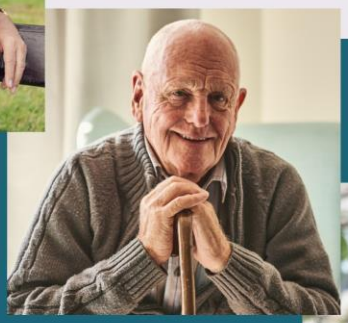
Statewide Office of Advance Care Planning



Section 2: ACP Education resources

- Overview of the education resources
- Online education modules
- ACP Champion workshop
- Peer support guide
- ACP Champion workshop resources

Version 2.0 - April 2022

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Supported by PallConsult
Support for clinicians delivering end-of-life care

Queensland Government

Overview of the education resources

Section 2 offers a package of education resources that can be used to embed an ACP program in your facility. This package has three main components:

- Online education modules
- ACP Champion workshop
- Peer support.

After completion of the online education modules and the workshop, you will be able to begin your role as the designated ACP Champion or in your workplace.

The peer support activities are designed to promote sustainability of the ACP program in your facility, and to mentor and develop new staff in becoming ACP Champions in their own right.

Objectives

After completing Section 2, you should be able to:

- Explain ACP and its importance and benefits to residents, their families and/or substitute decision(s) in your Residential Aged Care Facility (RACF)
- Identify the best practice principles for implementing ACP in residential aged care
- Develop an understanding of the commonly used documents available in your jurisdiction for advance care planning and their implications for clinical practice in a RACF
- Initiate ongoing ACP conversations with residents, their family and/or substitute decision maker(s)
- Facilitate the completion of a Statement of Choices by a resident/substitute decision maker(s) including the contribution and signature of the resident's doctor
- Outline the steps involved in getting a completed ACP document uploaded to The Viewer
- Educate staff in your RACF about ACP, how to respond to residents' cues and the processes and documentation in your RACF
- Identify resources for additional information ACP.

Online education modules

You are encouraged to complete five online education modules prior to conducting the ACP Champion workshop and other training modules. These modules will give you a sound grounding in ACP knowledge and skills, and confidence to deliver ACP education to your facility staff.

Aim of each module

Module	Aim
Module 1	Introducing ACP for the people in your care
Module 2	Understanding ACP documents commonly used in Queensland
Module 3	Supporting conversations to complete a Statement of Choices document
Module 4	Cultural considerations for end-of-life care
Module 5	Using the PREPARED framework to support ACP conversations

Time for completion

Each module will take approximately 15 minutes to complete.

Certificate of completion

You will be able to print a certificate of completion for each module. Keep these certificates for your professional portfolio and for your facility's accreditation regarding person-centred care.

Accessing the modules

The modules can be accessed at:

https://www.caresearch.com.au/eolcareracf/tabid/4664/Default.aspx

ACP Champion workshop

Please note: for ease of presentation, this workshop focuses on only one ACP document – the Statement of Choices (SoC). If required, the workshop can focus on the completion of an Advance Health Directive (AHD) or an Enduring Power of Attorney (EPOA).

Suggested Program (morning start, half-day workshop)

TIME	TOPIC
8:00 – 8:30 am	Tea and coffee Registration
8:30 - 8:50 am	Welcome Acknowledgement of Country Overview of the workshop Introductions
8:50 – 9:35 am	The Good Conversation
9:35 - 10:20 am	Starting the Good Conversation
10:20 - 10:40 am	MORNING TEA
10:40 - 11:00 am	Quiz!
11:00 – 12:20 pm	Having the Good Conversation
12:20 – 12:50 pm	LUNCH
12:50 – 1:20 pm	Future Good Conversations
1:20 - 1:30 pm	Concluding the Good Conversation

Facilitators

ACP Champions in your workplace – it is good to have two facilitators if possible, depending on participant numbers.

Objectives

After completing this workshop, you should be able to:

- Initiate and undertake ACP discussions with residents, families and/or substitute decision maker(s) (SDM)
- Champion ACP within your current place of practice
- Train other staff about ACP and its benefits for residents in your RACF
- Enhance the ACP process through reflective practice.

Peer support

Another important component of a sustainable ACP Champion program is peer support. It is recommended that you develop a peer group of ACP Champions within your facility.

By meeting regularly and sharing both workload and ideas you will build knowledge, skills, and confidence in your ACP practice over time. It is much more fun when you share.

What is peer support?

Peer support involves informal sharing with peers from learned experiences through informal and democratic conversation. It may occur:

- In person, over telephone or via the internet
- Between two people, a small group or within a larger group.

Benefits of peer support

The benefits of peer support include:

- helping individuals to know where to find information to get answers
- helping ACP Champions, in conjunction with their managers, to develop and refine ACP processes within your facility.
- Sharing expertise with other ACP Champions may empower both the people giving and receiving the information.

Suggested peer support activities

1. Statement of Choices critique

- After each of you first support a resident/substitute decision maker to consider completing a Statement of Choices, employing respect and confidentiality, share your experience and your key learnings with your peers. Alternatively, you may wish to support a resident to complete an Advance Health Directive (AHD), especially the values section (*refer to Section 3*), and/or an Enduring Power of Attorney (EPOA) and share your experience with your peers.

- Resources/references you can use for this activity include:
    - Guide for health professionals: how to use the Statement of Choices (*refer to Section 4*)
    - Tips for completing a Statement of Choices (*refer to Section 4*)
    - Steps for completed ACP documents to be uploaded to The Viewer (*refer to Section 4*)
    - OACP review of ACP documents (*refer to Section 4*)
    - Clayton JM, Handcock KM, Butlow PN, Tattersall MHN, Currow DC. Clinical practice guidelines for communication prognosis and end-of-life issues with adults in the advanced stages of a life limiting illness, and their caregivers. *Med J Aust*. 2007; 186:S76-108.

2. See the ACP process through

- The junior ACP Champion can 'buddy' with an experienced ACP Champion to 'walk' the entire ACP process for one resident, from initiating the ACP discussion with a resident/substitute decision maker, through making an appointment to support completion of an ACP document, to arranging the consultation with the GP and ensuring a copy of the document is sent to the Statewide Office of Advance Care Planning and other administrative processes according to the facility's procedures.
- Before starting, the Champion ensures they have:
    - An understanding of the resident's clinical history.
    - If there is an existing AHD, EPOA or any other advance care planning documentation, these documents must be located and read thoroughly.
- The ACP Champion will conduct the ACP discussion with a resident, family and/or substitute decision maker(s).
- The discussion is documented in the resident's clinical record by the ACP Champion.
- If appropriate, an ACP document may be completed as per the current workplace practices of the facility.
- If completing a SoC or the values section of the AHD, ensure that the resident's own words indicating their values, beliefs and health care preferences are documented.
- If an ACP document has been completed, the Champion ensures the process of uploading a copy of the document to The Viewer is followed. The resident may choose to upload a copy of the ACP document to their My Health Record.

3. Provide peer education

- The ACP Champion will 'buddy' with another Champion to provide ACP education to their staff
- For this activity, the Champions will conduct a training session with other RACF staff, ensuring all staff are updated and supported
- The ACP Champion may use one or more of the short training sessions included in Section 3 of *the Guide*.
    - Electronic copies of these short training sessions are available in *the Guide* accessible via www.mycaremychoices.com.au and www.pallconsult.com.au
- This peer exercise will include a debrief and feedback session with the other ACP Champion(s) after completing the training session.

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ACP Champion workshop resources

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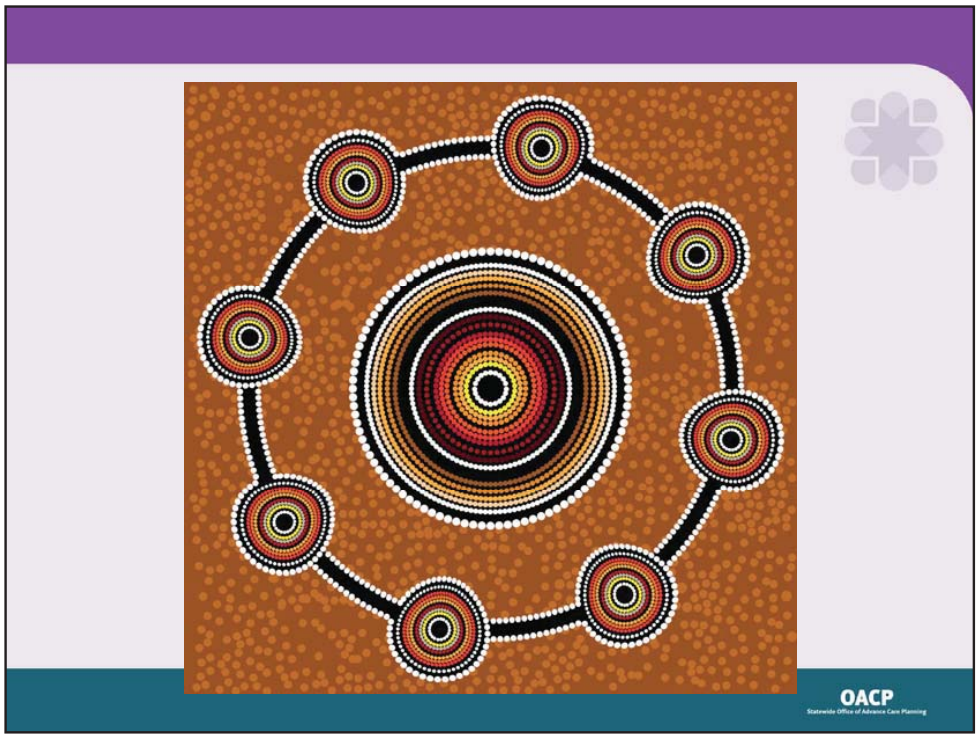
Workshop facilitator notes

- Registration desk
- Have Attendee list – encourage update of any new details

- Require internet/ video/ audio access

- Initial Welcome



Workshop facilitator notes

Acknowledge the Custodians of the Land, for example:

Hello my name is [*insert name of speaker*]. I would like to begin by paying my respect to the [*insert local Indigenous*] people, the custodians of this land on which we meet today and to recognise their continuing connection to land, water and community. I celebrate the uniqueness of the world's oldest living cultures and respectfully acknowledge the diversity of cultural and spiritual beliefs. I pay respect to the Elders past, present and those yet to come as we walk together towards a healthier future.

Workshop facilitator notes

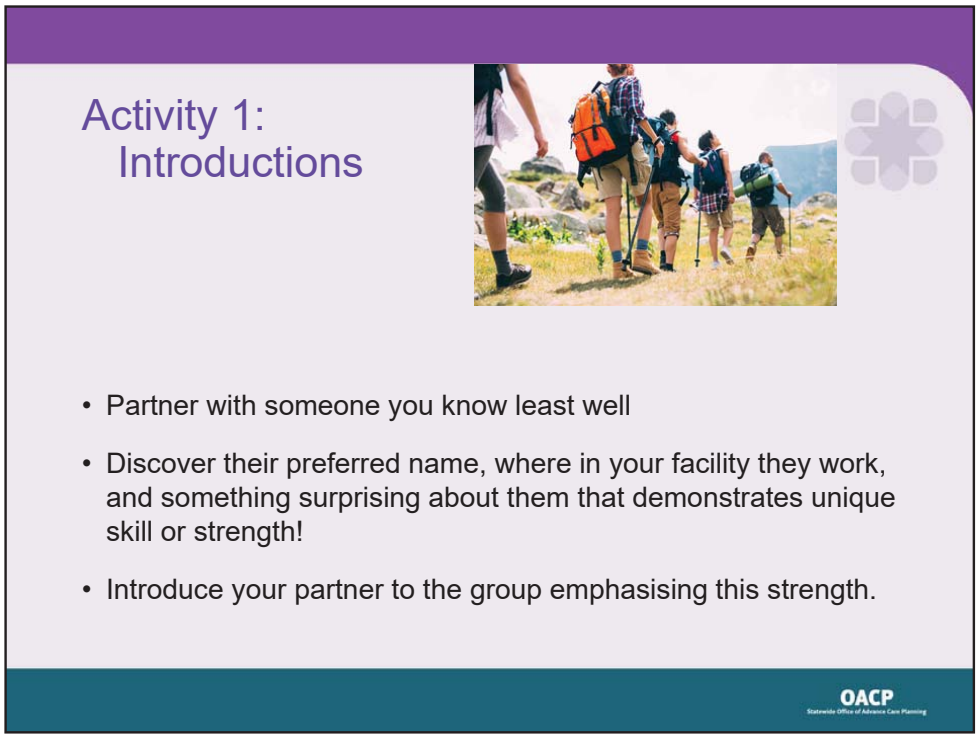
Our vision for the day is to:

- build real skills
- build networks for ongoing support
- enhance the ACP process through reflective practice

Refer to *The Guide*

The Guide is for your use as an on-going resource in your workplace. We will familiarise you with *the Guide's* resources throughout the course of this workshop

To begin building our mutual trust, we need to know a little bit about each other…… to next slide …

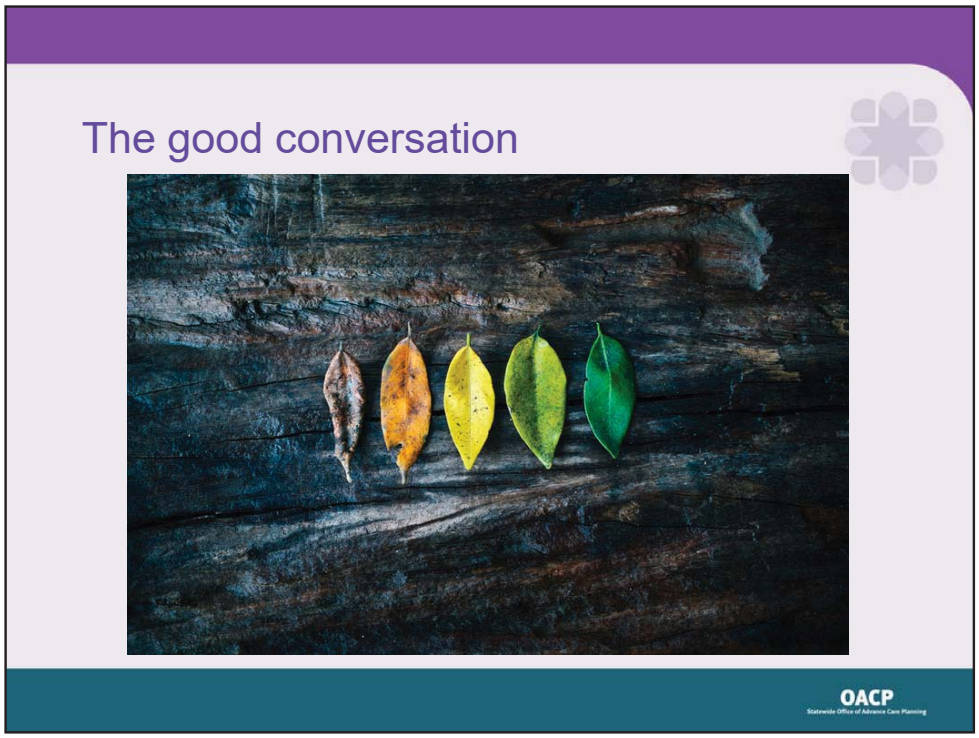


Workshop facilitator notes

Deliver instruction
Allow 5 minutes
Model the activity

Timing:
- 5 mins to find and discover
- 10 mins to intro each other

TOTAL: 15mins



Workshop facilitator notes

In a sensitive conversation there is much that is outside our control. There are however many elements we can influence. We aim for a good ACP conversation each time.

