advance care planning (ACP)

palliative care and disability

southern metropolitan region palliative care consortium

fact sheet series

February 2016
Updated January 2024

Information for disability services staff working in group homes

what is advance care planning (ACP)?

Advance Care Planning (ACP) provides an opportunity for people to make decisions about the types of care and treatment they would like if they are unable to communicate their wishes in the future. It is advisable for people with a terminal illness to undertake advance care planning.

how does ACP apply to people with disabilities living in group homes?

A diagnosis of a life limiting illness can be very distressing and talking about death and dying can be challenging. It may be necessary for decisions to be made quickly.

ACP can assist families and guardians to make decisions that better reflect the wishes and beliefs of the resident. For staff in Group Homes, ACP provides an opportunity to plan for the care that the resident might need including the resources to enable staff to support the resident and increase their understanding of their illness and their ability to be part of the decision-making process.

ACP can include:

- Advance Care Plan/Directive
- The resident's preferences, values, beliefs and wishes for future treatment and care. Where this is difficult to ascertain, direction can be taken from the resident's previous individual service planning.
- Appointment of a medical treatment decision maker and support person (this may already be in place but should be reviewed)
- Person responsible for consent
- Refusal of Treatment Certificate

who is involved and what are their roles?

To better support the resident, it is important that everyone understands the goals of care and participates in the ACP process. Those involved could include:

- Resident
- Family and significant others – to provide guidance regarding the resident's wishes if required
- Person Responsible, Guardian or Enduring Power of Attorney
- Group Home Staff, House Supervisor and/or Individual Worker - to provide support and guidance on the resident's wishes as well as what care the Group Home can provide
- GP – witness directives and provide information on the resident's illness and care required
- Advance Care Planning Support Service – information, support and resources

smrpcc website

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what is the process?

- identify the person's beliefs, values and goals
- involve family, person responsible and significant others in advance care planning discussions
- talk with the resident's GP about their health and future care needs
- document their wishes in an Advance Care Plan/Directive (these documents will need to be witnessed by their doctor)
- give copies of this document to all relevant people

You may also be able to get support in assisting the resident or their person responsible from your local hospital. Providers in the Southern Metro Region that may be able to assist with this include:

Alfred Health
T: 03 9076 6642
E: advancecareplanning@alfred.org.au
W: www.alfredhealth.org.au

Monash Health
Advance Care Planning Service
T: 03 9594 3475
E: acp@monashhealth.org.au
W: https://monashhealth.org/services/advance-care-planning/

Peninsula Health
T: 03 9788 1593 or 9788 1533
E: acp@phcn.vic.gov.au
W: www.peninsulahealth.org.au/services/services-a-e/advance-care-planning/

more resources

- www.health.vic.gov.au/patient-care/advance-care-planning-0
- www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-act
- www.advancecareplanning.org.au/
- www.publicadvocate.vic.gov.au/
- www.betterhealth.vic.gov.au/health/servicesandsupport/End-of-life-and-palliative-care-for-people-living-with-a-disability

The following site has specific resources on the topic for people with an intellectual disability or cognitive impairment:

- https://learningdisabilitynurse.co.uk/advance-care-planning