



Government of **Western Australia**  
Department of **Health**

# Health Professional Guide to Advance Care Planning in Western Australia



Readers are warned that this document may contain images of people who have deceased since the time of publication.

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### **Important disclaimer**

This guide is intended to provide an overview of advance care planning. It provides links to further information and resources. It should not be relied on as a substitute for legal or other professional advice. Independent advice should be sought for specific cases requiring legal or other professional input.

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# About this guide

The **Health Professional Guide to Advance Care Planning in Western Australia** (the guide) provides an overview of the role of health professionals in advance care planning.

The guide includes general information that is applicable for most roles and settings. Links to other resources for more information are provided where relevant.

Although targeted at health professionals, other care and support workers may also find the information useful.

## How to use this guide

This guide is intended as a first point of reference for health professionals to familiarise themselves with advance care planning. The guide can be used before or during the advance care planning process with people and their families. Use the contents page to navigate to relevant sections to learn more or refresh knowledge on specific aspects of advance care planning as required.

### Helpful sections within the guide include:

- **Executive summary**  
A 3-page quick reference summary of the role of health professionals in advance care planning, including key messages from the guide.
- **Table 1. Relevant legislation in WA and their implications for health professionals**  
An important summary of relevant legislation in WA to help health professionals understand their responsibilities and potential liabilities when enacting advance care planning documents.
- **Questions and case studies**  
Questions to help health professionals reflect on their understanding of the information contained within the guide.
- **Where to go for further information**  
A list of organisations providing support and information about advance care planning and related medical and legal advice.

# Executive summary

Contemporary best-practice supports community expectations that individuals have the right to autonomous decisions particularly when considering health and personal care. Advance care planning is a voluntary process that allows people to explore what they value most in life, to guide their current and future health and personal care. It is founded on respect for individual autonomy and allows quality of life to be determined by the individual. The values, beliefs, preferences and treatment decisions that are communicated and documented through the advance care planning process can be used by others to guide decision-making at a future time when that person cannot make or communicate their decisions.

Health professionals can play an important role in proactively identifying appropriate opportunities to raise advance care planning and allow people time to reflect and make considered and informed decisions that reflect their views, values and preferences. This can help people to identify and articulate treatments that they both want and do not want.

Advance care planning conversations should begin early when the person is best able to meaningfully participate in the process. It is an ongoing, iterative process that requires conversations to be revisited regularly to allow the person to review their decisions and documents, particularly when there are changes to their condition or health.

## Legislation and frameworks outlining health professional obligations

A range of legislative requirements inform obligations for advance care planning and support the inclusion of advance care planning as part of routine care:

- *Guardianship and Administration Act 1990*
- *Criminal Code*
- *Common Law*
- National Quality Standards for health services, general practice and aged care
- Codes of conduct and professional guidelines.

## Role and responsibilities of health professionals in advance care planning

In providing patient-centred care health professionals have an important role in supporting people through advance care planning and following advance care planning documents when a person loses capacity.

Health professionals can raise or positively respond to queries on advance care planning and encourage people to begin the process using the following communication skills:

- a non-biased and non-judgemental approach
- active listening
- attending and reflecting
- use of clarifying questions
- summarising.

Many health professionals have the skills, confidence and expert knowledge to have in-depth advance care planning conversations whilst others may need additional training and support.

## There are 4 main elements to advance care planning: Think, Talk, Write, Share.

Health professionals can support people as they move between these elements and change their choices to suit changes in their personal situation, health or lifestyle.

### 1. Think

- Introduce advance care planning early as part of ongoing, routine care, rather than at the point of or following health decline.
- Be open to engage in conversations and look for opportunities to discuss advance care planning.
- Acknowledge and validate the importance of the conversation.
- Triggers for advance care planning conversations include:
  - discussions of current or future treatment goals
  - scheduled health assessments
  - diagnosis of, or change in, a chronic or life-limiting illness or a disease that is likely to result in loss of capacity
  - changes in care arrangements or applications for assistance
  - if you would not be surprised if the person died within 12 months
  - Goals of Care discussions.

### 2. Talk

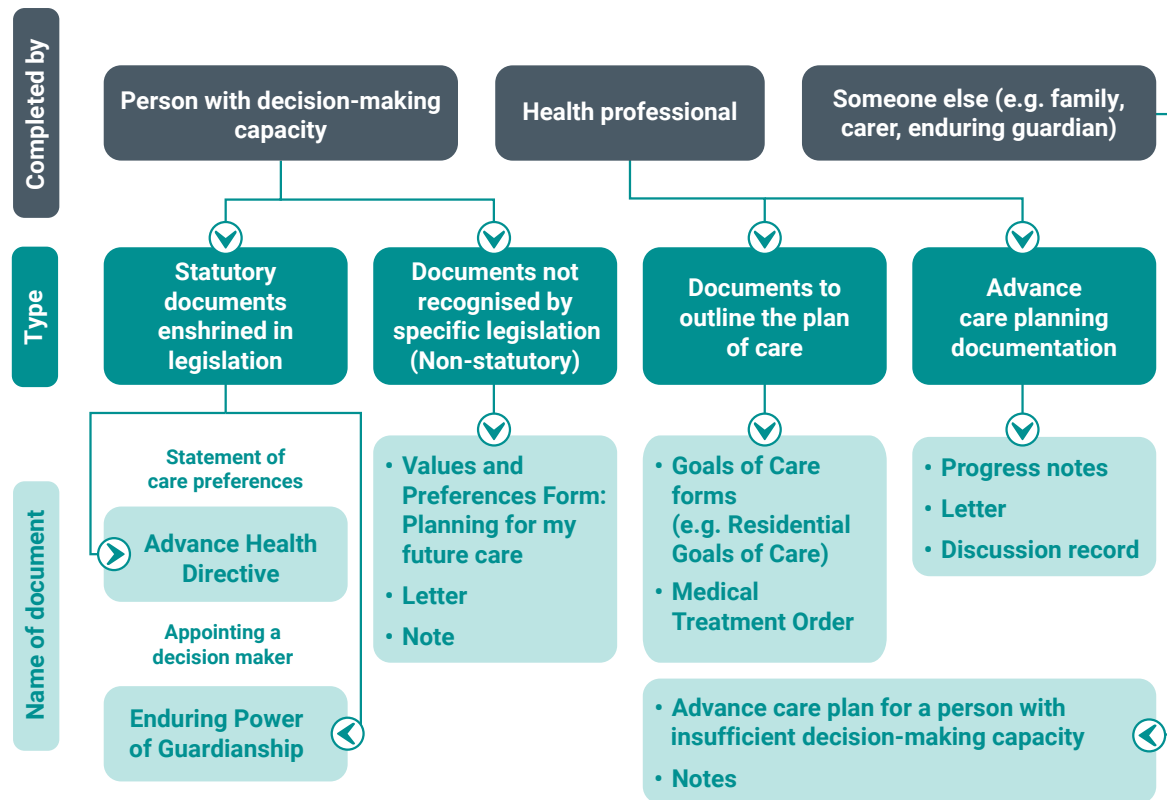
- Use '[Your Guide to Advance Care Planning in WA](#)' to facilitate discussions.
- Before you begin the discussion, consider:
  - is the environment private and comfortable?
  - who should be present?
  - is relevant clinical information available?
  - possible conversation starters.
- During the discussion the person may want to consider:
  - their current health or health problems, family history
  - concerns, worries or fears about future health care
  - reviewing any existing advance care planning documents.
- When closing discussions:
  - review and summarise the main points of discussion
  - ask the person for their understanding of the discussion
  - clarify inconsistencies or misunderstandings
  - offer take home information
  - arrange further meetings
  - encourage the individual to talk with others they trust and seek further advice (e.g. legal).



### 3. Write

- Support the person to:
  - understand their options for recording their values, preferences and treatment decisions
  - complete their chosen document.

#### Advance care planning documentation flow chart for WA



### 4. Share

- Encourage people to keep original advance care planning documents in a safe place and share copies with those they trust who are involved in their care:
  - family, friends and carers
  - enduring guardian (EPG)
  - health professionals or specialist(s) (e.g. GP)
  - residential aged care facility
  - local hospital
  - legal professional.
- Encourage and help people to upload advance care planning documents to My Health Record.
- Record details of topics and decisions discussed.
- Place written documentation in the person's file in a consistent, accessible section.
- Ensure documentation is included in handover documents to other settings.

# What is advance care planning?

Advance care planning is a voluntary process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions.

Source: National Framework for Advance Care Planning Documents

WA Health has developed a set of principles to promote a common understanding of advance care planning and consistency in how health professionals support the process in WA.

## Principles of advance care planning

Advance care planning:



is voluntary, person-centred, and focused on empowering people to have choice and control over their future medical 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 and ideally commences before a person is unwell



is inclusive and can involve as many, or as few, people a person chooses to involve (e.g. family, carers, friends, health professionals, legal professionals)



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 values, priorities and preferences and encompasses more than the completion of advance care planning 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.



# The importance of advance care planning

Advance care planning has a number of benefits for the person, their family, carers and for health professionals and organisations providing their care. 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 people to plan what is important for their future health and personal care, and to take comfort in sharing this with others.
- Enables decision-making to occur by the person without the pressure of acute clinical decline.
- Assists people to make decisions when they are able to communicate so they receive care that is consistent with their beliefs, values, needs and preferences if they become unable to communicate decisions.
- Reduces non-beneficial transfers to acute care and unwanted interventions.
- Improves patient and family satisfaction with care, with families experiencing less anxiety, depression and stress.

## Obligations and legislative requirements

Health professionals and aged care workers have an obligation to provide care in accordance with the person's Advance Health Directive and as directed by enduring guardians under the *Guardianship and Administration Act 1990*.

Other guidelines in relation to advance care planning are contained within:

- National Quality Standards for health services, general practice and aged care
- various codes of conduct and professional guidelines for both registered health practitioners and other health and aged care workers.

[Table 1](#) provides a summary of relevant legislation in WA and their implications for health professionals. It is important that health professionals understand their responsibilities and potential liabilities when enacting advance care planning documents.



**Table 1. Relevant legislation in WA and their implications for health professionals**

<p><i>Guardianship and Administration Act 1990</i> (<a href="http://www.legislation.wa.gov.au">www.legislation.wa.gov.au</a>)</p>	<p>The Act enables individuals to complete an Advance Health Directive and/or appoint an enduring guardian by completing an Enduring Power of Guardianship.</p> <ul style="list-style-type: none"> <li>• The Act outlines the <a href="#">Hierarchy of treatment decision-makers</a>, which explains the order in which health professionals must consult decision-makers when seeking a treatment decision for a person who lacks the capacity to make their own judgements.</li> <li>• Valid Advance Health Directives and Enduring Powers of Guardianship are legal documents that must be followed by all health professionals. There are limited exceptional circumstances in which health professionals can disregard Advance Health Directives or the advice given by an enduring guardian.</li> <li>• For example, if circumstances relevant to a treatment decision have changed since the person made the treatment decision (e.g. a new treatment becomes available) and the person could not have reasonably anticipated the change at the time they made the treatment decision and it is reasonable that a person with knowledge of the change of circumstances would now change their mind.</li> </ul>
<p><i>Criminal Code</i> (<a href="http://www.legislation.wa.gov.au">www.legislation.wa.gov.au</a>)</p>	<p>Health professionals who act in good faith and with reasonable care and skill are legally protected if they withhold or withdraw treatment in accordance with an Advance Health Directive, a Common Law Directive or a decision by an Enduring Guardian, even when the person dies.</p>
<p><i>Common law</i></p>	<p>Under common law, a person can prepare a written or verbal Common Law Directive that conveys their wishes for health treatment to be provided or withheld in specific future circumstances. There are no formal requirements for Common Law Directives. However they have legal standing under common law and health professionals must comply with a valid Common Law Directive in the same way as they would with an Advance Health Directive. There can be significant difficulties in establishing that a particular Common Law Directive is valid at law and can be followed. For this reason, it is not recommended that people develop a Common Law Directive for making treatment decisions. If you are uncertain whether a Common Law Directive is valid seek advice from your professional association.</p>

## *Mental Health Act 2014*

([www.legislation.wa.gov.au](http://www.legislation.wa.gov.au))

The requirement to follow an Advance Health Directive for people with mental illness who lose capacity depends on whether the person is under voluntary or involuntary care. If a person with mental illness makes an Advance Health Directive when they have full legal capacity, and they subsequently lose capacity:

- the Advance Health Directive must be respected and followed if the person is under voluntary care or treatment
- treatment without consent can be given if the person is under involuntary care and if the person's psychiatrist believes the treatment to be in the person's best interest.

