Produced in Collaboration with Northern Sydney Central Coast Health

***USER GUIDE***

# ADVANCE CARE DIRECTIVE

**"LIVING WILL"**
**(Personal Future Health Care Plan)**

**STEP 1** USE CHECKLIST — Sheet **A**

---

**STEP 2** PROVIDE PATIENT/CLIENT/CARER With A Copy of the Fact Sheet — Sheet **B**

---

**STEP 3** USE ADVANCE CARE DIRECTIVE

"Let Me Decide" — Enclosed Sheet **C**

Or if preferred use: "My Health my Future My Choice"

*Highly recommended self explanatory booklet*
*Cost $12 – (see resources-Fact Sheet B)*

**OR**

***If "No capacity" eg Dementia, Psychosis, Depression etc;***

Use "Plan of Treatment" — Enclosed sheet **D**

(Needs assistance from a Health Care Professional)

---

**STEP 4** File a copy in a Prominent Place in Patient/Client Record

Make copy available as need arises eg: for Accident and Emergency, Hospital Admissions, Aged Care Facilities etc

……………………

Developed in Collaboration with Northern Sydney Central Coast Health

A

# Advance Care Planning
# Checklist

*(For Health Professionals)*

Please use this document to assist future Health Care Planning.

Place this checklist in a prominent place in the patient notes or Health Assessment/Care Plan.

Patient/Client Name [ ] D.O.B. [ / / ]

**1. Is there an enduring guardian arrangement?**

☐ Yes Name of Guardian

..................................................................

No
Using the hierarchy on the information sheet B, who is the person responsible?

**2. Is there an existing Advance Care Directive?**

Yes Please attach a copy to this form AND print a spare copy in the event of the patient/client being transported to hospital. If not attached please indicate location – No further action required.

☐

No Proceed to items 3 and 4.

**3. Has the Patient/Client capacity to decide care issues themselves?**

Yes Consider giving patient/client Fact Sheet B and "Let Me Decide" Fact Sheet C

No
Consider giving person responsible Fact Sheet B and discuss Plan of Treatment D

☐ Unsure Comment

..................................................................

**4. Has Fact Sheet B been given to patient/client/carer/relative with a view to completing an Advance Care Directive or Plan of Treatment?**

Yes Discuss follow up

☐ No Please provide reason

..................................................................

If No, Review Date:- ___/___/___

Other Comments
....................................................................................................................................................

....................................................................................................................................................

| Staff Name | Signature | Date Completed |
|---|---|---|
| | | |

B

# Advance Care Planning

# INFORMATION SHEET

For Patients, Carers and Health Professionals

The following information has been compiled to assist you in understanding the issue of future care planning. Patients, carers, families, health care professionals, hospitals and aged care homes all benefit from clear guidelines to follow in the event of future health issues.

**Advance Care Directive or Plan of Treatment?**

An **Advance Care Directive** is a written statement regarding ones wishes for one's own future health care. An Advance Care Directive can be made now by anyone who has the capacity to do so and is only used if at some point in the future you become incapable of making health care decisions for yourself (through illness or accident). You may have received an Advance Care Directive with this fact sheet or else you can obtain one from your GP.

When a person does not have the capacity to make their own medical decisions, it is possible for the person responsible to make these decisions on their behalf. The person responsible can state their wishes for the person's health care, based on what they believe is in the patient's best interest and reflecting what the patient would have wanted. A **Plan of Treatment** is a written document made by the person responsible that outlines these wishes. It is available from your doctor or nurse and needs to be completed with them. Advance Care Directives and Plans of Treatment should both be reviewed regularly to ensure that wishes have not changed.

**What is Capacity?**

It is important to be clear about someone's ability to make their own decisions whether these be financial, personal or health related. A person who is able to understand the question at hand, weigh up and understand the consequences of their own choices is said to have capacity. This person has the right to make their own financial, health and lifestyle decisions. All people are assumed to have capacity. Capacity is only questioned if there is a valid reason to do so (such as advancing dementia, delirium, psychosis etc). In these cases a capacity assessment is carried out by the health or legal professional involved.

**Who is the Person Responsible?**
There is a clear hierarchy set out by the Guardianship Act stating which people have the right to make decisions on someone's behalf if that person can do longer decide. It is no longer necessarily the person's next of kin.
In order, the person responsible is
The court appointed or enduring guardian if one has been appointed. If none then
The most recent spouse or defacto who has an ongoing relationship with the person. If none then
The person's primary unpaid carer. If none then
A relative or friend who has a close personal relationship with the person.

In cases of conflict or absence of an appropriate person the Guardianship Tribunal can advise. Freecall: 1800 463 928.

