Flowchart for Advance Care Planning for Aged Care Homes in Victoria

This flowchart is to be used in conjunction with the Advance Care Planning Information Guide for Residential Aged Care Homes (Victoria) which was developed by Respecting Patient Choices, Austin Health, 2008.

Advance care planning supports people to think about and plan preferences for their current and future health care. An Advance Care Plan guides health care decisions if a person is unable to speak for themselves (see ACP Guide p 5,6 & Appendix 1).

The purpose of the Guide and this Flowchart is to provide Aged Care Home staff with information to guide them step-by-step through the advance care planing process with residents and their families. The process can begin on admission of a new resident, or at any time for existing residents.

Note:

<u>Person Responsible</u> = a person legally able to make treatment decisions on behalf of someone who is unable to do so for themselves. This may be a MEPOA, a family member or other agent.

MEPOA = Medical Enduring Power of Attorney ACP = Advance Care Plan **STEPS KEY** Balloons refer to Obtain copy of documentation Ensure MEPOA is current pages in 'ACP Find out information Guide YES Place MEPOA's name & contact for Residential Aged Does details in resident's file what is in Care Homes (Vic) Resident have MEPOA? place If resident has capacity (See Step 2) Discuss & encourage appointment of NO p. 11, 16-17, & App 1 Go to Step 6 YES (Review) Does Resident have ACP? Go to Step 2 YES Go to Step 3 Assess Does resident have capacity to resident's participate in ACP process? capacity Identify 'person responsible'/MEPOA NO then go to Step 3 p. 6, & App 1 GP Role ■ Assess capacity Provide information about ACP to resident/family/person ■ Discuss & witness MEPOA Discuss responsible/MEPOA ■ Provide information on medical 3. future health p. 13,17, 25-26 Discuss future health care preferences with conditions, benefits & burdens Guide to discussion resident/family/person responsible/GP.
Identify expectations of current & future health care (eg quality of life, goals, benefits & burdens of treatment) of treatment p 16-19, 20-22 & App 1 Discuss resident's wishes care wishes ■ Implement resident's choices ■ Review Document Document discussion: who was present, what was discussions & discussed & any specific choices/decisions. p. 19, 21-22, 27-28 & App 1 Complete ACP (Statement of Choices) outcomes Communicate & Provide copy of Step 4 documentation to relevant people implement Incorporate into residents' care plan
Develop 'Alert System' for staff eg sticker p. 19, 22, 24 & 28 5. resident's Consult document when major decisions need to be made choices Ensure documented choices/ACP reflects resident's current condition & wishes Review 12 monthly, or if change in resident's condition p. 19 & 22 or wishes Set date for review Consider linking review date to other cyclical reviews

(eg ACFI, CMA)