Desktop Dispatch

GPHLO Information for Busy Practitioners

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Advance Care Planning

In the acute care setting, end of life decisions often have to be made quickly and in crisis, and without the opportunity for individuals to discuss options with family members. This can contribute to additional stress during difficult periods as well as conflict among family members. Advance care planning can help patients put procedures in place to ensure that their choices for future care will be heard and respected in the event of lost capacity.

For this reason, end of life decisions as part of Advance Care Planning should be considered in the primary health environment. Queensland Health has developed resources to encourage patients consider Advance Care Planning, with general practice encouraged to address these issues with patients.

To assist patients with Advance Care Planning, the following steps are advised:

1. T**hinking** about it - Consideration should be given for preferences for future health care and treatment and what would be important at the end of life. This includes consideration of such issues as where the individual wants to live, types of home services and funeral planning.

2. **Discussing** the choices and decisions the individual has made and are still thinking about with family and friends.

3. **Encouraging** the patient to discuss choices for future health care and any concerns with their GP – seeing what is possible and planning for it. As their GP, you can advise about healthcare options, the implications of choices and clarify what might happen if patients want to receive or refuse certain kinds of medical treatment.

4. **Deciding** on future health care preferences, and letting family and friends know. It is important to inform all involved about the choices that have been made.

5. The fifth step is optional and involves formally **recording** choices and/or nominating one or more people to make decisions on the behalf of the patient. This will involve completing legal documents such as an Advance Health Directive or Enduring Power of Attorney. It is important to note that these documents come into effect ONLY once patients lose the capacity to make or communicate decisions about health care.

6. Ensuring **copies** of legal documents are provided to necessary people, including family members, close friend, GP or local hospital.

7. Regularly **reviewing** advance care planning documents - All stages of advance care planning are entirely voluntary. Remind patients that they are able to change their mind and plans at any time while they have capacity. No one should be forced into advance care planning.

Resources for patients and general practice:

The Advance Care Planning Booklet can be downloaded for further information.

The Advance Care Planning Brochure can be downloaded for more information.

Do you have an idea, a problem or a solution?
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