Government of **Western Australia**
Department of **Health**

Understanding WA's new Advance Health Directive & Advance Care Planning resources

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WA Department of Health

Acknowledgement of Country

I would like to acknowledge the traditional owners of the land we meet on today, the Wadjuk people of the Noongar nation. I would also like to pay my respect to Elders past, present and emerging.

What I'll cover

- What is Advance Care Planning?
- The benefits of Advance Care Planning
- A model for Advance Care Planning
- Overview of the revised AHD
- New resources
- How to be hopeful and prepared
- How you can help

Some facts…

- Death and dying are a normal part of life
- 15,891 deaths in WA in 2021 (171,469 in Australia)
- In WA, more than 80% due to 5 causes:
  - Cancers (29%), heart & other circulatory diseases (25%),dementia (10%), respiratory diseases (8%), external causes (9%)
- **Only a small % of deaths were unpredictable**
  - Stroke (4%), heart attack (4%), accidents and injuries (4%) and suicide (2%)

Most of us will have some warning…

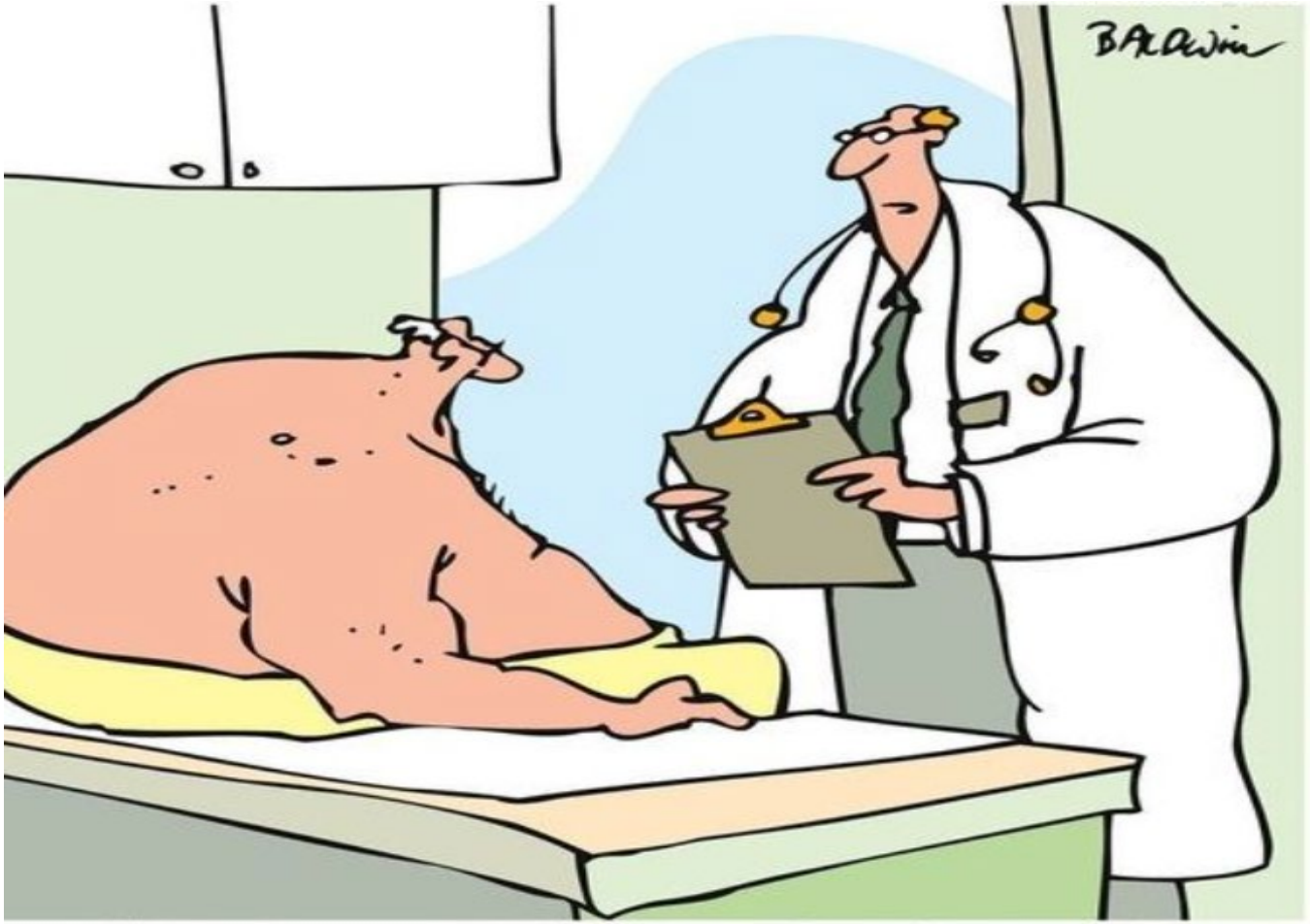
What is advance care planning?

A **voluntary process** of planning for future health and personal care whereby the **person's values, beliefs and preferences** are made known to **guide decision-making at a future time** when that person cannot make or communicate their decisions.

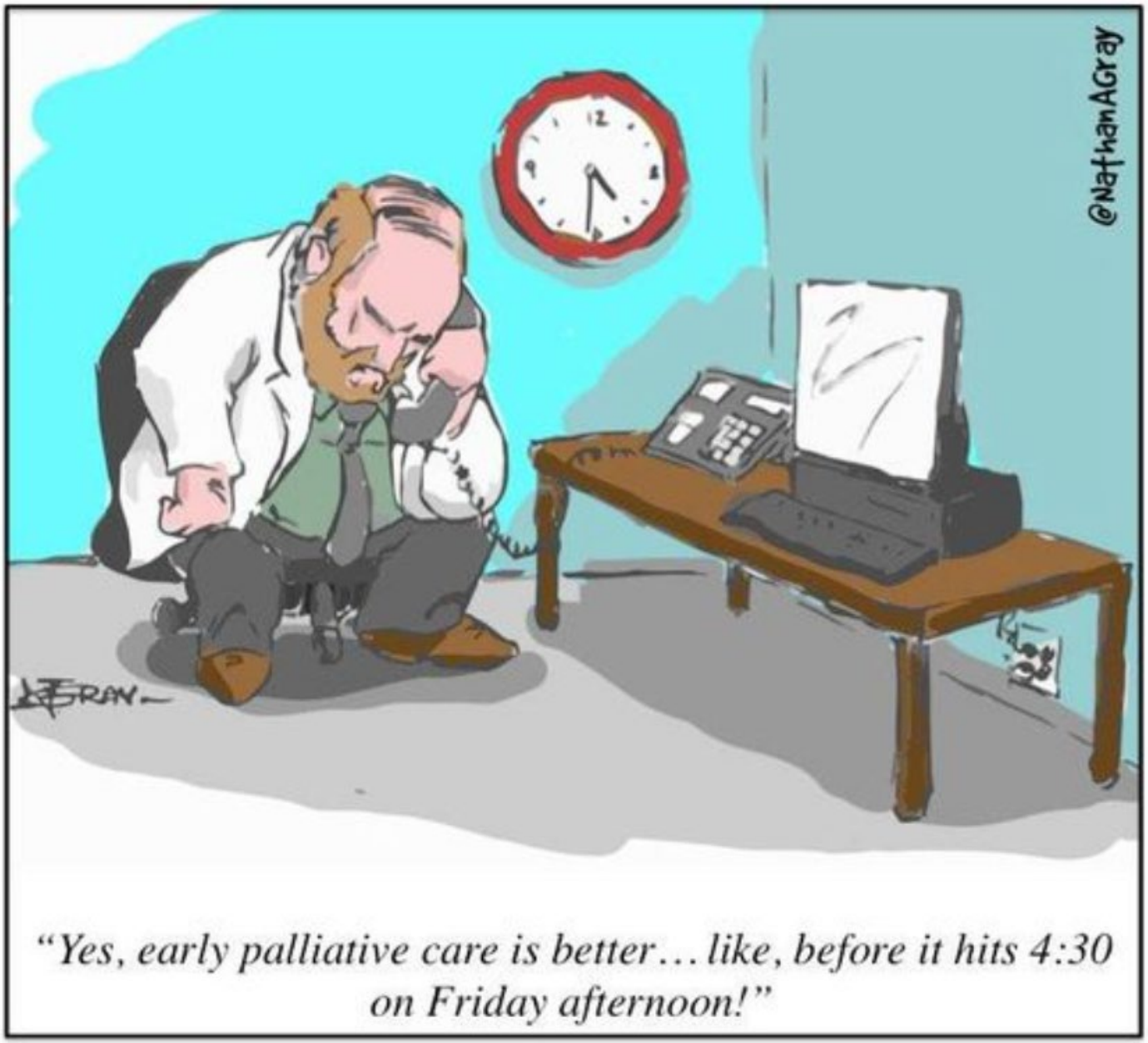
National Framework for Advance Care Planning Documents

Benefits of ACP

- Opportunity to plan
- Guides health professionals and substitute decision makers
- Helps ensure care provided is consistent with the person's beliefs, values, needs and preferences
- Families experience less anxiety, depression, and stress
- Reduces non-beneficial transfers to acute care.



"You've got six months, but with aggressive treatment we can help make that seem much longer."



"Yes, early palliative care is better… like, before it hits 4:30 on Friday afternoon!"

