

ADVANCE HEALTH CARE DIRECTIVE

(for use in Residential Aged Care Facilities)

This form deals with your future health care.

The time may come when you cannot speak for yourself. By completing this form, you can give directions about what medical treatment you would want, or not want, at such a time.

In this Facility, we are committed to giving you a high standard of care in order to provide you with comfort and dignity.

However, we do not use invasive technology to prolong life.

EXPLANATORY NOTES

Every competent adult has the legal right to accept or refuse any medical treatment or health care. This is relatively easy when people are well and can speak for themselves.

Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes – at the very time when many critical decisions need to be made.

By completing this Advance Health Care Directive, you can make your wishes known before this happens.

Who is involved in completing this document?

- **You, as the principal.** (You are referred to as the principal because you are the person principally involved.) You complete Sections 1 to 4 and Section 6.
- **A doctor** who completes Section 5 (you also sign that Section).
- If you have any specific religious or spiritual beliefs, you may also wish to discuss this document with a **Minister of Religion** or **Spiritual Advisor**.
- **Your witness** completes Section 7. Your witness should be a Justice of the Peace, a lawyer or a Clerk of the Courts. He/she should not be your Enduring Guardian, a relation of yours or of your Enduring Guardian, a beneficiary under your will, your current paid carer or your current health-care provider (e.g. nurse or doctor).

Note 1: Your doctor signs the document before the witness signs it.

Note 2: 'Paid carer' does not mean someone receiving a carer's pension or similar benefit, so you are free to choose someone who is receiving such a benefit for looking after you.

What do I do with the completed form?

A copy will be put into your medical record in the Residential Aged Care Facility where you live. You should give a copy to your doctor, to your Enduring Guardian if you have appointed one, to a family member or friend and, if you wish, to your solicitor.

If you are admitted to hospital, make sure the hospital staff know that you have an Advance Health Care Directive and either give them a copy of it or tell them where a copy can be obtained.

SECTION 1: YOUR DETAILS

It is strongly recommended that, before completing this document, you discuss it with your family and/or Health Care Team (i.e. your general practitioner and nursing staff in the Residential Aged Care Facility where you are living). Your doctor will be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decisions you have made in the document and will also complete and sign Section 5 of the document. You must also sign that Section, as well as Section 6.

Complete this section by writing on the lines.

TO MY FAMILY, FRIENDS AND HEALTH-CARE PROVIDERS

1. I, _____
[Print your full name here]

of _____
[Print here the name of the Facility and the suburb it is in]

State: _____ Postcode: _____

Born on: _____
[Print here the date of your birth]

make this directive after careful consideration and of my own free will. If at any time I am unable to take part in decisions about my medical care, let this document stand as evidence of my views, wishes and beliefs about my quality of life and the medical treatment I require. I request that all who are responsible for my care respect the directions given in this document.

This directive should never be used if I have the capacity to speak competently for myself or if there is evidence that it has been revoked.

SECTION 2: GENERAL INSTRUCTIONS

(Complete this section by ticking the appropriate boxes and writing on the lines.)

2. **If I temporarily lose capacity and am unable to give directions for my health care because of injury or illness, I want my health-care providers to give me:**

- all treatment available in this Facility
- all available treatment except for:

[Use these lines to describe any treatment you would not want to have in any circumstances]

SECTION 3: ACCEPTABLE LEVEL OF FUNCTIONING

Question 3 provides a list of conditions that some people would consider unacceptable. Not everyone will have the same list. Read through the list, and circle the number that matches how acceptable that condition would be to you. You may also add anything else that you would consider to be unacceptable for a good quality of life.

3. How acceptable would the following levels of functioning be to you? (Please circle one number for each statement)

Level of Function	Unacceptable	Neither	Acceptable
(a) not being able to recognise people who are important to you	1	2	3
(b) not being able to communicate	1	2	3
(c) not being able to eat by mouth	1	2	3
(d) not having control of your bladder and bowels	1	2	3
(e) Other 1 (Please specify)	1	2	3

Now complete Question 4: Consider the points carefully, then tick the box next to each statement that you want to apply to you and write your initials on the line that follows the statement. If there is any point that you do not wish to apply to you, draw a line across that part and write your initials on the line.

4. If my condition includes a level of functioning which I have said would be unacceptable to me, I request that:

<input type="checkbox"/>	everyone responsible for my care provide <i>only</i> those measures that are considered necessary to maintain my comfort and dignity, with particular emphasis on the relief of pain.	_____
		<i>[Initial here]</i>
<input type="checkbox"/>	any treatment that might obstruct my natural dying either not be started or be stopped.	_____
		<i>[Initial here]</i>
<input type="checkbox"/>	unless required for my dignity and comfort as part of my palliative care, no surgical operation is to be performed on me.	_____
		<i>[Initial here]</i>

SECTION 4: ADMISSION TO HOSPITAL

Because you are living in a Residential Aged Care Facility, it is highly likely that you need assistance with basic activities of daily living. Despite this, you may still find life interesting and enjoyable. However, there may come a time when you feel that your quality of life is no longer acceptable to you and at this time you may prefer that the focus of your care be on maintaining your comfort and dignity. The care required to achieve these goals can usually be well managed by the nursing staff in the facility where you are living, together with your General Practitioner.