**Enduring Guardian vs Power of Attorney**

An **Enduring Guardian** is someone you choose to make **personal**, **health** or **lifestyle** decisions on your behalf if and when you lose the capacity to make decisions yourself. A **Power of Attorney** is a legal document authorising someone else to carry out **business**, **financial** or **property** affairs on your behalf. A standard Power of Attorney ceases to have effect once you lose capacity. An **Enduring Power of Attorney** remains valid if you lose the capacity to carry out these transactions independently.

Enduring Guardianship and Power of Attorney may only be made by someone who has capacity. Telephone; 1800 463 928 for free forms. Or download from www.planningwhatiwant.com.au Completed forms need to be witnessed by a lawyer or t an appointment with your local courthouse.

# Resources

- **My Health, My Future, My Choice / An Advanced Care Directive for NSW.**
  To order the book contact the Advanced Care Directives Association (18/113 Johnston Street, Annandale NSW 2038 or Ph: 0423 157 003)

- **Guidelines for End of Life Care and Decision Making.**
  NSW Health. http://www.health.nsw.gov.au/pubs/2005/pdf/end_of_life_care.pdf

- **Using Advanced Care Directives.**
  For free copies telephone: (02) 9816 0452
  http://www.health.nsw.gov.au/pubs/2004/pdf/adcare_directive.pdf

Developed in Collaboration with Northern Sydney Central Coast Health

C

# Let Me Decide

## Health and Personal Care Directive
## New South Wales Version

**1. Introduction**
In this Directive I am stating my wishes for my health and personal care should the time ever come when I am not able to communicate because of illness or injury. This Directive should never be used if I am able to decide for myself. It must never be substituted for my judgement if I can make these decisions.

If the time comes when I am unable to make these decisions, I would like this Directive to be followed and respected. Please do everything necessary to keep me comfortable and free of pain. Even though I may have indicated that I do not want certain treatments, I recognise that these may be necessary to keep me comfortable.

I understand that my choices may be overridden if a treatment is necessary to maintain my comfort.

I have thought about and discussed my decision with my family, friends and family doctor. In an emergency, please contact my “person responsible” or my family doctor listed over. If these people are not available, then please do as I have requested in this Directive.

I understand that I can revise this Directive at anytime and that it should be reviewed once a year, after an illness or if there is a change in my health. If I need to update the Directive I can fill in a new form otherwise I can endorse the contents by signing again on the last page.

**Person(s) Responsible (contact details on page 4 of this document)**
I, ________________________________________ (*print name*), acknowledge that:
_ ________________________________________ (*print name*) is my person responsible because they are my (*please circle*):

i. Enduring guardian, who possesses the legal authority to act, either (*please circle*):
(a) separately; or (b) jointly with _______________________________ (*print name*); or
ii. Spouse / defacto, with who I have a close, continuing relationship; or
iii. Unpaid carer who provides (or previously provided) support to me; or
iv. Relative / friend with whom I have a close personal relationship

If my “person/s responsible” indicated above is/are not available for any reason, declines in writing to exercise their functions, or a medical practitioner or qualified person certifies in writing that the
person/s responsible’ is/are not capable for carrying out the functions, then I acknowledge that:
_ ________________________________________ (*print name*) becomes my person responsible, according to the hierarchy set by the Guardianship Act, because they are my (*please circle*):

i. Spouse / defacto, with who I have a close, continuing relationship; or
ii. Unpaid carer who provides (or previously provided) support to me; or
iii. Relative / friend with whom I have a close personal relationship.

** Adapted to NSW context by: Central Sydney Division of General Practice;
Centre for Education and Research on Ageing; NSW Guardianship Tribunal;
NSW Young Lawyers; Concord Repatriation General Hospital
Source: “Taking Charge” – The Benevolent Society
Author: Dr D. W. Molloy

## 2. Definitions

<u>A. Loss of functioning that is NOT acceptable AND NOT reversible</u>
An *un*acceptable and *ir*reversible loss in my ability to function may result from:
a) An illness or injury that is *not* reversible and that leaves me with a loss in ability to function that consider to be *not* acceptable.

<u>B. Loss of functioning that IS acceptable AND/OR IS reversible</u>
An acceptable and/or reversible loss in my ability to function may result from either:
b) A life threatening illness or injury that is reversible. This is curable, meaning that losses in my ability to function are not permanent. *OR*
c) An illness or injury that is *not* reversible, but that leaves losses in my ability to function that I consider to be acceptable.

<u>C. Cardiac Arrest (CPR)</u>

**CPR** — Use cardiac massage with mouth-to mouth breathing ; may also include intravenous lines, electric shocks to the heart (defibrillators), tubes in throat to lungs (endotracheal tubes).

**NO CPR** — Make no attempt to resuscitate.

<u>D. Feeding</u>

**Basic** — Spoon-fed with a regular diet. Give all fluids by mouth that can be tolerated, but make no attempt to feed by special diets, intravenous fluids or tubes.