BRAINSTORM

Ask group "*From your experience what are the elements that increase the likelihood of a good conversation?"*

Instructions for facilitators:

Facilitate group discussion

Scribe responses on whiteboard

Framework for a good conversation

- A well respected framework *PREPARED* guides health professionals in facilitating end-of-life conversations. [1]
- We recommend its use to support ACP discussions.

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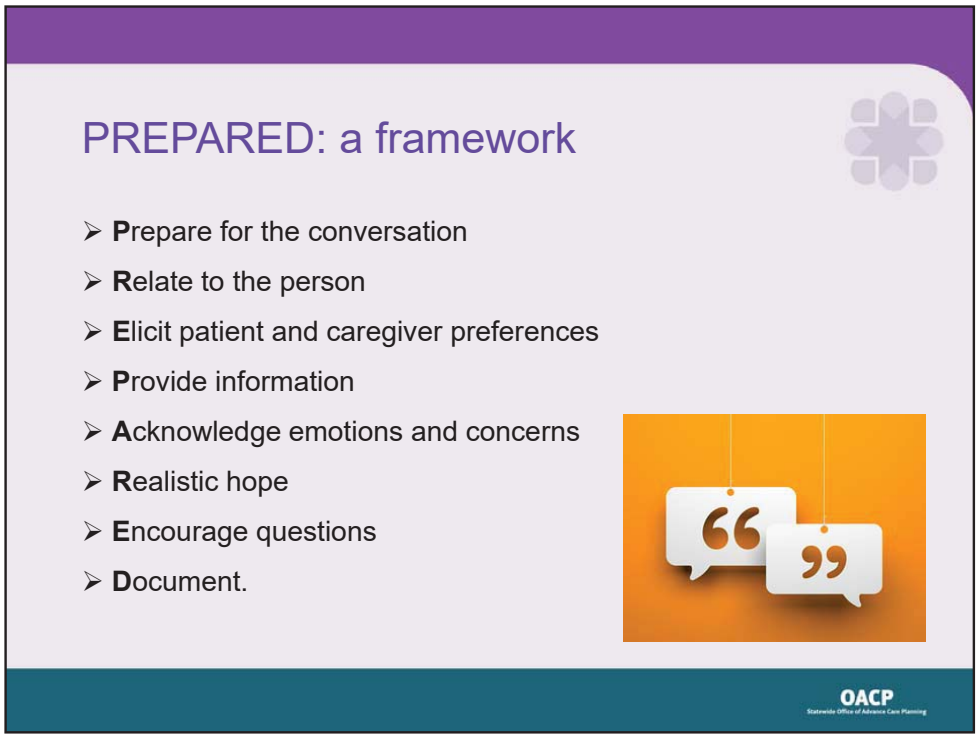
Workshop facilitator notes

- Explain that the PREPARED framework provides a structured method for the delivery of successful end-of-life conversations



Workshop facilitator notes

- Work through each dot point and explain that each dot point will be expanded in the following slides

Prepare for the discussion

- Gain consent from resident and/or SDM(s) for ACP conversation
- Ascertain who will attend, e.g. resident, family, SDM(s), general practitioner (GP) and/or Allied Health
- Prepare a quiet, private space and uninterrupted time
- Prepare yourself– review resident's history and be self-aware.

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Workshop facilitator notes

Points to prompt discussion

- Ensure appropriate participants are invited to attend; include GP invitation or input if unable to attend
- Pre-book an appropriate meeting place, could be resident's room
- Prepare with offer of water, tissues, cup of tea, pre-empt toileting of resident.

Workshop facilitator notes

Open discussion sharing measures participants employ

Points to prompt discussion

- Introduce self prior to commencement, and informal chat to break the ice- everyone may be a bit nervous about meeting and what to expect
- A warm tone and open posture are important to make all feel comfortable; remember >70% communication is non-verbal
- Relay some important information that you know about the resident /family from a strength-based perspective.

Elicit resident, SDM and family preferences

- Discuss the reason for the conversation and elicit the expectations of residents, families and/or SDM(s)
- Clarify understanding of the situation and establish how much detail is required from the outset and progressively
- Consider cultural and contextual factors that inform preferences.

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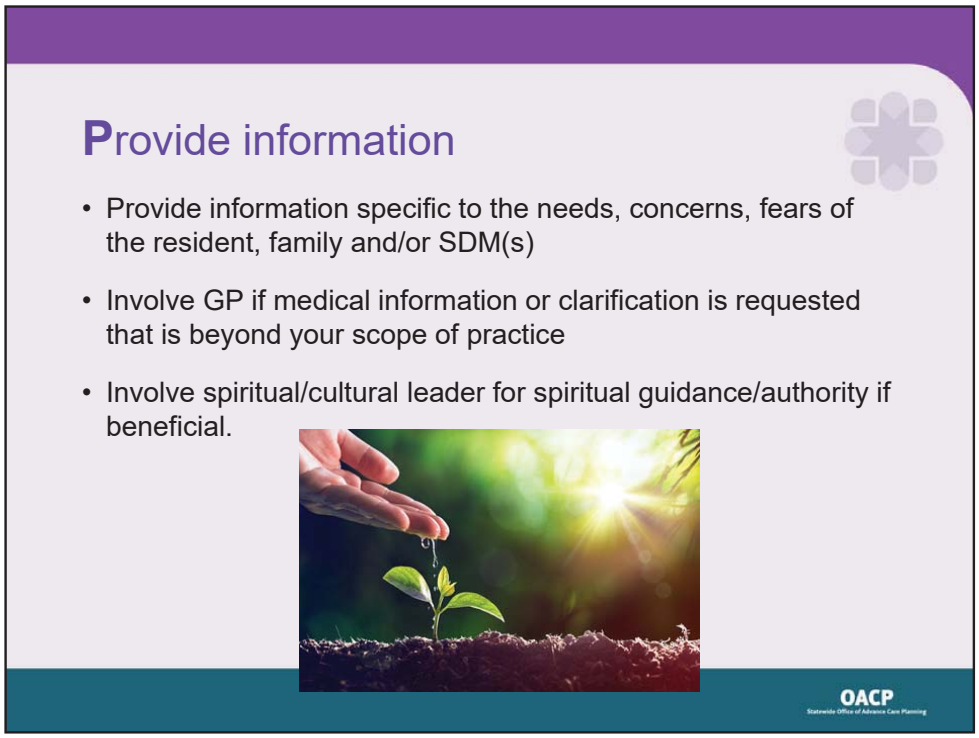
Workshop facilitator notes

Points to prompt discussion

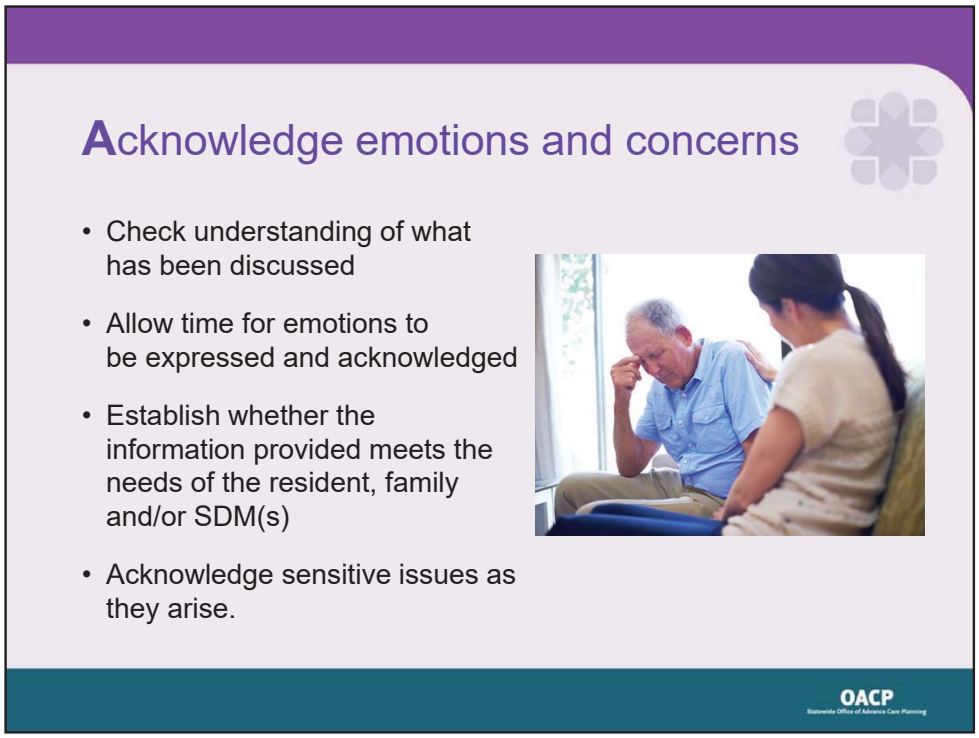
- Give summary of reason for discussion and draw out resident/family expectations
- Ask if there are any cultural/religious aspects/rituals important to resident/family which should be honoured.



Workshop facilitator notes

Points to prompt discussion

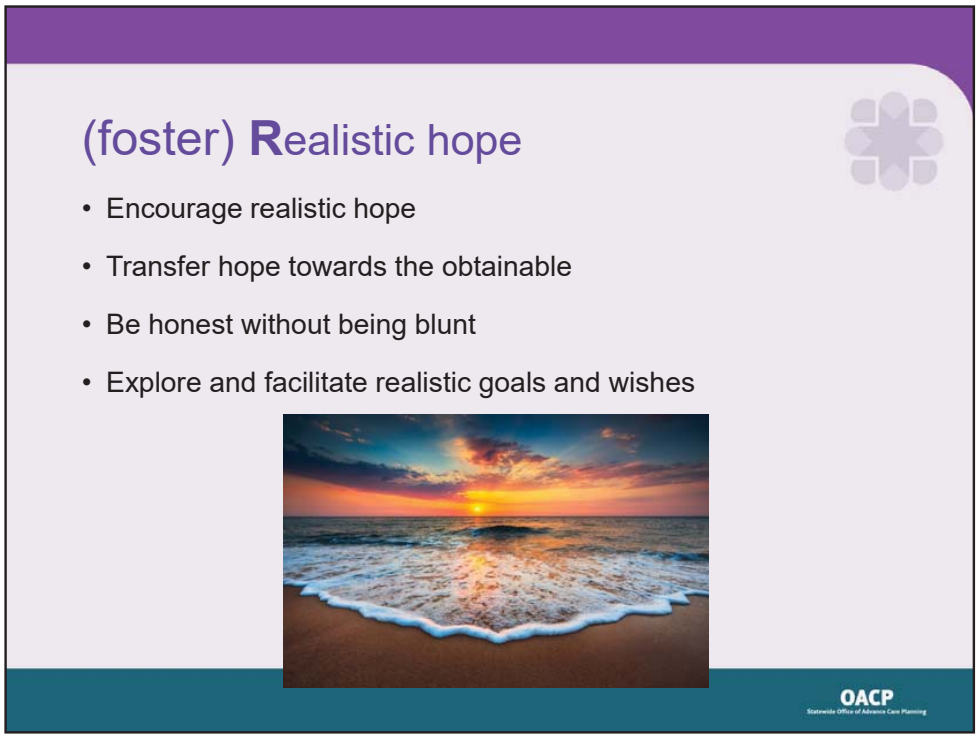
- Be knowledgeable about residents' conditions which may impact discussions
- Be knowledgeable about residents' religious/cultural beliefs and how those beliefs may impact discussions
- You may need to give prompts like: "Some people in your situation have been concerned about pain/lack of privacy/gasping for breath/dying alone…."



