Advance Care Planning Australia

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Subject – Primary Care Community	Level 1 skills / knowledge	Expected behaviour for case study
Case study Michael is a 70 year old man with chronic obstructive pulmonary disease (COPD) who lives with his wife Cherry and they have 3 adult children. Michael and Cherry are attending his general practice as part of his chronic disease plan. Michael has not had an advance care planning discussion before with a healthcare professional.		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	HCP is able to assess Michael's insight to his health status and whether he is able to communicate his decision and the rationale.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP is aware of the documents relevant for Michael to complete in the area in which he lives.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	If documentation is completed HCP is aware of how to ensure other healthcare team members know to access it.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	Healthcare professional (HCP) raises advance care planning with Michael and asks if he has thought about who would speak for him if he could not speak for himself. Michael thought they would just ask his wife. HCP follows up with Cherry and asks if she would know what Michael would want if he collapsed. Cherry says she is not sure.
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP recognises the triggers as being the review of the chronic disease plan, and the diagnosis of COPD, and that the wife is present for the review.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion with Michael is appropriate.

	Reflects on their personal values and preferences and can differentiate between these and consumer agenda	HCP has reflected on their own preferences for care and the need to discuss these with their substitute decision-maker (SDM). HCP is alert to the fact that Cherry and Michael have not discussed the role of the SDM or Michael's preferences for care. Considers the need for Cherry and Michael to discuss values and preferences for health care.
Communication - with the team	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	HCP identifies the need to involve Michael, Cherry, and other family if needed as well as the GP, and other allied health team involved in the care e.g. physio and OT. HCP refers to GP to follow-up and have a case management meeting if needed.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	On discussing with Michael and Cherry, it is clear that they have not identified values and preferences. HCP recognises the importance of stating and possibly documenting preferences for care. HCP provides written and other multimedia resources on these issues.
	Is aware of processes to receive, store and share advance care planning documents	HCP documents discussion and resources provided in the medical record along with need for follow-up discussion to encourage completion of advance care directive and if needed appointing an SDM.
Ethics	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	HCP states to Michael the benefits of writing down preferences for care, such as if the situation is stressful, having preferences written down can guide the SDM. This would reduce the risk of confusion from differing opinions.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP can advise Michael and Cherry of the role of a SDM and having written advance care information can guide decision-making.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	HC identifies to Michael the benefits of an ACD and appointing and SDM. Michael agrees to discuss his values with his SDM and his GP.
	Recognises triggers to review	HCP explains to Michael that the ACD, once

	advance care planning documents	completed ideally it would need review at least every 12 months if not before. HCP is also able to identify other triggers such as admission to hospital, chest infection, if Cherry becomes unwell.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP assesses Michael as being well and able to speak for himself at this time. HCP is aware that the chronic COPD that Michael experiences puts him at risk of not being able to speak for himself at some stage in the illness.
	Informs the team of the existence of any advance care planning documents.	HCP is aware of the need to make sure the GP, community health team, and the local acute hospital are provided with a copy of any completed documentation.

Points of assessment / discussion	Advance care planning discussions should be part of routine care. Understanding triggers for initiating and reviewing advance care plans. Clarifying what has been discussed and what needs further thought regarding values and preferences. Identifying the role of the SDM.
Method of assessment	MCQ re. trigger points and how to clarify values and preferences and how to locate relevant documents.