ACP model for consumers

1. THINK

Triggers to start or revisit ACP conversations

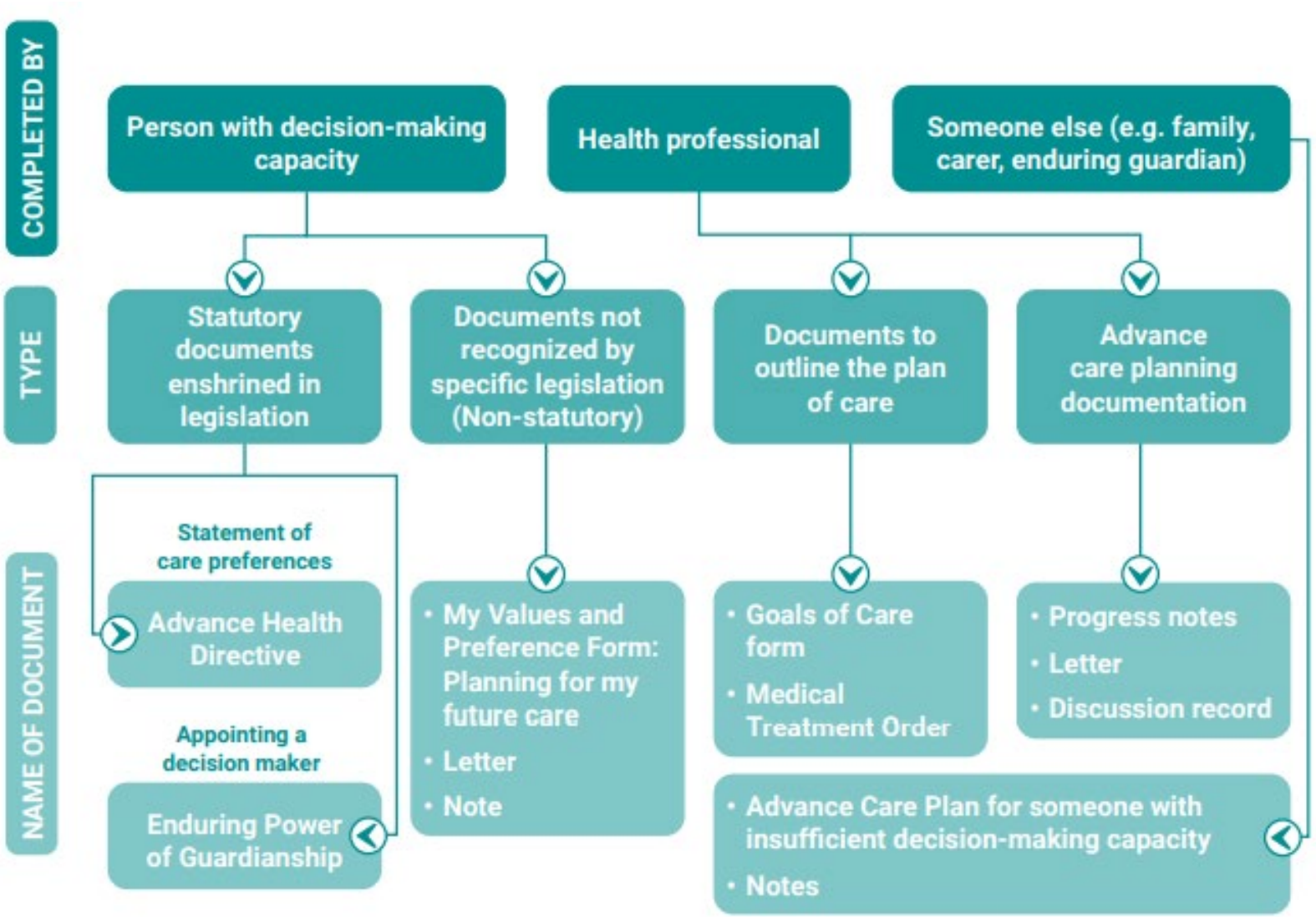
- Discussions of current or future treatment goals
- Scheduled health assessments
- Diagnosis of, or change in, a chronic or life-limiting illness, especially if individual may lose capacity
- Changes in care arrangements or applications for assistance
- If you would not be surprised if the person died within 12 months
- Recent hospital admission.

2. TALK

During the discussion

- Explain what ACP is
  - Provide or direct them to reliable, easy to read information
- Review any existing ACP documents.
- Consider current health/history and concerns/worries/fears about future health care
- Encourage the person to talk with family and friends
- Acknowledge and respect the person's own beliefs and values
- Plan time to continue the conversations in the future.

ACP documentation flow in WA



3. WRITE

Documents completed by a person with decision-making capacity

- Statutory (Recognised under legislation and generally must be followed)
  - Advance Health Directive
  - Enduring Power of Guardianship

- Non-statutory (do not carry the same legal force but may guide future decision-makers)
  - Values and Preferences Form

3. WRITE

Documents that can be made on behalf of a person without decision-making capacity

- Advance care plan for a person with insufficient decision-making capacity

4. SHARE

Storing ACP documents

- Record details of ACP discussions
  - Place written documentation in person's file
  - Include copies of documents and discussions in referrals where relevant

- Advise to store:
  - Original in safe place
  - Upload to My Health Record

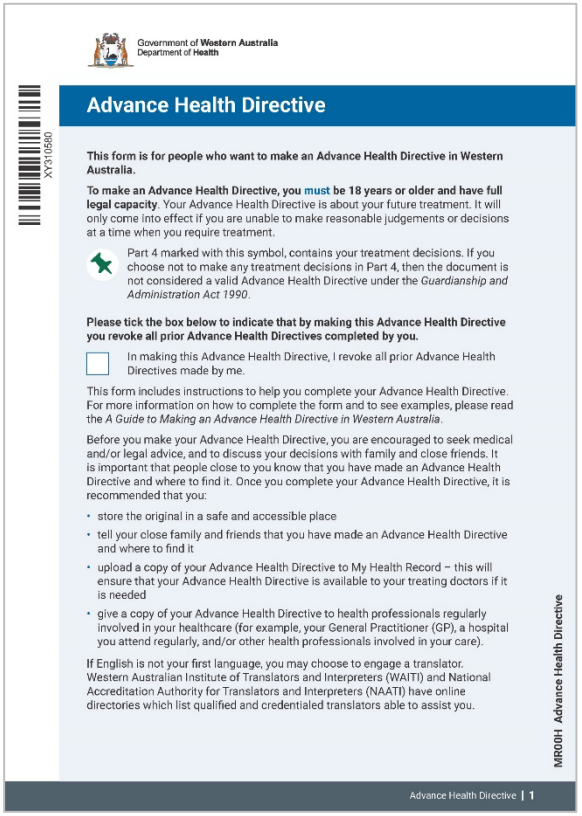
- Encourage to share with:
  - Family/friends/carers
  - Enduring guardian (EPG)
  - GP/specialist/ health professional
  - Local hospital
  - Residential aged care home
  - Legal professional

My Health Record

OVERVIEW OF REVISED ADVANCE HEALTH DIRECTIVE

Revised AHD & Guide

- Revised Advance Health Directive
- Guide to Making an Advance Health Directive in Western Australia



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Advance Health Directive

This form is for people who want to make an Advance Health Directive in Western Australia.

To make an Advance Health Directive, you must be 18 years or older and have full legal capacity. Your Advance Health Directive is about your future treatment. It will only come into effect if you are unable to make reasonable judgements or decisions at a time when you require treatment.

Part 4 marked with this symbol, contains your treatment decisions. If you choose not to make any treatment decisions in Part 4, then the document is not considered a valid Advance Health Directive under the *Guardianship and Administration Act 1990*.

Please tick the box below to indicate that by making this Advance Health Directive you revoke all prior Advance Health Directives completed by you.

☐ In making this Advance Health Directive, I revoke all prior Advance Health Directives made by me.

This form includes instructions to help you complete your Advance Health Directive. For more information on how to complete the form and to see examples, please read the *A Guide to Making an Advance Health Directive in Western Australia*.

Before you make your Advance Health Directive, you are encouraged to seek medical and/or legal advice, and to discuss your decisions with family and close friends. It is important that people close to you know that you have made an Advance Health Directive and where to find it. Once you complete your Advance Health Directive, it is recommended that you:

- store the original in a safe and accessible place
- tell your close family and friends that you have made an Advance Health Directive and where to find it
- upload a copy of your Advance Health Directive to My Health Record – this will ensure that your Advance Health Directive is available to your treating doctors if it is needed
- give a copy of your Advance Health Directive to health professionals regularly involved in your healthcare (for example, your General Practitioner (GP), a hospital you attend regularly, and/or other health professionals involved in your care).

If English is not your first language, you may choose to engage a translator. Western Australian Institute of Translators and Interpreters (WAITI) and National Accreditation Authority for Translators and Interpreters (NAATI) have online directories which list qualified and credentialed translators able to assist you.

MR00H Advance Health Directive

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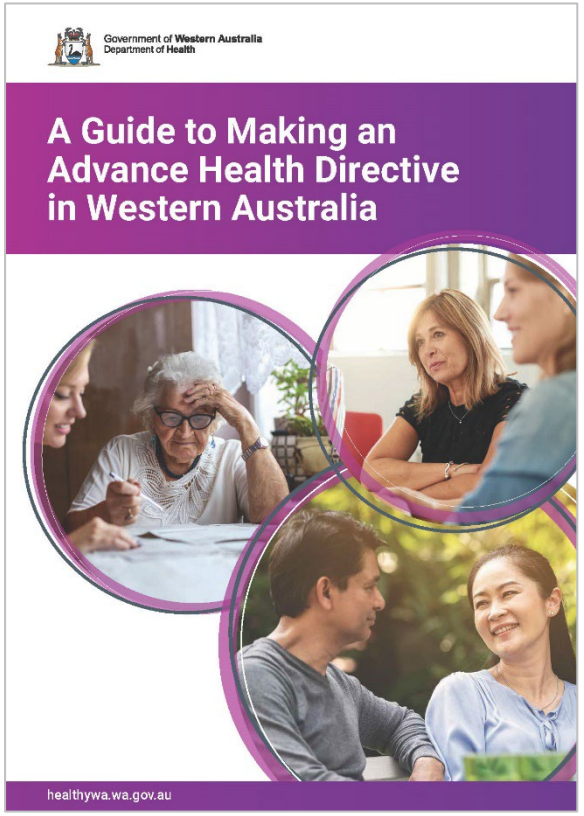