Workshop facilitator notes

Points to prompt discussion

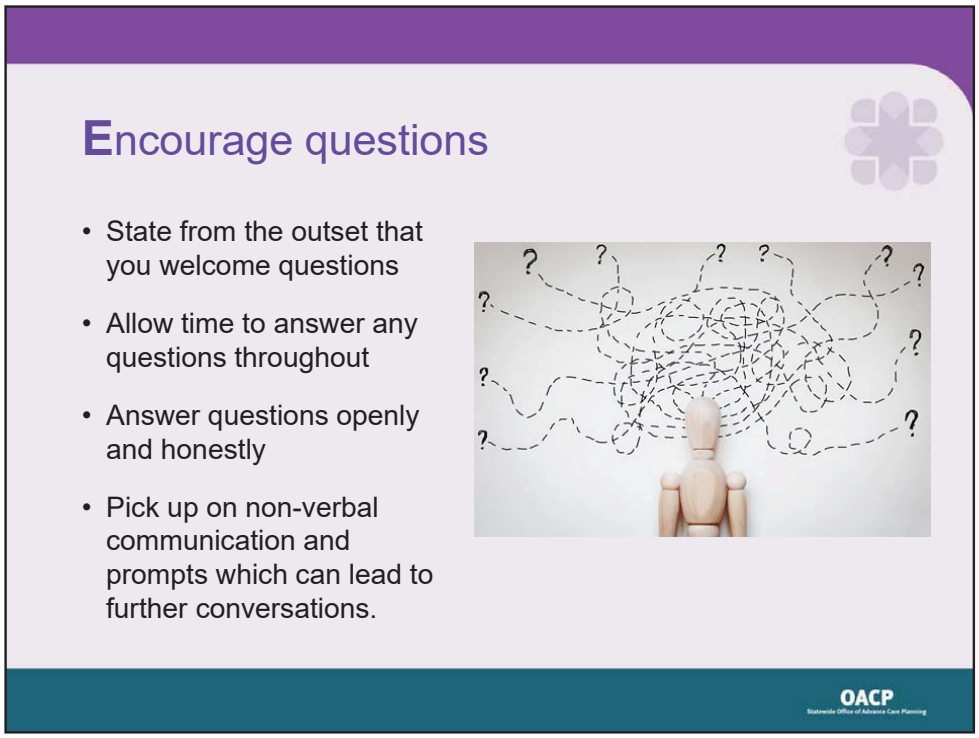
- Acknowledge that this may be the first time family and resident have discussed these topics and what their wishes are
- Acknowledge and name emotions as they come up
- Ask resident and family to repeat back certain information to ensure they understand what has been said
- Ask what the resident/family is MOST worried about and address these concerns promptly



Workshop facilitator notes

Points to prompt discussion

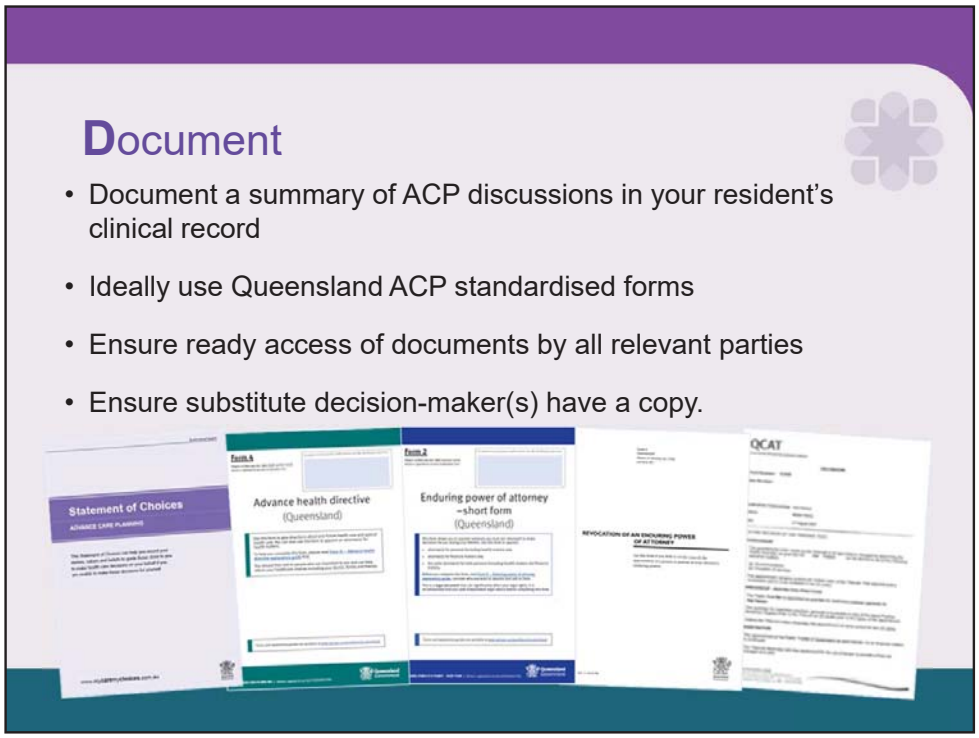
- Be realistic in answering questions, don't offer false hope
- Do not promise anything you can not deliver – fidelity is vital for building trust and fostering hope
- Outcome statistics are good to have at hand if resident or SDM wishes to know about CPR /life sustaining treatments and benefits verses burden in elderly



Workshop facilitator notes

Points to prompt discussion

- Encourage questions and allow for subsequent discussions if questions evolve later out of today's conversation
- May be a series of ACP conversations before any documents are completed
- If unable to answer questions don't be afraid to admit you're not sure, but will find out and get back to them, or GP may be more appropriate to ask at the next visit.



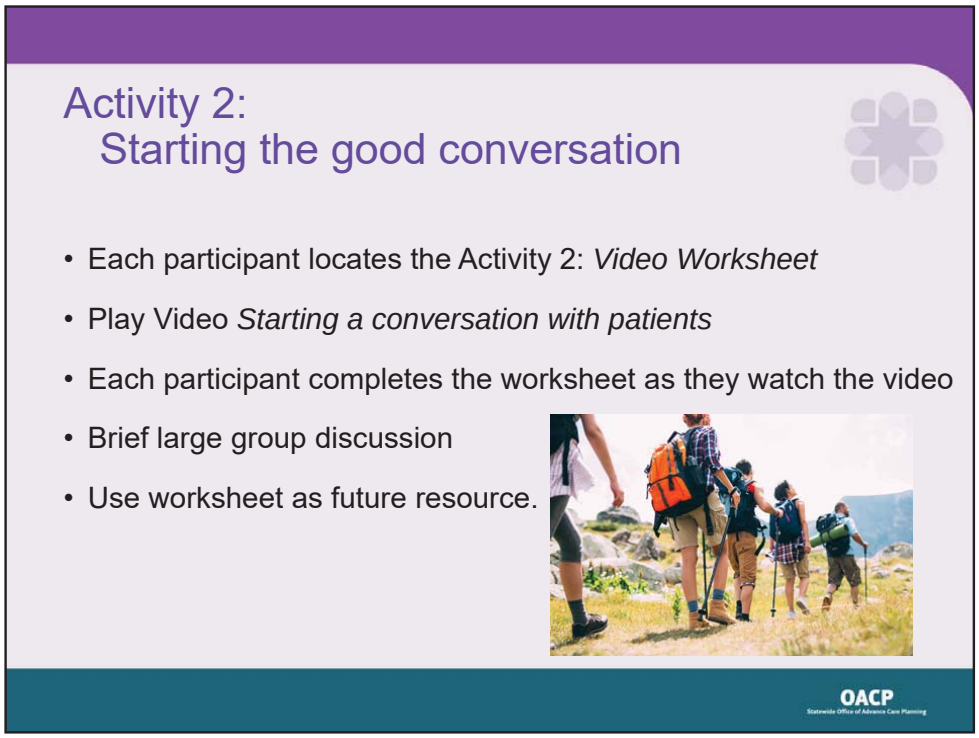
Workshop facilitator notes

Points to prompt discussion

- New concepts may not be immediately or fully understood. We need to find the words that most express the meaning for each resident/family
- Ideally will include completion of ACP documents
- Ensure passing on of important information
- What are facilities process of alert to completion of ACP docs and dissemination?

"Don't worry if you forget any of this information as there is a handout for you!"

Refer to explanatory guides and tips sheets in *Guides to completing ACP documents* in Section 4 of *the Guide*.



Workshop facilitator notes

Handout:
Ask participants to retrieve the *Activity 2: Video Worksheet* (located in *Workshop activity worksheets* in Section 2 of *the Guide*)

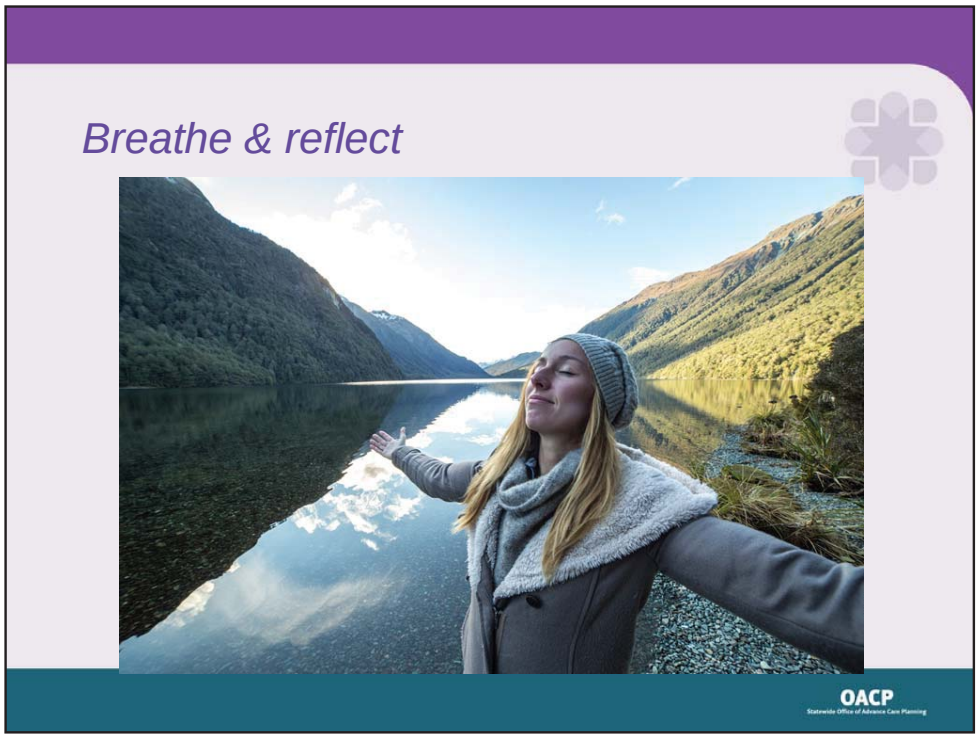
Work individually to complete the worksheet while the video is being played (video is on Slide 17)

Timing:
10 mins for group discussion
(You might need to keep a close eye on the timing here)

Workshop facilitator notes

- Click on the 'play' symbol to start the video (video is embedded in this PowerPoint)

- **Video:** *Starting a conversation with patients*
  Duration: 2:07

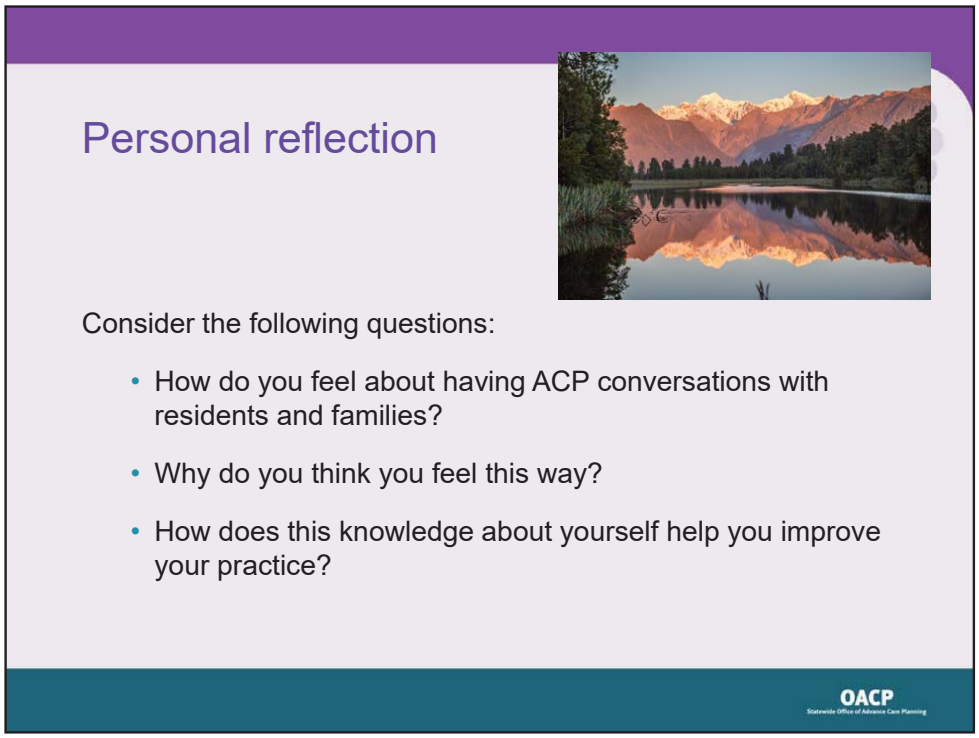


Workshop facilitator notes

Instruction:

1. “We know that the most effective way of learning as an adult is to consider what you have just heard or experienced and make sense of it in regard to your own practice”

2. So….close your eyes and take a deep cleansing breath”

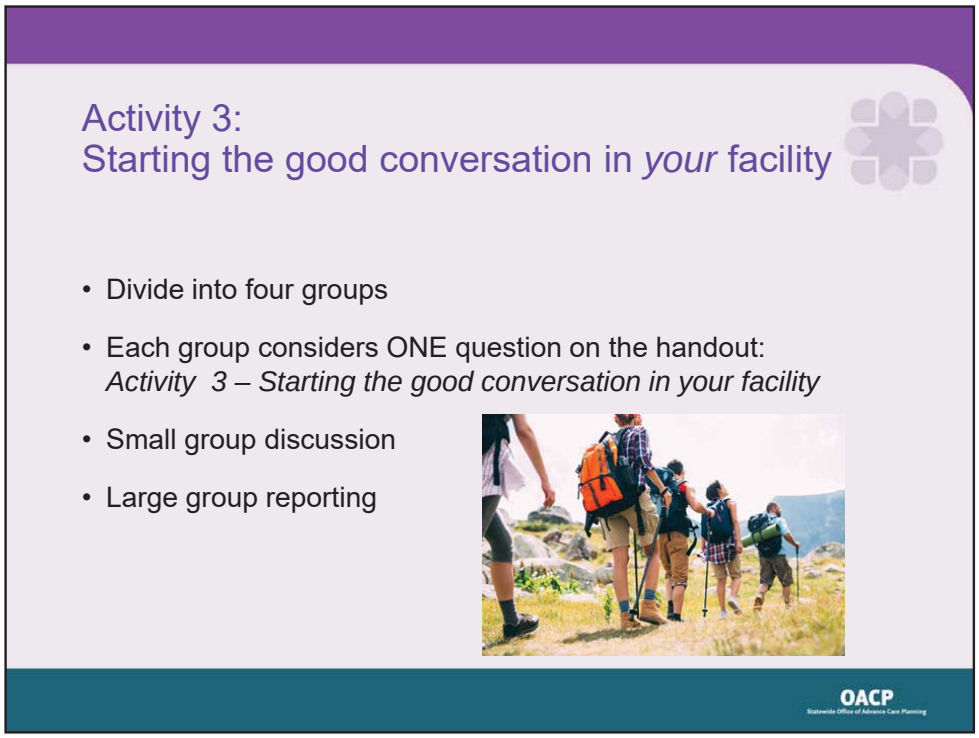


Workshop facilitator notes

Rules are:

- Start with complete silence while you have the opportunity to do some deep thinking.
- After three mins if you wish to – please share these reflections with your partner
- Offer them the opportunity to share to the larger group anything surprising about what you said or what you heard.

