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

Your guide to advance care planning in Western Australia

A workbook to help you plan for your future care

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

Suggested citation

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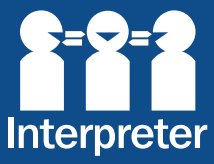
Important disclaimer

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.



Interpreting service

Please ask for an interpreter if you need help to speak to a health service in your language.

Aboriginal Interpreting WA

Phone: 0439 943 612
Website: aiwaac.org.au

National Accreditation Authority for Translators and Interpreters (NAATI) online directory

Website: naati.com.au

TIS National

Phone: 131 450
Ask for an interpreter and ask them to telephone any of the agencies from the Where to get help list.

Contents

This workbook can help you learn about advance care planning (ACP). It includes activities to help you gather your thoughts, get started, and guide you through the process.*

Undertaking advance care planning requires you to think deeply about future situations in which you are unwell and unable to make decisions about your health care. If this is distressing, please seek the support of a family member, friend, or healthcare provider.

My future care

What is advance care planning?

You may want to have a say in the type of care you receive throughout your life. This can become difficult at times when you are unwell and may be unable to make or communicate your wishes.

Advance care planning involves talking about your values, beliefs and preferences for health and personal care with your loved ones and those involved in your care.

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

Advance care planning can start at any age. It is best started when you are feeling well and able to make decisions. The process works best when you are honest and open about what is important to you – even though for some people this can be hard.

Advance care planning:

- **is voluntary**
- **is personal – it focuses on what is most important to you**
- **is respectful of your beliefs, values and culture**
- **can involve as many, or as few, people as you choose**
- **is a flexible ongoing process that allows you to make and change decisions as your situation, health or lifestyle changes.**

* This workbook is an information resource. If you are ready to make specific care and treatment decisions, please refer to Section 3: Write for a list of available advance care planning documents in WA.

Why is advance care planning important?

Advance care planning can help us:

- think through what is important to us in relation to our future health and personal care
- describe our beliefs and values and how they may affect our decisions about future health and personal care
- make a plan for our future health and personal care based on what is most important to us, and share this plan with others
- take comfort in knowing that someone else knows our wishes in case a time comes when we are no longer able to make or tell people about our decisions and what is important to us.

Advance care planning can also be helpful for families, friends, and health professionals involved in a person's care.

- People who take part in advance care planning as part of considering their future health and personal care say they feel less anxious, depressed, stressed and are more pleased with care received.
- Advance care planning may reduce the need for hospital stays.
- Advance care planning can reduce the likelihood of unwanted treatments.

How can advance care planning help?

The decision to start advance care planning is a personal one. It can be useful to start by thinking about other people's experiences and what they have found helpful about advance care planning. Figure 1 provides some examples.

Figure 1. Examples of how advance care planning can help during different life experiences

Do any of these situations apply to you?

I'm healthy, in my 20s, and have a young family.

I have decided to share what is important to me so my health professionals and family can make decisions about my care if something unexpected happens in future.

I'm 61, have no children, and live alone.

I have got my finances in order but am worried about who will look after me if I become unwell. I have found it helpful to talk to my friends, health professionals, and lawyer about where I want to live and what will be important to me if my health deteriorates.

I have recently been diagnosed with a life-limiting condition.

Talking with my loved ones and health professionals about what might happen as my condition progresses has helped them understand the care I do or do not want in future. It has also set my mind at ease knowing they understand what is important for me.

I will soon be moving to a residential care facility.

I want to make decisions about where I live, and who I want around me when I move. I have talked to my general practitioner (GP) about my future care, likely treatments I will need, and what support is available to me.

Activity 1: Let's get started – your situation

Write down your current situation in life (for example your age, health, family). Make a note of any thoughts on why you are thinking about advance care planning.

What is involved in advance care planning?

Advance care planning involves 4 main elements:

- think
- talk
- write
- share.

These elements are described in Figure 2.

Your advance care planning process will be guided by you. This workbook includes activities to help you understand and explore each element.

Figure 2. Advance care planning model

1. Think

What matters most to me now? What will matter most to me if I become less well in the future?

A good place to start is to think about your values, beliefs, and preferences. This may help you to work out what matters most to you in relation to your health and personal care.

Helpful resources

- Visit the MyValues website (myvalues.org.au) which provides a set of statements designed to help you identify, consider, and communicate your wishes about future medical treatment.
- Call Palliative Care WA (palliativecarewa.asn.au/carers-and-families/advance-care-planning/) **1300 551 704** (Monday to Friday)
  - Free advance care planning community workshops
  - Advance Care Planning Support Service for help with completing documents
- For information on advance care planning in other languages and resources for Aboriginal people, visit healthywa.wa.gov.au/AdvanceCarePlanning

Activity 2: Values, beliefs, and preferences

The following questions may help you think about your values, beliefs, and preferences. There are no wrong answers to these questions.

Your life

What does 'living well' mean to you?

- ☐ Spending time with family and friends.
- ☐ Living independently.
- ☐ Being able to visit my home town, country of origin, or spending time on country.
- ☐ Being able to care for myself (e.g. showering, going to the toilet, feeding myself).
- ☐ Keeping active (e.g. playing sport, walking, gardening, getting outside, communicating with neighbours).

- [ ] Enjoying recreational activities, hobbies, and interests (e.g. music, travel, volunteering, puzzles).
- [ ] Practising religious, cultural, spiritual, or community activities (e.g. prayer, attending religious services).
- [ ] Living according to my beliefs or cultural and religious values (e.g. eating halal food, meditation, or living as an atheist).
- [ ] Working in a paid or unpaid job.
- [ ] Others (use the space below to write down other things that are important to you or to provide more details about the items you have ticked).

Thinking of what living well means to you, what are the most important things in your life? (e.g. family, financial security, health, being able to travel)

Do you have any worries about your future? If so, what are they? (e.g. being able to look after my parent, partner, or child, having to live apart from my family).

Your current health

Does your health affect your day-to-day life? Does ill health stop you doing things you like to do? If so, how? (e.g. I can't go for a daily walk because of my arthritis, but I can sit in the park).

Your future health and care

If you become unwell or more unwell in future, what worries you most about what might happen? (e.g. being in pain, not being able to make decisions, not being able to care for yourself).

Managing your future health and care

If you become unwell or more unwell in future, what will be important to you?

Think about:

- who you would like around you
- which people know enough about you to make decisions for you or with you
- where you would prefer to receive your care
- what would give you comfort (e.g. having pain managed, cultural and religious traditions, your pet, having things that are important around you such as favourite photos or music).

Remember that you can review and change any of your choices and documents to suit changes in your personal situation, health or lifestyle.

2. Talk

Talking about advance care planning is a way of letting your loved ones and those involved in your care know what you do and do not want to happen with your future health and care. A close or loving relationship does not always mean someone knows what is important to you. Having a conversation can be very important.

Who can you talk to about advance care planning?

You might want to discuss your needs and what is important for you with people you trust. This may include:

- family
- friends
- carer(s)
- enduring guardian(s) (if appointed)
- GP or another member of your healthcare team (e.g. Aboriginal health worker or practitioner, nurse, support worker, or psychologist)
- legal professional
- cultural or spiritual person.

The Where to get help section has a list of services who you can talk to about advance care planning.

What are some things to talk about?

You may talk about different things with different people. For example, when talking to loved ones you may want to share:

- your values and beliefs
- preferences for when you are unwell.

With your health professionals, you may:

- discuss concerns about your health
- talk through your options for future care
- ask for advice on the positives and negatives of those options e.g. are they practical, affordable, or relevant.

Here are some conversation starters that can help you when talking to others.

About me	Being able too... is the most important thing to me.	I was thinking about what happened to... and it made me realise that...	As part of my culture, values and beliefs...is important to me because...
About life	A good day for me is one where I... because...	What I value and enjoy the most in my life is... because...	The most important things on my bucket list are...
About health care	I would prefer to receive my health care at... because...	When... happens I get worried about my health care because...	I would want these people... included in discussions about my health..
About choices	An unacceptable health outcome for me would be... because...	I would not want... treatments if there was little chance of recovery because...	If I was choosing between quantity and quality of life I would choose... because...

Source: Advance Care Planning Australia (advancecareplanning.org.au)

It can be uncomfortable to talk with people close to you about what might happen if you become unwell in future.

Family and friends often have their own opinions about what you should consider in advance care planning. While it may be helpful to hear what others think, remember that you should decide what is best for you. It may help to think about the right time to have the conversation and find a place that feels comfortable.

Take your time – remember that advance care planning is an ongoing conversation and you do not need to talk about everything at once.

Other things you may want to talk about

Voluntary assisted dying (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 but if it is something you might consider as an option, you can speak with your healthcare provider or contact the WA VAD Statewide Care Navigator Service (email VADcarenavigator@health.wa.gov.au or call 9431 2755). The care navigators who staff the service are qualified health professionals with a wealth of knowledge regarding voluntary assisted dying as an end-of-life choice. They have extensive experience supporting patients and families.

Other useful resources

- Advice on starting the conversation from Advance Care Planning Australia (advancecareplanning.org.au/understand-advance-care-planning/starting-the-conversation)
- Dementia Australia Start2talk (dementia.org.au/information/about-dementia/planning-ahead-start2talk)

Activity 3: People to talk to

Who are the people you would like to talk to about your future health and personal care? Make a list below.

When might be a good time to have a conversation, with the people listed above, about advance care planning? (e.g. this year, before your next specialist appointment, or before your next birthday). Where you would like to have the conversation with them? (e.g. by phone, over dinner, or while on a walk).

Here are some ideas for conversation starters you could use. Tick which ideas might be helpful for you to use. You can also add some notes with your own ideas below.

Opportunity	Example
☐ Financial planning around retirement	'As we get closer to retirement, maybe we should start thinking about how we are going to spend our money and where we want to live. It might be a good idea for us to make a plan in case one or both of us becomes unable to make important decisions in future.'
☐ Medical check-ups	'I'm seeing my GP next week for my yearly check-up. There are a few things I want to discuss with the doctor. I know that in future I may need to make some decisions about my healthcare. It would be good to talk to you about this as well as the GP.'

Opportunity	Example
☐ Death of a friend or relative	'After seeing my friend's experience as he reached the end of his life, it has made me think about the sort of care I'd like in future. Can we spend some time talking about this? Perhaps we could write down some thoughts about what's important to us and then chat about it.' 'I felt really comforted that Mum's wishes about how she wanted to die were followed by our family and her doctors. It's made me think about what's important to me and I'd like to know what's important for you. Can we have a chat about this? Maybe we could write a few things down so we know what will be important for us when we reach that point in future.'
☐ Movies or news items in the media	'It was so sad to see what that person went through at the end of her life because nobody knew what she would have wanted. I'd hate that to happen to us. Can we have a conversation about what would be important to us?'

Your ideas for how to start the conversation.

What are the top 3 things you would like to cover during your conversations?

1. _____

2. _____

3. _____

Remember that you can review and change any of your choices and documents to suit changes in your personal situation, health, or lifestyle.

3. Write

It is a good idea to write down what you decide once you have thought about what is important and talked to others.

In WA there are different documents you can use to make your values and preferences for your future care known.

Some of these are statutory documents that are recognised in law. Others are non-statutory documents that are not recognised by specific legislation and do not have the same legal force. The Where to get help section of the workbook includes information about where to go to find out more about the legality of advance care planning documents.

Statutory documents

The strongest and most formal way of recording your wishes for future health and personal care is a statutory document (e.g. Advance Health Directive and Enduring Power of Guardianship).

These documents are recognised under legislation in WA and, in most situations, must be followed.

Statutory documents must:

- be made by an adult with capacity*
- be made by the person (not by someone else on their behalf)
- be signed by the person and witnessed according to formal requirements.

***An adult with capacity is a person who is able to make a formal declaration or decision and who can fully understand what will happen as a result of making that decision.**

Non-statutory documents

Other less formal documents can also be used for advance care planning. These are called non-statutory documents. Examples in WA include:

- a Values and Preferences Form: Planning for my future care (this is a form that captures values and preferences but does meet the more formal requirements of a statutory document)
- an Advance Care Plan for someone with insufficient decision-making capacity (this is a document written on someone's behalf because they do not have capacity)
- Goals of Patient Care (this is where a health professional makes notes about goals related to a current episode of care with a patient and their family).

Non-statutory documents can be used to capture your values and wishes. However, they do not carry the same legal force and may be less likely to be followed.

Each of the different documents listed above is described later in this section.

Common Law Directives

Some non-statutory documents may be recognised as a Common Law Directive. These are written or verbal communications describing a person's wishes about treatment to be provided or withheld in specific situations in future. There are no formal requirements in relation to Common Law Directives. It can be difficult to legally establish whether a Common Law Directive is valid and whether it should or should not be followed. For this reason, Common Law Directives are not recommended for making treatment decisions.

Who will make treatment decisions for me if I cannot make or communicate my own decisions?

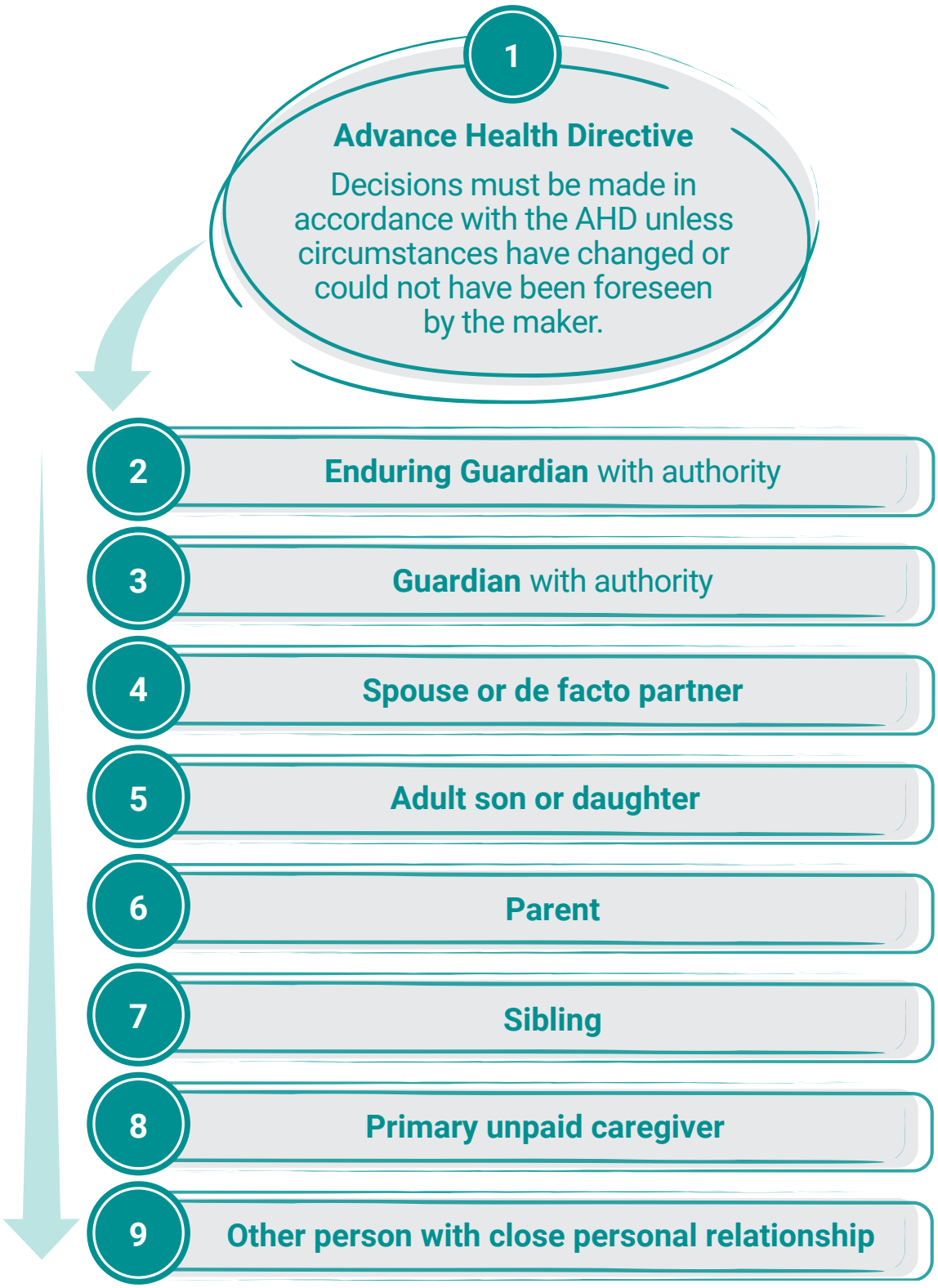
Health professionals must follow a certain order when seeking a decision about treatment for you if you are unable to make decisions or tell people what you want.

