The Respecting Patient Choices (RPC) Program is an advance care planning program that trains staff and implements system changes to provide individuals with the opportunity to have a greater say in their current and future health care.

Advance care planning is a process enabling a person to make decisions about his or her future health care in consultation with their health care providers, family members and other important people in their lives.

This guide provides health care professionals with an outline of how they can identify and meet a number of accreditation standards, as a result of implementing the Respecting Patient Choices advance care planning program in their residential aged care facility (RACF).

It may also be used by staff from RACFs that haven't yet implemented the RPC Program to identify the standards that could be met through the implementation of the RPC Program and following this guide.

For each identified Accreditation Standards relevant to advance care planning, an outcome measure has been suggested and a variety of tools have been developed to record these measures.

How does Respecting Patient Choices work?
The RPC Program is based on systematic communication and documentation of the issues underlying advance care planning. It enables residents to reflect on what is important to them, on their beliefs, values and goals in life, and how they want to be cared for if they reach a point where they cannot communicate or make decisions for themselves at a time when important medical decisions need to be made.

Often residents do not have the opportunity to speak to their families, doctors or carers about what is important to them and how they would want to be cared for. This is critical when decisions need to be made about treatments for a resident who can no longer communicate or make medical decisions.

Discussions with residents and families about future treatments can be challenging, emotionally charged and time-consuming. Residents expect doctors and other health professionals to raise the topic for discussion. However, doctors may find it difficult to find the time and resources to have these discussions with their residential patients.

The RPC Program trains health care professionals, usually nursing, social work or other allied health staff within an organisation, to initiate and facilitate these advance care planning discussions. General Practitioners play a crucial role in the discussion, providing medical advice and support for the resident to discuss their beliefs, values and goals. The RPC Program takes a more comprehensive approach to end-of-life planning. The Program...
provides for the involvement of family, carers and doctors in the process and ensures that the documentation is available when required and that the appointed agents and relevant health care professionals are aware of a person’s wishes.

Residents are encouraged to discuss how they would want to be cared for if they were seriously ill, or injured or had deteriorated to a point where they couldn’t communicate or make decisions for themselves. These discussions include information about their ‘best interests’ and appropriate medical care, life-sustaining treatments and transfer to hospital, as well as other wishes relating to end-of-life care. These wishes may be as specific; such as playing certain music, calling the person’s family together or having the person’s spiritual leader visit, if that is important to them.

This approach to end-of-life planning is a significant cultural change for many organisations. Results from both the original Respecting Choices™ Program from La Crosse, Wisconsin, USA, and the Australian RPC Program at Austin Health, have established that a systematic advance care planning program, with continuing education makes certain that patients’ future treatment wishes are known and respected in end-of-life care.

RACFs that implement the RPC Program are able to:

- Promote an individual's understanding of their current health and treatment options;
- Facilitate conversations between the resident, their agent and the significant people in their lives about their values, beliefs and goals in life, and, in light of their current health status, what medical treatments they would and would not want, in the future;
- Assist individuals to document their wishes and preferences for future medical treatment, particularly end-of-life treatment, in an Advance Care Plan;
- Ensure this documentation is transferable so that it goes with the patient to other health care services;
- Appropriately follow plans in a thoughtful and respectful way;
- Comply with current state legislation (e.g in Victoria the Program is based on powers enabled by the Victorian Medical Treatment Act 1988, and the Guardianship and Administration Act 1996 and encourages residents to appoint a Medical Enduring Power of Attorney (MEPOA) called the ‘agent’.

The Program has been adapted and developed for implementation in SA, NSW and Qld and is currently being developed for implementation in WA, Tasmania, NT and ACT during 2006..

Aged Care Standards and Accreditation Agency

The Aged Care Standards and Accreditation Agency is the independent body responsible for managing the accreditation and ongoing supervision of Australian Government funded aged care homes.

There are four Accreditation Standards:

- Management systems, staffing and organisational development
- Health and personal care
- Resident lifestyle
- Physical environment and safe systems.

Within the four Accreditation Standards are 44 expected outcomes

A home must be accredited by the Agency in order to receive funding from the Australian Government. Even after a home receives accreditation, the Agency continues to monitor homes to ensure residents continue to receive a high level of care and that all standards continue to be met. Homes must also show to the Agency that they regularly seek feedback from staff, residents and their families, and look at ways they can improve.