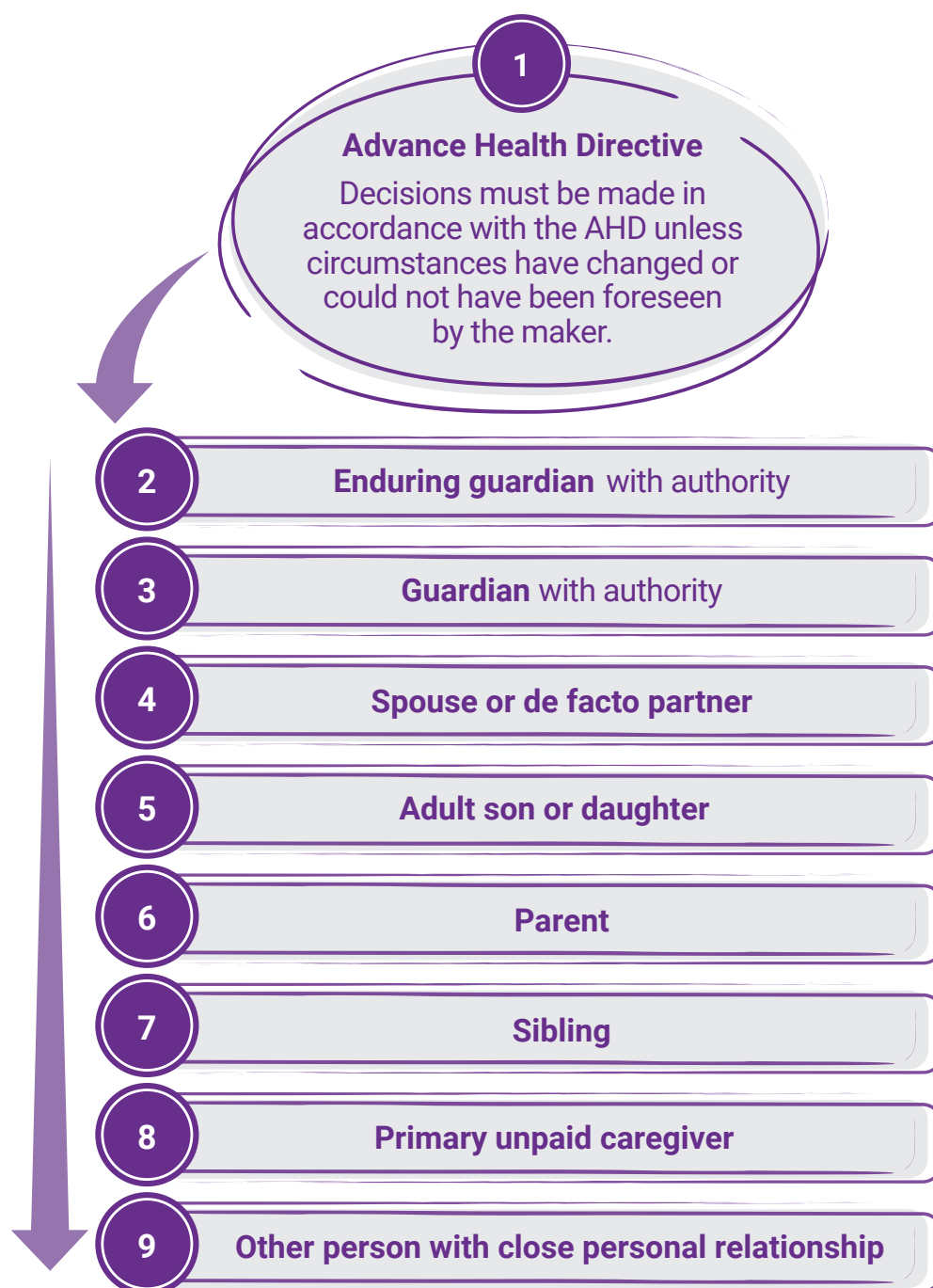
### **More information**

- Advance Care Planning Australia - further information on ethics in advance care planning ([advancecareplanning.org.au/law-and-ethics/ethics-in-advance-care-planning](http://advancecareplanning.org.au/law-and-ethics/ethics-in-advance-care-planning)).
- Department of Health WA – frequently asked questions on health professional responsibilities in advance care planning ([health.wa.gov.au/Articles/A\\_E/Advance-Care-Planning/FAQs](http://health.wa.gov.au/Articles/A_E/Advance-Care-Planning/FAQs)).
- Department of Health WA – information about the role of health professionals in relation to Advance Health Directives. ([health.wa.gov.au/AHD](http://health.wa.gov.au/AHD)).
- QUT's End of Life Law in Australia ([end-of-life.qut.edu.au](http://end-of-life.qut.edu.au)) – accurate and practical information on end-of-life laws in each Australian State and Territory. The information provides an understanding of your rights and responsibilities and assists with navigating legal issues that can arise with end-of-life decision-making.
- Chief Psychiatrist of WA's information on Treatment decision different to the Advance Health Directive of Involuntary patients. ([chiefpsychiatrist.wa.gov.au/monitoring-reporting/treatment-decision-different-to-the-advanced-health-directive](http://chiefpsychiatrist.wa.gov.au/monitoring-reporting/treatment-decision-different-to-the-advanced-health-directive)).



**Figure 1. Hierarchy of treatment decision-makers**

Where an Advance Health Directive (AHD) does not exist or does not cover the treatment decision required, the health professional must obtain a decision for non-urgent treatment from the first person in the hierarchy who is 18 years or older, has full legal capacity and is willing and available to make a decision.





# Role and responsibilities of health professionals in advance care planning

Health professionals have an important role in initiating conversations and supporting people through the process of advance care planning. Health professionals across the multidisciplinary team need to be able to facilitate advance care planning conversations effectively.

Figure 2 outlines the 4 elements of advance care planning. Health professionals can use the model when explaining advance care planning to people.

Figure 3 briefly describes the role health professionals can play in each element of the process.

## More information

- Refer to local organisational procedures and policies in relation to advance care planning to clarify the expectations around your role.
- Advance Care Planning Australia Video: Understanding advance care planning ([advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-explained](https://advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-explained)).
- WA Health video – Advance care planning in WA: The role of health professionals ([health.wa.gov.au/ACP](https://health.wa.gov.au/ACP)).



Figure 2. Advance care planning model for consumers



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**Figure 3. The role of health professionals in advance care planning**





## Skills for effective advance care planning conversations

Any health professional with good communication skills can raise or positively respond to queries on advance care planning and encourage people to begin the process. In particular, general practices are well placed to support patients with advance care planning, given many people have a long standing and trusted relationship with their general practitioner.

Health professionals can play an important role in proactively identifying appropriate opportunities to raise advance care planning, rather than waiting for the person to raise the topic. Good communication allows people time to reflect and make considered and informed decisions that reflect their views, values and preferences. This can help people 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 advance care planning conversations and support people through the advance care planning process. Some health professionals may feel that discussions about advance care planning are beyond their scope of practice. It is important to understand your own capability, seek additional training as required and recognise when to refer people for more support.

Encourage people to continue the advance care planning process and give them or direct them to further information to reflect on and explore.

### Tips for good communication

Effective communication skills include:

- a non-biased and non-judgemental approach
- active listening
- attending and reflecting
- use of clarifying questions
- summarising.

### More information

- The Communication Skills Education Videos for Health Professionals ([pasce.com.au](http://pasce.com.au)) produced by Cancer Council WA, Palliative and Supportive Care Education (PaSCE) provide further information on communication skills in advance care planning and end-of-life discussions.
- The End-of-Life and Palliative Care Education and Training Framework ([health.wa.gov.au/Articles/A\\_E/End-of-Life-Education-and-Training-Framework](http://health.wa.gov.au/Articles/A_E/End-of-Life-Education-and-Training-Framework)) is a reference tool to identify the knowledge and skills required by health professionals and staff who care for people with end-of-life and palliative care needs.

The following sections provide further detail on the role of health professionals in relation to the 4 elements of advance care planning.

# 1. Think

## Preparing for advance care planning discussions

- Consider learning about advance care planning through relevant [training and resources](https://health.wa.gov.au/ACP) ([health.wa.gov.au/ACP](https://health.wa.gov.au/ACP)).
- Familiarise yourself with relevant information resources.
- Look for and take opportunities to talk to people about advance care planning.

## Opportunities to raise advance care planning

Triggers for advance care planning conversations can include:

- when a person or family member asks about current or future treatment goals
- at scheduled health assessments (e.g. as part of 75+ years health assessments, GP Management Plan and Team Care Arrangements, or during chronic disease management consultations)
- when an older person receives their annual flu vaccination
- at the time of diagnosis of, or change in, a chronic or life-limiting illness or disease that could result in loss of capacity e.g.
  - a metastatic malignancy
  - end organ failure
  - neurodegenerative disease (e.g. early dementia)
- if there are changes in care arrangements (e.g. admission to a residential aged care facility)
- when someone is applying for care assistance (e.g. Aged Care Assessment Team (ACAT) assessment or the National Disability Insurance Scheme (NDIS))
- if you would not be surprised if the person died within 12 months
- during or following Goals of Care discussions.

### Tips for encouraging advance care planning

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

### Useful tools

The Supportive and Palliative Care Indicators Tool (SPICT™) ([spict.org.uk](https://spict.org.uk)) can help identify people with deteriorating health due to advanced conditions or serious illness, and can prompt the need for holistic assessment and future care planning. SPICT-4ALL aims to make it easier for everyone to recognise and talk about signs that a person's overall health may be declining so that those people and their carers get better coordinated care and support whether they are at home, living in a residential care facility or in hospital.

There are no Medicare Benefits Schedule (MBS) items specifically for advance care planning, however there are MBS items that may support advance care planning in general practice ([advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-areas/advance-care-planning-in-general-practice](https://advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-areas/advance-care-planning-in-general-practice)).

## Responding to interest in advance care planning

- Be open to engaging in advance care planning conversations.
- Acknowledge and validate the importance of the conversation.
- Provide or direct people to reliable, easy to read information (e.g. Your Guide to Advance Care Planning in WA: A workbook to help you plan for your future care [healthywa.wa.gov.au/AdvanceCarePlanning](https://healthywa.wa.gov.au/AdvanceCarePlanning)).
- Encourage people 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 keep free from own biases).
- Recognise the different needs ([advancecareplanning.org.au/understand-advance-care-planning/health-professionals-roles-and-responsibilities](https://advancecareplanning.org.au/understand-advance-care-planning/health-professionals-roles-and-responsibilities)) of priority groups (e.g. people from culturally and linguistically diverse backgrounds, Aboriginal people, LGBTIQ+ people, people with disability).
- Recognise advance care planning as an ongoing, evolving process and plan time to continue the conversations.

### Tips for talking about advance care planning

- Remember, advance care planning is **voluntary** and people should not feel pressured to participate in discussions or write advance care planning documents.
- Offer written information for the person to take away if they are interested.

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

'How will I know when the time comes to stop this treatment/medication?'

'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?'

### More information

- Advance Care Planning Australia Video: Starting a conversation with patients ([advancecareplanning.org.au/understand-advance-care-planning/starting-the-conversation](https://advancecareplanning.org.au/understand-advance-care-planning/starting-the-conversation)).
- Advance Care Planning Australia Video: Advance Care Planning as a part of routine care ([youtube.com/watch?v=IEwfthRJICl](https://youtube.com/watch?v=IEwfthRJICl)).
- Communication Skills Education Videos for Health Professionals ([pasce.com.au](https://pasce.com.au)) produced by PaSCE.

