MY ADVANCE CARE PLAN

Patient name	Date of birth	MRN

CAPACITY ASSESSMENT

The patient is capable of making informed decisions regarding their care ☐

This form is to be completed by medical or nursing staff following discussion with the patient, and their family, Enduring Guardian, and /or Person Responsible.

The patient is does <u>not</u> have capacity to make their own informed decisions regarding their care ☐

For patients that do not have capacity to make their own decisions, this form it is to be competed following discussion with the patient's Enduring Guardian and/or Person Responsible.

MY SURROGATE DECISION MAKERS

If I become incapable of making decisions regarding my own care, the people responsible for making decision for me are:

My Enduring Guardian is (for health decisions)	Name	Phone
	Relationship	Mobile
My Person Responsible is (for health decisions if no Guardian)	Name	Phone
	Relationship	Mobile
My Power of Attorney is (for money/finance decisions)	Name	Phone
	Relationship	Mobile
My other contact person is	Name	Phone
	Relationship	Mobile

In addition to the above, I would like the following people to be included in healthcare decisions, if there is time:

Name	Relationship	Contact
Name	Relationship	Contact

MY HEALTHCARE WISHES

I have a current and valid ADVANCE CARE DIRECTIVE	**NO** ☐ **YES** ☐ Date completed ___ / ___ / ___ Copy obtained ☐
I have a REFUSAL OF TREATMENT CERTIFICATE (VICTORIA)	**NO** ☐ **YES** ☐ Date completed ___ / ___ / ___ Copy obtained ☐

For Residents of Residential Aged Care Facilities / Residential Aged Care MPS only:

If my condition deteriorates acutely (suddenly) and is potentially reversible (curable) with treatment: **I would like to be transferred and/or admitted to hospital**	**YES** ☐ **NO** ☐	***<u>Explanation Note:</u>*** *STABLE, UNSTABLE AND DETERIOATING PHASES: This would involve transport to the nearest acute hospital emergency department by Paramedic Ambulance for treatment of an unexpected, acute and potentially reversible deterioration e.g. UTI, Pneumonia, Delirium, Fall, Fracture, etc.*
If my condition deteriorates and is not reversible: **I would like to stay at Residential Aged Care Facility / MPS**	**YES** ☐ **NO** ☐	***<u>Explanation Note:</u>*** *STABLE, UNSTABLE AND DETERIOATING PHASES This involves the joint care by the Registered Nurses, Personal Care Assistants at the RACF, with visits from the GP and Specialist Palliative Care Team (if required)* ****DO NOT ASK OF RESIDENTs IN TERMINAL PALLIATIVE CARE PHASE****

MY RESUSCITATION PREFERENCES

I have a current NOT FOR RESUSCITATION (NFR) ORDER	**NO** ☐ **YES** ☐ Date completed ___ / ___ / ___ Copy obtained ☐
NFR order was signed by	**General Practitioner** ☐ **Hospital Doctor / Specialist** ☐
If completed in hospital: GP reviewed on return to RAC	**NO** ☐ **YES** ☐ Date reviewed ___ / ___ / ___
Discussion revisited with patient/family	**NO** ☐ **YES** ☐ Date discussed ___ / ___ / ___

If my heart or breathing stops due to old age or irreversible (not curable) health problems, my choice would be:

- ☐ Please try to restart my heart or breathing **(Attempt CPR)**
- ☐ Please allow me to die a natural death. Do not try to restart my heart or breathing **(NO CPR)**
- ☐ I cannot answer this question. Please let my Enduring Guardian / Person Responsible / family member OR Nurse OR Doctor make the right decision in my best interest at the time

<u>Explanation Note:</u>
Cardiopulmonary Resuscitation (CPR) is used when the heart stops beating. It may include: mouth to mouth/mask to mouth resuscitation, external heart massage, inserting a needle into the veins for intravenous fluids and medications, giving electric shocks to the heart, and a breathing tube down the throat.
The likelihood of a successful resuscitation attempt outside hospital is <3%.
<u>Prompts for staff:</u> "What is your understanding of resuscitation?" and explanation of CPR vs NFR and comfort end of life care.

MY OTHER END OF LIFE CARE WISHES		
If I am nearing death and cannot speak or be understood, these are the wishes that are important to me:		
The place where I wish to be cared for and die is		
The things that I would wish for (e.g. music, flowers, massage, privacy, etc.)		
The things that I would not wish for		
The spiritual practices I would like observed are		
My Pastor/Clergy/Religious representative is	Name	Contact
If I am nearing death and cannot speak, these are the things I would like my family and friends to know		
Other wishes I would like you to know to help you to care for me at the end of my life are		

MY FUNERAL ARRANGEMENTS			
These are my funeral preferences and wishes after my death:			
I have written a will	**NO □ YES □**	Location	Contact
I have a pre-arranged funeral	**NO □ YES □**	Plan	Contact
My Funeral Director of choice is	Name		Contact
I would like my jewellery to	Remain in place □ Be removed □ and given to		
The person I would like to be notified is	Name		Contact
I am registered with the State Trustee	**NO □ YES □**	If registered, the State Trustee MUST be notified	
Other wishes I would like you to know to help you to care for me after my death are			

SIGNATURES		
PATIENT (if has capacity)		
Name	**Signature**	**Date**
ENDURING GUARDIAN or PERSON RESPONSIBLE		
Name	**Signature**	**Date**
NURSING / MEDICAL STAFF FACILITATING ADVANCE CARE PLANNING DISCUSSION		
Name	**Signature**	**Date**
ENDORSMENT BY REGISTERED NURSE (if completed by EEN in RACF/RAC MPS)		
Name	**Signature**	**Date**
ENDORSMENT BY MEDICAL PRACTIONER (if completed RN)		
Name	**Signature**	**Date**

REVIEW

- Advance Care Planning discussions and this form should be reviewed at least annually, at every Palliative Care Phase change, at MDT Case Conference, or when whenever the patient / Enduring Guardian / Person Responsible wishes
- **If the wishes remain the same and this Advance Care Plan is unchanged:** the table below should completed and signed
- **If the wishes change:** this form should be cancelled and a new form completed and endorsed by their medical practitioner

Review Date:	Reviewer Name:	Reviewer Signature:	Comments:	Next Review Due: