Advance care planning Education Capability Framework: Implementation Guide

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Advance Care Planning Australia

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1. Introduction

This guide is for Australian education providers who are responsible for developing a capable health and aged care workforce. This workforce includes all health practitioners, registered and unregistered, and individual support workers. The guide aims to support the implementation of the advance care planning education capability framework into Vocational Education and Training (VET) courses, undergraduate, postgraduate and/or specialty training.

The need for a coordinated and standardized approach to teaching advance care planning in health professional curricula in Australia has been identified [1, 2]. This research, as well as consultation with the National Advance Care Planning Australia Education Advisory Group, has informed the development of this Advance Care Planning Education Capability Framework and accompanying education resources.

2. Current situation

Community expectation of person-centered health care, self- determination, dignity and the avoidance of suffering, have focused attention on advance care planning. Nationally, *The Palliative Care Strategy* and *The National Framework for Advance Care Directives,* prioritise advance care planning and advance care directives. Jurisdictions provide advance care planning and medical treatment decisions legislation, forms and policy, placing obligations on health practitioners.

A qualified and capable health workforce is crucial in ensuring the effective provision of health care services to meet the needs of the Australian population [3]. Many health practitioners lack confidence to participate in advance care planning discussions as few receive education in advance care planning as part of their vocational training, undergraduate, postgraduate or specialty training courses [4, 5]. Recommendations from the literature support the need to improve education of health, aged care and relevant legal workforce in order to maximize uptake of advance care planning within the wider community. Currently, the uptake of advance care planning remains low with less than 15% of Australians in the general community and 25% of people aged 65+ having an advance care directive documented [6, 7].

The advance care planning education capability framework aims to provide a structure to support the development of health professionals' knowledge and skills in the area of advance care planning. It intends to provide evidence based information and resources to ensure the health and aged care workforce has the capability to promote, provide access to, implement and enact advance care planning and advance care directives. The framework was developed to be flexible to suit the education requirements for several health practitioner groups at varying levels of experience and be integrated into existing curricula via numerous teaching strategies.

3. The underpinning principles of the Framework

3.1 What is the purpose of this framework?

This guide is a resource for academic and clinical teaching providers to increase advance care planning curricula.

Strategically, it is anticipated that the implementation of the advance care planning education capability framework will assist education providers to incorporate advance care planning into their curriculum to help meet the education needs of health practitioners nationally and maximise participation in advance care planning across the workforce. At a practical level, the framework aims to provide a range of education resources including on line modules, lecture topics and interdisciplinary case studies that allow for simulation and role-play.

This framework aims to provide:

- A structure on which education providers can build advance care planning education into curricula, including a tool to facilitate evaluation and assessment
- An outline of advance care planning learning outcomes which aim to enhance the teachings of clinical and academic educators
- Directions for students regarding expected capabilities and self- assessment against outlined criteria/ outcomes
- A resource tool for regulatory and professional bodies to evaluate and accredit advance care planning curricula against specified criteria
- Health care services with an understanding of expected health professionals' capabilities on entry into the workforce in regards to advance care planning
- Consumers with information relating to the minimum standards of care expected of health professionals
- Further resources for students who wish to complete additional reading / study on the topic

3.2 Who is the intended audience for this framework?

This education framework is primarily intended for health practitioner educators at varying levels of experience including vocational education and training courses, undergraduate and postgraduate courses and/or specialty training via learned colleges. Specific areas of health practice may include;

- Medicine
- Nursing
- Allied Health
- Individual support workers

Respecting a patient's decision-making autonomy is recognised as a fundamental ethical requirement of *all* health professionals [8]. However, there remains a level of uncertainty amongst health professions relating to the legal standing of advance care planning and advance care directives, resulting in professionals becoming reluctant to engage in such planning with their patients [9]. Furthermore, many health professionals do not feel confident to participate in advance care planning as few health professionals receive formal education on the topic as part of their undergraduate, post graduate or specialty training [10].

Advance Care Planning Australia recommends that all health professionals and individual support workers to have the core knowledge and skills required and relevant to advance care planning, including an understanding of their legal and professional obligations.

3.3 Benefits of the framework

The capability framework will provide multiple benefits across various groups (see Table 1.)

