

Tips for Nurses: Advance Care Planning



What it is: Advance care planning (ACP) is where a person plans for their future care by discussing and/or recording their preferences and values. An Advanced Care Directive (ACD) is a written advance care plan. In different states and territories of Australia an ACD may have a different name. An ACD may include care preferences and values, and instructions about future treatment. What can be included and the forms to be used depends on the relevant state or territory law.

An older person can name someone to make decisions for them about health and personal care if later they are unable to. This person is called a substitute decision-maker (SDM). Some states and territories include this in an ACD.

An ACD is sometimes known as a living will because it is completed and signed by a competent adult and records their preferences for the future.

Why it matters: Advance care planning helps people receive the care that they would wish to receive. Nurses have a role in ensuring ACDs are referred to when planning care. It is particularly important for an older person who may:

- have advanced illness
- have multiple chronic illnesses
- be frail
- have cognitive impairment or live with dementia
- have unplanned admission(s) to hospital
- lose the capacity to make decisions or express their wishes.

What I need to know: It is not compulsory to have an ACD. ACDs only go into effect when a person is unable to make decisions for themselves. They do not replace the SDM.

A person may choose to forgo treatment. This is not giving up nor does it mean that care will stop. It means the focus of care will be on comfort, dignity and the support of the person and their family and carer(s).

Actions

ACDs can be changed whenever the person wants and should be reviewed when circumstances change. “We had a conversation where we decided on A, B and C, is that still current and what you want? If so, are you happy to record these changes so that they can be referred to if you cannot express your wishes?”

An assessment of capacity may be needed. This should occur at a time of day when the person is most likely to understand and when they are free of pain or other distressing symptoms. This assessment is usually made by the person’s GP.

A person is considered competent or to have competency or have capacity if they can:

- understand the information
- retain information long enough to indicate their wishes, and
- express their wishes.

Remember to:

- store ACDs safely
- have ACDs accessible to staff who make decisions about care
- have ACDs accessible to visiting service providers including GPs
- make sure that a current ACD accompanies the older person moving to or from hospital or residential aged care.

Have clearly documented and accessible the contact details of the substitute decision-maker and person to contact in case of an emergency or death. These may not be the same person. Be clear about who you should contact.

Tools

Tools that may be useful include:

Visit Advance Care Planning Australia for state and territory forms and information on requirements.

Name:

My reflections:

How many of the older people I care for have an ACD? Where are they kept, and have I read them?

When should I implement an ACD?

What is the ACD legislation in my state/territory?

Have I thought about advance care planning for myself or my family?

My notes:

See related palliAGED Practice
Tip Sheets:
After-Death Choices
Palliative Care
Talking about Dying

For references and the latest version of all the Tip Sheets visit
www.palliaged.com.au/PracticeTipSheets