



IRT Group **Advance Care** **Planning - NSW** Information Pack

November 2021



Dear resident, family and friends

At IRT, we encourage our residents and customers to plan for their future health and care needs to ensure their values and preferences are respected and honoured. We've put together some information to help you and your family consider advance care planning, if you haven't already done so.

Advance care planning is the process of enabling a person to record their wishes, values, life goals and preferred outcomes or directions about care. This is particularly important if you are frail, have a chronic illness, multiple diseases, an early cognitive impairment, or are approaching the end of your life. IRT can help guide you on the appropriate advance care planning documents for each state and territory.

The enclosed Advance Care Planning Information Pack includes:

1. Relevant state and territory advance care planning documents and fact sheets*.
2. Fact sheet, *What Matters to Me: Conversation Guide*.
3. Fact sheet, *What do you want for your end of life care?*

We believe it is a basic human right to have your values, beliefs and preferences respected by family, carers and medical professionals if you can no longer express your wishes, so we encourage you to consider this information carefully. If you have any questions about advance care planning, please don't hesitate to contact your Care Manager.

Yours sincerely

Nia Briguglio
EGM – Aged Care Centres

**Please note for NSW residents who do not have capacity to express their own preferences, IRT recommends the use of the Queensland Health Statement of Choices document. This is because there is no statewide Statement of Choices document available in NSW.*



Cardio Pulmonary Resuscitation (CPR)

Information for residents, customers, representatives and family

IRT's position on Cardio Pulmonary Resuscitation (CPR)

IRT understands it has a duty of care to its residents and customers, while also recognising that death is inevitable and a natural part of life. Our approach to life-prolonging measures such as CPR is guided by these two principles.

IRT has taken the position that our employees will not perform CPR on all residents/customers who are found unresponsive and not breathing normally (i.e. residents/customers who have suffered cardiac arrest).

However, in some emergency situations designated employees working in our aged care centres or providing home care services may perform CPR. An ambulance will always be called if CPR has been commenced.

When CPR will not be performed

Our employees will not perform CPR in the following circumstances:

- The resident/customer has a palliative approach in place, nearing the end of their life. (see *CPR in an emergency situation*, for residents with Advanced Care Planning documents)
- The resident/customer has expressly communicated their wish not to be resuscitated under any circumstances, via an Advance Care Directive or Statement of Choices.
- The cardiac arrest does not appear to be the result of an emergency situation.

CPR in an emergency situation

Employees who are trained in CPR are supported to perform CPR in the following circumstances:

- The cardiac arrest appears to be the result of an emergency - such as an accident, fall, choking event or medical episode - as distinct from a natural ending of life.
- The cardiac arrest does not appear to be the result of an emergency but the employee knows the resident/customer has expressly communicated their wish for CPR to be performed in all cases, via an Advance Care Directive or Statement of Choices.

IRT aged care centres and home care employees do not have access to Automatic External Defibrillators. If CPR is commenced an ambulance will always be called and defibrillation will only be performed by ambulance officers.

Advance care planning

IRT supports all residents/customers to be given the opportunity to complete an Advance Care Directive (ACD). A Statement of Choices (SoC) can be completed by the resident/customer's substitute decision-maker where the resident/customer does not have capacity to make decisions relating to their advance care planning.

ACD is a legally enforceable document, whilst a SoC helps guide decision making at a future time when the resident is unable to communicate their own wishes. SoC is not a legally enforceable document.



MAKING AN ADVANCE CARE DIRECTIVE

NSW MINISTRY OF HEALTH

100 Christie Street
ST LEONARDS NSW 2065
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source.

It may not be reproduced for commercial usage or sale.

Reproduction for purposes other than those indicated above requires written permission from the NSW Ministry of Health.

© NSW Ministry of Health 2018

SHPN (OCHO) 190329
ISBN 978-1-76081-189-1 (Print)
ISBN 978-1-76081-190-7 (Online)

Further copies of this document can be downloaded from the NSW Health website www.health.nsw.gov.au

August 2019

Making an Advance Care Directive

The purpose of this Information Booklet is to provide information to help you complete your Advance Care Directive. An Advance Care Directive form is provided at the end of the booklet, for you to complete and tear off.

An Advance Care Directive is an important way of letting people know your wishes about your healthcare and treatment should you find yourself in a position where you are seriously ill or injured and not able to make decisions. Having an Advance Care Directive will make it easier for your loved ones and health staff if they need to make decisions for you.

An Advance Care Directive is an important result of Advance Care Planning.

For more information about Advance Care Planning, please see <http://www.health.nsw.gov.au/patients/acp/Pages/default.aspx>

What is an Advance Care Directive?

An Advance Care Directive is a way to say what healthcare treatments you would like to have or refuse, should you be in a position where you are seriously ill or injured and unable to make or communicate decisions about your care and treatment.

An **Advance Care Directive** can only be made by you as an adult with decision making capacity. **If it is valid, it must be followed.** Health professionals and family members have no authority to override a valid Advance Care Directive.

An Advance Care Directive may include one or more of the following:

- the person you would like to make medical decisions for you if you are unable to make decisions
- details of what is important to you, such as your values, life goals and preferred outcomes

- the treatments and care you would like or would refuse if you have a life-threatening illness or injury.

This booklet will help guide you through decisions that you may wish to consider when making an Advance Care Directive.

Why is an Advance Care Directive important?

Making an Advance Care Directive is an important part of Advance Care Planning.

None of us know what will happen in the future or can predict what might happen with our health.

Medical advances mean that there are treatments which can keep you alive when you are seriously ill or injured, and which may prolong your life. Some people have firm ideas about how they want to live the rest of their life, including conditions or treatments that they might find unacceptable.

In a crisis your family may find it difficult to decide what treatment is best for you. An Advance Care Directive will help your family and doctors to know what you would want when you are not able to tell them yourself. It's best to write your Advance Care Directive so that your wishes are clearly recorded.



How do I prepare for making an Advance Care Directive?