5. If your condition included a level of functioning that you have said would be unacceptable to you and if you experienced any of the following conditions, would you prefer to be kept comfortable in the facility where you live or would you rather go to hospital?

(Please circle one number on each line)	Stay in RACF	Go to Hospital
(a) a severe infection	1	2
(b) breathing difficulties	1	2
(c) pain that was difficult to control	1	2
(d) a broken bone (e.g. arm or hip)	1	2
(e) chest pain	1	2

Palliative Care at the End-of-Life

Palliative Care is competent and compassionate care for people who are at the end stage of their lives. It provides relief from pain and other distressing symptoms and includes supporting residents and their families with psychological and spiritual care. It also provides care to family members and close friends of the resident after the resident has died.

Palliative care aims to maintain comfort and dignity, and can usually be provided in the facility where you live, by the nurses you know and your general practitioner.

6. If you could no longer speak for yourself and you had reached a stage where you required end-of-life palliative care, would you prefer to remain in the facility where you live or would you prefer to be transferred to hospital?

(Please circle one number only)	Stay in RACF	Go to Hospital
(a) Preferred place for end-of-life care	1	2

7. Do you have any particular wishes about your health care other than those listed above?

- No - *Go to Section 5*
- Yes.

8. Record your wishes here. (For example, you may wish to write something similar to the following: 'I value life, but not under all conditions. I consider dignity and quality of life to be more important than mere existence' or 'I request that I be given sufficient medication to control my pain, even if this hastens my death'.)

SECTION 5: DOCTOR INVOLVEMENT

It is strongly recommended that, before completing this document, you discuss it with your general practitioner. The doctor will then be able to explain any medical terms that you are unsure about and will also be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decisions you have made in the document.

After the doctor signs this section, facility staff will ask an independent witness (such as a Justice of the Peace, a Lawyer or a Clerk of the Courts) to sign Section 7 - this does not have to be done on the same day.

9. Doctor's name: _____

Doctor's address: _____

Postcode: _____ Doctor's telephone number: _____

10. Statement of nominated doctor

(a) I have discussed this document with _____ (name of resident) and, in my opinion, he/she (cross out he or she where applicable) is not suffering from any condition that would affect his/her capacity to understand the things necessary to make this directive, and he/she understands the nature and likely effect of the health care described in this document, and

(b) *(tick one box only)*

_____ (name of resident) signed this part of this document in my presence,

in my presence, _____ (name of resident) instructed another person to sign this part of this for him/her, and the person signed it in my presence and in the presence of _____ (name of resident),

(c) I am not

- the person witnessing this Advance Health Care Directive
- or the person signing the Advance Health Care Directive for the principal
- or an Enduring Guardian of the principal
- or a relation of the principal or of an Enduring Guardian of the principal
- or a beneficiary under _____ (name of resident) will.

X _____
[Principal signs here]

X _____
[Doctor signs here]

[Doctor writes the date here]

SECTION 7: WITNESS’S CERTIFICATE

IMPORTANT NOTICE TO THE WITNESS

Your role goes beyond ensuring that the signature of the principal (the person making the directive) is genuine. You certify that the principal appeared to understand the decisions he/she made in the document. In the future, you may have to provide information about the principal’s capacity to understand these matters when making the directive. Check that the section 5 has been completed by a doctor. If you are doubtful about the principal’s capacity, and it is more than 1 month since the doctor signed the document, it is strongly recommended that you discuss this with the principal’s doctor.

As witness, you complete this section by writing on the lines and ticking the appropriate boxes.

12. I, _____, state that:
[Print your full name here]

- a) I am at least 18 years of age;
- b) I am a Justice of the Peace/Lawyer/Clerk of the Courts; *(cross out whichever do not apply)*
- c) I am not an Enduring Guardian for the principal or a relation of the principal, or a relation of the principal’s Enduring Guardian (if any) or a beneficiary under the principal’s will or a current paid carer or health-care provider for the principal.
- d) I have verified that Section 5 of this document has been signed and dated by a doctor.
- e) *(Tick one box only)*
 - the principal signed this directive in my presence
 - in my presence, the principal instructed another person to sign for the principal,
 - and the person signed it in my presence and in the presence of the principal,and
- f) at the time that this directive was signed, the principal appeared to me to understand the decisions he/she made in the document.

X _____
[Witness signs here]

SECTION 8: REVIEW OF THIS DOCUMENT

It is strongly recommended that you review this document every 6 months as your wishes may change or, if the state of your health changes significantly.

Each time you review your document, if your wishes have not changed, sign and date one of the acknowledgments below. If your wishes have changed a great deal, you should complete a new document.

REVIEW OF DOCUMENT: 1

I affirm that I have reviewed this document and that there is nothing I would like to change.

Signature: _____

Date: _____ 20____

REVIEW OF DOCUMENT: 2

I affirm that I have reviewed this document and that there is nothing I would like to change.

Signature: _____

Date: _____ 20____

If you have any queries in relation to the form, please contact the Aged Services Learning & Research Collaboration, Southern Cross University; .email: aslarc@scu.edu.au or telephone: 02 66593197