Supplementary Table 1 Characteristics of responders / non responders to the organisational survey of ACP policies and practices

	Number of facilities	
	Respondents (n=12)	Non respondents (n=7)
Organisation type		
State Government operated	6	3
Not for profit	5	2
Private, for profit	1	2
Located in		
Metropolitan area	6	5
Inner regional area	6	2
Number of beds		
1-50	5	2
51-100	3	5
Over 100	4	0
Care level		
Low care with aging in place	5	2
Low and high care	4	1
High care	3	4

Supplementary Table 2 Staff survey respondents' self-reported confidence in undertaking specified roles/activities within ACP

Tasks/roles/Activities	Number of respondents (%)		
	Not at all confident /a little confident	Quite confident / very confident	Not applicable
Knowing the role of surrogate decision makers	31 (68.9)	10 (22.2)	4 (8.9)
Initiating advance care plan discussions with residents*	19 (42.2)	22 (48.9)	4 (8.9)
Answering residents' questions about advance care plans	21 (46.7)	20 (44.4)	4 (8.9)
Answering family members' questions about advance care plans	21 (46.7)	21 (46.7)	3 (6.7)
Complying with the provisions of residents advance care plans	10 (22.2)	32 (71.1)	3 (6.7)
Implementing institutional policy and procedures for advance care plans	18 (40.0)	21 (46.7)	6 (13.3)
Mediating when there is a disagreement between residents and family members regarding end of life decisions	31 (68.9)	11 (24.4)	3 (6.7)
Teaching other health care providers about advance care plans	30 (66.7)	13 (28.9)	2 (4.4)
Knowing state laws regarding advance care plans	38 (84.4)	5 (11.1)	2 (4.4)

Supplementary Table 3 Staff survey respondents' ACP general knowledge around ACP

	ACP General Knowledge statement	Correct (%)	Incorrect (%)	Don't know (%)
1	People must have both a written advance care plan and a substitute decision maker for health care before end-of-life decisions are honoured. (ANS = False)	21 (46.7)	19 (42.2)	5 (11.1)
2	An advance care plan enables individuals to describe in writing the type of health care they do or do not wish to receive when they are no longer able to speak for themselves. (ANS = True)	43 (95.6)	0	2 (4.4)
3	A substitute decision maker for health care gives a person the authority to make health care decisions for the individual when he/she is no longer able to make those decisions. (ANS = True)	40 (88.9)	2 (4.4)	3 (6.7)
4	People may appoint anyone they wish as their substitute decision maker (ANS = False)	6 (13.3)	33 (73.3)	6 (13.3)
5	Appointment of a substitute decision maker for health care must always be signed and witnessed. (ANS = True)	36 (80.0)	3 (6.7)	6 (13.3)
6	If a resident lacks decision-making capacity and does not have a substitute decision maker, health care providers must seek legal permission to stop life-sustaining treatment. (ANS = False)	10 (22.2)	20 (44.4)	15 (33.3)
7	An advance care plan becomes effective when people are not able to make and/or communicate their medical treatment decisions. (ANS = True)	32 (71.1)	9 (20.0)	4 (9.9)

Supplementary table 4. ACP general knowledge score by age, years of aged care experience and educational level.

Demographic/employment variable		Median ACP general knowledge score	Mann-Whitney U	Statistical significance
Age	<40 years	4.5	138.50	Not significant
	≥40 years	4.0		
Experience in aged care	< 10 years	4.0	179.0	Not significant
	≥10 years	4.0		
Educational qualifications	Undergraduate degree or lower	4	241.0	Not significant
	Postgraduate diploma or higher	4		

Supplementary Table 5 Participants' attitudes towards aspects of developing and implementing ACPs and End-of-life plans

	Statement	Percentage whose response to statement was: (n=45)		
		Disagree or strongly disagree	Agree or Strongly agree	Don't know
1	Residents with decision-making capacity who are not terminally ill should have right to refuse life support even if that decision may lead to death	2.2	97.7	0.0
2	Most of the time residents don't know enough about health care to prepare Advance Care Plans	40.0	60.0	0.0
3	Staff should go against relatives' wishes if they conflict with the resident's end of life decisions	37.7	44.5	17.8
4	It is appropriate to give medication to relieve pain even if it may hasten a resident's death	4.4	91.1	4.4
5	Staff should be actively involved in helping residents complete advance care plans	4.4	91.1	4.4
6	It is not the nurse's responsibility to confer with the doctor about medical treatment if a resident's rights have not been considered	66.7	20.0	13.3
7	Staff should persuade residents to accept treatment when this is best for them regardless of the Advance Care Plans	86.6	8.9	3.3
8	Staff should help inform residents about their condition and treatment alternatives when preparing an Advance Care Plan	0.0	93.3	6.7
9	It is impossible to make good end-of-life plans if a resident and their family have difficulty communicating	55.5	40.0	4.4
10	With Advance Care Plans residents are able, even in conditions of incapacity, to retain their authority and autonomy regarding their health care	2.2	93.4	4.4
11	Health care providers usually know the wishes of their residents regarding end-of-life care without having formal documentation	77.8	22.2	0.0
12	The information in an Advance Care Plan is usually sufficient to guide treatment	17.8	68.9	13.3
13	Some resident are excluded from making decisions about their care because they are inappropriately judged to lack capacity to make decisions	17.7	73.3	8.9
14	When providers disagree with a resident's Advance Care Plan, providers use their own judgment whether to follow the Advance Care Plan.	77.8	8.9	13.3
15	Most of the time family members know the resident's preference regarding end-of-life care	51.1	48.9	0.0
16	Helping residents complete an Advance Care Plan is emotionally draining	48.9	42.2	8.9