Queensland Health

Advance care planning clinical guidelines

Version 1 | June 2026

DELIVERING FOR QUEENSLAND

Queensland Government

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About this guide

The purpose of the *Queensland Health advance care planning clinical guidelines* is to support routine implementation of the advance care planning (ACP) process in Queensland Health services and facilities; and to increase awareness of the Queensland Health systems and structures supporting ACP in Queensland.

This guideline provides high-level guidance to Hospital and Health Services (HHS) in the development of local ACP related policies and procedures, and where relevant, includes links to other resources for more information.

With the introduction of the strengthened Aged Care Quality Standards, it is acknowledged that content in this guideline may also be applicable to residential aged care and community-based aged care providers. Although aimed at health professionals, other care and support workers may also find the information useful.

The information contained in these guidelines is general in nature and is not intended to replace clinical judgement or act as legal advice. ACP scenarios may be complex and health professionals must consider the individual person's circumstances and seek additional clinical, legal or ethical advice as required.

Out of scope

Duplication with content in other Queensland Health/related guidelines such as:

- Guide to Informed Decision-making in Health Care (PDF) | Queensland Health (health.qld.gov.au)
- Capacity Assessment Guidelines 2020 | Queensland Government (publications.qld.gov.au)

Acknowledgements

This resource has been adapted from the *Health Professional Guide to Advance Care Planning in Western Australia (PDF)*, used with permission from Department of Health Western Australia. We acknowledge their valuable work and thank them for allowing its use in this adapted form.

The ACP screening interviews in the appendix has been adapted with permission from the Advance Project®. Additional resources are available at theadvanceproject.com.au. The ACP process on **page 20** has been adapted with permission from Advance Care Planning Australia.

List of abbreviations

ARP	Acute resuscitation plan
ACP	Advance care planning
AHD	Advance health directive
EPOA	Enduring power of attorney
HHS	Hospital and Health Service
HPP	Health Provider Portal
QCAT	Queensland Civil and Administrative Tribunal
QHERS	Queensland Health Enterprise Reporting Service
QWAU	Queensland Weighted Activity Units
SDM	Substitute decision-maker
SoC	Statement of choices

Privacy and confidentiality in advance care planning processes

The ACP processes described within the *Queensland Health advance care planning clinical guidelines* involve the collection, use and disclosure of identifying information, including 'confidential information' under the *Hospital and Health Board Act 2011* and 'personal information' under the *Information Privacy Act 2009*, and these activities must be authorised under the relevant legislation.

These processes include:

- Clinicians sending ACP documents relevant to a patient direct to Queensland Health's Statewide Office of Advance Care Planning (for example, may be authorised under s144 or s145 of the *Hospital and Health Board Act 2011*)
- Queensland Health's Statewide Office of Advance Care Planning:
  - receiving ACP documents
  - reviewing ACP documents
  - uploading ACP documents into the ACP Tracker, which sits within The Viewer, a Queensland Health database (for example, may be authorised under s144 or s145 of the *Hospital and Health Board Act 2011*)
  - supporting clinician access to ACP documents/comments in the ACP Tracker (for example, may be authorised under s144 or s145 of the *Hospital and Health Board Act 2011*)
  - reporting on data held within the ACP Tracker (for example, may be authorised under s150 of the *Hospital and Health Board Act 2011*).
- Access to the ACP Tracker via the Health Provider Portal (HPP) by registered and authenticated eligible health practitioners external to Queensland Health (for example, may be authorised under s161A of the *Hospital and Health Board Act 2011*).

In all cases, the preferred authority is with the consent of the patient or substitute decision-maker (for example, under s144 of the *Hospital and Health Board Act 2011*). However, there may be circumstances where obtaining this consent is not possible, and another authority may be relied on, for example, under s145 of the *Hospital and Health Board Act 2011* regarding the disclosure of patient information for the care and treatment of that patient.

Executive summary

Advance care planning (ACP) is an essential component of person-centred care across Queensland's health system. These guidelines provide high-level guidance to HHSs to:

- Support the development of local ACP policies and procedures that standardise ACP practice, strengthen communication between clinicians and individuals, and alignment of care that reflects an individual's wishes and preferences.
- Describe the systems that support ACP in Queensland.
- Outline best-practice processes for multidisciplinary health professionals to assist individuals through the stages of the ACP process (think, talk, record, share, and review).
- Provide guidance for enactment of the person's choices and related documents.
- Includes options for monitoring and evaluating ACP activities to ensure continuous improvement.

ACP is a voluntary and ongoing process that supports individuals to reflect on their values, express their preferences for future care, and appoint a substitute decision-maker. It is separate from goals of care, routine consent and end-of-life planning, although it can help guide these areas. High quality ACP relies on culturally responsive communication, respect for personal autonomy, and a shared decision-making approach.

The ACP process applies to adults at all stages of health and is especially important for those with chronic, progressive, or life-limiting conditions, and children or young persons who are unwell. These guidelines encourage embedding ACP into routine care and support the proactive identification of appropriate moments to introduce it, preferably when a person is clinically stable or during key transition points such as diagnosis of a chronic, progressive or life-limiting condition, hospital admission, entry to an aged care home or when care needs change. Clinicians are encouraged to initiate ACP conversations, explore the person's values, and support the ACP process including the completion and review of ACP documents, as appropriate.

A clinicians review and routine use of the ACP Tracker to document ACP actions and access uploaded ACP documents, together with sharing copies of ACP documents with the Statewide Office of Advance Care Planning, helps ensure these documents are available across care settings and supports the ongoing ACP process.

Legislation and obligations

The guidelines reflect health professional obligations and the legislative requirements of Queensland's legal framework, including the *Powers of Attorney Act 1998*, *Guardianship and Administration Act 2000*, reinforcing the integration of ACP as a routine element of care.

Ethical principles of autonomy, beneficence, non maleficence, and justice underpin all ACP activities.

Health professional role

Health professionals play a key role in delivering person-centred care by supporting individuals and substitute decision-makers through the ACP process and honouring a person's views, wishes and preferences and any ACP documents when they lose capacity. They assist individuals as they move through the five key elements of ACP (think, talk, record, share, and review) and adapt their choices in response to changes in their personal circumstances, health, or lifestyle. While many clinicians have the skills, confidence, and expertise to undertake comprehensive ACP conversations, others may benefit from additional training and support. The guideline includes a range of helpful resources to assist with building capability and confidence.

Implementation and quality improvement

Queensland Health supports HHSs in implementing ACP through healthcare purchasing and performance measurement, as outlined in the *Performance Measures Attribute Sheet: 036 Advance Care Planning (PDF)* under the Safety and Quality Marker. These mechanisms aim to expand opportunities for the person to consider ACP and make informed choices about their future healthcare, including care at the end of life.

The guidelines describe reporting tools and quality indicators that HHSs can use to monitor and measure ACP implementation. These tools help HHSs gain the visibility needed to improve performance, meet required standards, and ensure that Queenslanders receive care that aligns with their values and preferences.

Expected outcomes

Implementation of these guidelines is expected to strengthen alignment between the care provided and each person's preferences (across all care settings), reduce unwanted or non beneficial interventions, improve communication between clinicians, substitute decision-makers and families, and promote more coordinated, culturally safe, and person-centred care across Queensland's health system.

What is advance care planning?

Advance care planning (ACP) is a process of planning for future health and personal care whereby the person's views, wishes and preferences are made known to guidelines decision-making at a future time when that person cannot make or communicate their decisions[1]. It is a voluntary process where discussions may lead to the documenting of wishes and preferences in an ACP document.

This conversational, supportive and ongoing process is founded on the respect for individual autonomy and gives the person a voice in their health care, supporting them to have choice and control over future treatment decisions.

As a foundation stone of person-centred care, ACP informs health professionals about what matters most to those in their care.

It is through the process of ACP discussions that health professionals attain a deeper understanding of the person's views, wishes and preferences, which can enhance their relationship with the person; and help to shape care so that it supports achievement of person and family-centred outcomes. It is an integral part of day-to-day clinical practice and part of the role of all health professionals[2].

Implementation of the ACP processes aligns with:

National Safety and Quality Health Service Standards[3] including:

- Patient safety and quality systems (action 1.07)
- Health care rights and informed consent (action 2.05)
- Partnering with patients in their own care (action 2.06)
- Developing the comprehensive care plan (action 5.09)
- Delivering comprehensive care (action 5.17)
- Communication at clinical handover (action 6.08)
- Communicating critical information (action 6.09)

Strengthened Aged Care Quality Standards[4] related to:

- The individual (outcome 1.1.2, 1.3.3)
- The organisation (outcome 2.7, 2.9.4, 2.9.6)
- The care and services (outcome 3.1.6, 3.2.9, 3.3.1)
- Clinical care (outcome 5.4.1, 5.4.4, 5.6.2, 5.7.2, 5.7.3, 5.7.4)
- The residential community (outcome 7.2.1)

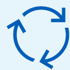
1. Australian Government Department of Health, *National framework for advance care planning documents* (Canberra, 2021), https://www.health.gov.au/resources/publications/national-framework-for-advance-care-planning-documents?language=en
2. Keri Thomas, Ben Lobo, and Karen Detering, eds., Advance Care Planning in End of Life Care, 2nd ed. (Oxford University Press, 2017).
3. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* 2nd ed. (Sydney, 2021), https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition
4. Australian Government Aged Care Quality and Safety Commission, *Strengthened Aged Care Quality Standards* (Canberra, 2025), https://www.agedcarequality.gov.au/strengthened-quality-standards

The *National Framework for Advance Care Planning Documents (PDF)* outlines ethical considerations and best practice principles that guide the ongoing process of ACP, from initiating conversations, to creating, revisiting, accessing, and enacting ACP documents.

The following considerations are in addition to these and aim to promote a common understanding of ACP and consistency in how Queensland Health staff support the ACP process.

Advance care planning:

Is **voluntary, person-centred** and focused on **empowering the person** to have choice and control over their future treatment decisions.



Is an **ongoing process** that a person can engage in at any time, and requires regular review allowing a person to make and change decisions as their circumstances and preferences change.

Can be **undertaken at any age**, becoming more important when a person is living with chronic illness and more critical when nearing the end of life.

Should be **initiated early** for those with life-limiting illness to optimise the person's quality of life and minimise potentially burdensome and unwanted treatment.

Is **inclusive**, ideally including the person's key supports/substitute decision-makers; however, can involve as many or as few people a person chooses.

Should be **holistic and respect the whole person**, with broad consideration of healthcare needs (i.e. not limited to medical treatments).

Should **acknowledge and respect a person's attitudes** towards health and wellbeing, including cultural and spiritual considerations.

Is focused on the **person's views, wishes and preferences** and encompasses more than the completion of ACP documents.

May involve many, and **sometimes challenging, reflections and discussions**; these may need to be facilitated to ensure the person understands all their options when it comes to planning for their future care.

Needs to **follow an ethical process** and support the person's right to meaningfully participate in decision-making to the greatest extent possible.

Across care settings is supported by ACP Tracker comments made when discussions are held, a document completed, existing documents reviewed or when it is declined.

Document copies sent to the **Statewide Office of Advance Care Planning for upload to the ACP Tracker** (in the person's Queensland Health electronic hospital record) supports authorised clinicians to have timely access to quality ACP documents when they are needed.

Documents, wishes and preferences should be enacted when a care decision is required and a person has impaired decision-making capacity.

- Noting: If the person has capacity, independently or with supported decision-making, they retain the right to provide their own consent and to accept or refuse treatments in accordance with their wishes.

The importance of advance care planning

Advance care planning provides benefits for the person, their family*, substitute decision-maker(s), and health services and systems. A range of legislative requirements also inform obligations for advance care planning. Together, these benefits and obligations justify the inclusion of advance care planning as part of routine care.

Benefits of advance care planning

- Provides an opportunity for the person to plan what is important for their future health and personal care, and to take comfort in sharing this with others.
- Enables the person to make decisions without the pressure of acute clinical decline.
- Assists the person to make decisions when they are able to communicate so they receive care that is consistent with their views, wishes and preferences if they become unable to communicate decisions.
- Can support the person to:
  - Make legally recognised choices about the type and nature of health care that they would like to receive if they lose the capacity to make such decisions.
  - Appoint attorney(s) of their own choosing to make decisions for them, should the need arise.
- Can improve individual and family satisfaction with care, reduce emotional distress and anxiety during decision making, and support bereavement.
- Can reduce non-beneficial and unwanted transfers to acute care, interventions, end-of-life hospitalisation and costs[5,6].

*In this document, the term ‘family’ is used inclusively to encompass the person’s key supporters, chosen family, or culturally recognised family, rather than being limited to biological relatives, immediate household members, or similar traditional definitions.

5. Preshit N Ambade et al., “Predictors of advance care planning in 11 high-income nations,” *Journal of the American Geriatrics Society* 72, no.12 (2024): 3855-3864, doi: 10.1111/jgs.19226
6. Ian Scott et al., “Association of advance care planning with hospital use and costs at the end of life: a population-based retrospective cohort study,” BMJ Open 14, no. 11 (2024): https://bmjopen.bmj.com/content/14/11/e082766

Obligations and legislative requirements

In Queensland, if consistent with good medical practice, health professionals are legally obligated to provide care that is in accordance with a person's advance health directive (AHD) made under the *Powers of Attorney Act 1998*, and when applicable, follow directions from substitute decision-makers under the *Guardianship and Administration Act 2000*. There are also codes of conduct for health practitioners and obligations within the codes that facilitate ACP, see 9.1 in *Advance care planning Education Capability Framework: Implementation Guide 2022 (PDF)*.

Legislation supporting ACP is in place throughout every Australian jurisdiction (except in NSW where ACP is recognised under common law). In Queensland, the key laws that apply to ACP and to healthcare decisions for adults who are unable to make decisions for themselves are outlined in Table 1.

Additional guidance is available through these main sources:

- The *Queensland Capacity Assessment Guidelines 2020 (PDF)*, which explain how to understand and assess decision-making capacity, including the legal criteria and the requirements for completing an enduring ACP document.
- The Queensland Health *Guide to Informed Decision-making in Health Care (PDF)* and the Flowchart for Health Care Decision-Making in Adults Without Capacity (Appendix 1), which describe how ACP documents should be enacted in practice.
- End of Life Law for Clinicians (ELLC), which provides key concepts relating to the law at end of life in Australia.

Table 1: Relevant legislation related to advance care planning in Queensland

Powers of Attorney Act 1998	This Act allows adults to make decisions or arrangements for decision making that can be implemented in the future. Under this Act, such arrangements can be established through an AHD or an enduring power of attorney (EPOA). The adult must have capacity to make these documents, and on signing them is confirming they are making the document freely and voluntarily; and understand the nature and effect of document. Formal document requirements are also outlined in this Act. Valid AHDs and EPOAs for health matters apply only when the person has impaired decision-making capacity. Operation of an AHD is outlined in s36 of this Act. For further information about AHDs and when they apply, see *Queensland Health Guide to Informed Decision-making in Health Care (PDF)*. Under s34 of this Act, an EPOA made in another jurisdiction in Australia, or in New Zealand, can be recognised in Queensland, as long as it meets the legal requirements of the place where it was made. Guidance from your legal team can confirm whether the document is properly executed, and for what matters (health/personal and/or financial) it can be relied upon in Queensland. Although s40 of this Act mentions enduring healthcare documents from other states, there is currently no regulation that requires health professionals in Queensland to recognise or act on them. This means the document does not carry the same legal weight as a Queensland AHD and clinicians are not legally obligated to follow it in Queensland.

