Advance Care Directives



Guide

Plan for your future health and end of life care

This guide has information about Advance Care Directives and a step-by-step guide on how to complete an Advance Care Directive Form.

Government of South Australia

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Introduction

There may be a time in your life when you can't make your own decisions.

This could be because:

- of a sudden accident or serious mental health episode
- of dementia or a similar health condition
- of a serious stroke
- you are unconscious or in a coma.

If this happened to you, how would you want decisions to be made about your health care, where you live ('living arrangements'), and other personal matters?

Importantly, who would you want to make these decisions for you?

What is an Advance Care Directive?

An Advance Care Directive is a legal form.

By completing an Advanced Care Directive, you can make clear legal arrangements for your future health care, end of life care, preferred living arrangements and other personal matters.

It allows you to choose who you would like to make decisions on your behalf ('Substitute Decision-Makers') if you are not able to make your own decisions the future.

This Advance Care Directive is not a will. It cannot be used to make financial or legal decisions.





Who can write an Advance Care Directive?

You can write an Advance Care Directive whether you are young, older, healthy or sick.

To write an Advance Care Directive, it must be your choice and you must:

- be over the age of 18
- know what an Advance Care Directive is; and
- know what it will be used for and when it will be used.

When will it be used?

Your Advance Care Directive can only be used if you are not able to make your own decisions. It can be used temporarily, or permanently.

Sharing your Advance Care Directive

It is important that you let people know you have an Advance Care Directive and where to find it, especially in an emergency.

You should:

- Make multiple certified copies
- Give a certified copy your chosen Substitute Decision-Makers (people who you would like to make decisions on your behalf)
- Give certified copies to people who care about you and care for you, for example, your family, close friends, doctor and any other health practitioner, hospital or health service you regularly visit.
- Take a certified copy with you if you go to a hospital, hospice or aged care facility, or if you travel interstate or overseas.
- Upload a copy onto the Australian Government's online 'My Health Record'.

What if I have other documents in place?

If you have already completed an Enduring Power of Guardianship, a Medical Power of Attorney or an Anticipatory Direction, these are still legally effective, unless you complete the Advance Care Directive Form.

If you do not have an Advance Care Directive, but you do have an Enduring Power of Guardianship, a Medical Power of Attorney or an Anticipatory Direction, it is important to review them regularly as your values, wishes and relationships can change over time.

Non-statutory documents (sometimes called 'advance care plans') are often completed by people with limited or impaired decision-making ability, to share their preferences for future health care, end of life, preferred living arrangements and other personal decisions. These documents are valid and are recognised under common law.

Can I change my existing Advance Care Directive?

Yes. You can update your current Advance Care Directive by completing a new Advance Care Directive Form.

A current Advance Care Directive Form will continue to be valid unless you complete a new Advance Care Directive Form.

Once you have completed a new Advance Care Directive form, make sure your old one is destroyed (including any copies) and removed from any electronic platform, such as My Health Record, and replaced with your new one.



Advance Care Directive Form

Where can I find an Advance Care Directive Form?

There are three ways you can find and complete your own Advance Care Directive Form:

1. Complete an Advance Care Directive Form online, using the interactive form at www.advancecaredirectives.sa.gov.au
2. Download or print the Form by visiting the Advance Care Directives website.
3. Obtain an Advance Care Directive Form from Service SA.

Step-by-step guide to completing your Advance Care Directive Form:

Part 1: Personal details

Fill in your personal details on page 1 of the Advance Care Directive Form.

Part 2a: Appointing Substitute Decision-Makers

Go to page 2 of the Form to complete this section.

Choosing one or more Substitute Decision-Makers in your Advance Care Directive, means you are trusting someone with the legal authority to make future health care, end of life, preferred living arrangements and other personal decisions for you.

Having a Substitute Decision-Maker can help to avoid family conflict by making it clear who you want to make decisions for you, and how.

You can also make sure the most culturally appropriate person (or people) have legal authority to make decisions, by appointing them in your Advance Care Directive.

In your Advance Care Directive, you can tell your Substitute Decision-Makers how you want them to make decisions for you. For example, if you have more than one, you can say whether you want them to make decisions together or separately. See Part 2b Conditions of Appointment, page 3.

If you do not choose a Substitute Decision-Maker, other people close to you may be asked to make decisions for you if you are not able to.

They must follow any relevant wishes or instructions you have written in your Advance Care Directive.

It is a good idea to appoint one or more Substitute Decision-Makers, and talk to them about what is important to you. Write down your wishes on the Advance Care Directive Form so they, and others, know what you want or do not want.

If you do not want to appoint any Substitute Decision-Makers in your Advance Care Directive, you can still write down what is important to you. This can include your culture, beliefs, wishes and instructions for your future health care, your dying wishes, where you wish to live and other personal wishes.

Whatever you decide, make sure you give certified copies to any appointed Substitute Decision-Makers, close family or friends, your doctor and specialist, health service or aged care facility.

Visit the Advance Care Directives website for the 'How to make certified copies' fact sheet.

How many Substitute Decision-Makers should you have?

It can be helpful to have more than one Substitute Decision-Maker.

Having more than one Substitute Decision-Maker means that:

- more than one person is prepared and able to make decisions for you if needed in the future; and
- another person is available should one unexpectedly become sick, change their mind or die.

While you can appoint as many Substitute Decision-Makers as you like, we do not recommend appointing more than four people. This helps to reduce confusion and/or family conflict or disagreements.

If you would like to appoint more than four Substitute Decision-Makers, please fill in section XX of the Form / visit the website to download the additional Substitute Decision-Maker pages. (to be decided)

How to choose your Substitute Decision-Maker(s)

Choose a person who:

- Is 18 years old or over.
- Can make decisions.
- Knows you well, and is someone you trust.
- Respects what is important to you.
- Can put themselves in your position and work out what decision you would make.
- Can make serious decisions for you during emotional times.
- Wants and agrees to be your Substitute Decision-Maker and understands what this means.

You cannot appoint someone who is paid to care for you, like your doctor, nurse or a professional paid carer (for example, the Director of Nursing in an aged care facility or a community care worker).

Family members or friends who are paid a Carers' Allowance by Centrelink can be appointed as Substitute Decision-Makers.

Your Substitute Decision-Maker(s) must agree to be appointed.

Talk to the person or people you want to be your Substitute Decision-Maker.

Tell them:

- What types of decisions you want them to make for you; and
- How you want them to make decisions for you.

The person or people you choose to be your Substitute Decision-Maker(s) must sign the Form to say that they understand what it means to be your Substitute Decision-Maker and that they agree to be appointed.

What it means to be a Substitute Decision-Maker is explained in the Substitute Decision-Maker Guidelines, on page 31. Make sure your Substitute Decision-Maker(s) reads and understands this information before they sign your Form.

Your Substitute Decision-Makers should follow and respect what you write in your Advance Care Directive. It is recommended that you talk to your Substitute Decision-Maker(s) and other people close to you about your Advance Care Directive.

Before you sign your Advance Care Directive in front of a witness, any Substitute Decision-Makers you appoint must accept and agree to being appointed, and must sign Part 7 of the Form.

If your Substitute Decision-Makers are located interstate or overseas, your Substitute Decision-Makers can sign the Form electronically, so long as you use the online form to complete your Advance Care Directive.



AARTI'S STORY

Aarti (42) put a condition in her Advance Care Directive that her close friends, who she appointed as her Substitute Decision-Makers, must speak to her brother Raj, who lives in Victoria, about any decisions. She hopes this will avoid conflict with any of her family members in the future.



AUNTY'S STORY

Aunty (59) had a few things wrong with her health – diabetes and heart problems. She came from a big mob, lived in a small community and was worried there might be big family arguments and worry if she got really sick and family couldn't sort out what was right for her. If she did get very sick, Aunty decided to appoint her daughter, Josie, in her Advance Care Directive to make decisions for her if she couldn't make decisions herself. Aunty talked to her daughter about what she wanted and also made sure her family and community knew her wishes. Doing this on a legal form gave her peace of mind because she knew her wishes would be clear and could be acted upon, and she could continue to be respected as an Elder.

Part 2b: First point of contact

Go to page 3 of the Form to complete this Part.

In part 2b of the Advance Care Directive Form, you can nominate one of your Substitute Decision-Makers to be the first person contacted in an emergency.

This does not mean you are choosing this person as a first preferred contact. Instead, it means they are most likely be the first person contacted in a situation that needs a quick response.

This person may also be your first preferred Substitute Decision-Maker to make decisions on your behalf, or to coordinate decisions with any other chosen Substitute Decision-Makers.

Part 2c: Conditions of appointment of Substitute Decision-Makers

Go to page 3 of the Form to complete this Part.

In Part 2c of the Advance Care Directive Form, you can write down how you want your Substitute Decision-Makers to make decisions for you and what types of decisions they can make about your health care, living arrangements or personal matters.

This is called putting 'conditions' on their appointment.

You can ask that they talk with certain family members, friends and/or your Enduring Power of Attorney, if decisions will impact your financial situation.

For example, you may want two or more Substitute Decision-Makers to either:

- make decisions together
- make decisions individually
- make decisions in an order of preference; or
- Make decisions as they are available.

The choice is yours.

If your Substitute Decision-Makers cannot agree on a decision, you can write down how you would like these differences to be resolved.

You can also assign different decisions (for example, living arrangements or health care) to different Substitute Decision-Makers.



What are conditions of appointment?

Conditions of appointment mean you can choose what types of decisions your Substitute Decision-Maker(s) can make and how you would like them to make decisions. You can:

- Appoint one Substitute Decision-Maker to make all your decisions.
- Appoint two or more Substitute Decision-Makers and write down what types of decisions they can make (for example, health care decisions).
- Appoint two or more Substitute Decision-Makers and request that they make all decisions together.

If you do not write down any conditions, your Substitute Decision-Maker(s) will be able to make decisions either together or separately. This will mean that if only one Substitute Decision-Maker can be contacted, a decision can still be made, but if two or more Substitute Decision-Makers are available they can decide together.

If you want your Substitute Decision-Makers to make all decisions together, please write this in the space provided on Part 2c of the Form.

If you choose this option, it is important to remember:

- It could take your Substitute Decision-Makers longer to make a decision, because they all need to agree.
- There is a chance your Substitute Decision-Makers may not agree.

The best approach is to make sure your Substitute Decision-Makers can communicate well and agree together.

When you choose your Substitute Decision-Makers, think about their relationship to each other, and how well they can make decisions in stressful and emotional environments and/or situations.

In this section you might also like to:

- Write down the names of people your Substitute Decision-Maker must talk to when making decisions for you, for example, family members, close friends, religious adviser or Aboriginal Elders.
- Write down the name of your Enduring Power of Attorney (someone you have chosen to make financial and legal decisions) if you have one. Your Substitute Decision-Maker will need to speak to your Financial Attorney if decisions they make on your behalf might affect your finances.

A health care worker is only responsible for contacting one Substitute Decision-Maker (whoever they can reach).

Your Substitute Decision-Maker is responsible for contacting other Substitute Decision-Makers if you have appointed more than one.

Part 3: What is important to me - my values and wishes

Go to page 4 and 5 of the Form to complete this Part.

In Part 3 of the Advance Care Directive Form you can write down:

a. What is important to me
b. What I don't want to happen to me
c. Health care I prefer
d. Where I want to live
e. Other personal arrangements
f. My dying wishes.

When you are writing about want you want to happen in different situations or circumstances, you might like to use 'linking words'.

Linking words are words such as 'unless', '*if*' and '*when*'. For example:

"I don't want to live in a supported residential facility unless I am unable to feed, wash or dress myself."

