

Advance Care Planning in NSW

<http://advancecareplanning.org.au/resources/new-south-wales>

This website has a lot of information and links to all the websites and forms needed:

In NSW the components of an advance care plan are:

- **Enduring Guardian** – legally appoint a substitute decision maker under the Guardianship Act 1987. Must be in the approved form.
- **Advance Care Directive** – to provide specific information relating to your wishes, values, and any treatments you would not wish to receive. Can be on a form, or in some other way, for example a letter. Supported under common law.

Forms:

[Enduring Guardianship in New South Wales: your way to plan ahead](#) - Information booklet, including forms, from Office of the Public Guardian NSW
[Advance Care Plan](#) - prepared by Hunter New England Local Health District

OR:

NSW Advance Care Directive Comprehensive Form by C.Cartwright

The form below and or website can also be printed and used

http://dwdnsw.org.au/documents/2013/ACD_CC_1308.pdf

Dying with Dignity NSW wishes to thank Professor Colleen Cartwright and the ASLaRC Aged Services Unit of Southern Cross University for their permission to reproduce parts of this NSW advance care directive.

For further information supporting this document please see the ASLaRC Aged Services Unit website www.scu.edu/aslarc/ or the Personal Researcher Page of Colleen M Cartwright www.works.bepress.com/colleen_cartwright/

For further information about ACDs and Enduring Guardianship please see the Dying with Dignity NSW document Guide to NSW Advance Care Directive & Appointment of Enduring Guardian - printed February 2013.

Completing

an advance care directive form

and appointing an Enduring Guardian

gives you the best chance of ensuring that you will not be given unwanted medical treatment at the end of life. It can also make it easier for your family and health care providers to understand and respect your wishes.

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Section A: Your Details

It is strongly recommended that, before completing this directive, you discuss it with your

General Practitioner or a specialist medical practitioner who knows your medical history

and views. The doctor will 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 any condition that would

affect your ability to understand the decisions you have made in the document.

Complete

this section by writing on the lines.

1. To my family, friends and health-care providers

I, _____

[Print your full name here]

of _____

[Print here your address here]

New South Wales Postcode: _____ Date of Birth: _____

being over the age of 18 years, 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 health care and medical treatment, let this document stand as

evidence of my views and wishes in relation to the care and treatment I do or do not want.

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. I request that all who are responsible for my

care respect and uphold the instructions given in this Directive.

Section B: General Treatment Instructions

In this section you are asked to identify and explain how any existing health conditions or

religious values might impact future health care and medical treatment decisions.

You are

also asked to think about treatment you do or do not want if you are temporarily unable

to communicate your wishes. Complete this section by ticking the appropriate boxes and

writing on the lines.

2. Are there any special conditions that your health-care providers should know about, such as asthma or any allergy to medication?

Q Yes – complete 2(a)

Q No

2(a). Describe these special conditions here (for example, ‘I develop a severe rash when given penicillin’ or ‘I have insulin-dependent diabetes’):

3. Do you have any religious beliefs that may affect your health care and medical treatment?

Q Yes – complete 3(a)

Q No

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3(a). Describe here how your religious beliefs might affect your health care and medical treatment (for example, ‘Because of my religious beliefs, I do not want to receive any blood transfusions or organ transplants’).

4. If you have temporarily lost capacity and were unable to give directions for your health care and medical treatment because of injury or illness, what level of treatment would you want your health provider to give you? (for example, there may be some treatments that you would not wish to receive under any circumstances). Please tick one of the two options below.

Q all available treatment

Q all available treatment except for:

Section C: End-of-Life Treatment Instructions

In this section you are asked to give specific instructions for future health care and

medical treatment decisions you do or do not want, if you are terminally ill.

Definitions of terms used in this section

- Irreversible: unable to be turned around – there is no possibility that the patient will recover.
- Terminal phase of an irreversible illness: the person is dying and the process is irreversible. Life expectancy is usually considered to be just a few days.
- Permanent unconsciousness (coma): when brain damage is so severe that there is little or no possibility that the patient will regain consciousness.
- Persistent vegetative state: severe and irreversible brain damage, but vital functions of the body continue (e.g. heart beat and breathing).

• Palliative care: compassionate care for people with a terminal illness, focused on prevention of suffering and relief from pain and other distressing symptoms.

