Advance Care Planning Guidelines
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Gippsland Region Palliative Care Consortium
Clinical Practice Group

Title
Advance Care Planning Guidelines

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Person-centred, decision making, end of life, conversations planning, and clients’ outcomes.

Ratified
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Purpose
The intent of this document is to assist health services and clinical staff across the Gippsland region to facilitate End of Life Care discussions and development of an Advance Care Planning for clients nearing end of life.

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Pages
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1. **Background**

Death is part of life and living, but the “management of death and dying” has had a direct impact on the way in which society communicates, or avoids communicating about, end of life care. The advance care planning strategy for Victorian health services 2014–2018 was developed following extensive consultation across the health sector, including primary, secondary and tertiary healthcare providers, representatives from professional colleges and organisations, peak bodies, aged care and private health providers. This strategy aims to ensure all Victorians accessing health services will have opportunities to express their preferences for future treatment and end of life care, through advance care planning.

People need to be supported to develop an advance care plan that will guide medical treatment and care if they become unable to communicate their wishes, values, beliefs and preferences or participate in decision making.

2. **Purpose of these guidelines**

The purpose of advance care planning guidelines is to support clinical staff to “have the conversation” with clients and caregivers about end of life decision making, engage clients and their families in decisions about their care and help them to undertake advance care planning. These guidelines aim at assisting health services in the Gippsland region to:

- develop and structure their own policies and procedures regarding introduction and progression of advance care planning;
- adapt and customise these guidelines to cater for their individual clinical needs and context of practice; and
- ensure effective initiation of advance care planning process and conversations that promotes clients and caregivers informed decision-making.

3. **Context of practice and target population**

This guideline applies to all interdisciplinary clinical staff, including general practitioners, who deliver palliative care in any of the subregional health services, including residential aged care facilities, in Gippsland.

4. **The objectives of these guidelines are to**:

- encourage clinical staff to engage in advance care planning conversations with clients when the client is stable and thinking clearly;
- facilitate a process of planning for the future health, treatment and care whereby a person’s values, beliefs and preferences are made known; and

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3. *Ibid*, page 1
• guide clinical decision making at future time when that person cannot make or communicate their decisions due to lack of capacity.⁴

4.1 Intended benefits of these guidelines

The advance care planning process can involve writing an advance care plan that contains the client’s clearly expressed values and preferences. An advance care plan can also be used by clinical staff and doctors to inform decision making when the client becomes too unwell to participate directly.

Advance care planning places the client at the centre of care, involving them, their substitute decision maker, their family (if appropriate), carers and their doctors in medical and personal care decisions⁵.

Advance care planning is relevant to everyone but is particularly important for key groups. The advance care planning; have the conversation: A strategy for Victorian Health Services 2014-2018 focuses on priority groups of people who would benefit from support to articulate their wishes for future treatment and care. These include:

• aged or older people who are frail;
• people of any age with chronic progressive and life-limiting conditions;
• people approaching end of life;
• people with multiple comorbidities and/or at risk of conditions such as stroke or heart failure; and
• people with early onset of cognitive impairment⁶.

5. The importance of advance care planning for health services

The introduction of advance care planning as part of usual clinical practice is important because health services are responding to a range of changing needs and demands that include:

• delivering person-centred care; and
• caring for an ageing population.

The advance care planning process can take place at any stage of an adult person’s life and can result in:

• expression of values and preferences for treatment and care;
• completion of Refusal of Treatment Certificate; and
• appointment of a substitute decision maker.

Some suggested times to talk to clients about advance care planning, particularly in the palliative setting, are:

• when a client is making a will that may include Medical Enduring Power of Attorney;
• when the client’s illness enters a new advancing phase;

⁴ Ibid, page 11

⁵ Advanced care planning; have the conversation: A resource for doctors. Department of Health Victoria 2014, page 6.