"My cat, Sasha, is an important part of my life. I want Sasha to live with me if it is possible and practical."

It is good to be specific.

Unclear statements like 'I don't want to be a vegetable', or 'I don't want to be a burden on my family' can make it harder for people to make decisions for you.

a) What is important to me?

Writing down what is important to you about your life and health will help your Substitute Decision-Makers, people close to you, health care workers and others to make decisions for you if you can't make them yourself.

The statements listed below may help you decide what is important to you.

You may want to write one or more of these on your Form, or you may have words of your own you want to use to give more detail.

Some suggested statements:

- Relationships with my family and my friends are very important to me.
- Being free from pain is important to me.
- Being able to do daily self-care for myself is important to me.
- Being able to talk to my friends and family is important to me.
- I would like my family and friends to be involved in my life.
- I prefer my pets to be near me or continue to be able to see them.
- Being independent is important to me and I would prefer not to have to rely on others daily.
- My cultural practices are important to me. I would like them to be followed where possible and practical and to always be respected.
- I have lots of cultural practices, and some are secret, some are not.
- My family and Substitute Decision-Maker (if appointed) will let my carers / health professionals know what is important to me, and when. Please listen to them and follow their instructions about specific cultural practices wherever this is possible.
- My religion is very important to me. My decisions are guided by my religious faith which is...
- I value my cultural identity and like being with people who speak my first language.
- Health and medical research is important to me. I provide consent in advance to participating in future research studies, relevant to my condition, even if I do not have capacity at the time to consent.
- I have spent my life in the gay and lesbian community and I want to stay in contact with them.

b) What I don't want to happen to me (outcomes of care I want to avoid)

It is very hard to know what health care you may want in the future – especially if you are well and don't know what health problems you might have later.

Sometimes when you are sick or hurt, having health care will mean that you get better and go back to the way you were before (for example, if you have a blood infection, antibiotics can often help cure this so you become healthy again).

Other times, health care can only help you a little.

Even though you may improve, you may not be able to live the same way as you did before (for example, you may have had a stroke and need physiotherapy, but afterwards you may not be fully mobile and need help to dress yourself, shower, cook or need assistance walking).

How you feel, and what your life is like after receiving health care is called an outcome of health care.

You may want to write down outcomes of care you want to avoid.

You might like to use these suggested statements, or you may like to write your own, in your own words.

Thinking about what is important to you to will help guide what you write down in this part.

Some suggested statements:

- I do not want any health care that will not help me recover, unless it gives me time to say goodbye to my family and friends.
- I would prefer comfort care to maintain my dignity if I have a serious car accident or illness and I am not likely to recover.
- I do not want health care that keeps me alive if I am in a permanent coma, or if I am not likely to communicate meaningfully again. I would prefer to be comfortable and allowed to die with dignity. I would like to donate my organs/tissues if possible.
- I would prefer to receive my usual treatment at home and not be put into institutional care if I have a mental health episode, unless...
- Being permanently unable to make my own decisions would not be acceptable to me. If this happened and I needed life sustaining treatment, I would want nature to take its course and be kept comfortable.
- I do not wish to participate in health and medical research if I am in the terminal phase of an illness.

c) Health care I prefer

You may have clear wishes or instructions about specific health care (including medical treatment) you prefer.

When you need health care, health care workers think about what is wrong with you and tell you what health care they think will help you or your illness. There may be one choice of health care, or many.

Your health practitioner should clearly explain your health care options to you, your Substitute Decision-Maker or Person Responsible, and what those options will mean for your health and life.

If you want to write health care instructions, you might like to think about these suggested statements.

Some suggested statements:

- I only want medical treatment that keeps me comfortable (for example, pain relief and sedation) if I am permanently unable to communicate, or recognise my family and friends.
- I want to live as well as possible for as long as possible and I am willing to accept medical treatment that my doctors and family think is appropriate.
- I prefer to be given my usual medications if I have a mental illness and I am temporarily unable to make my own decisions, even if I refuse them at the time.
- I am happy to be alive and would accept all health care offered to me if I have a serious brain injury, unless that health care leaves me with physical or mental disabilities.
- I will accept all health care and medical treatment that will improve my health and give me more time with my family, if considered appropriate.
- I agree to surgery if I have dementia and I fall and break my hip if it is considered medically appropriate/unless it is not considered medically appropriate.
- I have a mental illness and when I am unwell, I want my caregivers to follow my Ulysses Agreement which can be found (give details).



KATERINA'S STORY

Katerina (30) had a recurring mental illness. Sometimes she was well and sometimes she went off her medicine and became unwell. She knew that medicine X had terrible side-effects, however medicine Y did not. She wrote in her Advance Care Directive that she wanted medicine Y, but not medicine X if she ever became unwell. Katerina was glad she could make her wishes clear in her Advance Care Directive in case she couldn't tell her doctor at the time.

d) Where I want to live

In the future, you might not be as independent as you are now. You might need:

- Extra support at home to be able to live independently, provided by family, friends or professionals.
- to be looked after in a disability or aged care facility.
- temporary care or support, or a permanent or long-term arrangement.

Some suggested statements:

- I prefer to be supported and cared for at home, for as long as possible, if it is safe for me to do so.
- I prefer to live with my family for as long as possible.
- I prefer to maintain my independence for as long as possible.
- I prefer to live close to family and friends so they can visit me easily.
- I prefer to live where my spiritual needs will be met.
- I prefer to live somewhere where they respect my sexuality.
- I prefer to live in a place where the staff speak my language.
- I prefer to live where treatment and care can be provided to me.
- I prefer to live somewhere that has a garden or is near the beach.

e) Other personal arrangements

You might have some activities, interests or hobbies which are important to your life. You can write these down on your Advance Care Directive Form so that other people know what you like and dislike.