**Supplemental** — Give supplements or special diets (eg. high calorie, fat or protein supplements).

**Intravenous** — Give nutrients (water, salt, carbohydrate protein and fat) by intravenous infusions.

**Tube** — Use tube feeding. There are two main types:
Nasogastric Tube: a soft plastic tube passed through the nose or mouth into the stomach.
Gastrostomy Tube: a soft plastic tube passed directly into the stomach through the skin over the abdomen.

**Subcutaneous Fluids** — Fluids (usually saline) which are inserted through a plastic canula (inserted under the skin) to improve hydration

<u>E. Levels of Care</u>

**Palliative Care**
Keep me warm, dry and pain free. Do not transfer to hospital unless absolutely necessary. Only give measures that enhance comfort or minimise pain (eg. morphine for pain). Intravenous line started only if it improves comfort (eg. for dehydration). No x-rays, blood tests or antibiotics unless given to improve comfort.

**Limited Care (includes Palliative)**
May or may not transfer to hospital. Intravenous therapy may be appropriate. Antibiotics should be used sparingly. A trial of appropriate drugs may be used. No invasive procedures (eg. surgery). Do not transfer to Intensive Care Unit.

**Surgical Care (includes Limited)**
Transfer to acute care hospital (where patient may be evaluated). Emergency surgery if necessary. Do not admit to Intensive Care Unit. Do not ventilate (except during and after surgery ie. Tube down throat and connected with machine).

**Intensive Care (includes Surgical)**
Transfer to acute care hospital without hesitation. Admit to Intensive Care Unit if necessary. Ventilate me if necessary. Insert central line (ie. main arteries for fluids when other veins collapse). Provide surgery, biopsies, all life support systems and transplant surgery. Do everything possible to maintain life.

## ***TO THE MEDICAL OFFICER***

**3. Health and Personal Care**

***Personal Statement.***

I would consider an unacceptable level of functioning for me to include:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

so,

**If my loss of functioning is NOT acceptable and NOT reversible (Definition A) then please treat me as I have indicated below**

| ***Cardiac Arrest***<br>*(Definition C.)* | ***Life threatening Illness***<br>*(Definition E.)* | ***Feeding***<br>*(Definition D.)* |
|---|---|---|
| *CPR*<br>*No CPR* | *Intensive*<br>*Surgical*<br>*Limited*<br>*Palliative* | *Tube*<br>*Intravenous*<br>*Supplemental*<br>*Basic*<br>*Subcutaneous Fluids* |
| | | |

(Write your choice in the box provided)

**If my loss of functioning IS acceptable and/or IS reversible (Definition B) then please treat me as I have indicated below**

| ***Cardiac Arrest***<br>*(Definition C.)* | ***Life threatening Illness***<br>*(Definition E.)* | ***Feeding***<br>*(Definition D.)* |
|---|---|---|
| *CPR*<br>*No CPR* | *Intensive*<br>*Surgical*<br>*Limited*<br>*Palliative* | *Tube*<br>*Intravenous*<br>*Supplemental*<br>*Basic*<br>*Subcutaneous Fluids* |
| | | |

(Write your choice in the box provided)

I would agree to the following procedures (write yes or no)

Blood transfusion ______
Organ transplant ______

In the event of my death, I consent to the following procedures (write yes or no)

Organ donation ______
Post Mortem ______
Cremation ______

**4. Signatures**

**Person Completing the Directive**

I, ______________________________ (*print name*)
Of address:
___________________________________________________________________________
am voluntarily completing this Advance Care Directive document of my own free will on this date:_____________
Signed: ____________________________

**Person(s) Responsible**

I/we have read, understood and agree to act in accordance with the contents of this Directive:

1. Name ___________________________________________
   Signature ___________________________________________
   Date ____________________________
   Address ___________________________________________________________________________
   Ph: (hm) _________________________________ (wk) _______________________________

2. Name ___________________________________________
   Signature ___________________________________________
   Date ____________________________
   Address ___________________________________________________________________________
   Ph: (hm) _________________________________ (wk) _______________________________

3. Name ___________________________________________
   Signature ___________________________________________
   Date ____________________________
   Address ___________________________________________________________________________
   Ph: (hm) _________________________________ (wk) _______________________________

**Enduring Guardian/s**

If I have an enduring guardian/s, they were appointed on the date: ______________________________
And the document is held at: ______________________________________________________________________

**General Practitioner**

Name __________________________________________________________
Signature _____________________________________
Date _____________________________________
Address __________________________________________________________________________________
Ph: (hm) _____________________________________ (wk) ______________________________________