The following is a guide for aged care providers that will assist them to meet a number of accreditation standards as a result of implementing the Respecting Patient Choices Program.
Accreditation Standards

Standard 1 - Management systems, staffing and organisational development

Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

Intention of standard: This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

1.1 Continuous improvement
The organisation actively pursues continuous improvement.

RPC Impact:
The RPC Program is a structured continuous improvement program which identifies residents’ needs through a systematic approach and aids to implement care to meet these needs. The RPC Program encourages the organisation to review its current practices of advance care planning and formalise its process into their care practices. It will assist the organisation to identify improvements in:

- Standards of resident care
- Service delivery
- Documentation
- Residents and family information
- Residents and family satisfaction
- Continuing education.

Suggested Measure:
Medical record audits will provide evidence of:

- advance care planning discussions with residents, their families, and the health care professionals
- the completion of documents how these are filed appropriately in the resident’s medical record
- the resident’s expressed wishes, and if they were met at the end of their life (if died in the RACF).

1.2 Regulatory compliance
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.

RPC Impact:
The RPC Program, through its structured implementation method, ensures that all advance care planning discussions are recorded and documents are filed in a common place in the resident’s medical file and that all staff are educated how and when to retrieve and use this information.

Education sessions are held and staff learn about legislation relating to advance care planning, and enduring powers of attorney. The Program encourages all residents to appoint an agent (if competent), complete a Refusal of Treatment Certificate (if appropriate) and a Statement of Choices document.

If the resident is no longer legally capable of making their own decisions staff are educated and provided with information to identify the legal ‘person responsible’ that can make medical decisions for the resident. Education also includes information about the process and documentation of advance care planning and how this information can be transferred when...
the resident moves from one health care setting to another (e.g. an acute hospital) or by another health care professional (such as GPs or after hours locum services).

**Suggested Measure:**
- Number of documents filed in the resident's medical record, or correct identification and documentation of the resident's 'person responsible'.
- Reviews of all resident deaths to compare if any expressed wishes are met.
- It is recommended that all organisations review their current policies and procedures to ensure that they include advance care planning procedures, or write a policy for this.

### 1.3 Education and staff development

Management and staff have appropriate knowledge and skills to perform their roles effectively.

**RPC Impact:**
The RPC Program offers a variety of education sessions to ensure staff are updated with legislation information and have the necessary skills and knowledge to discuss future care preferences and end of life decisions with residents and relatives. The education sessions offered by the RPC Program include:

**a) In-service**
All staff are encouraged to attend in-service education to gain a general knowledge about the RPC Program, understand how it will be implemented in their organisation and understand their role, the role of the RPC Consultants and other staff.

**Suggested Measure:**
- Names and positions of staff who attend these sessions are recorded. Evaluation of the in-service is recommended in accordance with organisational policy.

**b) RPC Consultant’s 2-day Training Course**
The RPC Consultant’s 2-day Training Course consists of 8 learning modules, videos, group discussion and debate, problem solving and role-plays. It aims to provide staff with the necessary skills and knowledge to meet the RPC 5 aims. It is emphasised in the RPC Consultant Training Course that advance care planning is a team responsibility, and each member of the team is only responsible for acting within the boundaries of their position. Some RPC Consultants may initiate an advance care planning discussion, identify the resident's needs and make appropriate referrals to other team members, such as GPs, senior nursing staff etc and facilitate the process fully to the completion of documents whereas other RPC Consultants may make initial steps in the facilitation process and then refer on to another member of staff for follow up. The RPC Program also assists Managers and Directors of Nursing to identify suitable staff for training.

**Suggested Measure:**
- Names and positions of staff who attend these sessions are recorded.
- Evidence of completion certificates and badges are provided.
- It is recommended that a list of RPC Consultants is displayed (+/- photo) on resident and relative information boards, so that they may be easily identified.

**c) Resident’s and Relatives information sessions**
The facility is encouraged to conduct a resident and relative information session just prior to, or immediately after, the staff have attended the RPC Consultant Training Course, and then as further sessions are required (estimate 6-monthly). This session may be conducted by the RPC Project Team (based at the acute health service) or by the facility staff. This information session should include information about the resident's rights and responsibilities related to advance care planning and the legal implications.

**Suggested Measure:**
Attendance should be recorded and the session evaluated in accordance with organisational policy.
d) Mentoring model (for senior staff)
Part of the RPC model is to create a system whereby senior staff are responsible for educating and mentoring new and junior staff about advance care planning and the RPC Program. This is support is provided by RPC Program team at the local acute health services.