⁶ Advanced care planning; have the conversation: A resource for doctors. Department of Health Victoria 2014, page 12.
• when the client is isolated and/or vulnerable; and
• when a client has differing opinions, values or beliefs to their carer and/or family members.

6. Summary

Advance care planning has benefits for the person and their family, the health professional and the broader health system. These include:

• supporting better client outcomes;
• assisting clinicians to provide person-centred care; and
• optimising the use of health resources.

It would be unreasonable to expect people to understand the full implications of a medical decision, even those with an advancing and progressive illness, under all potential and possible scenarios. Advance care planning that contains clearly articulated values and life philosophies will help clinicians to avoid ambiguity and substitute decision makers to make decisions in the person’s best interest.7

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Appendix 1: **Guideline: Advance Care Planning**

### 1.0 POLICY STATEMENT

All clients at XXX Palliative Care Service are offered support and guidance to complete an ACP during the admission process and through the episode of care. This clinical approach is supported by an evidence based and quality framework to accurately reflect clients’ values and expressed wishes about future health care and medical decisions.

### STRATEGIC DIRECTION

**Strengthening Palliative Care: policy and strategic directions 2016**

Strategic direction 1: Informing and involving clients and carers

“Actively involve clients and carers in the planning and delivery of their care”

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This policy and procedure is to be read in conjunction with:

- Advance Care Planning Assignment;
- Care planning;
- Use of interpreters; and
- Guidelines for Deactivation of Implantable Cardioverter Defibrillators at End of Life.

**This policy and procedure contains:**

- ACP Procedure
- ACP Person Responsible - **appendix 1**

### 2.0 EXPECTED OUTCOMES

- Clients and carers are supported to complete an advance care plan that clearly documents their wishes and preferences in relation to future medical treatment.
- XXXX has an effective ACP system and process in place to enable ACP planning documentation.
- ACP planning and development:
  - is conducted in partnership with clients, families and carers;
  - is timely documented and updated by XXXX clinical staff in the client’s electronic clinical record; and
  - is incorporated into the client’s care plan followed by appropriate filing of ACP hard copies record.
- When a client is identified as lacking capacity for medical decision making, it is the clinician’s responsibility to ensure this is clearly documented in the client’s ACP notes together with the name of the substitute decision making.

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(accessed March 2016)
• Clinical staff understands the legal implications of each component of the client’s ACP.

3.0 DEFINITIONS

1. **Advance Care Plan (ACP)** is the process of planning for future health and personal care whereby a person’s values, beliefs and preferences are made known so they can guide clinical decision-making at a future time when the person cannot make or communicate their decisions due to lack of capacity. The ACP mainly consists of:
   a. appointment of a substitute decision maker ([when the person loses decision making capacity]);
   b. written record of the person’s preferences or instructions for future health care and end of life; and/or
   c. written Advance Care Directive and/or Refusal of Treatment Certificate.

2. **Advance Care Directive (ACD)** is one way of formally recording an advance care plan. ACD is a type of written ACP recognised by common law or authorised by legislation that is completed and signed by a competent adult. An ACD can record the person’s preferences for future care and appoint a substitute decision maker to make decisions about health care and personal life management.

3. **Adult Patient** a person 18 years or older

4. **Medical Enduring Power of Attorney (MEPOA)** is a legal document that appoints another person (agent) to make decisions about a person’s medical treatment. The appointment begins if and when the person is unable to make decisions about their medical treatment. The agent should be someone who will closely and objectively follow the decisions the client has made about their treatment.

5. **Substitute decision maker (SDM)** is a general term for a person that is either appointed or identified to make care decisions on behalf of a person whose decision-making capability is impaired. Depending on the situation a SDM maker may be either:
   a. formally appointed by the person under the Medical Treatment Act in which case they would be referred to as agent under an enduring power of attorney (medical treatment) sometimes referred to as medical enduring power of attorney (MEPOA). Appointing an enduring power of attorney for medical treatment is a highly recommended option through the process of developing an advance care plan;
   b. appointed by the person under the Guardianship and Administration Act 1986, in which case they are a guardian; and

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9 Advance care planning; have the conversation. A strategy for Victorian health services; Department of Health 2014-2018
10 National Consensus Statement: essential elements for safe and high-quality end-of-life Care. Australian Commission on Safety and Quality in Health Care, page 32-32
11 Advance care planning; have the conversation. A strategy for Victorian health services; Department of Health 2014-2018 page 56-58
c. appointed by the competent person under the Guardianship and Administration Act 1986, in which case they will be referred to as an enduring guardian.

