Office of the Public Advocate

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Advance care planning in residential aged care facilities

Contents

The information in this guide relates to the law in Victoria.

What is advance care planning?

Advance care planning is the process of planning for future medical treatment in the event that a person is not capable of making medical treatment decisions.

It is an expression of autonomy, involving making and communicating decisions, and expressing preferences and values.

See the Office of the Public Advocate (OPA) fact sheet *Advance care planning and substitute medical treatment decision making* for further information.

Terms used in this document

The following terms are all defined in the *Medical Treatment Planning and Decision Act 2016* and, when used in this document, are done so consistently with those legal definitions:

- decision-making capacity
- advance care directive which can include an instructional directive and/or values directive
- medical treatment
- medical treatment decision
- medical treatment decision maker
- health practitioner.

Residential aged care facilities Aged Care Quality Standards

Residential aged care facilities must comply with Aged Care Quality Standards[1]:

Standard 1	Consumer dignity and choice
Standard 2	Ongoing assessment and planning with consumers
Standard 3	Personal care and clinical care
Standard 4	Services and supports for daily living
Standard 5	Organisation's service environment
Standard 6	Feedback and complaints
Standard 7	Human resources
Standard 8	Organisational governance.

Standard 2 is particularly relevant to advance care planning. The statement is:

> The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer's needs, goals and preferences.

Part of the requirement of this is:

> ...assessment and planning identifies and addresses the consumer's current needs, goals and preferences including advance care planning and end of life planning if the consumer wishes.

The standards emphasise the rights of consumers to exercise choice and independence, to be supported to do so, to make decisions about their own care and to make decisions about when others should be involved in their care.

1 These Standards commence on 1 July 2019

Why are residents of residential aged care facilities encouraged to consider planning for future medical treatment decisions?

Planning for the future is a good idea for everyone at any stage of life.

However, there are various trigger points in a person's life for when they themselves might wish to engage in advance care planning or a person who cares about them may encourage them to do so:

- significant medical treatment decision making of (or for) a family member or friend, including when that person has died
- diagnosis of terminal or chronic health condition
- admission to a residential aged care facility.

The reason that admission to a residential aged care facility is a trigger point for encouraging advance care planning discussions is that residents there are likely to have multiple and complex medical conditions associated with ageing and the majority of people who enter the facility permanently will die there, or on transfer to hospital.

Consequently, planning for good medical decisions, and end-of-life care, is critical for the wellbeing of residents and their families.

> "How people die remains in the memory of those who live on." (Dame Cicely Saunders, founder of the hospice movement).

Although advance care planning is often associated with end-of-life decision making, it is not specific to that.

Not all residents of residential aged care facilities are necessarily immediately facing end-of-life medical conditions and may be dismayed if it is not made clear that advance care planning is something that all adults are encouraged to engage in, regardless of state of health or age.

Increasingly, people in the community are becoming accustomed to the idea of advance care planning and so incoming residents or their family members may already have engaged in some form of advance care planning.

However, for many people this concept will be new to them.

Options for advance care planning available to residents who have decision-making capacity

Like any other adult, a resident in a residential aged care facility may elect to do any of the following:

(1) appoint a medical treatment decision maker

(2) appoint a support person

(3) make an advance care directive

  (a) instructional directive

  (b) values directive

(4) document their preferences and values in a format other than an advance care directive

(5) discuss their preferences and values with family members and health practitioners.

In relation to options (1), (2) and (3) above, the resident needs to have decision-making capacity to do so.

Most importantly, it is a choice whether to elect to complete any of the documentation. It cannot be a requirement of a residential aged care facility that incoming residents complete such documents in order to be admitted. The Aged Care Quality Standards emphasise the choice and preferences of residents.

Even if a resident does not have decision-making capacity to do options (1), (2) and (3) it will always be open to them to express their preferences and values so long as they are able to do so — and they should be encouraged to.

Presumption of decision-making capacity

An adult is presumed to have decision-making capacity, unless there is evidence to the contrary.