• Life-sustaining measures: treatments (medical procedures) that replace or support an essential bodily function (e.g. cardiopulmonary resuscitation, artificial ventilation, artificial nutrition and hydration, dialysis).

(i) cardiopulmonary resuscitation: emergency measures to keep the heart pumping (by massaging

chest or using electrical stimulation) and artificial ventilation (mouth-to-mouth or ventilator) when

breathing and heart beat have stopped.

(ii) assisted ventilation: use of a machine, such as a ventilator, to help the patient breathe when

he/she is unable to breathe unaided.

(iii) artificial feeding and hydration: provision of food and fluid by artificial means when the patient is unable

to eat or drink. This may be done by passing a tube through the nose into the stomach or by inserting a tube into

a vein or directly into the stomach. (If you do not have artificial feeding, your mouth will still be kept moist.)

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5. If in the opinion of my treating medical practitioner I am:

(NB: Your treating medical practitioner may not always be your usual doctor if you become extremely

ill. He or She will be the medical practitioner (doctor) who is providing your treatment at the time your

directive will be used to inform your care and treatment.)

• in the terminal phase of an irreversible illness or condition; or

• in a persistent vegetative state; or

• permanently unconscious; or

• so seriously ill or injured that I am unlikely to recover to the extent that I can survive without the

continued use of life-sustaining measures

Or I am in any of the following states that I consider to be an unacceptable quality of life, and the

state is permanent (tick all that apply):

Not being able to recognise people important to me

Not being able to communicate

Not being able to eat by mouth

Not having control of my bladder and bowels

Other (please specify)

Then, I request that everyone responsible for my care (tick all that apply):

Provide treatment for my comfort and dignity ONLY, with particular emphasis on pain relief

Withhold or withdraw treatment that might obstruct my natural dying

Q Do NOT perform surgery on me, unless required for my comfort and dignity
In the following optional section you can give more specific instructions for treatment you do or do not want, under four specific conditions. If you think that your decisions listed in statement number 5 above would be sufficient to guide your treating doctors, you may draw a line through each of the following sections and write your initials on the line.

6(a). If I am in the terminal phase of an incurable illness:

I do not want cardiopulmonary resuscitation. Initial here: _____

I do want cardiopulmonary resuscitation. Initial here: _____

I do not want assisted ventilation. Initial here: _____

I do want assisted ventilation. Initial here: _____

I do not want artificial hydration. Initial here: _____

I do want artificial hydration. Initial here: _____

I do not want artificial nutrition. Initial here: _____

I do want artificial nutrition. Initial here: _____

I do not want antibiotics unless needed as part of my palliative care. Initial here: _____

I do want antibiotics. Initial here: _____

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Other treatment (specify):

I do not want _____ Initial here: _____

I do want _____ Initial here: _____

6(b). If I am permanently unconscious (in a coma):

I do not want cardiopulmonary resuscitation. Initial here: _____

I do want cardiopulmonary resuscitation. Initial here: _____

I do not want assisted ventilation. Initial here: _____

I do want assisted ventilation. Initial here: _____

I do not want artificial hydration. Initial here: _____

I do want artificial hydration. Initial here: _____

I do not want artificial nutrition. Initial here: _____

I do want artificial nutrition. Initial here: _____

I do not want antibiotics unless needed as part of my palliative care. Initial here: _____

I do want antibiotics. Initial here: _____

Other treatment (specify):

I do not want _____ Initial here: _____

I do want _____ Initial here: _____

6(c). If I am in a persistent vegetative state

I do not want cardiopulmonary resuscitation. Initial here: _____

I do want cardiopulmonary resuscitation. Initial here: _____

I do not want assisted ventilation. Initial here: _____

I do want assisted ventilation. Initial here: _____

I do not want artificial hydration. Initial here: _____

I do want artificial hydration. Initial here: _____

I do not want artificial nutrition. Initial here: _____

I do want artificial nutrition. Initial here: _____

I do not want antibiotics unless needed as part of my palliative care. Initial here: _____

I do want antibiotics. Initial here: _____

Other treatment (specify):

I do not want _____ Initial here: _____

I do want _____ Initial here: _____

6(d). If I am so seriously ill or injured that I am unlikely to recover to the extent that I can live without the use of life-sustaining measures:

I do not want cardiopulmonary resuscitation. Initial here: _____

I do want cardiopulmonary resuscitation. Initial here: _____

I do not want assisted ventilation. Initial here: _____

I do want assisted ventilation. Initial here: _____

I do not want artificial hydration. Initial here: _____

I do want artificial hydration. Initial here: _____

I do not want artificial nutrition. Initial here: _____

I do want artificial nutrition. Initial here: _____

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I do not want antibiotics unless needed for my comfort and dignity Initial here: _____

I do want antibiotics. Initial here: _____

Other treatment (specify):

I do not want _____ Initial here: _____

I do want _____ Initial here: _____

End of Optional Section 6

Section D: PERSONAL STATEMENT

If you have any specific views about particular types of health care or special health matters that have not

already been covered in this directive, you can record them in this section. It is recommended that you discuss

this section with your doctor before completing it, as it is important that anything you write should be readily

understood by medical staff who are treating you.

It is your legal right to refuse any medical treatment. However, you may not be entitled to insist on receiving

a particular treatment (for example, if your doctor's professional opinion is that the treatment would not be of

benefit to you). You also cannot demand access to treatments which are currently deemed to be against the law

of NSW, such as medically assisted dying.

7. Do you have any other particular wishes about your health care or medical treatment that have

not already been covered in this form? (for example, you may wish to write something like: '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'.

Q Yes – complete 7(b)

Q No

7(b). Record your wishes here.

Section E: TISSUE / ORGAN DONATION

8. Have you given consent for the removal of your tissue/organs after death with the Australian Organ Donor Register

Q Yes

Q No

For more information about tissue and organ donation go to

www.donatelife.gov.au/decide or

call 1800 777 203 or visit your local Medicare Customer Service Centre

8(b). (Optional) Record any comments about tissue donation that you would like to

make.

Section f: RESIDENTIAL CARE (OPTIONAL SECTION)

On this page you may record your wishes for care or treatment that you want, or do not want, if you are ever

living in a Residential Aged Care Facility (RACF). (Note: Residential Aged Care Facilities were previously called

hostels or nursing homes). If you are currently living in a RACF it is strongly suggested that you complete

this Section now. If you are not currently living in a RACF you may still choose to complete this Section but you

should review it if, at some future time, you do become a resident in a RACF.

If you are living in a RACF, it is highly likely that you need assistance with basic activities of daily living. Despite

this, we hope that you 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 RACF together with your General Practitioner.

Question 9 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 in a RACF.

9. 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 (Please specify) _____

1 2 3

10. If you were in a RACF, and your condition included a level of functioning that you have said

would be unacceptable to you, would you prefer to be kept comfortable in the RACF or

would you rather go to hospital, if you experienced any of the following conditions (remember, your directive will only be used if you can no longer speak for

yourself):)

(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

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Palliative Care at the end of life.

Palliative Care (defined in Section C) at the end of life can usually be provided in the RACF, by the nurses you know and your General Practitioner. Alternatively, your end-of-life care could be provided in

a local hospital. This would require that you be transferred to hospital in an ambulance and admitted to

a ward via the Emergency Department.

The way in which your end-of-life care is managed should be the same, whether you are in the RACF

or if you go to hospital. However, what will be different will be whether you require transportation to

hospital, the location of care and the staff who provide the care.

11. If you were in a RACF and 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 RACF or would you prefer to be transferred to hospital?

(Please circle one number on each line) Stay in RACF Go to Hospital

(a) Preferred place for end-of-life care 1 2

Note: If you choose not to complete this section, please draw a line through both pages before you

sign the document. If at a later stage you are admitted to a RACF you may wish to complete a new

Advance Care Directive, including this Section.

End of Optional Section F

Section G: Enduring Guardianship

This section relates to whether you have appointed an Enduring Guardian to make

decisions on your behalf about your health care and other personal matters, if you

are no longer able to do so, and to advocate on your behalf to ensure that your

wishes are respected.

12. Have you appointed an Enduring Guardian?

Q Yes – attach a copy of your Appointment of Enduring Guardian form to this ACD

Q No - consider whether you would like to appoint one or more Enduring Guardians

Note: Dying with Dignity NSW supports the position of NSW Health that completing both an

Advance Care Directive and an Appointment of Enduring Guardian nomination form

gives you the best chance of ensuring that you will not be given unwanted medical treatment at the end of life. These forms can also make it easier for your family and health care providers to understand and respect your wishes.