Guardianship and Administration Act 2000	This Act sets out the legal framework for substitute decision-making in health care, including the order of priority for identifying a statutory health attorney (see Figure 1) when no formal substitute decision-maker has been appointed. This Act ensures that healthcare decisions are made lawfully and in the person's best interests, even in the absence of formal documentation. It also underpins the authority of Queensland's guardianship system including: • Queensland Civil and Administrative Tribunal (qcat.qld.gov.au) • Office of the Public Guardian (publicguardian.qld.gov.au) • Public Trustee Queensland (pt.qld.gov.au) • The Public Advocate (publicadvocate.qld.gov.au) This Act includes **general principles** and **health care principles** that must be followed by anyone making decisions or taking actions under the Act for someone who has impaired capacity. These principles help ensure that substitute decision-making is ethical, lawful, and person-centred.
Human Rights Act 2019	This Act works to respect, protect and promote human rights in Queensland. Under this Act, there are 23 protected human rights. It requires public entities such as Queensland Health and HHSs to act and make decisions that are compatible with these rights.
Mental Health Act 2026	This Act requires clinicians to consider whether there is a less restrictive way available to obtain consent for a person's treatment, other than providing involuntary treatment under a Treatment Authority. A less restrictive way includes consent provided in an AHD (if made by the person when they have capacity), or with the consent of an attorney or guardian, if the person's treatment needs can be met in that way. • *A Guide to the Mental Health Act 2016 (PDF)* • *Advance Health Directives and less restrictive way of treatment (PDF)* • *Advance health directive for mental health (PDF)*
Common law	In Queensland, only statutory AHDs created under state legislation are legally binding. Common law advance care directives, which are based on court decisions, are not recognised under Queensland law. Common law advance care directives, including values-based documents or written statements of wishes, are not legally binding in Queensland. However, these documents can still be clinically useful. They may: • Help guide substitute decision-maker(s) and clinicians. • Reflect the person's values, preferences, and goals of care. • Be considered an 'objection' under guardianship law, which may influence decisions about treatment. When a person has impaired decision-making capacity and no statutory directive is available, these informal documents can support ethical clinical decision making and person-centred care.

More information

Advance care planning and the law | Advance Care Planning Australia (advancecareplanning.org.au)

Professional considerations | Advance Care Planning Australia (advancecareplanning.org.au)

End of Life Law for Clinicians | End of Life Law in Australia | Queensland University of Technology (end-of-life.qut.edu.au)

A training program to support clinical practice | End of Life Law for Clinicians | Palliative Care Education and Training Collaborative Learning Management System (palliativecareeducation.com.au)

End of Life Law Toolkit | End of Life Directions for Aged Care (eldac.com.au)

Order of priority in decision-making

If a person has capacity to make a healthcare decision, they can direct, and be responsible for their health, treatment and care decisions.

The guardianship laws in Queensland were designed to ensure that there is always someone to represent the person who has impaired capacity. Under the guardianship legislation, except in some urgent situations, consent is required from the relevant decision-maker(s) for all healthcare decisions including the withholding or withdrawing of life-sustaining measures from a person who has impaired capacity.

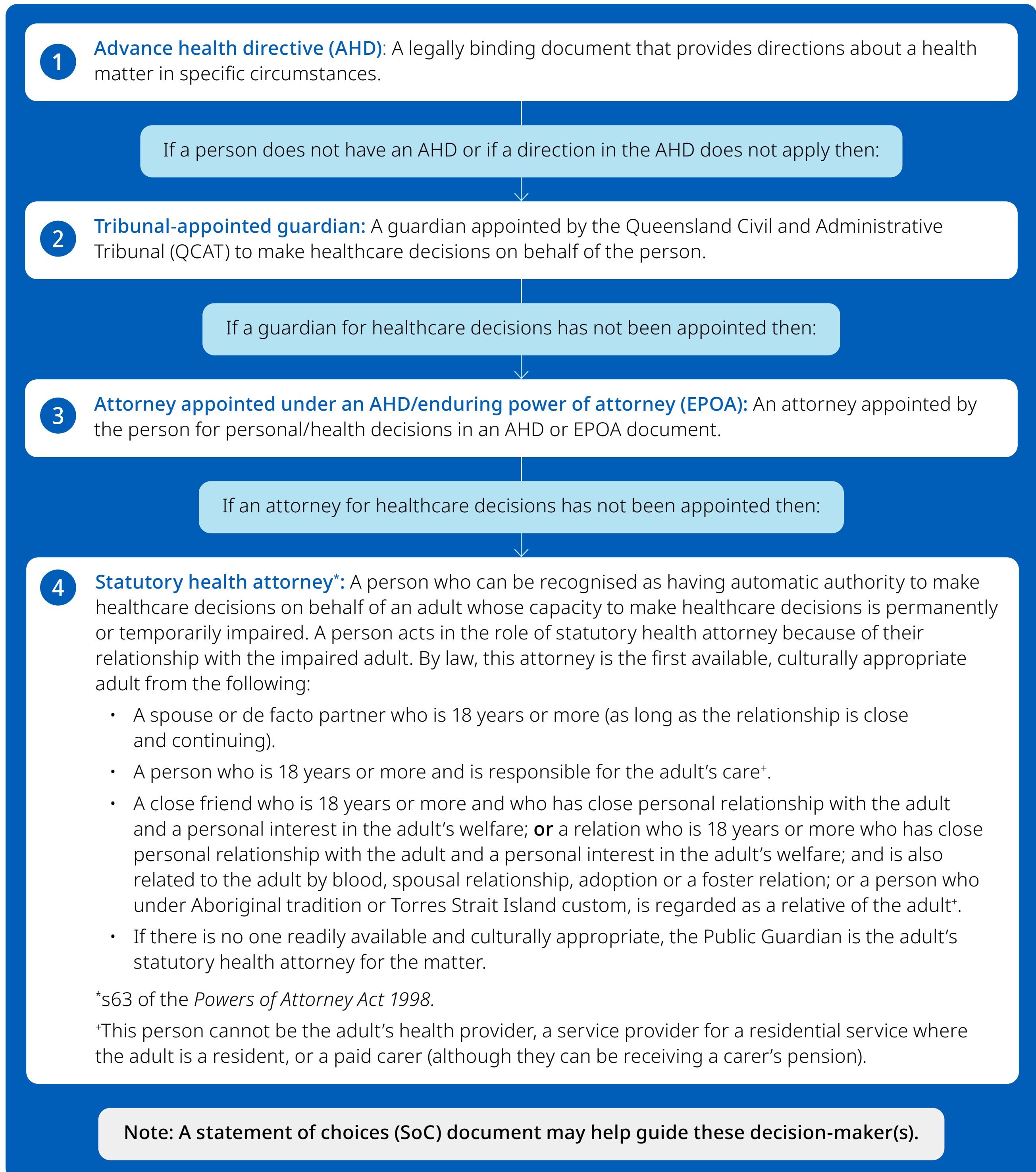
As per s66 of the *Guardianship and Administration Act 2000*, Figure 1 shows the order of priority in decision-making for a health matter in Queensland and its association with relevant ACP documents.

The general principles and health care principles of the *Guardianship and Administration Act 2000* emphasise the importance of involving adults with impaired capacity in care decisions, as much as practicable, to ensure a respectful, inclusive, and person-centred approach.

This includes:

- Seeking their input, even if capacity is limited
- Using clear and simple communication methods
- Engaging family, key supporters, or advocates to assist in expressing preferences
- Regularly reviewing decisions and alignment with their views, wishes, preferences and personal circumstances.

Figure 1: Order of priority in decision-making where someone does not have capacity to make a health care decision[7]



7. Statewide Office of Advance Care Planning, *Statement of Choices* (Queensland, 2025), https://www.qld.gov.au/__data/assets/pdf_file/0017/506015/soc-qldhealth-form-a.pdf

System supporting advance care planning in Queensland

Advance care planning is a high-value intervention, that has the potential to deliver person-centred care and reduce the use of resources that are not in line with the person’s wishes. In recognition of this, a unified and standardised system to promote ongoing advance care planning and provide real-time access to quality advance care planning documentation across service settings has been implemented by Queensland Health.

Key components of the system

- Statewide digital infrastructure known as the ACP Tracker.
- Statewide Office of Advance Care Planning and in some Hospital and Health Services, ACP facilitators.
- ACP incentives, activity reports and resources including the My Care, My Choices website.

ACP Tracker

The ACP Tracker is an online repository enabling clinicians to have real time access to ACP documents and comments across service settings.

It is a critical part of the infrastructure in Queensland enabling person's preferences and choices for care to be accessible as required and is supporting the highest quality of person-centred care across service settings by:

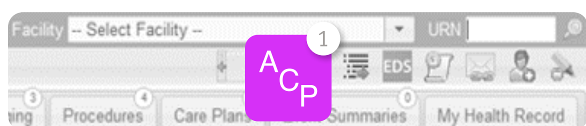
- Providing a mechanism to share ACP documents/related comments.
- Allowing easy recognition of, and access to quality ACP documents and identification of substitute decision-maker(s).
- Promoting continuance of ACP conversations, even if they are in different settings.
- Supporting the 'review' step in the ACP process, with a structure that allows for changes over time and access to historical ACP documents.

Accessing the ACP Tracker

The ACP Tracker is launched from The Viewer, or in ieMR from the Advance Care Planning menu item, and can be accessed via tablets, desktops and mobile devices by:

- Authorised clinicians across all Queensland Health services and facilities (including Queensland Ambulance Service) and Mater Health.
- All APHRA registered health professionals, including general practitioners/medical specialists, nurses (aged care and general practice) and midwives, pharmacists, optometrists external to QH who have registered for access to the Health Provider Portal.

Look for the ACP icon



The ACP Tracker provides access to:

- Uploaded ACP documents allowing easy recognition of, and access to quality ACP documents and identification of substitute decision-maker(s).
- Acute resuscitation plan (ARP) documents created digitally (or uploaded).
- ACP comments that have been entered.

Every document uploaded to the ACP Tracker is clearly labelled with its name and date. The documents are shown in the order they should be used, based on Queensland's healthcare decision-making framework. Clinicians also have access to helpful tips and links to more information to support their decision-making.

An individual can have multiple ACP documents, and these can change over time. The structure of the ACP Tracker allows for multiple versions of the same document type to be uploaded, and for these to be displayed in the correct order.

To support the ongoing process of ACP, Queensland Health staff (and Brisbane Mater Public clinicians) can add comments to the ACP Tracker when:

- ACP conversations are held.
- A document is completed.
- An existing document is reviewed.
- ACP is declined.

Although ACP comments made while the person is an inpatient are included in the discharge summary, all comments made over time can be viewed in the person's ACP Tracker.

For **Queensland Health services**, adding an ACP Tracker comment can also generate Queensland Weighted Activity Units (QWAUs), which are in addition to the QWAUs of a normal patient episode. The *Healthcare Purchasing and System Performance Division Queensland Funding Model Localisation Specifications (PDF)* for ACP can be accessed on QHEPS. See **page 52** for more information.

Importantly, access to the ACP Tracker (via the Health Provider Portal or otherwise), allows for the ACP process to be continued, even if this is in a different facility.

Statewide Office of Advance Care Planning

The Statewide Office of Advance Care Planning is a free service funded by Queensland Health that supports and promotes the important processes of ACP.

This recurrently funded, multidisciplinary service:

- Provides information and resources to consumers and health professionals about ACP.
- Receives and reviews copies of ACP documents.
- Uploads ACP documents to the person's Queensland Health electronic hospital record (ACP Tracker).
- Connects individuals to ACP services in their local area (where available).
- Manages a de-identified central database of Queenslanders' end-of-life care preferences.

A key function of the Statewide Office of Advance Care Planning is to provide a statewide, standardised clinical approach to the receipt, quality review and upload of ACP documents. A copy/scan of ACP documents can be sent to the service by individuals, as well as acute, community and aged care services from across Queensland.

The Statewide Office of Advance Care Planning reviews each document received, and if it meets criteria, based on legislative and administrative requirements, will upload it to the ACP Tracker in the person's Queensland Health electronic hospital record.

This process is supporting clinicians, from across care settings, that are involved in the person's care to have direct, real-time access to ACP documents, and to have confidence in the quality of the documents being accessed from the system.

It is also providing peace of mind to individuals, that their ACP documents can be accessed when needed, and that their preferences and values about health care, can be made known and respected, if they are unable to speak for themselves.

Visit mycaremychoices.com.au for more information.

More information

Accessing The Viewer as an external provider | Queensland Health (health.qld.gov.au)

Using The Viewer | Queensland Health (health.qld.gov.au)

Guides, factsheets and updates on system enhancements to help practitioners use The Viewer | Queensland Health (health.qld.gov.au)

Health Provider Portal privacy and security | Queensland Health (health.qld.gov.au)

Information about The Viewer for consumers | Queensland Health (health.qld.gov.au)

Accessing ACP documents | Queensland Health (health.qld.gov.au)

Role and responsibilities of health professionals in the advance care planning process

Health professionals across the multidisciplinary team have an important role in initiating advance care planning conversations, supporting the person and their substitute decision-maker(s) through the process, and accessing and enacting related documents when the person is unable to make decisions for themselves.

The incorporation of ACP into routine care in this way helps health professionals to know what kind of care the person wants and can improve the concordance between the person's wishes and provided care. Actions by health professionals to proactively identify appropriate opportunities to raise ACP, can allow the person time to reflect and make considered and informed choices about future health care that reflect their views, wishes and preferences.

ACP is a voluntary, personal, reflective, and iterative process that requires sensitive, engaging and focused support.

The process itself will be experienced differently according to the unique circumstances of the person, however, in general it begins with:

Step 1. Think – A person taking time to think about what matters most in their life. This includes clarifying their values and priorities, considering possible future health scenarios, and reflecting on treatments and outcomes that may be relevant to their circumstances.

It also involves identifying their care preferences and choosing **substitute decision-maker(s)** who will:

- Accept the role.
- Talk with the person about their goals, values and preferences.
- Advocate for and follow those choices, even if they personally disagree.
- Be able to make decisions when required.

Step 2. Talk – The next step is the sharing of personal reflections about values, preferences and wishes with the people who need to know. **Talk** involves creating a shared understanding through open conversations with family, friends and carers, engaging with health professionals, preparing others for their roles, and addressing any misunderstandings that may arise.

Step 3. Record – Ideally, it includes **recording** of views, wishes and preferences in a Queensland ACP document.

Step 4. Share – Includes **sharing** of completed documents with those close to the person, their doctor, healthcare services involved in their care and the Statewide Office of Advance Care Planning.

Step 5. Review – Includes the regular **review** of choices and documents and updating/sharing accordingly.

The five key elements of the ACP process are:

1. **Think**
2. **Talk**
3. **Record**
4. **Share**
5. **Review**

Health professionals across the multidisciplinary team can support the person to move between these key elements as their personal, health or lifestyle circumstances change.

A health professional's role also includes knowing when to enact and follow the person's formal ACP documents, and when to use informal documents, like written statements or values-based ACP documents, to help guide conversations with substitute decision-makers.