This presumption includes residents of residential aged care facilities. However, clearly in the case of many residents this presumption will be rebutted by evidence to the contrary.

According to Dementia Australia, 52 per cent of residential aged care facility residents have dementia. However, a diagnosis of dementia does not in itself mean that the person lacks decision-making capacity for any specific decision.

The point in time when a resident is admitted to a residential aged care facility will ordinarily be a stressful time for them and may follow some crisis in the community or discharge from hospital.

It is, therefore, possible that for some residents their decision-making capacity may be more impaired at this time when they settle into their new accommodation and lifestyle.

It may, therefore, be wise to wait a while before attempting to engage a person in advance care planning discussions to maximise their capacity for decision-making.

A person has decision-making capacity to make a decision if they are given practicable and appropriate support.

This may mean:

- as suggested, waiting until the person has settled in or their precipitating medical condition has stabilised allowing enough time for discussions, including allowing for several separate discussions
- ensuring that a person who may not previously have thought they needed an interpreter, nonetheless, has an interpreter given the possible complexity of the discussion (noting that it is common for people for whom English is a second language to lose some language capacity associated with dementing processes)
- creating a calm non-conflictual space
- choosing the time of the day when the person is most cognitively alert.

Supporting a person with dementia (or any other cognitive disability) to engage in advance care planning

In addition to the suggestions already detailed, about providing practicable and appropriate support to a person so they can exercise their decision-making capacity, there are some other ways in which any resident can be supported to engage in an advance care planning discussion.

Respect privacy

Some individuals will be prepared to discuss their health-related conditions with family members and others will be reluctant to do so. The privacy of all residents must be respected. If a resident is reluctant to share information, then it is important to reassure them about the reason information is sought and how it will be stored and acted on.

Reassure fears about death and dying

Some individuals will prefer not to discuss health-related matters as the fear of death and dying is very prevalent in the community. The message of advance care planning is that, if you cannot make decisions for yourself in the future, then presumably you want decisions, nonetheless, to be made consistently with your own preferences and values. However, some people may prefer to leave the responsibility of making decisions, in future, to others and this is a choice which should be respected.

Reassure concerns about upsetting others

Some individuals may find it hard to make and communicate choices that they think others may disapprove of or impose responsibilities onto others to make decisions for them. This is why advance care planning is a process — it can take time to think things through, and discuss with relevant people. Allow time and do not pressure the person to make choices they do not want to make or are not yet ready to make.

Ensure collaboration between family members

Family members and others should try to collaborate with each other and have a consistent message to the resident rather than subjecting them to multiple, and conflicting, messages and information.

Respect choices

The point of advance care planning is to promote the autonomy of the person. Therefore, if the person elects not to appoint a medical treatment decision maker or support person or complete an advance care directive, such choices should be accepted and respected.

Similarly, if the resident elects to appoint one adult child in preference to others as their medical treatment decision maker or support person that, too, should be respected.

Options for family members if the resident does not have decision-making capacity

If the resident lacks decision-making capacity to complete an advance care directive they may, nonetheless, be able to discuss their preferences and values with family members and health practitioners, or their preferences and values may already be known to family members.

Family members who are concerned about future medical treatment for the person may want to ensure that the person's preferences and values for medical treatment are given effect to.

The option for family members and others is to complete the: *What I understand to be the person's preferences and values form*.

This is available on the Northern Health website. Also find a link to this form on the 'When a person cannot plan for their future' page of the OPA website.

Refer also to the OPA booklet: *A medical treatment decision maker's guide: For when the person lacks capacity to undertake advance care planning*.

It is important to understand that this documentation does not constitute a medical treatment decision and should not be treated as such. It may, however, be invaluable to a medical treatment decision maker who can take it into account when making any future medical treatment decisions.

The medical treatment decision maker might also request to meet with the resident's general practitioner (GP) to be clear about the resident's medical conditions and any likely decisions that might need to be made in order to think ahead and be prepared, if the time comes.

Decisions a medical treatment decision maker may be asked to make for a person who lives in residential aged care facility

On every occasion a health practitioner offers medical treatment they are legally required to assess if the person has decision-making capacity to make the medical treatment decision.

