Guide for health professionals using the Statement of Choices

This guide is provided to help clinicians when they talk with people about advance care planning or guide them to complete a Statement of Choices document as part of an advance care planning process.

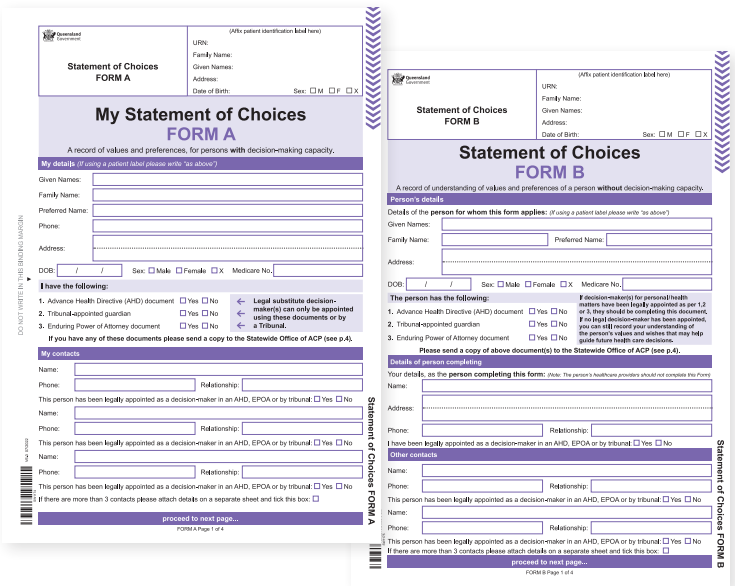
Fast facts:

- The Statement of Choices document (SoC) provides guidance to Substitute Decision Maker(s) (SDMs) and clinicians about a person's individual views, wishes and preferences for care in the event the person is unable to make health care decisions for themselves.
- The SoC is not legally binding and does not provide consent to health care in advance.
- **Participation in any aspect of advance care planning (ACP) is voluntary**. Health professionals must not coerce or direct individuals to participate in ACP and complete documentation.
- Doctors should only provide treatment that is consistent with good medical practice.
- All clinicians must act **only** within their scope of practice when discussing ACP or helping to complete a SoC.

Top tips:

- Before introducing the SoC to others, familiarise **yourself** with the content of both forms:
  - **Form A –** for people **who can make health care decisions for themselves**
  - **Form B –** for people **who cannot make health care decisions for themselves**.
- Allow people time to think and reflect. ACP and completing the SoC may take more than one discussion.
- Explain that it is useful to complete all fields in the SoC, though not all fields are mandatory.

Page 1


Statement of Choices FORM A

My Statement of Choices FORM A

A record of values and preferences, for persons with decision-making capacity.

Statement of Choices FORM B

Statement of Choices FORM B

A record of understanding of values and preferences of a person without decision-making capacity.

My details (Form A) / Person's details (Form B):

- ✓ Place ID sticker on each page OR ensure all details are completed including name of residential aged care facility (RACF), if applicable.
- ✓ Check all identity details are correct, including date of birth, Medicare number and telephone numbers.
- ✓ Tick the boxes to indicate what other documents have been completed or if a Guardian has been appointed by the Queensland Civil and Administrative Tribunal.

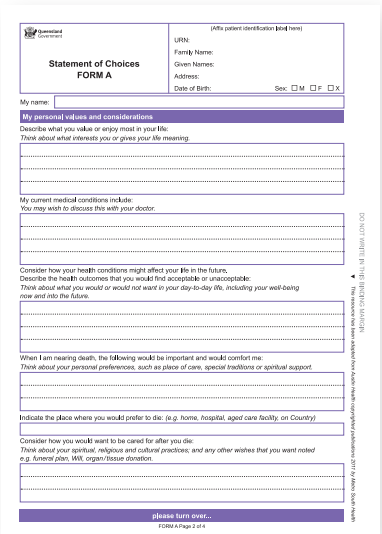
Details of person completing (Form B):

- ✓ Note: The person's legally appointed SDMs should be the person completing a Form B; or if not applicable, person(s) in a close and continuing relationship with the individual.
- ✓ A person's health care provider should not complete the SoC on a person's behalf.