Table 1. Advance care planning education capability framework benefits

Group	Anticipated benefits
Students	- Identifies and develops knowledge and skills required to facilitate ACP - Provides a more holistic view on provision of health care - Determines personal education and areas for development - Allows for establishment of own learning goals, opportunity for feedback, reflection and consolidation
Educators	- A structure to identify and develop the knowledge and skills required to ensure the provision of effective ACP - Assistance in planning and developing curricula - Flexible resources to allow for integration into existing curricula - A basis for evaluating capability at differing levels of expertise
Health practitioners/ Individual support workers	- Increased confidence in initiating and facilitating ACP discussions - Development of a highly skilled workforce with a focus on person-centred care - Management of change, flexibility and ability to move beyond competency - Knowledge and skill development at an expert/ advanced level
Employers	- Effective and efficient service provision with appropriately skilled workforce - Staff who are adequately trained to ensure patient-centred care - Potential for reduced health care costs by helping to avoid provision of unwanted treatments
Community	- Meets with community expectations regarding ability for the person to have control and make decisions about their future medical treatment - Avoid unnecessary medical treatment by helping to ensure a person's values and preferences are clearly documented

3.4 Capability framework levels

The framework intends to be flexible in its application across a broad spectrum of education levels. Therefore, the framework considers expected advance care planning knowledge and skills of health practitioners and individual support workers at three levels; novice, competent and expert. See Table 2 for details.

Table 2. Capability levels, novice through to expert

Level	Description
Level 1- Novice	The novice learner has limited to no experience with advance care planning, but is familiar with the term. They lack confidence to provide a general explanation of advance care planning and require maximum guidance to identify the ethical and legal considerations relevant to advance care planning.
Level 2- Competent	The competent learner has work experience as a health professional within the health care workforce for 2 or more years. They demonstrate a general understanding of advance care planning and are able to provide an explanation of advance care planning to patients and families, including outlining the benefits for the patient. The competent learner is aware of when to initiate and who to refer the patients to for advance care planning. They can identify, access and act upon relevant legal documents involved in advance care planning, including advance care directives.
Level 3- Expert	The expert learner is a health practitioner and has a comprehensive understanding of advance care planning. They are able to initiate, participate in and facilitate the more complex advance care planning discussions and medical treatment decision making. May participate in providing training on advance care planning to others at levels 1 and 2.

(*Adapted from/ broadly based on the 'Benner's Stages of Clinical Competence' and the NZ ACP competencies)*

4. The need for advance care planning

4.1 What is advance care planning?

Advance care planning is a 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 [11]. Advance care planning is a priority for person-centered and quality care that promotes an individual's choice and control over their own health care decisions. It is recognized as an important element of consent and medical treatment decision-making for persons without capacity.

The process of advance care planning requires coordinated communication and medical planning between a person, their family, carers and/or treating healthcare team. Ideally, values and preferences for medical treatment should be documented in an advance care directive. An advance care directive is a written advance care planning document where a person can outline their preferences for future care and/or appoint a substitute decision-maker for a time where they lack capacity [12]. If the person no longer has decision-making capacity, health practitioners have an obligation to access and enact a person's advance care directive and/or consult with their substitute decision-maker [13]. Health practitioners require the knowledge and skills to initiate, facilitate and/or implement quality advance care planning.

Case study- Importance of ACP

Having spent her working life as a teacher and with her kids grown up, Jan was living life in regional Victoria with her husband Rob. In 2014 Jan was diagnosed with chronic lymphocytic leukaemia. She was treated with chemotherapy and her treating doctors were hopeful that she would experience a remission of around 7 years leaving Rob and Jan feeling relatively optimistic about the future. Unfortunately, just four years later Jan received news that the leukaemia had returned. Jan's health continued to decline and whilst on holiday, Jan collapsed and was rushed to hospital where she was admitted.

"Jan was really sick at this stage. It took five days of exhaustive testing to discover that she had a fungal infection in her lung which had then spread to her brain. It was very serious. The hospital staff informed us that she urgently needed to be transferred to a tertiary hospital for treatment. Jan had been unconscious for several days and could not provide any assistance towards her own decision making. During the five days of testing, before diagnosis, I was investigating the possibility of a transfer home to Victoria so that she could potentially die at home. It was something that we had discussed. She did not want to die in a hospital and I had promised her that I would do all that I could so she wouldn't die in a hospital."

Knowing Jan's aversion to hospitals, the family had a quick phone discussion and resolved that a transfer to another hospital, with associated invasive treatments and a "very poor" outlook would only prolong Jan's suffering and would be against her wishes. "We made the decision to keep her comfortable and not transfer her to another hospital."

Jan's condition deteriorated rapidly. She died a few days later. "I think the hardest thing was having to make such a big decision about Jan's care without being certain of her wishes. An Advance Care Directive would have given me more certainty that I was making the right decisions as we would have been implementing her written wishes." The life-changing experience motivated Rob to write his own Advance Care Directive within a month after losing Jan. "Making treatment decisions under these circumstances is a terrible burden for families to bear – particularly when they are already suffering."

4.2 Legislation and obligations

Legislation to promote advance care planning exists in all Australian jurisdictions. All jurisdictions have legislation or common law to enable competent adults to document their instructional preferences or values for future health care. All jurisdictions have legislation to enable competent adults to appoint a substitute decision- maker.

Health legislation places obligations on registered health practitioners. 16 health professions are regulated by nationally consistent legislation under the National Registration and Accreditation Scheme. According to the Health Practitioner Regulation National Law [14], a registered health practitioner means an individual who practices a health profession listed under this law. Registered health professions abide by codes of conduct which explicitly state the professional behaviours and expectations surrounding the facilitation of advance care planning. This implies there are obligations to implement or enact advance care planning inclusive of advance care directives.

Unregistered health practitioners, including individual support workers, provide health services but are not subject to the scheme for registration under the Health Practitioner Regulation National Law. These unregistered health professionals are subject to the National Code for Health Care Workers which sets out minimum standards for professions providing a health service. They are further subject to the codes of ethics and other professional standards imposed by the specific professions. All health practitioners have a role in advance care planning and require the capability to facilitate these important discussions [10, 15].

Currently, advance care planning and medical treatment decisions legislation do not refer to unregistered health practitioners or individual support workers. This means there are no obligations, protections or exceptions in current legislation that applies to these professions. Ethically and morally, the law should apply to *all* health practitioners, inclusive of those which are not registered. Tables 1-3 (see Appendix) describe the specific health practitioner/individual support worker code of conduct and the obligations within the codes to facilitate advance care planning.

5. Context for the Framework

The Advance Care Planning Education Capability Framework has been informed by literature reviews, a national scoping survey and evaluation (see Figure 1). For further detail regarding these activities refer to *Advance Care Planning Education Capability Framework: summary of research and evaluation [2].*