This is called the Hierarchy of treatment decision-makers.

It is important to understand who may be making decisions for you. This can help you decide who you need to tell about what is important to you and which advance care planning document(s) would be useful.

Hierarchy of treatment decision-makers

Where an 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.



In the event that you become unable to make or communicate your own decisions:

- if you **have** an Advance Health Directive, it will be used to guide treatment decisions for you
- if you **do not have** an Advance Health Directive but you have appointed an Enduring Guardian, your Enduring Guardian will be asked to make treatment decisions on your behalf
- if you **do not have** an Advance Health Directive **or** an Enduring Guardian, then health professionals will use the list above to find someone to make treatment decisions on your behalf, in the order listed until someone suitable and available is found.

Advance care planning related documents

Thinking about what type of decisions and thoughts you want to share with others will help you decide which document(s) could be useful for you. You do not have to use any of these documents, but they can be helpful in different situations.

To help you understand when you might use different documents for advance care planning and other future planning, you can think of them in the following way:

Remember statutory documents are the strongest and most formal way to record our wishes.

Documents related to your health and care

- Values and Preferences Form: Planning for my future care
- Advance Health Directive
- Enduring Power of Guardianship
- Organ and tissue donation

Documents related to estate and financial matters

- Will
- Enduring Power of Attorney

Documents that may be completed by others on your behalf

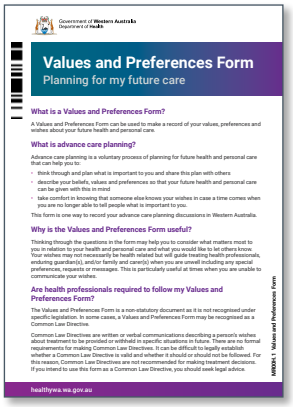
- Advance Care Plan for someone with insufficient decision-making capacity
- Goals of Patient Care

Each of these documents is briefly described on the next pages.

Documents related to your health and care

Values and Preferences Form: Planning for my future care

healthywa.wa.gov.au/AdvanceCarePlanning


Government of Western Australia
Department of Health

Values and Preferences Form
Planning for my future care

What is a Values and Preferences Form?

A Values and Preferences Form can be used to make a record of your values, preferences and wishes about your future health and personal care.

What is advance care planning?

Advance care planning is a voluntary process of planning for future health and personal care that can help you to:

- think through and plan what is important to you and share this plan with others
- describe your beliefs, values and preferences so that your future health and personal care can be given with this in mind
- take comfort in knowing that someone else knows your wishes in case a time comes when you are no longer able to tell people what is important to you.

This form is one way to record your advance care planning discussions in Western Australia.

Why is the Values and Preferences Form useful?

Thinking through the questions in the form may help you to consider what matters most to you in relation to your health and personal care and what you would like to let others know. Your wishes may not necessarily be health related but will guide treating health professionals, enduring guardian(s), and/or family and carer(s) when you are unwell including any special preferences, requests or messages. This is particularly useful at times when you are unable to communicate your wishes.

Are health professionals required to follow my Values and Preferences Form?

The Values and Preferences Form is a non-statutory document as it is not recognised under specific legislation. In some cases, a Values and Preferences Form may be recognised as a Common Law Directive.

Common Law Directives are written or verbal communications describing a person's wishes about treatment to be provided or withheld in specific situations in future. There are no formal requirements for making Common Law Directives. It can be difficult to legally establish whether a Common Law Directive is valid and whether it should or should not be followed. For this reason, Common Law Directives are not recommended for making treatment decisions. If you intend to use this form as a Common Law Directive, you should seek legal advice.

