Gippsland Region Palliative Care Consortium

GRPCC Aged Care News #2

(In the time of the COVID19 pandemic)

Welcome to the second biweekly newsletter we will be circulating to RACFs in Gippsland over the next few months in response to the COVID 19 pandemic.

Please find below a quick reference guide to advance care planning documents and access links. Many thanks to SMRPCC for sharing this resource.

Our next Aged Care Network Meeting on ZOOM will be this week, Thursday 23rd April at 1.30pm. This is an informal 30 min meeting for RACFs to come together for a supportive discussion and an opportunity to discuss any concerns or issues. Our guest this week will be Bernie Wicks, Grief and Bereavement Counsellor with GRPCCS.

Carol

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Advance Care Directives: What Form Do I Use?

When entering a permanent residential facility, ALL residents with capacity should be offered an opportunity to complete an Advance Care Directive. If the resident lacks capacity to complete an Advance Care Directive, others who know them well can record what is known of the person's preferences and values on a different type of form (this form is not an Advance Care Directive). In addition, EVERY resident should have a Goals of Care – Medical Treatment Order form (or similar) completed by their doctor

If a resident enters your facility with a completed Advance Care Directive or other Advance Care Planning document, please place a copy of this in their file. DO NOT transcribe the details on to one of the facility forms. Check that all the information is current and relevant (date and ask the person to re-sign the document). Note, that if a person has completed an Advance Care Directive and has then lost capacity to make their own medical decisions, that Advance Care Directive cannot be changed, nor should anyone else re-sign it.

Form Name	Who is it for?	Where do I get it?
Goals of Care – Medical Treatment Order	EVERYONE – every resident who enters a care home should have a Goals of Care – Medical Treatment Order form completed by their GP in consultation with the resident and / or their Medical Treatment Decision Maker.	www.nh.org.au/resources-for-people-who-lack-capacity-to-undertake-advance-care-planning/ Click on "Generic Goals of Care" under Medical Treatment Plan
Advance Care Directive for Adults Values Directive section	Individuals who have capacity to communicate their own preferences and values for future medical treatment, should they lose medical decision-making capacity	www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms Click on Advance Care Directive For Adults
Advance Care Directive for Adults Instructional Directive section	Individuals who have capacity for medical decision making and want to consent to or refuse specific treatment in advance for a time when they might lose medical decision-making capacity. – **remember** if a resident has completed an instructional directive, this is binding consent or refusal, and cannot be overridden by the Medical Treatment Decision Maker or other family.	www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms Click on Advance Care Directive For Adults
Advance Care Directive for Adults For Someone Completing Signing On Your Behalf	Individuals who have cognitive capacity but may not have the physical capacity to complete a written document. The individual directs their nominated person to complete the form identifying their preferences and values	www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms
Preferences and Values Form for Another Person	Individuals who do not have the cognitive capacity to complete their own Advance Care Directive. May be completed by their Medical Treatment Decision Maker or others who know them well.	Northern Health Advance Care Planning website. www.nh.org.au/resources-for-people-who-lack-capacity-to-undertake-advance-care-planning/