My Contacts (Form A) / Other contacts (Form B):

- ✓ Complete this section to name SDMs who may have been legally appointed to give consent for health matters. Note: SDMs will only be required to give consent when the person is unable to make or communicate decisions for themselves.
- ✓ Encourage completion of all relevant lines in the box, including whether the listed person(s) is appointed as an attorney in an Enduring Power of Attorney (EPOA) or Advance Health Directive (AHD) or as a guardian under a Queensland Civil and Administration Tribunal (QCAT) Decision.
- ✓ A Statutory Health Attorney is a person who has authority to make health decisions in the absence of formally appointed decision-makers and acts as SDM only when the need arises (see SoC Glossary of Terms for full criteria).

Page 2



Statement of Choices
FORM A

My name:

My personal values and considerations

Describe what you value or enjoy most in your life:
Think about what interests you or gives your life meaning.

My current medical conditions include:
You may wish to discuss this with your doctor.

Consider how your health conditions might affect your life in the future.
Describe the health outcomes that you would find acceptable or unacceptable:
Think about what you would or would not want in your day-to-day life, including your well-being now and into the future.

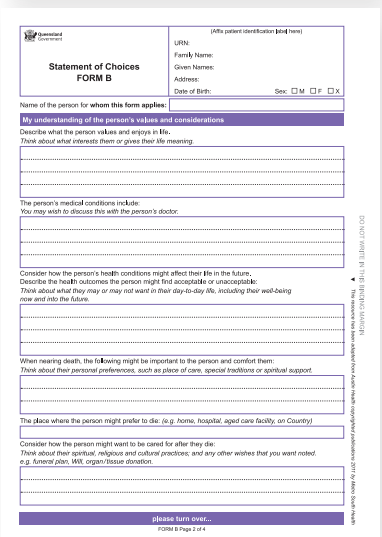
When I am nearing death, the following would be important and would comfort me:
Think about your personal preferences, such as place of care, special traditions or spiritual support.

Indicate the place where you would prefer to die: *(e.g. home, hospital, aged care facility, on Country)*

Consider how you would want to be cared for after you die:
Think about your spiritual, religious and cultural practices; and any other wishes that you want noted e.g. funeral plan, Will, organ/tissue donation.

please turn over...

FORM A Page 2 of 4



Statement of Choices
FORM B

Name of the person for whom this form applies:

My understanding of the person's values and considerations

Describe what the person values and enjoys in life..
Think about what interests them or gives their life meaning.

The person's medical conditions include:
You may wish to discuss this with the person's doctor.

Consider how the person's health conditions might affect their life in the future..
Describe the health outcomes the person might find acceptable or unacceptable:
Think about what they may or may not want in their day-to-day life, including their well-being now and into the future.

When nearing death, the following might be important to the person and comfort them:
Think about their personal preferences, such as place of care, special traditions or spiritual support.

The place where the person might prefer to die: *(e.g. home, hospital, aged care facility, on Country)*

Consider how the person might want to be cared for after they die:
Think about their spiritual, religious and cultural practices; and any other wishes that you want noted. e.g. funeral plan, Will, organ/tissue donation.

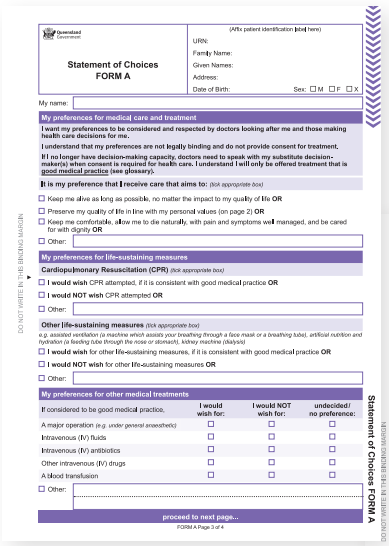
please turn over...