6. Agent the agent may be temporary or permanent and must be 18 years of age or over and be mentally competent to make decisions.

7. Statement of Choices is a document that stipulates the person’s agent (if appointed), family and doctor of their medical treatment and wishes to facilitate decision-making when the person is no longer able to do so. Statement of Choices is not a legally binding document.

8. Refusal of Treatment Certificate is a document that enables the person to state legally binding instructions regarding the treatment they DO NOT want to have for their current medical condition. This document becomes in force when the person is unable to make decisions for himself/herself.

9. Not for Resuscitation are orders designed to prevent the use of cardiopulmonary resuscitation (CPR) in situations when it is deemed futile or unwanted. The term CPR refers to a range of resuscitative efforts, including basic and advanced cardiac life support to reverse a cardiac pulmonary arrest.

10. Statutory Advanced Care Directive one authorised by Victorian legislation. In Victoria, this includes appointment of an Enduring Power of Attorney – Medical Treatment and/or completion of a Refusal of Treatment Certificate.

Definition of family

- The closest to the person in knowledge, care and affection. This may include the immediate biological family, the family of acquisition (related by marriage/domestic partnership); and the family of choice and friends (not related biologically or by marriage/domestic partnership).

In Aboriginal and Torres Strait Islander communities, kinship connections extend beyond family to community and carry specific roles and responsibilities.

Definition of decision making capacity also referred to as legal capacity

- A person is assumed to have decision-making capacity unless there is evidence to indicate it is in doubt. Assessment of capacity should take place as close as possible to the time at which the decision is required. A person with capacity should:
  - know the decision facing them;
  - know the possible options;
  - know the reasonably foreseeable outcomes of the options available;

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12 Ibid page 56
14 Palliative Care Australia. Palliative care; glossary of terms. Canberra: Palliative Care Australia, 2008.
- provide a rationale for decisions they have made and therefore demonstrate ability to weigh the information, balance the risks and make a choice; and
- be offered practicable and appropriate support to enhance their ability to make their own decisions.

- Diminished or absence of decision making capacity may be temporary, **a person should always be presumed to have decision making capacity unless there is evidence to the contrary**
- Assumptions about a person’s capacity to make decisions should not be made on the basis of their appearance or because they have a made a decision that is considered unwise
- Loss of permanent capacity is the trigger to act on an advance care plan (if the person has capacity they will participate in decision making directly).

- **The Guardianship and Administration Act 1986**, states that a person:
  - does not have the legal capacity to consent to medical and dental treatment if they are:
    - ‘incapable of understanding the general nature and effect of the proposed procedure or treatment’
    - Or
    - ‘incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment’

**Primary attributes of ACP**

- Is person directed
- Provides opportunities to inform and educate patients, caregivers and family about their illness/es, including prognosis and likely outcomes of alternative care and treatment plans
- Define the key priorities in end-of-life care and offers an structure to capture and address these priorities and associated concerns
- Informs future clinical care to fit the client’s preferences and values.

**Potential Benefits of ACP**

- Help clients find hope and meaning; and
- Strengthen relationships with loved ones.

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General Information

- A culturally appropriate ACP recognises the physical, social, emotional, cultural and spiritual matters important to the individual
- All clients over the age of 18 are eligible to participate in ACP processes and are provided with the relevant ACP information
- ACP is only applicable to medical treatment and only comes into effect if and when a person is unable to make decisions for themselves
- When Clinical staff identify a client wishes to complete an ACP, they must timely refer to the Practice Leader - Psychosocial
- XXX staff are not permitted to witness or sign any sections of the ACP
- Aboriginal and Torres Strait Islander clients who do not have an ACP should be provided with the cultural resource 'Taking control of your Health Journey'.