Different health professionals have different responsibilities in ACP, but all play an important role in helping the person have choice in their care.

All medical, nursing, allied health clinicians and First Nations health professionals are encouraged to participate in the ACP process with patients, their families and key supporters. If required, this includes seeking support or input by a member of the multidisciplinary team who may be more experienced in the different elements of the ACP process.

A brief description of the role of health professionals in each of these elements is shown in Figure 2.

More information

Refer to local policy and procedures in relation to ACP to clarify expectations around your role

Professional considerations | Advance Care Planning (advancecareplanning.org.au)

Figure 2: Role of health professionals in the advance care planning process

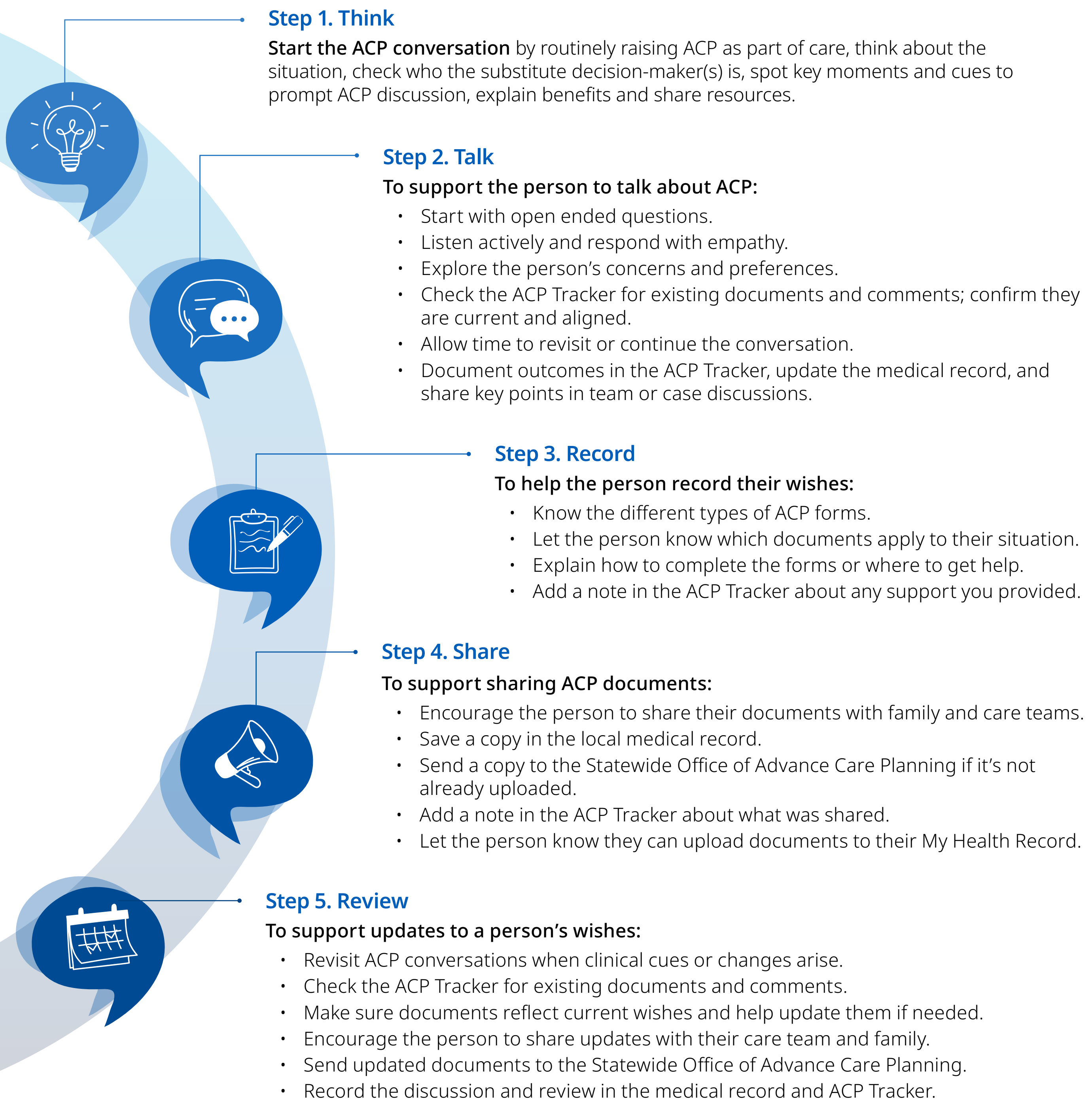


Figure adapted with permission from [Advance Care Planning Australia (advancecareplanning.org.au)](advancecareplanning.org.au)

Enact

When a care decision is required and a person has impaired decision-making capacity, health professionals in accordance with good medical practice, should:

- Check the ACP Tracker in the person's hospital record.
- Review any ACP documents and comments.
- Consider how the documents apply to the current decision and legal requirements.
- Identify the substitute decision-maker(s) and note any conditions or limits on their role.
- Involve the person as much as possible in decisions.
- Advocate for what matters most to the person, including their preferred place of care.
- Reflect the person's choices in treatment plans and team discussions to support coordinated care.

Advance care planning can support care in alignment with an individual's expressed values and leave a positive bereavement legacy for family, friends, and other important people in their life.

Skills for effective advance care planning conversations

Communication is a core part of every clinician's role and a fundamental part of ACP. Any health professional with good communication skills can raise or positively respond to queries about ACP.

Health professionals (in all settings) can play an important role in proactively identifying appropriate opportunities to raise ACP, rather than waiting for the person to raise the topic.

Good communication allows the person time to reflect and make considered and informed decisions that reflect their views, wishes and preferences. This can help the person to identify and articulate treatments that they both want and do not want.

Many health professionals have the skills, confidence and expert knowledge to have in-depth ACP conversations and support individuals through the ACP process. Some health professionals may feel that discussions about ACP are beyond their scope of practice. It is important to understand your own capability, seek additional training as required and recognise when to refer the person for more support.

Encourage the person to continue the ACP process and give them or direct them to further information to reflect on and explore.

Tips for good communication

In ACP, effective communication skills include:

- Active listening
- Open-ended questioning
- Use of clear and understandable information (plain language)
- Empathy and validation (compassion)
- Reflection and clarification questions
- Respect for the person's autonomy (a non-biased and non-judgemental approach)
- Summarising.

Caring conversations support an atmosphere of trust and openness, encouraging honest communication.

More information

A range of evidence-based communication tools and resources are available to support health professionals' communication skills in ACP and end-of-life discussions

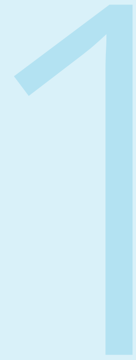
Online learning courses | Advance Care Planning Australia (advancecareplanning.org.au)

Module 2: Communicating with people affected by life-limiting illness | PCC4U (pcc4u.org.au)

Communication skills for serious illness | VitalTalk (vitaltalk.org)

Quick guides | VitalTalk (vitaltalk.org)

Communication training resources | End-of-Life Essentials (endoflifeessentials.com.au)



Think

Thinking about and planning for future care involves personal reflection and identifying what matters most to each person. This process is crucial for improving choice and coordinating care, particularly towards the end of life. Routinely raising advance care planning as part of care, and supporting the person to reflect on what is important to them, helps create space for honest consideration of concerns, preferences and the possible future impact of illness.

While some individuals may not want to think about the future, many value the opportunity to reflect and prepare for decisions that may arise. Engaging in this reflective process can enhance a person's sense of control, self-determination, optimism and hope.

Health professionals play a crucial role in enabling this reflective stage. They help create the conditions for safe, supported thinking by:

- Spotting key moments or cues that encourage the person to reflect on their views, wishes and preferences.
- Normalising conversations about future care so they become a routine and expected part of care.
- Providing clear, relevant information about the person's health status and likely future scenarios.
- Providing the person with information about ACP and helping them revisit and refine their plans over time as their health, circumstances or preferences evolve.

Through their guidance, reassurance and clinical insight, health professionals help individuals feel informed, supported and confident as they think about what matters most.

Preparing for advance care planning discussions

- Consider learning about ACP through relevant training, including education and training provided by the Statewide Office of Advance Care Planning available on Education | Statewide Office of Advance Care Planning (health.qld.gov.au)
- Familiarise yourself with relevant information and ACP resources.
- Look for and take opportunities to talk to individuals about ACP.

Tips for encouraging advance care planning

- Introduce ACP early as part of routine care, rather than the result of health decline or crisis.
- Consider the person's condition and when it might be appropriate or important to start or revisit ACP.
- For individuals who are not interested in ACP, highlight the benefits and let them know they can revisit the topic at any time.

Opportunities to raise advance care planning

In addition to initiation of the conversation by the person or their family member, triggers for ACP conversations can include:

- A diagnosis of a chronic, progressive or life-limiting condition that could result in loss of capacity.
- People with multiple co-morbidities.
- Aged or older people who are frail, vulnerable or isolated.
- A change or deterioration in condition.
- If there is a change in personal circumstances (for example, moving to an aged care home, loss of a family member).
- Consideration of the "Surprise Question", where you would not be surprised if the person died within 12 months. See below useful tools – Prompts for End-of-Life Planning (PELP) Framework.
- During acute resuscitation planning discussions.

Useful tools

The Prompts for End-of-Life Planning (PELP) Framework can be used in any setting. It guides health professionals to:

- Consider the person's condition and when it might be appropriate or important to start or revisit ACP.
- Reflect on the question 'Would I be surprised if this person died within 12 months?'
- If the answer is **no**, the PELP Framework can help you to consider which trajectory the person is in, how ACP applies to their situation, and related clinical care.

The Supportive and Palliative Care Indicators Tool (SPICT) (PDF) helps identify individuals with deteriorating health due to advanced conditions or serious illness, and can prompt the need for holistic assessment and future care planning.

Advance care planning screening interviews

Implementation of ACP screening interviews as part of routine care helps to normalise the topic of ACP and introduce it to the person in a non-threatening way.

This structured approach provides a mechanism for health professionals to:

- Introduce the topic of ACP.
- Determine the person's preferred substitute decision-maker(s).
- Identify previous involvement in ACP and any documents completed.
- Assess the person's willingness to further explore ACP.

Individuals who are frail, have multiple health conditions, or are living with a progressive illness that is expected to worsen and may eventually affect their ability to make healthcare decisions are important groups to include in routine ACP screening interviews.

The type of ACP screening interview to use depends on capacity of the person.

The following two screening interviews have been modified (with permission) from The Advance Project® screening interviews to suit the Queensland context. See:

- Appendix 2: For individuals who can make their own healthcare decisions, as well as those who need support in making healthcare decisions for themselves
- Appendix 3: If the person you are caring for does not have capacity to make healthcare decisions for themselves

Responding to interest in advance care planning

- Be open to engaging in ACP conversations.
- Acknowledge and validate the importance of the conversation.
- Provide or direct the person to reliable, easy to read information, for example, mycaremychoices.com.au, *Advance care planning brochure (PDF)*, *Advance care yarning brochure (PDF)*, *advance care planning getting started guide (PDF)*.
- Encourage the person to talk with their family and friends about what is important to them.
- Acknowledge and respect the person's own beliefs and values (be aware of and avoid imposing own biases).
- Recognise the different needs of priority groups, for example, children and young people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, refugee and asylum-seeking backgrounds, people with a mental illness, people with a disability, LGBTIQA+ people.
- Use a culturally safe, trauma-informed approach to ACP conversations that prioritises respect, empathy and empowerment. This approach ensures individuals feel heard and supported in making decisions about their care, while recognising the influence of culture and trauma on their experiences. By adopting this approach, health professionals can foster trust and build meaningful relationships with individuals and their families.
- Recognise ACP as an ongoing, evolving process and plan time to continue the conversations.
- Add a comment to the ACP Tracker about ACP discussions.

Tips for talking about advance care planning

- Remember, ACP is **voluntary** and the person should not feel pressured to participate in discussions.
- Offer written information for the person to take away if they are interested.
- Offer to connect to services/supports as applicable and available (for example, treating team, local ACP facilitators/ services/champions, Statewide Office of Advance Care Planning).

Comments that may suggest a person is interested in advance care planning:

- "How will I know when the time comes to stop this treatment?"
- "Just keep me comfortable"
- "What is going to happen to me in the future?"
- "Is there any hope of recovery?"
- "If I'm always going to feel like this, I don't want to go on."
- "Do you think palliative care might help my mother/father?"
- "My mother doesn't want to go back to hospital again. How can we make sure that doesn't happen?"

Health professionals can support successful ACP by:

- Recognising the triggers to initiate or review ACP.
- Using good communication skills.
- Understanding the options available.
- Being aware of the processes for documentation and dissemination.

More information (for health professionals)

Talk about your choices | Advance Care Planning Australia (advancecareplanning.org.au)

Learning | Advance Care Planning Australia (advancecareplanning.org.au)

Home | The Palliative Care Education Directory (pace.org.au)

Home | End of Life Directions for Aged Care (eldac.com.au)

eLearning Modules | Gwandalan Palliative Care | (gwandalanpalliativecare.com.au)

Practical tips for advance care planning conversations (youtube.com/watch?v=ewxaUz-ZWTM)

Resources to share with individuals

Advance care planning information

Queensland advance care planning forms | Statewide Office of Advance Care Planning (qld.gov.au)

My Care, My Choices brochure | Statewide Office of Advance Care Planning (qld.gov.au)

Advance care planning in your language | Advance care planning support | Statewide Office of Advance Care Planning (qld.gov.au)

Other languages | Queensland Public Trustee (pt.qld.gov.au)

The Questions That Matter Most | Advance Care Planning Australia (youtube.com)

Discussion starters

Conversation starters | Advance Care Planning Australia (advancecareplanning.org.au)

Discussion starters | Palliative Care Australia (palliativecare.org.au)

Shared decision making – The Care Companion | Queensland Health (health.qld.gov.au)

Julian's Key Health Passport | Queensland Health (health.qld.gov.au)

Advance care yarning

Support for Aboriginal and Torres Strait Islander peoples | Advance care planning support | Statewide Office of Advance Care Planning (qld.gov.au)

2

Talk

Talking about future care focuses on communication and building shared understanding. It helps create open, honest conversations that explore a person's concerns and preferences, clarify what matters most, and ensure others understand the person's wishes. Conversations with health professionals, family and friends support reflection and help prepare everyone for future decision-making. Advance care planning is not a single conversation, but a series of discussions that are revisited over time, particularly as a person's health changes.

Proactively raising discussions about ACP provides a safe environment to explore the likely impact of illness, discuss options and address questions or uncertainties. These conversations are foundational in supporting alignment of care with the person's view, wishes and preferences, and highlight the essential role health professionals play in initiating, guiding and sustaining meaningful ACP dialogue.

Health professionals play a central role in this communication stage. They:

- Initiate and normalise conversations about ACP as part of routine practice.
- Create a safe, respectful environment where the person feels comfortable expressing their values and concerns.
- Provide clear, accurate information to support informed choices.
- Facilitate discussions between the person, their family and key supporters to build shared understanding.
- Record outcomes in the ACP Tracker, document key points in the medical record, and share relevant information in team or case discussions.
- Revisit conversations over time to ensure plans remain aligned with the person's evolving goals and health status.