FORM B Page 2 of 4

Personal values and considerations:

- ✓ Try to include SDMs/family members in the discussion. This is important information for them to have.
- ✓ Build a rich description of the person's life, **what they value, what brings them joy and gives their life meaning.** This might include their past work; personal stories; preferred surroundings, rituals, enjoyable activities; what they value most regardless of declining health; past hospital or health experiences; what puts a smile on their face now.
- ✓ All **major health conditions** should be recorded such as chronic illnesses, disease states, previous major surgery, a pacemaker. This list is particularly important when using Form B as diagnoses listed can help to indicate to other health professionals why the person did not have sufficient capacity at the time to complete a Form A.
- ✓ Confirm that the person completing the form understands the likely impacts/outcomes of the medical conditions listed. If not, encourage them to discuss further with their doctor who can assist them to understand.
- ✓ Include other information to help guide medical decision making such as being pain free, not suffering, to be treated with dignity, hold honest discussions with SDMs and what would be important as death is approaching.
- ✓ Encourage people to consider health outcomes **they would find acceptable.** Avoid ambiguous phrases when recording health outcomes, **they would find unacceptable**, such as "being a vegetable". Expand on the thoughts behind their words; situations they want to avoid such as "unable to feed myself or go to the toilet", "be a burden to the family", "be alone".
- ✓ Expand on the person's preferred environment as they come to **the end of their life** so that others know how to comfort them, e.g. place of care, special traditions, spiritual needs or rituals, family being present, type of music, TV use, pets nearby.
- ✓ Record the **preferred place of death**. This may change if unexpected conditions or circumstances arise e.g. home, hospital, aged care facility, on Country.
- ✓ Record special preferences for **care after they die**. Record any spiritual, religious, or cultural practices; and other wishes the person wants noted e.g. funeral plan, Will, organ/tissue donation.

Page 3


Statement of Choices FORM A

(Affix patient identification label here)

URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐X

My name:

My preferences for medical care and treatment

I want my preferences to be considered and respected by doctors looking after me and those making health care decisions for me.

I understand that my preferences are not legally binding and do not provide consent for treatment.

If I no longer have decision-making capacity, doctors need to speak with my substitute decision-maker(s) when consent is required for health care. I understand I will only be offered treatment that is good medical practice (see glossary).

It is my preference that I receive care that aims to: *(tick appropriate box)*

☐ Keep me alive as long as possible, no matter the impact to my quality of life **OR**
☐ Preserve my quality of life in line with my personal values (on page 2) **OR**
☐ Keep me comfortable, allow me to die naturally, with pain and symptoms well managed, and be cared for with dignity **OR**
☐ Other:

My preferences for life-sustaining measures

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

☐ **I would wish** CPR attempted, if it is consistent with good medical practice **OR**
☐ **I would NOT wish** CPR attempted **OR**
☐ Other:

Other life-sustaining measures *(tick appropriate box)*

e.g. assisted ventilation (a machine which assists your breathing through a face mask or a breathing tube), artificial nutrition and hydration (a feeding tube through the nose or stomach), kidney machine (dialysis)

☐ **I would wish** for other life-sustaining measures, if it is consistent with good medical practice **OR**
☐ **I would NOT wish** for other life-sustaining measures **OR**
☐ Other:

My preferences for other medical treatments

If considered to be good medical practice,	I would wish for:	I would NOT wish for:	undecided/ no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐
☐ Other:			