Suggested Measure:
- In-service education is available for all staff both in paper and electronic form.
- Education about the RPC Program (including information about advance care planning and the documentation) is included in all new staff orientation.
- Staff who have attended the RPC Consultant Training Course report feeling confident to have advance care planning discussions.

1.6 Human Resource Management
There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives.

RPC Impact:
Through the appropriate identification and selection of staff to become RPC Consultant’s Course a core number of staff will be trained as advance care planning facilitators. On-going training courses ensure that a critical mass of trained staff are always available to address natural attrition of staff.

Suggested Measure:
- Names and positions of staff who attend these sessions are recorded.
- It is recommended the staff who complete the RPC Consultant Training Course have their names +/- a photo displayed on resident and relative information board so that they may be easily identified as having advance care planning facilitation skills.

1.7 Inventory and equipment
Stocks of appropriate goods and equipment for quality service delivery are available.

RPC Impact:
The RPC Program requires a set of materials for successful implementation. These include:
- Green sleeves
- Advance Care Planning Discussion Cards
- Advance Care Plan (ACP)
  - Competent Adult
  - For Adults who cannot legally make decisions for themselves
- Patient education leaflet and booklet
- Promotional Posters for staff areas and patient areas
- Medical record stickers

Suggested Measure:
Through an auditing process evidence can be collected that:
- Posters are being displayed in appropriate areas
- Information materials are available to give to residents and families
- Materials are available to document the advance care planning process
- Documents are stored according to organisation policy.

1.8 Information systems
Effective information management systems are in place.

RPC Impact:
The RPC Program offers a systematic way to manage the information obtained through the advance care planning process and to capture residents preferences for future medical care and end-of-life care. The following materials enable this:
• The Green Sleeve – a green plastic sleeve that is located at the front of a resident's medical file and contains the advance care planning discussion card and the Advance Care Plan.

• Advance care planning discussion card – this card records any advance care planning discussions and a summary of documents developed. If a resident expresses preferences for health care but does not wish to record it themselves the discussion card may be used to communicate that this conversation has occurred and what the preferences of the resident were. This may be copied and sent to other health care organisations that the resident may attend.

• Medical Enduring Power of Attorney document (or equivalent) – if this document has previously been completed by the resident or is completed as part of the advance care planning process, a copy should be located in the Green Sleeve to immediately identify to the staff who the resident’s person responsible is if the resident becomes incompetent.

• Statement of Choices
• Refusal of Treatment Certificate

Suggested Measure:
• A medical records audit can be used to ensure that the above materials are used to document relevant information and filed appropriately in the resident’s medical file.
• Questioning of staff regarding their awareness of the RPC materials, knowledge of where they are stored (if they have been developed) and knowledge of how to use and implement if the time is appropriate.

1.9 External Services
All externally sourced services are provided in a way that meets the residential care service’s needs and services quality goals.

RPC Impact:
The advance care planning discussions should include the resident’s preferences regarding site of care. This may include transfer to hospital for acute care by, preference for palliative care in a specialised palliative care unit, integration of external services into the facilities care such as care from the resident’s GP, visits from a priest, involvement of family in decision making, palliative care services from a community-based program, etc. Once these preferences have been identified by the resident appropriate referrals can be made and discussions held to ensure that these requests are met.

Suggested Measure:
• Audit of events surrounding the resident’s death will identify if their wishes were respected and if these services were utilised.
Standard 2 - Health and personal care

Principle: Residents’ physical and mental health will be promoted and achieved at the optimum level, in partnership between each resident (or his or her representative) and the health care team.

2.1 Continuous improvement
The organisation actively pursues continuous improvement.

RPC Impact:
The RPC Program is based on the ethical principle of individual autonomy, self-determination, and understanding the individual’s beliefs, values and goals. It is a systematic process of ensuring all residents are offered the opportunity to participate in advance care planning.

Suggested Measure:
- Evidence that the advance care planning discussions have included the resident, their family and health care providers.
- Each ACP is individual, based on the resident’s beliefs, values and goals and reflects their individual preferences for future care both medical and non-medical.
- An audit process will show the proportion of residents introduced to the Program.

2.2 Regulatory compliance
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about health and personal care.

RPC Impact:
The RPC Program operates within relevant state/territory legislation. Staff receive education about relevant Acts and how to complete and comply with documents (such as a MEPOA, Statement of Choices or Refusal of Treatment Certificate) developed. The RPC Program encourages the organisations to develop policies and procedures to ensure there is a process for staff to know that documents exist and know how and when to use them.

Suggested Measure:
- Development of policies and procedures to support advance care planning and the RPC Program.