Through their communication skills, clinical insight and ongoing engagement, health professionals help support the understanding, respect and integration of a person's wishes into future care planning.

Supporting advance care planning discussions

Normalising ACP conversations helps make them a consistent and expected part of care. When raised routinely, ACP can be discussed in the broader context of goals for healthy living, wellbeing and positive mental health. This reinforces that ACP is not only relevant at the end of life, but also during periods of advancing illness when the person may lose capacity to make decisions.

Proactively raising the topic of ACP is about providing clear information and enabling the person to make informed choices. Doing so supports individuals to consider the personal aspects of their care, be better prepared for future decisions, and begin early conversations with those close to them.

Health professionals play a central role in supporting these discussions. By introducing ACP in a calm, respectful and routine way, they help create a safe environment where the person can explore the likely impact of illness, discuss options and address questions or uncertainties. Their guidance helps ensure that ACP becomes a meaningful, ongoing process that aligns care with the person's views, wishes and preferences.

Before you begin the discussion consider:

- Is the environment private and comfortable with no or minimal interruptions?
- Who should be present?
- Does the person, their family or key supporters have capacity to participate in the discussion?
- Do you have all relevant clinical information available (review files and notes)?
- Are there any cultural or religious needs to consider?
- Should support from an Aboriginal and Torres Strait Islander Liaison Officer, Health Worker or health professional be considered?
- Do you need an interpreter/translator to help with the discussion?
- Are assistive communication devices or health professionals experienced in supporting communication required?
- Is extra time needed for the appointment?

Starting the conversation

An initial focus on the person's values and preferences rather than on particular treatments, interventions or outcomes is considered to be the most effective approach.

Use general open questions and be guided by the person's cues and responses to explore further.

Two questions that may be useful in initiating an ACP discussion are:

- If you cannot participate in healthcare decisions, who should we speak with?
- If you cannot participate in decision making, what should we consider when making decisions about your care?[8]

8. Margaret M. Mahon, "An Advance Directive in Two Questions," Journal of Pain and Symptom Management 41, no. 4 (2011): 801–07, doi: 10.1016/j.jpainsymman.2011.01.002

Examples of conversation starters

For a healthy person

"If you became unwell and were unable to make or communicate your own decisions, who would you want to make decisions on your behalf?"

"Do you know what you would want them to say?"

"I try to talk to all my patients about what they would want if they become more unwell. Have you ever thought about this?'"

"What does it mean to you to 'live well'?"

"I am pleased to see you recovering from your recent illness. If you became very sick again, have you thought about the treatment that you would want or not want?"

For someone with a life-limiting illness(es)

"When you think of the future, what worries you the most?"

"I am pleased to see you recovering from your recent illness. If you became very sick again, would you like to discuss how we should approach your care during the times when you are not well? What is important to you? Who would you like me to involve?"

"Have you given any thought to what kinds of treatment you would want (or not want) if you became unable to speak for yourself?"

"This is a long-term condition and there are going to be periods when you are well and periods when you will not be so well. What do you understand about where things stand right now with your illness?"

For someone expected to deteriorate or die within the next 12 months

"We have discussed what I think is likely to happen in the future. I would like to know more about how you think we should approach your care from here.

What is important to you? Who would you like me to involve? Have you been thinking much about what happens?"

For someone with a mental illness

"Thinking back to when you were unwell, what care would you have liked to have received or not received?"

During the discussion

Explain what ACP is and why it may be useful for the person to talk about ACP with their family and friends. The person may want to consider:

- Current health and health problems and family history.
- Concerns or worries about their future health care.
- Their fears about their future health and wellbeing (for example: pain, losing the ability to communicate, being dependent on family members or key supporters, being removed from life support too soon).
- Any other concerns or worries.
- Important values or personal goals for care.
- Preferences for types of care or treatment.

Check whether the person already has an ACP document, and if so, whether it needs to be reviewed.

Other considerations

- Use language that the person can understand and relevant communication aids, such as visual aids, pictures, or assistive technologies, to support understanding.
- Encourage the person to express their wishes and explore their options without fear of judgment or pressure.
- Give enough information to make informed choices without overloading the person.
- Clarify any ambiguous statements that the person makes, for example:
  - Person: "I don't want heroics"
  - Professional: "Can you help me understand what you mean by heroics?" or "Are there specific treatments or interventions you're concerned about?"
- Openly explore concerns and preferences.
- Recognise and respond to the person's emotions and feelings.
- Maintain a sensitive and compassionate approach, mindful of cultural, linguistic, and personal factors that may influence the person's decision-making process.
- While voluntary assisted dying (VAD) cannot be requested via an ACP document or a substitute decision-maker(s), the topic of VAD may arise during ACP discussions. Health professionals need to be prepared for discussions about VAD and know how to respond appropriately, regardless of their views. The following factsheets provide information about ACP and VAD, including the role of health professionals in these conversations:
  - *Advance care planning and voluntary assisted dying (PDF)*
  - *Navigating the topic of Voluntary Assisted Dying in Advance Care Planning Conversations (PDF)*

When closing discussions

Review and summarise discussions with the person and those present; and clarify any inconsistencies or misunderstandings.

Offer take-home information and resources for the person to consider.

Arrange another time to continue, complete or review the discussion or refer to appropriate supports.

Encourage the person to continue discussions with others they trust including:

- Substitute decision-maker(s)
- Family
- Friends
- Key supporters
- Other members of their healthcare team
- Cultural or spiritual support person
- Legal professionals.

Outcomes of discussions

The potential outcomes of ACP discussions include:

- The **person does not wish to engage in ACP at that time**. For individuals who are not interested in ACP, highlight the benefits. Let the person know they are welcome to revisit the discussion at any time. If appropriate, reoffer into the future.
- The person **talks about** their views, wishes or preferences in relation to future care and explains their feelings, beliefs and values that govern how they make decisions. This may include discussion about medical and non-medical matters. These conversations can be recorded in the person's ACP Tracker and medical records.
- The **person decides to write down their views, wishes or preferences** in relation to future care in a values-based document. A statement of choices form A can be used by a person who can make healthcare decisions for themselves, and a statement of choices form B is used for a person who cannot make health decisions for themselves. Such statements are not legally binding but as per the health care principles and general principles in the *Guardianship and Administration Act 2000*, must be considered when making healthcare decisions on behalf of the person.
- The **person decides to write an advance direction** about their future health care and special health care (for example, life-sustaining treatment in certain circumstances, other health care or blood transfusions) in an AHD. There are formal requirements for this type of document to be legally binding and applicability factors to consider when acting on directions. Values statements may also be included in this type of document.
- The **person decides to formally appoint an attorney(s) to whom they give decision-making powers** should they lose capacity to make decisions for themselves. This could be in an AHD or EPOA document. Formal requirements also apply for this document to be legally binding.
- The person reviewing their existing ACP documents and shared documentation that summarises key goals and priorities and treatment options.

Open exploration of concerns and preferences may lead to a different direction or outcome to one that you or the one the patient envisaged, for example, the person talking with a trusted individual or key supporter about something they previously did not have the confidence to do.

Referring individuals for additional support

During ACP discussions, individuals may bring up topics that extend beyond the expertise or scope of some health professionals. Common examples include queries about Wills, EPOAs or voluntary assisted dying.

In such cases, it is important to guide individuals to appropriate services that can provide specialised advice and support.

Refer to the **page 57 (where to go for further information)** for a list of services who can assist individuals or health professionals with matters related to ACP.

3

Record

Ideally, the process of advance care planning will include the recording of wishes and/or directions in an advance care planning document.

A range of ACP documents exist. Queensland ACP documents can be grouped into statutory and non-statutory, with each varying in its purpose, role and function.

An individual's choice, needs and decision-making capacity influences the type of form that can be completed. Whilst a person has capacity, they can choose to complete any document they feel meets their needs.

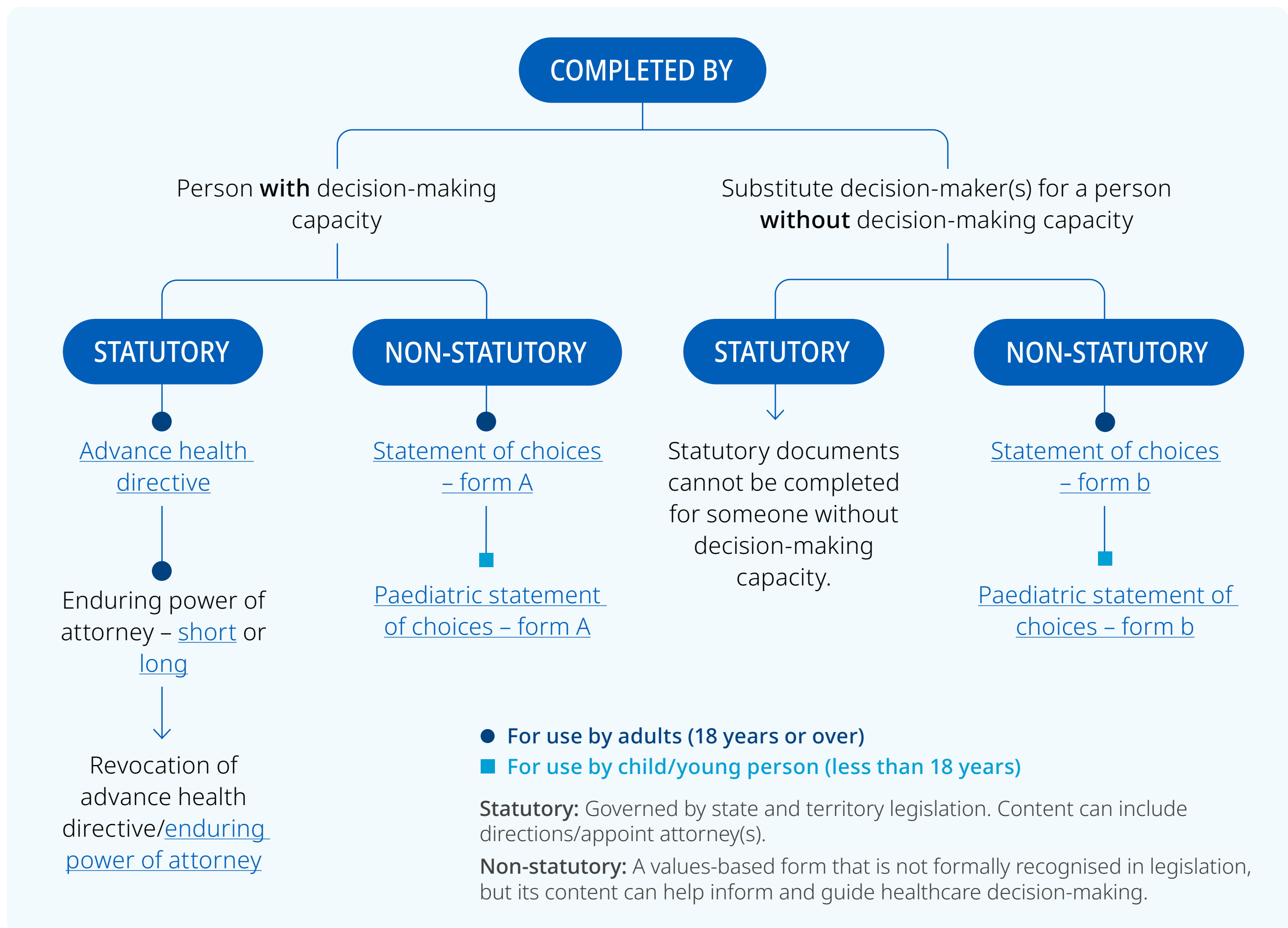
Advance care planning documentation flowchart for Queensland

Figure 3 provides an overview of the standardised ACP forms used in QLD, with more detail available on **pages 35 to 39**.

ACP forms are available electronically from Queensland advance care planning forms | Statewide Office of Advance Care Planning (qld.gov.au)

A health professional cannot make an ACP document on behalf of the person. Goals of care type documents (for example, an ARP) are medical orders, initiated and completed by a medical officer or nurse practitioner. Although an ARP is informed by the persons views, wishes and preferences/ACP documents, they are not considered to be an ACP form.

Figure 3: Standardised advance care planning forms used in Queensland



Tips for talking about advance care planning forms

When describing different forms, encourage the person to consider which form(s) are right for them.

Refer to the **page 57 (where to go for further information)** for a list of services who can support the person with completing ACP documents.

Figure 3 note: An AHD must be written and may be in the approved form, but must follow s44 of the *Powers of Attorney Act 1998*. The *Advance health directive for mental health guide and form (PDF)* is commonly used to assist making an AHD for mental health and was Office of the Chief Psychiatrist post introduction of the *Mental Health Act 2016*.

Legal enforceability of advance care planning documents

A statutory ACP document is the most formal way to record an individual's views, wishes, preferences and decisions. There are unique statutory documents for Queensland (for example, AHD and EPOA). Such documents are recognised under Queensland legislation and must:

- Be made by an adult with capacity. The legal test of capacity to make an enduring document is outlined in the *Queensland Capacity Assessment Guidelines 2020 (PDF).*
- Be made by the person, not by someone else on their behalf.
- Meet formal witnessing and signing requirements.

Considering the above requirements, statutory documents have the strongest legal weight and generally must be followed.

Non-statutory ACP documents are not made under Queensland legislation, are not legally binding, and do not provide consent in advance. They do not carry the same legal weight as a statutory document; however, as the views, wishes and preferences of the person are required to be considered when making care decisions on the person's behalf, the content of non-statutory documents have legal effect.

Both statutory and non-statutory documents can play a crucial role in future planning and communication with potential substitute decision-makers.

Statutory and common law advance care planning documents from other states and territories

There is variation in legislation across jurisdictions related to ACP and the recognition/use of related documents.

Interstate and New Zealand EPOA type documents are made under different legislation; however, they may be recognised in Queensland. Consultation with a legal professional can confirm the legal position of a document in Queensland pursuant to s34 of the *Powers of Attorney Act 1998* and verify whether the powers conferred in the document are for personal/health and/or financial matters. Such legal advice will provide the necessary clarity and confidence for Queensland Health clinicians to act upon the content of the document, when required.

Interstate AHD type documents are made under the legislation of a different jurisdiction and there is no regulation prescribing that this document can be recognised in Queensland, as required by s40 of the *Powers of Attorney Act 1998*.

Common law advance care directives from other states and territories are not recognised in Queensland. If a person with decision-making capacity is permanently moving to Queensland, encouraging them to update their documentation using Queensland standardised forms is recommended.

Seeking clarity on the validity of documents

The formal requirements of statutory documents are outlined in s44 in the *Powers of Attorney Act 1998*.

Each ACP document received by the Statewide Office of Advance Care Planning is reviewed against criteria based on legislative and administrative requirements.

If the document meets criteria, it is uploaded to the ACP Tracker in the person's Queensland Health electronic hospital record. Documents that do not meet criteria are incomplete (ineffective) and not able to be used as intended. In such instances, the sender is notified of document issues, options to remedy and a comment added to the ACP Tracker about the document issue.

Where there are concerns about the validity of a statutory document for a person with capacity, these should be discussed with the person. Individuals may choose to consult a legal professional to ensure statutory documents related to ACP are executed properly. Alternatively, they may wish to make a new document.