Workshop facilitator notes



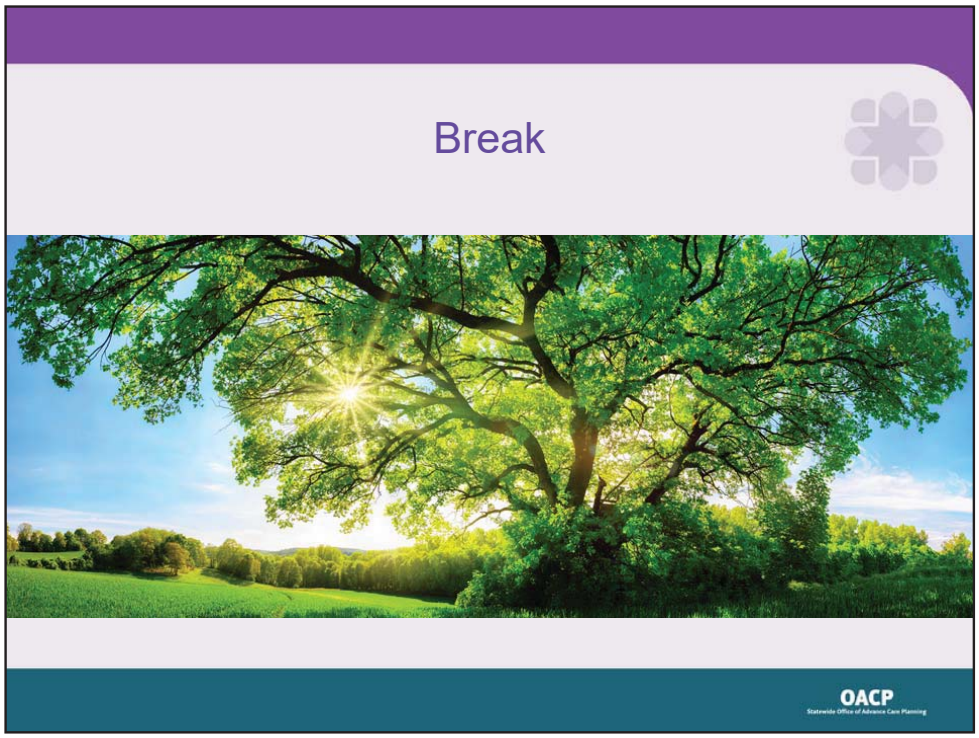
Workshop facilitator notes

Handout:
Ask participants to locate the handout *Activity 3: Staring the good conversation in your facility* (located in *Workshop activity worksheets* in Section 2 of *the Guide*)

Break into four groups

Each group chooses ONE question and brainstorms the answers
One person from each group presents answers back to larger group

Timing:
10 mins for small group discussion
5 mins per group to feed back to larger group.
(You might need to keep a close eye on the timing here)

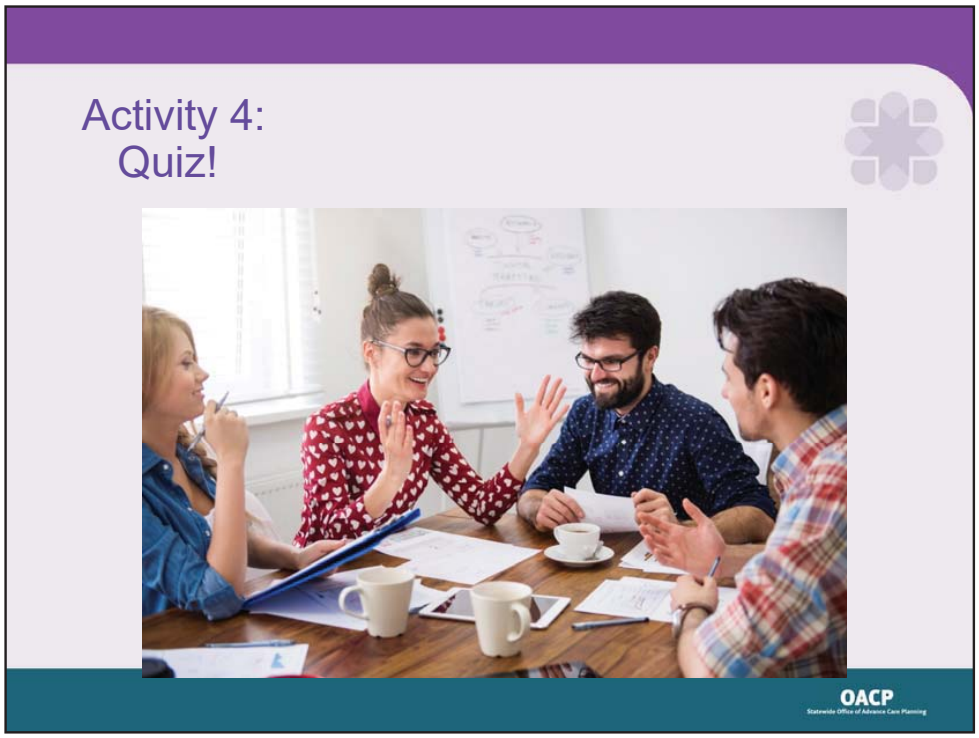


Workshop facilitator notes

Take the Statement of Choices (SoC) and OACP review of SoC Document (located in *Workshop resources* in Section 2 of *the Guide*) to your break because when we get back, we are going to have a quiz!

And all the answers for the quiz are on the SoC and OACP review documents.

Remind the group of exactly the time you expect them back after the break.



Workshop facilitator notes

The purpose of this exercise is to examine more closely one of the ACP documents used in Queensland, i.e. the Statement of Choices (SoC); and to put its use, and that of other ACP documents, into context regarding health care decision making for a person who can no longer decide for themselves.

Preparation: familiarise yourself with the SoC (including the outer cover sheet) and the OACP review document (located in *Workshop resources* in Section 2 of *the Guide*).

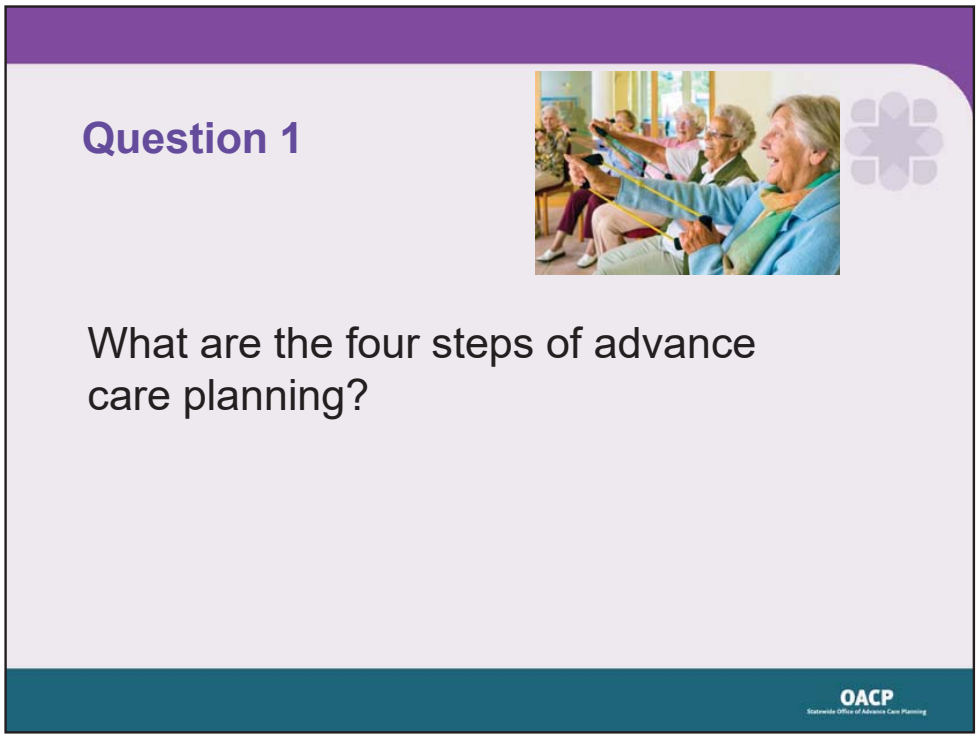
The group divides into evenly sized groups.

Handout:
Activity: 4 the Quiz answer sheet (located in *Workshop activity worksheets* in Section 2 of *the Guide*)

Groups to swap answer sheets to mark.

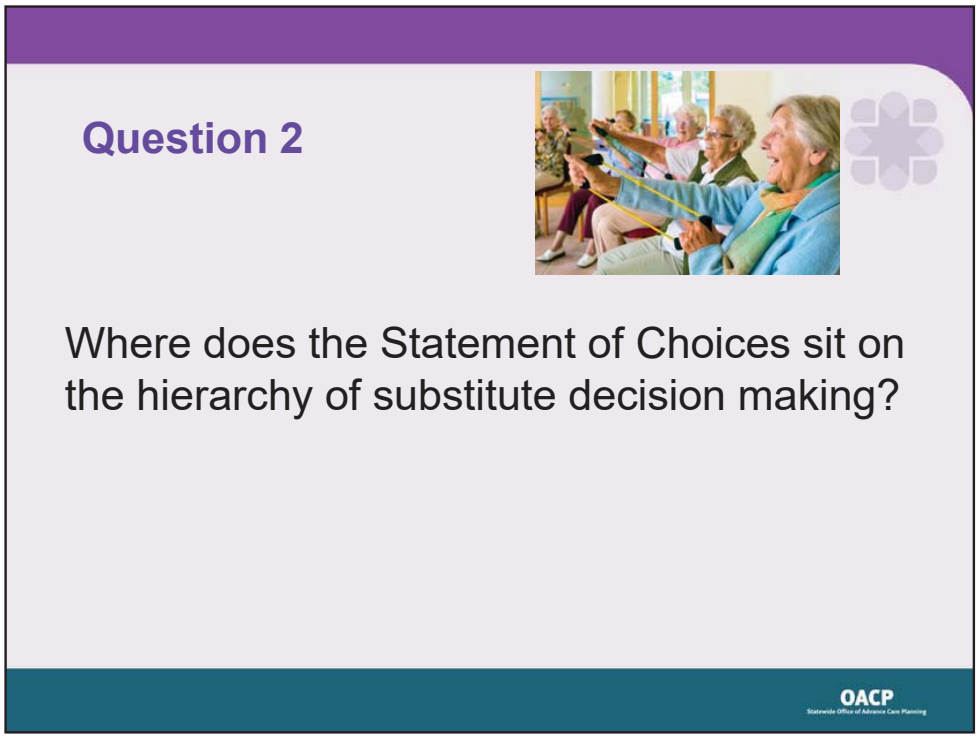
Timing:
Approx. 1 minute per slide (slides 24-33)

Discuss any disparity, reinforce consensus
Chocolate frogs or socks for winning team?



Workshop facilitator notes

- Ask questions clearly
- Move on after one minute
- Prompt (if you see participants struggling): answer may be on *cover* of SoC document



Workshop facilitator notes

- This question is designed to promote review of, and discussion about, the substitute decision-making hierarchy.

- At this point, if you think it useful, you may ask someone in the audience to list the substitute decision-making hierarchy

Question 3

Which advance care planning documents require witnessing by a qualified witness like a Justice of the Peace?

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Workshop facilitator notes

- If you think it useful, await responses to this question

Question 4

Choose ONE of the following answers

The Statement of Choices document:

a) Is another name for Advance Health Directive

b) Is legally-binding and cannot be refuted at time of decision making

c) Is not legally-binding but can inform doctors and substitute decision-makers about what is important to the resident

d) Is only recognised under Queensland law.

