Advance Care Planning Australia

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Subject - Dementia	Level 1 skills / knowledge	Expected behaviour for case study
Case study Trevor has been the main carer for his mother, Joan 81 years old who has advanced dementia on a background of osteoarthritis and recent pneumonia. Joan was admitted to a residential aged care facility 3 months ago and is experiencing another chest infection that is likely to be aspiration pneumonia and a decision of whether to go to hospital is discussed. Joan is responsive but does not have capacity. There are no other children and Joan's husband is deceased.		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	HCP includes Joan in discussions but as she lacks capacity Trevor is required to make the decisions.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP is aware of the validity of SDM documents provided by Trevor.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	HCP is able to state process for recording of SDM for the setting.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	Healthcare professional (HCP) discusses with Trevor and Joan if a substitute decision-maker (SDM) has been appointed and if any advance care directives (ACD) have been documented. HCP is able to explain what a SDM and ACD is.
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP recognises that the triggers for ACD and SDM discussion include: admission to a residential aged care facility, and diagnosis of pneumonia, another chest infection and dementia.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion should be initiated with Trevor and Joan.
	Reflects on their personal values and preferences and can differentiate between these and consumer agenda	HCP can reflect on what care they might choose for their own mother but is able to differentiate this from what Joan wants and requires.

Communication - with the team	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	HCP identified the team might include the geriatrician, social worker and GP along with any other family members.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	HCP recognises Trevor is unsure about having to make a decision for Joan regarding admission to hospital to treat a chest infection. HCP asks Trevor what Joan would have wanted to guide him with the decision-making.
	Is aware of processes to receive, store and share advance care planning documents	HCP documents the discussion with Trevor including clarifying if there was an ACD, and a SDM appointed and the options for care.
Ethics	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	HCP recognises the change in the goal of care may be difficult for Trevor to accept initially. HCP focuses discussion with Trevor on Joan and what she would have wanted.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP advises Trevor that as there is no ACD he could reflect on previous discussions with his mother to help guide his decision-making. Healthcare team are able to explain options for Joan's care.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP focuses Trevor on what his mother would have wanted if she could speak for herself and supports his decision. HCP asks if there are any other supports for Trevor, e.g. siblings.
	Recognises triggers to review advance care planning documents	HCP guides Trevor in identifying that Joan's health status has deteriorated and consideration for the medical interventions that Joan would have wanted is required.
	Informs the team of the existence of any advance care planning documents	HCP clarifies there is no ACD but that Trevor was appointed SDM. HCP reviews the documentation provided by Trevor re. SDM and ensures there is a copy with Joan's medical record.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP identifies that Joan no longer has capacity to make her own decisions and that implementation of any advance care preferences is now required.

Points of assessment / discussion	Assessing capacity for people with dementia, negotiating change of goals care, supporting the SDM.
Method of assessment	MCQ on types dementia, triggers for discussion. Reflection on changes in goals of care and advocating for person's preferences for care.

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