Advance Care Planning

If a person becomes very ill they may not be able to make (or communicate) decisions about their preferred health care. Advance care planning (ACP) gives residents the opportunity to think about, discuss and hopefully write down their personal values and care preferences for the future. It also allows them to nominate a substitute decision maker to act on their behalf if they are unable to do so because of illness. These choices can help guide care providers to deliver treatments that are in line with the resident's wishes.

Advance care planning is not usually a single event - it involves an ongoing discussion over time. Ideally, ACP discussions will be with the resident, their family, substitute decision maker and the care team including the doctor, and will result in the completion an ACP document(s). If possible, ACP discussions should commence prior to moving into the residential aged care facility, and should also be a part of routine care for every resident soon after they move into the residential aged care facility.

Key messages

- Every resident should have the opportunity to express their wishes for their future health care.
- ACP is about planning ahead and having a clear plan written down that can be used by care providers to guide treatment if the resident is unable to communicate their wishes.
- ACP is an ongoing process rather than a single event. Any advance care plan needs to be reviewed regularly to remain relevant.

What can you do?

- Listen when residents mention concerns or wishes about their future care – e.g. "I hope they can keep me pain free", "what will happen to me?", and report back to the nursing staff.
- Ask the resident and/or family member(s)/substitute decision maker if they would like to talk with a nurse about their concerns, and report back to the nurse so s/he can arrange a meeting.

Why it works

- Ensures the care team, family and/or substitute decision maker know what the resident's wishes are so they can be respected and followed.
- Ensures that difficult health care decisions made for the resident by their family and/or substitute decision maker do not just happen in a crisis.
- Written ACPs improve end of life care for the resident and reduce unwanted or unneeded medical treatments and transfers to hospital.

Related pages

Introduction to a Palliative Approach - clicking here will open a printable version of the flipchart that gives an overview of ACP in a palliative approach for careworkers in residential aged care (see pages 19-26).

Being Part of the Care Process – clicking here will take you to a video presentation (13 minutes) that highlights the role of the careworker in ACP.

Self-Directed Learning Package (Careworker) – clicking here will open a printable version of the package that describes the process of ACP (see pages 121-4).

Self-Directed Learning Package for Careworkers – clicking here will take you to an online version of the package.

Relevant links

Advance Care Planning Australia – www.advancecareplanning.org.au

CareSearch – www.caresearch.com.au

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