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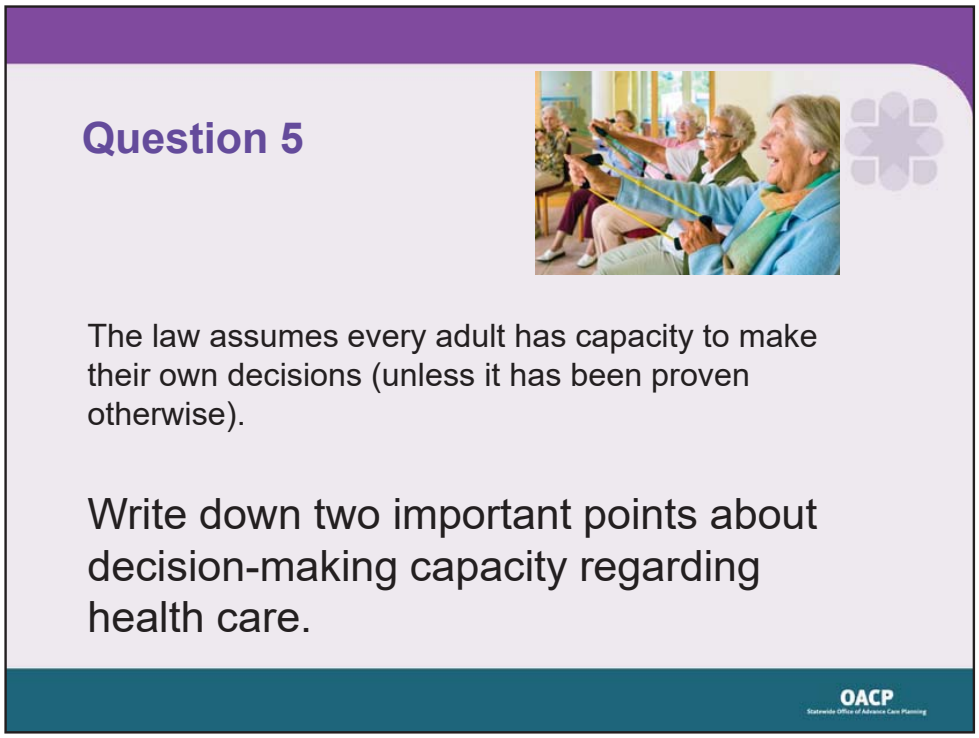
Workshop facilitator notes

- If you think it useful, await responses to this question



Workshop facilitator notes

- If you think it useful, await responses to this question

- It may be useful to review the definition of 'Capacity'. The *Queensland Capacity Assessment Guidelines 2020* provides a guide to understanding capacity, capacity assessment and the legal tests of capacity under Queensland's guardianship legislation. For further information visit: http://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/capacity-guidelines.

Question 6

In which health care environments do ACP documents apply?

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Workshop facilitator notes

- If you think it useful, await responses to this question

Question 7

For residents whose health care decisions are covered under The Public Guardian, there is no value in completing a Statement of Choices.

True or False?

Justify your answer

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Workshop facilitator notes

- Encourage discussion concerning this statement or await responses

Question 8

Who keeps the original ACP document(s)?

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Workshop facilitator notes

- If you think it useful, await responses to this question

Question 9

What are the important elements required by the Statewide Office of Advance Care Planning to upload the Statement of Choices to The Viewer?

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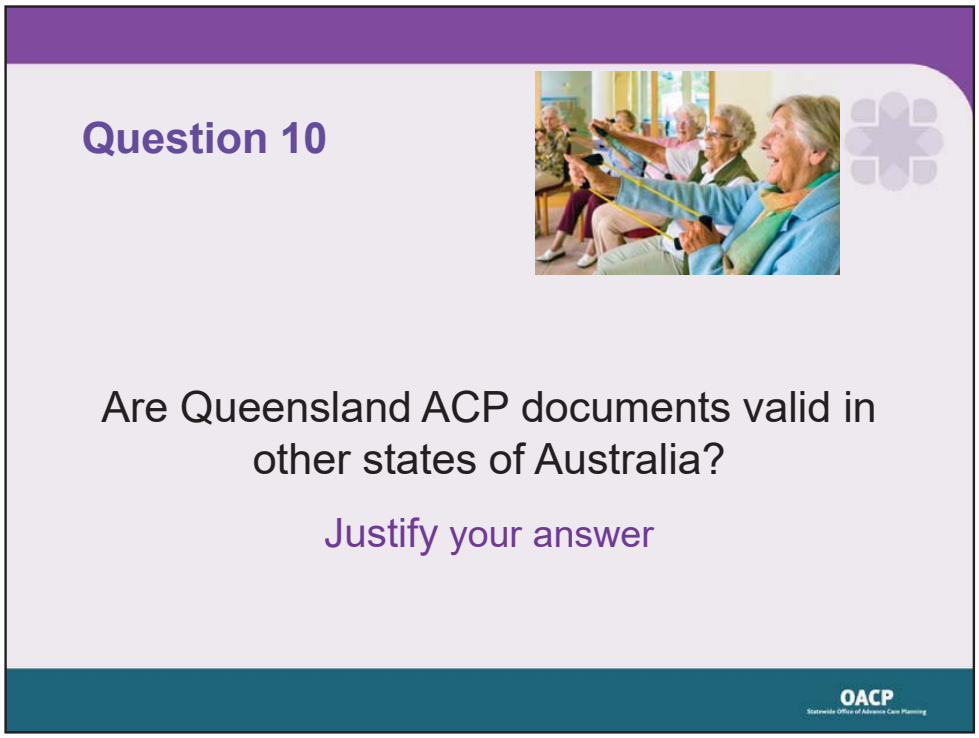
Workshop facilitator notes

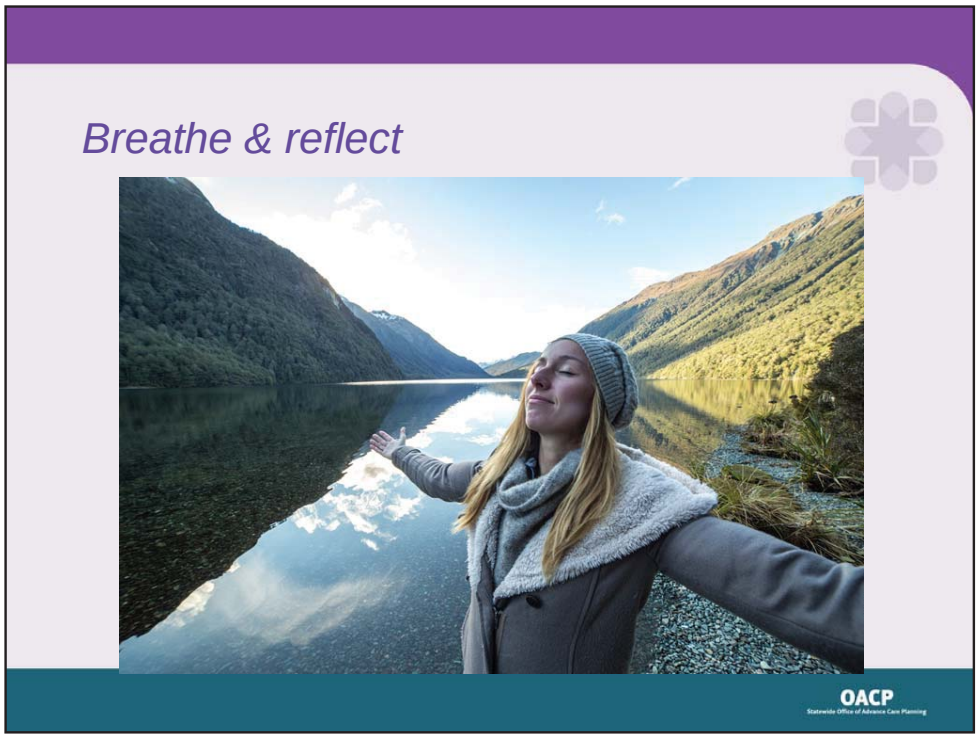
- If you think it useful, encourage responses
- It may be useful to repeat the important elements



Workshop facilitator notes

After last slide of Quiz questions (slide 33), groups swap answer sheets to mark each other's work. (see instructions on *Activity: 4 the Quiz* answer sheet)

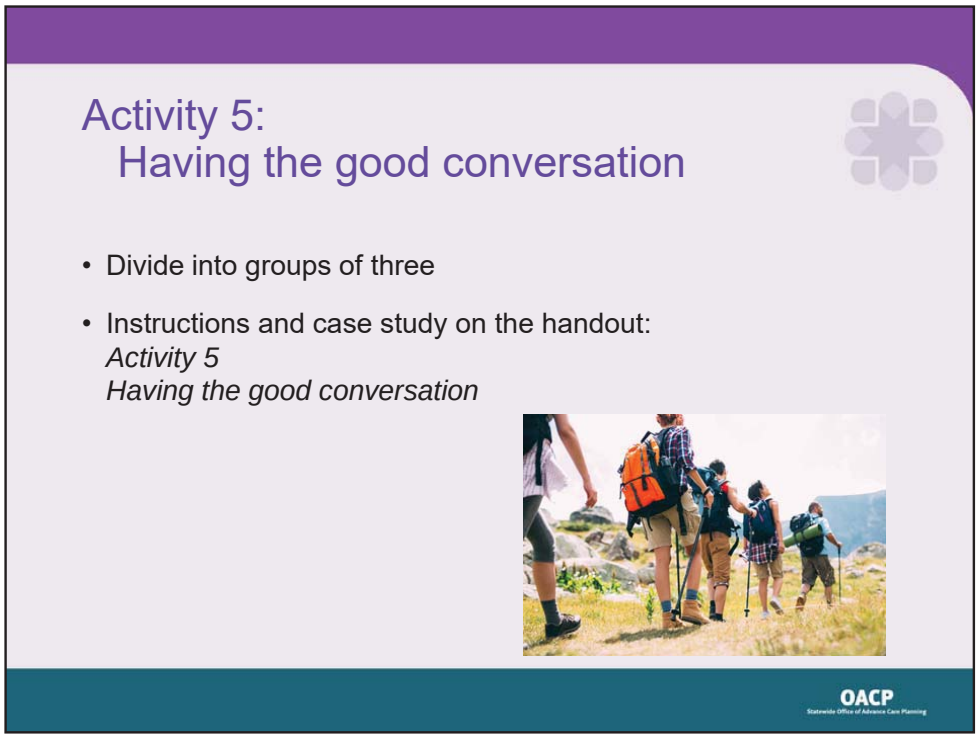
If you think it useful, the group may wish to further discuss some of the answers



Workshop facilitator notes

Guided breathing exercise 1 min

Workshop facilitator notes



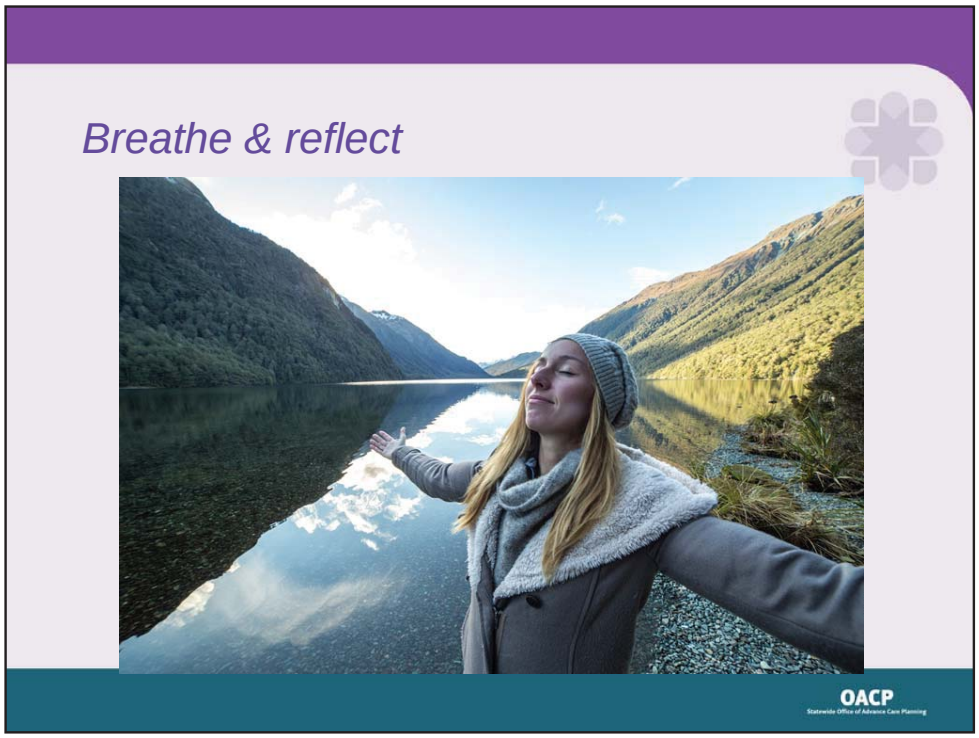
Workshop facilitator notes

Handout:
Activity 5: Having the good conversation (located in *Workshop activity worksheets* in Section 2 of *the Guide*)

Facilitator: hand out the three separate roles in the triad: Patient Daisy, Daughter Janine, and Nurse – self.
Each character to absorb role and NOT to share information with the other two in the triad

Facilitated wrap-up guiding notes
- How did you feel as the ACP Champion?
- How did you feel being Daisy?
- How did you feel being Janine?

- What do you think the other members did well to enhance the conversation?
- What have you learned that you can incorporate into your own practice?
- What were some of the challenges and barriers that you faced?
- What strategies might you be able to implement to address these challenges?



Workshop facilitator notes

Close your eyes and take a deep cleansing breath…
Write down any conviction that springs to mind.

In conclusion

- You don't have to know all the answers
- There are guidelines to follow, but there is no formula
- Get to know the resident, family and/or SDM(s) to understand what their needs are
- The discussions are ongoing – start early and revisit regularly
- Share and document conversations accurately.

