easternhealth
GREAT HEALTH AND WELLBEING

Advance Care Plan/Directive Aged Care

Facility Name.....

UR Number:.....

Surname:.....

Given Name:.....

Date of Birth: ___/___/___ Sex: M / F

(Affix Hospital I.D. Label if Available)

FEH002700~

Advance Care Planning (ACP)

Advance care planning is a process which enables person centred care whereby a person's values and beliefs and preferences for their health care are made known so they can guide clinical decision making at a future time when that person cannot make or communicate their decisions due to lack of capacity.

Who should I share my ACP with?

It is very important a copy of your plan is placed in your medical record for future reference. We also recommend your substitute decision maker/s, family; GP and local hospital also have a copy of your plan. You keep the original document/s.

Please note you may decide to complete all or part of this document.

Full name: .....

Current health condition/s include:.....

.....

This plan is being completed by: ☐ Self **OR**

Note: If the resident is not competent one of the following persons may complete this plan on their behalf. *Copy of substitute decision maker documentation attached Yes / No*

☐ Enduring Power of Attorney (Medical) ☐ Enduring Guardian

☐ VCAT appointed Guardian with Medical Powers

☐ Person Responsible *(indicate relationship)* .....

If not completed by SELF please print full name and include contact number below:

.....

1. We are all unique and often have different beliefs, values and goals. **What does quality of life or living well mean to you?** For example: enjoyable activities, independence, pets, spiritual or religious beliefs, family and friends:.....

.....

.....

.....

2. Life is unpredictable and it is almost impossible to know in advance how we may feel in the future about our health care. However, your values and beliefs may mean that there are some health outcomes that you would find unacceptable and therefore may not want your life prolonged in some circumstances. **An unacceptable health outcome for me is:** for example: to not be able to communicate meaningfully, to be completely bed bound, to be dependent on others for hygiene, to not be able to eat and drink naturally:.....

.....

.....

.....

3. If I have an illness or injury that may need transfer to hospital. My preference is to: *(Please **sign** only one box)*

☐ Remain at my usual residence and not go to hospital unless it is not possible to provide the necessary care here.

☐ Immediate transfer to hospital for assessment and possible treatment.

Please note: where possible if the resident is for comfort measures or conservative management then the aim is to provide care and treatment at their usual residence.

Acknowledgements: Southern Health, © Respecting Patient Choices, © Respecting Patient Choices, SA Statement of Choices April 2011 Northern Health, Tasmanian Health, Canterbury Health Care. Alfred Health, Conversation Project 2012, Advance care planning: have the conversation A strategy for Victorian health services 2014-2018

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EH 002700

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What happens if I want to change my ACP?

It is very easy to revoke or change an ACP. Simply complete a new one and destroy the old one. The most recently dated document overrides the older document. It is important to share the new plan with everyone who has a copy of the old one.

We recommend

An annual review to ensure your ACP is current, valid and continues to reflect your wishes.

Please note: If there is not enough room to write all of your request and wishes, please attach further pages as necessary. All additional pages need to be signed, dated and witnessed.

If you wish to record any other end of life wishes (e.g. organ, tissue or body donation), you can attach documents to this plan.

4. **If I have a potentially life-threatening illness or injury where I am unable to communicate**, the following best describes my preferences for care. I understand that treatments deemed non-beneficial may not be provided by health professionals. *(Please **sign** only one box)*

☐ I am willing to receive life prolonging treatments.

OR

☐ I wish to be kept comfortable and allowed to die naturally, in comfort and dignity and without distress. I do NOT want to receive cardio pulmonary resuscitation (CPR) in the event I am unresponsive and not breathing.

OR

☐ I wish the doctors caring for me to make decisions on my behalf taking into account my advance care plan and, in consultation with my substitute decision maker.

5. **Requests about specific medical treatments NOT wanted and/or any other comments:**

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6. **If I am nearing death the following things would be important to me:**

for example: music, contact with friends or family members, cultural and/or spiritual beliefs met

.....

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If I'm unable to communicate please give my family and friends the following message or I would like the healthcare team to know the following: .....

.....

.....

Signature of person completing ACP .....date.....

Witness name .....signature.....

Witness relationship.....date.....

I Dr .....have reviewed this document and integrated the residents wishes into their care planning.

Dr's signature .....date.....

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