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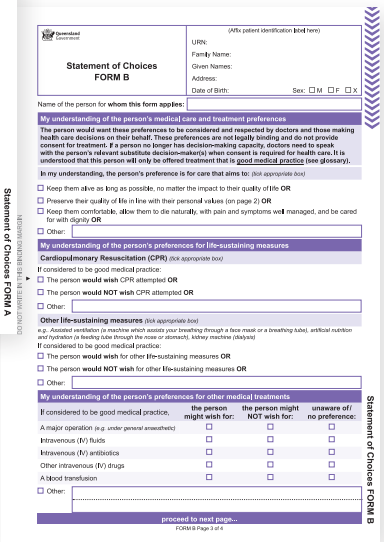
FORM A Page 3 of 4

DO NOT WRITE IN THE BINDING MARGIN

Statement of Choices FORM A


Statement of Choices FORM B

(Affix patient identification label here)

URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐X

Name of the person for **whom this form applies:**

My understanding of the person's medical care and treatment preferences

The person would want these preferences to be considered and respected by doctors and those making health care decisions on their behalf. These preferences are not legally binding and do not provide consent for treatment. If a person no longer has decision-making capacity, doctors need to speak with the person's relevant substitute decision-maker(s) when consent is required for health care. It is understood that this person will only be offered treatment that is good medical practice (see glossary).

In my understanding, the person's preference is for care that aims to: *(tick appropriate box)*

☐ Keep them alive as long as possible, no matter the impact to their quality of life **OR**
☐ Preserve their quality of life in line with their personal values (on page 2) **OR**
☐ Keep them comfortable, allow them to die naturally, with pain and symptoms well managed, and be cared for with dignity **OR**
☐ Other:

My understanding of the person's preferences for life-sustaining measures

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

If considered to be good medical practice:
☐ The person **would wish** CPR attempted **OR**
☐ The person **would NOT wish** CPR attempted **OR**
☐ Other:

Other life-sustaining measures *(tick appropriate box)*

e.g. Assisted ventilation (a machine which assists your breathing through a face mask or a breathing tube), artificial nutrition and hydration (a feeding tube through the nose or stomach), kidney machine (dialysis)

If considered to be good medical practice:
☐ The person **would wish** for other life-sustaining measures **OR**
☐ The person **would NOT wish** for other life-sustaining measures **OR**
☐ Other:

My understanding of the person's preferences for other medical treatments

If considered to be good medical practice,	the person might wish for:	the person might NOT wish for:	unaware of/ no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐
☐ Other:			

proceed to next page...

FORM B Page 3 of 4

DO NOT WRITE IN THE BINDING MARGIN

Statement of Choices FORM B

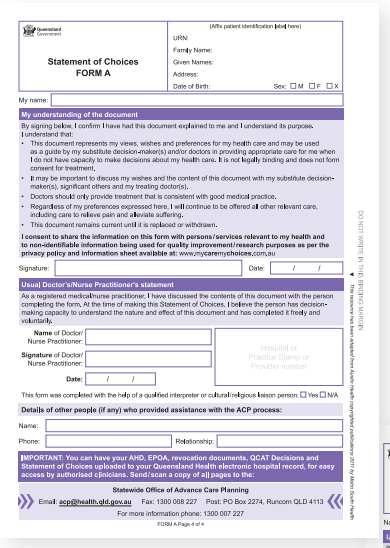
Preferences for medical care and treatment:

- ✓ Encourage the person to consider the medical care, treatment preferences and goals of care they would want considered and respected by doctors and those making health care decisions on their behalf.
- ✓ Explain to the person these preferences are not legally binding and do not provide consent for treatment. Remind that doctors should only offer/ provide treatment that is consistent with good medical practice.

Life-sustaining measures and medical treatments:

- ✓ Be prepared, **within your scope of practice**, to answer questions, provide information or explain in general terms the likely outcomes of treatments in relation to their health conditions and values.
- ✓ Encourage the person to make an appointment with their usual doctor to discuss their preferences for treatments.
- ✓ Use the **"Other"** boxes in the medical treatments section, if required, to qualify the "would wish" or "would not wish" preferences. For example, "please discuss benefits and limitations of other treatments fully with my family"; "I don't wish to die in an ICU".