## Resources to share with individuals

- Your Guide to Advance Care Planning in WA: A workbook to help you plan for your future care ([healthywa.wa.gov.au/AdvanceCarePlanning](https://healthywa.wa.gov.au/AdvanceCarePlanning)).
- MyValues website ([myvalues.org.au](https://myvalues.org.au)) which provides a set of statements designed to help people identify, consider and communicate their wishes about future medical treatment.
- Advance care planning workshops and support by Palliative Care WA
  - free workshops held in the metropolitan area, regions and also online
  - free individual and family support by the Advance Care Planning Support Service available via home visits, phone or Zoom
  - 1300 551 704 or [palliativecarewa.asn.au](https://palliativecarewa.asn.au)
- Information on advance care planning in other languages and resources for Aboriginal people: [healthywa.wa.gov.au/AdvanceCarePlanning](https://healthywa.wa.gov.au/AdvanceCarePlanning)



## 2. Talk

### Supporting advance care planning discussions

Normalising advance care planning conversations can help them become a consistent part of care, with advance care planning discussed in the context of goals for healthy living and positive mental health. Advance care planning is not only relevant for end-of-life care, but also for instances during advancing illness where capacity has been lost.

Examples of conversation starters are provided below.

#### Tips for supporting conversations

- Look for opportunities to link advance care planning in with other existing processes i.e. Goals of Patient Care.
- Remember to revisit advance care planning conversations regularly and review documents every 2 years or when there are changes to a person's condition or health.

<b>For a healthy person</b>	'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'? What are your goals at this time?'
	'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?'
<b>For someone with a life-limiting illness(es)</b>	'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? 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?'
<b>For someone expected to deteriorate or die within the next 12 months</b>	'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?'



## 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 carer 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?
- Do you need an interpreter to help with the discussion?
- Is extra time needed for the appointments?

## During the discussion:

Explain what advance care planning is and why it may be useful for the person to talk about advance care planning 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 (e.g. pain, losing the ability to communicate, being dependent on loved ones, being removed from life support too soon)
- any other concerns or worries.

Check whether the person already has an advance care planning document (e.g. Advance Health Directive and/or Enduring Power of Guardianship) and if so, whether it needs to be reviewed. Refer to the [Section 3. Write](#) for more detail on advance care planning documents.

## When closing discussions:

Always review and summarise with the person and those present, and clarify any inconsistencies or misunderstandings. Offer take-home information and resources for the person to consider. Arrange further meetings or offer your contact details for future reference.

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

- family
- friends
- carer(s)
- enduring guardian(s)
- other members of their healthcare team
- legal professionals
- provider of cultural or spiritual support.

### Tips for discussions about advance care planning

- Use Your Guide to Advance Care Planning in WA ([healthywa.wa.gov.au/AdvanceCarePlanning](https://healthywa.wa.gov.au/AdvanceCarePlanning)) to facilitate discussions. This consumer guide walks people through things to consider about their health, values, preferences and future care.

## Referring people for additional support

Some people may raise topics during advance care planning discussions that are beyond the scope of health professionals. Examples are listed below.

- **Questions about Wills and Enduring Power of Attorney**

Individuals can be advised to seek legal advice on these matters or contact the Public Trustee and the Office of the Public Advocate. See [Where to go for further information](#) for contact details.

- **Questions about voluntary assisted dying (VAD)**

Voluntary assisted dying ([health.wa.gov.au/voluntaryassisteddying](https://health.wa.gov.au/voluntaryassisteddying)) is a legal option for Western Australians who meet the required eligibility criteria. It is not possible to include voluntary assisted dying in an Advance Health Directive. However, a person considering voluntary assisted dying can be referred to the WA VAD Statewide Care Navigator Service. The care navigators who staff the service are qualified health professionals with a wealth of knowledge regarding voluntary assisted dying and have extensive experience supporting patients, families and health professionals.

Refer to the [Where to go for further information](#) section for a list of services who can talk to individuals or health professionals about advance care planning.

### More information

- Communication Skills Education Videos for Health Professionals produced by PaSCE ([pasce.com.au](https://pasce.com.au))
- Advance Care Planning Australia Video: A nurse introduces advance care planning to her patient ([youtube.com/watch?v=w8xllj6W8wA](https://youtube.com/watch?v=w8xllj6W8wA))
- Advance Care Planning Australia Video: A nurse practitioner discusses advance care planning ([youtube.com/watch?v=xPYqfJIGd60](https://youtube.com/watch?v=xPYqfJIGd60))
- Advance Care Planning Australia Video: Revisiting your advance care plan ([youtube.com/watch?v=BFZhaGdHMjo](https://youtube.com/watch?v=BFZhaGdHMjo))
- Advance Care Planning Australia Video: Changing priorities and advance care planning ([youtube.com/watch?v=X77VDBTupcM](https://youtube.com/watch?v=X77VDBTupcM))
- End-of-Life and Palliative Care Education and Training Framework ([health.wa.gov.au/Articles/A\\_E/End-of-Life-Education-and-Training-Framework](https://health.wa.gov.au/Articles/A_E/End-of-Life-Education-and-Training-Framework))
- WA Health Aboriginal End-of-Life and Palliative Care Framework ([health.wa.gov.au/Articles/N\\_R/Palliative-Care/Resources](https://health.wa.gov.au/Articles/N_R/Palliative-Care/Resources)) for guidance for providing services that respect the cultural values and beliefs of Aboriginal people.





