Advance Care Planning Screening Interview – Substituted Approach version

This version of the Advance Care Planning (ACP) Screening Interview tool can be used to introduce ACP to a family member or Substitute Decision Maker when the resident/client/patient does not have capacity to make healthcare decisions (e.g. due to advanced dementia).

Knowing whether or not a person has capacity to make decisions is not always clear. Generally, when a person does not have capacity to make a particular decision they cannot:

- Understand and appreciate the facts and choices involved
- Weigh up the consequences
- Communicate the decision

A person's ability to make decisions may also fluctuate over time depending on their health or stress levels. **People should be supported to make their own healthcare decisions as much as possible**. When this is not possible, it is then appropriate to discuss ACP with the appropriate Substitute Decision Maker(s). There is another version of this Advance Care Planning Screening Interview tool that can be used to initiate ACP discussions with a person who needs support to take part in the discussion due to early or moderate dementia.

Notes for Interviewer

Suggested introduction

"As part of our routine care, we ask all families about the conversations they have had with their relative about their future health wishes. Are you OK to talk with me about this for about 10 minutes?"

OR

"In the next 10 minutes or so, could I ask you a few questions about the conversations you have had with your relative about their future health care wishes?"

Consider adding: "Your answers will give me useful information about your relative's needs and wishes and the best way to care for them and support you as well (with Advance Care Planning)".

What is Advance Care Planning?

Advance Care Planning is a process that helps to plan for a person's future health care. This process involves thinking about the person's values, beliefs and wishes about health and medical care if they became more unwell. It is a way to make sure that the person's wishes and values are taken into account when planning their care. As part of this process, we may choose to write an Advance Care Plan that records what is known about your relative's specific wishes in relation to their health care. **It is important to revisit Advance Care Planning regularly as the person's wishes or health situation changes.**

Instructions for use

The numbered questions written in bold are questions for the interviewer to ask the resident/client/patient's relative and record the response. There are prompts and notes for the interviewer with some requiring a written response. On page 4, there is space to write additional notes about what is known about the resident/client/patient's wishes or priorities, and the families concerns that come up during the interview.

For further information about Advance Care Planning, and substitute decision making legislation relevant in your state please refer to:

Advance Care Planning Australia http://advancecareplanning.org.au

End of Life Law for Clinicians in Australia https://end-of-life.qut.edu.au/treatment-decisions/adults/state-and-territory-laws

Modified by the Advance Project Team from Cheang F et al. Internal Medicine Journal 2014; 44: 967-974

Resident/Client/Patient's Name: **Date of entry:**

Name of family member(s) or close friend consulted for this initial discussion and their relationship to the resident/client/patient:

1. **Has your relative ever signed a legal document to appoint someone to make health or medical decisions on their behalf?** ☐ Yes ☐ No

   Note:
   - There are different terms for this in each state/territory
   - This is different to appointing someone to make money or finance decisions

   If so, is a copy of the documentation available in the resident/client/patient's records? ☐ Yes ☐ No ☐ N/A

   If so, is this person's contact details listed above or in the resident/client/patient's records? ☐ Yes ☐ No ☐ N/A

2. **If answer to question 1 is 'No': Have there been previous discussions about who would be making the medical decisions if your relative was too unwell to speak for themself? If so, who?**

   ☐ Spouse
   ☐ Family/friend carer
   ☐ Relative
   ☐ Friend
   ☐ Not sure
   ☐ No-one identified

   Note – There is a hierarchy of who should be consulted for medical decision making in each state/territory when the person no longer has capacity to make their own decisions. Specific state/territory information is available at End of Life Law for Clinicians *or* Advance Care Planning Australia

   Is the Substitute Decision Maker's name and contact details listed below or clearly recorded in the resident/client/patient's records? ☐ Yes ☐ No ☐ N/A

   Substitute Decision Maker's Name:

   First contact number: Second contact number:

3. **Has your relative ever spoken to you about their wishes, values and beliefs about medical treatment and care in case they become more unwell?** ☐ Yes ☐ No

4. **Has your relative spoken to other family members or their doctor or other health professional about this? If so, with whom?**

5. **Has your relative ever written down their wishes, values and beliefs about medical treatment and care in case they became seriously ill and unable to make their own decisions?** ☐ Yes ☐ No

   If so, in what type of document?

   Is a copy available in the resident/client/patient's record? ☐ Yes ☐ No ☐ N/A

   When was it last updated or completed by the resident/client/patient? (check the most recent version signed by the resident/client/patient is available) **Date:**

Resident/Client/Patient's Name: **Date of entry:**

6. **Have you previously heard of Advance Care Planning?** ☐ Yes ☐ No

   Explain to the family member about Advance Care Planning using the script on page 1 as necessary.

7. **Would you be comfortable to have a meeting with a member of the team to further discuss Advance Care Planning for your relative?** ☐ Yes ☐ No

8. **Which family members or other people (e.g. spiritual/community leader or close friend) would be important to involve in the Advance Care Planning discussion?**
   (list names and relationships below)

   Arrange family meeting to further discuss Advance Care Planning as appropriate.

9. **Is there anything you think would be important for the team to know about** your relative's **wishes or priorities when it comes to their health care?**
   (record details here or on the next page if more space is required) ☐ Yes ☐ No

   Emphasise that you are asking the relative to reflect on what the person (who no longer has capacity) would have wanted rather than what the family member would want.

10. **Are there any questions or concerns that you would like to talk about at the Advance Care Planning discussion? (or prompt relative to write down their questions and bring them to the meeting)**
    (record details here or on the next page if more space is required) ☐ Yes ☐ No

    *If appropriate, provide the relative with a copy of the Advance Project **"Planning for"** guide to take home and consider, and also discuss with other family members prior to the family meeting to further discuss Advance Care Planning.*

11. Please rate your level of comfort with our conversation today.

- ☐ Very comfortable
- ☐ Somewhat comfortable
- ☐ Uncomfortable

Notes about the resident/client/patient's wishes or priorities about their future health care:

Notes about the family's questions or concerns they would like to discuss at the Advance Care Planning meeting:

Time taken to complete the interview *(minutes)* ☐

Interview completed by: ☐

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