The **first step** is to think about what would be important to you at end of life and what matters to you – your values. This may include:

- thinking about what kind of care you would like to receive or refuse
- who you would like to make decisions on your behalf and
- where you would like to be cared for if you were dying.

In the Advance Care Directive form at the back of this booklet, Section 2 includes space for you to write some statements if you wish. There is no right or wrong answer – it is up to you to identify what is important to let others know. This information will help your family and those making decisions for you to understand what treatment and care you want.

Some examples of statements about values are provided in the **Common Terms** section on page 9. If you're not sure what you would want, or would like to read more, the following websites might be helpful:

- Dying to Talk <http://dyingtotalk.org.au/>
- MyValues <https://www.myvalues.org.au/>

The **next step** is to talk with your family, friends and health professionals.

Talking to your family and friends can be difficult. You might start by saying that like writing a will, you are planning ahead for a time when you might not be able to make decisions about your health. Make it clear to your loved ones what treatments you would accept or refuse if you are very unwell.

Your doctors can help by explaining what treatments you could include in your Advance Care Directive based on your current health. They can also make sure that what you write can be understood by a health professional.

Working through the Advance Care Directive form at the back of this booklet will help identify what is important to you, and what you would like to let your loved ones and healthcare providers know about.

How do I make an Advance Care Directive?

In NSW, an Advance Care Directive can be spoken or written.

Unlike in other states, in NSW there isn't a specific form to use for an Advance Care Directive. An Advance Care Directive can simply be written on a piece of paper, not witnessed and still be legally enforceable. However, signed Advance Care Directives are the recommended way to ensure that your wishes are recorded.

If you want to make an Advance Care Directive you can choose to:

- use the Advance Care Directive form developed by NSW Health at the back of this booklet
- use another form, such as one of those available from www.planningaheadtools.com.au
- write a letter or statement about your wishes
- tell someone that you trust and who knows you well.

Deciding who will make decisions for you if you cannot make them.

It is important to think about who you would like to make healthcare decisions for you if you are seriously ill or injured and can no longer make decisions. Some people choose a family member or close friend or appoint an **Enduring Guardian/s**.

If it's not clear in your Advance Care Directive who this person or people are, your doctor will ask someone else to make the decision for you. This person is known as the **Person Responsible**. A Person Responsible is not always a relative. You may also hear people use the term Substitute Decision Maker.

Further information about these terms is provided in the **Common Terms** section on page 9.

When does my Advance Care Directive apply?

Doctors and health care professionals will only look at your Advance Care Directive if you are unable to make or communicate decisions about your healthcare and treatment.

Your Person Responsible must refer to your Advance Care Directive before making any medical or health decisions.

Before acting on any instructions that your Advance Care Directive may contain about your treatment or care, doctors will assess if it is valid. Part of that assessment is understanding whether it applies to your current situation.

For example, if you were admitted to hospital because you had fallen over and hit your head and had concussion, and were not able to communicate your wishes, you would be expected to get better and parts of your Advance

Care Directive that relate to end of life care may not be considered to apply to that situation.

However, if you had suffered a major stroke or heart attack and were unconscious and not able to communicate, and were not expected to get better, the doctors may consider that your Advance Care Directive may apply in that situation.

Pain relief and managing discomfort are always important. If your Advance Care Directive states you want to die a natural death, you will still be given pain relief if needed.

When is my Advance Care Directive valid?

An Advance Care Directive will only be used when you do not have capacity to decide for yourself or to communicate your wishes.

Your doctor will consider your Advance Care Directive to be valid if:

- you had capacity when you wrote it
- it has clear and specific details about treatments that you would accept or refuse
- it applies to the situation you are in at the time.

The NSW Supreme Court has said that valid Advance Care Directives must be followed. This is because they are a part of a person's right to make decisions about their health. If an Advance Care Directive is valid, it must be followed. Health professionals and Persons Responsible have no authority to override a valid Advance Care Directive.



Where should I keep my Advance Care Directive?

You should keep your Advance Care Directive in a place that is easy for you or someone else to find it. It is a good idea to keep a copy with you, or to keep a card in your wallet that lets people know that you have an Advance Care Directive and where it can be found.

It is a good idea to leave a copy with your Person Responsible, family and/or carer, doctor and/or healthcare facility.

Make sure you know where all the copies are. If you change your Advance Care Directive, you will need to replace all of the copies.

Frequently Asked Questions

Can I record my wishes regarding future healthcare in my will?

No. Your will only starts to operate after your death. Any information about your health in your will not be available to your Person Responsible or doctor(s) while you are alive.

Can someone appointed as my Power of Attorney consent to medical and dental treatment on my behalf?

No. Their role is to manage your business, property and financial matters.

Is an Advance Care Directive permission or consent for euthanasia?

No. You cannot request or direct a doctor or any other person to actively and deliberately end your life. Euthanasia or assisted dying is illegal in all Australian States and Territories.

I prepared an Advance Care Directive when I lived interstate. Is this recognised now that I live in NSW?

Yes. Advance Care Directives made in other Australian states and territories are recognised in NSW.

I have an Advance Care Directive but have decided that I would like my Enduring Guardian to make the best decision they can at the time. Can I revoke my Advance Care Directive?

Yes, you can retract/cancel/void your Advance Care Directive at any time while you have capacity. It is important to make sure you let people know you have revoked your Advance Care Directive and destroy all copies.

What if I change my mind about my Advance Care Directive?

You can change your Advance Care Directive as often as you like, as long as you have capacity. It is a good idea to read over anything you have written once a year, to make sure it is still current.

If you change your Advance Care Directive, you should make sure you let people know and replace all of the copies with the new Advance Care Directive.

What's the difference between an Advance Care Directive and an Advance Care Plan?

An **Advance Care Directive** can only be made by you as an adult with decision-making capacity. If it is valid, it must be followed. No one can override your Advance Care Directive, not even your legally appointed guardian.

An **Advanced Care Plan** can be written by you or on your behalf. It documents your values and preferences for healthcare and preferred health outcomes. The plan is prepared from your perspective and used as a guide for future healthcare decision making, if you are unable to speak or otherwise communicate your wishes for yourself.