Only if the answer to that is no, then they need to ascertain if the person has made an advance care directive.

If so, and if it includes a relevant instructional directive, then they respect that medical treatment decision of the person.

If there is no relevant instructional directive then they ask the medical treatment decision maker to make the medical treatment decision.

A medical treatment decision maker may be asked to make the usual range of medical treatment decisions that anyone at any stage of life might need to make (such as dentistry, an annual influenza vaccination) but, in addition, there are a range of medical treatment decisions which routinely arise for most residents in residential aged care facilities.

Medication
Most residents in residential aged care facilities are prescribed multiple pharmaceutical drugs. This might include anti-depressants or medication to manage behavioural and psychological symptoms of dementia. Antibiotics might be prescribed for urinary tract infections or pneumonia.

Podiatry
Many residents will need a podiatrist to attend to feet-related health issues.

Transfer to hospital for treatment
Some treatment may only be possible in a hospital, including scans and diagnostic tests.

How does a medical treatment decision maker make a medical treatment decision?

A medical treatment decision maker must make the medical treatment decision that they reasonably believe is the decision that the person would have made if the person had decision-making capacity.

There are various considerations that the medical treatment decision maker must take into account and they must act in good faith and with due diligence.

It is not possible for a medical treatment decision maker to make a medical treatment decision unless the health practitioner has provided them with relevant clinical information, including:

- the likely effects and consequences of the medical treatment, including the likely effectiveness of the medical treatment and
- whether are any alternatives, including refusing medical treatment.

The medical treatment decision maker must inform themselves about the preferences and values of the person by considering, in the following order:

- the values directive in an advance care directive, if the person made one
- any other documentation completed by the person in which they noted their preferences and values
- any documentation completed by others which details what is understood to be the person's preferences and values and any other communications by others (that you think the person would reasonably expect you to consult) indicating what they understand to be the person's preferences and values.

What are Goals of Care (Medical Treatment Plans)?

In hospitals, it is common to record a Goals of Care (Medical Treatment Plan) that is completed by a doctor in the form of a Medical Treatment Order.

Similarly, a doctor treating residents in residential aged care facilities may elect to complete such documentation.

Although the word 'order' is sometimes used, such documents are not legal documents; they are not court orders.

The purpose of the documents, in part, is to indicate a clinical assessment of the viability or futility of likely future medical treatment.

This documentation is also sometimes called 'Resuscitation Plan' or 'Not for Resuscitation' but Goals of Care forms do not have to be limited to the issue of resuscitation.

See the OPA guides:

- *A medical treatment decision maker's guide: For when the person lacks capacity to undertake advance care planning*
- *A clinician's guide to medical treatment decision making: For when the person lacks capacity to undertake advance care planning*.

It is important to understand that Goals of Care (Medical Treatment Plans) are clinician's documents and do not constitute medical treatment decisions. That is, they are not decisions of a medical treatment decision maker, although a doctor in formulating a Goals of Care form should do so in consultation with the resident's family.

Health practitioners make a clinical assessment of whether or not to offer medical treatment. If medical treatment is offered, then the medical treatment decision maker can make a medical treatment decision.

What about treatment in an emergency?

A health practitioner may administer medical treatment to a person without consent if they believe, on reasonable grounds, that the medical treatment is necessary as a matter of urgency to save the person's life, or prevent serious damage to the person's health or prevent the person from suffering or continuing to suffer significant pain or distress.

Therefore, for residents in residential aged care facilities (as for any person), if the treatment is required as a matter of urgency, there is no need for a medical treatment decision maker to make a medical treatment decision.

If the person had completed an instructional directive refusing the medical treatment then the health practitioner cannot provide the treatment. Refer to the OPA booklet: *Health Practitioners and the Medical Treatment Planning and Decisions Act 2016*.

Planning for decision-making (particularly refusal of treatment) for a potential emergency is one of the key reasons for completing an advance care directive with an instructional directive.

What about resuscitation?