If the adult does not have capacity, staff can:

- Follow internal processes for resolution of document concerns.
- Discuss this with their relevant legal team and consider making an application to QCAT about the validity of an enduring document.
- Consider appropriateness/suitability of substitute decision-maker(s) making a non-statutory document.

Role of the Queensland Civil and Administrative Tribunal

QCAT is an independent, accessible tribunal that can make decisions on applications about adults who may have impaired decision-making capacity on human rights matters including guardianship and administration.

QCAT can also make various orders about enduring documents, including:

- A declaration about whether an adult has capacity to make an enduring document.
- An order about the validity of an EPOA.
- An order removing an attorney.
- An order changing the terms of the document.
- An order revoking (cancelling) the document.
- An order giving directions, advice or recommendations.
- An order granting leave for an attorney to resign.

More information

Checklists and criteria used to determine if documents are complete and eligible for upload to The Viewer | Statewide Office of Advance Care Planning (health.qld.gov.au)

Make an application | Decision-making for Adults with impaired capacity | QCAT (qcat.qld.gov.au)

Decision-making for Adults with impaired capacity | QCAT (qcat.qld.gov.au)

Supporting individuals to complete advance care planning documents

When the person documents their preferences in writing they have a greater chance of ensuring their preferences for treatment and care will be followed at a time when they are no longer able to make decisions for themselves.

Health professionals can support individuals to document their views, wishes and preferences for care by:

- Discussing the intent and purpose of different documents.
- Providing information and guidance about treatment decisions to consider and the potential outcomes(s) of their choices.
- Encouraging the person to write down their directions about medical treatment in their own words.
- Offering written information for the person to take away and consider (including instructional guides for relevant forms).
- Recommending the person seeks medical and/or legal professional assistance when completing a statutory document.
- Refer the person to relevant organisations for assistance. See where to go for further information on **page 57**.

An individual can choose whichever ACP form they feel meets their need. When helping the person decide which ACP documentation is right for them, it is useful to refer to the order of priority in decision-making for a health matter in Queensland (**page 14**, Figure 1). This explains the order in which health professionals must consult decision-makers when seeking a treatment decision for a person who has impaired capacity. AHDs are at the top of the hierarchy.

Details of Queensland advance care planning documents

Advance health directive

Form: Advance health directive - form | Publications portal | Queensland Government (publications.qld.gov.au)

Type of document: Statutory

Form 4

Advance health directive
(Queensland)

An advance health directive (often referred to as an AHD) is a legal document completed by a competent adult that contains decisions regarding future health care and special health care and can also appoint an attorney(s) for health matters.

It includes directions about life-sustaining treatments, blood transfusions and other health care and specifies the treatments for which consent is provided, refused or withdrawn under specific circumstances. The person can also include their views, wishes and preferences and note things that are most important to them about their health and care. It will only operate when the person becomes incapable of making or communicating their decisions.

The *Advance health directive explanatory guide (PDF)* provides detailed explanatory notes about the information required to complete the form. It steps through the questions and provides useful information, practical examples, hints and tips.

A doctor or nurse practitioner is required to complete the certificate stating the person has capacity to make the document.

To be complete, an AHD must also be witnessed by an eligible witness (Justice of the Peace, Commissioner for Declarations, Lawyer or Notary Public). An *Interpreter's/translator's statement (PDF)* should be used by an interpreter or translator who interprets or translates an AHD.

All health professionals should understand what an AHD can and cannot be used for, and when it applies. There are some circumstances that may affect the operation of an AHD (see *Powers of Attorney Act* in Table 1 on **page 11**, Appendix 1: Flowchart for Health Care Decision Making in Adults Without Capacity and *Guide to Informed Decision-making in Health Care*).

Advance health directives cannot be used to:

- Request voluntary assisted dying* as this requires a person to have decision-making capacity through the entire process. The Queensland Voluntary Assisted Dying Support and Pharmacy Service provides advice and support to Queenslanders about voluntary assisted dying.
  Email: QVADsupport@health.qld.gov.au or call 1800 431 371.
- Request or authorise euthanasia or any act that deliberately causes death.
- Request treatments that are not medically appropriate+.
- Record directions about organ and tissue donation after you have died.

*s37 of the *Powers of Attorney Act 1998*
+s103 of the *Powers of Attorney Act 1998*

Advance health directive for mental health

Form: Guide and form for completing an advance health directive | Advance health directive for mental health | Queensland Health (health.qld.gov.au)

Type of document: Statutory

An AHD for mental health, or other document, may be made where the person, while having capacity, specifies their preferences for future mental health treatment if they are later unable to make decisions for themselves.

It allows the person to document their wishes about specific treatments (like consenting to or refusing certain medications) and can also appoint an attorney to make decisions on their behalf.

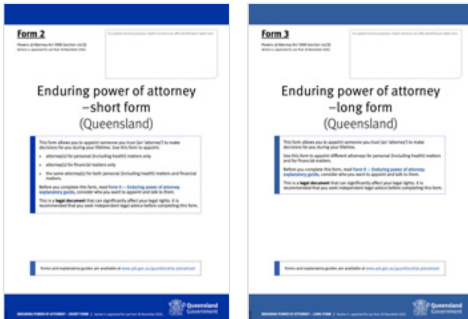
The document only takes effect if the person loses the capacity to make and communicate their own decisions.

Enduring power of attorney

Short Form: [Enduring power of attorney - short form | Publications portal | Queensland Government (publications.qld.gov.au)]

Long Form: [Enduring power of attorney - long form | Publications portal | Queensland Government (publications.qld.gov.au)]

Type of document: Statutory


Form 2
Enduring power of attorney
–short form
(Queensland)

Form 3
Enduring power of attorney
–long form
(Queensland)

An enduring power of attorney (often referred to as an EPOA) is a legal document in which the person appoints an attorney(s) to make decisions about personal (including health) matters and/or financial matters on their behalf; and sets out the terms and instructions for its operation.

Personal (including health) matters, relate to personal or lifestyle decisions. This includes decisions about:

- Support services.
- Where and with whom the person lives.
- Health care (medical treatments, procedures and services to treat both physical and mental conditions; as well as life-sustaining treatments).
- Legal matters that do not relate to financial or property matters.

Financial matters, relate to decisions about financial or property affairs including:

- Paying expenses.
- Making investments.
- Selling property.
- Carrying on a business.

In terms of operation, an attorney(s) for personal matters (including health matters) can only make decisions when the person does not have capacity to make those decisions for themselves. However, for financial matters, the EPOA document may indicate an attorney(s) power to make decisions begins, for example:

- Immediately.
- From a specific date.
- In particular circumstances or occasions.

There are two types of EPOA documents:

- EPOA short form appoints the same attorney(s) for health and/or financial matters.
- EPOA long form appoints different attorney(s) for health and/or financial matters.

The *Enduring power of attorney explanatory guide (PDF)* provides detailed explanatory notes about the information required to complete the form. It steps through the questions and provides useful information, practical examples, hints and tips.

An EPOA document must be witnessed by an eligible witness (Justice of the Peace, Commissioner for Declarations, Lawyer or Notary Public). An *Interpreter's/translator's statement (PDF)* should be used by an interpreter or translator who interprets or translates an EPOA.

An attorney has important legal duties and obligations they must comply with. Encouraging attorney(s) involvement in ACP discussions can support them in this role.

See more information at:

- Factsheet: Obligations of attorneys under an enduring document| Publications portal | Queensland Government (publications.qld.gov.au)
- Factsheet: General principles and health care principles under Queensland's guardianship framework | Publications portal | Queensland Government (publications.qld.gov.au)

Revocation of an enduring power of attorney

Form: Enduring power of attorney - revocation | Publications portal | Queensland Government (publications.qld.gov.au)

Type of document: Statutory

REVOCATION OF AN ENDURING POWER OF ATTORNEY

A revocation of an EPOA is a legal document that allows the person to revoke (cancel) the appointment of a person or persons as their attorney(s).

The person can revoke (cancel) their EPOA at any time while they have capacity to do so. When revoking an EPOA, the person must take all reasonable steps to advise all their attorney(s) that it has been revoked.

See page 19 of the *Enduring power of attorney explanatory guide (PDF)* for circumstances of when an EPOA may be revoked or cancelled.

Revocation of an advance health directive

There is no approved form to revoke an AHD.

Type of document: Statutory

A revocation of an AHD is a legal document that allows the person to revoke (cancel) their AHD. The person can revoke (cancel) their AHD at any time while they have capacity to do so.

There is no specific form to revoke an AHD; however, any revocation must be in writing and the person must take all reasonable steps to advise any attorney(s) (if appointed) that it has been revoked.

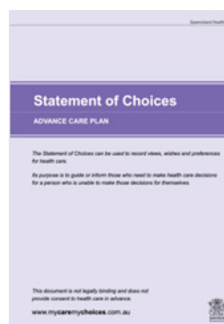
See page 19 of the *Advance health directive explanatory guide (PDF)* for circumstances of when an AHD may be revoked or cancelled.

Statement of choices – form A and form B

Form A: Statement of Choices - Form A | Queensland Government (qld.gov.au)

Form B: Statement of Choices - Form B | Queensland Government (qld.gov.au)

Type of document: Non-statutory


Statement of Choices
ADVANCE CARE PLAN

The statement of choices (often referred to as a SoC) is a values-based document that records the person's wishes and preferences for their health care into the future.

The content provides guidance to substitute decision-makers and clinicians about the person's views, wishes and preferences for care in the event the person is unable to make healthcare decisions for themselves. It helps decision-makers to consider what decisions the person might have made in the circumstances if they had capacity to do so. It is not legally binding and does not provide consent to, or refusal of, treatment.

There are two different forms for the SoC:

- Form A is used by individuals who can make healthcare decisions for themselves.
- Form B is used for individuals who cannot make healthcare decisions for themselves.

Please note: Form B should be completed by the person's legally appointed substitute decision maker(s) or, if not applicable, person(s) in a close and continuing relationship with the individual. The person's healthcare providers should not complete the SoC on the person's behalf.

These guides support completion of the form:

- *Tips for completing a Statement of Choices Form A (PDF)*
- *Tips for completing a Statement of Choices Form B (PDF)*
- *Guide for health professionals using the Statement of Choices (PDF)*

A doctor or nurse practitioner signs and dates the form but the form does not require being witnessed.

Paediatric statement of choices

Form A: [Paediatric Statement of Choices - Form A | Queensland Government (qld.gov.au)]

Form B: [Paediatric Statement of Choices - Form B | Queensland Government (qld.gov.au)]

Type of document: Non-statutory

The paediatric statement of choices is a values-based document used to record a child/young person's views, wishes and preferences for their health care.

Its purpose is to guide or inform those who need to make healthcare decisions when a child or young person is unable to make those decisions for themselves. It helps decision makers to consider what decisions the child/young person might have made in the circumstances if they had competence (see right for definition) to do so. It is not legally binding and does not provide consent to health care in advance.

There are two different forms for the paediatric SoC:

- Form A is used by a young person with decision-making competence.
- Form B is used by parents (or guardian/delegated officer) of a child or young person requiring support with decision-making.

A doctor or nurse practitioner signs and dates the form but the form does not require being witnessed.

Competence (definition)

A Gillick-competent child has the legal capacity to consent to the provision of medical treatment if they can demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of action.

There is no fixed age at which a young person (aged less than 18 years) is automatically capable of consenting to medical treatment generally, or to specific types of medical treatment. Because of the critical nature of decisions around life prolonging treatment, Queensland Health's policy position is that even if the child is Gillick-competent, parents or persons with decision-making authority must be involved in all decisions. A medical officer, supported by the healthcare team, has the responsibility of assessing whether a child is Gillick-competent.

Other considerations not related to health that may be considered at the time of advance care planning

Organ and tissue donation

Requests for organ and tissue donation may be raised during ACP conversations; however, these preferences cannot formally be registered using ACP documents. Refer the person to DonateLife to formally register their wishes for organ and tissue donation.

It is important for the person to talk to those close to them about these types of wishes, as relatives will be asked to agree before organ and tissue donation occurs. For information about organ or tissue donation, visit donatelife.gov.au

Wills

The topic of Wills may be raised during ACP discussions; however, a Will is a legal document setting out what the person wants to do with their money and belongings after they die.

Although important for end-of-life care planning, a Will is not considered an ACP document.

For more information, refer to About Wills | Queensland Public Trustee (pt.qld.gov.au)

Body donation programs

Body donation is a process where individuals can choose to donate their body to medical schools or research institutions to support medical education, training, and research. Although this topic may be raised during ACP conversations, body donation cannot be requested in an ACP document.

In Queensland, body donation is typically coordinated through university anatomy departments. Individuals must register their intent with the relevant university's body donation program. This usually involves completing a consent form and discussing their decision with their family, as their involvement is crucial after death.

For information about body donation programs in Queensland, visit:

- Body Donor Program | University of Queensland (biomedical-sciences.uq.edu.au)
- Become a donor | Griffith University (griffith.edu.au)
- Human Bequest Program | James Cook University (jcu.edu.au)

More information

Queensland advance care planning document summary | Statewide Office of Advance Care Planning (health.qld.gov.au)

Education series for health professionals – Part 3, 5 and 6 | Statewide Office of Advance Care Planning (health.qld.gov.au)

Voluntary assisted dying and advance care planning | Statewide Office of Advance Care Planning (health.qld.gov.au)

New EPOA and AHD forms – which version to use? | Publications portal | Queensland Government (publications.qld.gov.au)

Advance Health Directives for Mental Health – How to complete the form | Aged and Disability Advocacy Australia (youtube.com)

Advance health directives and enduring powers of attorney – Checklists for enduring documents (PDF) | Queensland Health (health.qld.gov.au)

4

Share

Ideally, advance care planning discussions result in the recording of a person's wishes in an advance care planning document. To ensure a person's wishes are known and accessible when needed, health professionals should encourage the sharing of completed ACP documents and related discussions.

Where appropriate, the person should share their ACP documents with anyone who may be involved in future care decisions, such as:

- Decision makers
- Family
- Close friends
- Healthcare providers.

Sharing advance care planning documents

The sharing of ACP documents and related discussions across healthcare settings is supported by the:

- ACP Tracker, which allows easy recognition of, and access to quality ACP documents, and related comments.
- Statewide Office of Advance Care Planning which supports the receipt, quality review and upload of ACP documents to the ACP Tracker.

Together these components are enabling clinicians, including first responders to have timely access to a person's ACP documents, quickly establish a person's views, wishes and preferences for care and identification of substitute decision-maker(s); as well as, supporting the ongoing and iterative process of ACP (across service settings).

Each of the Queensland standardised ACP forms include a prompt to send a copy/scan of completed documents to the Statewide Office of Advance Care Planning via:

- **Email:** acp@health.qld.gov.au
- **Fax:** 1300 008 227
- **Post:** PO Box 2274, Runcorn QLD 4113

The forms also include a reminder that the person can upload their document to their My Health Record.

The Statewide Office of Advance Care Planning:

- Reviews each document received, and if it meets formal and administrative requirements, uploads it to the ACP Tracker in the person's Queensland Health electronic hospital record (including establishment of an electronic alert in ieMR about uploaded documents).
- Is not able to provide legal advice about ACP documents and independent legal advice should be obtained if required.

Use of ACP documents on the ACP Tracker must be in accordance with Queensland legislation, including legislative privacy and confidential obligations.