An Advanced Care Plan may be developed for and/or with a person with limited capacity (ability to make decisions), so therefore it does not need to be followed.

What is capacity?

Capacity refers to an adult's ability to make a decision for him or herself.

Capacity is specific to the particular decision that needs to be made. In some circumstances, the law sets out what tests must be met for capacity to make certain decisions, for example to consent to medical treatment.

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.

Can I insist on being given a particular treatment or procedure?

No. Your health care team will consider your wishes, but does not have to offer you treatment that may not benefit you.

What about organ and tissue donation for transplantation?

Organ donation is a life-saving and life-transforming medical process. Organ and tissue donation involves removing organs and tissues from someone who has died (a donor) and transplanting them into someone who, in many cases, is very ill or dying (a recipient).

People 16 years of age or older can register their donation decision on the Australian Organ Donor Register at <https://www.humanservices.gov.au/customer/services/medicare/australian-organ-donor-register> or by contacting their local Centrelink or Medicare Service Centres, myGov shopfront or Access Points.

It is important that you let your family know your decisions about organ and tissue donation. In Australia your family will always be asked to confirm your donation decisions before organ and tissue donation can proceed.

Some patients are so severely injured or ill that they do not respond to lifesaving medical treatments. The doctors caring for that patient may agree that they will not survive and that further medical treatment is no longer of any benefit to them.

The doctors may then ask their family about that person's wishes about organ and tissue donation.

If the person had indicated that they wanted to become an organ and tissue donor after their death, the doctors may also ask the family about several treatments which may be given before that person dies, only for the purpose of improving the function of any donated organs when transplanted. These treatments are of no medical benefit to the patient and are called **antemortem interventions**. Examples include antibiotics, blood thinning drugs or drugs to control blood pressure.

If you want to be an organ donor, the Advance Care Directive asks you to declare your consent to antemortem interventions.

If you do not consent to antemortem interventions, it is still possible to be an organ donor.

I've heard about Body donation – what is that?

Body donation is where a person's body is given to a body donor program and / or a licensed anatomical facility either following the person's written consent prior to their death or with the consent of their senior available next of kin after their death. Bodies may be used for the teaching of medical and health students, training of surgeons in new surgical techniques or for research.

In NSW a body donation program is usually organised through a university or medical research facility.

Most body donation programs encourage people to register to be an organ donor as well as a body donor, if they would like to do so. Where a person has consented to body donation and organ

donation, preference is given to organ donation if suitable, because of its life saving benefits.

If you have registered your wish to donate with a body donor program you should make sure that your family knows your decision. That way either your family or hospital staff can contact the program you are registered with when you die.





An Advance Care Directive is an important way of letting people know your wishes about your healthcare and treatment should you find yourself in a position where you are seriously ill or injured and not able to make decisions.

Common Terms

Advance Care Planning

Advance Care Planning involves thinking about what medical care you would like should you find yourself in a position where you are seriously ill or injured and cannot make or communicate decisions about your care or treatment. It includes thinking about what is important to you - your values, beliefs and wishes.

Advance Care Planning can include one or more of the following:

- talking with your family, carers and/or health professionals
- developing an Advance Care Plan
- making an Advance Care Directive.

Ideally Advance Care Planning happens early, when you are well and are able to understand the choices available to you about your healthcare and treatment. However it can be done at any time you have capacity.

An Advance Care Plan records preferences about health, personal care and treatment goals. It may be completed by discussion or in writing.

If you are able to make decisions about your future healthcare, you can make an Advance Care Plan by yourself or together with people that you trust and/or who are important to you.

If you are not able to make decisions, an Advance Care Plan can be made by a family member or someone who knows you well, together with a health professional. It should include your known wishes about treatment.

Advance Care Directive

An Advance Care Directive is a way to say what healthcare treatments you would like to have or refuse, should you find yourself in a position where you are seriously ill or injured and unable to make or communicate decisions about your treatment and care.

An Advance Care Directive may include one or more of the following:

- the person or people you would like to make medical decisions for you if you are unable to make decisions
- details of what is important to you, such as your values, life goals and preferred outcomes
- the treatments and care you would like or refuse if you have a life-threatening illness or injury.

Person Responsible

In *NSW the Guardianship Act 1987 (NSW)* states that the **Person Responsible** is (in order):

1. Your guardian

This is a person or people who have been legally appointed to make medical and/or dental decisions for you. In some situations a guardian may be appointed for someone, but most people are able to choose their own guardian.

If you are 18 years of age or older and have capacity, you can appoint an **Enduring Guardian** (you can appoint one or two). When you appoint the Enduring Guardian(s) you can decide what medical and/or dental decisions you would like them to be able to make for you, if you do not have the capacity to make the decision yourself.

Your Enduring Guardian must consider your Advance Care Directive before they make a decision.

2. Your spouse, de facto or same sex partner

Person with whom you have a close and continuing relationship.

3. Your carer

Person who currently provides support to you or did before you entered residential care. This person cannot be a paid carer. The carer support payment is not considered payment.

4. A close friend or relative

Person with whom you have an ongoing relationship.

Substitute decision maker

A substitute decision maker is a person who is appointed or identified by law to make decisions for an individual whose decision making capacity is impaired. A substitute decision maker may be appointed by the individual (for example appointing an Enduring Guardian or making a Power of Attorney), appointed for the individual (for example a guardian appointed by the Guardianship Division), or identified as a substitute decision maker for medical and dental treatment by the NSW Guardianship Act 'Person Responsible' hierarchy.

Values statements

Some people may choose to record general statements about what is important to them - their values, beliefs and wishes - on their Advance Care Directive or in their Advance Care Plan. The following values statements are provided as examples of what you may wish to include in Section 2 of the form (there is no right or wrong - it is entirely up to you what you record to let others know):

Beliefs and values:

It is important for me to be able to communicate in some way, even if I cannot speak.

Life has meaning when I can enjoy nature and when I can practise my faith.

I value my privacy.