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A Guide to Making an Advance Health Directive in Western Australia

healthywa.wa.gov.au

Features of the revised AHD

- Includes the individual's values and preferences, in addition to treatment decisions
- Combines tick box and free text questions so it is easier to complete
- More guidance and examples
- Includes consent to medical research
- Greater focus on person-centred care

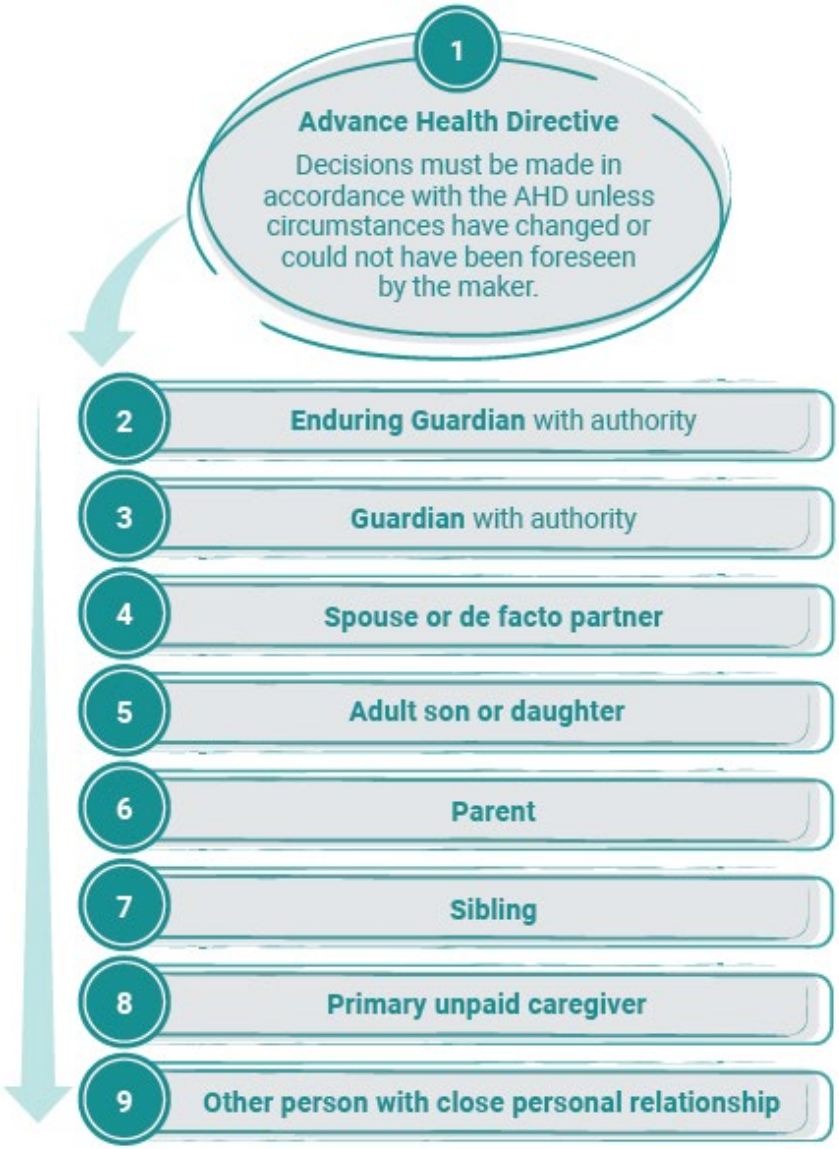
What an AHD cannot be used for

- ✘ Request voluntary assisted dying (VAD)
- ✘ Request or authorise a health professional to take active steps to unnaturally end life
- ✘ To compel health professionals to provide medical treatments that may be considered futile or are not clinically indicated
- ✘ Record wishes about organ and tissue donation

When should an AHD be enacted?

- An AHD would come into effect only if:
  - it applied to the person's circumstances and the treatment required AND
  - the person was unable to make reasoned judgements about a treatment decision at the time that the treatment was required.

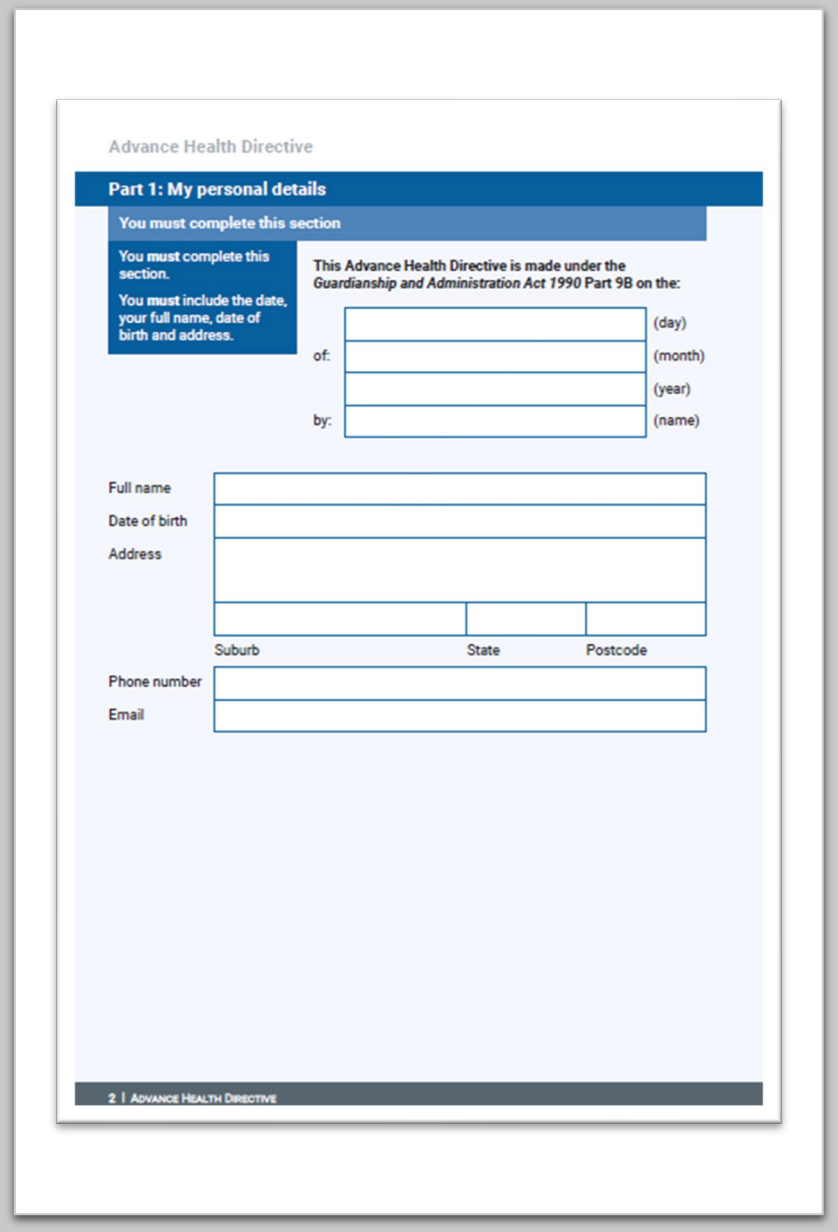
Hierarchy of treatment decision-makers



PARTS OF THE REVISED AHD

Part 1 – My personal details

- Respondent needs to specify when the AHD was made (date/month/year)
- Covers the standard demographic questions.



Advance Health Directive

Part 1: My personal details

You must complete this section

You must complete this section.

You must include the date, your full name, date of birth and address.

This Advance Health Directive is made under the *Guardianship and Administration Act 1990* Part 9B on the:

of: (day) (month) (year)

by: (name)

Full name

Date of birth

Address

Suburb State Postcode

Phone number

Email

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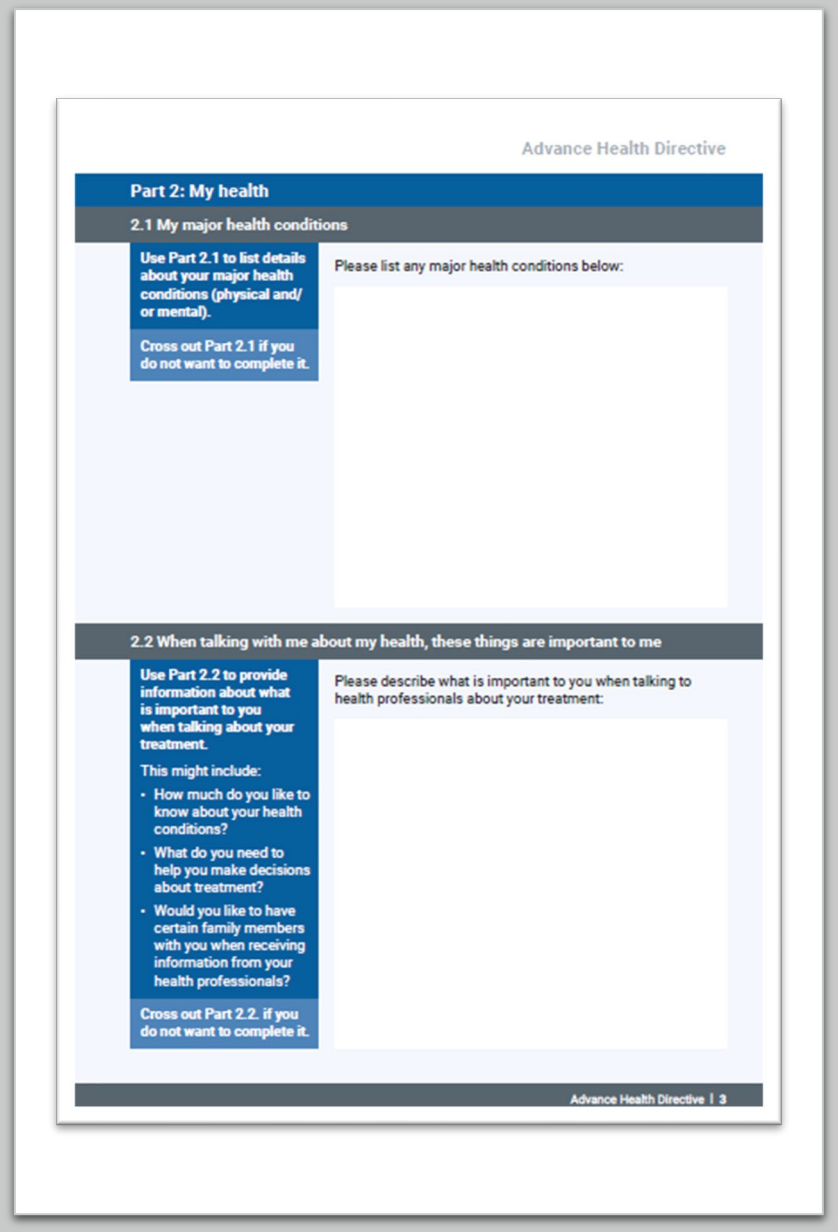
Part 2 – My health

- Includes questions relating to:
  - Major health conditions
  - What is important to the individual when talking to them about their health



Advance Health Directive

Part 2: My health

2.1 My major health conditions

Use Part 2.1 to list details about your major health conditions (physical and/or mental).