Things to consider:

- Activities you enjoy and would like to keep doing if you are able to, for example, walking, gardening or singing in a choir.
- Things you do not like to do, such as playing bingo or long car drives.
- Organisations or groups that you belong to and want to continue with.
- Relationships that are important to you.
- Your favourite music.
- Grooming requirements such as haircuts and removal of facial hair.
- Who you prefer to spend holidays with.
- People who you do or do not want to visit you.
- What you like or don't like to wear (for example, I do not want to wear tracksuits at any time of the day or night).
- Who you would prefer to look after your children and/or pets if supported care is required.

f) Dying wishes

Writing down your wishes for the end of your life is hard to do.

To help, think about what would be most important to you at this time.

For example:

- Situations you want to avoid or that would be unacceptable when you are dying.
- Where you would prefer to die (at home, in your aged care facility or hospital).
- Who you want to be there when you die.
- What or who is important to you at the end of your life.
- Spiritual, religious or cultural traditions that are important to you.
- Aboriginal and Torres Strait Islander practices that you want followed (for example, Return to Country).
- Your burial or cremation wishes or funeral arrangements.

Some suggested statements:

- I want more time with my family.
- I would prefer to have better quality of life for a shorter time.
- I want to be in a comfortable, familiar environment surrounded by my memories.
- When I am dying, I would like my favourite music playing and the room lit with soft light/candles.
- When I am dying, please make sure my room is full of happiness and joy. I want people to celebrate my life, and not mourn my dying.
- My spirituality is important to me, so please let nature take its course and just make sure I am comfortable.
- My religion is important to me, and I want my religious adviser contacted (insert contact details).
- I want time to say goodbye to my family if possible. Please try and keep me alive so my family can see me before I die.
- If I am dying, I do not want to go to hospital unless my comfort and dignity cannot be maintained in my home/nursing home.
- My cultural practices are important to me. My family or Substitute Decision-Maker will inform carers or health care workers what these are and when they should happen.
- I prefer to be cremated.
- I prefer to be buried at X cemetery.



EDWARD'S STORY

Edward (87) had been in his nursing home for the past four years and it had become home to him. Edward had written in his Advance Care Directive that he wanted to die where he lived, have his children present and his favourite music playing. Edward became more and more sick over three weeks. He died peacefully in the nursing home where he lived surrounded by his large family because his wishes were known.

Part 4: Binding refusals of health care

Go to page 6 of the Form to complete this Part.

If you do not want to receive certain types of health care, you can write this in your Advance Care Directive. This is called a refusal of health care.

If you do this, it is important to make sure you write down when, or under what circumstances, you want to refuse health care (for example, if I have a condition or illness that I will not be able to recover from).

If you have refused specific health care in your Advance Care Directive, it is a binding refusal, which means it is illegal for your health practitioner to give you that health care.

If your Substitute Decision-Maker or Person Responsible says no to health care (because they believe it is the decision you would have made) your health practitioner cannot give you that health care.

If you want to write specific refusals of health care or life-sustaining treatment, you could consider these statements.

Some suggested statements:

- I refuse any treatments that try to sustain or extend my life if I am not going to fully recover.
- I cannot decide at this point. I want my Substitute Decision-Maker/s to make decisions about life sustaining treatment for me when the decision needs to be made, using the information in this directive and by speaking with my health care providers.
- I do not want to be fed by a tube, even if this means I may die. I only want to be offered foods and fluids by mouth.
- I do not want to be fed by a tube or kept on any medication unless it is pain relief that helps to keep me comfortable.
- I wish to have full palliative care, including pain relief and comfort care to manage and respect my dignity as I die.
- I do not want any treatment that would leave me with worse symptoms if I will never be able to communicate and make my own decisions again (for example, because of dementia or a serious stroke) – even if it means I will live longer. I only want treatment that improves my physical and mental health, and to be kept comfortable.
- I do not want to be resuscitated for cardiac or respiratory failure in any form if I can't communicate my wishes, and there is no chance that I will be able to recover to my former self. I do not want to be put on life support or admitted to intensive care. I want no surgical intervention.

- I do not want any life sustaining treatments if I have a terminal illness and I am dying. Please keep me comfortable.
- I do not want any treatment which prolongs my life if I have a serious condition that I am not going to recover from, I am incontinent, cannot eat without help and I rely on others to wash and move me. Please keep me comfortable where I live if possible.
- I do not wish to have any medical treatments that will prolong my life if I am permanently unable to communicate. Please give me palliative care.
- I do not want to have my heart started if it stops at any stage of my life. I would prefer to die quickly.
- I do not want my limbs amputated, even if I might die.
- I only want health care to make me comfortable and which doesn't extend my life if I am permanently living in institutional care or requiring care 24/7.
- I do not wish to receive medical interventions to extend my life, but, I am willing to accept medical interventions that may be required so I can donate my organs or tissues.

You cannot refuse compulsory mental health treatment (for example, treatment listed in a community treatment order, if you have one).





LUCIA'S STORY

Lucia (85) had a history of heart disease as well as previous care for serious stomach problems. She went to the Emergency Department (ED) with severe pain and could not make her own decisions. Lucia had made it clear in her Advance Care Directive that she only wanted comfort care in this situation. The ED staff respected her wishes, set her up in a separate room on the ward where her family could be with her. She died 36 hours later surrounded by her family, without pain, the way that she wanted to.

A health practitioner can only go against a refusal of health care if:

- there is evidence that suggests you have changed your mind, but did not update your Advance Care Directive; or
- the health practitioner believes you did not mean it to apply to the current circumstance.

If this happens, the health practitioner will need consent from your Substitute Decision-Maker, if you have one, or a Person Responsible (for example, close family or friend).

You should review your binding refusals of health care at least every two years, or if your health has changed.

For more information about different types of life sustaining treatment and common medical terms, read the fact sheet on the website. (to be developed)



BILLY'S STORY

Billy (42) wrote in his Advance Care Directive that he did not want any antibiotics. Billy got a bladder infection and was in a lot of pain, which meant he could not make his own decisions. His doctor questioned whether the refusal was meant to apply in this situation. His doctor spoke to his Substitute Decision-Maker and discovered that Billy actually only wanted the refusal to apply if he had a terminal illness, not when he was fit and well.