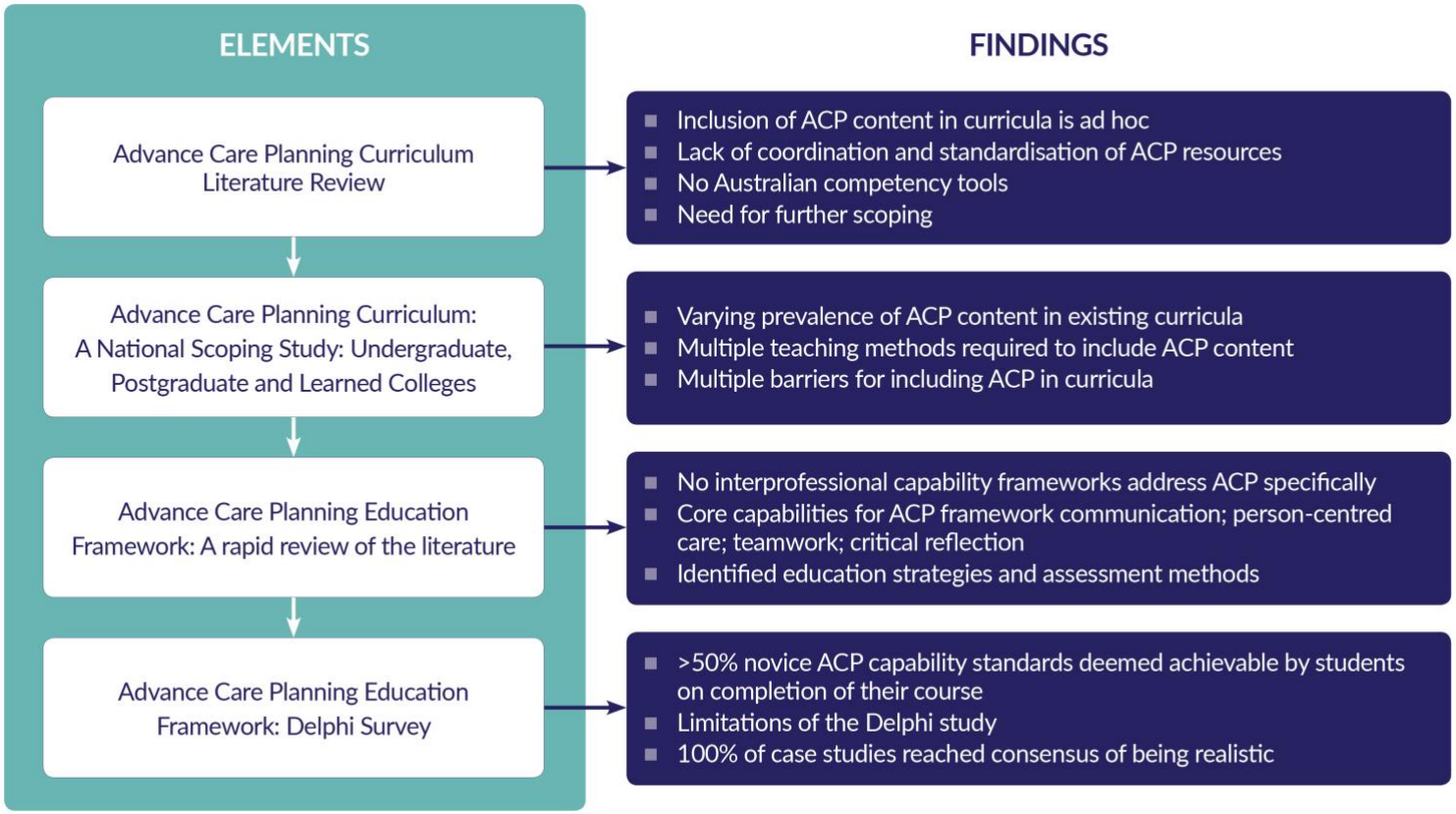

Figure 1. Overview of research and evaluation

6. Advance care planning capability education framework

The terms ‘capability’ and ‘competency’ are often used interchangeably and inconsistently without recognizing or defining the fundamental differences [16]. Capability is described as the “combination of skills, knowledge, values and self-esteem which enables individuals to manage change, be flexible and move beyond competency”[17]. Competency standards do not necessarily reflect the complexities involved in the process of learning and are described as the minimum standards or basic skills to deliver a safe service [18]. Advance care planning is a complex process which is well suited to a capability framework.

The framework is as a resource which can be applied across a broad spectrum of education levels, acknowledging that capability is a continuum [19], whereby knowledge and skill development extends beyond the years of graduate education through to specialist and expertise. The capability-based framework places emphasis on the learner, promoting increased responsibility and self-assessment of their performance against set criteria [20].

The framework includes interdisciplinary capabilities applied to advance care planning content and outlines expected skills that a health professional would demonstrate across five content areas; communication with the person/ family; communication with the team; communication over time; ethics and law.

Figure 2 shows all the advance care planning capability content areas and defines the expected outcomes for each level of expertise.

Figure 2. ACP education capability framework

	TITLE	LEVEL ONE	LEVEL TWO	LEVEL THREE
Law	**Assess decision-making capacity**	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	**AND** initiates discussions with the team if there are any concerns about a person's capacity	**AND** assesses decision-making capacity utilising factors such as understanding, retaining, using or weighing information and communicating the decision in some way
	Understand relevant documentation	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	**AND** understands the role of the substitute decision-maker and advance care planning documentation to inform care	**AND** interprets all the components of relevant advance care planning documents and can assist a person to complete them
	Understand implications of documented preferences	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	**AND** describes the implications for care for various advance care planning documents	**AND** appraises advance care planning documents and identifies whether they are legally binding
Communication – with the person / family / carers	**Respond to cues**	Explains advance care planning and can provide general information about it	**AND** identifies the most appropriate time to initiate advance care planning conversations	**AND** uses appropriate communication strategies to assess willingness to engage in advance care planning
	Tailors communication	Recognises trigger factors where advance care planning may assist a person and can refer to others	**AND** facilitates a safe and meaningful discussion allowing the person to express their own views, recognising it is a voluntary process	**AND** tailors communication so it is sensitive to culture and diversity and can meet the person's and their loved one's needs