Cross out Part 2.1 if you do not want to complete it.

Please list any major health conditions below:

2.2 When talking with me about my health, these things are important to me

Use Part 2.2 to provide information about what is important to you when talking about your treatment.

This might include:

- How much do you like to know about your health conditions?
- What do you need to help you make decisions about treatment?
- Would you like to have certain family members with you when receiving information from your health professionals?

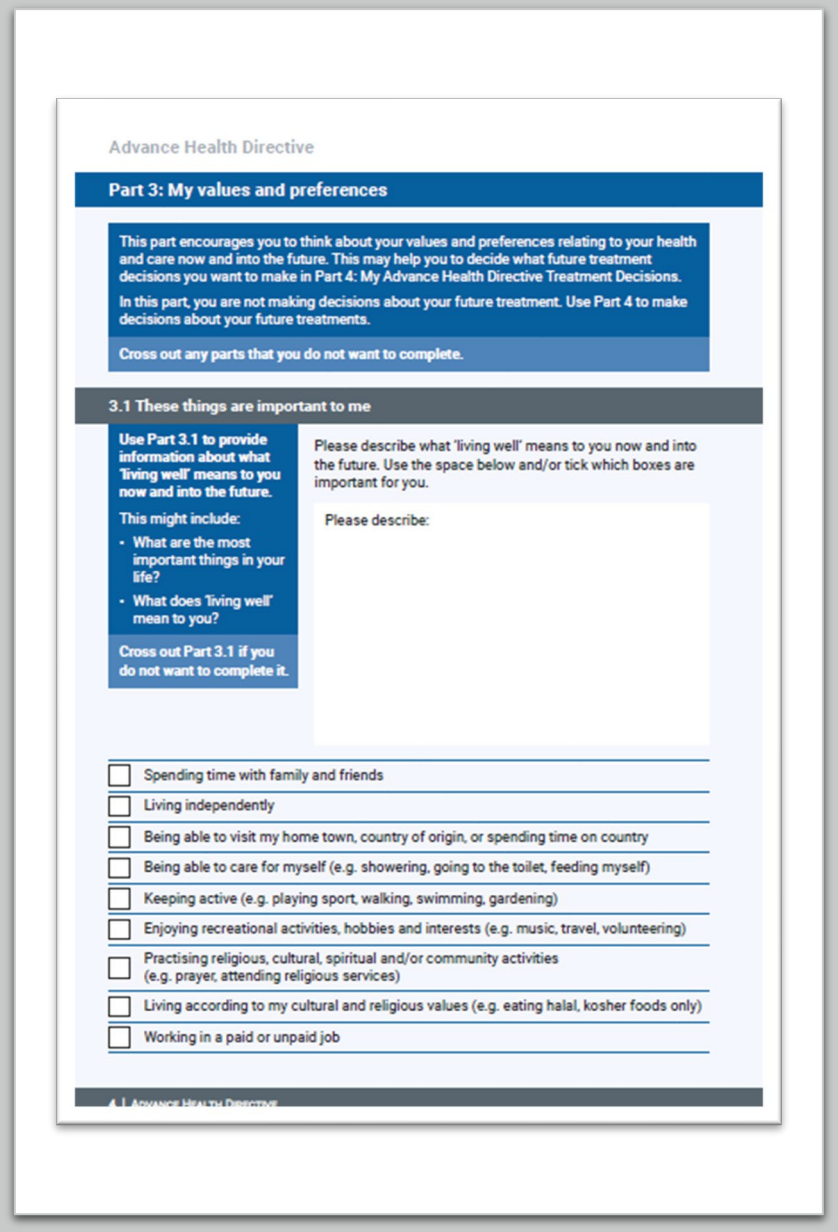
Cross out Part 2.2. if you do not want to complete it.

Please describe what is important to you when talking to health professionals about your treatment:

Advance Health Directive | 3

Part 3 – My values and preferences

- Includes questions relating to:
  - What ‘living well’ means
  - Future health worries
  - End of life questions – preferred place of death, comfort measures



Advance Health Directive

Part 3: My values and preferences

This part encourages you to think about your values and preferences relating to your health and care now and into the future. This may help you to decide what future treatment decisions you want to make in Part 4: My Advance Health Directive Treatment Decisions.

In this part, you are not making decisions about your future treatment. Use Part 4 to make decisions about your future treatments.

Cross out any parts that you do not want to complete.

3.1 These things are important to me

Use Part 3.1 to provide information about what 'living well' means to you now and into the future.

This might include:

- What are the most important things in your life?
- What does 'living well' mean to you?

Cross out Part 3.1 if you do not want to complete it.

Please describe what 'living well' means to you now and into the future. Use the space below and/or tick which boxes are important for you.

Please describe:

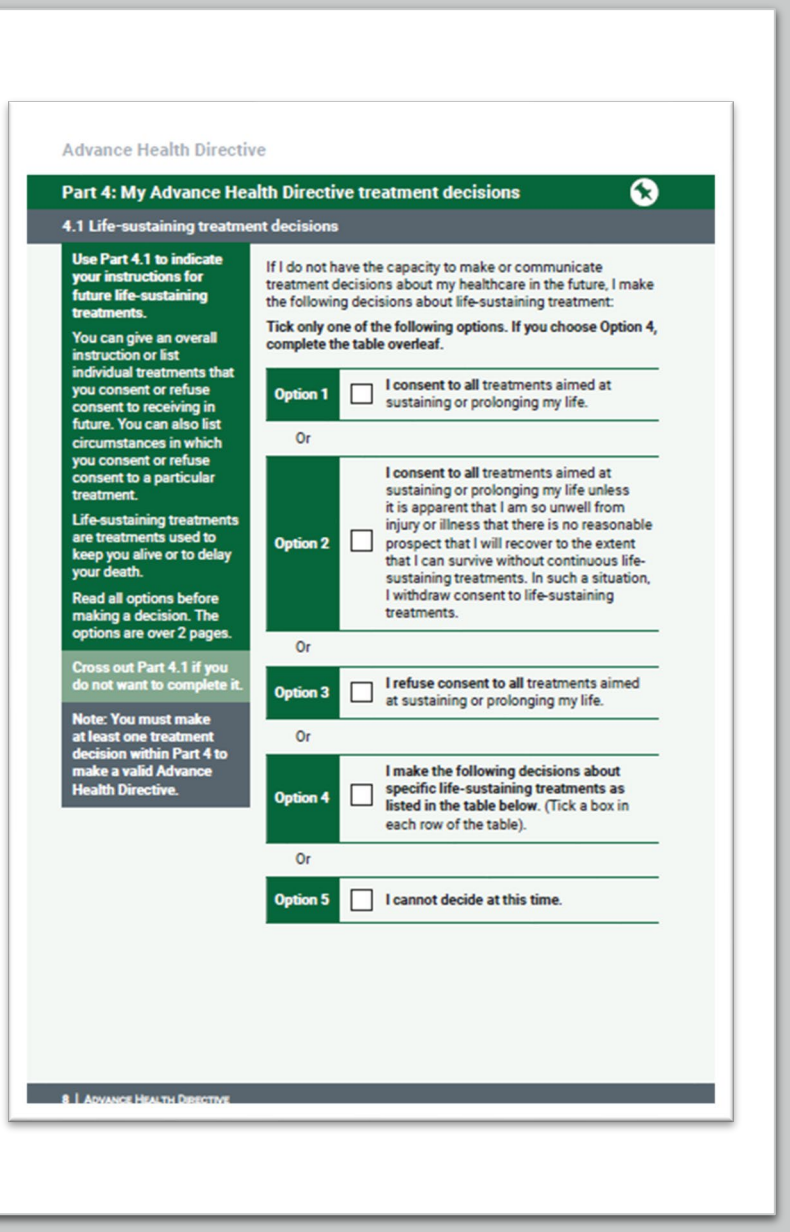
- ☐ Spending time with family and friends
- ☐ Living independently
- ☐ Being able to visit my home town, country of origin, or spending time on country
- ☐ Being able to care for myself (e.g. showering, going to the toilet, feeding myself)
- ☐ Keeping active (e.g. playing sport, walking, swimming, gardening)
- ☐ Enjoying recreational activities, hobbies and interests (e.g. music, travel, volunteering)
- ☐ Practising religious, cultural, spiritual and/or community activities (e.g. prayer, attending religious services)
- ☐ Living according to my cultural and religious values (e.g. eating halal, kosher foods only)
- ☐ Working in a paid or unpaid job

Part 4 – My Advance Health Directive treatment decisions

- Treatment decision definition.
- **At least one treatment decision MUST be made in Part 4** to make a valid Advance Health Directive.

Part 4 cont.