MN004.1 Values and Preferences Form

healthywa.wa.gov.au

Type of document: Non-statutory (but may be recognised as a Common Law Directive in some cases)

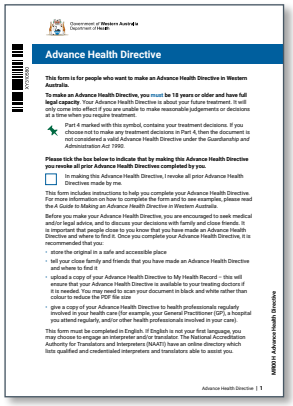
What it is: A statement of your values, preferences and wishes in relation to your health and personal care.

Why it is useful: To let people know your values, preferences and wishes. Your wishes may not necessarily be health related but will guide treating health professionals, enduring guardians(s), and family as to how you wish to be treated, including any special preferences, requests, or messages.

What is included: The questions are the same as the 'My Values and Preferences' section of the Advance Health Directive (see below). If you are not yet ready to complete a full Advance Health Directive with formal witnessing and signing requirements, you may like to start with completing this form.

Advance Health Directive (also called an AHD)

healthywa.wa.gov.au/AdvanceHealthDirectives


Government of Western Australia
Department of Health

Advance Health Directive

This form is for people who want to make an Advance Health Directive in Western Australia.

To make an Advance Health Directive, you must be 18 years or older and have full legal capacity. Your Advance Health Directive is about your future treatment. It will only come into effect if you are unable to make reasonable judgements or decisions at a time when you require treatment.

Part 4 marked with this symbol, contains your treatment decisions. If you choose not to make any treatment decisions in Part 4, then the document is not considered a valid Advance Health Directive under the *Guardianship and Administration Act 1990*.

Please tick the box below to indicate that by making this Advance Health Directive you revoke all prior Advance Health Directives completed by you.

☐ In making this Advance Health Directive, I revoke all prior Advance Health Directives made by me.

This form includes instructions to help you complete your Advance Health Directive. For more information on how to complete the form and to see examples, please read the *A Guide to Making an Advance Health Directive in Western Australia*.

Before you make your Advance Health Directive, you are encouraged to seek medical and/or legal advice, and to discuss your decisions with family and close friends. It is important that people close to you know that you have made an Advance Health Directive and where to find it. Once you complete your Advance Health Directive, it is recommended that you:

- store the original in a safe and accessible place
- tell your close family and friends that you have made an Advance Health Directive and where to find it
- upload a copy of your Advance Health Directive to My Health Record – this will ensure that your Advance Health Directive is available to your treating doctors if it is needed. You may need to scan your document in black and white rather than colour to reduce the PDF file size
- give a copy of your Advance Health Directive to health professionals regularly involved in your health care (for example, your General Practitioner (GP), a hospital you attend regularly, and/or other health professionals involved in your care).

This form must be completed in English. If English is not your first language, you may choose to engage an interpreter and/or translator. The National Accreditation Authority for Translators and Interpreters (NAATI) have an online directory which lists qualified and credentialed interpreters and translators able to assist you.

MN001F Advance Health Directive

Advance Health Directive | 1

Type of document: Statutory

What it is: A legal record of your decisions about treatment(s) you do or do not want to receive if you become unwell or injured in future. It can only be made by a person older than 18 years who is able to make and communicate their own decisions.

When it is used: An Advance Health Directive is only used if you become unable to make or communicate decisions or tell people what you want. If this happens, your Advance Health Directive becomes your 'voice'. It can only be used if the information in it is relevant to the treatment or care you need. The Advance Health Directive is at the top of the Hierarchy for treatment decision-makers.

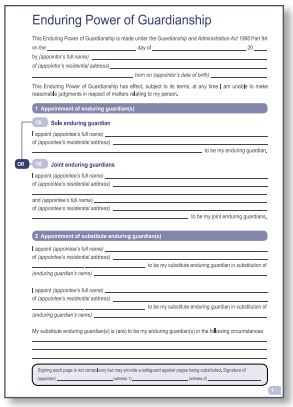
What is included: You decide what decisions and treatments you want to include in the Advance Health Directive. You can include medical, surgical and dental treatments, palliative care, and measures such as life-support and resuscitation. It is helpful to be as specific as possible in your treatment decisions.

A Guide to Making an Advance Health Directive in WA provides step-by-step instructions on what can be included in an Advance Health Directive and how to have it signed and witnessed correctly.

The form also includes a 'My Values and Preferences' section where you can write down things that are most important to you about your health and care. The questions in this section are the same as those in the Values and Preferences Form.

Enduring Power of Guardianship (also called an EPG)

justice.wa.gov.au/epg


Enduring Power of Guardianship

This Enduring Power of Guardianship is made under the *Guardianship and Administration Act 1990* Part 9A
on the _____ day of _____ 20__
by (appointer's full name) _____
of (appointer's residential address) _____
_____ born on (appointer's date of birth) _____

This Enduring Power of Guardianship has effect, subject to its terms, at any time I am unable to make reasonable judgments in respect of matters relating to my person.