	Initiates discussion early	Initiates an advance care planning discussion	**AND** identifies what the person wants to achieve from the advance care planning discussion	**AND** guides advance care planning discussions that focus on the person's current and future health status and preferences for care
	Identifies values and preferences	Reflects on their personal values and preferences and can differentiate between these and consumer agenda	**AND** uses appropriate questioning styles to assist the person to express their values and preferences	**AND** facilitates the documentation of values and preferences in advance care planning documents
Communication - with the team	**Recognises the team**	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	**AND** engages other health professionals and care workers in advance care planning conversations relevant to the person	**AND** widely promotes advance care planning, leads initiatives to raise awareness and promotes inclusion into routine practice
	Negotiates differing perspectives	Recognises and discusses when treatment interventions may not match stated values and preferences for care	**AND** facilitates a discussion with the person and their team regarding intervention decisions	**AND** advocates for the person based on the preferences stated/documented, recognising the team may not be unified
	Communicates with team	Is aware of processes to receive, store and share advance care planning documents	**AND** appropriately documents any advance care planning conversations had with the person	**AND** informs the team of any values and preferences expressed by the person and negotiates different perspectives

Ethics	**Person-centred care guides decision-making**	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	**AND** outlines that a person's values and preferences for care are to be given priority, despite any conflicting views, unless there is concern about their accuracy	**AND** demonstrates how to raise and escalate any ethical concerns or challenges
	Considers outcomes of treatment	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	**AND** describes to the person what conditions may arise and what treatments may be available to them including any treatments that would be considered futile	**AND** guides the person and/or their substitute decision-maker through possible outcomes for treatment and reviews alignment with the person's values and preferences
Communication - over time	**Reviews advance care planning documents**	Recognises triggers to review advance care planning documents	**AND** describes why advance care planning documents need review and assists the person to complete it, if they desire	**AND** appropriately involves the person's substitute decision-maker(s), loved ones and healthcare team in the review process
	Advocacy for the person	Informs the team of the existence of any advance care planning documents	**AND** encourages decision-making, for those with insufficient capacity, to be based on documented preferences and/or person-centred care	**AND** advocates that care delivered by the team is consistent with any values and preferences expressed and/or advance care planning documents
	Implements preferences for care	Recognises the loss of decision-making capacity and discusses this with the healthcare team	**AND** knows to contact the person's substitute decision-maker and look for advance care planning documents to clarify the person's values and preferences	**AND** implements care as per the advance care directive and insight from the substitute decision-maker or advance care planning documents

7. Learning and teaching advance care planning

Advance care planning may be integrated into curricula via a range of advance care planning resources. Capabilities that are considered to be core to health practitioners to facilitating advance care planning are communication skills, person centred care, critical reflection and team work.

Key Resources

Table 3. Key resources to facilitate learning and teaching advance care planning

ACPA Resource	Description
The ACPA Learning website	Provides consumers with opportunities for increasing advance care planning knowledge via workshops, webinars and online modules. There is a suite of 11 modules which address specific areas of advance care planning. (See example of modules below)
ACPA case studies	Ten case studies have been developed to support the education of advance care planning in relation to specific content areas outlined below. These case studies have been developed to meet the learning outcomes defined in level 1 of the framework. www.advancecareplanning.org.au/casestudies
ACPA website	Provides resources for consumers including patients, families/ carers and health and care workers. It delivers specific resources on individual states and territories, including legal requirements. www.advancecareplanning.org.au
The ACPA YouTube channel	Delivers a resource of informative videos including real life stories and situations involving advance care planning.
Advance Care Planning Support service	The advisory team offers mentoring, support and advice on advance care planning. Call 1300 208 582. Clients, their loved one or carers can also be referred to our free phone support service. We'll help them by providing individual advance care planning support to suit their needs. https://www.advancecareplanning.org.au/about-us/referral