Part 5: Organ donation

Go to page 7 of the Form to complete this Part.

This part of the Form does not register you to become an organ and tissue donor.

By completing this section, you are stating that you have visited the DonateLife website and understand your options for organ and tissue donation.

The decision to donate your organs and tissue is up to your family.

However, 90% of families will consent to donation if you are a registered donor.

It is important to know that some medical interventions may be necessary for organ and tissue donation to happen.

For more information about organ and tissue donation or to register to become a donor, visit www.donatelife.gov.au

Part 6: Interpreter statement

Go to page 7 of the Form to complete this Part.

If you used an interpreter to help you fill in the Advance Care Directive Form, your interpreter will need to fill in this part of the form to certify that they meet the requirements under section 14(2) of the Act.

See page 40-41 of the Guide for an information sheet for interpreters.

Using a qualified interpreter is strongly recommended, to make sure your wishes are accurately recorded in English.

Where possible, your interpreter should be over the age of 18 and have legal capacity.

Only fill in this part of the form if you used an interpreter. If you did not use an interpreter, please draw a large “Z” across this section.

If you are using the online form to fill in your Advance Care Directive, your interpreter can use a digital signature in this section of the Form.

Part 7: Substitute Decision-Makers/s Acceptance

Go to page 8 of the Form to complete this Part.

Before you sign your Advance Care Directive in front of a witness, any Substitute Decision-Makers you appoint must accept and agree to being appointed, and must sign Part 7 of the Form.

It is important that your Substitute Decision-Makers read the Substitute Decision-Maker Guidelines so they understand and accept their role and responsibility.

If you are using the online form to fill in your Advance Care Directive, your Substitute Decision-Maker/s can use a digital signature in this section of the Form.

Part 8: Declaration

Go to page 9 of the Form to complete this Part.

In this part, you are declaring that it is your own decision to complete this Advance Care Directive, and that another person is not forcing you to complete it.

You must sign this form in-person, in front of an independent authorised witness. You must also initial each page in front of your witness.

There is space for an extra execution statement under Part 9 of the Form, if you are physically not able to sign the declaration yourself.

If you are using the online form to fill in your Advance Care Directive, Digital signatures are not permitted in this section of the Form.

Part 9: Witness Statement

Go to page 9 of the Form to complete this Part.

Only an independent authorised witness can sign your Advance Care Directive.

Authorised witnesses include health care workers, registered teachers, police officers, legal practitioners, Justices of the Peace and registered social workers – as outlined in the Advance Care Directives Regulations 2014.

Your independent authorised witness will tell you to fill in this part of the Form after you have read the Information Statement on page 27-30 of this Guide.

If you are using the online form to fill in your Advance Care Directive, digital signatures are not permitted in this section of the Form.

See page 36-39 of the Advanced Care Directive Guide for the Information Statement for witnesses.

Certified Copies

Your witness can help you make multiple certified copies of your Advance Care Directive Form.

You will need to give your Substitute Decision-Makers, other people close to you, your doctor or other health care workers a certified copy.

Any person from the witness list can certify copies for you at a later time.

The person you ask to certify copies of your Advance Care Directive does not have to be independent of you.

Next Steps

Once the Form is signed by you, your Substitute Decision-Makers and your witness, make multiple certified copies give them to:

1. any appointed Substitute Decision-Makers
2. your doctor, health service and/or aged care facility
3. friends, family and those close to you
4. display it on your fridge with your Emergency Medical Information Booklet (www.emib.org.au)
5. add it to your Electronic Health Record if you have one (www.ehealth.gov.au).
6. upload into your My Health Record if you have one.



Information Statement

Your witness will ask you to read this Information Statement, and then ask you some questions. This is to make sure that you understand what you are doing by making an Advance Care Directive, and that it is your choice to write one.

What is an Advance Care Directive?

An Advance Care Directive is a legal form that allows people over the age of 18 years to:

- write down their wishes, preferences and instructions for future health care, end of life, living arrangements and personal matters; and/or
- appoint one or more Substitute Decision-Makers to make these decisions on their behalf when they are not able to make decisions for themselves.

It cannot be used to make financial decisions.

If you have written a refusal of health care, it must be followed if it is relevant to the circumstances at the time.

All other information written in your Advance Care Directive should be used to help your Substitute Decision-Maker(s), your health care workers or persons responsible (for example, close family/friends) make decisions on your behalf.

It is your choice whether or not to have an Advance Care Directive. No one can force you to have one, or to write things you do not want to write. These are offences under the law.

You can change your Advance Care Directive at any time while you are still able by completing a new Advance Care Directive Form.

Your new Advance Care Directive Form will replace all other documents you may have completed previously, including an Enduring Power of Guardianship, Medical Power of Attorney or Anticipatory Direction.

When will it be used?

Your Advance Care Directive can only be used if you are not able to make your own decisions, either temporarily or permanently.

You will be considered unable to make your own decisions if you cannot:

- understand information about the decision
- understand the risks and benefits of the choices
- remember the information for a short time; and
- tell someone what the decision is and why you have made the decision.

If any of the above statements apply to you, someone else will need to make your decisions for you.

Who will make decisions for you if you cannot?

It is your choice whether you appoint one or more Substitute Decision-Makers.

If you have appointed one or more Substitute Decision-Makers, they will be legally able to make decisions for you about your health care, living arrangements and other personal matters when you are not able to.

You can choose the types of decisions you want them to make in Part 2b: Conditions of Appointment of your Advance Care Directive.

If you do not appoint any Substitute Decision-Makers, other people close to you (like close family or friends) may be asked to make decisions for you. These people are called 'Person Responsible'.

They must follow any relevant wishes or instructions you have written in your Advance Care Directive.