This guideline aligns with:

Other ACP associated documents

- Enduring Guardianship (GAA 1986)
- A Statement of Choices (SOC)
- Medical Treatment Act 1988

4.0 RESPONSIBILITY

<table>
<thead>
<tr>
<th>Who, where, when and how: nurses, doctors, allied health members of the MDT (context of practice: community, inpatient RACF)</th>
<th>Clinical staff awareness and adherence to the guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant stakeholders Organisation, NP, NPCs, senior clinical staff, nursing and allied health</td>
<td>Capacity building requirements</td>
</tr>
</tbody>
</table>

| Incorporation of guideline into each organisation End of Life Care clinical governance framework |

5.0 RECORDS & DOCUMENTATION

- Initial Assessment
- Care plan
- End of Life Care module
- Progress notes

6.0 PROCEDURE guideline itself
This ACP procedure guides members of the XXX interdisciplinary team in supporting and facilitating clients and families to develop an ACP.

The ACP procedure:

- Reflects integrated interdisciplinary (IDT) clinical practice systems and processes;
- Promotes safe, responsive, effective and seamless care;
- Informs and educates IDT members; and
- Facilitates ACP consistent documentation, tracking and auditing.

**Scope**

This procedure applies to all IDT members

**Roles and responsibilities**

The responsibility for ensuring that this procedure is understood and followed lies with the XXX Clinical Operational Manager.

It is the responsibility of all clinical staff working at XXX to:

- open up ACP discussions from admission;
- adhere to the XXX ACP policy and procedure; and
- seek support and coaching when having difficulties in starting and/or progressing the “difficult conversations”.

Many clients may expect their health care team to initiate such discussions. It is therefore essential that health care professionals are:

- sensitive to circumstances and cues when it may be an appropriate time to offer ACP; and
- able to identify when clients might be indicating their readiness to discuss\(^{\text{17}}\).

It is important to note, there is no recommended time frame to initiate or to progress ACP discussions. These may be ongoing and can take place over several visits.

Intake nurse title of designated organisational role

When a referral is received, the intake nurse:

- Checks referral documents and/or SCTT for evidence of an ACP. If an ACP has been provided with the referral information the intake nurse reviews available ACP information prior clinical staff conducting initial assessment;
- Contacts referrer to enquire whether an ACP exists or whether there is any information available related to advance care planning;
- Requests a certified copy, if an ACP exists, with the referral information, if appropriate attach ACP information to client’s record, hard copy or electronic and opens the end of life plan item/module;
- Highlights any notification relevant to ACP for the staff member conducting the assessment; and
- Ensures any ACP information is then followed through at initial client’s assessment.

ACP Process (refer to the ACP flow chart in appendix 2)

On admission

- If the client already has an ACP clinical staff conducting assessment discuss client’s choices and preferences, updates information and documents ACP components on the client’s record
- If an ACP exists but has not been provided as part of the referral process; the assessor requests a certified signed copy of the ACP (either by the client or by a person who has authority to sign statutory declarations). This copy can be obtained at initial face-to-face contact during the assessment process (or as soon as is appropriate and practicable).