Best practices for health professionals

- Recommend the person keep original ACP documents in a safe place.
- Advise the person on how to share their ACP documents with those involved in their care.
- Check the ACP Tracker to determine if the ACP document has been uploaded (a number on the ACP Tracker icon alerts you to check the ACP Tracker), and if not, support the person to send a copy/scan of their document to the Statewide Office of Advance Care Planning.

Tips for sending advance care planning documents to the Statewide Office of Advance Care Planning

- Attach a patient label sticker with DOB/URN to ensure accurate record matching.
- Review scanned documents to confirm all pages are included.
- Mark emails as urgent when documents require priority processing due to the person's clinical needs.

- Adhere to legislative and local requirements for collection, storage and visibility of documents*.
- Add a comment to the ACP Tracker about documents shared and discussions held to support visibility of ACP actions for others involved in the person's care (including Queensland Ambulance Service).
- Include copies of the ACP documents/notes about discussions in clinical handover/transfer to another care setting.
- Remind the person to notify relevant persons about changes to their ACP documents and to share any updated documents as needed.

Note: *Local policies may require a certified copy of an original statutory document. See page 18 of the *Advance health directive explanatory guide (PDF)* and *Enduring power of attorney explanatory guide (PDF)* for information on how to make a certified copy of an AHD and EPOA document.

More information

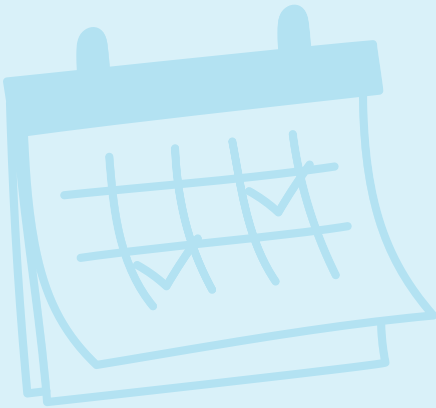
Accessing ACP documents | Statewide Office of Advance Care Planning (health.qld.gov.au)

Refer to relevant local policies and procedures for instruction on storing ACP discussions and documents.

Care at End of Life – Care Alert Kit Care Alert Kit (used to store hardcopy healthcare documents in a person's home) | Clinical Excellence Queensland (clinicalexcellence.qld.gov.au)

National Guidelines – Using My Health Record to store and access advance care planning and goals of care documents | Australian Digital Health Agency (digitalhealth.gov.au)

5



Review

As a person's circumstances change, or their health deteriorates, their preferences and decisions about current and future health care may also change.

Regularly reviewing ACP documents helps to ensure that the person's current views, wishes and preferences are accurately captured, increases the likelihood that the ACP document will be considered valid and applicable when required, and that the person's preferences for care will be respected. Health professionals have a key role in facilitating and supporting this element of the ACP process.

Triggers to review advance care planning

Changes in the person's health, for example:

- Admission to hospital.
- Diagnosis of a new illness.
- Diagnosis of a life-limiting illness or serious co-morbid medical condition which will impact their prognosis and/or quality of life.
- Deterioration in medical condition with associated significant functional decline.
- New treatment or medical care becomes available, which, for example, changes the person's prognosis, treatment plan and care needs.

Changes in the person's personal or living situation, for example:

- Death of a carer/partner/key supporter.
- Changes in place of residence, location of care.

Changes expressed by the person, for example:

- Perception of quality of life.
- Values or goals as their condition progresses.
- Preference to change their ACP document/ substitute decision-makers.

Administrative or planned review points:

- When the person (with capacity) revokes their AHD or EPOA.
- At an agreed review point.
- When making an ARP for the person.

To support recognition of changes to a person's views, wishes and preferences, it is best practice for health professionals to:

- Revisit ACP discussions, as appropriate and in a sensitive manner.
- Check the ACP Tracker for uploaded ACP documents/related comments.
- Ensure that all completed ACP documents are checked and that they continue to reflect the person's wishes.
- Support the person to update their document with links to resources, information, forms and supports.
- Send a copy of updated or new ACP documents to the Statewide Office of Advance Care Planning.
- Remind the person to discuss/share updates with substitute decision-maker(s) so that they are well prepared for their role and can make accurate and congruent decisions.
- Document discussions/review of existing documents in the person's medical record and add a comment to the ACP Tracker.

Enact

It is important that health professionals understand when to enact statutory advance care planning documents or use non-statutory advance care planning documents to guide clinical decisions and discussions with substitute decision-maker(s).

ACP documents do not preclude or replace a person's right to make decisions whilst they are able to do so. It is only when a person cannot make decisions for themselves that ACP documents for health matters should be enacted.

Enacting of ACP documents requires health professionals to consider:

- The type of decision that must be made.
- The complexity of the decision.
- When the decision must be made.
- The support and information available.

The *Queensland Government Capacity Assessment Guidelines 2020 (PDF)* helps health professionals to understand capacity, capacity assessment and the legal tests of capacity under Queensland's guardianship legislation.

In Queensland, a person will have decision-making capacity for medical treatment if it is possible for them to make a decision with appropriate support. This concept is referred to as **supported decision-making**. If a person cannot make their own decision with support, **substitute decision-making** can occur.

It is when substitute decision-making is required for a care decision involving a person with impaired decision-making, that their documents, wishes and preferences should be enacted.

Practical steps that can support decision-making

- Providing information in a way the person can understand (adjust language, use visual aids or technology).
- Allowing the person more time to process and discuss the information with others.
- Including a support person.

To support person-centred care that aligns with a person's views, wishes and preferences, when substitute decision-making is required, health professionals should:

- Check the ACP Tracker in the person's electronic hospital record.
- View ACP documents/comments.
- Make decisions in line with good medical practice and consider how the ACP document applies in the context of required decision-making and legislative obligations.
- Identify substitute decision-maker(s), noting any terms and conditions related to this.
- Continue to include the person to the greatest extent practicable.
- Advocate for what matters most to the person (including preferred place of care).
- Integrate the person's choices into medical treatment plans and related meetings and promote a coordinated care environment.

Please see Appendix 1: Flowchart for Health Care Decision Making in Adults Without Capacity for more information.

Balancing law, ethics and clinical realities when applying advance care planning documents

Enactment of ACP documents require consideration of the legal frameworks for ACP as well as ethical reasoning. Legislation governing ACP documents sets out who can make an ACP document, the formal requirements that must be met and how health professionals must act when applying them. Even with laws in place, enactment of ACP documents requires ethical reasoning and interpretation that considers the persons autonomy (respecting the person's right to decide their own future care), beneficence (acting in the person's best interest), non-maleficence (avoidance of harm, especially when treatment may prolong suffering) and justice (ensuring fair treatment and resource allocation).

Real-life cases can be complex and ethical reasoning and professional judgment can bridge the gap between the written law and the person's lived reality.

When enacting ACP documents, legal frameworks ensure validity and enforceability, and ethical reasoning ensures decisions are compassionate, person-centred, and context-sensitive. Clinicians, families, and sometimes courts must interpret the law in light of the person's values and the clinical situation.

Legal considerations in advance care planning

Some outcomes of the ACP process have potential legal implications under Queensland guardianship legislation.

During the ACP process there can be many outcomes and decisions relating to the person's financial, personal and health matters that emerge from discussions or are recorded in formal documents, not all of them having direct legal implications for the person or the healthcare team.

When decisional capacity is impaired for a particular decision that is required now, the person's substitute decision-maker must apply the general principles for personal matters and the health care principles for health matters when making decisions on their behalf.

Personal matters may include following the person's wishes for care, place of dying and who is present; observing and carrying out wishes for cultural, spiritual or religious rituals at the time of death. Personal matters under the guardianship legislation also include health care for the person. For certain health matters, such as withholding or withdrawing life-sustaining medical treatment, there are more explicit legal provisions.

These include situations where a person completes an AHD or EPOA, formally appoints an attorney, refuses specific medical treatment, requests that certain treatments be provided if they later experience impaired capacity. It may also include identification of individuals they want to be present before or after death, management of their body after death and who can participate in ACP discussions about health, personal care, or financial matters.

Other ACP outcomes generally do not carry legal implications (beyond privacy, confidentiality, and good clinical practice) such as preferences about place of death, funeral arrangements, or cultural, spiritual, or religious rituals to be observed before or after death.

Queensland's healthcare decision-making legal framework

Enacting a person's directions for future health care and/or their views, wishes and preferences, whether formal or informal, that a person has made during the ACP process involves obtaining appropriate consent to put them into practice.

When an adult is no longer able to make their own decisions, the legal aspects of ACP in Queensland are governed by the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*. These laws establish a structured consent framework for adults with impaired capacity, which may involve an AHD, substitute decision-maker(s), or orders made by the Queensland Civil and Administrative Tribunal (QCAT).

They also outline the types of health care that may be provided without consent, including urgent treatment to save life or prevent harm, emergency withholding or withdrawal of life-sustaining measures, minor and uncontroversial health care, and necessary hospital admissions or transfers, noting that exceptions apply where the adult has expressed objections.

These laws make it clear that substitute decision-making only applies once a person has impaired decision-making capacity and a decision is required about their personal, health or financial matters. These laws mandate that substitute decision-makers must act in accordance with the general principles and the health care principles, and that these provisions apply only to adults, as separate legislation governs decisions for children and young people.

The *Queensland Health Guide to Informed Decision-making in Health Care (PDF)* and the Flowchart for Health Care Decision Making in Adults Without Capacity (Appendix 1) provide guidance on how ACP documents are used in healthcare decision-making (including when to defer to substitute decision-maker(s) and their hierarchy). See Figure 1 on **page 14** for more information.

Legal advice should be sought if there are any questions about the validity or compliance of an AHD or EPOA, including if made interstate, so that any regulation requirements can be checked.

See HHS legal contact list (qheps.health.qld.gov.au).

Health professional considerations when disagreements arise about health matters

When a person's care decisions are clearly understood and shared with everyone well before any acute deterioration, and when the substitute decision-maker(s) and the healthcare team are aligned on the overall treatment plan, disputes or conflict are uncommon.

Disagreements may occur when substitute decision-maker(s) are not fully aware of or misunderstand the person's ACP directions or dispute the healthcare team's views on treatment, prognosis, or views on treatment or prognosis. They may also occur when substitute decision-maker(s) requests treatment that is inconsistent with good medical practice.

Most disagreements can be resolved through sensitive communication that refocuses everyone on the person's known wishes and current circumstances. When a person has documented their preferences in an AHD, those directions have legal authority and cannot be overridden by substitute decision-maker(s).

Key considerations for health professionals when disagreements arise about health matters are outlined in Table 2.

Table 2: Key considerations when disagreements arise about health matters

Consideration	Response
The person's rights and wishes come first	**Even when capacity is impaired, the person:** • Should be involved in decisions to the greatest extent possible • Has the right to express preferences, values, and concerns • Must have their dignity, autonomy, and cultural background respected. **Health professionals should always start by clarifying what the person would want, based on known:** • Prior expressed wishes • ACP documents • Patterns of values or beliefs.
Substitute decision-maker(s) have defined legal authority	**Health professionals need to clarify:** • Who is legally authorised to make decisions (for example, enduring power of attorney, guardian, statutory health attorney). • What decisions they are allowed to make (health matters vs. personal matters vs. financial matters) • Any limits on their authority.
The hierarchy of decision-makers matters	Health professionals must follow the legally defined order of priority for health matters for adults with impaired capacity. Refer to the *Queensland Health Guide to Informed Decision-Making in Health Care (PDF)* for information about consent for children and young people.
The decision must protect the person's rights and wellbeing, be made in the least restrictive way, and be consistent with good medical practice	**When substitute decision-maker(s) disagree, health professionals should anchor discussions in:** • The person's known values • Their likely preferences • The expected benefits and burdens of treatment • Quality-of-life considerations. This helps shift the conversation away from family conflict and back to the person.
Clear communication is essential	**Disagreements often arise from:** • Misunderstanding the clinical situation • Differing expectations • Emotional distress. **Professionals should:** • Provide consistent, plain-language explanations • Clarify prognosis and treatment options • Explore the reasons behind each party's viewpoint • Use structured family meetings when needed.
Documentation protects everyone	**Accurate, timely documentation by health professionals should include:** • Capacity assessments • Who was consulted • What disagreements occurred • The rationale for decisions • Any ACP documents considered. This is crucial if decisions are later reviewed.

Consideration	Response
Conflict resolution pathways should be used early	**Health professionals should know when and how to escalate. This may include:** • Involving senior clinicians • Requesting ethics consultation • Using mediation services • Contacting local legal services • Seeking guidance from guardianship bodies when legally required. Early escalation often prevents entrenched conflict.
Emergency situations are treated differently	**If urgent treatment is required to prevent serious harm, clinicians may proceed without resolving all disagreements, provided there is no known objection from the adult and they act:** • In a way that promotes and protects the person's rights, interests and opportunities in the least restrictive way • Within legal emergency provisions and good medical practice.
Cultural, spiritual, and family dynamics matter	**To help support compassionate care, health professionals should be aware of:** • Cultural decision making norms • Family structures • Spiritual or religious considerations • The emotional weight of the role of the substitute decision-maker(s) when there is conflict.
Self-care and professional boundaries are important	**Disagreements can be stressful. Health professionals should:** • Seek support from colleagues • Maintain professional boundaries • Avoid being drawn into family disputes.

For children and young persons

In cases where there is disagreement between the child or young person, their parents/guardian and the doctor about current or future treatment, a court may need to decide what will happen. The court must consider what is in the best interests of the child or young person when making its decision. This is a rare occurrence and usually all attempts are made to reach consensus before having to take a case to the court.

When to contact guardianship bodies for an adult

The Public Guardian may exercise power for a health matter if there is a disagreement about the health matter for an adult, and the disagreement cannot be resolved by mediation*.

The Public Guardian may exercise power for a health matter if guardian or attorney:

- Refuses to make healthcare decision, and this refusal is contrary to healthcare principle of the *Guardianship and Administration Act 2000*.
- Makes a healthcare decision and the decision is contrary to the healthcare principle of the *Guardianship and Administration Act 2000***.

*s42 of the *Guardianship and Administration Act 2000*
**s43 of the *Guardianship and Administration Act 2000*

Where a decision is required, and reasonable attempts by the hospital to resolve the matter have been unsuccessful, the Public Guardian can be contacted to consider further action, or to make the health care decision. Where this occurs, the treating team should contact the relevant local legal team, who must then make a formal written request to the Public Guardian (see **page 58**).

Due to the significant and intrusive nature of these matters, the Public Guardian requires detailed information and must ensure that all attempts at resolving the disagreement have been exhausted before exercising powers under these provisions.

Attachment 2 in the *Office of the Public Guardian Health Care Decision Making Framework Adult (PDF)* lists the information required by the Public Guardian before a decision can be considered.

Note: In some complex situations, it may be more appropriate to refer the matter directly to the Queensland Civil and Administrative Tribunal (QCAT) to make a determination on the appropriateness of a substitute decision maker, and where necessary, appoint an alternative decision maker.

