

## Advance care plan - personal stories



Peter and his wife, Josie, start to notice that he is experiencing some memory loss.

Peter reflects on his own father's experience of cognitive deterioration which included many admissions to hospital, behavioural changes and family tensions related to decisions about his treatment and care.

Peter and Josie spend time talking about what matters to him in making decisions about the possibility of a future medical condition, and what he would want if he became unable to make decisions directly for himself.

Peter explains that what he values most is staying at home with Josie, going for regular walks and being active in the garden.

Based on what he saw happen when his father was sick, he decides that he would not want cardiopulmonary resuscitation. If he became seriously ill he would not want any life prolonging treatments, including transfer to intensive care or antibiotics.

He also decides that when it is time for him to die he wants to receive palliative care at home and not be transferred to hospital.

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One year later, Peter is diagnosed with dementia by the cognitive, dementia and memory clinic at his local hospital.

This diagnosis triggers Peter to review and update his advance care directive, which he does in consultation with the clinic's neuropsychologist.

The neuropsychologist also suggests he appoint a medical treatment decision maker. Peter appoints his wife as his medical treatment decision maker.

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18 months after Peter is diagnosed, he collapses due to a chest infection and is taken to hospital where the treating clinician notes that Peter has an instructional directive in his medical record.

The clinician also consults with Josie about Peter's goals of care. Josie requests that, consistent with Peter's values directive, Peter be discharged home with palliative care. The clinician arranges home-based palliative care for Peter.

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Peter dies peacefully at home with his wife beside him soon after returning home.

**This page has been produced in consultation with and approved by:**

Advance care planning, Department of Health & Human Services

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