Advanced Care Planning

Advance Care Planning is a process that enables care recipients and families to make decisions about the care recipient's future health care, in consultation with aged care staff and the care recipient's medical practitioner. The care recipients wishes and preferred treatment are documented, particularly their end of life wishes.

An advanced care plan is offered to all care recipients or his/her representative. This care plan when signed is transferrable to an acute facility or other aged care facility.

- Upon admission to Cooinda end of life wishes and a Medical Power of Attorney are discussed.

- You will be given an "Advance Care Plan for Aged Care" to complete which covers information such as who is the care recipient's Power of Attorney, what is their current health status, their values and beliefs and future health directions. It also asks specific treatment they would or wouldn't like should their health deteriorate and document their goals for end of life care.

- There are two sections to the Advance Care Form. Section 1 covers specific wishes should staff find the care recipient deceased. Section 2 about treatment choices in the event of becoming unwell. You will be asked to complete both sections.

- The completed Advance Care Plan is co-signed by the care recipient's Medical Practitioner.

- After consultation representatives, a Palliation Care Plan and End of Life Care Pathway are completed in the last few weeks of a person's life to ensure a serene and peaceful death.

- Benalla Health's Palliative Care Team is available for consultation during the final phase of life.

- The advanced care plan may be changed at any time should there be an expressed desire to do so.

Advance Care Plan for Aged Care

Has a Medical Enduring Power of Attorney (MEPOA) been appointed? Yes / No

MEPOA Name _____ Contact Number(s) _____
Alternate MEPOA Name _____ Contact Number(s) _____

COPY OF MEPOA (IF NOMINATED) in Resident File: Yes / No

Current state of health: In your own words – please explain your current health problems:

Values and beliefs: What are the things that matter most to you? (eg: family & friends, familiar activities, independence, spiritual beliefs, religious practices, cultural beliefs).

Future health situations: What health conditions would you find unacceptable:
(eg: can't talk, can't walk, can't eat /drink normally).

Specific treatments: Please write any specific treatments that you would or would not want:
Wanted:

Not wanted:

Goals for end-of-life care: What do you hope for most when you are near the end of your life?
(eg. presence of family or other persons; access to places or items of significance; music; any personal, religious or cultural practices to be followed):

My Requests: **(Initial ONE box in each section which best describes your wishes)**

Section 1:

- ○ If I am found deceased in bed by Cooinda care staff I do not wish to be resuscitated

OR

- ○ If I am found deceased in bed by Cooinda care staff I wish to be resuscitated

Section 2:

- ○ If I am acutely ill, and it is reasonably certain that I will not recover, I want to be allowed to die naturally in my familiar surroundings. I do not want my life prolonged by extraordinary or overly burdensome treatments. I wish to receive palliative care that includes treatments to keep me comfortable, pain relief, and be offered food and drink of my choice.

OR

- ○ In the event of sudden or significant deterioration in my health I request to be transferred to hospital for assessment and possible treatment.

OR

- ○ I would like all decisions about medical treatments to be made by my doctors and those I have listed below. I request that they consider my wishes as outlined in this Advance Care Plan.

Declaration by competent person:

I ask that if possible my MEPOA or trusted representative(s) include the following people in discussions and decisions about my health care:

_____

_____

_____

_____

I, _____ (Print name) declare that the information completed above is a true record of my wishes on this date.

Signature: _____ Date: _____

Witness Name: _____ Witness signature: _____

Relationship: _____ Date: _____

OR

Declaration by MEPOA / Trusted representative

(on behalf of a non-competent person):

I, _____ (Print name) declare that the information completed above is a true record on this date.

Signature: _____ Date: _____

Phone: _____ Relationship: _____

Witness Name: _____ Witness signature: _____

Staff Member Completing Form:

Name:: _____ Signature: _____

Doctor's review of plan:

Name:: _____ Signature: _____

Date: _____