Physical or mental health concerns that you may want considered:

I do not want to struggle to breathe.

I do not want to be in pain.

It is important to me that I spend time in my garden.

Other information that you would like considered:

I would like to stay at home as long as it is not too hard on my family or the people caring for me.

I would not like to die at home.

I worry that my family or the people caring for me will not know what to do.

I want flowers in my room.

Cultural, spiritual and/or social care:

I would like prayer, religious or spiritual rituals in my own language.

I would like my music to be played.

SECTION 1

YOUR DETAILS AND YOUR PERSON RESPONSIBLE

Family name: _____

Given names: _____

Date of birth: _____

Address: _____

I have been provided with and read the 'Making an Advance Care Directive' information booklet. Please tick if yes

I have legally appointed one or more people as my Enduring Guardian/s and they are aware of this Advance Care Directive. Please tick if yes

ENDURING GUARDIAN 1

ENDURING GUARDIAN 2

Name: _____

Home phone number: _____

Mobile phone number: _____

Email address: _____

I have not appointed an Enduring Guardian

If, because of my medical condition, I am not able to understand and make decisions about my treatment or can't tell the doctors or my family, my Person Responsible as determined according to the hierarchy within the NSW Guardianship Act (1987) is

PERSON 1

PERSON 2

Name: _____

Relationship: _____

Home phone number: _____

Mobile phone number: _____

Email address: _____

Information about your values is important as it is not possible for this document to cover all medical situations. Information about what is important to you may help the person who is making decisions on your behalf when they are speaking to the doctors about your care and treatment.

In this section you can include:

- things that are important to you at the end of life (your beliefs and values)
- issues that worry you, and
- personal, religious or spiritual care you would like to receive when you are dying.

If you do not want to complete this section, you should sign the bottom of the section on page 3

If I am unable to communicate and not expected to get better:

- I would like my pain and comfort managed; and
- when deciding what treatments to give to me or not to give me, I would like the person/people making health decisions for me to understand how the following would make me feel (initial the box that is your choice).

If I am unable to communicate by any means, and not expected to get any better:

VALUES	Bearable	Unbearable (I would like treatment discontinued and to be allowed to die a natural death)	Unsure
1. If I can no longer recognise my family and loved ones, I would find life...			
2. If I no longer have control of my bladder and bowels, I would find life...			
3. If I cannot feed, wash or dress myself I would find life...			
4. If I cannot move myself in or out of bed and must rely on other people to reposition (shift or move) me, I would find life...			
5. If I can no longer eat or drink and need to have food given to me through a tube in my stomach I would find life...			
6. If I cannot have a conversation with others because I do not understand what people are saying, I would find life...			

SECTION 2

PERSONAL VALUES ABOUT DYING

At the end of my life when my time comes for dying, I would like to be cared for, if possible

(initial the box of your choice)

At home

In a hospital

Other location (e.g hospice, residential aged care - please provide details) _____

I do not know. I am happy for my Person Responsible/family to decide.

When my Person Responsible is making decisions about care at the end of my life, I would like them to consider the statements below.

If you need extra space please attach an additional page.

I do not want to complete Section 2:

(Signature)

This section applies to when you are unable to make or communicate decisions about your health care and medical treatment, including CPR.

If you are able to communicate you will be included in decisions about your care.

If you do not want to complete this section, you should sign the bottom of this section

Cardio Pulmonary Resuscitation (CPR)

CPR refers to medical procedures that may be used to try to start your heart and breathing if your heart or breathing stops. It may involve mouth to mouth resuscitation, very strong pumping on your chest, electric shocks to your heart, medications being injected into your veins and/or a breathing tube being put into your throat.

CPR

If I am **not expected to recover**, or if my life is unbearable as indicated in my Personal Values About Dying, Section 2 on page 2,

THEN, if my heart or breathing stops (please initial one box only):

I would accept CPR

OR

I would not accept CPR. Do not try to restart my heart or breathing

OTHER MEDICAL TREATMENTS

If I am **not expected to recover**, or if my quality of life is unbearable as indicated in the table my Personal Values About Dying, Section 2 on page 2 and 3, **THEN the following treatments would be UNACCEPTABLE to me:** the following medical treatments (initial the box/boxes that apply to your wishes):

Artificial ventilation through a tube (also called 'life support', 'breathing machine')

Renal dialysis - (kidney function replacement)

Life prolonging treatments that require continuous administration of drug

OTHER (e.g. food and fluid through a tube). Please list below:

Even if I am expected to get better I would never want the following medical treatments:

I do not want to complete Section 3:

(Signature)

SECTION 4

SPECIFIC REQUESTS FOR ORGAN, TISSUE AND BODY DONATION

If you do not want to complete this section, you should sign the bottom of this section

My wishes about organ, tissue and body donation for transplantation following my death are (initial your choice for each statement):

Yes **No**

I would like to donate my organs and tissues for transplantation following my death.

I have discussed my organ and tissue donation wishes with my family and friends and they are aware of my decision.

I would like to, or have already made arrangements to, donate my body for education and/or scientific research

Antemortem interventions for organ donation (treatment/s immediately before my death only for the purpose of organ donation)

Yes **No**

It is my wish to donate my organs for transplantation after my death. If I am dying, I consent to the doctors providing treatments for my **organs** before my death (including artificial ventilation, insertion of intravenous lines and administration of medications) intended only for the purpose of enabling me to donate my organs and tissue for transplantation.

I do not want to complete Section 4:

(Signature)

PERSONAL DETAILS

By signing this document, I confirm that:

- I have read the accompanying information booklet, or had the details explained to me
- I understand the facts and choices involved, and the consequences of my decisions
- I am aware that this Advance Care Directive will be used in the event that I cannot make or communicate my own health care decisions. If I am able to communicate, I will be asked to make decisions about my care.
- I have completed this Advance Care Directive of my own free will.