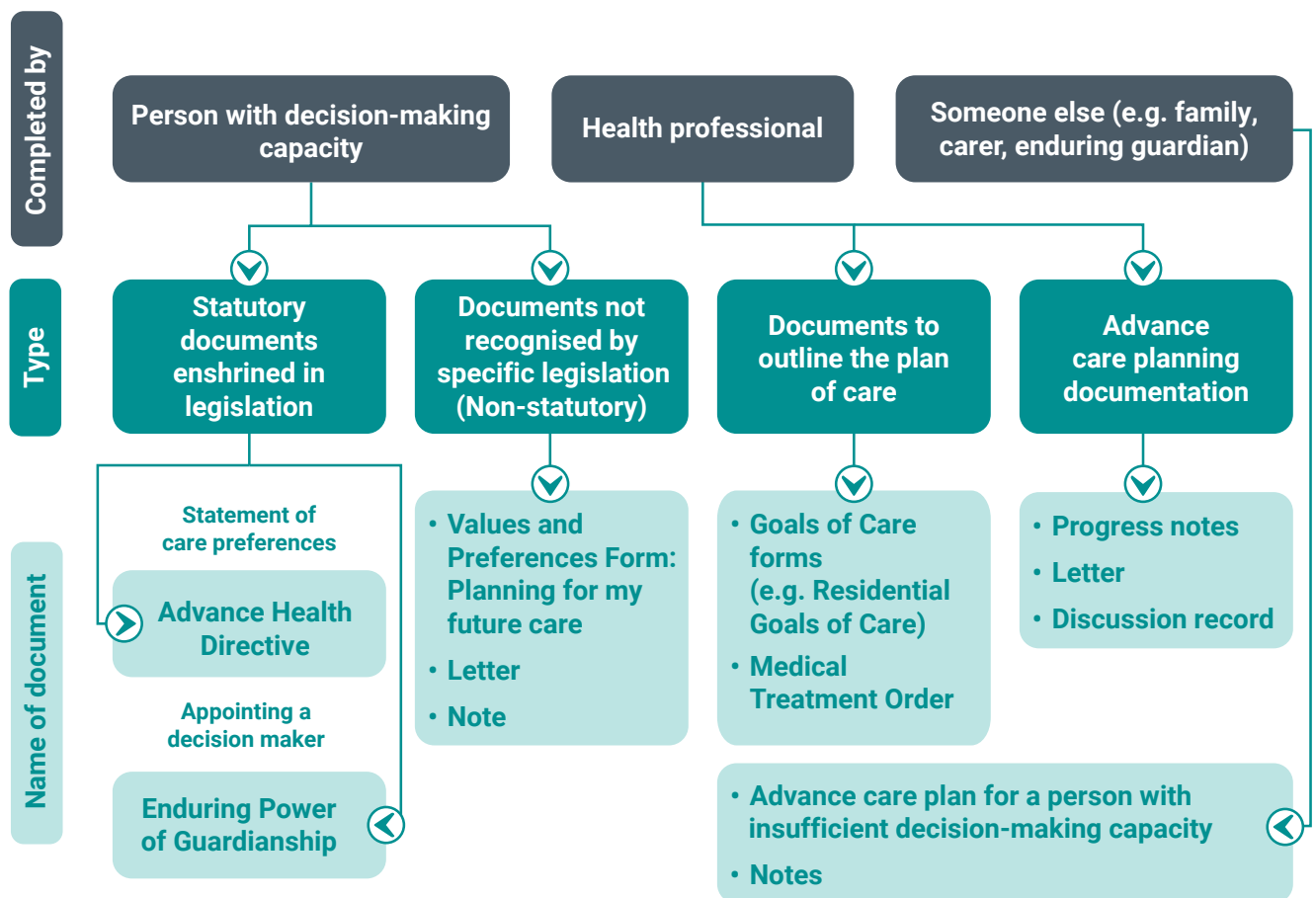
### 3. Write

## Advance care planning documentation flow chart for WA

It is recommended that people put their values, beliefs and preferences for future treatment in writing. A range of different advance care planning documents exist. Some are statutory and some are non-statutory. Some documents are completed by the person, some by a health professional and some by another person such as a family member, carer or enduring guardian.

Figure 4 provides an overview of the types of advance care planning documents that can be used in WA. Documents are available at [healthywa.wa.gov.au/AdvanceCarePlanning](https://healthywa.wa.gov.au/AdvanceCarePlanning).

**Figure 4. Advance care planning documentation flow chart for WA**



### Tips for talking about advance care planning documents

- When describing different documents, encourage the person to consider which document(s) are right for them.
- The [Where to go for further information](#) section in the guide lists some services to support people with completing advance care planning documents.

## Legal enforceability of advance care planning documents

A statutory advance care planning document is the most formal way to record a person's values, preferences and treatment decisions. There are unique statutory documents for WA (e.g. Advance Health Directive and Enduring Power of Guardianship). Such documents are recognised under WA legislation (see [Table 1](#)) and must:

- be made by an adult with capacity (adults are considered to have capacity unless proven otherwise)
- be made by the individual, not by someone else on their behalf
- meet formal witnessing and signing requirements.

Because of these requirements, statutory documents have the strongest legal force and generally must be followed.

Non-statutory documents are not recognised by WA legislation and do not carry the same legal force as a statutory document. In some cases, non-statutory documents may be recognised as a Common Law Directive. There can be significant difficulties in establishing that a particular Common Law Directive is valid at law and can be followed. For this reason they are not recommended for making treatment decisions. All documents, including non-statutory documents, are important in terms of having conversations with loved ones that may become decision-makers on behalf of that individual in the future.

Individuals can consult a legal professional to ensure statutory documents related to advance care planning (and Common Law Directives if developed) are executed properly.

## Seeking clarity on the validity of documents

If you have concerns about the validity of an Advance Health Directive or Enduring Power of Guardianship, and the person has capacity, you should discuss your concerns with the person.

If the person does not have capacity, you should:

- follow your organisation's internal processes for resolution of such concerns
- seek advice from your professional association
- consider making an application to the State Administrative Tribunal (SAT) ([sat.justice.wa.gov.au](http://sat.justice.wa.gov.au)) if there is any doubt about whether an Advance Health Directive or EPG applies in a given situation, and/or if concerns cannot be resolved.

## Role of the State Administrative Tribunal (SAT)

The SAT is the organisation responsible for resolving concerns/conflicts in relation to either an Advance Health Directive or Enduring Power of Guardianship and can be contacted at any time if a health professional or family member has concerns in relation to an Advance Health Directive or Enduring Power of Guardianship.

# Supporting people to complete advance care planning documents

Health professionals can support people to document values, beliefs and preferences by:

- discussing the options of different documents – noting which documents are statutory and which are not
- providing advice and guidance about treatment decisions to consider and the potential outcome(s) of their choices
- encouraging the person to write down their decisions about medical treatment in their own words
- offering written information for the person to take away and consider (including instructional guides for relevant documents)
- recommending the person seeks medical and/or legal professional assistance when completing a statutory document(s)
- refer people to relevant organisations for assistance (see [Where to go for further information](#))
- encouraging a review of advance care planning document(s) every 2 years or when there are changes to a person's condition or health.

## Tips for supporting a person to document their decisions

- Find out about and stay up to date with advance care planning resources.
- Understand the differences between statutory and non-statutory advance care planning documents.

When helping people decide which advance care planning documentation is right for them, it is useful to refer to the Hierarchy of treatment decision-makers ([Figure 1](#)). This explains the order in which health professionals must consult decision-makers when seeking a treatment decision for a person who lacks capacity. Advance Health Directives are at the top of the hierarchy.



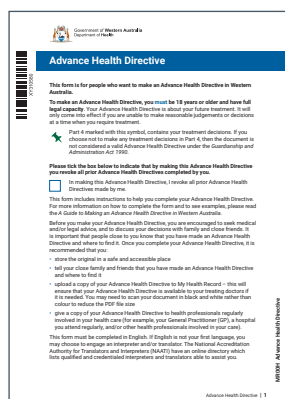
# Details of WA advance care planning related documents



## Documents completed by a person with decision-making capacity

### Advance Health Directive

[health.wa.gov.au/AHD](http://health.wa.gov.au/AHD)



#### Type of document: Statutory

An Advance Health Directive (often referred to as an AHD) is a legal document completed by a competent adult and contains decisions regarding future medical treatment. It specifies the treatment(s) for which consent is provided, refused or withdrawn under specific circumstances and only comes into effect if it applies to treatment a person requires, and only if the person becomes incapable of making or communicating their decisions.

The term treatment includes medical, surgical and dental treatments, including palliative care and life-sustaining measures.

An Advance Health Directive includes a values and preferences section where individuals can note things that are most important to them about their health and care. Questions in this section are the same as those in the Values and Preferences Form. By completing an Advance Health Directive, all the information can be included in one statutory document.

The Guide to Making an Advance Health Directive in WA ([healthywa.wa.gov.au/AdvanceHealthDirectives](http://healthywa.wa.gov.au/AdvanceHealthDirectives)) provides instructions on how to complete an Advance Health Directive.

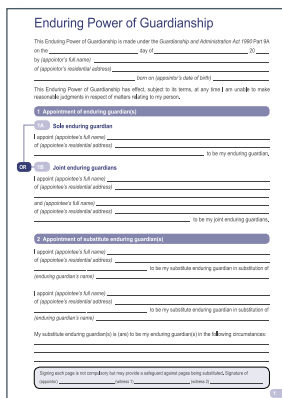
All health professionals should understand what an Advance Health Directive can and cannot be used for. There are some circumstances that may affect the operation of an Advance Health Directive (see [Table 1 – Guardianship and Administration Act](#)).

An Advance Health Directive cannot be used to:

- request voluntary assisted dying as this requires a person to have decision-making capacity throughout the entire process (individuals who are considering VAD can be referred to the WA VAD Statewide Care Navigator Service for support – email [VADcarenavigator@health.wa.gov.au](mailto:VADcarenavigator@health.wa.gov.au) or call 9431 2755)
- request or authorise a health professional to take active steps to unnaturally end life
- request specific interventions that are not clinically indicated
- request treatment that is considered to be medically futile
- record wishes about organ and tissue donation – an AHD is ineffective after death.