2.3 Education and staff development
Management and staff have appropriate knowledge and skills to perform their roles effectively.

RPC Impact:
The RPC Program offers a variety of education sessions to ensure staff are updated with legislation information and have the necessary skills and knowledge to discuss future care preferences and end of life decisions with residents and relatives. The education sessions offered by the RPC Program include:

   e) In-service
   All staff are encouraged to attend in-service education to gain a general knowledge about the RPC Program, understand how it will be implemented in their organisation and understand their role, the role of the RPC Consultants and other staff.

Suggested Measure:
- Names and positions of staff who attend these sessions are recorded. Evaluation of the in-service is recommended in accordance with organisational policy.

   f) RPC Consultant’s 2-day Training Course
   The RPC Consultant’s 2-day Training Course consists of 8 learning modules, videos, group discussion and debate, problem solving and role-plays. It aims to provide staff with the
necessary skills and knowledge to meet the RPC 5 aims. It is emphasised in the RPC Consultant Training Course that advance care planning is a team responsibility, and each member of the team is only responsible for acting within the boundaries of their position. Some RPC Consultants may initiate an advance care planning discussion, identify the resident’s needs and make appropriate referrals to other team members, such as GPs, senior nursing staff etc and facilitate the process fully to the completion of documents whereas other RPC Consultants may make initial steps in the facilitation process and then refer on to another member of staff for follow up. The RPC Program also assists Managers and Directors of Nursing to identify suitable staff for training.

Suggested Measure:
- Names and positions of staff who attend these sessions are recorded.
- Evidence of completion certificates and badges are provided.
- It is recommended that a list of RPC Consultants is displayed (+/- photo) on resident and relative information boards, so that they may be easily identified.

g) Resident's and Relatives information sessions
The facility is encouraged to conduct a resident and relative information session just prior to, or immediately after, the staff have attended the RPC Consultant Training Course, and then as further sessions are required (estimate 6-monthly). This session may be conducted by the RPC Project Team (based at the acute health service) or by the facility staff. This information session should include information about the resident’s rights and responsibilities related to advance care planning and the legal implications.

Suggested Measure:
Attendance should be recorded and the session evaluated in accordance with organisational policy.

h) Mentoring model (for senior staff)
Part of the RPC model is to create a system whereby senior staff are responsible for educating and mentoring new and junior staff about advance care planning and the RPC Program. This is support is provided by RPC Program team at the local acute health services.

Suggested Measure:
- In-service education is available for all staff both in paper and electronic form.
- Education about the RPC Program (including information about advance care planning and the documentation) is included in all new staff orientation.
- Staff who have attended the RPC Consultant Training Course report feeling confident to have advance care planning discussions.

2.4 Clinical care
Residents receive appropriate clinical care.

RPC Impact:
The process of advance care planning assists residents to be involved in the development of an Advance Care Plan (ACP). A copy of the plan should be made available to the resident and anyone else to whom they choose to give a copy. The preferences and wishes expressed in the resident’s ACP should be reflected in their clinical care plan.

A process of reviewing the residents ACP should be completed routinely each year, on return from hospital or with any change in health condition. A system then needs to be established to ensure the outcomes of the review is acted upon. The RPC Program offers a systematic process of providing all healthcare providers, including the resident’s regular GP or locum medical staff, with information about the resident’s preferences for healthcare and who their surrogate decision maker if a time comes that the resident cannot communicate for themselves and decisions about care need to be made.

Suggested Measure:
- Documentation on the Contact Information Page of the ACP identifies who has received copies of an ACP is captured.
2.5 Specialised nursing care needs
Residents’ specialised nursing care needs are identified and met by appropriately qualified nursing staff.

RPC Impact:
If, through the advance care planning process mentioned in 2.4, specialised nursing care needs are identified then appropriate referrals to relevant healthcare professionals are made and care needs are met. This would include consideration for any medical treatments, which are being refused on either verbally, on a Statement of Choices or on a refusal of Treatment certificate (Vic only).

Suggested Measure:
- An audit of clinical care plans shows evidence that the content of ACPs have been considered when developing a resident’s clinical care plan.

2.6 Other health and related services
Residents are referred to appropriate health specialists in accordance with the resident’s needs and preferences.

RPC Impact:
Through the advance care planning discussions resident’s preferences for site of care, and/or by whom, should be discussed. This may include transfer to hospital for acute care ambulance, preference for palliative care in a specialised palliative care unit, integration of external services into the facilities care such as visits from a priest, involvement of family in decision making, palliative care services from a community-based program, etc. Once these preferences have been identified by the resident appropriate referrals can be made and discussions held to ensure that these requests are met.