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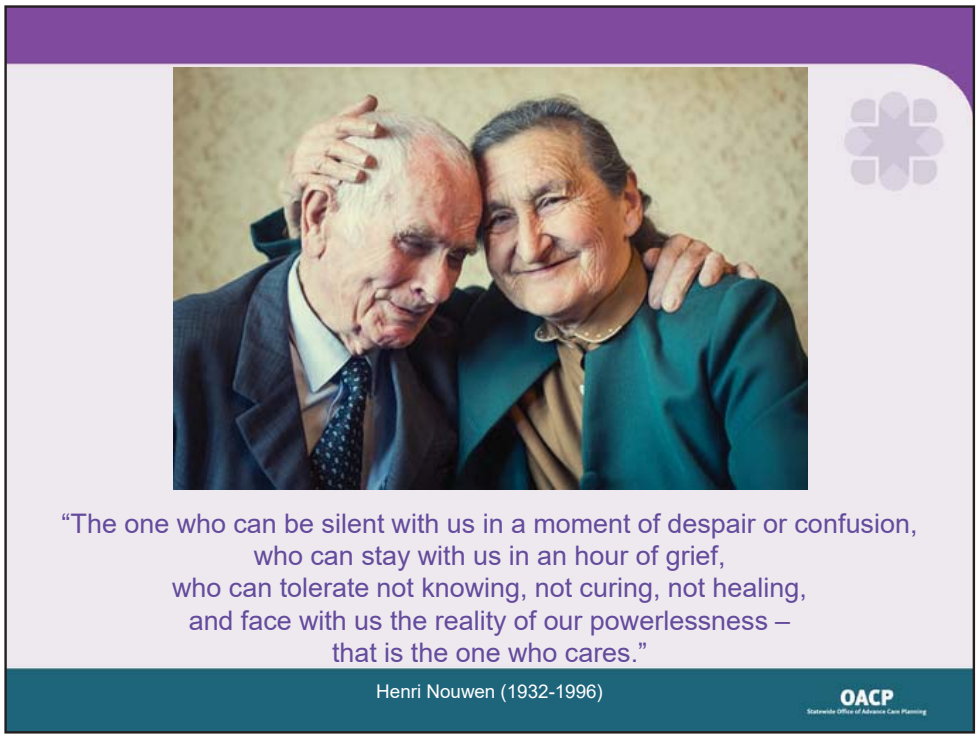
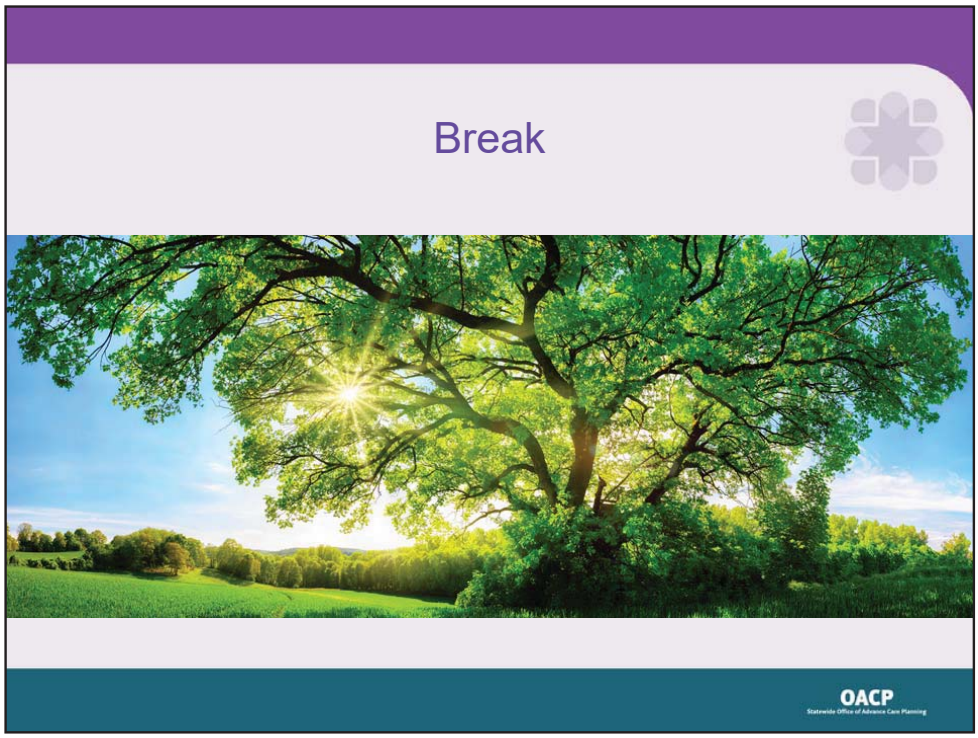
Workshop facilitator notes

- Simply read the content of the slide



Workshop facilitator notes

- Could read contents of the slide

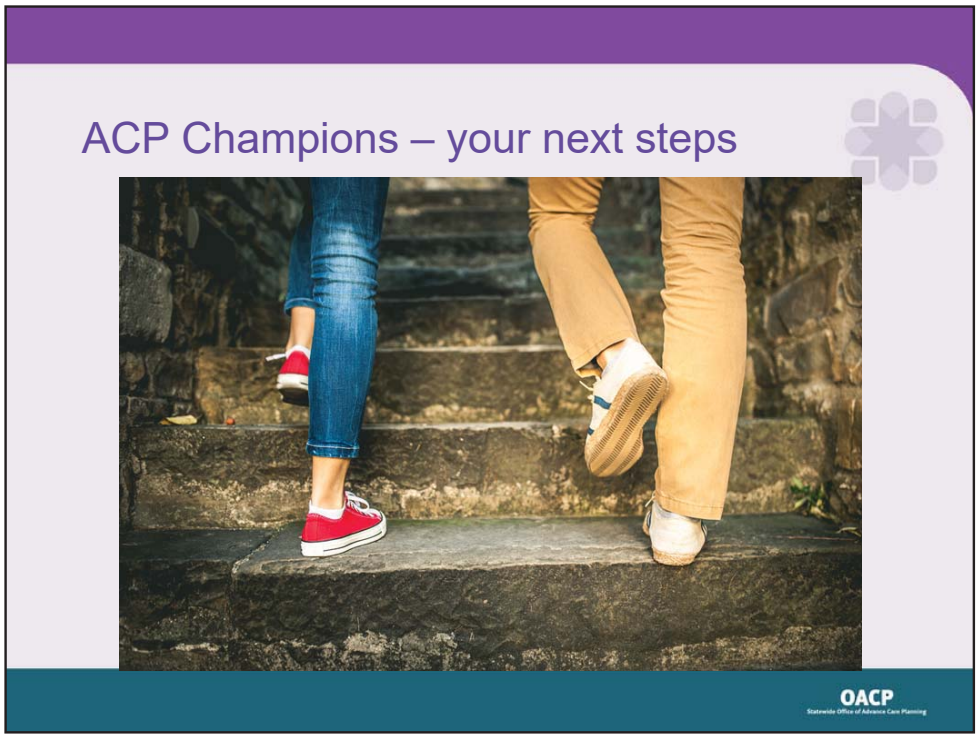


Workshop facilitator notes

- Time for a well earned lunch

Workshop facilitator notes

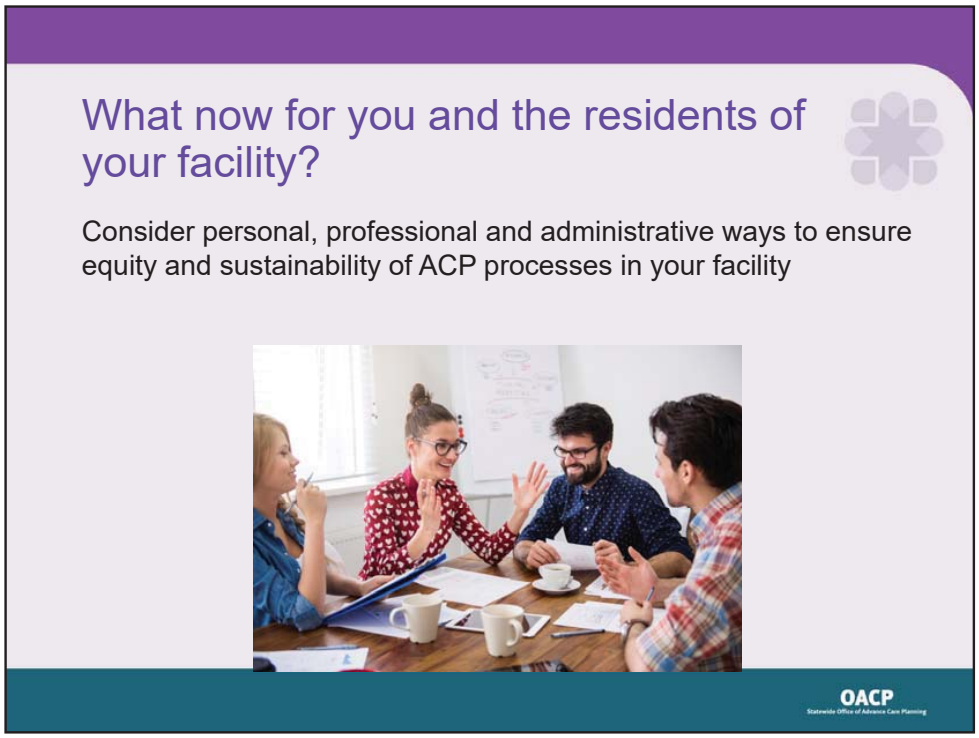
- Welcome the audience back



Workshop facilitator notes

Keep this slide up and summarize what they have achieved so far…

- Online module
- Workshop
- Peer support session
- Conversations with residents



Workshop facilitator notes

Brainstorm on how to ensure all residents in your facility receive the support they require to make their future health care wishes known and accessible when and where health care decisions are made.

Peer support

- You are not alone!
- Learning from peers may improve clinical decision-making capacity and communication skills
- Peer support helps individuals in knowing where to find information to get the answers
- Peer support may help ACP Champions to develop, in conjunction with their managers, ACP processes within their facilities
- Sharing expertise with other ACP Champions may empower both the people giving and receiving the information.

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Workshop facilitator notes

- Encourage short discussions on these points

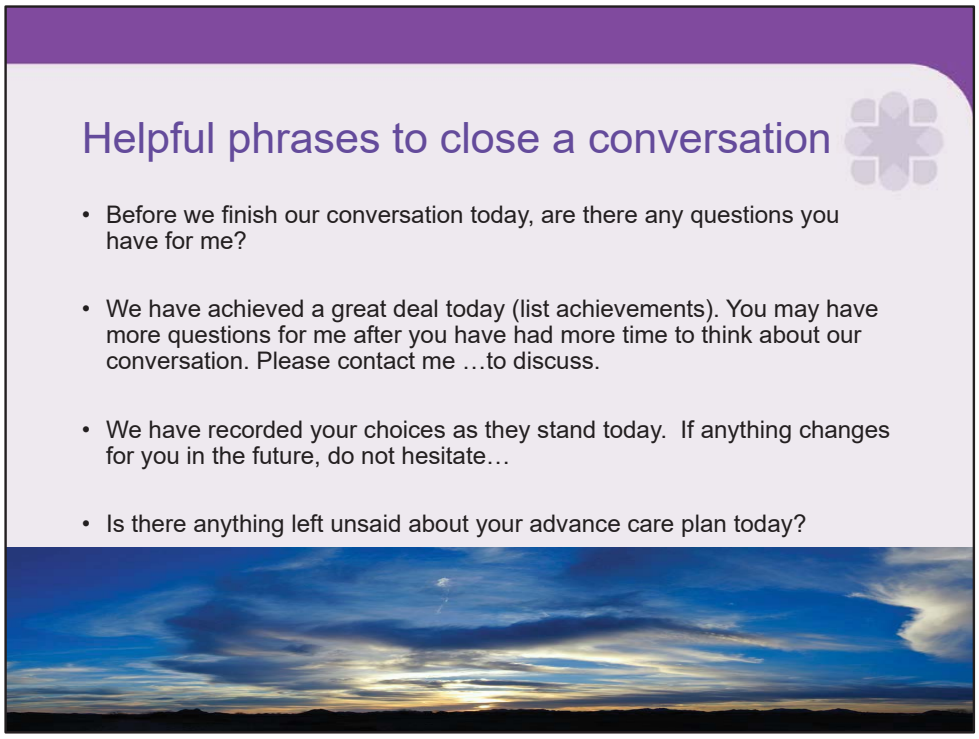
Workshop facilitator notes

- Reiterate that now facility staff are ready to start ACP discussions

- The resources referenced in the slide are in Section 4 of *the Guide*, and Activity 2 worksheet is in *Workshop activity worksheets* in Section 2 of *the Guide*.

Workshop facilitator notes

- Explain that it can be useful to complete an ACP discussion by inviting further discussion at a later time

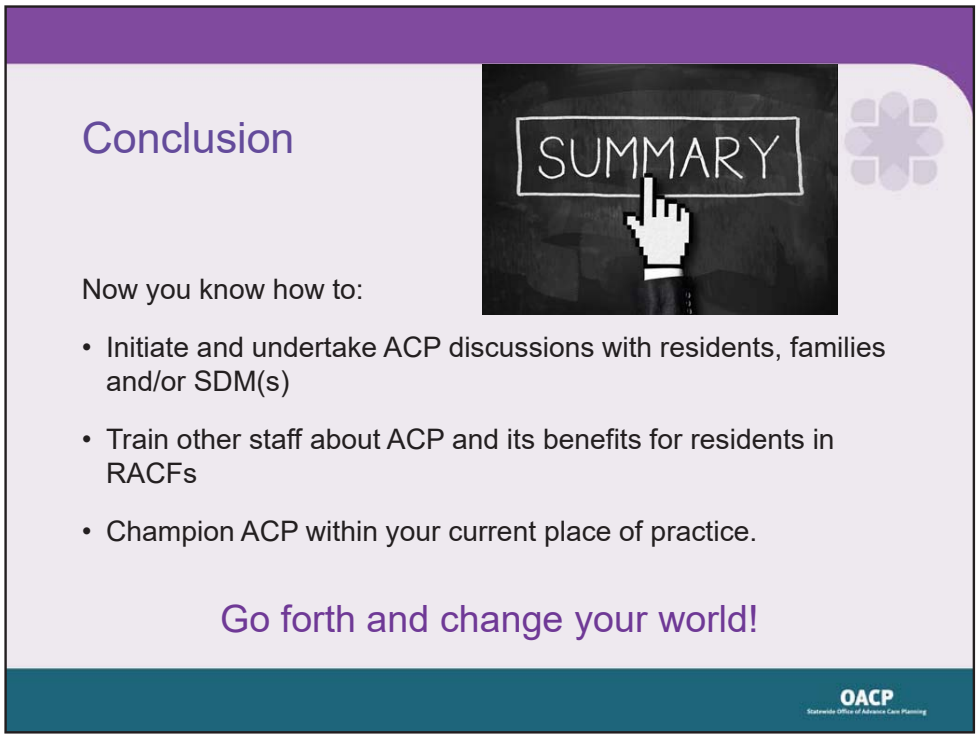


Workshop facilitator notes

- Here are some phrases to use at the close of an ACP conversation

Workshop facilitator notes

- Finally a few thoughts on sustainability – read dot points
- Ask if audience has any other ideas



Workshop facilitator notes

We hope that you have enjoyed this education workshop.