## Enduring Power of Guardianship

[justice.wa.gov.au/epg](http://justice.wa.gov.au/epg)

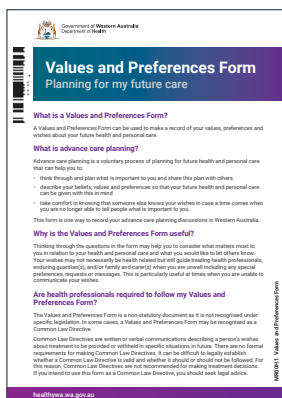
The image shows a form titled 'Enduring Power of Guardianship'. It includes sections for appointing an enduring guardian, appointing a substitute enduring guardian, and appointing a joint enduring guardian. The form is designed to be filled out by a person who is at least 18 years old and has the capacity to make decisions about their future care.

### Type of document: Statutory

An Enduring Power of Guardianship (EPG) is a legal document in which a person nominates an enduring guardian to make personal, lifestyle and treatment decisions on their behalf in the event that they are unable to make reasonable judgments about these matters in future. An EPG is different from an Enduring Power of Attorney (see below), which relates to financial and property matters. A person can have more than one enduring guardian. However, if more than one enduring guardian is appointed, these individuals must act jointly, which means they must reach agreement on any decisions they make on the person's behalf.

## Values and Preferences Form: Planning for my future care

[healthywa.wa.gov.au/AdvanceCarePlanning](http://healthywa.wa.gov.au/AdvanceCarePlanning)

The image shows a form titled 'Values and Preferences Form: Planning for my future care'. It includes sections for 'What is a Values and Preferences Form?', 'What is advance care planning?', 'Why is the Values and Preferences Form useful?', and 'Are health professionals required to follow my Values and Preferences Form?'. The form is designed to help a person express their values and preferences for future health and care.

### Type of document: Non-statutory

A Values and Preferences Form is a statement of a person's values, preferences and wishes in relation to their future health and care. Wishes may not necessarily be health-related but will guide treating health professionals, enduring guardian(s), family members and carer(s) in how a person wishes to be treated, including any special preferences, requests or messages. In some cases, this may be considered a valid [Common Law Directive](#) – although this is not the recommended format to make treatment decisions.

The questions in this form are the same as the 'Values and preferences' section of the Advance Health Directive. If people are

not yet ready to complete a full Advance Health Directive with formal witnessing and signing requirements, they may like to start with a Values and Preferences Form. They can then use this information when completing an Advance Health Directive.

## Organ and tissue donation

Organ and tissue donation is not technically a part of advance care planning as it occurs after the person has died. However, people may ask about organ and tissue donation during advance care planning conversations. Preferences for organ and tissue donation cannot formally be registered using advance care planning documents. Refer people to [donatelife.gov.au](http://donatelife.gov.au) to formally register their wishes for organ and tissue donation.

It is important for people to talk to family about their wishes, as relatives will be asked to agree before organ and tissue donation occurs.





## Documents completed on someone's behalf

### Advance care plan for a person with insufficient decision-making capacity

[advancecareplanning.org.au/\\_data/assets/pdf\\_file/0029/178427/advance-care-plan\\_full-name.pdf](http://advancecareplanning.org.au/_data/assets/pdf_file/0029/178427/advance-care-plan_full-name.pdf)



#### Type of document: Non-statutory

An Advance care plan for a person with insufficient decision-making capacity is an advance care plan that can be completed by a person's recognised decision-maker(s) (i.e. person highest on the [Hierarchy of treatment decision-makers](#) who is available and willing to make decisions) who has a close and continuing relationship with the person. This plan can be used to guide decision-makers and health professionals when making medical treatment decisions on behalf of the person, if the person does not have an Advance Health Directive or Values and Preferences Form. It should only be used when a person no longer has sufficient decision-making capacity to complete an Advance Health Directive or Values and Preference Form. This form cannot be used to give legal consent to, or refusal of treatment.



## Documents completed by health professionals

### Goals of Patient Care

[health.wa.gov.au/Articles/F\\_I/Goals-of-patient-care](http://health.wa.gov.au/Articles/F_I/Goals-of-patient-care)

#### Type of document: Non-statutory

Goals of Patient Care (GoPC) establishes the most medically appropriate, realistic, agreed goal of patient care that will apply in the event of clinical deterioration, during an episode of care. GoPC and advance care planning are separate but related processes. A GoPC form is available for use in WA. This document prompts and facilitates proactive shared decision-making between treating health professionals, the person and their families.

GoPC forms have a number of benefits including:

- GoPC forms can describe care during clinical deterioration especially in the absence of formal advance care planning documents.
- GoPC eForms can easily be updated, stored and shared across healthcare settings especially when uploaded to My Health Record.

GoPC forms should align with the person's advance care planning documents and may include treatment decisions that were not considered when the person prepared their advance care planning documents. The content of any advance care planning document should be discussed during a GoPC discussion. The health professional should ask the person if they agree to upload a copy of their GoPC to My Health Record.

The GoPC form has been adapted for use in different settings of care e.g. the Paediatric GoPC and the Residential Goals of Care (RGoC) form. The RGoC form is specifically for residents of aged care facilities to support shared decision-making between the resident, their family, carer, recognised decision maker and the healthcare team in the context of preferences and priorities for end of life care. These forms are ideally done during case conferences or family meetings where there is sufficient time for discussion. Once documented, RGoC forms should still be reviewed regularly with the resident, their family, carers and recognised decision makers.



## Documents not related to health that may be considered at the time of advance care planning

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### Will

[publictrustee.wa.gov.au](http://publictrustee.wa.gov.au)

**Type of document:** Statutory

A Will is a written, legal document that documents what a person wants to do with their money and belongings when they die. Refer to the Public Trustee for more information.

### Enduring Power of Attorney (EPA)

[justice.wa.gov.au/epa](http://justice.wa.gov.au/epa)

**Type of document:** Statutory

An Enduring Power of Attorney (EPA) is a legal agreement that enables a person to appoint one or more trusted person to make financial and property decisions on their behalf.

An EPA is an agreement made by choice that can be executed by anyone over the age of 18 years, with capacity.



## 4. Share

### Storing and sharing discussions and decisions

It is best practice for health professionals to:

- record details of advance care planning discussions including:
  - individuals present
  - others consulted in relation to the decisions made
  - details of topics discussed e.g. what the person considers acceptable treatment and any specific treatment decisions
- put written documentation (e.g. notes and copies of advance care planning documents) in the person's file in a consistent and accessible section
- include copies of the advance care planning documents or notes about discussions in clinical handover for transfer to another care setting
- encourage individuals to upload their advance care planning documents to their My Health Record ([digitalhealth.gov.au/healthcare-providers/advance-care-planning](https://digitalhealth.gov.au/healthcare-providers/advance-care-planning)), and if necessary, assist them to do so (this can also be done on the person's behalf if they have appointed an authorised or full access nominated representative to access their My Health Record)
- recommend people keep original advance care planning documents in a safe place and share copies with as many of the following people they trust and feel comfortable with:
  - family, friends and carers
  - enduring guardian(s) (EPG)
  - enduring attorney(s) (EPA)
  - GP or local doctor
  - other specialist(s) or health professionals involved in their care
  - residential aged care facility
  - a local hospital where you may receive emergency, outpatient and/or inpatient care
  - legal professional.
- advise people to keep a list of everyone who has a current copy of their advance care planning documents so they can be contacted if they revoke or update the document(s) in future.

#### Tips for sharing advance care planning documents

An AHD Alert Card ([health.wa.gov.au/~media/Files/Corporate/general-documents/Advance-care-planning/PDF/AHD\\_Alert\\_Card.pdf](https://health.wa.gov.au/~media/Files/Corporate/general-documents/Advance-care-planning/PDF/AHD_Alert_Card.pdf)) or a Medic Alert ([medicalert.org.au](https://medicalert.org.au)) can also be considered as a way of letting people know a person has an advance care planning document.

#### More information

- Refer to relevant organisational policies and procedures for instruction on storing advance care planning discussions and documents. e.g. WA Clinical Alert (MedAlert) Policy ([health.wa.gov.au/About-us/Policy-frameworks](https://health.wa.gov.au/About-us/Policy-frameworks))
- National Guidelines using My Health Record to store and access advance care planning and goals of care documents ([digitalhealth.gov.au/healthcare-providers/advance-care-planning](https://digitalhealth.gov.au/healthcare-providers/advance-care-planning)).

