Quality Domain **HEALTH** **How is My Health?** *How I Manage a Resident's Health*	Aged Care Services ***Advance Care Planning Form***	

Resident Name: ………………………………………………………..……………

Room No.: …………………………

Place Photo Here

D.O.B: ………………………………

Advance Care Planning has been demonstrated to reduce the burden of decision making during crisis situations, and facilitates clearer understanding of the resident's wishes for the management of both life-limiting and life-threatening illnesses, as well as during end-of-life care.

The purpose of this Advance Care Plan is as a communication tool between you, your representatives and staff to ensure that in all circumstances your wishes are known and upheld. Whilst it is not mandatory to complete this form we strongly advise that you do so.

Further information is available in the booklet *"Affirming Life: What is a Palliative Approach?: A guide for family and friends with loved ones in aged care."* Appointments can also be made with the Clinical Care Coordinator.

	Date	Initials
Person completing this Plan: ☐ Competent Resident. Note: if resident is not competent one of the following persons should complete this form: ☐ Enduring Power of Attorney (Medical) *Vic only* ☐ Guardian ☐ Person responsible		
Is there already a documented plan or request list for your management?: ☐ No ☐ Yes *(please provide a copy)*		
CARDIOPULMONARY RESUSCITATION (if there is no pulse and no breaths) ☐ **Attempt resuscitation**/CPR *Note – CPR could include compressions to the chest which can sometimes result in rib fractures, needles and tubes placed in your arms or legs to administer fluids and/or drugs, and tubes placed in your throat to assist your lungs.* *These interventions may or may not restore life.* ☐ **Do Not Attempt resuscitation**/DNR *Note : only the resident or the resident's GP can choose this option*		
MEDICAL INTERVENTIONS (if there is a pulse and/or breaths) ☐ **Comfort Measures** (Allow Natural Death) – relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital **for comfort needs** (should needs not be able to be met in current location). *Treatment plan* : **maximise comfort through symptom management** ☐ **Limited Additional Interventions** – in addition to the care described in Comfort Measures, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. Use less invasive airway support (eg. CPAP, BiPAP) as indicated. **Transfer to hospital** if indicated. *Treatment plan* : **provide basic medical treatments** ☐ **Full Treatment** – in addition to the care described in Comfort Measures and Limited Additional Interventions, use intubation, advanced airway interventions and mechanical ventilation as indicated. **Transfer to hospital and/or intensive care unit** if indicated. *Treatment plan* : **full treatment including life support measures in the intensive care unit**		
Additional Orders: …………………………………………………………………………….. ………………………………………………………………………………………………..		

General Practitioner; *I have explained the various medical options, including the process of CPR, to the stated resident, Enduring POA (Medical), Guardian or Person Responsible (as appropriate) / These CPR and medical intervention orders are consistent with the resident's current medical condition and known wishes (non competent residents)*

Name:……………………………..………….. Signature: ………………….……..…..………… Date:……………..

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What are the things that matter most to you? (eg. family & friends, independence, spiritual or cultural beliefs)

………………………………………………………………………………………………………

………………………………………………………………………………………………………

………………………………………………………………………………………………………

Do you wish to follow the rites & traditions of any particular faith/religious denomination? Date Initials

☐ No ☐ Yes *(see below)*

If yes, please specify the faith or religion type and the particular rites and/or traditions that you wish to follow or to have done:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

When the time comes that you are nearing death, please list anything that you would like to take place *(please provide details)***:** Date Initials

☐ People I would like to be present ……………………………………………………………

………………………………………………………………………………………………………

☐ I would like people to talk to me and hold my hand, even if I don't seem to respond

☐ I would like people to pray for me

☐ I would like the following customs and/or cultural beliefs taken into account ……………………..

………………………………………………………………………………………………………

☐ I would like my favourite music to be played …………………………………………………

………………………………………………………………………………………………………

☐ Other ……………………………………………………………………………………………

………………………………………………………………………………………………………

☐ What I particularly don't want is …………………………………………………………….

………………………………………………………………………………………………………

Can we call your contact person during the night if required? ☐ Yes ☐ No Date Initials

Details of persons involved in Advance Care Planning discussion:

Name	*Relationship to Resident*	*Date of Discussion*

Details of staff members involved in Advance Care Planning discussion:

Name	*Designation*	*Date of Discussion*

Resident or Representative:

Name: Signature: Date:

This Advance Care Plan has been reviewed and does not require any changes to be made

Date	Name	Designation	Signature

Date	Name	Designation	Signature

OFFICE USE ONLY

☐ Noted in PeoplePoint Progress Notes ☐ Note ACP *on Summary of Daily Care Needs*

File this document in the front of the resident's paper file