1 Appointment of enduring guardian(s)

1.1 Sole enduring guardian

I appoint (appointee's full name) _____
of (appointee's residential address) _____
_____ to be my enduring guardian;

OR

1.2 Joint enduring guardians

I appoint (appointee's full name) _____
of (appointee's residential address) _____
and (appointee's full name) _____
of (appointee's residential address) _____
_____ to be my joint enduring guardians;

2 Appointment of substitute enduring guardian(s)

I appoint (appointee's full name) _____
of (appointee's residential address) _____
_____ to be my substitute enduring guardian in substitution of
(enduring guardian's name) _____

I appoint (appointee's full name) _____
of (appointee's residential address) _____
_____ to be my substitute enduring guardian in substitution of
(enduring guardian's name) _____

My substitute enduring guardian(s) is (are) to be my enduring guardian(s) in the following circumstances:

Signing each page is not compulsory but may provide a safeguard against pages being substituted. Signature of (appointer) _____ witness to _____

Type of document: Statutory

What it is: A legal document that authorises a person to make personal, lifestyle, and treatment decisions on your behalf. You can choose the person who undertakes this role. This person is known as an enduring guardian or health and lifestyle decision-maker. An Enduring Power of Guardianship can only be made by a person older than 18 years who is able to make and communicate their own decisions.

When it is used: An Enduring Power of Guardianship is only used if you become unable to make or communicate decisions.

What is included: An Enduring Power of Guardianship can be used to authorise someone to make all, or some, decisions on your behalf. This may include decisions about:

- where you live
- the support services you have access to
- the treatment(s) you receive.

You can have more than one enduring guardian. However they must agree on any decisions they make on your behalf. An enduring guardian cannot make decisions about property or finances on your behalf.

Tip: You can have both an Advance Health Directive and an Enduring Power of Guardianship.

Organ and tissue donation

What it is: A way of registering whether you want to donate organs and tissue when you die. This information cannot be captured in an advance care planning document.

When it is used: Organ and tissue donation is only relevant after a person dies. It is important to let family know about your preferences for organ and tissue donation, as relatives will be asked to agree.

Organ and tissue donation can only formally be registered at Donate Life donatelife.gov.au

Documents related to estate and financial matters

Will

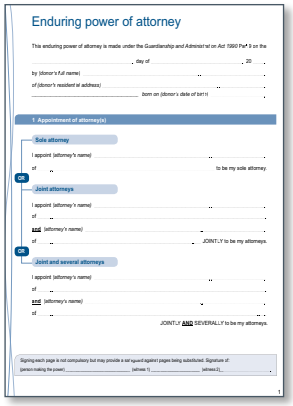
publictrustee.wa.gov.au

Type of document: Statutory

What it is: A Will is a written, legal document that says what a person wants to do with their money, personal belongings and property (including land) when they die.

When it is used: A Will comes into effect after you pass away.

Enduring Power of Attorney (also referred to as EPA or Financial decision maker)


Enduring power of attorney

justice.wa.gov.au/epa

Type of document: Statutory

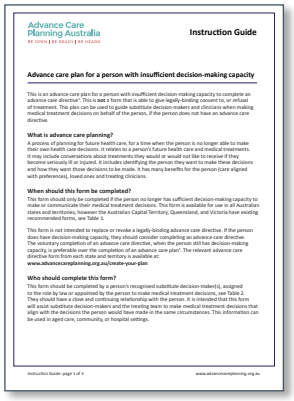
What it is: A document used to appoint a trusted person or people to make financial and property decisions on your behalf.

When it is used: You can choose for authority to start immediately or only if you lose capacity. An Enduring Power of Attorney can only be made by a person older than 18 years who is still able to make and communicate their own decisions.

Documents that may be completed by others on your behalf

Advance Care Plan for someone with insufficient decision-making capacity

www.advancecareplanning.org.au/__data/assets/pdf_file/0029/178427/advance-care-plan_full-name.pdf


Advance Care Planning Australia

Instruction Guide

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

This is an advance care plan for a person with insufficient decision-making capacity to complete an advance care directive*. This is **not** a form that is able to give legally-binding consent to, or refusal of treatment. This plan can be used to guide substitute decision-makers and clinicians when making medical treatment decisions on behalf of the person, if the person does not have an advance care directive.

What is advance care planning?

A process of planning for future health care, for a time when the person is no longer able to make their own health care decisions. It relates to a person's future health care and medical treatments. It may include conversations about treatments they would or would not like to receive if they become seriously ill or injured. It includes identifying the person they want to make these decisions and how they want those decisions to be made. It has many benefits for the person (care aligned with preferences), loved ones and treating clinicians.

When should this form be completed?

This form should only be completed if the person no longer has sufficient decision-making capacity to make or communicate their medical treatment decisions. This form is available for use in all Australian states and territories, however the Australian Capital Territory, Queensland, and Victoria have existing recommended forms, see Table 1.

This form is not intended to replace or revoke a legally-binding advance care directive. If the person does have decision-making capacity, they should consider completing an advance care directive. The voluntary completion of an advance care directive, when the person still has decision-making capacity, is preferable over the completion of an advance care plan*. The relevant advance care directive form from each state and territory is available at: **www.advancecareplanning.org.au/create-your-plan**

Who should complete this form?

This form should be completed by a person's recognised substitute decision-maker(s), assigned to the role by law or appointed by the person to make medical treatment decisions, see Table 2. They should have a close and continuing relationship with the person. It is intended that this form will assist substitute decision-makers and the treating team to make medical treatment decisions that align with the decisions the person would have made in the same circumstances. This information can be used in aged care, community, or hospital settings.