In the event of a resident seemingly suffering cardiac or respiratory arrest the question will arise as to whether resuscitation should be provided.

A health practitioner is not required to administer a futile or non-beneficial medical treatment. If the health practitioner considers that resuscitation would be futile or non-beneficial then they would not be required to administer it. Possibly, the GP may have previously completed a Goals of Care (Medical Treatment Plan) stating that, for this person, resuscitation would be futile or non-beneficial. Then, in the event that the person does have a cardiac event, resuscitation is not offered.

If this is the case, there is not a medical treatment decision for a medical treatment decision maker to make. However, it is to be expected that a treating team would communicate their clinical decisions and reasoning to family members.

Otherwise, given the situation would constitute an emergency, if resuscitation is provided it would not require a medical treatment decision by a medical treatment decision maker.

If the person made an advance care directive with an instructional directive stating that they refuse resuscitation, then a health practitioner would not be able to provide it.

Can a medical treatment decision maker or family member sign a 'Not for Resuscitation' form?

No.

However, there are three types of documents relevant to this issue.

(1) **Document completed by the person containing binding medical treatment decision**

If the person had completed either:

- a Refusal of Treatment Certificate: Competent Person (this would need to have been done prior to 12 March 2018) on the correct form
- an advance care directive (on any date since 12 March 2018) containing an instructional directive

then the health practitioner cannot administer it.

Note: Prior to 12 March 2018, it was also possible for a guardian appointed by the VCAT or a medical agent appointed under a medical enduring power of attorney to complete A Refusal of Treatment Certificate Agent or Guardian of Incompetent Person.

(2) **Document completed by a registered medical practitioner providing clinical view that treatment not clinically indicated**

A doctor may have completed a Goals of Care (Medical Treatment Plan) stating that resuscitation is not clinically indicated and should not be provided.

As indicated in section 11 above, Goals of Care/Medical Treatment Plans/Not for Resuscitation documents are clinical documents and do not constitute a medical treatment decision by a medical treatment decision maker.

(3) **Document completed by family members or others communicating what is understood about the person's preferences and values**

It is possible for a family member, or another person, to document their understanding about the person's preferences and values in relation to medical treatment. Such documentation does not constitute a medical treatment decision but is information which possibly may assist a medical treatment decision maker in the future to make a medical treatment decision consistent with the person's preferences and values.

The dilemma is that, in an emergency, there is no requirement for a health practitioner to seek a medical treatment decision from a medical treatment decision maker.

Any document which purports, in effect, to be an advance care directive signed by anyone but the person (in accordance with legislative requirements) cannot be treated as a medical treatment decision. See the Office of the Public Advocate Position Statement.

How can a family member plan for decisions about resuscitation?

It is recommended that family members consult with the resident's GP to discuss the possibility of completion of a Goals of Care (Medical Treatment Plan).

If the GP forms the clinical view that resuscitation would be futile or non-beneficial, or not, then the GP can complete a Goals of Care (Medical Treatment Plan) form stating this.

In some circumstances the GP may not be prepared to state that resuscitation would be futile or non-beneficial, but the family member may be of the view that the person would not want to be resuscitated.

In these circumstances the following is suggested.

Whoever is the medical treatment decision maker can engage in a due diligence process. They can make it clear and transparent that they have considered all relevant information to make a medical treatment decision consistent with the legislative requirements of the Medical Treatment Planning and Decisions Act. They can do this in advance in case they are asked to make a medical treatment decision about resuscitation. (See example 4(c) on page 21.)

It is noted, however, that given the need for resuscitation will constitute an emergency, the health practitioner will not be required by the Medical Treatment Planning and Decisions Act to ask the medical treatment decision maker to make a decision.

OPA considers that there is a deficiency in the Medical Treatment Planning and Decisions Act. Prior to the implementation of this Act, the Medical Treatment Act 1988 empowered a medical agent or guardian to complete a Refusal of Treatment Certificate for a current condition on one of two grounds:

- if the medical treatment would cause unreasonable distress to the patient or
- if there were reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and wellbeing would consider that the medical treatment is unwarranted.