When capacity is identified

- The client is asked whether she/he has an ACP or a MEPOA
  - If a MEPOA already exists, provide a copy of this document (signed by a person responsible for statutory declarations) for scanning on to the client’s medical record
- Discussion is initiated about development of ACP. Development of this discussion is assisted by XXX ACP Client Information Kit that includes:
  - ACP information sheet; and
  - Statement of Choices.
- The staff member facilitating ACP discussions arranges a time with the client and the nominated SDM to continue discussions aimed at completing ACP documentation
- Clinical staff liaise with the XXX departmental managers and/or clinical leaders for assistance and/or coaching on ACP communication skills
• Each team member is expected to follow up/build on introductory and/or previous ACP discussions at the next scheduled visit to determine whether the client wishes to proceed with ACP

• If the client wishes to proceed with ACP development; the staff member promptly completes a referral to clinical leader- psychosocial as soon as this is practicable

• It is recommended that the GP is encouraged to be an active part of the ACP discussion. The GP is expected to review and sign all the relevant documents completed by the patient

• When the ACP is signed and witnessed by the GP or treating medical specialist, update the end of life module on the client’s clinical record and attach the document

• When appropriate refer the client to their general practitioner for discussion and witnessing of the ACP and completion of the RTC if relevant

• Once all ACP documents are completed the client is encouraged to forward a copy to their treating hospital and medical team

• If the client does not wish to proceed with ACP discussions. The clinical staff member documents the decision in the end-of-life module in the client’s electronic record

• End of life care components such as client preferred place for end of life care and site of death must also be documented.

Timing for opening up ACP discussions

• At a minimum, ACP should be considered whenever the health care provider asks himself/herself the surprise question: “would I be surprised if this patient were to die within the next 12 months?”

• Whilst the discussion on ACP must be considered for all clients, there are those clients who are most likely to benefit from opening of the discussion these may include:
  
  o Clients identified as being stable or in the deteriorating phase of their illness
  o Clients who raise concerns about the future
  o Clients who state future preferences for healthcare
  o Clients with no-one or socially isolated
  o Clients with complex family structure and dynamics
  o Clients who are likely to be discharged from the service
  o Clients who may benefit from ACP discussions can also be identified at team meetings and handover activities

Clients with a life limiting or progressive illness known to have agreed to an NFR order during their last hospital admission.

- Clients who are competent can consent to, or refuse, treatment for themselves, or appoint a:
  - Medical Enduring Power of Attorney (agent) to consent or to refuse future treatment
  - Person responsible in writing to consent to treatment

- Clients identified lacking temporary or permanent capacity should still be invited to participate in ACP discussion and medical decision-making to the extent that they are capable.

- If the client is unable to provide ACP information and/or to engage in ACP discussion because of temporary or permanent capacity, information should then be sought from the client’s appointed Person Responsible or family/carer/other health professionals involved in the client’s care.

When unable to assess capacity - it must be noted that: a person is presumed to have decision making capacity unless there is evidence to the contrary:

- Refer the client to the general practitioner or treating specialist for confirmation of capacity
- If it is determined that the client does not have capacity:
  - Introduce, if appropriate, the ACP process to the family and caregiver to determine whether they wish to document a statement of choices for a non-competent patient
  - If family/caregiver agree, organise a meeting to discuss and complete the client’s non competent statement of choices.
- Document the outcomes of the assessment in the client’s clinical notes in their clinical record.

Refusal of Treatment Certificate

- Refusal of Treatment Certificate is to be reviewed by the client’s GP or treating specialist, and/or one of the XXX senior Medical Physicians involved the client’s care to ensure the document is appropriately completed
- XXX Departmental Managers and/or clinical leaders are responsible for ensuring that:
  - the RTC document has been reviewed by the relevant Medical Doctor;

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19 Advance Care Planning in 3 –Steps- Dr Barbara Hayes Palliative Care Physician & Clinical Leader- Northern Health ACP Program Wonthaggi 2015
the documentation is completed correctly;
all staff are aware of the RTC’s content;
copy of the completed document together with evidence of follow up and review processes is provided to the XXX senior physician and/or clinical leader upon completion;
the completed RTC (whether completed at XXX or at other health setting) is then scanned and uploaded onto the client’s clinical record; and
the RTC copy must evidence signature of a person with statutory declaration authority.

- Clients are recommended to forward copies of the RTC document to their GP, treating medical specialists and parent hospital.