ACPA MODULES	CONTENT
 MODULE 1 Advance Care Planning Introduction	**Learning Objectives** • Define advance care planning • Identify benefits of advance care planning • Describe components of advance care planning • Describe how organisations can best describe advance care planning
 MODULE 2 Advance Care Planning Conversations	**Learning Objectives** • Describe roles in advance care planning discussions • Recognise opportunities and barriers when discussing advance care planning • Describe how to prepare for a discussion on decision making • List skills and strategies for effective communication • Identify appropriate resources for documenting advance care planning
 MODULE 3 Advance care planning decision- making	**Learning Objectives** • Describe the roles in health care decision making • Recognise who will be the substitute decision-maker and how they will be appointed • Describe the legal processes for developing advance care plans • Awareness of the legal requirements to activate (implement) ACD

MODULE 4

Advance care planning Implementation

Learning Objectives

- Consider the benefits of implementation
- Discuss elements required for successful implementation
- Identify strategies to assist implementation
- Understand your role in implementing advance care planning

Case studies

- Acute emergency
- Aged care
- Community allied health
- Dementia
- Disability
- ICU
- Paediatric
- Palliative care
- Primary care community
- Rural

Other resources

- EOL essentials-

  end-of-life ESSENTIALS
  education for acute hospitals

  https://www.endoflifeessentials.com.au

- ELLC- End of Life Law for Clinicians

  https://palliativecareeducation.com.au/

- Palliative Care Curriculum for Undergraduates (PCC4U)

  PCC4U PALLIATIVE CARE CURRICULUM FOR UNDERGRADUATES

  http://www.pcc4u.org/

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9. Appendix

9.1 Health practitioner obligation according to codes of conduct

Table 1. Registered health practitioner obligation according to codes of conduct

Registered health practitioner	Code of conduct	Obligations within the code to facilitate advance care planning
Aboriginal and Torres Strait Islander health practice	Aboriginal and Torres Strait Islander Health Practice Board Code of Conduct	Yes
Chinese medicine	Chinese Medicine Board Code of Conduct	Yes
Chiropractic	Chiropractic Board Code of Conduct	Yes
Dental	Dental Board Code of Conduct	Yes
Medical	Good Medical Practice: A Code of Conduct for Doctors in Australia	Yes
Medical radiation practice	Medical Radiation Practice Board Code of Conduct	Yes
Midwifery	Nursing and Midwifery Board Code of Conduct for midwives	Yes
Nursing	Nursing and Midwifery Board Code of Conduct for Nurses	Yes
Occupational therapy	Occupational Therapy Board Code of Conduct	Yes
Optometry	Optometry Board Code of Conduct	No
Osteopathy	Osteopathy Board Code of Conduct	Yes
Paramedicine	Paramedicine Board Code of Conduct	Yes
Pharmacy	Pharmacy Board Code of Conduct	Yes

Physiotherapy	Physiotherapy Board Code of Conduct	Yes
Podiatry	Podiatry Board Code of Conduct	Yes
Psychology	Psychology Board Code of Ethics	No

The National Code of Conduct for Health Care Workers sets the standards of conduct and practice for all unregistered health practitioners and individual support workers. All unregistered health practitioners and individual support workers are bound by this overarching National Code. Tables 2 and 3 outline the profession specific codes of conduct/ practice standards.

Table 2. Unregistered health practitioner obligation according to code of conduct/professional standards

Unregistered health practitioner	Code of conduct/ professional standards	Obligations within the code to facilitate advance care planning
Audiology	Audiology Code of Conduct	No
Dietetics	Dietitians Association of Australia Code of Professional Conduct	No
Social work	Australian Association of Social Workers Practice Standards, 2013	No
Speech pathology	Competency-based Occupational Standards for Speech Pathologists (CBOS) entry level	No

Table 3. Individual support worker obligation according to code of conduct/professional standards

Individual support worker	Code of conduct/professional standards
Assistants in nursing	No specific code of conduct/professional standards
Personal carers	