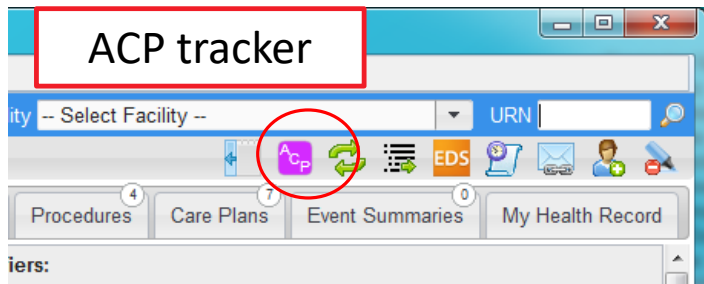


Advance Care Planning

The Viewer - Advance Care Planning Tracker



The Viewer The Advance Care Planning Tracker

- The Viewer is a web-based application (downloaded through QH App Store). Read-only access available for GPs and QAS
- Approved access to The Viewer is available by contacting Information Technology Services

Qld Health The Office of Advance Care Planning

- Audits and uploads advance care plans to the Viewer
- All Qld Health professionals are able to see your documents when required.
- Drs Leyton Miller and Terry Nash demonstrate ACP Tracker access and use:
- <https://vimeo.com/289014110>

You can view a document by clicking this icon

Document section

Comments section

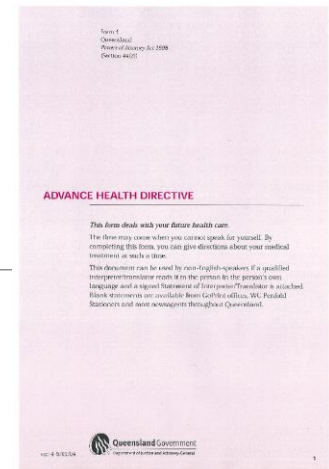
Date	Document type	Details
15-Nov-2017	ACP Note	
02-Mar-2017	Enduring Power of Attorney	Financial
12-Jan-2017	Statement of Choices	
28-Oct-2016	Guardian	Personal not including health care
12-Feb-2016	Advance Health Directive	Health care not including mental health

Date	Service Provider	Profession	Outcome
20-Jul-2017	Hospital (outpatient)	Doctor	ACP discussion
01-Jul-2017	Hospital (inpatient)	Social Worker	ACP discussion

Name	Relationship	Last Updated
Vanessa Kerry	General Practitioner	10-Feb-2017

Name	Relationship	Last Updated
Vanessa Kerry	General Practitioner	10-Feb-2017
Mr John Smith	Family Member - Sibling (Substitute Decision Maker) (Nominated Support Person)	01-Feb-2017
Mr Jacob Aaron	Carer - Other	24-Aug-2015

ACP Legal Documents



ENDURING POWER OF ATTORNEY

Appoints a family member or friend over 18yrs of age – more than one can be nominated

Attorney can make important health and / or financial decisions in specified circumstances

Only commences when the person is unable to speak for themselves or make these decisions (unless otherwise stated in document)

ADVANCE HEALTH DIRECTIVE

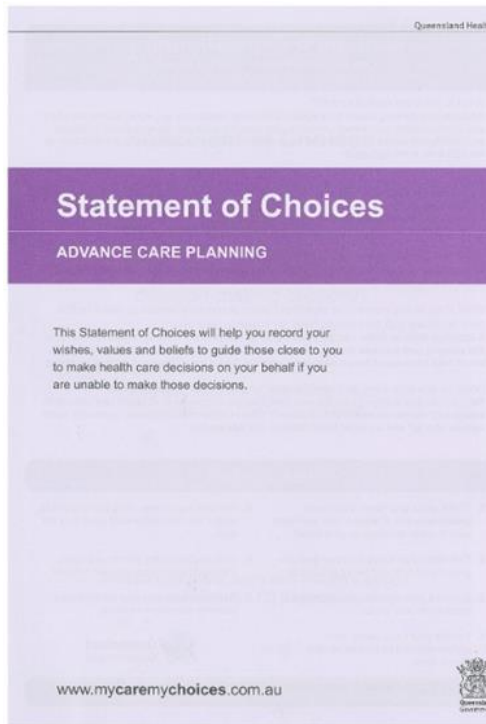
A written set of instructions for a person over 18 years of age with capacity to document their wishes for future healthcare

Allows a person to give directions about his or her health care in the future including refusing life-sustaining treatment

Only to be used in the event they are unable to speak for themselves

Direct and inform care provision for health professionals

Qld Statement of Choices



A standardised values-based document

Records a person's wishes and choices for their health care

May be used by a nominated substitute decision maker and health professionals to inform medical management plans

Only to be used if that person was unable to make or communicate decisions for themselves

Not a legally binding document

Acute Resuscitation Plan

A medical order completed by a medical officer in consultation with the patient, or, if unable to speak for themselves a nominated substitute decision maker

Can be used as part of the ACP process

Can be used to guide conversations between medical officers, patients and their families about appropriate resuscitation planning, such as whether CPR should be performed

Not a legal document

Queensland Government
Acute Resuscitation Plan (ARP)
For adults at risk of an acute deterioration

(Add identification label here)
URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: M F

Local assessment and appropriate treatment options should be guided by good medical practice, which includes discussions with the patient and/or their substitute decision-maker(s).