Anyone making a decision for you will need to make a decision they think you would have made in the same circumstances.

Refusals of health care

You may have written in your Advance Care Directive that you do not want certain types of health care (also known as a refusal of health care).

It is important to make sure you have written down when, or under what circumstances, any refusals of health care apply.

If you have refused specific health care in your Advance Care Directive, your Substitute Decision-Maker(s), Person Responsible and your health practitioner must follow that refusal, if it is relevant to the current circumstances.

This means that your health practitioner will not be able to give you the health care or treatment you have refused.

If you refuse health care but do not write down when the refusal applies, it will always apply when you cannot make the decision.

A health practitioner can only go against a refusal of health care if they have evidence to suggest you have changed your mind but did not update your Advance Care Directive, or the health practitioner believes you didn't mean the refusal of health care to apply in the current circumstance.

If this happens, they will need consent from your Substitute Decision-Makers, if you have any, or a Person Responsible, to provide any health care.

You cannot refuse compulsory mental health treatment included in a community or involuntary treatment order if you have one.

Letting people know you have an Advance Care Directive

To let people know you have an Advance Care Directive, it is recommended that you:

1. Download and complete a Wallet Card from www.advancecaredirectives.sa.gov.au
2. Give a certified copy to any appointed Substitute Decision-Makers, your doctor, your health service that you regularly attend, and other people close to you.
3. Keep a certified copy with you and where you can easily find it.
4. Fill out the Emergency Medical Information Booklet (EMIB) and display it with your Form on your fridge (www.emib.org.au).
5. Add it to your Electronic Health Record if you have one (www.ehealth.gov.au).

For more information, visit www.advancecaredirectives.sa.gov.au

This information statement has been translated into 15 different languages and can be found on the Advance Care Directive website.



Substitute Decision –Maker Guidelines

Read these guidelines before you agree to be appointed as a Substitute Decision-Maker. Keep these guidelines for future reference.

By signing the Advance Care Directive Form you are agreeing to be the person's Substitute Decision-Maker, and understand the responsibilities of this role.

Before you sign, make sure you understand:

- what types of decisions you will be able to make
- how the person wants you to make those decisions for them; and
- whether you are able to be a Substitute Decision-Maker.

People who cannot be appointed as a Substitute Decision-Maker include the person's doctor, nurse, or paid professional carer.

Family members or friends who are paid a Carers' Allowance by Centrelink can be appointed as Substitute Decision-Makers.

After you are appointed, you should keep a certified copy of the completed and signed Advance Care Directive where you can easily find it.

You should try to have regular discussions with the person who appointed you in case their circumstances change.

What is the role of a Substitute Decision-Maker?

As a Substitute Decision-Maker, you must try to make a decision you believe the person would have made for themselves in the same situation.

As a Substitute Decision-Maker, you can make all the decisions the person wanted you to make, but you cannot:

- make a decision which would be illegal, such as requesting voluntary euthanasia.
- refuse food and water to be given to them by mouth.
- refuse medicine for pain or distress (for example, palliative care).
- make legal or financial decisions (unless you have also been appointed as an Enduring Power of Attorney for financial matters).

When contacted and asked to make a decision, you must:

- Only make a decision when the person who appointed you cannot make their own decision, whether it be temporary or permanent.
- Support that person to make their own decisions if they are able to. Section 10 of the *Advance Care Directives Act 2013* states:
  (d) a person must be allowed to make their own decisions about their health care, residential and accommodation arrangements and personal affairs to the extent that they are able, and be supported to enable them to make such decisions for as long as they can;
  (e) a decision made by a person on behalf of another in accordance with this Act—
  (i) must, as far as is reasonably practicable, reflect the decision that the person would have made in the circumstances; and
  (ii) must, in the absence of any specific instructions or expressed views of the person, be consistent with the proper care of the person and the protection of his or her interests; and
  (iii) must not, as far as is reasonably practicable, restrict the basic rights and freedoms of the person.
- Produce an original or certified copy of the person's Advance Care Directive Form or advise if it can be accessed in an electronic record.
- Only make decisions that you have been appointed to make.
- Try to contact any other Substitute Decision-Maker who has been appointed to make the same types of decisions as you.
- Only make a decision on your own if no other Substitute Decision Maker with the same decision-making responsibility as you cannot be contacted, or if the decision is urgent.
- Inform any other Substitute Decision-Maker(s) of the decisions you make.
- Try to make a decision you believe the person would have made in the same circumstances. For guidance, when making decisions, look at the Decision-Making Pathway on the next page, or for more detail visit www.advancecaredirectives.sa.gov.au

Where to get help, advice and more information

Visit the Advance Care Directives website.
www.advancecaredirectives.sa.gov.au, to download the:

- How to assess decision making capacity' fact sheet
- 'Supporting a person to make a decision' fact sheet
- 'How to make a decision – standing in the person's shoes' fact sheet

You can also call the Legal Services Commission help line on 1300 366 424.

Office of the Public Advocate

- Website: www.opa.sa.gov.au
- Advice line: 8342 8200
- Dispute Resolution Service website:
- www.opa.sa.gov.au/what_we_do/dispute_resolution_service



Stand in my shoes: a guide to decision making for Substitute Decision-Makers

STEPS

1. **Is the person able to make a decision?** As Substitute Decision-Maker, you may want to assess whether the person is able to make their own decision for yourself. To help you make an assessment, read the 'How to assess decision making capacity' fact sheet. If the person is unable to make their own decision (meaning a substitute decision is required), move to Step 2.

2. **Check whether the person's preferences are included in their Advanced Care Directive.** Check whether preferences relevant to the decision have been included in the person's Advanced Care Directive, or mentioned to you in a previous discussion.

3. **Listen to health professionals.** For decisions relating to the person's health, listen to the advice given by health professionals about treatment, health care options and likely outcomes. Think about how this advice lines up with the person's wishes, in particular:
   - interventions some people might think are overly burdensome or intrusive; and
   - 'What I don't want to happen to me (outcomes of care I wish to avoid)', included in Part 3 and 4 of the Form.

