AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

INFORMATION for clinicians

Comprehensive Care Standard

Advance care planning

Advance care planning is a process of discussing, determining and documenting a person's preferences for their future care should they be unable to make and communicate decisions about their care. Advance care planning is commonly associated with end-of-life care, however, it is also useful for people with physical or cognitive impairment or mental illness which could affect their capacity for decision making. Their capacity may be affected permanently or temporarily. Advance care planning is a way of ensuring that people receive care in accordance with their wishes, even when they are unable to express those wishes.[1]

The process of advance care planning includes discussion of an individual's values, preferences, and personal and family circumstances, in the context of their medical history and condition.

An advance care planning discussion will often result in the development of a formal advance care plan. An advance care plan documents the patient's specific preferences about health and personal care, including care and treatment they do and do not want to receive, and their goals of care. Advance care plans should be made in partnership with the person, and then come into effect when the person cannot speak up for themselves.

Policies, processes and legislation about advance care planning varies between states and territories. The **Advance Care Planning Australia** website includes links to information and resources, specific to each state and territory, and for different populations (including children) and different settings (such as, mental health or intensive care).

The value of advance care planning

Advance care planning can benefit patients, their families and carers, clinicians and health service organisations. Advance care plans contribute to improved ongoing care and enhanced patient experience and family satisfaction through the delivery of comprehensive care that is consistent with the patient's beliefs, values, needs and preferences. These include improvements in patient autonomy, confidence and agency, healthcare team morale, communication, and reduction of costs through unnecessary interventions and transfers.

Advance care planning for end of life is important as it clarifies the patient's preferences and informs clinicians with respect to clinical treatment and comprehensive care plans, goals of care, and limitations of medical treatment. For more information, refer to ***National Consensus Statement: essential elements for safe, high-quality end-of-life care***.

NSQHS Standards

The NSQHS Standards have actions that directly relate to advance care planning:

Item	Action
Policies and procedures	1.7 The health service organisation uses a risk management approach to: c. Review compliance with legislation, regulation and jurisdictional requirements
Sharing decisions and planning care	2.6 The health service organisation has processes for clinicians to partner with patients, and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Planning for comprehensive care	5.9 Patients are supported to document clear advance care plans
Comprehensive care at end of life	5.17 The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Clinical handover	6.8 Clinicians use structured clinical handover processes that include: d. Being aware of the patient's goals and preferences

When you might start advance care planning

There may be a range of triggers that could indicate the need for a discussion with a patient about their preferences for care in the future including if the patient:[1]

- Raises the subject of advance care planning
- Has an advanced chronic illness (such as COPD or heart failure)
- Has been diagnosed with dementia or has had an episode of delirium
- Has a life limiting illness (such as advanced cancer)
- Is aged 75 years or older, or 55 years or older if they are an Aboriginal and/or Torres Strait Islander person
- Is a resident of, or is about to enter, an aged care facility and is at risk of losing competence (such as has early dementia)
- Has a new significant diagnosis (such as metastatic disease or transient ischemic attack)
- Is at a key point in their illness trajectory (such as recent or repeated hospitalisation, or commenced on home oxygen)
- Does not have anyone (such as a family, caregiver or friend) who could act as substitute decision-maker
- May anticipate decision-making conflict about their future healthcare

Or if you would not be surprised if the patient died within the next 12 months.

Tips for the conversation

Things you can do, as a clinician, to encourage and support advance care planning include:

- Initiate the conversation early with patients who may lose their capacity to make decisions about their care
- Communicate openly and honestly with patients about their prognosis and options
- Check patients' understanding of the discussion you are having
- Give patients time to digest information, and offer to come back for a follow up conversation to go over any questions they might have
- Offer to include a support person in the conversation or clarify how they like to be supported in making decisions
- Provide patients with alternative sources of information about their health and care
- Ask patients how much they'd like to be involved in decision making, and who they'd like to be involved in the future, should they be unable to make decisions
- Ask patients what matters to them, including their expectations about their health and care, cultural and spiritual needs, and other personal preferences that may be important to their care experience.

1. Advance Care Planning Australia. What do I need to know about advance care planning? : Austin Health; 2018. Available from: **https://www.advancecareplanning.org.au/for-health-and-care-workers**

Further information and resources about advance care planning

Advance Care Planning Australia

End of life directions for aged care

RACGP advance care planning

Add an advance care plan to My Health Record

Cognitive Decline Partnership Centre – Advance care planning

Dementia Australia – planning ahead

Supporting decision-making: A guide for people living with dementia, family members and carers

Questions?

For more information, please visit: **safetyandquality.gov.au/comprehensive-care**

You can also contact the Comprehensive Care project team at: **mail@safetyandquality.gov.au**