Suggested Measure:
- Preferences for healthcare including external services are documented on the Advance Care Planning Discussion Card or Statement of Choices. Referrals are made and care implemented to reflect preferences stated by the resident. Audit of events surrounding the resident’s death will identify if their wishes were respected.

2.8 Pain management
All residents are as free as possible from pain.

RPC Impact:
During advance care planning discussions RPC Consultants address the resident’s preferences for comfort care. This becomes more important when the resident has a medical condition from which they may die within the next 12 months. Considerations to be covered include pain medications, preferences for surroundings and other forms of comfort care such as music or warmth.

Suggested Measure:
- Preferences for comfort care are documented on the Advance Care Planning Discussion Card or Statement of Choices.
- Audit of events surrounding the resident’s death will identify if their wishes were respected.

2.9 Palliative care
The comfort and dignity of terminally ill residents is maintained.

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RPC Impact:
The RPC Program promotes early discussion about palliative care so that the resident is able to express their preferences well before a crisis or critical event happens. As the advance care planning discussions are about the future, residents are encouraged to express their treatment preferences, as well as their comfort preferences for the future, taking into account their current medical condition and their beliefs, values and goals. The discussions may include consideration of medical treatment preferences, spiritual preferences, religious preferences, cultural considerations, pain management and comfort preferences, dignity, psychological support needs and support from family and friends. Discussions are encouraged to include the resident’s family and healthcare providers so that they can discuss the preferences of the resident, their beliefs and values behind the preferences and ensure that if the resident becomes incompetent their surrogate decision maker will be able to advocate their preferences for them.

Suggested Measure:
- Evidence of preferences are documented on the Advance Care Planning Discussion Card or Statement of Choices.
- Evidence of the names of people involved in the planning (both family and healthcare providers) are recorded on the Advance Care Planning Discussion Card.
- Audit of events surrounding the resident’s death will identify if their wishes were respected.
**Standard 3 - Resident lifestyle**

**Principle:** Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

**3.1 Continuous improvement**
The organisation actively pursues continuous improvement.

**RPC Impact:**
The RPC Program is based on the ethical principle of individual autonomy, self-determination, and understanding the individual's beliefs, values and goals. It is a systematic process of ensuring all residents are offered the opportunity to participate in advance care planning.

**Suggested Measure:**
- Evidence that the advance care planning discussions have included the resident; their family and health care providers.
- Each ACP that is developed is individual, based on the resident's beliefs, values and goals and reflects their individual preferences for future care both medical and non-medical.
- An audit process will show the proportion of residents introduced to the Program.

**3.2 Regulatory compliance**
The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines, about resident lifestyle.

**RPC Impact:**
The RPC Program operates within relevant state/territory legislation. Staff receive education about relevant Acts and how to complete and comply with documents (such as a MEPOA, Statement of Choices or Refusal of Treatment Certificate) developed. The RPC Program encourages the organisations to develop policies and procedures to ensure there is a process for staff to know that documents exist and know how and when to use them.

**Suggested Measure:**
- Development of policies and procedures to support advance care planning and the RPC Program.

**3.3 Education and staff development**
Management and staff have appropriate knowledge and skills to perform their roles effectively.

**RPC Impact:**
Information referring to an individual’s rights both at a legal and consumer level are covered in the 2-day RPC Consultant’s Course in both modules 3, 5 and 8.

**Suggested Measure:**
- Names and positions of staff who attend these sessions are recorded.
- It is recommended the staff who complete the 2-day RPC Consultant’s Course have their names +/- a photo displayed on resident and relative information board so that they may be easily identified as having advance care planning facilitation skills.

**3.4 Emotional support**
Each resident receives support in adjusting to life in the new environment and on an ongoing basis.
RPC Impact:
The process of advance care planning promotes the resident to ask questions about their health and current condition, express their fears about the future and, with the support of the RPC Consultant, work through what will help them to live well. The process of improved communication between the resident, their family and the health care providers creates an environment of each feeling supported and understanding that they can ask questions and discuss how they are feeling.

The RPC Program has demonstrated a positive impact on the dying process of residents due to the fact that when a critical event happens to a resident has participated in advance care planning preferences for treatment have already been discussed and may simply be revisited and reviewed with the resident. If the resident has become incompetent the plan can be acted upon with the support of the family and their agent if one has been appointed. In this way the staff report feeling more comfortable with their ability to support the resident and their family during this time and they know the specific wishes of the.