(Signature)

____/____/____
(Date)

DETAILS OF WITNESS*

I confirm that _____ signed this document on ____/____/____

Signed: _____ Name (please print): _____

Address: _____ Phone: _____

TREATING HEALTH PROFESSIONAL*

Name: _____ Designation _____

Address: _____

Phone: _____

Email: _____

I confirm that I had no reason to doubt the capacity of the person

I confirm that _____ had capacity and was aware of the implications of the information in this Advance Care Directive. (Medical officer only)

(Signature)

____/____/____
(Date)

*While not legally required, it is strongly recommended that a witness co-signs this Advance Care Directive and/or a health professional witnesses you sign this form. Once completed this form is to be given to your Personal Responsible, Enduring Guardian and medical professionals.



What is advance care planning?

If you were very unwell, and not able to communicate your preferences for care to others, who would you want to speak for you? And more importantly, what healthcare decisions would you want them to make?

Advanced illness or serious injury can sometimes mean that people cannot make their own decisions about health and personal care. This can happen to people of all ages, and especially towards end of life.

Writing an Advance Care Directive (values and/or instructional) lets you say what you would want, if you are ever unable to communicate for yourself.

Benefits for you and the people who care for you

Advance care planning:

- helps to ensure that a person's preferences, beliefs and values about health care are known and respected if they are too unwell to speak for themselves
- benefits those who are close to them. Research has shown that families of people who have done advance care planning have less anxiety and stress when asked to make important healthcare decisions for other people.

Making healthcare decisions for others can be difficult. An Advance Care Directive can give peace of mind and comfort as preferences are clear, understood and respected.



When should you make an Advance Care Directive?

You should start planning when you're healthy – before there's actually an urgent need for a plan. But having an Advance Care Directive in place becomes particularly significant towards the end of a person's life. About 85% of people die after chronic illness, not as the result of a sudden event – so it's important that your Advance Care Directive is ready in case it's required someday.

What do you need to do?

Be open

- Think and talk about your values, beliefs and preferences for current and future health care.
- Decide who you would like to speak for you if you become very sick and are not able to speak for yourself. Ask them if they are prepared to be your substitute decision-maker.

Ideally, they need to be:

- available (ideally live in the same city or region)
- over the age of 18
- prepared to advocate clearly and make decisions on your behalf when talking to your doctors, other health professionals and family members.

Depending on your state/territory, you may be able to appoint more than one substitute decision-maker.

Be ready

- Talk about your values, beliefs and preferences with your substitute decision-maker and other people involved in your care, such as family, friends, carers and doctors.
- Write your plan and/or appoint your substitute decision-maker. See advancecareplanning.org.au for the relevant form or advance care planning legal factsheet. Your GP or other health professionals can help support you to document your choices.

There are different legal requirements in different Australian states and territories, so it is a good idea to ask for help. In some states and territories there are important rules regarding who can witness documents for you. See your relevant advance care planning legal factsheet.

Be heard

- A written Advance Care Directive will make things easier for your substitute decision-maker(s), if the need ever arises. It will give everyone peace of mind, knowing your preferences are heard and respected.

Make copies and store them with:

- your substitute decision-maker(s)
- your GP/local doctor
- your specialist(s)
- your residential aged care home
- your hospital
- myagedcare.gov.au.

You don't have to give a copy to each of the above, but make sure your substitute decision-maker and main doctor each has a copy.

- Load your Advance Care Directive into your 'My Health Record' at myhealthrecord.gov.au
- Review your Advance Care Directive regularly – for instance each year. You should review it if there is a change in your health, personal or living situation.
- Give your substitute decision-maker and doctors an updated copy of your Advance Care Directive if you make changes and keep it safe.

Conversation starters

To get started, choose a quiet setting where you have a lot of time, so you know that you won't be interrupted. Be patient and take your time: you and your loved ones might need a few moments to think.

Sometimes you might get a bit sidetracked and that's okay. Let the conversation happen naturally. You don't need to talk about everything all at once. Remember that advance care planning is an ongoing conversation.

Starting the conversation can be the hardest part, so here are a few ways to begin:

- I was thinking about what happened to ... and it made me realise that ...
- I would want ... to make medical decisions on my behalf if I was unable to.
- Being able to ... is the most important thing to me.
- If ... happened to me, I would want ...

Where can I get more information?

Advance Care Planning Australia

- advancecareplanning.org.au
- National Advisory Service: 1300 208 582
- learning.advancecareplanning.org.au

The law and advance care planning

Different states and territories in Australia have different laws on advance care planning. When planning for your own future care, it will be helpful to understand the law in your own state/territory. See advancecareplanning.org.au for information.

Depending on the state/territory:

- A substitute decision-maker may be legally appointed as an Attorney, Enduring Guardian, Decision-Maker or Medical Treatment Decision-Maker.
- An Advance Care Directive may also be called an Advance Health Directive, Health Direction or Advance Personal Plan.

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 directive¹. 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 plan¹. The relevant advance care directive form from each state and territory is available at:

www.advancareplanning.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.

How to complete this form?

This form allows you to provide information about the values and preferences relating to future medical treatment for a person who has lost the capacity to make their own decisions. The information provided in this form should be guided by the person's past choices and decisions, and any previously expressed values and preferences. When completing this form, you should consider what decisions the person would have made in these circumstances, if they had the decision-making capacity to do so.

When completing this form, the following **guiding principles** should be used:

- When considering the person's values, think about how they like to live their life, what they enjoy doing, and what matters most to them, taking into account things they have said or done in the past.
- Any previously expressed preferences or choices made relating to healthcare, medical treatment, or life prolonging treatments², and type or location of care should be regarded.
- Any previously expressed views the person made about acceptable or unacceptable health outcomes should be taken into account.
- Consideration should be given to any observations made in relation to the person including how they make decisions and what their priorities and interests are.

How should this form be used?

Before relying on this form, the person's clinicians should consider their legal obligations relating to consent of medical treatment decisions in the state or territory that they practice in. They should be sure that the person does, at the time that decisions must be made, lack the capacity to make those decisions.

Where possible, the responsible clinicians should ascertain, the most up-to-date advance care directive for preferences for care and/or appointment of a substitute decision-maker. The clinician should also ensure that the person completing this form is the most appropriate substitute decision-maker if no-one has been appointed.