There is no equivalent provision in the Medical Treatment Planning and Decisions Act.

Roles, relationships, documentation

Roles

Residential aged care facilities
As described on page 4, all residential aged care facilities must comply with the Aged Care Quality Standards.

Doctors
Although GPs and specialists may visit residents in residential aged care facilities, they are not employees of the residential aged care facility. The visits are, in effect, home visits. However, doctors will rely on information provided to them by residential aged care facility staff — such as observation of the resident and documentation about various matters (such as weight, nutritional intake, and apparent side effects of medication.)

Doctors owe a duty of care to their patients and, if providing medical treatment, must ensure they obtain a valid consent (and if the patient can't make a medical treatment decision, to ascertain if there is an advance care directive and who the medical treatment decision maker is). See OPA's fact sheet titled *Health Practitioners and the Medical Treatment Planning and Decisions Act 2016*. Doctors may find it helpful to be referred to the AMA position statement on *End of Life Care and Advance Care Planning*.

Family members/friends
Family members and friends do not have any formal role, however understandably, they may wish to support the person and can advocate on their behalf, and, as described on page 9, can complete the 'What I understand to be the person's preferences and values' form.

Medical treatment decision maker
If a health practitioner offers medical treatment, and the person lacks capacity to make this decision, and did not previously make an instructional directive in an advance care directive, then the medical treatment decision maker makes the medical treatment decision.

Relationships

One of the principles of the Medical Treatment Planning and Decisions Act is that a partnership between a person and the person's family and carers and health practitioners is important to achieve the best possible outcomes.

A collaborative approach is highly recommended to ensure clarity of communication between the health practitioner (who has clinical expertise), the person (to the extent they can express their preferences and values) and their family and carers (who are concerned about the person and also have knowledge about their preferences and values).

In the case of residents in residential aged care facilities it is important that there are relationships between all the following:

- the resident
- the health practitioners
- the residential aged care facility
- the medical treatment decision maker
- family members and friends.

Documentation

Resident
The resident may have completed any or all of the following:

- Appointment of a medical treatment decision maker
- Appointment of a support person
- Advance care directive
  - » instructional directive (a decision consenting to or refusing treatment) which is directed towards a health practitioner in relation to medical treatment which is being, or might be, offered
  - » values directive that details the person's preferences and values which is information that the medical treatment decision maker must consider if asked to make any medical treatment decision.
- Other documentation (eg statement of choices) in which they have communicated their preferences and values, which the medical treatment decision maker also must consider if asked to make any medical treatment decision.

All of this documentation should be placed on the resident's clinical file.

Doctor
The doctor may have completed a Goals of Care (Medical Treatment Plan).. This can be done whether or not the person currently has decision-making capacity. As described on page 12, this is not a medical treatment decision: it is a clinical decision. If treatment is not offered then there is no medical treatment decision to be made.

Family members/friends/medical treatment decision maker
Family members, friends, or the person's medical treatment decision maker may have completed 'What I understand to be the person's preferences and values' form.

As described on page 9, this does not constitute a medical treatment decision and should not be treated as such.

Residential aged care facilities
Residential aged care facilities may have their own forms to assist with meeting the Aged Care Quality Standards but, in Victoria, these need to be consistent with the Medical Treatment Planning and Decisions Act.

Case examples

Example 1

Doctor explains that medical treatment is futile or non-beneficial

Elizabeth is admitted to hospital following a fall from her bed.

Elizabeth, 93, has advanced dementia and a range of complex medical conditions.

The treating doctor anticipates that Elizabeth is likely to die during the admission and speaks with her son, Robert, who is her medical treatment decision maker.

She explains that resuscitation would be futile and of no benefit to Elizabeth and, therefore, will not be offered; the focus will be on making sure that Elizabeth receives necessary pain relief and comfort care.

Robert understands the information that has been provided to him and, although sad his mother is likely to die soon, is relieved to know that his mother will not suffer.