**Documentation**

- XXX recognises the following forms as valid client’s documentation:
  - ACP forms: MEPOA, RTC, ACD forms or any other ACP related documents from health services, the Office of the Public Advocate and/or solicitors.

- XXX staff ensures to follow up on any ACP documentation (including certified copies) not already provided at referral processes. Once these are provided, documents are uploaded onto the client’s electronic record followed by timely documentation in the client’s record

- ACP becomes a mandatory item in the client’s care plan under the ACP heading that evidences:
  - Completed ACP documentation—either through initial assessment and/or through client’s stay in the XXX PC program—are scanned into the client’s record
  - The client and/or their agent retain original ACP documents
  - When a Refusal of Treatment Certificate (RTC) is completed:
    - Sighted evidence of the RTC is noted in the XXX client’s electronic record
    - Scanned certified copy of document is also uploaded to XXX ACP/EOL module
    - Evidence of RTC documents is recorded in the client’s care plan and updated accordingly.
Please note

ACP documents can be revoked by the client, either verbally or in writing, while they remain competent. Revoked documents must be noted in the client’s progress notes ACP/EOL module XXX clinical record. Completed revoked documents must be scanned and attached to the client’s XXX clinical record.

Staff education

XXX is committed to support clinical staff develop and strengthen their ACP communication skills.

When opening up ACP discussion clinical staff are expected to:

- Display impeccable professional and ethical behaviour and exhibit knowledge of:
  - Assessment of a person’s capacity to make medical treatment decisions;
  - Enduring Power of Attorney – Medical Treatment;
  - VCAT Guardianship Orders;
  - The ‘Person Responsible’ as distinctive from ‘Next of Kin’ or ‘Contact Person’;
  - Written ACP and ACD;
  - ACP timely documentation; and
  - How to access ACP information and brochures for clients and caregivers.

Key Clinical Staff Considerations

Facilitating ACP discussions and communication skills

Communication skills are central to holding effective ACP and end-of-life discussions21

- **Take the lead in starting the discussion.** Many clients are reluctant to initiate an ACP discussion; physicians, counsellors and nurses can “open the door” to such discussions by asking:
  - How do you feel things are going?
  - Have you given any thought to how you wish to be cared for should your illness worsen?
  - Who would make medical decisions for you if you were too ill to do this for yourself? And

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o How would they know what you want?\(^{22}\)

**Explain the reasons for developing an ACP.** Clients identify ACP as an important part of medical care if they have a good understanding of how the process will benefit them:

o What are you most hoping for? If that doesn’t work out, what else would you be hoping for?

o I’d like to spend some time talking to you about the future course of your illness so that I have a clear understanding of your wishes and preferences.

**Use effective communication skills.** Do not use medical jargon (e.g. ‘ventilator’); language should be clear and succinct. Use empathetic and active listening skills:

o be mindful of your posture;

o make eye contact if culturally appropriate;

o touch can be used if desire to respectfully convey a supportive and compassionate gesture, particularly if the person becomes anxious and/or visibly upset;

o endeavour to build trust; and

o ensure privacy and allow sufficient time for discussion. If there is no sufficient time make an appointment to continue the discussion as soon as practicable.

**Identify a SDM**

o Clients should be encouraged and assisted to:
  * identify a SDM (surrogate) decision-maker; and
  * discuss/clarify their wishes with this appointed person.

**The value of ACP discussions is in the sharing of the information between the client, caregiver, SDM, other family members and the health care team**

**The SDM is presumed to have the greatest knowledge of the client’s preferences and values**

**If appropriate and agreed with the client, schedule a meeting to progress discussions and facilitate understanding between the client, their SDM and other family members as nominated by the client.**

**Cautionary notes**

**The ACP process must be sensitive to disease, gender, age, social and cultural contexts**

• Not everyone will be willing or ready to discuss ACP or end-of-life components. Clinical staff, however, must always endeavour to provide opportunities to open up and to facilitate ACP conversations.