4. **Comply.** Make sure you comply with specific refusals of medical treatments or health care and interventions, if they apply to the current circumstances (Part 4 of the Form).

5. **Consider other preferences.** Consider other preferences and directions in the Advanced Care Directive, relevant to your current decision (Part 3 of the form).

6. **Consultation.** If there are no other specific relevant preferences or directions, contact other people close to the person to see if there were any relevant, previously expressed views and social or relationship factors to consider in decision making.

7. **What do you know about the person?** Think about the person's known values, life goals and cultural, linguistic and religious preferences, and make the decision that the person would make if they had access to current information and advice.

8. **Consider the options.** If you find you have many options that meet the decision-making criteria, choose the least restrictive option, that makes sure the person will have the overall best care and well-being.

9. **Post-decision care.** Think about where the person will live once the decision has been made-do informal arrangements for the person's care already exist, and are they suitable?

10. **Decide.** If there is no evidence of what the person would have decided, make the decision that best reflects the person's health, well-being and values.



Information for Witnesses

What to know before witnessing an Advance Care Directive

The following persons or classes of persons are considered authorised witnesses.

Check that you fit one of the authorised witness categories:

☐ Health practitioners, as defined under the *Health Practitioner Regulation National Law (South Australia) Act 2010*
☐ Justices of the Peace, as defined under the *Justices of the Peace Act 2005*
☐ Legal practitioners, as defined under the *Legal Practitioners Act 1981*
☐ Police Officers, as defined under the *Police Act 1998*
☐ Social workers registered with Australian Association of Social Workers
☐ Teachers registered with the Teachers Registration Board of South Australia

You must be independent of the person you are witnessing for, and cannot be:

- a beneficiary in their Will – for example a family member
- appointed as their Substitute Decision-Maker; or
- their health practitioner or paid professional carer.

If there is a chance you will be the person's health practitioner in the future, you should not witness their Advance Care Directive.

It is your choice whether or not you witness a person's Advance Care Directive.

- To be valid, an Advance Care Directive must be completed on the official Advance Care Directive Form. It may be completed in handwriting or electronically.
- Do not witness the Advance Care Directive until it has been finalised, including signed by any Substitute Decision-Makers (you do not need to witness the acceptance).
- It is not your role to check the content of the person's Advance Care Directive.
- If you think the person is not competent to complete an Advance Care Directive, you can request they provide medical documentation which states that they are.

Checklist for witnesses

To fulfil your obligations as a witness, you must complete the following checklist:

- ☐ Confirm that the identity of the person matches the details on the Form.
- ☐ Give the person the Advance Care Directive Information Statement page.
- ☐ Speak with the person alone so you can assess if they are voluntarily giving the Advance Care Directive and to limit the possibility of coercion by others.
- ☐ Once the person has read the Advance Care Directive Information Statement ask the questions below to make sure you are satisfied the person appears to understand the Information Statement and that they do not appear to be acting under duress or coercion.
  - ☐ What is an Advance Care Directive?
  - ☐ When will your Advance Care Directive be used?
  - ☐ What types of decisions will it cover?
  - ☐ Who will have to follow your Advance Care Directive?
  - ☐ Why have you decided to complete an Advance Care Directive?
  - ☐ Have you appointed any Substitute Decision-Makers? Why did you choose them? What decisions will they be able to make? When will they be able to make decisions for you?
- ☐ If the person has appointed any Substitute Decision-Makers, make sure they have signed the Form and accepted their appointment. This must be done before you witness the document. You do not need to witness the acceptance.
- ☐ Check whether there are any alterations to the Form (including white-out). You and the person completing the Form should initial and date any alterations. Make sure any blank sections have a large “Z” drawn across them.
- ☐ If you are satisfied that the person appears to understand the Advance Care Directive Information Statement and that they do not appear to be acting under duress or coercion, ask the person to sign the Form in front of you. If they are physically unable to sign due to an injury, illness or disability, another person can sign on their behalf. This person should not be an appointed Substitute Decision-Maker.
- ☐ Fill in the Witness Statement in Part x of the Advance Care Directive Form. Record your name, occupation and contact details and then sign the Form. Both you and the person must initial and date each page of the Advance Care Directive in the boxes provided.
- ☐ Make multiple certified copies of the document after it has been signed by all parties and witnessed. Please see page x of the Guide or visit the website for information about certifying copies of the original Advance Care Directive Form.

Training

Online training for all witnesses is available from Justices of Peace Training Organisation

- Go to: http://sa.jpto.org.au/
- TAFE – email: advancecare.online@tafesa.edu.au





Information for Interpreters

You are reading this because you have been asked to help someone complete an Advance Care Directive, and they require assistance with the English language.

Under Section 14 of the *Advance Care Directives Act 2013*, as an interpreter you must fulfil the following requirements, and be:

a. an adult with capacity; and

b. subject to similar requirements as apply to witnesses under section 15, to ensure that interpreters cannot also:

   a. be Substitute Decision-Makers,

   b. have an interest in the estate of the person giving the Advance Care Directive,

   c. be a health practitioner responsible for the care of the person,

   d. occupy a position of authority by virtue of their employment in a hospital, aged care facility or other institution.

The person may have already completed an Advance Care Directive in their own language. If they have, you will need another blank Advance Care Directive Form (available on the website) to translate their words into English on a blank Form.

The official copy of the person's Advance Care Directive must be in English so others, especially those providing healthcare, can read it.

As the interpreter, you must fill in Part x of the Advance Care Directive Form.

