Advance Care Planning Australia

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Subject – ICU	Level 1 skills / knowledge	Expected behaviour for case study
Case study Carmel is a 52-year-old female who is in ICU following a ruptured brain aneurysm. Carmel is unconscious and her prognosis is poor. Carmel is divorced with 3 children ranging from 18 - 25 years old. Carmel is in a new relationship (4 months) with her partner Geoff who has recently moved into Carmel's house. Carmel is not able to speak for herself, there is a possibility of organ donation, and so intubation may be required.		
Legal	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	Carmel is currently not able to communicate.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP able to document that Carmel is not able to communicate.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	The HCP is able to check for alerts in the medical record regarding advance care planning information
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	Healthcare professional (HCP) recognises the priority is to establish who is the appointed SDM or if there is not one appointed who would be the decision-maker according to the state/territory guidelines.
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP identifies the trigger to discuss advance care plans is Carmel's inability to speak for herself, the potential for organ donation, the poor prognosis. Aware that establishing the SDM is important.
	Initiates an advance care planning discussion	HCP identifies the importance of having an advance care planning conversation with Carmel's family or loved ones.

	Reflects on their personal values and preferences and can differentiate between these and consumer agenda	HCP considers own preferences for organ donation. HCP can consider Carmel's situation and is aware that she may have different preferences for organ donation and seeks to clarify if these were stated.
Communication - with the team	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	HCP considers the local doctor as a source of information to identify if any advance care plans had been discussed. HCP clarifies contact details for GP.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	As Carmel is not able to speak for herself HCP looks for any documentation indicating Carmel's preferences for care including any documentation regarding organ donation.
	Is aware of processes to receive, store and share advance care planning documents	HCP is aware of how to check medical records to establish if there is anything in Carmel's medical history to indicate appointment of an SDM and / or preferences for care.
Ethics	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	Identifies the potential for differing perspectives regarding organ donation and therefore the need to establish any advance care planning documents.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP is aware of the importance of an SDM as Carmel is not able to speak for herself.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	As Carmel is not able to discuss her preferences for care, HCP to identify SDM and establish any documentation of preferences. Focus is to establish what Carmel would have wanted.
	Recognises triggers to review advance care planning documents	HCP recognises trigger to review any documentation would be if Carmel recovers enough to be able to speak for herself.
	Informs the team of the existence of any advance care	HCP advises the healthcare team if they can find any advance care planning

	planning documents	documentation in Carmel's records.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP able to recognise that if Carmel's condition deteriorates – the potential for organ donation would require interventions that need further discussion with the SDM.

Points of assessment / discussion	Review of requirements of SDM - do they have to have an ongoing relationship? Considers the potential for differing perspectives. Reviews validity of documents considering changed context.
Method of assessment	MCQ regarding role of SDM, validity of documents. Reflects on need for review of ACD regularly.

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