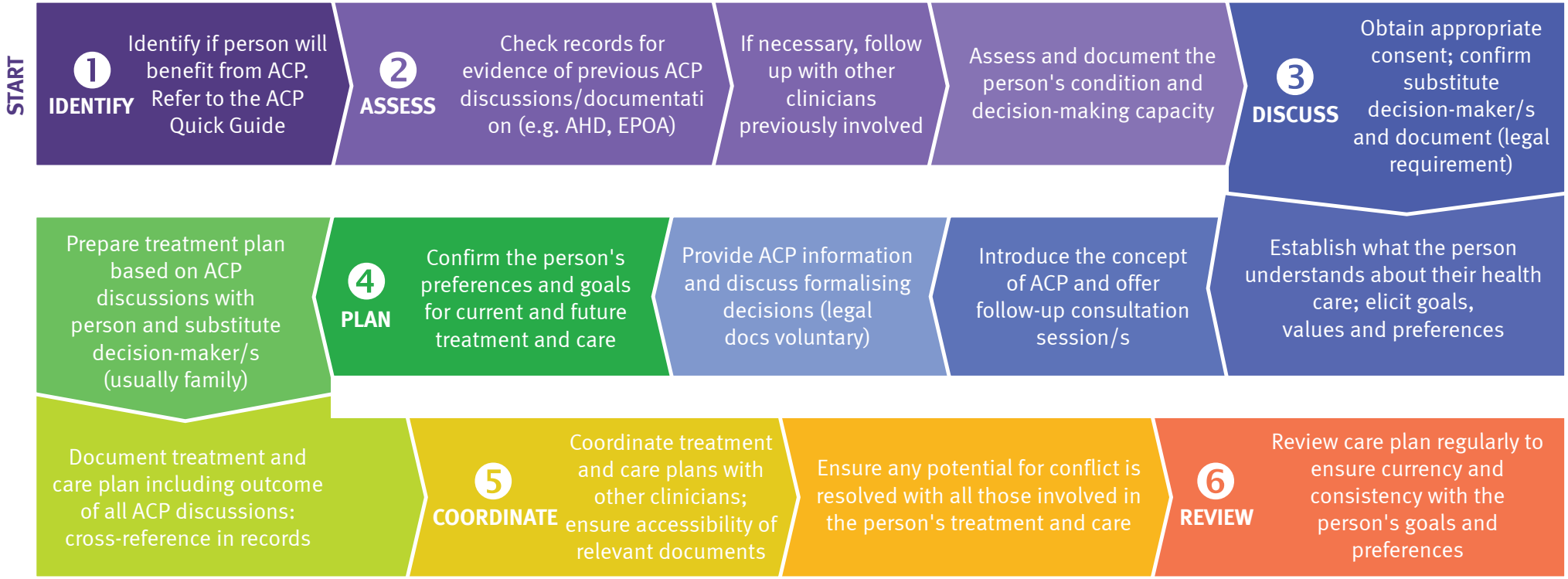
6 Step Advance Care Planning Process

Advance care planning (ACP) is a person-centred approach for planning current and future health and personal care that reflects the person's values, beliefs and preferences. The process of ACP is collaborative and coordinated. It aims to develop an understanding of the person's treatment and care goals in order to assist health professionals to better meet their needs.

Effective ACP involves ongoing communication between the person, those closest to them, and a multidisciplinary healthcare team to optimise the person's current treatment, care, and quality of life. ACP can be carried out at any time and will be driven by the person's care needs and their willingness to participate.

ACP is an iterative process and should be integrated into clinical practice and routine care. ACP plans should be reviewed regularly to ensure plans remain consistent with the person's values, beliefs and preferences for health and personal care.



ACP is an iterative process and can commence at any stage. Repeat stages as required. Carefully document to ensure all clinicians can access.

Please note:

This resource is designed primarily for health professionals treating and caring for those at or approaching the end of life.
More information about the 6 step ACP process can be found in the *ACP Clinical Guidelines*, or at https://www.health.qld.gov.au/careatendoflife

Queensland Government

6 Step Advance Care Planning Process - Considerations

ACP can include:

- assessing the person's current condition and likely prognosis
- establishing the person's health and personal goals, values and preferences
- discussing current and future treatment and personal care options
- identifying the person's decision-makers for a time when they might lack capacity
- documenting treatment and care plans and ensuring they are appropriately communicated and available when needed
- assisting the person to formally document their wishes if they choose to do so
- coordinating treatment and care to reflect the person's goals, values and preferences.