Page 4


Statement of Choices FORM A

(Affix patient identification label here)

URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐X

My name:

My understanding of the document

By signing below, I confirm I have had this document explained to me and I understand its purpose.
I understand that:

- This document represents my views, wishes and preferences for my health care and may be used as a guide by my substitute decision-maker(s) and/or doctors in providing appropriate care for me when I do not have capacity to make decisions about my health care. It is not legally binding and does not form consent for treatment.
- It may be important to discuss my wishes and the content of this document with my substitute decision-maker(s), significant others and my treating doctor(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of my preferences expressed here, I will continue to be offered all other relevant care, including care to relieve pain and alleviate suffering.
- This document remains current until it is replaced or withdrawn.

I consent to share the information on this form with persons/services relevant to my health and to non-identifiable information being used for quality improvement/research purposes as per the privacy policy and information sheet available at: www.mycarermychoices.com.au

Signature: Date: / /

Usual Doctor's/Nurse Practitioner's statement

As a registered medical/nurse practitioner, I have discussed the contents of this document with the person completing the form. At the time of making this Statement of Choices, I believe the person has decision-making capacity to understand the nature and effect of this document and has completed it freely and voluntarily.

Name of Doctor/ Nurse Practitioner:
Signature of Doctor/ Nurse Practitioner:
Date: / /

Hospital or Practice Stamp or Provider number

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

Details of other people (if any) who provided assistance with the ACP process:

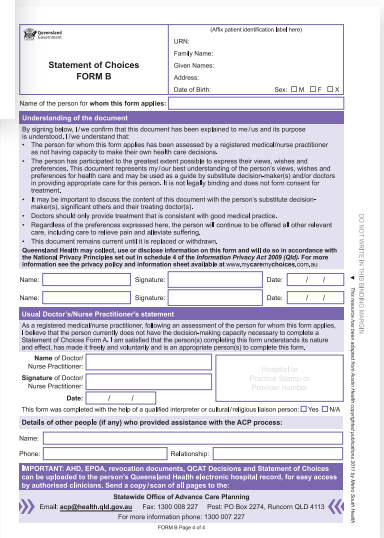
Name:
Phone: Relationship:

IMPORTANT: You can have your AHD, EPOA, revocation documents, QCAT Decisions and Statement of Choices uploaded to your Queensland Health electronic hospital record, for easy access by authorised clinicians. Send/scan a copy of all pages to the:

Statewide Office of Advance Care Planning
Email: acp@health.qld.gov.au Fax: 1300 008 227 Post: PO Box 2274, Runcorn QLD 4113
For more information phone: 1300 007 227

FORM A Page 4 of 4

DO NOT WRITE IN THE BINDING MARGIN


Statement of Choices FORM B

(Affix patient identification label here)

URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐X

Name of the person for **whom this form applies:**

Understanding of the document

By signing below, I/we confirm that this document has been explained to me/us and its purpose is understood. I/we understand that:

- The person for whom this form applies has been assessed by a registered medical/nurse practitioner as not having capacity to make their own health care decisions.
- The person has participated to the greatest extent possible to express their views, wishes and preferences. This document represents my/our best understanding of the person's views, wishes and preferences for health care and may be used as a guide by substitute decision-maker(s) and/or doctors in providing appropriate care for this person. It is not legally binding and does not form consent for treatment.
- It may be important to discuss the content of this document with the person's substitute decision-maker(s), significant others and their treating doctor(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of the preferences expressed here, the person will continue to be offered all other relevant care, including care to relieve pain and alleviate suffering.
- This document remains current until it is replaced or withdrawn.