Suggested Measure:
- Evidence of wishes are expressed and documented on the Advance Care Planning Discussion Card or on a Statement of Choices completed by the resident or their family.

3.5 Independence
Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

RPC Impact:
Advance care planning encourages a resident's independence whilst supporting them to make their wishes for health care known. It provides them with a forum to discuss their needs in relation to their beliefs, values and goals. It provides a structured way to document the preferences of the resident and their beliefs, values and goals (such as religious, cultural or spiritual). It's structure also means that referrals identified by the RPC Consultant (such as need to talk to their GPs) are made and followed-up.

Suggested Measure:
- Evidence of wishes are expressed and documented on the Advance Care Planning Discussion Card or on a Statement of Choices completed by the resident or their family.

3.6 Privacy and dignity
Each resident’s right to privacy, dignity and confidentiality is recognised and respected.

RPC Impact:
Advance care planning discussions about end-of-life care often refer to a resident’s request for dignity. The Program assists the resident, family and health care staff to explore and identify what this means for each individual and document this on the ACP. Often residents will express preferences for after death care and this may also be documented on the ACP (eg: organ donation, special wishes for funerals etc.)

Consideration of a resident’s privacy in regard to advance care planning is paramount to advance care planning. This is in regard to both the discussions and the distribution of the plan. Residents should be asked who they would like involved in the advance care planning discussions and then who should receive a copy of the plan if it is formalised. The resident should also be informed that if they are transferred it is advisable that a copy of the plan is sent with them so that other health care professionals may know and be able to respect, their wishes.

Suggested Measure:
- Staff are aware of the residents wishes regarding who is involved in decision-making and who should receive copies of the documents developed.
- This is recorded on the Advance Care Planning Discussion Card.
3.7 Leisure interests and activities
Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them.

RPC Impact:
One of the goals of advance care planning is to focus the discussion on 'living well'. RPC Consultants are taught the "Living Well" structured Interview. This helps the resident identify what is important to them and what gives their life meaning. Through this the impact of illness and medical treatments may be discussed in reference to their benefits and burdens to the resident. When asked the residents sometimes make very simple but unexpected requests.

Suggested Measure:
- RPC Consultants document on the Advance Care Planning Discussion Card that they have included the ‘Living Well’ structured interview in their advance care planning discussions.

3.8 Cultural and spiritual life
Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.

RPC Impact:
Through advance care planning discussions reference to the resident’s beliefs, values and goals are constantly being made. These are documented on the Statement of Choices under the headings:
- If I am nearing my death, I want the following (list things that would be important to you)……
- If I am nearing my death and cannot speak, please give my family and friends the following message…….

Suggested Measure:
- Preferences for the resident’s end-of-life wishes, which are reflective of their beliefs, values and goals are documented on a Statement of Choices or Advance Care Planning Discussion Card and stored in the green sleeve.

3.9 Choice and decision-making
Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

RPC Impact:
The RPC Program facilitates a process for the resident to understand their health condition and the future scenarios they may encounter, types of treatments they may require and alternative treatments that may be available. It encourages them to take time to reflect on this information and think about what is important to them, what helps them to live well and the impact their health condition has on their life. It assists them to talk their family, GP and other health care professionals about their preferences for future health care and, to document their preferences for a time when they are not legally competent to make, or can no longer communicate their own decisions.

The Program continues to support the individual to be given the opportunity to make their own decisions whilst they are able to do so and, through the appointing of a MEPOA, this right is continued when the resident loses their legal capacity or is unable to communicate their own decisions for medical care.
To aid this process, and the resident’s and their families understanding of the Program a patient information leaflet and booklet is given to the resident and/or their family as appropriate. One of the modules in the RPC Consultant Training Course is called “Cultural religious and spiritual perspectives on advance care planning”. In this module RPC Consultants are educated on cultural considerations including language and cultural considerations.

**Suggested Measure:**

- Evidence of advance care planning discussions are recorded on the discussion card and show that the resident and their family have been involved in the discussions.
- These discussions may be individual discussions with a resident or group discussions such as a resident and relatives information session.
- Documents are completed and fulfill the legal requirements, and are located in the green sleeve in the resident’s medical file.
- A Statement of Choices is completed if appropriate (they reflect the resident’s beliefs, values and goals) and are filed in the green sleeve.
- Refusal of Treatment Certificates (Vic only) are completed if appropriate and filed in the green sleeve.