Instruction Guide: page 1 of 5

www.advancecareplanning.org.au

Type of document: Non-statutory

What it is: An Advance Care Plan written on your behalf by a recognised decision-maker(s) who has a close and continuing relationship with you (i.e. the person highest on the Hierarchy of treatment decision-makers who is available and willing to make decisions). This type of Advance Care Plan would only be developed if you no longer have the ability to make or communicate decisions and you have not made an Advance Health Directive or Values and Preferences Form.

When it is used: This type of Advance Care Plan is used when making medical treatment decisions on behalf of someone who does not have an Advance Health Directive and who is no longer able to make or communicate their own decisions. It can only be used to guide and inform care and treatment decisions. It cannot be used to give legal consent to, or refusal of treatment.

What is in it: This form is used to capture information about a person's values and preferences for future medical treatment based on known preferences and the person's past choices and decisions.

Goals of Patient Care (GoPC) and Residential Goals of Care (RGoC)

healthywa.wa.gov.au/Articles/F_I/Goals-of-patient-care

Type of document: Non-statutory, clinical

What it is: Goals of Patient Care and Residential Goals of Care are clinical care planning processes completed by your healthcare team in hospitals and residential aged care facilities. The process involves a conversation with you and, where relevant, your family or carer(s), to decide which treatments may be useful for you if your condition worsens. Your health professional uses a Goals of Patient Care form to write down the decisions you make together.

When it is used: These forms are used to inform the care you receive if your condition worsens during a hospital stay, other episode of care or while you are at a residential aged care facility. It can also be used as a communication tool between clinicians in different care settings. These discussions should happen regularly with your healthcare team.

What is in it: You and the members of your healthcare team decide what goes into your Goals of Patient Care form. The form records which treatments will be used if you become very unwell and are unable to make or communicate decisions.

Advance care planning and discussions about goals of care are separate but related processes. If you have an advance care planning document such as an Advance Health Directive or a Values and Preferences Form, you should share a copy with your healthcare team. This can help inform your goals of care discussions.

Tips

- Your answers to the activities in this workbook may help you to fill in the required information in some advance care planning documents.
- If you are visually impaired or unable to read or write, you can still complete advance care planning documents:
  - ask someone to read the documents to you and write down what you say
  - ask someone to sign the document on your behalf
  - sign the document by making a mark but you must complete a 'marksman clause' to make it clear this is your mark. It is recommended you seek legal advice if you choose this option.
- The Where to get help section lists services to support you in completing advance care planning documents, including legal advice, and help to understand, read or complete forms (i.e. help for people who are deaf or have a hearing or speech impairment).
- If you are moving between states in Australia, you should seek legal advice on which advance care planning documents are accepted. Each state has its own legislation. See advancecareplanning.org.au/law-and-ethics to learn more about state and territory-specific advance care planning laws.

More information

- The Office of the Public Advocate (wa.gov.au/government/publications/who-will-make-decisions-you) has more information on who can make decisions for you if you cannot make your own.

Activity 4: Choosing an advance care planning document

Your decision about which advance care planning document(s), if any, are right for you starts with one question: Do you want to record things that are important to you so this can be used to guide your future treatment and care?

If the answer to this question is yes, the next decision is which document(s) to use. Use the list below to think about which document(s) may be useful for you.

Can you relate to any of the following statements?

I have strong views on the treatment(s) I would or would not want to receive in future.

I could:

- make an Advance Health Directive to record my treatment decisions

and/or

- appoint an enduring guardian using an Enduring Power of Guardianship and tell them about my preferences.

I have strong values and beliefs that will affect the care I would or would not want in future. However, I am not ready to make decisions about specific treatments I do or do not want to receive.

I could:

- complete a Values and Preferences Form

and/or

- appoint an enduring guardian using an Enduring Power of Guardianship because I believe they know me well and would make decisions about my care in the same way I would.

I want to make sure my finances and assets are in order.

I could:

- make a Will

and/or

- appoint an Enduring Power of Attorney.

If you are still unsure whether any of these documents are right for you, you can:

- talk to friends or loved ones, or to health professionals involved in your care
- call Palliative Care WA 1300 551 704 (Monday to Friday)
  - free advance care planning community workshops
- Advance Care Planning Support Service for help with completing documents
- seek specific advice from a relevant organisation (see the Where to get help section).

Remember that you can review and change any of your choices and documents to suit changes in your personal situation, health or lifestyle.

4. Share

Once you have written down your preferences and wishes, it is important that people close to you know where to find this information.

Where should I store my advance care planning documents?

If you have written an advance care planning document(s), keep the original in a safe place.

You can store a copy of your advance care planning document(s) online using My Health Record (myhealthrecord.gov.au). This will help health professionals who are involved in your care to access your documents. Health professionals can also upload documents for you if you ask them to.

Who should I share my advance care planning document(s) with?

You may choose to give a copy of your advance care planning document(s) to people you trust. This could include your:

- family, friends, and carers
- enduring guardian(s)
- enduring power of attorney(s)
- GP or local doctor
- other specialist(s) or health professionals
- residential aged care facility
- local hospital
- legal professional.

Make a list of the people who have a copy of your advance care planning document(s). This will be a good reminder of who to contact if you change or cancel your document(s) in future. Use the checklist on the next page to note who has a copy.