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Section H: Doctor's Involvement

In this section you need to obtain your doctor's signature to confirm that you have discussed the instructions in this directive with him/her and that the doctor is confident that you understand the nature and likely effect of the directions stated in the directive. Your doctor and your independent witness (see Section J) do not have to sign on the same day.

Doctor's name: _____

Doctor's address: _____

Postcode: _____

Doctor's telephone number: _____

Statement of nominated doctor

(a) I have discussed this document with the principal and, in my opinion, he/she 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)

the principal signed this document 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.

(c) I am NOT

the person witnessing this advance care directive, or

the person signing the advance 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 the principal's will.

x_____ x_

[Principal signs here] [Doctor signs here]

[Doctor writes the date here]

13. If this directive is ever required for your health care and medical treatment, do you want the

doctor named above to be consulted by your treating medical practitioner?

Q Yes

Q No . This is not necessary.

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Section I: Statement of Understanding and Signature

In this section you are asked to declare that you fully understand the instructions you have given

in this directive. Read through it carefully and then sign on the line that follows.

I understand:

Q the nature and the likely effects of each instruction stated in this directive;

Q that an instruction operates only while I have impaired capacity for the matter covered

by the direction;

Q that I may change or revoke an instruction in the directive at any time where I have the

capacity to make a decision about the matter covered by the instruction;

x_____ x_

[Principal signs here] [Witness signs here]

_____/_____/20

[Witness writes the date here]

If you are not physically able to sign for yourself, you may have another person sign the directive

on your behalf, but you must be in the presence of the witness when you instruct that person to

sign for you and when he/she actually signs. He/she must be at least 18 years old and must not be

the witness to this document or your Enduring Guardian. Any person who signs on your behalf

should print his/her name and designation (e.g. nurse, doctor, neighbour, daughter) in the space

indicated, tick the boxes, and then sign the statement with his/her own signature.

or If you are signing for the principal (as per the circumstances explained above):

I, _____, state that:

[print your full name here]

Q I am at least 18 years old

Q I am not a witness for this advance care directive or an Enduring Guardian for the principal.

x_____ /_____/20_____

[Person signing for the principal signs here] [Write the date here]

x_____ /_____/20_____

[Witness signs here] [Witness writes the date here]

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Section J: Witness' Certificate

To give this Advance Care Directive the best possible legal status, you should sign it in front of

a qualified witness - that is, a Justice of the Peace, a Solicitor or a Registrar of the

Court. The witness should not be your Enduring Guardian, a relation of your Enduring Guardian, your current paid carer* or your current health care provider.

*Note: "Paid carer" does not mean someone receiving a carer's pension or similar benefit.

If you are not physically able to sign for yourself, you may have another person sign the directive on your behalf, but you must be in the presence of the witness when you instruct that person to sign for you and when he or she actually signs. See Section I.

In this section your witness is required to certify that:

- the signature of the principal (the person making the directive) is genuine AND
- the principal appears to sign this directive of his or her own free will, without threats or offered inducements AND

- the principal appears to understand the matters stated in Section I

If the witness is in doubt about the principal's capacity, the he or she should insist that the

directive has been signed by the principal's doctor in Section H. The doctor should be in the best

possible position to assess the principal's capacity.

I, _____, state that:

(a) I am at least 18 years of age;

(b) I am a Justice of the Peace/ Solicitor/ Registrar of the Court; (cross out whichever does 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 or a beneficiary under the principal's will or a current paid carer or health-care provider for the principal.

(d) the principal signed this directive in my presence; OR

in my presence, the principal instructed another person to sign for the principal, and the person signed this directive in my presence and in the presence of the principal;

(e) at the time that this directive was signed, the principal appeared to me to be acting by his/ her own free will and without threats or inducements.

(f) I have verified that Section H of this document has been signed and dated by a doctor.
and/ or

at the time that this directive was signed, the principal appeared to me to understand the matters stated in Section I.

_____/20
[Witness signs here] [Witness writes the date here]

In this section you can indicate when you have reviewed this document. Your care or treatment wishes may change or there may be advances in medical technology, therefore it is strongly recommended that you regularly review this document (i.e. ideally every two years or earlier if the state of your health changes significantly). Each time you review your document and 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 advance care directive.

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__ ____

REVIEW OF DOCUMENT: #3

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

Signature: _____

Date: _____ 20__ ____

DWDnsw thanks Professor Colleen Cartwright and ASLaRC Aged Services Unit of Southern Cross University for permission to reproduce parts of this document.