AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

INFORMATION for health service organisations

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 in the event they become 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 patients 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 a patient'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 or 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).

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

To meet the NSQHS Standards health service organisations are required to develop and implement systems and processes that support patient-clinician discussions about the patient's preferences for care in the future, to document advance care plans, and to act on advance care plans as part of comprehensive care delivery. In addition, the health service organisation needs to have systems and processes in place to receive advance care plans developed outside of the organisation.

The policy and legislation that governs advance care plans differ across states and territories. Health service organisations should be familiar with the legislation and state-based policy that is relevant to their organisation, and use these to guide development of advance care planning processes locally.

Some ways in which health service organisations can support improvements in advance care planning include:

- Developing policies that describe the roles and responsibilities of patients, carers, substitute decision-makers and clinicians in advance care planning
- Developing a process for receiving, documenting and updating advance care plans in the patient record
- Identifying a senior clinical lead to oversee implementation, evaluation and improvement of advance care planning processes
- Providing information, resources, forms and other tools on advance care planning to patients and carers
- Training clinicians on how to initiate advance care planning and document advance care plans in accordance with patient's wishes.

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

References

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

Questions?

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

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

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