- **Part 4.1: Life-sustaining treatment decisions**
  - Includes 5 options – can select ONLY 1 option
  - Option 4 allows the respondent to specify:
    - under which circumstances they consent to each life-sustaining treatment
    - to outline any other life-sustaining treatments they consent or do not consent to receiving



Advance Health Directive

Part 4: My Advance Health Directive treatment decisions

4.1 Life-sustaining treatment decisions

Use Part 4.1 to indicate your instructions for future life-sustaining treatments.

You can give an overall instruction or list individual treatments that you consent or refuse consent to receiving in future. You can also list circumstances in which you consent or refuse consent to a particular treatment.

Life-sustaining treatments are treatments used to keep you alive or to delay your death.

Read all options before making a decision. The options are over 2 pages.

Cross out Part 4.1 if you do not want to complete it.

Note: You must make at least one treatment decision within Part 4 to make a valid Advance Health Directive.

If I do not have the capacity to make or communicate treatment decisions about my healthcare in the future, I make the following decisions about life-sustaining treatment:

Tick only one of the following options. If you choose Option 4, complete the table overleaf.

Option 1 ☐ **I consent to all** treatments aimed at sustaining or prolonging my life.

Or

Option 2 ☐ **I consent to all** treatments aimed at sustaining or prolonging my life unless it is apparent that I am so unwell from injury or illness that there is no reasonable prospect that I will recover to the extent that I can survive without continuous life-sustaining treatments. In such a situation, I withdraw consent to life-sustaining treatments.

Or

Option 3 ☐ **I refuse consent to all** treatments aimed at sustaining or prolonging my life.

Or

Option 4 ☐ **I make the following decisions about specific life-sustaining treatments as listed in the table below.** (Tick a box in each row of the table).

Or

Option 5 ☐ **I cannot decide at this time.**

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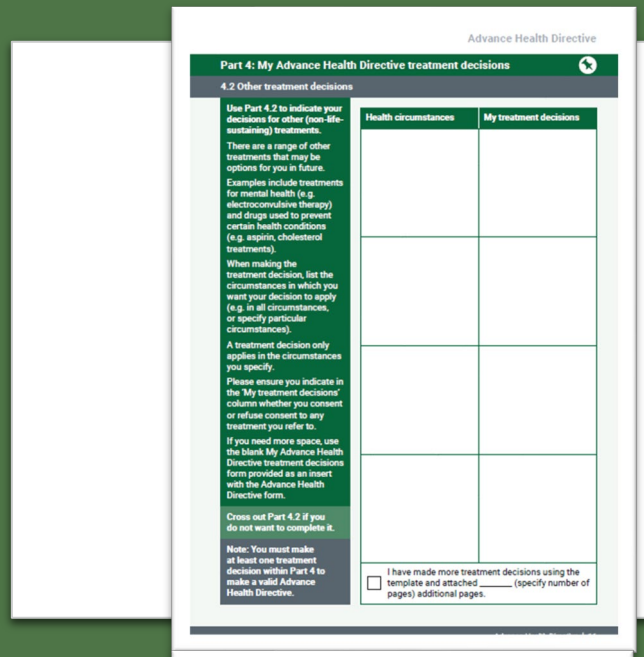
Part 4 cont.

- **Part 4.2: Other treatment decisions**
  - Allows respondent to indicate their decisions for other (non life-sustaining treatment decisions).
- **Part 4.3: Medical research**
  - Allows respondent to provide treatment decisions about the types of medical research they consent or do not consent to participating in, and the circumstances in which these treatment decisions apply


Advance Health Directive

Part 4: My Advance Health Directive treatment decisions

4.2 Other treatment decisions

Use Part 4.2 to indicate your decisions for other (non-life-sustaining) treatments.

There are a range of other treatments that may be options for you in future.

Examples include treatments for mental health (e.g. electroconvulsive therapy) and drugs used to prevent certain health conditions (e.g. aspirin, cholesterol treatments).

When making the treatment decision, list the circumstances in which you want your decision to apply (e.g. in all circumstances, or specify particular circumstances).

A treatment decision only applies in the circumstances you specify.

Please ensure you indicate in the 'My treatment decisions' column whether you consent or refuse consent to any treatment you refer to.

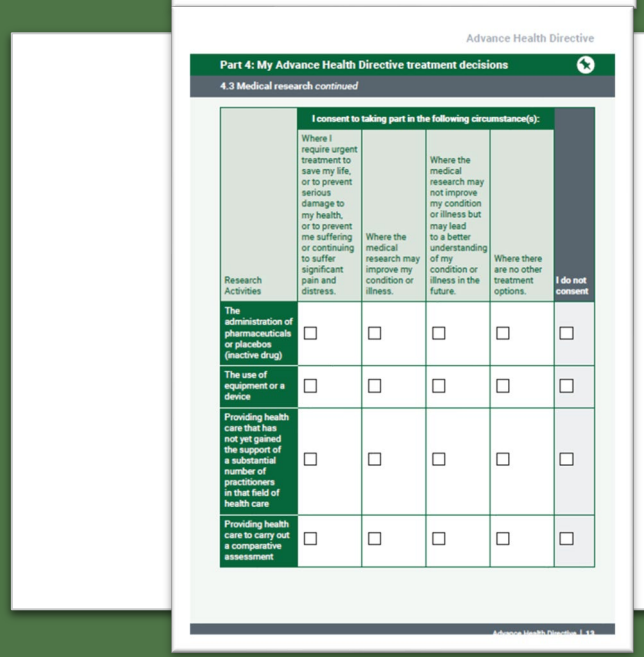
If you need more space, use the blank My Advance Health Directive treatment decisions form provided as an insert with the Advance Health Directive form.

Cross out Part 4.2 if you do not want to complete it.

Note: You must make at least one treatment decision within Part 4 to make a valid Advance Health Directive.

Health circumstances	My treatment decisions

☐ I have made more treatment decisions using the template and attached _____ (specify number of pages) additional pages.


Advance Health Directive

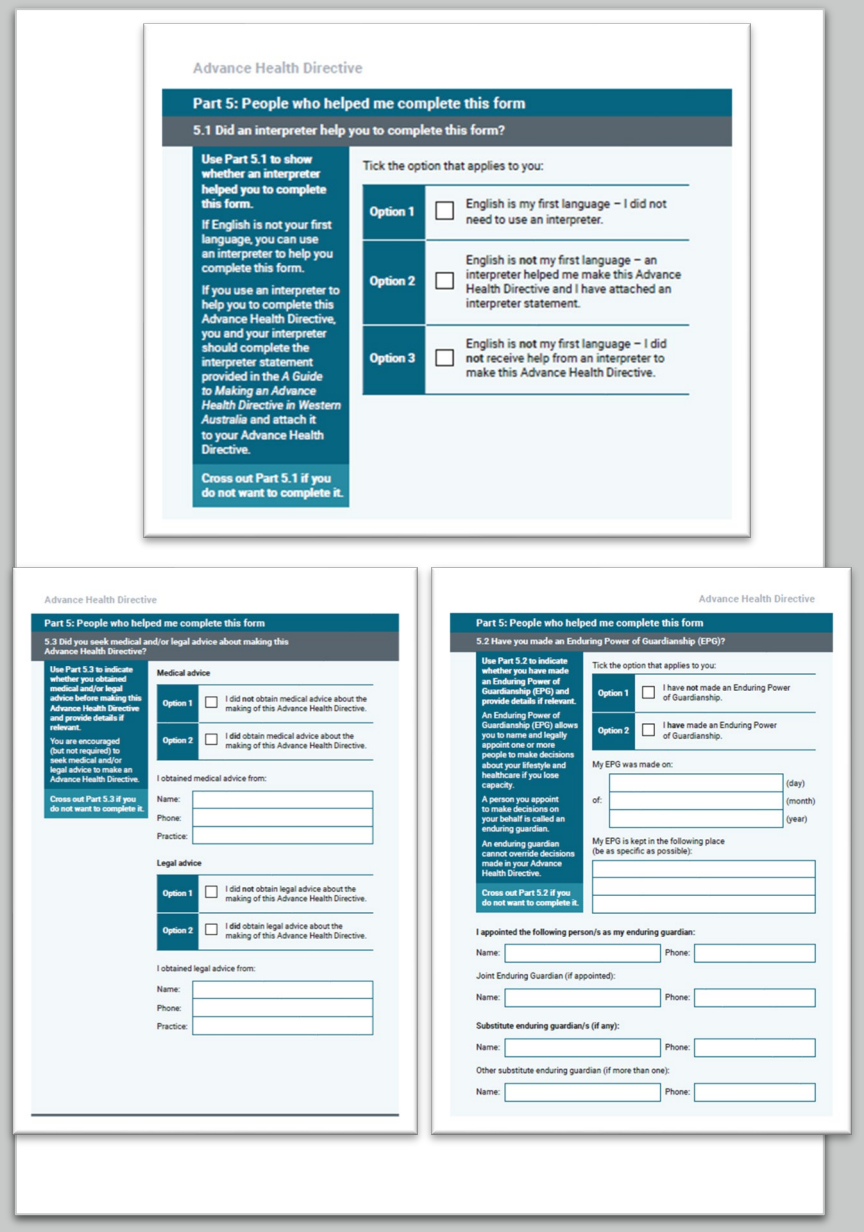
Part 4: My Advance Health Directive treatment decisions

4.3 Medical research *continued*

Research Activities	I consent to taking part in the following circumstance(s): Where I require urgent treatment to save my life, or to prevent serious damage to my health, or to prevent me suffering or continuing to suffer significant pain and distress.	Where the medical research may improve my condition or illness.	Where the medical research may not improve my condition or illness but may lead to a better understanding of my condition or illness in the future.	Where there are no other treatment options.	I do not consent
The administration of pharmaceuticals or placebos (inactive drug)	☐	☐	☐	☐	☐
The use of equipment or a device	☐	☐	☐	☐	☐
Providing health care that has not yet gained the support of a substantial number of practitioners in that field of health care	☐	☐	☐	☐	☐
Providing health care to carry out a comparative assessment	☐	☐	☐	☐	☐

Part 5 – People who helped me complete this form

- **Part 5.1 – Services of a translator**
  - May need to complete an attach a translator statement
- **Part 5.2 – Enduring Power of Guardianship**
- **Part 5.3 – Medical or legal advice sought**



Advance Health Directive

Part 5: People who helped me complete this form

5.1 Did an interpreter help you to complete this form?

Use Part 5.1 to show whether an interpreter helped you to complete this form.