More information

Advance Care Directives - Unpacking the Confusion (youtube.com/watch?v=AiaNTjvrr9g)

Queensland | End of Life Law in Australia | Queensland University of Technology (end-of-life.qut.edu.au)

Supported decision-making | Cognitive Decline Partnership Centre | The University of Sydney (cdpc.sydney.edu.au)

Supported decision-making for health care and medical treatment – Factsheet| End of Life Law for Clinicians (qut.edu.au)

What types of decisions we make for you | Understanding guardianship | Office of the Public Guardian (publicguardian.qld.gov.au)

Health Care Decision Making Framework | Office of the Public Guardian (publicguardian.qld.gov.au)

Healthcare decision making in Queensland | Healthcare Decisions | ADA Law (adalaw.com.au)

Professional considerations | Advance Care Planning Australia (advancecareplanning.org.au)

Advance care planning activity and measurement

Queensland Health supports Hospital and Health Services to implement advance care planning through:

- *Healthcare Purchasing (PDF)*
- Hospital and Health Service performance measures (under safety and quality markers in the *Performance Measures Attribute Sheet (PDF)*)

This aims to increase the opportunity for individuals to contemplate advance care planning, with the intent to facilitate choices about their future health care including care at the end of life.

Advance care planning reporting tools

ACP data for Queensland Health HHSs is available through three key reporting tools:

- Statewide ACP Reporting Dashboard – a PowerBI app.
- Queensland Health Enterprise Reporting Service (QHERS).
- System Performance Reporting (SPR).

These reporting tools enable Queensland HHSs to:

- Track and assess ACP activity.
- Drive ongoing quality improvement initiatives.
- Demonstrate alignment with Queensland and national ACP-related healthcare standards, including requirements in the National Safety and Quality Health Service Standards (Action 5.09 and 5.17) and the strengthened Aged Care Quality Standards (Outcome 3.1 and 5.7).

Further detail on report types and access pathways for Queensland Health staff is provided in Table 3.

Table 3: Advance care planning activity reporting tools

<table>
<tr><th>Reporting tool</th><th>Advance care planning data</th><th>How to access</th></tr>
<tr><td>Statewide ACP Reporting Dashboard</td><td>Provides interactive reports on:
The volume and types of ACP documents submitted.
Recorded end-of-life preferences.
Comments entered by clinicians in the ACP Tracker.
Patterns of use of the ACP Tracker and ACP.</td><td>Queensland Health staff can access the dashboard via www.health.qld.gov.au/advance-care-dashboard

If it is your first time using the dashboard, there will be a pop-up message 'apply for access'. Click on this and follow the prompts.</td></tr>
<tr><td>QHERS</td><td>Includes several Excel-based reports that provide detailed insights into ACP activity recorded in the ACP Tracker, including:
ACP Statewide Activity Report – summarises ACP comments entered in the ACP Tracker including information about who recorded them.
ACP HPSU Funding Report – outlines ACP activity captured in the ACP Tracker and identifies items eligible for funding.
ACP Statewide Alert Inpatient Report – identifies current inpatients with ACP activity documented in the ACP Tracker.
ACP Document Upload Report – shows documents uploaded to the ACP Tracker for a person within a selected time frame.
Note: The ACP Statewide Activity Report and the ACP HPSU Funding Report are also available in the Statewide ACP Reporting Dashboard, with identifying person and staff information removed.</td><td>Complete the QHERS Access form
Send the completed form to acp@health.qld.gov.au
Login via https://qhers.health.qld.gov.au/BOE/BI</td></tr>
<tr><td>SPR</td><td>Provides comprehensive data on ACP activity and performance across Queensland.

Performance reports: Monthly PDF performance reports. Pre-generated System Performance Reports. Interactive report, including: System Performance dashboards presenting ACP key performance indicators, including: The number of in-scope individuals offered an ACP discussion across inpatient, outpatient, emergency department and community settings. Health equity measures related to ACP access and uptake. Purchasing localisation indicators showing ACP activity at local service levels.</td><td>Apply for access via System Performance Reporting - How to apply for access | Queensland Health IT Support (qldhealth.service-now.com) Login via the SPR Single-Sign-On</td></tr>
</table>

Advance care planning indicators

ACP indicators support HHSs to have the visibility needed to improve performance, meet standards and ensure that Queenslanders receive care that reflects their values and preferences.

Monitoring of ACP indicators can:

- Support safer, person-centred care.
- Improve clinical decision-making.
- Reduce avoidable stress for teams and families.
- Enhance workflow reliability.
- Support equity in care delivery.

Table 4 outlines a range of optional data domains, indicator examples and primary data sources that HHSs can track to support organisational ACP uptake, performance monitoring and quality improvement.

Table 4: Optional data domains, indicator examples and primary data sources for Hospital and Health Services

Optional data domains	Indicator examples	Primary data sources
Advance care planning engagement and activity		
• Offers of ACP discussions made to eligible or in-scope individuals. • ACP conversations completed, including depth or level of support. • Care setting where ACP occurred (inpatient, outpatient, emergency department (ED), community). • Clinician role recording ACP activity. • Time or resources used for ACP support.	• Proportion of in-scope individuals offered an ACP discussion (by setting: inpatient, outpatient, ED, community). • Number of ACP conversations completed. • Rate of ACP activity per 1,000 separations/ encounters. • Clinician roles recording ACP activity.	• ACP Tracker (comments, activity fields). • QHERS ACP Statewide Activity Report. • HHSs clinical information systems.
Advance care planning documentation		
• Types of ACP documents completed or received (AHD, EPOA, SoC, other). • Number of ACP documents uploaded to the ACP Tracker. • ACP document quality review. • Frequency of ACP document updates or revisions.	• Number and type of ACP documents received (AHD, EPOA, SoC, other). • Number of ACP documents uploaded to the ACP Tracker. • Proportion of inpatients with at least one ACP document available. • Frequency of ACP document updates within a defined period.	• Statewide ACP Reporting Dashboard (document metrics). • QHERS ACP Document Upload Report.

Optional data domains	Indicator examples	Primary data sources
Preferences and clinical use		
• Documented preferences for future or end-of-life care. • Whether ACP documents were accessed during care. • Whether ACP preferences influenced clinical decisions. • Alignment between preferences and care delivered.	• Proportion of individuals with documented end-of-life preferences. • Proportion of relevant encounters where ACP documents were accessed. • Evidence of ACP preferences informing clinical decisions (e.g. documented in progress notes, care plans). • Concordance between documented preferences and care delivered (where measurable).	• ACP Tracker comments and flags. • Statewide ACP Reporting Dashboard (end-of-life preferences). • Clinical audit samples.
Equity and access		
• Demographic characteristics of the person engaging in ACP (age, gender, cultural background, language, disability, rurality). • Equity gaps in ACP offers and uptake. • Use of interpreters or culturally tailored resources.	• ACP offer and uptake rates by demographic group (age, gender, Aboriginal and Torres Strait Islander status, culturally and linguistically diverse background, language, disability, rurality). • Use of interpreters or culturally tailored ACP resources. • ACP activity by HHS and service type.	• SPR health equity measures interactive reports related to ACP access and uptake. • ACP Tracker (where linked to demographic data – Statistical Services Branch). • QHERS reports with HHSs and locality breakdowns. • Local data/HHS clinical information systems.
System performance and utilisation		
• Use of ACP systems and tools (for example, ACP Tracker utilisation). • Rates of ACP alerts for inpatients. • Localisation of ACP activity across HHSs.	• Use of ACP Tracker (number of users, entries, comments per month). • Number of inpatients with ACP alerts. • Localisation of ACP activity (HHSs, facility, service line).	• QHERS ACP Statewide Alert Inpatient Report. • QHERS ACP HPSU Funding Report. • Statewide ACP Reporting Dashboard.
Workforce capability		
• Number of staff trained in ACP. • Staff confidence or competency measures. • Frequency of ACP education sessions delivered.	• Number and proportion of staff trained in ACP (by profession and service). • Staff self reported confidence in ACP conversations (survey). • Number of ACP education sessions delivered.	• Education and training records. • Staff surveys. • Local education activity data.

Optional data domains	Indicator examples	Primary data sources
Outcomes and impact		
• Hospitalisations or ED presentations near the end of life. • Place of death compared with stated preferences. • Family or carer satisfaction with ACP processes. • Reduction in unwanted or non-beneficial treatments.	• Hospital and ED utilisation near the end of life (e.g. last 30/90 days). • Place of death compared with stated preferences (where available). • Family/carer satisfaction with ACP processes. • Rates of potentially non beneficial treatments at the end of life.	• Hospital activity data. • Mortality data. • Consumer experience surveys. • Targeted clinical audits.

More information

Advance Care Planning Improvement Toolkit | Quality and standards | Advance Care Planning Australia (advancecareplanning.org.au)

Supporting advance care planning activity for First Nations people | Advance care planning hub (qheps.health.qld.gov.au)

Where to go for further information

National and statewide advance care planning services

These services provide general ACP information, education, document support, and statewide coordination.

Advance Care Planning Australia: national ACP advice and education.

Advance Care Planning Australia is an Australian Government initiative. This service provides:

- Advice and support on ACP across Australia.
- Training and education programs for health and care professionals.
- ACP guidance for health and care professionals.
- Bespoke information for diverse communities and specific health settings.

Phone: 1300 208 582
Email: acpa@advancecareplanning.org.au
Website: www.advancecareplanning.org.au

Statewide Office of Advance Care Planning: Queensland-wide ACP information, education and document lodgement.

The Statewide Office of Advance Care Planning is a free statewide service (funded by the Queensland Department of Health) that helps Queenslanders to plan and share their healthcare wishes.
The service:

- Provides information, education and resources to consumers and health professionals about ACP.
- Receives and uploads ACP documents to the person's Queensland Health electronic hospital record.

Phone: 1300 007 227
Email: acp@health.qld.gov.au
Website: www.mycaremychoices.com.au

Specialist clinical advance care planning services

For people needing support in specific health contexts.

Queensland Health HHSs ACP facilitator contacts:

- Gold Coast Health
- Metro North Health
- Metro South Health
- West Moreton: WM-ACP@health.qld.gov.au

Paediatric Palliative Care Service (Queensland Children's Hospital): ACP support for children and young people.

The Paediatric Palliative Care Service at the Queensland Children's Hospital can help with ACP for people under 18. To learn more, watch Paediatric Advance Care Planning | Quality of Care Collaborative Australia (vimeo.com)

Phone: 07 3068 4699 or 1800 249 648
Email: ppcs@health.qld.gov.au
Website: www.childrens.health.qld.gov.au/services/palliative-care/palliative-care-queenslandchildrens-hospital

Legal and decision-making support for advance care planning

Justices of the Peace Branch: witnessing and certifying ACP documents.

Information on how to locate the services of a Justices of the Peace or a Commissioner for Declarations can be found at Search for your nearest JP or Cdec | Your rights, crime and the law | Queensland Government (www.qld.gov.au)

Email: jp@justice.qld.gov.au

Queensland Public Trustee: EPOA and will-making support.

The Queensland Public Trustee can help individuals to prepare general power of attorney, EPOA and power of attorney revocation documents. Information about how to book an appointment, fees and charges is at Enduring power of attorney services | Queensland Public Trustee (pt.qld.gov.au)

The Queensland Public Trustee also provides a free Will making service. Information about this service is available at Wills | Queensland Public Trustee (pt.qld.gov.au)

Phone: 1300 360 044
Email: clientenq@pt.qld.gov.au

Queensland Law Society: finding solicitors for ACP related legal advice.

Lawyers can provide legal advice and support in succession planning, including the making of EPOAs and AHDs. To find a solicitor visit Find a solicitor | Queensland Law Society (youandthelaw.com.au)

Community Legal Centres Queensland: free legal help relevant to ACP.

Provides free information, legal assistance and referral, representation and casework, community education and advocacy. Find a local Community Legal Centres at Find a CLC | Community Legal Centres (clcq.org.au)

Substitute decision-making and adult safeguarding services

Office of the Public Guardian: guidance on EPOA/AHD and guardianship roles.

This Office of the Public Guardian protects the rights and interests of adults who cannot make decisions for themselves, and children in care. It:

- Provides guidance on EPOAs and AHDs and roles and responsibilities as an attorney.
- Protects adults with impaired capacity and safeguards against misuse of decision-making power.
- Can be appointed as:
  - An attorney for personal and healthcare matters (by application)
  - A guardian for personal matters (including health care) by QCAT
  - Can act as a statutory health attorney of last-resort decision-maker.

General enquiries: 1300 653 187
Healthcare consent: 1300 753 624
Website: www.publicguardian.qld.gov.au

To contact the Office of the Public Guardian regarding disagreement about a health matter email: healthcare@publicguardian.qld.gov.au

Queensland Civil and Administrative Tribunal (QCAT): applications for guardianship, administration, and capacity matters.

Applications for guardianship and administration, as well as applications regarding capacity and attorneys can be made at QCAT.

Phone: 1300 753 228
Website: www.qcat.qld.gov.au

Office of the Public Advocate

The Public Advocate works to protect and promote the rights of adults with impaired decision-making ability through systemic advocacy. This means they focus on improving systems (like laws, policies, and services) rather than advocating for individuals.

Phone: (07) 3738 9513
Email: public.advocate@justice.qld.gov.au
Website: www.publicadvocate.qld.gov.au

Queensland Voluntary Assisted Dying Support Service

Queensland Voluntary Assisted Dying Support Service is a free service that provides advice and support to Queenslanders about voluntary assisted dying.

Phone: 1800 431 371
Email: qvadsupport@health.qld.gov.au

Document registration and authority verification

Titles Queensland: registration of powers of attorney for land transactions.

