Quick guide to introducing Advance Care Planning – Own or Supported Approach version

This version of the quick guide can be used to introduce Advance Care Planning (ACP) with a person who may need support to take part in the ACP discussion due to early or moderate 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 quick guide that can be used to initiate ACP discussions with the Substitute Decision Maker when the person themselves can no longer make their own health care decisions (e.g. due to advanced dementia).

Suggested introduction

"As part of our routine care, we ask everyone 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 your future health wishes?"

Consider adding: "Your answers will give me useful information about your needs and wishes and allow me to work out the best way to help care for you"

Purpose of the question	Suggested questions to ask the resident/client/patient	Prompts for the health professional
Determine the person's preferred Substitute Decision Maker	Have you thought about who you would like to make medical decisions for you if you became too unwell to speak for yourself? If so, who?	• Record persons' preferred Substitute Decision Maker(s), their relationship to the person and their contact details in resident/client/patient record
Determine if the person has a legally appointed Substitute Decision Maker	Have you ever signed a legal document to appoint someone to make health decisions on your behalf if you were unable to?	• If so, request copy of document for the client/resident/patient's record • Ensure contact details for the appointed person are recorded in the resident/client/patient record as above • It is important to encourage the person to legally appoint their preferred Substitute Decision Maker (SDM) if they still have capacity to do so, especially if their preferred SDM is someone who might not automatically be consulted according to the hierarchy in your state/territory. • Consider providing a copy of the Advance Project resource **"Who will speak for you if you can't speak for yourself"**

Purpose of the question	Suggested questions to ask the resident/client/patient	Prompts for the health professional
Determine the person's previous involvement in Advance Care Planning	Have you talked to *(name of preferred Substitute Decision Maker)* or other family or friends about your wishes for medical treatment and care in case you become seriously ill or unable to make your own decisions? • Have you spoken to a doctor about this? • Have you ever written down your wishes?	If written down: • In what type of document? • When was it last reviewed? • Check the most recent version is available in the client/resident/patient's record • Request copy of the most recent version of the document for the client/resident/patient's record, if not already provided
Determine the person's understanding of Advance Care Planning and provide information as needed	Have you heard of Advance Care Planning? Would you like to know more?	• Explain what ACP is and how it might help (see definition below)
Determine the person's readiness to discuss Advance Care Planning	Would you be comfortable to have a meeting with a member of our team to **further** discuss Advance Care Planning?	If Yes: • Which family members (or other people) would you like to be there to support you during the Advance Care Planning discussion? If No: • Would you be comfortable for a member of our team to have a meeting with *(name of person's preferred Substitute Decision Maker)* to discuss your future care?
Explore the person's wishes or priorities for future care.	Is there anything you would like our team to know about your wishes or priorities for health care now or in the future?	• Summarise key points and reflect back to the person to make sure you have understood • Write summary in resident/client/patient's record
Explore the person's questions or concerns they would like to discuss at the Advance Care Planning discussion	Do you have any questions or concerns that you would like to talk about at the Advance Care Planning discussion?	• Summarise key points and reflect back to the person to make sure you have understood their questions/concerns • Write summary in client/resident/patient's record • Prompt the person and their family to write down their questions and bring them to the ACP meeting

Next steps:

- Arrange further follow up meeting to discuss ACP as appropriate
- If appropriate, provide the resident/client/patient with a copy of the Advance Project **"Planning together"** guide to talk about and possibly complete with their preferred Substitute Decision Maker and/or support person(s) prior to the follow up meeting

Definitions and further information

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 helping the person to think about their values, beliefs and wishes about the health and medical care they would want if they became more unwell or unable to make decisions for themselves. 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 Advance Care Planning, you may choose to write down your wishes to help guide others who may need to make decisions for you in the future.

For further information about Advance Care Planning, and substitute (or surrogate) decision making legislation and the appointment of formal legal medical enduring guardians (or equivalent) in your state please refer to:

Advance Care Planning Australia advancecareplanning.org.au

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