

Advance care planning: have the conversation

Module 5: Record – How to document
the conversation



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Module 5: Record – How to document the conversation

Healthcare settings: GP practice, hospital, aged care

Target skills: communication skills, confidence, knowing your role

Time: 10 mins

5.1 A 10 step guide to recording the conversation

Many health services have procedures for how an advance care directive is developed, recorded, reviewed, stored, retrieved and activated. Become familiar with the storage and alert systems within your service. If there is no procedure in place, assist your service to develop a system to support advance care planning.

1. Document advance care planning discussions in the patient's clinical record in the designated location (such as My Health Record (formerly Personally Controlled Electronic Health Records (PCEHR)), the legal section or the advance care planning discussion record).
2. Assist the person to create an advance care directive using clear and unambiguous language that is easily understood. This should be done in the patient's own words, making sure that it will be clear to doctors and medical treatment decision makers who read the document in the future. Note that an advance care directive does not need to be written in the patient's handwriting, and another person can transcribe the patient's preferences and values.
3. Document the patient's values, preferred outcomes and medical treatment preferences using for example:
 - a template developed by health services or peak bodies,
 - a free-form letter.
4. Identify the medical treatment decision maker.
5. If the patient chooses, they can use the standard form to:
 - appoint one or more medical treatment decision-makers.
6. Give the original advance care planning documents (advance care directive and appointment of medical treatment decision maker) to the patient.
7. Place an advance care directive alert in their physical and/or electronic medical record.
8. Place a copy of the advance care directive in their medical record in the designated location.
9. Ask the patient to make sure the medical treatment decision maker has copies of the advance care directive.
10. With the patient's consent ensure that other treating doctors, including specialists, their GP or residential aged care facility, medical deputising services if used, and other relevant family members, are provided with copies of the advance care directive.

In general practice settings, it may be appropriate to ask the patient to complete an advance care directive in conjunction with their medical treatment decision maker independently and then review the document with the patient.

5.2 How to write it down

If a patient decides they want to create an advance care directive their doctor should encourage them to make it as clear as possible. This means making the document clear about the circumstances in which the patient wants it to apply and ensuring they have considered the consequences of this. If the patient wants to include statements about specific medical treatment, they should explain the basis for this decision and the circumstances in which they want it to apply. If the patient wants to include more general statements about their values, they should ensure these can be understood and applied by their medical treatment decision maker.

5.2.1 Legal requirements

- There are a number of legal requirements that must be met to create an advance care directive. If a document does not meet these requirements it may still be considered by a medical treatment decision maker, but it will not have the same legal force.
- To be valid, an advance care directive must:
 - be in English;
 - include the full name, date of birth, and address of the person giving it;
 - be signed by the person giving it (or by another person at their direction).
- The advance care directive must be witnessed by a medical practitioner and one other adult witness.
- The Department of Health and Human Services has developed a standard form that may be accessed at health.vic.gov.au

5.2.2 Use correct language

- If you are unsure that you have used the appropriate language, think about the 2.00am test – *would another doctor be able to understand what you have written in an emergency at 2.00am?*
- Help the patient to relate their advance care directive to their current health status. An advance care directive that clearly contemplates the current clinical circumstances of the patient will be more informative. However, note that if a patient is healthy and well they may still wish to document their preferences should they become unwell (e.g. as a result of a car accident, heart attack etc).
- Encourage the patient to use appropriate wording. An advance care directive will be stronger if it avoids vague or imprecise language. For example, to say, 'I refuse life-sustaining treatment unless I can be sure of a reasonable quality of life' is very difficult to apply because the question of what is 'reasonable' will vary from person to person.
- Similarly, references to specific treatments may not be relevant to their specific health status. Instead, advance care planning should be derived from a values-based discussion with the patient, where the patient identifies their own goals and values in their own words (e.g. I would like to live in my own home, or be near my family) as opposed to specific information about medical treatments.
- Encourage the patient to record the 'why' behind patient preferences; and not just the 'what'. Knowing why a patient has particular treatment preferences allows that information to also be applied to a different, unanticipated medical event.

5.2.3 Witnessing an advance care directive

- To be valid, an advance care directive must be witnessed by a medical practitioner. The medical practitioner must certify that, at the time of signing the advance care directive, the person:
 - appeared to have decision-making capacity in relation to each statement in their advance care directive;
 - appeared to understand the nature and effect of each statement in their advance care directive.
- The advance care directive must be witnessed by a medical practitioner and one other adult witness.
- The Department of Health and Human Services has developed a standard form that may be accessed at health.vic.gov.au
- A medical practitioner is witnessing the document in their role as a medical practitioner, and as such must bring their professional knowledge and skills to this task.
- To assess whether a patient understands the nature and effect of each statement in their advance care directive, a doctor must discuss these statements with the patient and ensure they understand their implications.
- This is particularly important if the person has included broad statements and the patient may have not considered how these statements could be applied in particular instances. For example, the statement 'I refuse cardiopulmonary resuscitation in all circumstances' should be discussed and a medical practitioner must ensure the person is aware that this could be applied in a broader range of circumstances than chest compression.
- A medical practitioner is under no obligation to witness an advance care directive if they do not believe the person meets the above requirements. In these circumstances the practitioner must not sign the document.