The identities of the person(s) filling out this form on behalf of the person with insufficient decision-making capacity to complete an advance care directive should be assessed carefully. Anyone relying on this form should be confident that the person(s) who completed this form truly represented the person's values and preferences.

How should this form be stored and shared?

Copies of the advance care plan should be shared with the person's substitute decision-maker(s), aged care, community or hospital provider, treating clinicians, General Practitioner and/or stored in My Health Record.

Who to contact for further information?

Advance Care Planning Australia

National Advance Care Planning Support Service: 1300 208 582

Email: acpa@austin.org.au

www.advancecareplanning.org.au

Table 1. Existing Advance Care Plans

State/Territory	Document name
Australian Capital Territory	Advance Care Plan Statement of Choices (No Legal Capacity)
Queensland	Statement of Choices Form B
Victoria	What I understand to be the person's preferences and values

Table 2. Title of legally-binding Advance Care Directives by state and territory

State/Territory	Advance Care Directive - preferences for Care	Advance Care Directive – appointment of a substitute decision-maker
Australian Capital Territory	Health Direction	Enduring Power of Attorney
New South Wales	Advance Care Directive	Appointment of Enduring Guardian
Northern Territory	Advance Personal Plan	Advance Personal Plan
Queensland	Advance Health Directive	Advance Health Directive/ Enduring Power of Attorney
South Australia	Advance Care Directive	Advance Care Directive
Tasmania	Advance Care Directive	Instrument Appointing Enduring Guardian(s)
Victoria	Advance Care Directive	Appointment of a Medical Treatment Decision Maker
Western Australia	Advance Health Directive	Enduring Power of Guardianship

Note: In the absence of a substitute decision-maker appointment by the person, state and territory law assigns this role via a hierarchy, with the exception of Northern Territory.

Reference

1. National framework for advance care planning documents. 2021. Australian Government, Department of Health.
2. Advance Care Planning Australia. Life prolonging treatments. 2021. Available: www.advancecareplanning.org.au/understand-advance-care-planning/life-prolonging-treatments

Disclaimer

This publication is general in nature and people should seek appropriate professional advice about their specific circumstances, including advance care planning legislation and policy in their state or territory.

If you are a health service or aged care organisation, add your logo within this space.

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

FORM

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 directive¹. 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.

Question 1

The person with insufficient decision-making capacity that this document applies to

Full name:

Date of birth:
(dd/mm/yyyy)

Address:

Question 2

The person completing this document

Full name:

Relationship to the person:

Address:

Phone number:

I believe that I am this person's legally recognised substitute decision-maker:

Yes No Unknown

If yes and appointed, please attach documentation that provides evidence of this (see Table 2 of the Instruction Guide).

If no, the person's legally recognised substitute decision-maker should complete and sign the form.

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

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

Question 3

Additional contributor to this document, if applicable

Full name:

Relationship to the person:

Address:

Phone number:

This person is a legally recognised substitute decision-maker:

Yes No Unknown

If yes and appointed, please attach documentation that provides evidence of this, (see Table 2 of the Instruction Guide).

If no, the person's legally recognised substitute decision-maker should be listed above as the person completing this document.

Question 4

Does the person have an advance care directive? (see Table 2 of the Instruction Guide)

Yes (please attach copy to this form) No Unknown

If you answered yes, was the person's advance care directive considered when completing this form?

Yes

No Please provide reasons:

Question 5

The person's main health conditions (list all relevant conditions)

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

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

Question 6

The person's values (as I best understand them)

I believe the things that are most important to this person are:

(Note: consider the guiding principles and the person's desire for independence, social connections, emotional well-being, functional mobility, and participation in activities. An example statement might be 'they would like to be able to have meaningful interactions with family and loved ones such as conversations, eating together, and celebrating special occasions').

I believe the things that would be unacceptable health outcomes to this person are:

(Note: consider the guiding principles and their desired functional requirements, emotional well-being, and willingness to receive medical interventions. An example statement might be 'being fully dependent on care and unable to interact with family and loved ones').

I believe the things that would be acceptable health outcomes for this person are:

(Note: consider the guiding principles and their desired functional requirements, emotional well-being, and willingness to receive medical interventions. An example statement might be 'living with equipment and support for the activities of daily living; being dependent on care if they can interact with family and loved ones').

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

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

Question 6 continued

I believe the things that this person is hoping to do now and in the future are:

(Note: consider the guiding principles and their desire for independence, social connections, emotional well-being, functional mobility, and participation in activities. An example statement might be 'live in their own home with support of family and paid carers; read novels or the paper daily').

Other values that are important to know about this person

Question 7

The person's treatment preferences (as I best understand them)

**If this person became very unwell with either an expected or unexpected deterioration with no hope of an acceptable outcome, the following statement best represents their views:
(tick one box only)**

(Note: Life prolonging treatment includes but is not limited to Cardiopulmonary Resuscitation (CPR), artificial ventilation, tube feeding, surgery, oral or intravenous antibiotics and/or dialysis.)

- Living as long as possible is their major goal no matter the outcome **OR**
- They would want life prolonging treatment that may extend their life, but not if it is likely to result in an unacceptable health outcome **OR**
- They would not want life prolonging treatment that may extend their life **OR**
- Not sure

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

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

Question 7 continued

Are there any life prolonging or particular treatments that the person would not want to receive?

I believe if this person is nearing death, they would like the following to be considered.
(Example: place of death, presence of family or loved ones, music, religious, cultural or spiritual support).

Additional notes

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

(For person health record purposes, attach a label here)

UR Number:

Surname:

Given name(s):

Date of birth:
(dd/mm/yyyy)

Question 8

Please tick all to indicate your understanding of the following statements.

I am of the reasonable belief that a person for whom this form applies does not have decision-making capacity to make medical treatment decisions.

I understand that this document does not provide legally-binding consent to, or refusal of treatment but may be used to guide substitute decision-makers and clinicians to make medical treatment decisions.