If you decide to make an Advance Health Directive, you can also carry:

- an Advance Health Directive (AHD) alert card (healthywa.wa.gov.au/AdvanceCarePlanning) in your purse or wallet
- a MedicAlert bracelet (medicalert.org.au) – the engraving will indicate you have an Advance Health Directive and includes an ID that health professionals can use to find your Advance Health Directive.

Order an AHD alert card by contacting the Department of Health Advance Care Planning Line on 9222 2300 or email acp@health.wa.gov.au.

Activity 5: Sharing advance care planning documents

If you have one or more advance care planning documents, use the list below to record who has a copy of each document.

		They have a copy of my:				
Details		Values and Preferences Form	Advance Health Directive	Enduring Power of Guardianship (EPG)	Enduring Power of Attorney (EPA)	Will
Who else has a copy?						
My family, friends, and carers	Person 1	Name				
		Contact details				
		☐	☐	☐	☐	☐
	Person 2	Name				
		Contact details				
		☐	☐	☐	☐	☐
My enduring guardian(s)	Enduring guardian 1	Name				
		Contact details				
		☐	☐	☐	☐	☐
	Enduring guardian 2	Name				
		Contact details				
		☐	☐	☐	☐	☐
My health professionals	GP	Name				
		Contact details				
		☐	☐	☐	☐	☐
	Specialist or health professional 1	Name				
		Contact details				
		☐	☐	☐	☐	☐
	Specialist or health professional 2	Name				
		Contact details				
		☐	☐	☐	☐	☐
	Residential aged care facility	Facility name				
		Contact details				
		☐	☐	☐	☐	☐
	Local hospital	Hospital name				
		Contact details				
		☐	☐	☐	☐	☐
Online versions						
My Health Record		☐	☐	☐	☐	☐
Other people who have a copy						
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

Storing my original documents

It is important to make sure you know where your original advance care planning document(s) are so that you and your family can access them easily if needed. It may be useful to keep them all in the same place.

Document	Where do I keep the original of my current advance care planning document(s)?
Values and Preferences Form	
Advance Health Directive	
Enduring Power of Guardianship (EPG)	
Enduring Power of Attorney (EPA)	
Will	

Where to get help

Advance care planning information and resources

Department of Health WA Advance Care Planning Information Line

General queries and to order free advance care planning resources (e.g. Advance Health Directives, Values and Preferences Form)

Phone: 9222 2300
Email: acp@health.wa.gov.au
Website: healthywa.wa.gov.au/AdvanceCarePlanning

National Advance Care Planning Free Support Service

General information and advice about advance care planning across Australia

Phone: 1300 208 582 (Monday to Friday 9 am – 5 pm AEST)
Website: advancecareplanning.org.au/about-us/contact-us
Email: acpa@advancecareplanning.org.au

Workshops and help with completing documents

Palliative Care WA

Provides free advance care planning community workshops and the Advance Care Planning Support Service for help with completing documents.

Phone: 1300 551 704 (Monday to Friday 9 am to 5 pm)
Website: palliativecarewa.asn.au

Enduring Powers of Guardianship and Enduring Powers of Attorney

Office of the Public Advocate

Phone: 1300 858 455
Email: opa@justice.wa.gov.au
Website: publicadvocate.wa.gov.au

Medical advice

See your GP, specialist, or local doctor for advice.

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

General legal advice

See your lawyer or solicitor (if you have one) for specific legal advice.

The Law Society of Western Australia

Phone: 9324 8652
Find a lawyer referral enquiry section:
lawsocietywa.asn.au/find-a-lawyer

Citizens Advice Bureau

Phone: 9221 5711
Website: cabwa.com.au

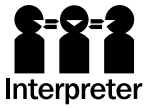
Community Legal Centres

Phone: 9221 9322
Website: communitylegalwa.org.au

Legal Aid WA

Phone: 1300 650 579
Website: legalaid.wa.gov.au

If you need an interpreter



If you have difficulty understanding this workbook or need language assistance:

- call **TIS National** on 131 450, ask for an interpreter and ask them to telephone any of the agencies from this Where to get help list.
- view the **National Accreditation Authority for Translators and Interpreters** (NAATI) online directory which lists qualified and credentialed translators and interpreters able to assist you, at www.naati.com.au
- contact **Aboriginal Interpreting WA** on 0439 943 612 or visit aiwaac.org.au

If you are deaf or have a hearing or speech impairment

Use the National Relay Service to phone any of the agencies from this Where to get help list. For more information visit:
www.accesshub.gov.au

Acknowledgements

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The following documents and resources informed the development of the workbook:

- Advance Care Planning Australia. *Advance care planning explained*. Austin Health, August 2021.
- Nous Group. *National Framework for Advance Care Planning Documents*. Department of Health Australia, May 2021.
- Palliative Care Australia. *Dying to Talk Discussion Starter: Working out what's right for you*. 2018.
- Palliative Care WA. *Advance care planning introductory model*. Perth, WA; PCWA ACP Consortium, 2022.

This document can be made available in alternative formats on request for a person with disability (contact 9222 2300 or acp@health.wa.gov.au). An easy read version of this document is available at healthywa.wa.gov.au/AdvanceCarePlanning.

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