)

Signed................................................................. Print Name: ..............................................Dated:.............
(to be signed by the same registered medical practitioner)

Continued over page
Appendix 4  Key guidelines specifically relevant to Advance Care Planning extracted from the Standards and Guidelines for Residential Aged Care Services Manual

3.9 Choice and Decision-Making

Preamble

Each resident’s wishes and preferences in relation to their lifestyle are important and must be considered when planning and providing services. Residents should be encouraged to participate in decisions about the services they receive.

The exercise of choice requires a partnership between residents, management and staff, in which choices can be negotiated and agreed.

In communal living arrangements it may be necessary for residents to be assisted to have more control over their lives. Residents and their representatives should be provided with information about the availability of assistance from advocacy services. Management styles and practices should encourage residents to exercise control over their lives.

Expected Outcome

Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

- Residents are encouraged to discuss and communicate their views
- Procedures for consulting with residents and assessing and documenting their needs and preferences
- Residents or their representatives informed, in a language they understand, of the implications of refusing treatment
- Documentation reflects a resident's decision to refuse treatment
- Procedures to ensure each resident’s wishes are respected
- Staff education and training cover issues relating to assessing and documenting residents' needs and preferences.

3.8 Cultural and Spiritual Life

Expected Outcome

Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.

Preamble

Cultural and linguistic diversity should be recognised, respected, fostered and valued in policies and practices relating to all aspects of the service. Staff of the service should be aware of the cultural and linguistic background of each resident. Staff development activities should include cross cultural awareness and communication, as appropriate.

Disclaimer: This document is intended as an educational sample of an ACP Policy and Procedure suitable for use in an aged care facility.
Considerations

- Identification and documentation of each resident's cultural, linguistic and spiritual needs, on admission
- Information on relevant linguistic, religious and cultural issues recorded and acted upon in care planning and delivery
- Identification and documentation of each resident's cultural, linguistic and spiritual needs, on admission
- Information on relevant linguistic, religious and cultural issues recorded and acted upon in care planning and delivery

3.6 Privacy and Dignity

Expected Outcome

Each resident's right to privacy, dignity and confidentiality is recognised and respected.

Preamble

This Expected Outcome addresses the issues of a resident's right to be treated with dignity and privacy and that information regarding their care and personal details is kept confidential. Professional relationships between residents and staff are enhanced by respecting each person's right to dignity and privacy.

Considerations

- Procedures to support residents' right to die with dignity
- Resident care plan identifies the resident's wishes in respect to cultural, religious and other aspects of their terminal care
- Fostering professional relationships between staff and residents and their families or their representatives

3.5 Independence

Expected Outcome

Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

Preamble

This Expected Outcome is concerned with autonomy and the encouragement and support necessary for residents' reasonable expectations of self-determination and individuality within a residential setting.

Education and staff development programs should include issues such as the impact of cultural stereotypes, the risk of staff directing residents' options, and the effect of residents' beliefs about appropriate roles and behaviour relating to social independence.

Staff should actively work to overcome any loss of independence arising from inappropriate acceptance of control by other people (staff or families) or withdrawal from social participation.
Considerations

• Regular consultation with each resident or their representative to ensure staff are fully aware of their interests and preferences.

• A system to ensure that outcomes of regular consultation are acted upon and documented

• Residents encouraged to express their individual cultural identity, including language and religion

• Open, reciprocal relations between residents or their representatives and management and staff of the service

• Residents encouraged to exercise their rights in ways that do not impinge on the rights of others.

• Provision of care services that support residents' autonomy and participation in activities

3.4 Emotional Support

Expected Outcome

Each resident receives support in adjusting to life in the new environment and on an ongoing basis.

Preamble

The lifestyle of communal living provided by the service will, in general, differ from the lifestyle the resident has experienced in their own home. This Expected Outcome addresses the need for the service to assist the resident and their family to adjust to the new environment as well as the person's changed circumstances.

Considerations

• Resident information prior to admission, if possible, about the new environment, the services that are available, residents' rights and responsibilities

• Procedures for assessing, documenting and reviewing each resident's needs including linguistic, cultural and spiritual needs

• Resident care plan details each resident's special needs

• Regular review of the special care needs of residents

• A system to ensure evaluation outcomes are acted upon and documented

2.9 Palliative Care

Expected Outcome

The comfort and dignity of terminally ill residents is maintained.

Preamble

All residents have the right to die with dignity and the needs of the terminally ill resident should be clearly documented in their individual care plan. When discussing the terminal care of residents, the service should consider the philosophy of the organisation and the requests made by the resident or their family. The service
should consider the various forms of palliative care (for example, pain management, conservative medical treatment, spiritual and emotional care). Specialist support may be available from local hospitals and hospices. A range of written material is also available relating to palliative care.

**Considerations**

- Requirements of Commonwealth and State legislation relating to palliative care
- The organisation’s philosophy regarding the terminal care of residents
- Staff awareness of the individual religious and cultural beliefs of each resident
- Documented consultation between residents, their representatives and relevant members of the health care team
- Identification and documentation of residents' wishes
- Resources available to staff to assist in meeting the needs and wishes of terminally ill residents
- Procedures for planning individual palliative care programs
- Programs address the cultural and religious beliefs of residents
- Programs encourage the involvement of relatives and friends in the care of terminally ill residents
- Information for residents, relatives and staff regarding support services available.

### 2.5 Specialised Nursing Care Needs

**Expected Outcome**

Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.

**Preamble**

This Expected Outcome addresses the specialised nursing care needs of residents.

**Considerations**

- Procedures for assessment, documentation, treatment and review of each resident's specialised nursing care needs (for example, the nursing process)
- Appropriately qualified staff perform these procedures
- Consultation with each resident or their representative in developing and reviewing the care plan
- Each resident’s choices regarding treatment and their right to refuse treatment is respected
- Residents’ care reflects consultation