# Questions and case studies

Use the questions below to help you reflect on your understanding of the information in this guide. See [the next page](#) for the answers.

1. Are the following statements True or False?
  - 1a. Advance care planning should only be done when the person is dying?
  - 1b. My patient has been diagnosed with dementia so I should consider talking to them about advance care planning.
  - 1c. An Advance Health Directive and Enduring Power of Guardianship are formal tools that can be used for advance care planning.
  - 1d. Martin would like to donate his organs after his death. He should identify this in his Advance Health Directive.
2. Diane is a 55-year-old woman whose mother has just died following a period of prolonged suffering due to a protracted illness. Diane would like to avoid experiencing the same level of suffering if she becomes ill in future. In particular she wants to ensure that if she becomes unable to communicate with her family, she would not be kept alive artificially. She wants to know how she can legally ensure her wishes will be followed. What is your advice?
3. Thomas is a 50-year-old man with acute kidney failure. He has dialysis several times a week and is no longer able to enjoy sports and other activities. He is aware that his life expectancy has been shortened by his condition. Thomas wants to complete an Advance Health Directive to refuse resuscitation. However, his wife has strong cultural and religious beliefs and does not agree. She would be his default decision-maker and refuses to engage in the conversation. Thomas is confident that his wife would not honour his wishes and would instruct medical staff to perform resuscitation if a treatment decision was required. What is your advice?
4. Sam and his wife Joan have always been very open about the treatment preferences they would want at end-of-life. Sam has very strong opinions on artificial nutrition. He has stated in his Advance Health Directive that, if he becomes unable to feed himself in future, he refuses food or fluids including someone feeding him or artificial nutrition. Sam develops a rapidly progressive dementia and can no longer safely swallow. Without enteral feeding, Sam will die.
  - 4a. You are aware that not feeding Sam will eventually result in his death. Should you follow his treatment wishes, and if so, will you expose yourself to criminal liability?
  - 4b. Sam's daughter disagrees with the treatment decision contained in his Advance Health Directive and says that it is wrong not to feed her father. Sam's wife does not wish to be part of the discussion. What should you do?

## Answers to reflection questions and case studies

- 1a. False. Advance care planning should be introduced early as part of routine care, rather than as a result of health decline or crisis.
- 1b. True. It is vital to start discussions about advance care planning early with people living with dementia. This helps to ensure that people can talk about how they would like their care to be managed in future while they still have full legal capacity.
- 1c. True. The Advance Health Directive and Enduring Power of Guardianship are statutory advance care planning documents available for use in WA.
- 1d. False. Advance Health Directives have no effect after death. An Advance Health Directive cannot be used to formally register interest in organ and tissue donation. Organ and tissue donation should be formally registered at [donatelife.gov.au/join-register](https://donatelife.gov.au/join-register). It is important for a person to let their family know their wishes for organ and tissue donation, as relatives will be asked to agree after their death.
2. You can advise Diane of legislation in WA that allows her to make an Advance Health Directive in which she can state her medical treatment preferences in relation to being kept alive artificially. You can reassure Diane that the Advance Health Directive is a legal document and that the treatment decisions she describes in the document must be followed if she becomes unable to make or communicate her wishes. You should advise Diane that if she becomes unwell in future she should be counselled about her treatment options. You should also encourage Diane to tell her family and future medical specialists about her wishes.
3. You can advise Thomas that an Advance Health Directive is a legal document that must be followed by health professionals. Tell Thomas that he should give copies of his Advance Health Directive to his GP and hospital doctors. You can also suggest that he uploads his Advance Health Directive to his MyHealthRecord so that doctors and nurses can access it if required. You can also suggest that Thomas wears a MedicAlert bracelet which provides a phone number for health professionals to call and confirm his preferences for resuscitation in an emergency. You can also talk to Thomas about the option of appointing an alternative person as an enduring guardian (EPG) if he is concerned that his wife would be unable or unwilling to honour his preferences.

It would be worth counselling Thomas that making these preparations without his wife's knowledge runs the risk of complications if the time comes to enact his decisions, and that there is a risk of causing her additional stress and emotional upset. You could suggest Thomas reads information from Advance Care Planning Australia to help guide the conversation with her or suggest he involves a third party to help facilitate the discussion.
- 4a. Health professionals must follow treatment decisions contained in a valid and operative Advance Health Directive. Sam has made a specific treatment decision that meets the current circumstances and you should respect this decision. The *Guardianship and Administration Act 1990* and the Criminal Code provide exemption from criminal responsibility including the withdrawal and withholding of medical treatment where non-provision or cessation of treatment is done in good faith and is reasonable to all the circumstances of the case, even where death ensues.
- 4b. It is important to listen and respond to the daughter's concerns. However, you should explain to the daughter that you are legally bound to the instructions Sam has given in his Advance Health Directive as it is a valid and operative document. You or Sam's daughter can contact SAT if you have any concerns.

# Where to go for further information

## Advance care planning

### WA Department of Health Advance Care Planning Information Line

General queries and to order free advance care planning resources and documents (e.g. Advance Health Directives)

Phone: 9222 2300

Email: [ACP@health.wa.gov.au](mailto:ACP@health.wa.gov.au)

Website: [health.wa.gov.au/ACP](http://health.wa.gov.au/ACP)

### Palliative Care WA - Advance care planning workshops and support

Free information, workshops and support with advance care planning for the community

Phone: 1300 551 704 (Monday to Friday)

Email: [info@palliativecarewa.asn.au](mailto:info@palliativecarewa.asn.au)

Website: [palliativecarewa.asn.au](http://palliativecarewa.asn.au)

### Advance Care Planning Australia Free Support Service

General queries from health professionals and consumers and support with completing advance care planning documents

Phone: 1300 208 582

Email: [admin@advancecareplanning.org.au](mailto:admin@advancecareplanning.org.au)

### WA Paediatric Palliative Care Service (WAPPCS)

Advice, support and liaison for children and families, their health providers and community services on paediatric palliative care.

Phone: 0429 687 698

Email: [pch.palliativecare@health.wa.gov.au](mailto:pch.palliativecare@health.wa.gov.au)

Website: [pch.health.wa.gov.au/Our-services/Palliative-Care](http://pch.health.wa.gov.au/Our-services/Palliative-Care)

## Enduring Power of Guardianship and Enduring Powers of Attorney

### Office of the Public Advocate

Phone: 1300 858 455 (local call rates from land line only).

Email: [opa@justice.wa.gov.au](mailto:opa@justice.wa.gov.au)

Website: [publicadvocate.wa.gov.au](http://publicadvocate.wa.gov.au)

## Professional trustee and asset management services

### Public Trustee

Includes assistance and advice with Will and Enduring Power of Attorney drafting

Phone: 1300 746 116 (New enquiries and appointments)

Phone: 1300 746 212 (Represented Persons)

Website: [publictrustee.wa.gov.au](http://publictrustee.wa.gov.au)

## General legal advice

### The Law Society of Western Australia

Phone: 9324 8652

Find a Lawyer referral enquiry section: [lawsocietywa.asn.au/find-a-lawyer](http://lawsocietywa.asn.au/find-a-lawyer)

### Citizens Advice Bureau

Phone: 9221 5711

Website: [cabwa.com.au](http://cabwa.com.au)

### Community Legal Centres

Phone: 9221 9322

Website: [communitylegalwa.org.au](http://communitylegalwa.org.au)

### Legal Aid Western Australia

Phone: 1300 650 579 (Monday to Friday 9 am to 4 pm)

Website: [legalaid.wa.gov.au](http://legalaid.wa.gov.au)

## Applications about the operation of Enduring Power of Guardianship and Advance Health Directives

### State Administrative Tribunal (SAT)

Phone: 1300 306 017

Website: [sat.justice.wa.gov.au](http://sat.justice.wa.gov.au)

## Advice and support for staff at residential care facilities

### Metropolitan Palliative Care Consultancy Service (MPaCCS)

A mobile specialist palliative care team that works collaboratively with GP's and other health professionals.