Queensland Health may collect, use or disclose information on this form and will do so in accordance with the National Privacy Principles set out in schedule 4 of the Information Privacy Act 2009 (Qld). For more information see the privacy policy and information sheet available at www.mycarermychoices.com.au

Name: Signature: Date: / /
Name: Signature: Date: / /

Usual Doctor's/Nurse Practitioner's statement

As a registered medical/nurse practitioner, following an assessment of the person for whom this form applies, I believe that the person currently does not have the decision-making capacity necessary to complete a Statement of Choices Form A. I am satisfied that the person(s) completing this form understands its nature and effect, has made it freely and voluntarily and is an appropriate person(s) to complete this form.

Name of Doctor/ Nurse Practitioner:
Signature of Doctor/ Nurse Practitioner:
Date: / /

Hospital or Practice Stamp or Provider number

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

Details of other people (if any) who provided assistance with the ACP process:

Name:
Phone: Relationship:

IMPORTANT: AHD, EPOA, revocation documents, QCAT Decisions and Statement of Choices can be uploaded to the person's Queensland Health electronic hospital record, for easy access by authorised clinicians. Send a copy/scan of all pages to the:

Statewide Office of Advance Care Planning
Email: acp@health.qld.gov.au Fax: 1300 008 227 Post: PO Box 2274, Runcorn QLD 4113
For more information phone: 1300 007 227

FORM B Page 4 of 4

DO NOT WRITE IN THE BINDING MARGIN

My understanding (Form A) / Understanding of the document (Form B):

- ✓ The person completing the SoC must sign and date the declaration.
- ✓ Consent to "sharing information" allows alerts and a copy of the SoC to be filed in the person's medical records, a copy to be uploaded to The Viewer, and for de-identified data to be used for service improvements. Note: The Viewer is a Queensland Health state-wide electronic application.

Usual Doctor/Nurse Practitioner's statement:

- ✓ Ensure a doctor or nurse practitioner signs and dates the document.
- ✓ The signature indicates to all health professionals that the person has been able to ask questions and adequately discuss health care preferences. The doctor/nurse practitioner indicates they believe the person has capacity and has freely and voluntarily completed the SoC for themself (Form A) or that (Form B) has been completed by an appropriate SDM.
- ✓ The doctor/nurse practitioner may not necessarily agree with the person's preferences.
- ✓ If applicable, add details of other people who provided assistance with the ACP process.

Note: Unless signed and dated by the person completing the SoC and a doctor or nurse practitioner the document cannot be uploaded to The Viewer.

What to do when you receive a completed SoC:

- ✓ Check through the document to ensure minimum criteria are completed (see Checklist for SoC to be uploaded to The Viewer).
- ✓ The original document should remain with the person named in the SoC, at the person's home or RACF.
- ✓ Copies should be made available for the GP, SDMs, family members, hospital (if applicable).
- ✓ Send a copy of the SoC by email, fax or post to the Statewide Office of ACP (see below) for upload the person's Queensland Health electronic hospital record (The Viewer) and easy access by authorised clinicians.

It is important to remember ACP is not a static event. People can change their minds over time or as their health changes. A new SoC may need to be completed at the time of review or at another preferred time.

Review of SoC:

- ✓ Encourage the person to review the health care preferences with their doctor, especially if there is a change in health status.
- ✓ Encourage a short review period if the person has very advanced disease. Over time evidence of further functional decline may alter perceptions about the treatment preferences.
- ✓ On review of a SoC, if a person wishes they can:
  - void the SoC (by putting two lines through it, signing and dating)
  - make a new SoC, or
  - make changes to the SoC—and initial and date these
  - a copy of voided, new, updated SoCs can be sent to the Statewide Office of ACP for uploading to the person's Queensland Health electronic hospital record. It will replace any earlier versions uploaded
  - documenting in medical records re: review/discussions/changes would also be relevant.

IMPORTANT: AHD, EPOA, revocation documents, QCAT Decisions and Statement of Choices can be uploaded to a person's Queensland Health electronic hospital record, for easy access by authorised clinicians. Send / scan a copy of all pages to the:

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