Example 2(a)

Family member completes a 'What I understand to be the person's preferences and values' form

Maurice and Natasha have been married for 60 years and are both in their mid-eighties. They both have complex medical issues. Maurice has early stage dementia. Natasha is worried about decisions that will need to be made in the future, and is particularly concerned about what will happen to Maurice if she dies before him. Maurice does not want to talk about any of this and Natasha feels this is a reflection of his dementia. However, she knows Maurice well and thinks it would be helpful for her to document what she understands to be his preferences and values.

This process of documentation could prove very helpful in the future whether it is Natasha or anyone else who needs to make a medical treatment decision about Maurice. However, it does not constitute an advance care directive.

Example 2(b)

Person completes an advance care directive

Natasha also decides to make an advance care directive for herself. She realises that Maurice won't be able to make any medical treatment decisions for her and does not think there is anyone else who would be sufficiently familiar with her preferences and values.

Example 3

Family member liaises with doctor for completion of a Medical Treatment Plan including 'not for resuscitation'

Carrie is the daughter of Donna. She is the eldest of Donna's three children.

Carrie makes an appointment with Donna's GP to discuss future likely medical treatment. The clinical care coordinator at the residential aged care facility also attends the appointment.

Everyone agrees that Donna now lacks decision-making capacity to make an advance care directive.

Carrie says that, over the years, she has had discussions with Donna which have given her clear insight into her preferences and values.

She says she has spoken with her mother's sister and her two brothers and that they all have a shared understanding that, if Donna suffered a cardiac or respiratory arrest, she would not want to be resuscitated and would be extremely distressed if such attempts were made and her quality of life was further compromised.

Carrie notes that her mother is in a lot of pain and complains all the time about this to all her family. She repeatedly tells family members that she does not think life is worth living anymore and that she is ready to die.

Carrie also notes that, when her father was in hospital and the doctors spoke to the family about him being 'not for resuscitation', her mother was relieved as she had watched her husband suffer with the last stages of cancer and did not want him to suffer anymore.

The clinical care coordinator agrees that Donna often complains to staff members that she is suffering and wants to be allowed to die.

The doctor explains that resuscitation would be unlikely to be effective treatment for Donna given her medical conditions and frailty.

The doctor speaks with Donna and explains that she has formed the clinical view that resuscitation would be futile or non-beneficial treatment and so she is proposing to record this in a Goals of Care (Medical Treatment Plan).

The doctor explains that, therefore, staff at the residential aged care facility would not attempt resuscitation and an ambulance would not be called — but that she would be provided with comfort care.

Donna thanks the doctor and says she feels relieved.

Example 4(a)

Medical treatment decision by medical treatment decision maker

Kamila lives in a residential aged care facility.

She falls and breaks her arm. She is transferred to hospital. Her daughter, Aisha, who is her medical treatment decision maker, rushes to the hospital.

The doctor explains to Aisha that she has assessed that Kamila does not have decision-making capacity to make the medical treatment decision whether or not to have surgery and confirms that Kamila did not previously make an instructional directive, relevant to the situation.

The doctor explains what the surgery involves, the risks, the alternatives, and the consequences if it is not carried out so that Aisha is in an informed position to make a medical treatment decision. Aisha thinks that her mother would consent to the surgery, if she did have decision-making capacity, and, so, this is the decision that she makes.

It is possible that the health practitioner might ask Aisha to sign a consent form. It is not usual for a medical treatment decision maker to write detailed reasons for their decision, however, if challenged, the medical treatment decision maker would need to be able to demonstrate they had made the decision according to law.

Aisha's explanation for her decision

I believe if my mother had capacity to make this decision, she would consent. She is a person who has always followed medical advice. I have been told she is in pain and I can see that for myself. If the fracture is not attended to, her arm movement will be severely restricted. She still enjoys crochet and I hope that she may still be able to do this if she recovers well from the surgery. I know that at her age and given her frailty that a general anaesthetic is quite risky and may exacerbate her dementing process.