Phone: 9217 1777

Email: [MPaCCS@bethesda.org.au](mailto:MPaCCS@bethesda.org.au)

Website: [bethesda.org.au/facilities-services/mpaccs](http://bethesda.org.au/facilities-services/mpaccs)

### Residential Care Line

A nurse practitioner led service that can provide residential aged care facilities with generalist palliative support within the Perth Metropolitan area.

Phone: 6457 3146 (8 am to 6 pm, 7 days a week)

Email: [RCL@health.wa.gov.au](mailto:RCL@health.wa.gov.au)

# Glossary

## Advance care directives

A catch-all term to refer to the instruments which are recognised in each Australian jurisdiction under advance care directive legislation or common law.

They are voluntary, person-led documents completed and signed by a competent person that focus on an individual's values and preferences for future care decisions, including their preferred outcomes and care.

They come into effect when an individual loses decision-making capacity. Advance Care Directives can also appoint substitute decision-makers who can make decisions about health or personal care on the individual's behalf. Advance Care Directives are focused on the future care of a person, not on the management of his or her assets.

Advance Care Directives are recognised by specific legislation (statutory) or under common law (non-statutory).

- **Common law (non-statutory) Advance Care Directive:** a structured document that is completed and signed by a competent adult and that is not a legislated statutory document. In Western Australia, this includes the Values and Preferences Form: Planning for my future care.
- **Statutory Advance Care Directive:** a signed document that complies with the requirements set out by a jurisdiction's legislation. In Western Australia, this includes an Advance Health Directive and Enduring Power of Guardianship which comply with the *Guardianship and Administration Act 1990*.

## Advance care plan

Documents that capture a person's beliefs, values and preferences in relation to future care decisions, but which do not meet the requirements for statutory or common law recognition due to the person's lack of competency, insufficient decision-making capacity or lack of formalities (such as inadequate person identification, signature and date).

An Advance Care Plan for a non-competent person is often very helpful in providing information for substitute decision-makers and health practitioners and may guide care decisions but are not legally binding.

An Advance Care Plan may be oral or written, with written being preferred. A substitute decision-maker (i.e. EPG) named in an Advance Care Plan is not a statutory appointment.

## Advance care planning

A voluntary process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions.

## Advance care planning documents

A catch-all term to include documents (including statutory and non-statutory) that result from advance care planning. In WA, this includes Advance Health Directives, Values and Preferences Form: Planning for my future care, Enduring Power of Guardianship, and the Advance Care Plan for People with Insufficient Decision-Making Capacity.

## Advance Health Directive

An Advance Health Directive (AHD) is a voluntary, person-led legal document completed by an adult with full legal capacity that focuses on an individual's values and preferences for future care decisions, including their preferred outcomes and care.

It specifies the treatment(s) for which consent is provided or refused under specific circumstances and only comes into effect if the person becomes incapable of communicating their wishes.

The term 'treatment' includes medical, surgical and dental treatments, including palliative care and life-sustaining measures.

An AHD would come into effect only if it applied to the treatment a person required and only if the person was unable to make reasoned judgements about a treatment decision at the time that the treatment was required. An AHD is one of the types of Advance Care Directives available in WA.

## Capacity

The ability to make a decision for oneself.

Decision-making capacity can be assessed by trained professionals, and its assessment depends on the type and complexity of the decision to be made.

Capacity assessment does not assess whether the decision is considered 'good' or 'bad' by others such as health practitioners or family, but rather considers the person's ability to make a decision and comprehend its implications.

Generally, when a person has capacity to make a particular decision they can do all of the following:

- understand and believe the facts involved in making the decision
- understand the main choices
- weigh up the consequences of the choices
- understand how the consequences affect them
- make their decision freely and voluntarily
- communicate their decision.

By default, people are assumed to have capacity, unless there is evidence to the contrary.

Full legal capacity refers to the capacity to make a formal agreement and to understand the implications of statements contained in that agreement.

## Common law directive

An instruction or directive completed and signed by a competent adult and that is not considered a legislated statutory document as it does not comply with the requirements set out in the *Guardianship and Administration Act 1990*, and is therefore recognised instead by common law.



## Competency

A legal term used to describe the mental ability required for an adult to perform a specific task. Competency is recognised in legislation and in common law as a requirement for completing a legal document that prescribes future actions and decisions, such as a Will or an Advance Health Directive.

A person is deemed to be either competent or not competent – there are no shades of grey. Competency must be assumed unless there is evidence to suggest otherwise.

## End-of-life

The timeframe during which a person lives with a life-limiting or potentially fatal condition. People are considered to be approaching end-of-life if it is likely they will die during the next 12 months.

## End-of-life care

Care needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness, frailty or old age.

## Enduring Power of Attorney (EPA)

A legal agreement that enables a person to appoint a trusted person, or people, to make financial and property decisions on their behalf. An EPA is made by choice and can be executed by anyone over the age of 18 years, with capacity.

## Enduring Power of Guardianship (EPG) and enduring guardian

A legal document in which a person nominates an enduring guardian to make personal, lifestyle and treatment decisions on their behalf in the event that they are unable to make reasonable judgments about these matters in the future. An EPG is different from an Enduring Power of Attorney (EPA), which relates to financial and property matters.

## Goals of care

Clinical and other goals of a patient's episode of care that are determined in the context of a shared decision-making process.

Goals of care may change over time, particularly as the patient enters the terminal phase and during end-of-life care.

Medical goals of care may include attempted cure of a reversible condition, a trial of treatment to assess reversibility of a condition, treatment of deteriorating symptoms, or the primary aim of ensuring comfort for a dying patient.

Non-medical goals of care articulated by the person may include returning home or reaching a particular milestone, such as participating in a family event.

Goals of care documents are different to Advance Health Directives. Goals of care are completed by healthcare staff but should align with the preferred health outcomes and treatment decisions made by the individual (to the capacity they have to participate in shared decision-making). The person may or may not have previously completed an Advance Health Directive. Where an Advance Health Directive has been completed, and the individual no longer has decision-making capacity, the goals of care should reflect the Advance Health Directive, and should include a discussion with the person's substitute decision-maker.

## **Guardian**

A person appointed by the State Administrative Tribunal (SAT) to act on a person's behalf. The SAT determines which powers the guardian may exercise on a person's behalf.

## **Health professional**

Any registered professional who practises a discipline or profession in the health area that involves the application of a body of learning, including a person belonging to a profession specifically defined by legislation.

## **Life-limiting condition**

A life limiting condition is a disease, condition or injury that is likely to result in death, but not restricted to the terminal stage when death is imminent.

## **Life-sustaining measures**

Any medical, surgical or nursing procedure that replaces a vital bodily function that is incapable of working independently. Includes assisted ventilation and cardiopulmonary resuscitation.

## **Palliative care**

An approach that improves the quality of life of a person with a life-limiting illness or condition and their family members or carers through the prevention and relief of suffering. Palliative care recognises the person and the importance and uniqueness of their family or carer. It considers physical, social, financial, emotional and spiritual factors that can influence the experience and outcomes of having a life-limiting illness.

## **Terminal illness**

An illness or condition that is likely to result in death. The terminal phase of a terminal illness means the phase of the illness reached when there is no real prospect of recovery or remission of symptoms (on either a permanent or temporary basis).

## **Treatment**

Any medical, surgical or dental treatment or other health care, including a life-sustaining measures or palliative care.

## **Treatment decision**

A decision to consent or refuse consent to the commencement or continuation of any treatment of the person.

## **Urgent treatment**

Urgent treatment means treatment urgently needed by a patient:

- to save the patient's life
- to prevent serious damage to the patient's health
- to prevent the patient from suffering or continuing to suffer significant pain or distress.


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The following documents and resources which informed the development of this guide:

- Palliative Care WA. Advance care planning introductory model. Perth, WA; Palliative Care WA ACP Consortium, 2022.
- Advance Care Planning Australia. Factsheet for healthcare professionals. Austin Health, August 2018.
- Nous Group. National Framework for Advance Care Planning Documents. Department of Health Australia, May 2021.



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