By signing your name, you are certifying that:

1. You gave the person the Advance Care Directive Information Statement (you may have to read it to them) and in your opinion, they appeared to understand the information given.
   The Information Statement is available in 15 different languages on the Advance Care Directive website.
2. Your translation and what you have written on the Advance Care Directive Form accurately reproduces in English the information and instructions of the person. There are penalties for writing false or misleading statements on an Advance Care Directive or forcing someone to write information in an Advance Care Directive that they do not want to write. You must explain to the person that they need to sign their Advance Care Directive in front of an authorised independent witness. You may also be able to witness their Advance Care Directive, if you are also an authorised witness as specified under the Act and Regulations.



Additional Information

For more information about:

- Making certified copies of Advance Care Directives
- Letting people know you have an Advance Care Directive
- What to do if there are problems with your Advance Care Directive; or
- How to cancel an existing Advance Care Directive and to download a cancellation form

Visit the Fact Sheet section at www.advancecaredirectives.sa.gov.au

To see an example of a completed ACD Form, visit: https://advancecaredirectives.sa.gov.au/upload/home/ACDFormSAMPLEsecure.pdf

Contact Information

Advance Care Directives website: Complete your Advance Care Directive online or download the Form from: www.advancecaredirectives.sa.gov.au

Australian Health Practitioner Regulation Agency (AHPRA): For concerns about misconduct in relation to an Advance Care Directive not being correctly followed under the Act, call 1300 419 495, or from outside Australia, +61 3 9285 3010.

Legal Services Commission:
For advice or to witness your Advance Care Directive. Visit: www.lsc.sa.gov.au or call 1300 366 424.

Office of the Public Advocate
For advice, help, and to resolve disputes visit www.opa.sa.gov.au, call 08 8342 8200 or 1800 066 969 (Country SA only).

SA Civil and Administrative Tribunal (formerly the Guardianship Board)
To resolve disputes, visit www.sacat.sa.gov.au or call 08 8368 5600 or 1800 800 501 (Country SA only).

Stop Elder Abuse: For concerns about the abuse of an older person's rights visit www.sahealth.sa.gov.au/stopelderabuse, or call 1800 372 310.

Aged Rights Advocacy Service
Visit www.sa.agedrights.asn.au or call 08 8232 5377 or 1800 700 600 (Country SA only).

Council on the Ageing
For assistance to complete your own Advance Care Directive.
Contact: www.cotasa.org.au; 08 8232 0422; Country SA only: 1800 182 324

Seniors Information Service
Contact: www.seniors.asn.au; 08 8168 8776; Country SA only: 1800 636 368

Palliative Care Council of South Australia
Contact: www.pallcare.asn.au;
08 8271 1643

Personally Controlled Electronic Health Record
Visit: www.ehealth.gov.au

Planning Ahead (SA):
Information on Planning Ahead
Visit: www.sahealth.sa.gov.au/planningahead

Start2Talk: Information on planning ahead. Visit: www.start2talk.org.au

Law Society of South Australia
Contact: www.lawsociety.sa.asn.au
08 8229 0200

Royal Association of Justices SA
Contact: www.rajsa.asn.au; 08 8297 4044



Key words explained

Advance Care Directive: is a legal form for people aged over 18 years. It can record your wishes and instructions for your future health care, end of life, preferred living arrangements and other personal matters. It can also be used to appoint one or more adults to make these decisions for you, if you are unable to make your own decisions.

To be legal, you must only use the official Advance Care Directive Form (which can be found online at www.advancecaredirectives.sa.gov.au).

Certified Copy: is a legal copy of a properly witnessed Advance Care Directive. The document is certified when an authorised witness (any person on the witness list) either stamps or makes a declaration on the front page, verifying that the copy being stamped or declared is a true copy of the original sighted by the witness.

Comfort care: is care that will keep you comfortable and manage your pain until you die, but will not cure your illness. .

Health care: ccan include medical treatment, life-sustaining treatment, surgery, mental health treatment, medications, dental treatment, maternity care, emergency care, nursing care, podiatry, physiotherapy, optometry, psychological therapy, Aboriginal health care, occupational therapy, and other services provided by registered health practitioners, such as traditional Chinese medicine.

Health and medical research: can involve many disciplines, activities, researchers and research institutions. Examples of health and medical research are laboratory research, clinical trials or epidemiological studies.

Health and medical research can take place in universities, hospitals and other medical institutions and companies by people including scientists, nurses, general practitioners and medical specialists.

Life-sustaining treatment: is treatment that keeps you alive but doesn't improve your health. For example, your heart being restarted (CPR), life support with machines keeping you alive, renal dialysis, or food and fluid given to you by a tube.

Palliative care: is end of life care. It aims to improve your quality of life, prevent suffering, manage your pain until you die, and support your family through the process and after your death.

Personal decisions: are all about your cultural or spiritual matters, your pets, holidays, employment, personal grooming, dress standards, care of children if you are in hospital temporarily, and relationships that are important to you.

You can make your own decision if you can:

- understand information about the decision
- understand the risks and benefits of the choices
- remember the information for a short time
- tell someone what the decision is, and why you have made the decision.

If, in the future, you can't do these four (4) things, it means you are unable to make the decision and someone else will need to make the decision for you.

Residential and accommodation decisions (called living arrangements in this guide): can include where you wish to live, whether to go into supported care, whether you prefer to have a view of the garden, live by the sea, live with others or on your own.

Substitute Decision-Maker(s): is an adult you choose and appoint in your Advance Care Directive to make decisions about your future health care, end of life, living arrangements and other personal matters when you can't make these decisions for yourself. This could be for a short time only, or permanently.

Voluntary assisted dying: is a decision to end your life. It must be voluntary, initiated and undertaken by the person themselves. Only people who are already dying from an incurable, advanced and progressive disease, illness or medical condition can access voluntary assisted dying.

For more information

Telephone: 1300 366 424
www.advancecaredirectives.sa.gov.au

To purchase hard copies of the guide and form visit your closest Service SA Centre.

Advance Care Directives
Department for Health and Wellbeing

The ACD brochure is available in 15 different languages on the ACD website.

https://creativecommons.org

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