I have spoken with my mother and tried to explain to her what is going on. She is quite confused but keeps telling me that she trusts me to do what is best. She is scared of having the surgery and she is scared about being in hospital, as it is all unfamiliar to her. Due to her osteoporosis she has had other falls and, last year, she needed treatment when she broke her foot. She was able to make her own decision then and she consented to surgery.

Mum has not made an advance care directive but we are close and have had many conversations over time about what it means to her to be old, to be frail and to be facing her death.

She is reconciled to death but complains about how much she hates the pains and discomforts of old age. I would describe her as a stoic, sensible person and have no doubt that she would consent to this surgery if she was in a position to do so.

I have consulted my two brothers for their views. We are in unanimous agreement.

Example 4(b)

Medical Treatment Plan form completed by GP

Kamila is discharged from hospital to her residential care facility after the surgery.

It is clear that the fall, the surgery, and the recovery have left Kamila much frailer. Aisha is worried about her and meets with Kamila's doctor to discuss likely future medical treatment issues. The doctor explains that she would not be surprised if Kamila died in the near future, and a possible cause of death would be a cardiac arrest.

The doctor explains that she proposes to complete a Goals of Care (Medical Treatment Plan) stating that resuscitation would be futile and non-beneficial and that this form will be placed on Kamila's clinical file.

Example 4(c)

Medical treatment decision maker documents her views and concerns

Aisha is glad that the doctor has completed this form but is concerned by stories she has heard from friends about attempts to resuscitate their aged, frail parents when locum staff or casual staff who did not know the person, disregarded Goals of Care (Medical Treatment Plan) forms and moved automatically into emergency mode. Aisha feels strongly that she needs to advocate for her mother to prevent this happening.

For this reason Aisha also writes down what her medical treatment decision about resuscitation would be, should someone form a contrary view to Kamila's doctor, as communicated in her Medical Treatment Plan.

Aisha decides to provide the following document to the residential aged care facility and to the doctor and to her brothers.

I have had a discussion with Dr Singh and understand that, it would not be at all surprising if, Mum was to suffer a cardiac arrest. Dr Singh has completed a Goals of Care (Medical Treatment Plan) form in which she has detailed that, to try to resuscitate Mum if she did have a cardiac arrest, would be futile and non-beneficial.

Even if another doctor formed a view that resuscitation should be attempted, as medical treatment decision maker for my mother, if asked to make a medical treatment decision about this, it would be to refuse such treatment. Given this situation would happen in an emergency, I have decided to document how I have reached this decision, according to law. I believe I have all the relevant information available to me such that I can make a fully informed decision.

My mother has not made an advance care directive, however, her preferences and values about this issue are well-known to me. Over the past several years we have had many conversations about the meaning and experience of life, suffering and death. My mother is a sensible woman who has always accepted good medical advice but she accepts her mortality. She is prepared for death. I believe she would be distressed if resuscitation was attempted when her body is clearly ready to let go. My view would be the same even there was some slight possibility of being resuscitated. I have discussed this with my brothers, and they have counter-signed below. They agree with me. There is no one else my mother would reasonably expect me to consult about this. If, for any reason, my mother is transferred to hospital I request a copy of this document and the GP's Goals of Care form be sent with her.

Example 4 (d)

Family member details preferences and values

Aisha also discussed with Kamila's doctor other possible causes of death.

The doctor said that residents in residential aged care often die of pneumonia and, if Kamila contracted pneumonia, a decision about antibiotics would need to be made.

Aisha cannot make a decision about this now, as Kamila does not actually have pneumonia.

If Kamila does contract pneumonia, there will be time for Aisha to make the decision then. However, it would be helpful for Aisha now to consider what she thinks Kamila's preferences and values about this might be, including discussing it with her mother, so that, should she need to make the decision, she will feel prepared to do so. Aisha could complete a 'What I understand to be the person's preferences and values' form documenting what she understands to be her mother's preferences and values.

Office of the
Public Advocate

Office of the Public Advocate
Level 1, 204 Lygon Street, Carlton, Victoria 3053
Phone: 1300 309 337
TTY: 1300 305 612 NRS: 133 677
Fax: 1300 787 510
www.publicadvocate.vic.gov.au