• ACP is an evolving process that may require a series of discussions until its value is demonstrated. Debilitated clients often have challenges in processing information and require time to reflect on the information provided and its impact on their lives.

**Person Responsible Hierarchy** see appendix 1

**The competent client**

The following ACP documents can only be completed by a competent person and only when the medical officer is satisfied the person has the capacity to do so. These documents are:

- Medical Enduring Power of Attorney
- Refusal of Treatment Certificate
- Statement of Choices – Competent Person.

In witnessing a Medical Enduring Power of Attorney, Refusal of Treatment Certificate or Statement of Choices-Competent Person the doctor is attesting to the competence of the person.

**Completion of ACP for a non-competent person**

- The completion of a Statement of Choices – Non competent Person, is structured similarly to that of the Statement of Choices -Competent Person

- The ACP can be completed on behalf of the non-competent person by their substitute decision maker, who is acting in the person’s best interest

- XXX ensures the GP or the treating specialist are involved in the ACP process, together with other family members, as appropriate

- A Refusal of Treatment Certificate for the non-competent person may only be completed by a previously appointed SDM in possession of a MEPOA

- If the SDM has not been appointed prior to the patient losing capacity; a RTC cannot be completed nor a MEPOA appointed. However, a Statement of Choices-Non-Competent Person document can still be completed on the client’s behalf by the SDM, if one has been designated and/or by a family member

- It is expected that the GP or the medical specialist from the treating medical team will be the authorised witness to sign any of the documents mentioned in the competent client section

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If a Refusal of Treatment Certificate has been completed, a copy must also be sent to the Victorian Civil & Administrative Tribunal (VCAT) within seven (7) days of its completion. A copy of the RTC is kept on file by the Executive Officer.

All XXX staff involved in the care of the client is timely informed of the existence of any RTC documents via the client’s progress notes, end of life module and the relevant form uploaded onto the client’s record.

Special considerations

If the client is deteriorating rapidly or in the terminal phase of their illness there may be insufficient time to introduce ACP discussion and or process. However, it is still important to identify and capture the goals of care and the client’s preferences for end of life care including place of death.

7.0 LEGISLATION


8.0 STANDARDS

National safety and quality health service standards (2012 September) NSQHS standards 1.18.1, .18.4, 9.8.1, 9.8.2

Palliative Care Australia (2005). Standards for providing quality Palliative Care for all Australian.

9.0 REFERENCES


4. Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011).
5. National Safety and Quality Health Service Standards, ACT.


10. Victorian Office of the Public Advocate
Appendix 1

Person Responsible Hierarchy

The ‘person responsible’ title designates the person who is available and willing to make medical decisions on behalf of the patient. This person can be, in order of priority:

1. An agent appointed by the patient under an enduring power of attorney (medical treatment)
2. A person appointed by the Victorian Civil and Administrative Tribunal (VCAT) to make decisions about the proposed treatment
3. A guardian appointed by VCAT to make medical treatment decisions
4. An enduring guardian with appropriate powers appointed by the patient
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
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 in order listed:
   a) son or daughter (the eldest, regardless of gender)
   b) father or mother (the eldest, regardless of gender)
   c) brother or sister (including adopted persons and ‘half’ relationships) (the eldest, regardless of gender)
   d) grandfather or grandmother (the eldest, regardless of gender)
   e) grandson or granddaughter (the eldest, regardless of gender)
   f) uncle or aunt (the eldest, regardless of gender)
   g) nephew or niece (the eldest, regardless of gender).

- If the medical officer believes the proposed treatment is in the best interests of the patient, but there is no person responsible or they cannot be found, the practitioner can proceed to treat the patient

- The medical officer must first submit a form under Section 42K of the Guardianship and Administration Act 1986 to the Office of the Public Advocate (OPA)

- The form sets out:
  - the proposed treatment;
  - why the practitioner proposes to undertake the treatment;
  - the efforts made to locate the person responsible; and
  - if the legislative requirements are met, the treatment can proceed.