Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

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

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