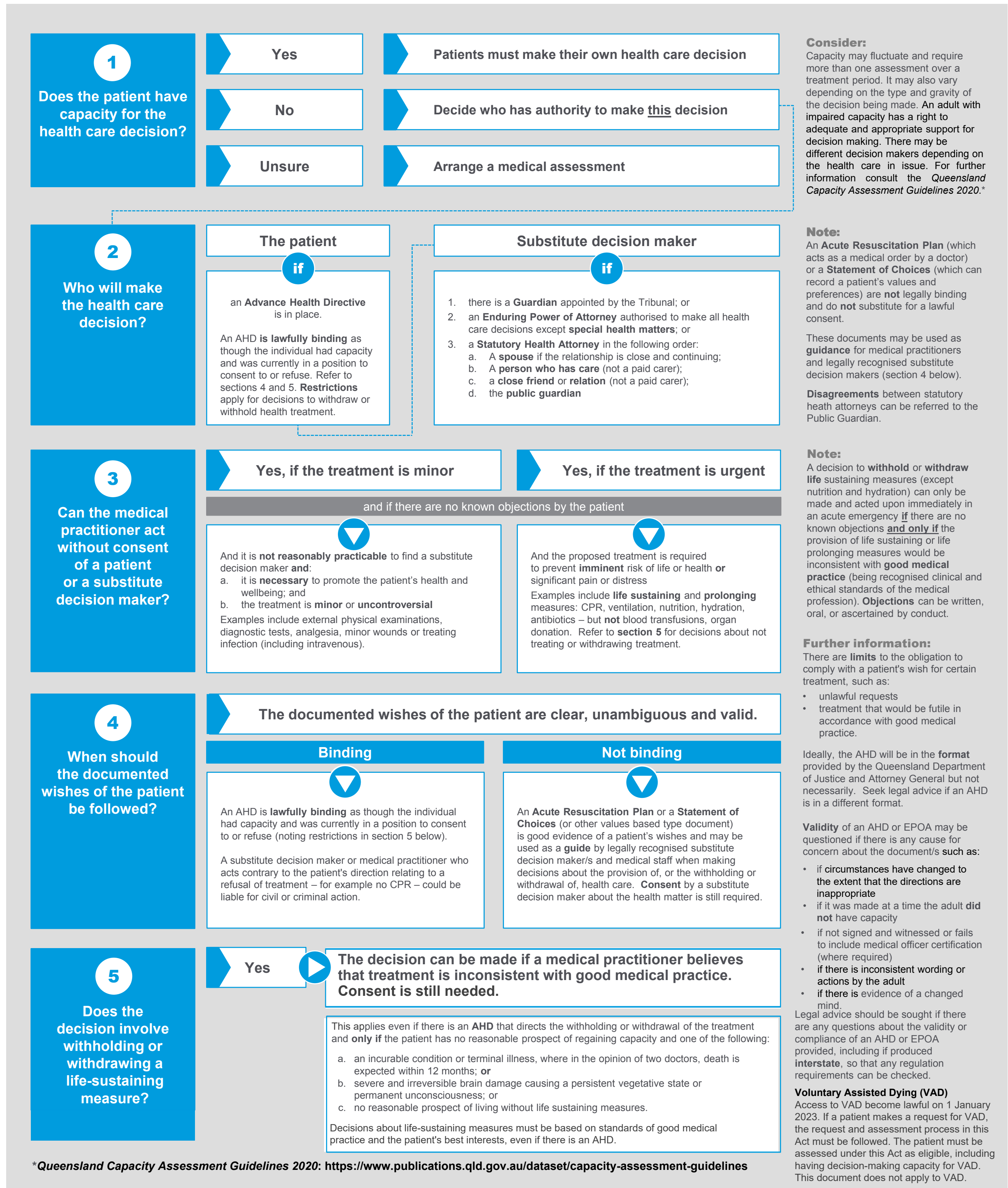
Titles Queensland manages the land and water titles registries for the state of Queensland. In order for an attorney to act on behalf of the principal in a transaction of land in Queensland, there must be a power of attorney authorising the attorney to do so, and this must be registered with Titles Queensland.

For information on how to register a power of attorney visit Registering a power of attorney | Titles Queensland (titlesqld.com.au)

Domestic phone: 3497 3479
International phone: +617349 73479

Appendix

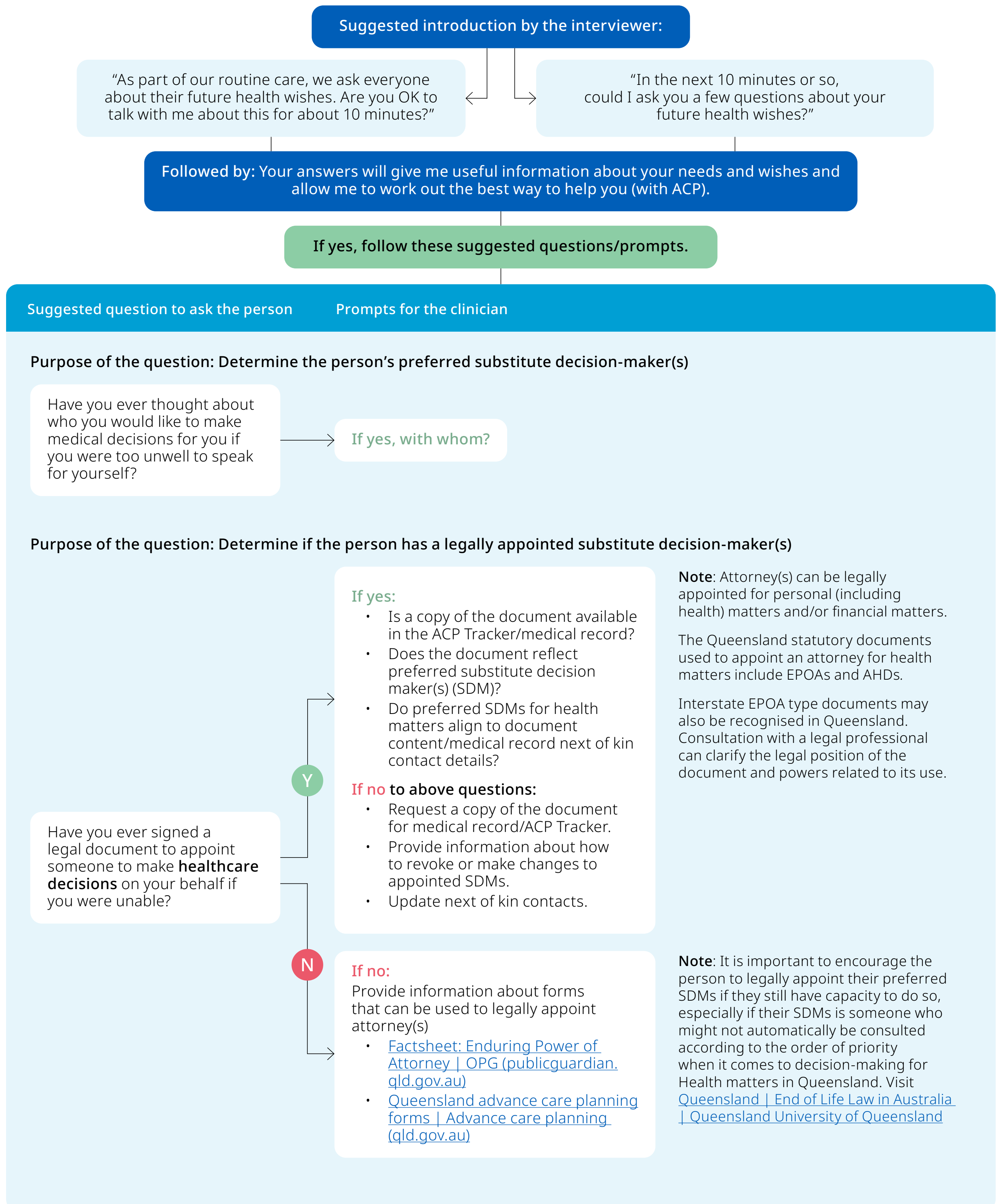
Appendix 1: Flowchart for Health Care Decision Making in Adults Without Capacity



Download via www.health.qld.gov.au/__data/assets/pdf_file/0037/1379944/advance-hlth-care-planning-for-adults-flow-chart.pdf

Appendix 2: For individuals who can make their own healthcare decisions, as well as those who need support in making healthcare decisions for themselves.

Adapted with permission from the Advance Project®.



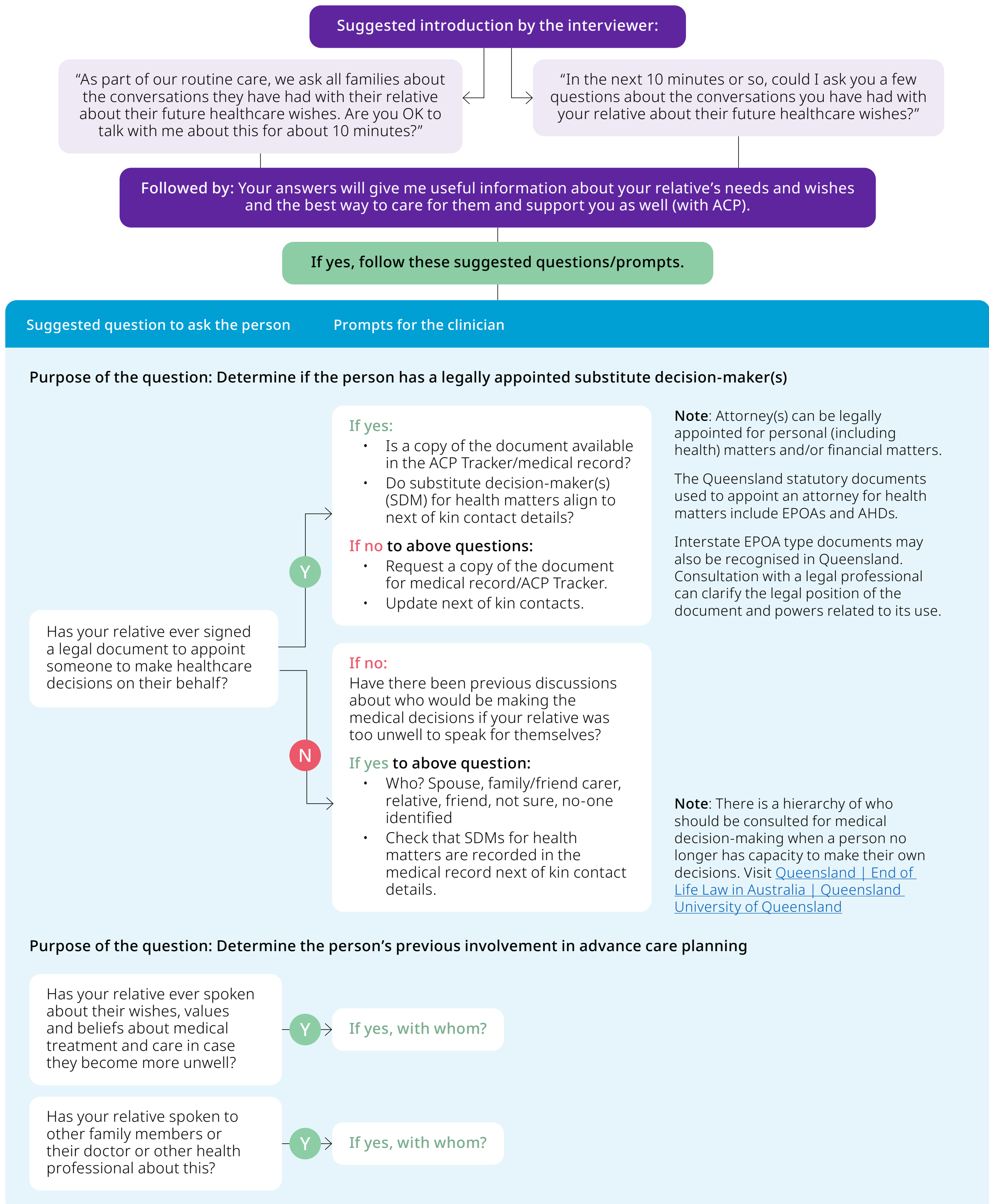
Suggested question to ask the person	Prompts for the clinician
Purpose of the question: Determine the person's previous involvement in advance care planning	
Have you talked to (name of SDMs) or other family or friends about your wishes for medical treatment and care in case you become seriously ill or unable to make your own decisions? → Y	If yes, with whom?
Have you spoken to a doctor or other professional about this? → Y	If yes, with whom?
Have you ever written down your wishes? → Y	If yes: • In what type of document? • When was it last reviewed? • Is a copy of the document available in the ACP Tracker/medical record? • If not previously provided – request a copy of the document for medical record/ACP Tracker.
Purpose of the question: Determine the person's understanding of advance care planning and whether they wish to know more	
Have you heard of ACP? →	**Explain ACP to the person as necessary.** ACP is making a plan for your future health care so doctors and family know your wishes if you can't speak for yourself. It means thinking ahead about what kind of health care you would want if you became too sick to speak for yourself. It's about: • Talking with your family, friends, and doctors about your values and wishes. • Recording those wishes in a document • Choosing someone you trust to make decisions for you if you can't. The goal is to make sure that, if you're ever seriously ill or injured, the care you receive matches what matters most to you, not just what others think should happen.
Would you like to know more? → Y	If yes: • Provide ACP information brochure • Highlight information available on My Care My Choices | Advance care planning | Health and wellbeing | Queensland Government (qld.gov.au) and welcome to contact the Statewide Office of Advance Care Planning. • Share resources to support individuals and carers to have honest conversations with their healthcare team and make decisions about their treatment and care at Shared decision making – The Care Companion | Clinical Excellence Queensland | Queensland Health (qld.gov.au)
Purpose of the question: Determine the person's readiness to discuss advance care planning	
Would you be comfortable if a member of the healthcare team were to further discuss ACP with you? → Y	If yes: • Find out which clinician they'd like to discuss it with • Refer to local ACP facilitator/services (where available) • Suggest they consider bringing their preferred SDMs with them to the consultation.
Purpose of the question: Explore the person's wishes or priorities for future care	
Is there anything you would like staff to know about your wishes or priorities when it comes to your health care? → Y	If yes: • Summarise key points and reflect back to the person to make sure you have understood • Write summary in medical record and ACP Tracker.

Next steps: Arrange further follow up to discuss ACP as appropriate.

Appendix 3: If the person you are caring for does not have capacity to make healthcare decisions for themselves.

Adapted with permission from the Advance Project®.

Please note: The general principles and health care principles of the *Guardianship and Administration Act 2000* emphasise the importance of involving adults with impaired capacity, as much as practicable, to ensure a respectful, inclusive, and person-centred approach.



Suggested question to ask the person	Prompts for the clinician

Purpose of the question: Determine the person's previous involvement in advance care planning

Has your relative ever written down their wishes?

If yes:

- In what type of document?
- When was it last reviewed?
- Is a copy of the document available in the ACP Tracker/medical record?
  - If not previously provided – request a copy of the document for medical record/ACP Tracker

Purpose of the question: Determine the relatives understanding of advance care planning and whether they wish to know more

Have you heard of ACP?

Explain ACP to the person as necessary.

ACP is making a plan for your future health care so doctors and family know your wishes if you can't speak for yourself. It means thinking ahead about what kind of health care you would want if you became too sick to speak for yourself. It's about:

- Talking with your family, friends, and doctors about your values and wishes.
- Recording those wishes in a document
- Choosing someone you trust to make decisions for you if you can't.

The goal is to make sure that, if you're ever seriously ill or injured, the care you receive matches what matters most to you, not just what others think should happen.

Would you like to know more?

If yes:

- Provide ACP information brochure
- Highlight information available on My Care My Choices | Advance care planning | Health and wellbeing | Queensland Government (qld.gov.au) and welcome to contact the Statewide Office of Advance Care Planning.
- Share resources to support individuals and carers to have honest conversations with their healthcare team and make decisions about their treatment and care at Shared decision making – The Care Companion | Clinical Excellence Queensland | Queensland Health (qld.gov.au)

Note: A person must have decision-making capacity to make a statutory ACP document.

The SoC – form B is used for a person who cannot make healthcare decisions for themselves. It is completed by the person's legally appointed SDMs or, if not applicable, person(s) in a close and continuing relationship with the individual.

Purpose of the question: Determine the person's readiness to discuss advance care planning

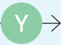
Would you be comfortable to have a meeting with a member of the team to further discuss ACP for your relative?

If yes:

- Find out which clinician they'd like to discuss it with
- Refer to local ACP facilitator/services (where available)
- Identify family members or other people that would be important to involve in the ACP discussion.
- If appropriate provide the relative with a copy of the SoC – form B and related tip sheet to take home and consider, and also discuss with other family members prior to the family meeting to further discuss ACP.

Purpose of the question: Explore the person's wishes or priorities for future care

Is there anything you think would be important for the team to know about your relatives wishes or priorities when it comes to their health care?



If yes:

- Summarise key points and reflect back to relative to make sure you have understood
- Write summary taken in medical record/ ACP Tracker

Note: Emphasise that you are asking the relative to reflect on the views, wishes and preferences of the person (who no longer has capacity).

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