If English is not your first language, you can use an interpreter to help you complete this form.

If you use an interpreter to help you to complete this Advance Health Directive, you and your interpreter should complete the interpreter statement provided in the *A Guide to Making an Advance Health Directive in Western Australia* and attach it to your Advance Health Directive.

Cross out Part 5.1 if you do not want to complete it.

Tick the option that applies to you:

Option 1	☐ English is my first language – I did not need to use an interpreter.
Option 2	☐ English is **not** my first language – an interpreter helped me make this Advance Health Directive and I have attached an interpreter statement.
Option 3	☐ English is **not** my first language – I did **not** receive help from an interpreter to make this Advance Health Directive.

Advance Health Directive

Part 5: People who helped me complete this form

5.3 Did you seek medical and/or legal advice about making this Advance Health Directive?

Use Part 5.3 to indicate whether you obtained medical and/or legal advice before making this Advance Health Directive and provide details if relevant.

You are encouraged (but not required) to seek medical and/or legal advice to make an Advance Health Directive.

Cross out Part 5.3 if you do not want to complete it.

Medical advice

Option 1	☐ I did **not** obtain medical advice about the making of this Advance Health Directive.
Option 2	☐ I did obtain medical advice about the making of this Advance Health Directive.

I obtained medical advice from:

Name:
Phone:
Practice:

Legal advice

Option 1	☐ I did **not** obtain legal advice about the making of this Advance Health Directive.
Option 2	☐ I did obtain legal advice about the making of this Advance Health Directive.

I obtained legal advice from:

Name:
Phone:
Practice:

Advance Health Directive

Part 5: People who helped me complete this form

5.2 Have you made an Enduring Power of Guardianship (EPG)?

Use Part 5.2 to indicate whether you have made an Enduring Power of Guardianship (EPG) and provide details if relevant.

An Enduring Power of Guardianship (EPG) allows you to name and legally appoint one or more people to make decisions about your lifestyle and healthcare if you lose capacity.

A person you appoint to make decisions on your behalf is called an enduring guardian.

An enduring guardian cannot override decisions made in your Advance Health Directive.

Cross out Part 5.2 if you do not want to complete it.

Tick the option that applies to you:

Option 1	☐ I have **not** made an Enduring Power of Guardianship.
Option 2	☐ I **have** made an Enduring Power of Guardianship.

My EPG was made on:

(day)
of: (month)
(year)

My EPG is kept in the following place (be as specific as possible):

I appointed the following person/s as my enduring guardian:

Name: Phone:

Joint Enduring Guardian (if appointed):

Name: Phone:

Substitute enduring guardian/s (if any):

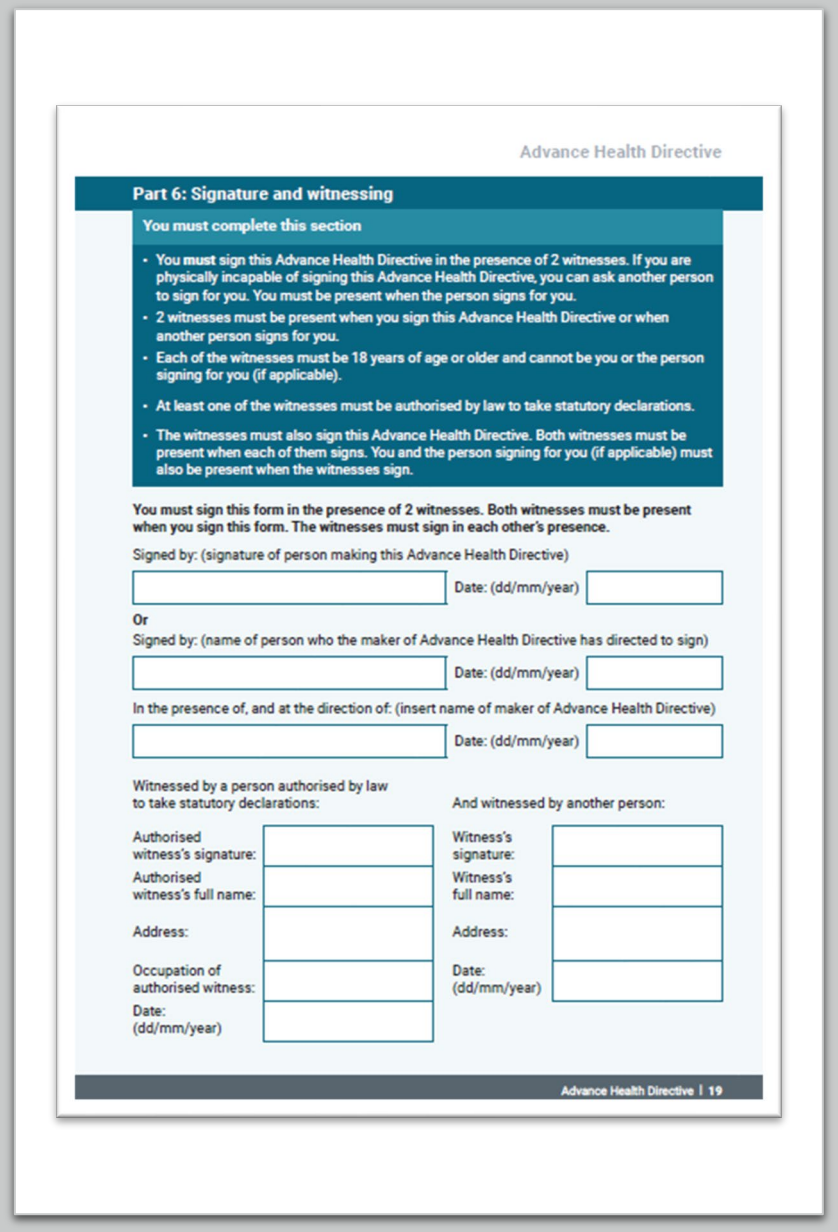
Name: Phone:

Other substitute enduring guardian (if more than one):

Name: Phone:

Part 6 – Signature and witnessing

- Respondent must sign their AHD in the presence of 2 witnesses.
- Both witnesses must be present when each of them and the respondent signs.
- Witnesses must be 18 years of age or older.
- At least one of the witnesses must be authorised to take statutory declarations.
- Options available for people who can't sign.



Advance Health Directive

Part 6: Signature and witnessing

You must complete this section

- You must sign this Advance Health Directive in the presence of 2 witnesses. If you are physically incapable of signing this Advance Health Directive, you can ask another person to sign for you. You must be present when the person signs for you.
- 2 witnesses must be present when you sign this Advance Health Directive or when another person signs for you.
- Each of the witnesses must be 18 years of age or older and cannot be you or the person signing for you (if applicable).
- At least one of the witnesses must be authorised by law to take statutory declarations.
- The witnesses must also sign this Advance Health Directive. Both witnesses must be present when each of them signs. You and the person signing for you (if applicable) must also be present when the witnesses sign.

You must sign this form in the presence of 2 witnesses. Both witnesses must be present when you sign this form. The witnesses must sign in each other's presence.

Signed by: (signature of person making this Advance Health Directive)

Date: (dd/mm/year)

Or

Signed by: (name of person who the maker of Advance Health Directive has directed to sign)

Date: (dd/mm/year)

In the presence of, and at the direction of: (insert name of maker of Advance Health Directive)

Date: (dd/mm/year)

Witnessed by a person authorised by law to take statutory declarations:

Authorised witness's signature:

Authorised witness's full name:

Address:

Occupation of authorised witness:

Date: (dd/mm/year)

And witnessed by another person:

Witness's signature:

Witness's full name:

Address:

Date: (dd/mm/year)

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Additional documents

The *Guide to Making an AHD in WA* comes in a presentation folder that includes the instructional guide, AHD Form and:

- Translator statement;
- Additional responses to Part 4.1 other life-sustaining treatments
- Additional responses to Part 4.2 other treatment decisions;
- Marksman clause
- AHD alert card.

Health professionals role in caring for patients with an AHD?

Enact & follow

- If patient does not have decision-making capacity, refer to their AHD and:
  - comply with the treatment decisions outlined within the AHD
  - provide care in accordance with their values and preferences
  - engage with the social work team to support families/carers with patient values and preferences
- If the AHD does not cover the treatment decision required or they do not have an AHD:
  - refer to the Hierarchy of treatment decision-makers

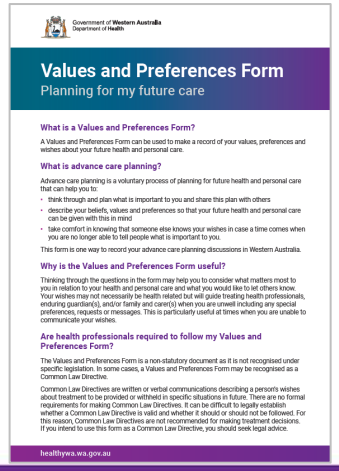
Review

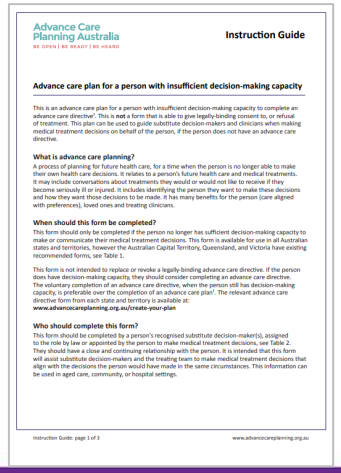
- Encourage person to review their AHD when their health changes or at least every 2 - 5 years.