**Witness**

I am the witness to this Directive. I verify that ______________________________(*print name of the person completing Directive*) signed this Directive on this date: ___________________________________ of his or her own free will, without threats or offered inducements. I am not a relative of the person completing this Directive nor of the person/s responsible and I am not involved in the person's medical treatment.
Name __________________________________________________________
Signature _____________________________________
Date _____________________________________
Address ___________________________________________________________________________________
Ph: (hm) _____________________________________ (wk) _____________________________________

**NOTE:** This Directive can either be completed on its own, or in conjunction with Enduring Guardianship forms, available from the NSW Guardianship Tribunal. Phone: 1800 463 928 (toll free) or (02) 9555 8500

**Updating this Directive (**in 12 months time)
If, after reviewing this document in 12 months time, I wish to endorse the contents, I do so by signing below:
Signature _____________________________ Date ______________

D

# Plan of Treatment

**Name** **Date**

I ………………………………………………………………………am a "Person Responsible" for healthcare decisions and consent to treatment,

for the patient ……………………………………………………………… as identified by the NSW Guardianship Act (1987)
(insert Name of Patient/ Care Recipient)

Dr………………………………………………………….. (name of treating)

confirms that………………………………………………………………..… (name of Patient/ Care Recipient) is **incapable** of consenting to medical treatment because:

✓tick one

- He/she cannot understand the nature and effect of the treatment, or ☐
- He/She cannot indicate whether or not he/she consents ☐

| **Name of persons responsible** | **Signature** |
|---|---|
| **Contact Details** | |
| **Name of GP** | **Signature** |
| **Contact Details** | |

The patient/care recipient's previously expressed wishes were: (if any, prior to incapacity)

……………………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………………

Name of person who reports stated wishes…………………………………………………………………………………………………………

- **As the "person responsible" I understand that I cannot consent to special medical treatment, nor can I consent to treatment if the patient objects to the treatment. Any treatment I consent to must be in the interests of the patient's health and well-being and must reflect any of their previously expressed wishes.**

- **Please do everything to keep the care recipient comfortable and free from pain, Even though I may have indicated that I do not want them to have certain treatments, I understand that these may be necessary to keep him/her comfortable. I am aware that the treatment choices may need to be reviewed if a treatment is necessary to maintain his/her comfort.**

- **I understand that the treatment options documented are an expression of wishes and may not necessarily be offered, if the treating doctor considers those treatments to be futile.**

**In the event of the following situations I/We request:………………………………………………………………(insert the patient's name)**
**Answer yes or no in each box**

| **CPR** | Reversible Illness **(Recovery to current level possible)** | Irreversible Illness **( No prospect of function improving)** | **Comments/ Special considerations** |
|---|---|---|---|
| **CPR:Cardio-Pulmonary Resuscitation**<br>Used when the heart stops beating. May include mouth to mouth resuscitation & heart massage, drugs and IV lines for fluid via a needle in the veins, electric shocks to the heart, breathing tube in the throat.<br><br>Answering no CPR means that no attempt will be made at CPR in the above conditions. | | | |

| *Levels of Treatment* | **Reversible Illness** | **Irreversible Illness** | ***Comments/ Special considerations*** |
|---|---|---|---|
| **Palliative 1**<br>Aims are to keep the person in current location, pain and discomfort. Any investigations or treatments will aim to provide pain relief & ease discomfort. | | | |
| **Palliative 2**<br>May include Palliative treatment in hospital, if necessary. Does not include elective surgery except for comfort or pain relief. No life support machines or Intensive Care | | | |
| **Active or Surgical**<br>Transfer to hospital & all possible treatment including operations. Breathing machine (ventilator) used only for the purpose of surgery, or recovery from surgery. | | | |
| **Intensive**<br>Everything possible will be done to maintain life. If necessary, intensive care unit and all possible means of life support will be used including surgery, transplants, dialysis and ventilator support | | | |

| Levels of Feeding | Reversible | Irreversible | *Comments/ Special Considerations* |
|---|---|---|---|
| **Oral or Basic**<br>Food & fluids by mouth, helped to eat and drink. No food via a tube or intravenous line (drip) into veins | | | |
| Supplementary<br>Oral plus additives to meet patients requirements. May include additional vitamins and high energy drinks | | | |
| **Intravenous (IV)**<br>Supplemental plus fluids & nutritional supplements given through a vein | | | |
| **Tube**<br>IV a tube into the stomach through the nose (nasogastric tube) or a tube through the skin into the stomach (gastrostomy tube) | | | |
| **Subcutaneous Fluids**<br>Fluids (usually saline) which are inserted through a needle under the skin to improve hydration | | | |

**Name of Person Responsible Completing Form:** ..........................................................................................

**Signature: ..........................................................................................Date:**...........................

**Name of Health Professional: .................................................................................................................................**

**Contact Details:** ..............................................................................................................

**Signature: ..........................................................................................Date:**...........................