I understand that if the person does have an advance care directive, the values and preferences expressed in a valid advance care directive will be respected, if their medical treatment decisions are clinically indicated and appropriate.

I understand that this person may still receive care for symptoms such as pain and to alleviate suffering regardless of the values or preferences stated in this form and that an advance care directive or advance care plan cannot refuse such measures.

I understand that I am documenting this person's values and preferences honestly, to the best of my knowledge and without intent to cause harm.

I understand this form should be reviewed if the persons condition changes, can be cancelled or changed whenever needed.

Signing

Legally recognised substitute decision-maker

By signing this form, I confirm this is an accurate record of this person's values and preferences as I understand them at the time of completing this form.

Full name:

Signature:

Date:

(dd/mm/yyyy)

The person's treating doctor or registered health professional

By signing this form, I certify to the best of my knowledge the person completing this form is an appropriate person to represent the values and preferences of the person with insufficient decision-making capacity.

Full name:

Signature:

Date:

(dd/mm/yyyy)

What is advance care planning?

If you knew someone who became very unwell and was not able to communicate their preferences to others, would you know what they wanted? Could you make healthcare decisions on their behalf?

If your loved one became more unwell or had a sudden emergency they may no longer be able to make their own decisions about health and personal care. This can happen to people of all ages, and especially towards end of life.

Writing an Advance Care Directive lets a person say what they would want, if they are ever unable to communicate for themselves.

Benefits for you and the people you care for

Advance care planning:

- Helps to ensure that a person's preferences, beliefs and values about health care are known and respected if they are too unwell to speak for themselves
- Research has shown that families of people who have done advance care planning have less anxiety and stress when asked to make important healthcare decisions for other people.



What does a substitute decision-maker do?

When a person prepares their Advance Care Directive, they may invite someone to be their substitute decision-maker. If the person loses their ability to make their own healthcare decisions, the substitute-decision maker can then make decisions on their behalf. The Advance Care Directive will provide direction and guidance.

Some state/territory laws may allow for more than one substitute decision-maker to be appointed.

How can a substitute decision-maker help with advance care planning?

Be open

- If someone asks you to be their substitute decision-maker, think about what it might mean for you before you agree.

Ideally, you need to be:

- Available (live in the same city or region) or readily contactable
- Over the age of 18
- Prepared to advocate and make decisions clearly and confidently on the person's behalf when talking to doctors, other health professionals and family members if needed
- Comfortable with encouraging the person to talk through their preferences with their family members and close friends.

Be ready

- Talk with the person about their values, beliefs and life goals. Make sure you understand and respect their approach to health care, living well and end-of-life decisions.
- If you and the person have conflicting beliefs, be honest with them. Remember that you may be called upon to advocate for them. If your beliefs are too different, it may be better for them to choose someone else.
- Talk about any potential issues that may arise with family members or partners who have different views. How will you cope with any disagreement that could arise? Do they know you are a substitute decision-maker?
- If you agree to being a substitute decision-maker, discuss whether they want you to be legally appointed.

Be heard

- Encourage the person to write an Advance Care Directive.
- Ask for a copy of the Advance Care Directive and keep it safe. Familiarise yourself with the person's preferences and ask them to explain anything that isn't clear.
- Encourage them to review their Advance Care Directive every year or if there is a change in their health or personal situation.
- Encourage them to load their Advance Care Directive onto 'My Health Record' at myhealthrecord.gov.au



What others say about being a substitute decision-maker

“I did what needed to be done to make her quality-of-life the best it could possibly be under the circumstances.”

“I’ve read Dad’s plan. It is so valuable to know because it’s not a plan I would have ever developed myself.”

“I was hoping that the decision I made was the same decision that the person I was acting on behalf of would have made.”

The law and advance care planning

When you are appointed as a substitute decision-maker, it will be helpful to understand the law in your state/territory. Different states and territories in Australia have different laws regarding advance care planning. There are also common law decisions in advance care planning.

Depending on the state/territory:

- A substitute decision-maker may be legally appointed as an Attorney, Enduring Guardian, Decision-Maker or Medical Treatment Decision-Maker.
- An Advance Care Directive may also be called an Advance Health Directive, Health Direction or Advance Personal Plan.

Conversation starters

To get started, choose a quiet setting where you have a lot of time, so you know that you won’t be interrupted. Be patient and take your time: you and your loved ones might need a few moments to think.

Sometimes you might get a bit sidetracked and that’s okay. Let the conversation happen naturally. You don’t need to talk about everything all at once. Remember that advance care planning is an ongoing conversation.

Here are some questions you may like to ask them:

- What do you currently value about your life?
- If your current health condition (e.g. cancer, dementia) got worse, what kind of medical treatment would you want and do not want?
- Describe a good day for you.
- If there was an emergency what kind of medical treatment would you want or not want?

At times, it can be challenging

Making medical decisions on behalf of someone else can be challenging.

When making decisions for someone else, you may:

- Feel uncertain about the outcomes of some decisions
- Feel that the preferences of the person for whom you are making decisions are unclear
- Question whether the decision you are making is the right one
- Have values and preferences that are in conflict with those of the person for whom you are making decisions
- Disagree with family members and/or treating health professionals over certain decisions.

Questions to ask your loved ones’s doctor:

- What are the risks and likely outcomes of this treatment or procedure?
- Are there other safer options available?
- What are the financial costs of this treatment or procedure?

Self-care is important

While being a substitute decision-maker is an important role, looking after yourself is also important. If you feel overwhelmed about being a substitute decision-maker we recommend that you seek counselling and support. You can also access your religious or spiritual communities and other social networks to help you through this process.

Knowing your rights

If you feel you are not the right person or you can no longer fulfil your duties, you can resign from your appointment. Be sure to inform the person who appointed you as their substitute decision-maker so they can appoint someone more suitable for the role.