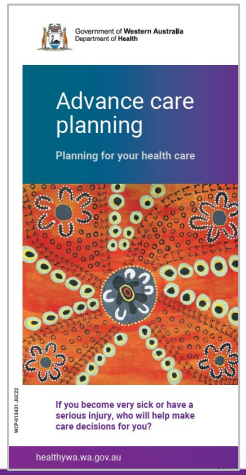
OTHER NEW RESOURCES

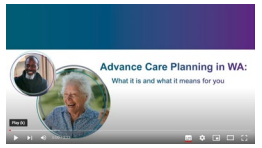
New resources for consumers

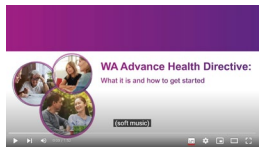
- Your Guide to Advance Care Planning in WA: A workbook
- Values & Preferences Form
- Advance Care Plan for a person with insufficient decision-making capacity
- Advance Care Planning brochure and A4 factsheet
- Your Choice to make an AHD and EPG brochure
- Advance Care Planning brochure for the Aboriginal community
- HealthyWA webpages with AHD and ACP videos





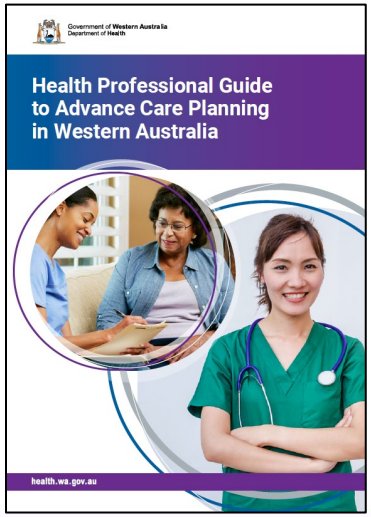


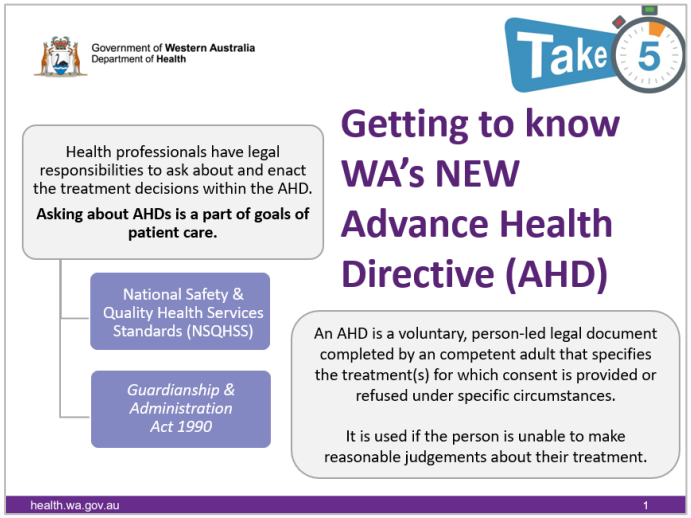


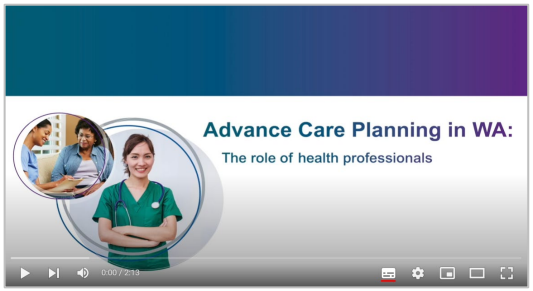


New resources for health professionals

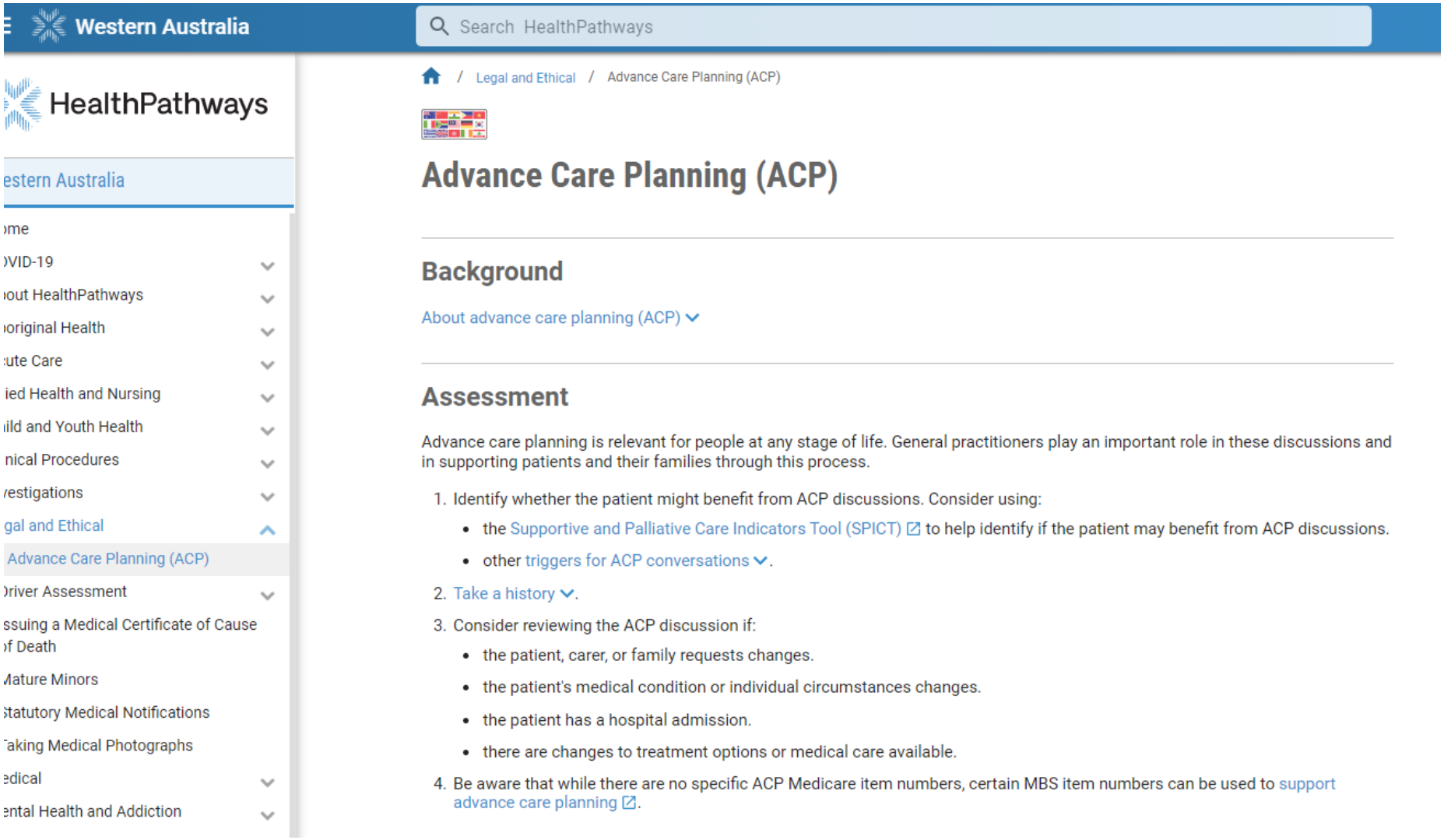
- Health Professional Guide to ACP in WA
- Take 5 – Getting to know WA's NEW Advance Health Directive
- Template advance care planning slides for health professionals
- Quick reference – Advance care planning resources in WA
- Health Professional AHD & ACP videos and webpages
- ACP Health Pathway
- Resources order form







ACP HealthPathway



wa.communityhealthpathways.org

Goals of Residential Care (Form)

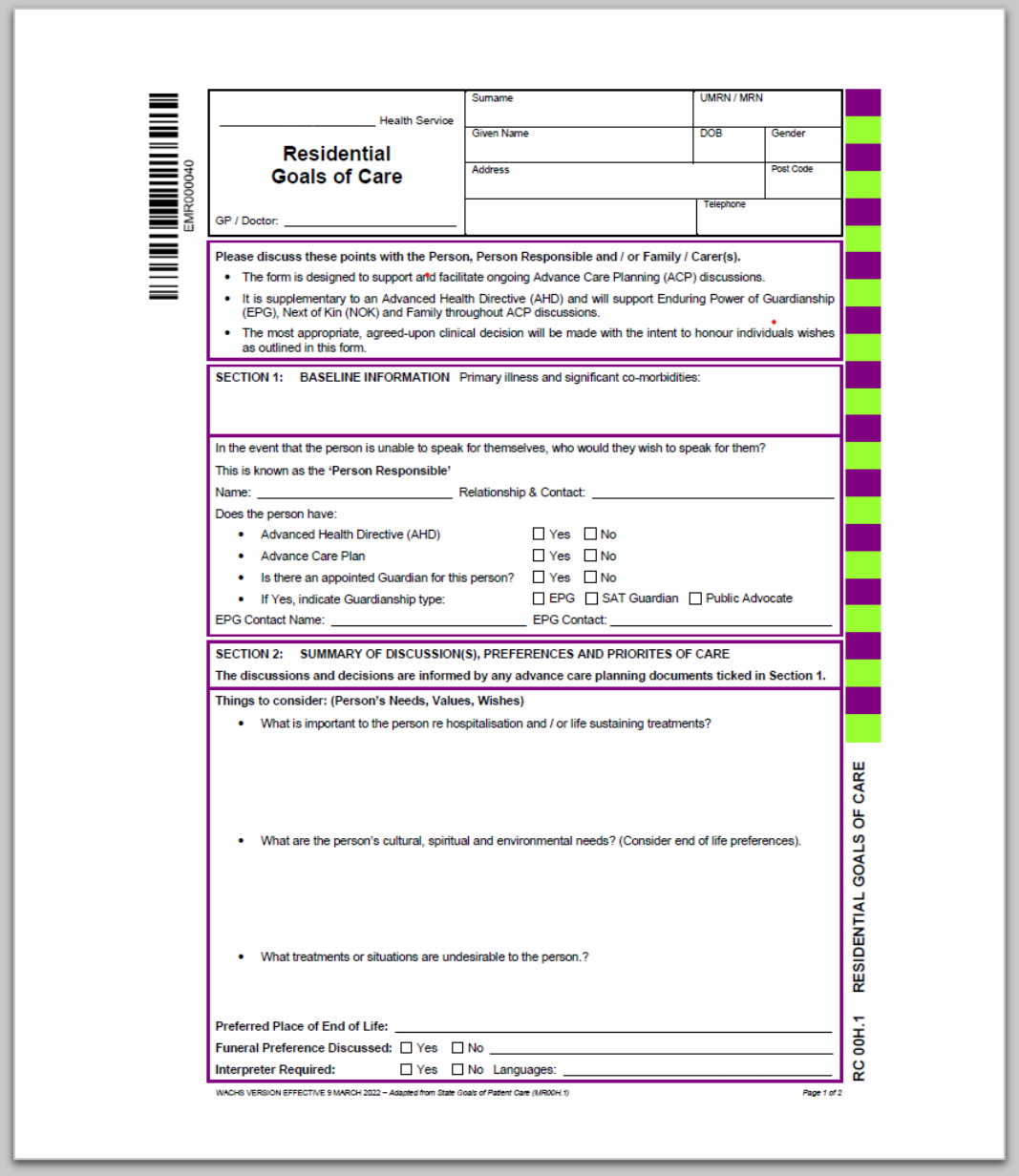
- Pilot adaptation of Goals of Care (GoC) form in WACHS RACFs
- Supports continuity of clinical care and complements advance care planning.
- Promotes conversations about GoC, limits of escalation of care, whether the resident wants to go to hospital, and may trigger ACP.