1 IDENTIFY

- Identify those who are most likely to benefit from ACP. Key groups broadly recognised as benefitting most include those: for whom the "surprise question" applies (i.e. would you be surprised if the person were to die in 12 months?), experiencing symptoms and signs of declining health, reaching or experiencing life's milestones (e.g. advancing age, retirement, bereavement)
- Check for general indicators of decline and disease specific indicators related to particular conditions
- Refer to the ACP Quick Guide (Appendix 2 of the ACP Clinical Guidelines)

2 ASSESS

- Check the person's clinical record for evidence of previous ACP discussions/documents - ensure enduring documents (e.g. Advance Health Directive [AHD], Enduring Power of Attorney [EPOA]) are valid (e.g. apply to the current circumstances, up to date)
- Follow up with other clinicians previously involved, particularly if other specialties are involved
- Assess the person's capacity for decision-making - (it is an established legal principle that all adults are presumed to have capacity unless assessed they do not)
- Assess the person's current condition and determine likely prognosis, options and uncertainties for treatment; document
- Consider the need for other decision-makers to be involved if the person has impaired capacity; take any disabilities into consideration

3 DISCUSS

- Obtain the person's consent – this need not be framed as *"Will you consent to this discussion?"* Rather, expressed as an invitation for the person to talk about their health and personal goals, their experience of illness and what they understand about their current condition; ensure the person remains comfortable to continue the discussion
- Obtain the person's consent to involve others in discussions (part of confidentiality requirements)
- Confirm substitute decision-maker/s and document consenting discussions (part of the legal requirement to document the decision-making pathway)
- Discuss diagnosis, prognosis and realistic treatment options; explain the uncertainties of predicting recovery
- Elicit the person's goals, values and preferences about proposed medical treatment and ongoing care
- Consider/discuss symptom control, pain relief, and other treatment options in the context of changing and deteriorating disease or condition
- Introduce the concept of ACP by describing it without using technical jargon – explain a key step is to identify substitute decision-maker/s in the event of impaired capacity
- If appropriate, introduce resuscitation planning – this is not the sole focus of ACP discussions and should not be forced; be alert for signs of distress
- Provide appropriate ACP information to the person/decision-maker/s – this may include brochures and/or references to ACP websites
- Discuss possibility of person formalising their decisions in legal documents, e.g. EPOA or AHD – ensure people are aware completing legal documents is voluntary
- If the person has impaired capacity, ACP discussions can also be held with their substitute decision-maker/s

4 PLAN

- Ensure open communication is maintained with the person and their substitute decision-maker/s while developing treatment and care plan
- Provide any further information as appropriate, such as for clinical specialty/ community support or other spiritual/cultural support networks
- Based on the person's goals of care and preferences, prepare a care plan that considers current and future treatment and care; build in review mechanisms
- Consider whether the treatment plan provides a realistic balance between active/curative measures and palliative and other support therapies
- Complete appropriate paperwork to support the person's treatment and care plan (e.g. Acute Resuscitation Plan [ARP], Statement of Choices [SoC], Care Plan for the Dying Person [CPDP])
- Ensure treatment and care plan is appropriately documented and communicated to ensure access by multi-disciplinary team

5 COORDINATE

- Involve other teams as appropriate, such as social workers, aged care, spiritual carers, and cultural representatives
- As the person's condition/prognosis deteriorates, coordinate with community care and/or palliative care teams for ongoing support as appropriate
- Any potential for misunderstanding or dispute should be resolved by this stage - involve senior clinicians and/or escalate to facility management
- Ensure processes are in place to manage place of dying and bereavement, including emotional, cultural, spiritual & social support to those closest to the person

6 REVIEW

- Revisit treatment and care goals, and discuss with the person and their family; escalate if any disputes remain unresolved
- Revisit resuscitation planning to ensure earlier decisions about cardiopulmonary resuscitation (for example), reflect person's current goals for treatment and care
- Review previous ACP discussions if, for example: person's circumstances change, hospital admission, unplanned surgery, deterioration in medical condition etc
- Review paperwork to ensure all relevant documents remain valid, current and accessible (e.g. AHD, EPOA, ARP, SoC)