We’re here to help

Free information is available from:

[Advance Care Planning Australia](#)

 advancecareplanning.org.au

 **National Advisory Service: 1300 208 582**

 learning.advancecareplanning.org.au

What Matters to Me: Conversation Guide



MY END OF LIFE **CARE**

Talking about what matters to me

Talking to loved ones about Your End-Of-Life Care

1

Getting started

Talking about end-of-life care is different for everyone—some people find it overwhelming and confronting, others may be more accepting. Be prepared to give it some time and, if necessary, have a number of conversations to make your wishes fully known and understood.

- Try and find a quiet space where you can speak openly and calmly.
- Think about who you would like in the room. Is it your spouse or partner? Your child, sibling, or good friend?
- Remember that you can share as much or as little information as you would like.

How do I start this conversation?



Why are we talking about this?

2

Talking about 'why'

Your loved ones may be wondering why you want to talk about end-of-life care.

They may not know much about Palliative Care or Advance Care Planning.

- You could try explaining to them that, if you were to become unexpectedly sick, you don't want them to have to make stressful decisions on your behalf.
- Remind them that this information will help them in a time of stress when emotions can run high.
- Gently communicate that it's important that your end-of-life care happens the way you want it to.



Talking to loved ones about Your End-Of-Life Care

3

I want to speak to you about my end-of-life care...



Conversation starters

Sometimes, the hardest part about difficult conversations can be knowing where to start. You could try some of the below openers to help you get started.

- "I know it might be hard to talk about, but it's really important to me."
- "We've talked a bit about what happens after I pass away, but we haven't spoken about my end-of-life care."
- "I've been speaking to my doctor, and they have asked me to think about a few things..."

4

Talking about your 'wishes'

An important part of this conversation is communicating your wishes clearly. Remember that there are no right or wrong answers—end-of-life care is very personal. If you haven't considered your end-of-life care before, the Palliative Care Australia website has useful resources that may help you. (www.palliativecare.org.au)

- "If I was no longer able to make decisions about my treatment or care, I would like this person to be my substitute decision-maker..."
- "When the end of my life approaches, I would like to be cared for at this location..."
- "This is the type of health care I would like to receive..."

These are the things that are important to me...



Talking to loved ones about Your End-Of-Life Care

5

Next steps

It is a good idea to end the conversation with some next steps. If you haven't already, you could start to formalise your wishes in the form of an Advance Care Plan (also known as an Advance Health Directive in some states).

This may involve making an appointment with a health professional including your GP.



Visit www.health.gov.au/palliativecare

MY END OF LIFE CARE

Talking about what matters to me



Australian Government
Department of Health



What do you want for your end of life care?



MY END OF LIFE CARE

Talking about what matters to me



It's normal not to want to talk about "it", that is "death or dying".

82% of Australians feel that talking about their death and dying wishes is important but when it comes down to it, most people don't actually bring themselves to have the conversation. In fact, almost half of us (43%), fall into the 'out of sight out of mind' way of thinking.

Why don't we want to talk about it?

While it's becoming more normal as we grow older to ponder our funeral plans or make a will so as to not burden loved ones, our approach to our end of life care is still very much taboo as a conversation topic.

Common reasons for this are:

- Not thinking it is necessary—because we're too healthy or too young
- Not knowing how to start the conversation
- Not wanting to upset loved ones by talking about death or dying
- Not understanding what's involved in palliative care versus end of life care and what steps you need to take to make a future plan.

Why talk about end of life care?

While talking about end of life care isn't easy, there are good reasons to start the conversation early:

- It helps empower you to take control about your end of life care and dying wishes ahead of time and in line with the things you value most
- It helps take the burden off loved ones trying to understand your desires and wishes.

Palliative Care is commonly mistaken as the medical care provided only when death or dying is imminent. Understandably, this misconception alienates many of us from having this important conversation much earlier in our lives.

What is palliative care?

Palliative care is about improving your quality of life when facing a life-limiting illness. It focuses on your individual needs and aims to prevent and relieve suffering by treating not only the physical, but also the emotional, social and spiritual symptoms.

Care may include:

- Relief of pain and other symptoms
- Resources such as medical equipment
- Assistance for families to come together to talk about sensitive issues
- Support for people to help meet cultural obligations
- Support for emotional, social and spiritual concerns
- Counselling and grief support.

What is end of life care?

End of life care is for people of any age and is about the palliative care services you and your family receive when you are facing your end of life.

It often involves many health professionals bringing together a range of skills to manage your illness. Wherever possible end of life care is provided where you and your family want care—at home, in hospital, in a hospice or a residential aged care facility.

Conversation starter.

So how do you talk about something nobody wants to talk about?

The ability to prompt discussions about end of life care will be easier for some of us. There are many factors at play—your mindset, values, beliefs, culture, health, family relationships and so on.

Some things to keep in mind:

- There is no right or wrong way to go about having a conversation—it's very personal to you, your family and friends
- The conversation doesn't have to be rushed—take time to first self reflect on what's important to you
- Conversations like this are likely to happen and be resolved over time—embrace suitable opportunities as they arise
- Resources and support services are available to help you make a start when you're ready.



Taking your wishes and turning them into a plan.

The next important step after having conversations with your family and health care professionals is to create a plan that documents your wishes. This is known as an **Advance Care Plan (ACP)** and is the process of planning your medical care in advance regardless of your age or health. It is particularly important if you have a chronic illness, a life-limiting illness, or are aged over 75 years.

It talks about your values, beliefs and preferences so your family and health care providers can guide decision making if you cannot make or communicate your decisions in the future.

An **Advance Care Directive (ACD)** is different from an Advance Care Plan—it records your preferences in a document that is recognised by common law or legislation. It is usually discussed with your doctor and ensures your decisions are informed by your health. An ACD ensures your treating doctor understands your wishes.

As part of your ACD you can choose someone you trust to make decisions on your behalf. This person is known as a substitute decision maker (SDM) and they can act as your voice, if you are no longer able to.

While end of life care planning can be overwhelming, having the conversation and documenting your wishes early will help to provide clarity and ease potential conflict with family and friends at a time when emotions run high.

For more information about having the conversation visit www.health.gov.au/palliativecare