Metropolitan Roll-out

- The Department of Health is scoping the implementation of Goals of Residential Care Form in private RACFs in metropolitan region.
- The form has been socialised with the other NPA projects and RACF reference group.

Next steps

- The Department will send a letter package – including the current form (RC00H.1) and FAQs.
- Options for education and training packages regarding goals of residential care are being investigated.



_____ Health Service

Residential Goals of Care

GP / Doctor: _____

EMR000040

Surname	UMRN / MRN	
Given Name	DOB	Gender
Address		Post Code
	Telephone	

Please discuss these points with the Person, Person Responsible and / or Family / Carer(s).

- The form is designed to support and facilitate ongoing Advance Care Planning (ACP) discussions.
- It is supplementary to an Advanced Health Directive (AHD) and will support Enduring Power of Guardianship (EPG), Next of Kin (NOK) and Family throughout ACP discussions.
- The most appropriate, agreed-upon clinical decision will be made with the intent to honour individuals wishes as outlined in this form.

SECTION 1: BASELINE INFORMATION Primary illness and significant co-morbidities:

In the event that the person is unable to speak for themselves, who would they wish to speak for them?

This is known as the **'Person Responsible'**

Name: _____ Relationship & Contact: _____

Does the person have:

- Advanced Health Directive (AHD) ☐ Yes ☐ No
- Advance Care Plan ☐ Yes ☐ No
- Is there an appointed Guardian for this person? ☐ Yes ☐ No
- If Yes, indicate Guardianship type: ☐ EPG ☐ SAT Guardian ☐ Public Advocate

EPG Contact Name: _____ EPG Contact: _____

SECTION 2: SUMMARY OF DISCUSSION(S), PREFERENCES AND PRIORITES OF CARE

The discussions and decisions are informed by any advance care planning documents ticked in Section 1.

Things to consider: (Person's Needs, Values, Wishes)

- What is important to the person re hospitalisation and / or life sustaining treatments?
- What are the person's cultural, spiritual and environmental needs? (Consider end of life preferences).
- What treatments or situations are undesirable to the person.?

Preferred Place of End of Life: _____

Funeral Preference Discussed: ☐ Yes ☐ No _____

Interpreter Required: ☐ Yes ☐ No Languages: _____

RC 00H.1 RESIDENTIAL GOALS OF CARE

WACHS VERSION EFFECTIVE 9 MARCH 2022 – *Adapted from State Goals of Patient Care (MR00H.1)* *Page 1 of 2*

The Seven Keys to Being Hopeful AND Prepared

Dr Hsien Seow and Dr Samantha Winemaker

1. Walk two roads

From the moment of diagnosis of a life changing illness, hope for the best and plan for the worst

Make contingency plans – always have a Plan B

2. Zoom out

Understand what the beginning, middle and end of the illness might look like

Find out about the help that is available to you if you need it in the future, and how to access it

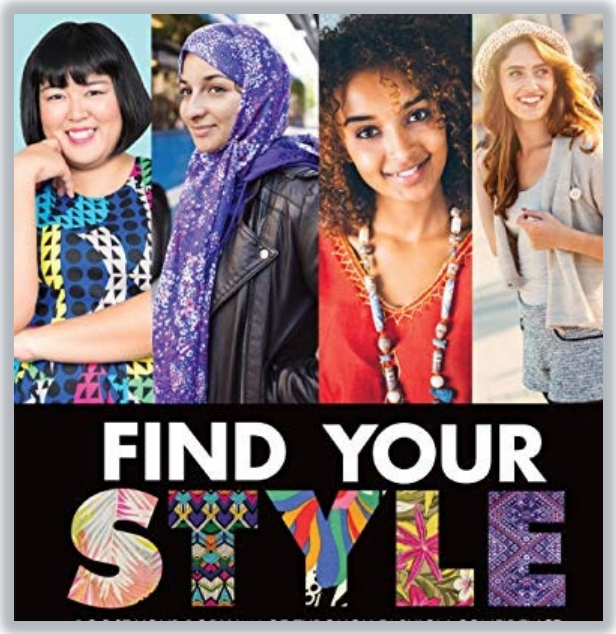
3. Know your style

Identify your coping strategies

- What has worked for you and those around you in the past?
- What new strategies will you try?

Let people know how you like to receive information

- Direct and to the point?
- A ‘softer’ approach?



4. Customise your order

What is most important to you?

Consider your preferences and how they are impacted by those around you.

Write them down and discuss them with your family, carer and professionals involved in your care.

5. Expect ripples

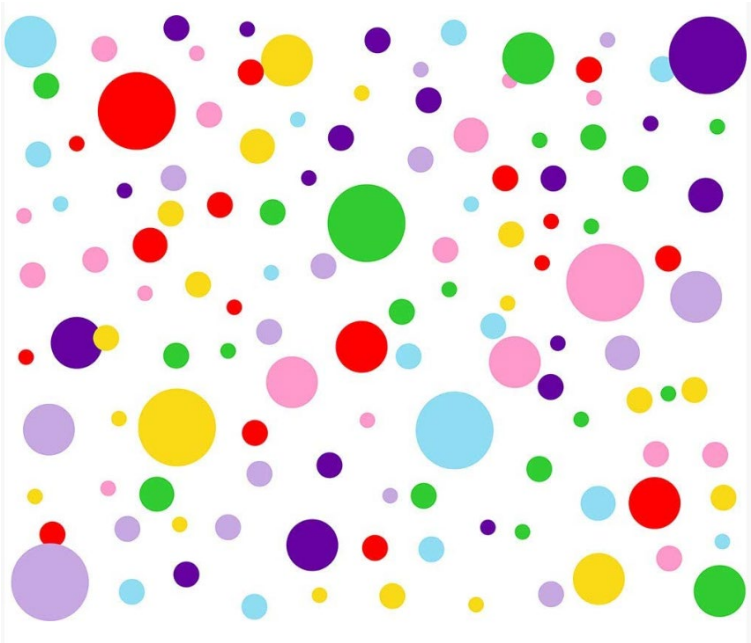
Remember the people around you have a parallel illness journey

Plan support for your carer(s) to avoid carer burnout

6. Connect the dots

Compassionate communities – who do you have around you who may be able to help you?

Link with your GP and know what wider services you can access



7. Invite yourself

Ask as many questions as you need to!

How can YOU help?

- **Let your patients, colleagues, and family and friends know** about the revised Advance Health Directive and ACP resources
- **Refer people to the Department of Health webpages** for easy to find and consistent information on advance care planning
- **Support your patients** to use these resources
- Talk about the importance of being hopeful AND prepared

Services and education

Residential Aged Care Excellence in Palliative Care (RACEPC) - Cancer Council WA
Provides targeted education to RACF staff with a focus on communication, and recognising and responding to the deteriorating resident. It aims to develop RACF workforce capability to provide quality EOL&PC to residents, families and carers.

Metropolitan Palliative Care Consultancy Service (MPaCCS) - Bethesda Health Care
Expansion of the specialist in-reach model to build RACF staff capability using patient-based care episode and scenario training. The expanded model aims to increase RACF residents' access to quality specialist EOL&PC in the outer east metropolitan region and support the metropolitan-wide coordination of integrated EOL&PC across hospitals and RACFs.

Residential Care Line (RCL) interim expansion - North Metropolitan Health Service (NMHS)
Provides acute clinical support to RACFs including palliative-related care, symptom management, advance care planning and Goals of Care discussions. It aims to improve the coordination and provision of services across the system with complex palliative care referrals made to MPaCCS or Silver Chain as required.

Further information and to order resources

Department of Health WA Advance Care Planning Information Line:
(08) 9222 2300
ACP@health.wa.gov.au

Consumer information:
healthywa.wa.gov.au/AdvanceCarePlanning
healthywa.wa.gov.au/AdvanceHealthDirectives
Palliative Care WA Helpline:1800 573 299, 9am-5pm

Health professional information:
health.wa.gov.au/ACP
health.wa.gov.au/AHD

Any questions?

A/Prof Alison Parr
Clinical Lead Palliative Care, WA Dept of Health

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