Thank you for your attendance.

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Activity 2:
Video Worksheet (slides 16-17)

Instructions

- Work individually with Activity 2 video worksheet
- Participants watch the Video: *Starting a conversation with patients* and complete worksheet as it relates to your workplace
- Group discussion to follow video
- Completed worksheet becomes a future resource

Video Content	Notes
1. A good time to start an ACP conversation with your residents	
2. The best way to start to introduce ACP to your residents	
3. Some tips for starting the conversation	(i) (ii) (iii)
4. Some questions to ask to start the conversation	(i) (ii) (iii)
5. Other things to consider	(i) (ii) (iii)

Activity 3:
Starting the good conversation (slide 21)

Instructions

- Participants are to divide into four groups
- Each group will be given ONE of the questions below
- Write down key points on butchers' paper or similar
- A nominated member from each small group is to present the key points to the larger group
- Timing: 10 minutes plus **5 mins per group** for feedback to the whole group.

Questions

1. What are the **challenges** to the good ACP conversation?
2. What are some **triggers** that may indicate to you the resident is ready to start the ACP conversation?
3. What are some **phrases** that would help start the ACP conversation?
4. What impact may **life experiences** (the resident's *and* yours) have on ACP conversations?

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Activity 4:
Quiz! (slides 23-33)

Team Name: _____

Instructions

- Evenly sized groups (three heads are better than one)
- Use the documents *Statement of Choices* and *Checklist for Statement of Choices to be uploaded to The Viewer* for reference
- Write answers to questions from the PowerPoint quiz onto this answer sheet
- Write team name at the top
- Swap your answer sheet with a neighbouring team for marking
- Return the sheet
- Group discussion

Q1	
Q2	
Q3	
Q4	
Q5	

Q6	
Q7	
Q8	
Q9	
Q10	

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Activity 4: Quiz! (slides 23-33)

Team Name: _____

Instructions

- Evenly sized groups (three heads are better than one)
- Use the documents *Statement of Choices* and *Checklist for Statement of Choices to be uploaded to The Viewer* for reference
- Write answers to questions from the PowerPoint quiz onto this answer sheet
- Write team name at the top
- Swap your answer sheet with a neighbouring team for marking
- Return the sheet
- Group discussion

Q1	1. Discuss -with your doctor about your current health conditions and how they may affect you – with your family about values, beliefs, and health care preferences 2. Record – your wishes in an ACP document – your substitute decision maker's (SDM) details 3. Share – copies of your ACP documents with SDM, family and health care providers via OACP – the resident may wish to upload their ACP documents to their myHealth Record 4. Review
Q2	SoC is not strictly on the hierarchy of substitute decision-making. SoC supports decision makers at every level to make decisions guided by the values, beliefs and wishes of the resident at the time he/she cannot express these themselves.
Q3	Advance Health Directive Enduring Power of Attorney – short and long forms
Q4	(C) The SoC is not a legally-binding document but can inform doctors and substitute decision-makers to make decisions in accordance with the persons values, beliefs and wishes.
Q5	1. Capacity refers to a resident's ability to make a health care decision about a particular matter at a particular time 2. It is made freely and voluntarily 3. The resident must demonstrate understanding of nature and effect of decision 4. The resident must be able to communicate the decision in some way. Note: people with impaired capacity have the right to the culturally safe support they require in order they can participate in decision making to their fullest potential.
Q6	In **all** health settings in Queensland including hospital, community health, General Practice, RACFs – wherever health care decisions are made for a person who can no longer decide for themselves.
Q7	False The Public Guardian has a responsibility to gather all relevant information about a resident to ensure the best decision possible is made in accordance with the resident's values, beliefs and wishes regarding health care outcomes. The Statement of Choices (particularly Form A) is a rich source of this information.

Q8	1. AHD, EPOA and SoC Form A – the resident themselves or a nominated proxy (family/RACF files) in accordance with resident's wishes. 2. SoC Form B – the named person completing the SoC Form B who ideally is the EPOA
Q9	Although completion of all elements maximises the SoC utility—a person may complete all or part of the SoC. Completion of the personal values and preferences for medical care and treatment sections is highly recommended and provides important information for substitute decision-makers and clinicians about a person's views, wishes and preferences for care. The elements of the SoC that are required in order for it to be uploaded to The Viewer include: 1. The document is legible 2. Personal details include the name and date of birth of the person to whom the SoC belongs (or addition of Resident Identification label) 3. In Form A: a. the person has signed and dated the SoC b. the person's doctor has signed and dated the SoC 4. In Form B: a. the person completing the SoC has signed and dated it b. a doctor of the person to whom the form belongs has signed and dated the SoC. 5. All pages of the SoC are included in the document. 6. Additional pages referenced in the document are attached.
Q10	AHD and EPOA are legally binding documents in QLD however they are not necessarily recognised in other jurisdictions. Recognition of these documents will depend on legislation in different states. SoC is not a legally-binding document, it does not need to conform with different jurisdictions; however as it is a Queensland Health form, it may not be so readily recognised in other states and there is no system within other states' health services allowing automatic access to the forms, so the physical form will need to be produced at the time of decision making.

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Activity 5:
Having the good conversation (slide 36)

Instructions

- Participants are to divide into groups of three.
- Use the Statement of Choices (SoC) to guide the ACP discussion.
- Hold onto the values, beliefs, wishes of your character as you enter into the role play.

Scenario: **Role-play character 1** - *Resident – 'Daisy'*

Your demographics

- 71 years old
- retired teachers' aide, know you're getting *forgetful*
- your husband Frank died in the Emergency Department 33 years ago after being admitted with a bleed from gastric cancer
- your only son Max drowned in the ocean later that same year, aged 12
- your daughter Janine is very supportive.

Your values

- close relationship with Janine and her son, Jimmy
- pride yourself that you made a difference in your life's work
- proud of your ability to manage as a single parent.

Your beliefs

- God abandoned you when your husband and son died only a few months apart
- you are now abandoning your daughter and grandson as you weaken
- on balance you are still a good person and will go to Heaven.

Your wishes

- to die peacefully
- to have time to say Goodbye
- to have Janine with you, but not Jimmy
- to be reunited in Heaven with Frank and Max
- to be cremated and your ashes joined with Frank's ashes
- to have Janine scatter both your ashes in the ocean where Max died.

Role-play character 2

Instructions

- Participants are to divide into groups of three.
- Use the Statement of Choices (SoC) to guide the ACP discussion.
- Hold onto the values, beliefs, wishes of your character as you enter into the role play.
- You have 20 minutes before we open up for group discussion.

Scenario: *Carer/Substitute Decision Maker – 'Janine' (daughter)*

Your demographics

- 41 years old
- hospital social worker (nearby)
- you have a son, Jimmy, aged 10
- you are your mum's legally appointed attorney for health and financial matters
- you went through an acrimonious divorce last year.

Your values

- your role as mother to your son Jimmy
- your identity as a giver as shown in your life's work
- your network of good friends who have supported you through tough times

Your beliefs

- God is angry with you and punishing you
- you are a good daughter who should be able to care for mum at home
- mum is 'giving up' before her time
- mum should have all treatments available when the time comes

Your wishes

- to be a strong advocate
- to do the right thing by mum
- to be 'enough' for the task of caring for dying mum
- to be forgiven for being less than a perfect daughter

Role-play character 3

Instructions

- Participants are to divide into groups of three.
- Use the Statement of Choices (SoC) to guide the ACP discussion.
- Hold onto the values, beliefs, wishes of your character as you enter into the role play
- You have 20 minutes before we open up for group discussion.

Scenario: *Nurse – the ACP Champion (use your own name)*

Daisy has recently been admitted to your facility. She has early stage dementia and multiple co-morbidities. She is accompanied by her daughter Janine who had been her carer at home for two years prior to coming into your facility three weeks ago.

You have invited Daisy and Janine to this meeting with the purpose of discussing ACP and Daisy's goals of care. Remember, you have several tools to help guide your conversation. These include:

- The Statement of Choices (*Section 2 of the Guide*)
- The Guide for Health Professionals completing the SoC (*Section 4 of the Guide*)
- Tips sheets for completing form A and form B (*Section 4 of the Guide*)
- The 'Tips for holding the good conversation' handout (*Section 4 of the Guide*)
- Activity 2 Video worksheet (*Section 2 of the Guide*)

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Statement of Choices

ADVANCE CARE PLANNING

This Statement of Choices can help you record your wishes, values and beliefs to guide those close to you to make health care decisions on your behalf if you are unable to make those decisions for yourself.

www.my**care**my**choices**.com.au

Queensland Government

Advance Care Planning

If you were suddenly injured or became seriously ill,
who would know your choices about the health care you would want?

What is advance care planning?

Advance care planning (ACP) means thinking about and making choices now to guide your future health care. It is a way of letting others know what is important to you if you could not communicate for yourself. It is a voluntary process which gives you the opportunity to discuss your beliefs and values, and helps give you peace of mind that you can receive the right care, at the right time, in the right place.

Why plan ahead?

- To have your wishes known to help guide the treatment and care you receive in the future
- To let your loved ones know what you would want if they need to make difficult decisions on your behalf
- To allow your choices about health care to be considered before a crisis occurs.

When will your advance care plan be used?

Your advance care plan may only be used if you are unable to make or communicate your own health care decisions.

What if my family member or someone I care for is currently unable to make health care decisions and they do not have an advance care plan?

A Statement of Choices can still be considered for that person. The form should be based on that person's best interests, their expressed wishes and the views of their significant others. It should take into account the benefits and burdens of the person's illness and medical treatment.

Does an advance care plan apply across all health care environments?

Yes, you can give a copy of your advance care planning document(s) to all health care services to allow your wishes to be known and considered. This includes hospitals, community health centres, your GP and any other health facilities you may access.

Steps of advance care planning

Step 1

Discuss with your usual doctor your health conditions and how they may affect you both now and in the future. Discuss with your family your values, beliefs and preferences for future health care.

Step 2

Record your wishes in an ACP document such as the Statement of Choices. You should also record who you may have already appointed to be your substitute decision-maker.

Step 3

Share copies of ACP documents with your family, GP and hospitals. Also send copies to the Office of Advance Care Planning (see page 4 Form A & B) to share your choices with health care providers.

Step 4

Review your preferences and values whenever there are changes in your health or life circumstances and update your ACP document(s) accordingly.

Think now. Plan sooner. Peace of mind later.

Statement of Choices

The Statement of Choices is a values-based document that records a person's wishes and choices for their health care into the future. Although the Statement of Choices is not included in Queensland legislation, the content can still have guiding effect by assisting substitute decision-makers and clinicians if a person is unable to communicate their choices.

Form A is used by people who **can** make health care decisions for themselves.
Form B is used for people who **cannot** make health care decisions on their own.

Legally-binding ACP documents in Queensland

If you have strong wishes about your future health care you should consider completing these legally-binding documents.

Advance Health Directive (AHD)

This is a legally-binding document that states a person's instructions for health care in specific circumstances. It must be completed with a doctor and signed in front of a qualified witness. It can also be used to appoint your substitute decision-maker for health decisions.

Enduring Power of Attorney (EPOA)

This is a legally-binding document that can appoint one or more person(s) to make personal, health and/or financial decisions on your behalf. It must be signed in front of a qualified witness and you can choose how the responsibility of decision-making is shared.

You can obtain a copy of these documents at: www.my**care**my**choices**.com.au

Order of substitute decision-making

In Queensland, when a person is unable to make or communicate their own health care decisions, there is an order of priority for substitute decision-making:

1.	**Advance Health Directive**	A legally-binding document used to give consent and direct medical management in specific health circumstances.
2.	**Tribunal-appointed guardian**	A guardian appointed by the Queensland Civil and Administrative Tribunal (QCAT) to make health care decisions on behalf of a person.
3.	**Attorney appointed under an AHD/EPOA**	A person (known as an "attorney") appointed for personal/health decisions in an Advance Health Directive or Enduring Power of Attorney document.
4.	**Statutory health attorney**	A relevant person who has authority to make health care decisions in the absence of the above decision-makers. See glossary for details.

Statement of Choices may help guide these decision-makers

Contact information

Office of Advance Care Planning:

PO Box 2274
Runcorn QLD 4113

Ph: 1300 007 227
Fax: 1300 008 227

Email: acp@health.qld.gov.au

www.my**care**my**choices**.com.au

GLOSSARY OF TERMS

Capacity

Capacity refers to a person's ability to make a specific decision in a particular area of their life. A person has capacity for health care decisions when they can understand the information provided by a doctor about their health and treatment options and are able to make a decision regarding their care. The person also needs to be able to communicate their decision in some way and the decision must also be made of the person's own free will.

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation includes emergency measures to keep the heart pumping (by compressing the chest or using electrical stimulation) and artificial ventilation (mouth-to-mouth or ventilator) when a person's breathing and heart have stopped. It is designed to maintain blood circulation whilst waiting for treatment to possibly start the heart beating again on its own. The success of CPR depends on a person's overall medical condition. On average, less than one in four patients who have CPR in hospital survive to be discharged home.[1,2]

Good Medical Practice

Good medical practice requires the doctor responsible for a person's care to adhere to the accepted medical standards, practices and procedures of the medical profession in Australia. All treatment decisions, including those to withhold or withdraw life-sustaining treatment, must be based on reliable clinical evidence and evidence-based practice as well as ethical standards. Good medical practice also requires respecting adults' wishes to the greatest extent possible.

Life Prolonging Treatment

Sometimes after injury or a long illness, the main organs of the body no longer work properly without support. If this is permanent, ongoing treatments will be needed to stop a person from dying. These treatments are collectively referred to as life prolonging and can include medical care, procedures or interventions which focus on extending biological life without necessarily considering quality of life. Certain life prolonging treatments acceptable to one person may not be acceptable to another.

