Advance Care Planning Australia

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Subject – Rural	Level 1 skills / knowledge	Expected behaviour for case study
Case study Margaret is 48 years old and is living with relapsing remitting multiple sclerosis (MS). Margaret lives in Albany, WA, a coastal town with her husband and her 15-year-old son. Margaret is experiencing fatigue, urinary incontinence and is unable to mobilise independently. Margaret has recently returned home following a hospital admission to Perth (400km away) following a recent exacerbation. Healthcare professional is reviewing Margaret at home.		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	HCP recognises that Margaret is aware of her health status, and currently abilities and preference to stay at home, and can provide a rationale for her decision-making and so is assessed as being able to complete advance care planning documentation.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP is aware of local documents required to appoint an SDM and / or documenting preferences for care and can locate these.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	HCP considers best options for communicating with care team the discussions held with Margaret.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	Margaret raises the issue of the distance between her house and the hospital with the healthcare professional (HCP). Margaret identified that she would prefer to stay close to home and not have to keep going to Perth. HCP introduces advance care planning to Margaret and provides written and multimedia information.
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP is able to state the triggers and risk factors for Margaret are: the diagnosis of MS, recent exacerbations and Margaret's concerns about distance to Perth. HCP suggests further discussion with the specialist and GP may help inform Margaret's thinking.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion with Margaret is appropriate.
	Reflects on their personal values and preferences and	The HCP reflects on personal values regarding optimal care versus being close to home. HCP focuses on the potential pathway for Margaret

	can differentiate between these and consumer agenda	and the possibility of further deterioration and increased dependence and considers what this might mean for Margaret in terms of care in the local town. Identifies Margaret's preference at this point is to stay home with her husband and son.
Communication - with the team	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	HCP is aware that Margaret requires assistance from allied health for home adjustments, equipment and maximising independence. HCP liaises with teams in Perth and Albany regarding Margaret's preferences for care and that the team could continue further advance care planning discussions.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	HCP identified Margaret's desire to remain at home. HCP highlights the need for Margaret to discuss and appoint a substitute decision maker (SDM) and clarify her preferences for care with the SDM so that Margaret is not transferred to Perth inappropriately. Margaret needs to be clear on when if ever she would want to be transferred to Perth. Margaret also needs to recognise the situation maybe unforeseen and the SDM may have no choice but to agree to transfer to Perth.
	Is aware of processes to receive, store and share advance care planning documents	HCP documents discussion with Margaret including advice re. appointing an SDM, and clarification of preferences.
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 desire of Margaret's husband to care for Margaret and Margaret's desire to remain at home. HCP also recognises that Margaret's care needs may increase to beyond what can be provided at home and suggests that she continue to review her advance care plans and discuss health needs with the healthcare team.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP discusses with Margaret the need to appoint an SDM and discuss her care preferences for care. HCP can inform Margaret of the advantage of having an SDM and the need to discuss with them her preferences for care particularly related to transfer to Perth.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP is aware that Margaret wants to minimise the trips to Perth and the main reason for appointing the SDM is to support this decision. HCP explains that the situation maybe unforeseen and the SDM may have no choice but to agree to transfer to Perth.

	Recognises triggers to review advance care planning documents	HCP identifies the need to review the ACP again and that a trigger for review maybe that Margaret experiences further deterioration or there may be a change in husband's health.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP able to recognise that there may be further relapses or other health issues that may require transfer to Perth and suggests Margaret talk to her GP about potential health issues.
	Informs the team of the existence of any advance care planning documents.	HCP discusses with the team Margaret's desire to stay at home, and that discussions about appointing a substitute decision maker and identifying preferences for care have started.

Points of assessment / discussion	People may feel the options for care may be limited because of access to local services. Choices may therefore not align with HCP. Need to advocate for patient and carers. Need for consideration of all options so the person can make informed decisions. Ethical dilemma if care is limited because of location of care.
Method of assessment	MCQ regarding triggers for discussion, advocating for pt. in MDT discussions. Reflection on ethics of care.