This ARP form is designed for use in all Queensland Health facilities (e.g. hospitals, aged care and other residential facilities). The Quick Guide attached to this form contains important information and should be read prior to completing the form. There is insufficient room on this form to record information, please cross-reference with the progress notes.

Clinical assessment
Record details/assessment of relevant medical conditions relating to the patient's physical and mental health. This section includes clinical reasons why resuscitation planning is necessary.

Capacity assessment
 I believe that the patient has capacity¹ to consent to and/or refuse medical treatment.
 I believe that the patient does not have capacity to consent to and/or refuse medical treatment.
There is a change in capacity, this form must be reviewed.
Details of assessment:

Resuscitation management plan
If an acute deterioration or critical event occurs, it is clinically indicated to:
Provide: e.g. ventilation, IV fluids, supportive therapies
Not provide: e.g. defibrillation, intubation, antibiotics
There is further documentation in the progress notes on the following dates:
If a cardiac or respiratory arrest occurs, it is clinically appropriate to:
CPR Provide Do not provide
A decision not to provide CPR does not limit other treatment or care.

Acting on the Resuscitation management plan: if this section differs from section 4 (Patient choices), follow an appropriate dispute resolution process (see Quick Guide). If the dispute remains unresolved, or this section is incomplete or unclear when a resuscitation decision is required, attending clinicians should exercise their clinical judgement based on the circumstances, and document this.

Form continued over page

Advance Health Directive – QUT Law



In Queensland, a health professional does not have to follow an Advance Health Directive if:

- a direction is inconsistent with good medical practice;
- a direction is uncertain (although they must first consult a substitute decision-maker if one is appointed under the Advance Health Directive); or
- circumstances have changed to the extent that the direction is no longer appropriate (for example, changes in medical science mean the direction should not be acted upon).

In those circumstances a health professional will not be liable for failing to comply with the Directive. The health professional will therefore need some other form of authority to determine treatment, for example, by obtaining consent from the substitute decision-maker to provide or withhold treatment.

[\[https://end-of-life.qut.edu.au/advance-directives/state-and-territory-laws/queensland#547671\]](https://end-of-life.qut.edu.au/advance-directives/state-and-territory-laws/queensland#547671) 4/06/2019 12:35 PM]

Qld Legal Framework

Queensland Health Advance Care Planning Clinical Guidelines

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life/guidelines>

More information:

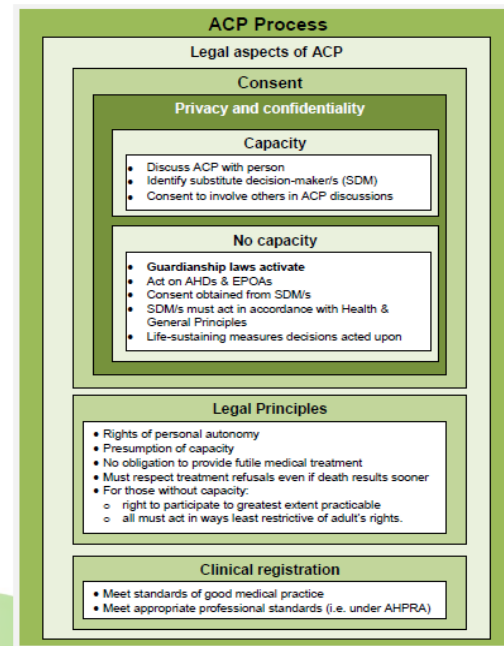
<https://end-of-life.qut.edu.au/>

<https://qheps.health.qld.gov.au/metro-north/advance-care-planning>

Appendix 8 – Queensland's legal framework

ACP is a broad patient-centred approach that occurs over time that assists people to plan for and decide about current and future care, while upholding their rights and protections under the various laws. While 'advance care planning' as a term is not specifically referred to in Queensland's legislation, there are essentially two legal domains which govern the spectrum of the ACP process:

1. While the person has capacity for decision-making – discussions and decision-making must involve them, reflecting confidentiality and privacy obligations under the relevant laws;¹⁴³ and
2. When the person loses capacity for decision-making – the guardianship laws in Queensland activate,¹⁴⁴ protecting the rights of the person when implementing and acting on decisions made while they had capacity. Note that privacy and confidentiality also applies.



The diagram to the left explains this further. There are three general legal requirements that apply to ACP: consent, legal principles such as patient autonomy, and clinical registration.

Irrespective of the person's capacity for decision-making, discussing and making decisions about current and future treatment, and then implementing decisions all fall within the ACP process. Privacy and confidentiality provisions will apply whether or not the person has decisional capacity.

For the most part, ACP discussions with a competent person are just like any other discussion involving health matters. Laws relating to privacy and confidentiality and the requirement to appropriately document the conversations apply. The legal issues become more complex when the person loses capacity for decision-making and directions made about life-sustaining measures acted upon.

Clinical Excellence Division

Advance Care Planning – Clinical Guidelines

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