Office of the Public Guardian

The Office of the Public Guardian is an independent statutory body that protects the rights and interests of vulnerable Queenslanders, including adults with impaired capacity to make their own decisions.

Organ or Tissue Donation

Donation involves removing organs and tissues from someone who has died (a donor) and transplanting them into a recipient who is on a waiting list. Organs that can be transplanted include the heart, lungs, liver, kidneys, intestine and pancreas. Tissues that can be transplanted include heart valves, bone, skin and eye tissue. Organ and tissue donation can save and significantly improve the lives of many people who are sick or dying. For additional information about donation and to register your wishes visit: www.donatelife.org.au

Statutory Health Attorney

A statutory health attorney is someone with automatic authority to make health care decisions for a person if they become unable to do so because of illness or incapacity. This attorney is not formally appointed; they act in this role only when the need arises. The statutory health attorney is the first available, culturally appropriate adult from the following list, in order: a spouse or de facto partner in a close and continuing relationship; an adult who cares for the person but is not employed to be their carer; or a close friend or relative who is not the person's employed carer. The Public Guardian may, under certain circumstances, become the statutory health attorney of last resort.

Substitute Decision-maker

Substitute decision-maker is a general term used to describe someone who has legal power to make decisions on behalf of an adult when that person is no longer able to make their own decisions. This may be: a person appointed in an Enduring Power of Attorney or Advance Health Directive; a tribunal-appointed guardian or a statutory health attorney.

For more information and resources visit: www.mycaremychoices.com.au

1. Morrison, Laurie J., et al. "Strategies for Improving Survival After In-Hospital Cardiac Arrest in the United States: 2013 Consensus Recommendations A Consensus Statement From the American Heart Association." *Circulation* 127.14 (2013): 1538-1563.

2. Girotra, Saket, et al. "Trends in survival after in-hospital cardiac arrest." New England Journal of Medicine 367.20 (2012): 1912-1920.

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Statement of Choices

FORM A

For persons **with** decision-making capacity.

A. My Details

(If using a patient label please write "as above")

Given Names:

Family Name:

Preferred Name: Phone:

Address:

DOB: Sex: ☐ M ☐ F ☐ I Medicare No:

I have the following:

1. Advance Health Directive (AHD) ☐ Yes ☐ No
2. Tribunal-appointed guardian ☐ Yes ☐ No
3. Enduring Power of Attorney (EPOA) (personal/health matters) ☐ Yes ☐ No

If you have a legally appointed substitute decision-maker as per 1, 2 or 3 you should fill in their details below.
If you have not appointed anyone you can still include the details of people you wish to be involved in discussions about your health care decisions in the future.

My Contacts

Name:

Phone: Relationship:

I have appointed this person as a decision-maker in my EPOA or AHD: ☐ Yes ☐ No

Name:

Phone: Relationship:

I have appointed this person as a decision-maker in my EPOA or AHD: ☐ Yes ☐ No

Name:

Phone: Relationship:

I have appointed this person as a decision-maker in my EPOA or AHD: ☐ Yes ☐ No

If there are more than 3 substitute decision-makers please attach details on a separate sheet and tick this box: ☐

please turn over...

DO NOT WRITE IN THIS BINDING MARGIN ▶

Advance Care Planning - Statement of Choices (FORM A)

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MSH051

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

My name:

B. Personal Values

Describe what you value or enjoy most in your life:
Think about what interests you or gives your life meaning.

Consider what you would like known about you when health care decisions are being made:
Think about your past experiences, wishes and beliefs or what is important to you.

Describe the health outcomes that you would find unacceptable:
*Think about what you would **not** want, including situations you consider may involve severe disability.*

Describe what would be important or comforting to you when you are nearing death:
Think about your personal preferences, special traditions or spiritual support.

Indicate the place where you would prefer to die: *(e.g. home, hospital, nursing home)*

Consider how you would want to be cared for after you die:
Think about your spiritual, religious and cultural practices; organ and tissue donation; and any other wishes that you want noted.

proceed to next page...

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

My name:

C. Medical Conditions

My current medical conditions include:

The health impacts of the conditions listed above have been explained to me and I understand them:
☐ Yes ☐ No *If you have answered 'No' please consult a doctor before continuing with this form.*

Medical and emergency preferences

Please remember, doctors need to speak with the relevant substitute decision-maker(s) at the time a decision is made. You will always receive relevant care to relieve pain and suffering.

Life Prolonging Treatments

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

☐ I **would wish** CPR attempted if it is consistent with good medical practice **OR**

☐ I **would NOT wish** CPR attempted under any circumstances **OR**

☐ Other:

Other Life Prolonging Treatments *(tick appropriate box)*

e.g. kidney machine (dialysis), feeding tube, breathing machine (ventilator)

☐ I **would wish** for other life prolonging treatments if consistent with good medical practice **OR**

☐ I **would NOT wish** for other life prolonging treatments under any circumstances **OR**

☐ Other:

Medical Treatments

If considered to be medically beneficial,	I would wish for:	I would NOT wish for:	undecided / no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐

Other:

please turn over...

DO NOT WRITE IN THIS BINDING MARGIN ▶

V5.1 02/2018 Professionally Printed

MSH051

Advance Care Planning - Statement of Choices (FORM A)

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

My name:

Statement of Choices

This document remains in place until it is updated or withdrawn.
You may indicate a time period when you want to review this document *(optional)*:

☐ 6 monthly ☐ 12 monthly ☐ Other:

My Understanding

I have had this document explained to me and I understand its importance and purpose. This is my true record on this date and I request that my wishes, values and beliefs are respected. I understand that:

- **This document may only be used if I am unable to make or communicate decisions for myself.**
- My substitute decision-maker(s) and doctors may only use this document as a guide when making decisions regarding my medical treatment in the future.
- I may complete all or part of this document and that I can change my mind regarding these choices at any time.
- It is important for me to discuss my wishes with my usual doctor, my family and my substitute decision-maker(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of any decisions about cardiopulmonary resuscitation and life prolonging treatments, I will continue to receive all other relevant care, including care to relieve pain and alleviate suffering.

I consent to share the information on this form with persons/services relevant to my health as per the privacy policy and to non-identifiable information being used for quality improvement/research purposes as per the information sheet. The privacy policy and information sheet are available at: www.mycaremychoices.com.au

Signature: Date:

Usual Doctor's Statement

As a registered medical practitioner, I believe that the person completing this form has the decision-making capacity necessary to complete this Statement of Choices. I am not an appointed attorney in this person's Enduring Power of Attorney or Advance Health Directive, a relation or a beneficiary under this person's will.

Doctor's Name:

Doctor's Signature:

Date:

Hospital or Practice Stamp

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

IMPORTANT: **To allow this document to be available to health care providers, please send a copy of all four (4) pages of FORM A to:**

Office of Advance Care Planning

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

For more information phone: 1300 007 227

www.mycaremychoices.com.au

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Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Statement of Choices

FORM B

For persons **without** decision-making capacity **OR** requiring supported decision-making.

A. Person's Details

Details of the person for whom this form applies: *(If using a patient label please write "as above")*

Given Names:

Family Name: Preferred Name:

Address:

DOB: Sex: ☐ M ☐ F ☐ I Medicare No:

The person has the following:

1. Advance Health Directive (AHD) ☐ Yes ☐ No
2. Tribunal-appointed guardian ☐ Yes ☐ No
3. Enduring Power of Attorney (EPOA) (personal/health matters) ☐ Yes ☐ No

If a decision-maker for personal/health matters has been legally appointed as per 1, 2 or 3 they should be the one completing this document. If no legal decision-maker has been appointed you can still write the values and wishes of the person to help guide future health care decisions.

Details of Person Completing

Your details, as the person assisting to complete this form:

Name:

Address:

Phone: Relationship:

I have been legally appointed as a decision-maker in an AHD, EPOA or by a tribunal: ☐ Yes ☐ No

Other Contacts

Name: Phone:

Relationship: This person is appointed in an EPOA or AHD: ☐ Yes ☐ No

Name: Phone:

Relationship: This person is appointed in an EPOA or AHD: ☐ Yes ☐ No

If there are more than 3 substitute decision-makers please attach details on a separate sheet and tick this box: ☐

please turn over...

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Advance Care Planning - Statement of Choices (FORM B)

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Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Name of the person **for whom this form applies**:

B. Personal Values

Describe what the person values or enjoys most in their life:
Think about what interests them or gives their life meaning.

Consider what the person would like known about them when health care decisions are being made:
Think about their past experiences, wishes and beliefs or what is important to them.

Describe the health outcomes the person would find unacceptable:
*Think about what they would **not** want, including situations which may involve severe disability for them.*

Describe what would be important or comforting to the person when they are nearing death:
Think about their personal preferences, special traditions or spiritual support.

The place where the person would prefer to die: *(e.g. home, hospital, nursing home)*

Consider how the person would want to be cared for after they die:
Think about their spiritual, religious and cultural practices; organ and tissue donation; and any other wishes that they would want noted.

proceed to next page...

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QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Name of the person **for whom this form applies**:

C. Medical Conditions

The person's current medical conditions include:

The health impacts of the conditions listed above have been explained to me and I understand them:
☐ Yes ☐ No *If you have answered 'No' please consult a doctor before continuing with this form.*

Medical and emergency preferences

Please remember, doctors need to speak with the relevant substitute decision-maker(s) at the time a decision is made. The person will always receive relevant care to relieve pain and suffering.

Life Prolonging Treatments

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

☐ The person **would wish** CPR attempted if it is consistent with good medical practice **OR**

☐ The person **would NOT wish** CPR attempted under any circumstances **OR**

☐ Other:

Other Life Prolonging Treatments *(tick appropriate box)*

e.g. kidney machine (dialysis), feeding tube, breathing machine (ventilator)

☐ The person **would wish** for other life prolonging treatments if consistent with good medical practice **OR**

☐ The person **would NOT wish** for other life prolonging treatments under any circumstances **OR**

☐ Other:

Medical Treatments

If considered to be medically beneficial,	the person would wish for:	the person would NOT wish for:	undecided / no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐

Other:

please turn over...

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Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Name of the person **for whom this form applies**:

Statement of Choices

This document remains in place until it is updated or withdrawn.
You may indicate a time period when you want to review this document *(optional)*:

☐ 6 monthly ☐ 12 monthly ☐ Other:

Understanding of the Document

I understand the person for whom this form applies does not have capacity to make independent health care decisions or requires support to make health care decisions. I give my views based on what I believe is in their best interests. I am taking into account their wishes as they are known to me and wishes reported to their significant others and the benefits and burdens of health care treatment as I understand them. I understand the views given in this document are not legally binding but can still have guiding effect.

I request the choices recorded in this document be taken into account by health professionals as part of their application of good medical practice. I also understand that regardless of the choices expressed here the person will continue to receive all relevant care including care to relieve pain and alleviate suffering.

I consent to share the information on this form with persons/services relevant to the health of the person named as per the privacy policy and to non-identifiable information being used for quality improvement/ research purposes as per the information sheet. The privacy policy and information sheet are available at: www.mycaremychoices.com.au

Your Name:

Your Signature: Date:

Usual Doctor's Statement

As a registered medical practitioner, I believe that the person for whom this form applies currently does not have the decision-making capacity necessary to complete a Statement of Choices on their own. I also believe that the person completing this form understands the importance and implications of this document and is acting in the best interests of the person for whom this form applies. I am not an appointed attorney in the Enduring Power of Attorney document or Advance Health Directive, or a beneficiary under the will of the person for whom this form applies.

Doctor's Name:

Doctor's Signature:

Date:

Hospital or Practice Stamp

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

IMPORTANT: **To allow this document to be available to health care providers, please send a copy of all four (4) pages of FORM B to:**

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Checklist for Statement of Choices to be uploaded to The Viewer

The Statewide Office of Advance Care Planning (ACP) can upload the following documents to The Viewer:

- Statement of Choices (SoC)
- Enduring Power of Attorney (EPOA) - Short Form and Long Form
- Advance Health Directive (AHD)
- Revocation of EPOA/AHD
- Queensland Civil and Administrative Tribunal Decisions.

This checklist outlines the steps and standard criteria used by the Statewide Office of ACP to determine eligibility of a SoC for upload to The Viewer. The criteria align with administrative requirements and supports clinicians to have access to quality documents.

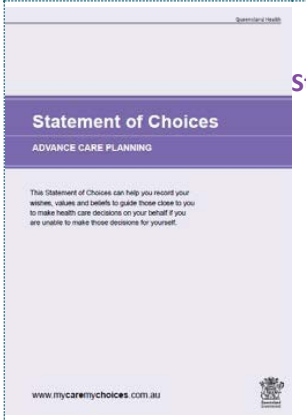
Prior to sending copies of SoC documents to the Statewide Office of ACP, you are encouraged to check that they are legible and meet uploading criteria. Please send all pages of the document to us and include the person's name and date of birth or their service ID sticker. This will help the Office to upload the document in a timely manner to the correct patient's record. If issues are identified that prevent uploading of the documents, you (as the sender) will be notified. You may be able to address these issues.

Note: The Statewide Office of ACP will check completion against standard criteria; however, **the Office is not responsible for confirming the content** of SoC documents uploaded to The Viewer. Use of SoC documents on The Viewer must be in accordance with Queensland legislation.

1. Statement of Choices

The following steps show the criteria used by the Statewide Office of ACP to review a SoC and determine if it is eligible to be uploaded to The Viewer.

Note: SoC versions differ in format and content. All versions of the SoC can be processed by the Statewide Office of ACP.



All the following are complete:

Step 1:

- ❑ The document is legible
- ❑ Personal details include the name and date of birth of the person to whom the SoC belongs
- ❑ **Form A:**
  - o the person has signed and dated the SoC
  - o the person's doctor has signed and dated the SoC
- ❑ **Form B:**
  - o the person completing the SoC has signed and dated it
  - o a doctor of the person to whom the form belongs has signed and dated the SoC.

Step 2:

- ❑ All pages of the SoC are included in the document.
- ❑ Additional pages referenced in the document are attached.

If Step 1 and Step 2 criteria are met, the document can be uploaded to The Viewer.