Advance Care Planning Australia

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Subject – Acute Emergency	Level 1 skills / knowledge	Expected behaviour for case study
Case study Dianne, 40 years old, with 2 children 14 and 12 years has chronic kidney disease which has progressed. Dianne is divorced and is a single mum. Dianne has a close relationship with her mother who also helps with childcare and is looking after the children at home whilst Dianne was brought into Emergency by ambulance. The children are cared for by their father every second weekend, and half of the school holidays. Dianne presents as confused secondary to possible delirium related to electrolyte imbalance from advanced kidney failure. Dianne is given emergency interventions and the delirium is resolving. There is a potential that Dianne will require dialysis at some stage.		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	Following the episode of delirium, the HCP encourages Dianne to reflect on her preferences for care and discuss these with her doctor and healthcare team on discharge.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP is aware of how to access the ACD forms for their state and their workplace to be provided to Dianne. HCP is able to identify who Dianne's substitute decision-maker will be.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	The discussion between the HCP and Dianne is documented and the plan for follow-up is included.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	The healthcare professional (HCP) checks Dianne's records to see if there is a substitute decision-maker appointed and any advance care plans in place. HCP asks Dianne if she has completed an advance care directive (ACD).
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP recognises a trigger factor for initiation / review of ACD is advanced disease process i.e. that Dianne's renal failure has progressed, her admission for delirium, and social situation.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion with Dianne after her delirium has resolved is appropriate.
	Reflects on their personal	HCP identifies their own values and how the

	values and preferences and can differentiate between these and consumer agenda	potential for renal dialysis may affect them. HCP focuses on exploring with Dianne if she has completed any advance care directives or appointment of an SDM in case she experiences a similar delirious episode.
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 renal team and other allied health supports for Dianne to provide her with information about her current health status and encourages Dianne to follow up with GP and community renal support team.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	Dianne has presented to A&E confused because of delirium and the medical records did not indicate a SDM had been appointed. When the confusion is resolved Dianne is encouraged to consider appointing an SDM and documenting her healthcare preferences so that her preferences for care can be followed.
	Is aware of processes to receive, store and share advance care planning documents	Dianne is asked if she has appointed a substitute decision maker (SDM) and / or completed an ACD. Discussion is documented.
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 complexity of Dianne's decision, for example the need to forward plan for the children. Identifies the need to appoint a SDM, particularly if there are differing perspectives within her support network. HCP suggests to Dianne she may want to see a Social Worker.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP reassures Dianne that if she completes an ACD and appoints an SDM that the documentation will be used to guide the SDM and the healthcare team in decision-making if she is not able to decide for herself.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP can explain the importance of an ACD and appointing an SDM particularly as Dianne may experience another delirious episode. HCP encourages Dianne to think about what is important to her, what she is most concerned about. HCP knows how to access local written information to assist Dianne reflect on her values and preferences.
	Recognises triggers to	HCP encourages Dianne to consider options and

	review advance care planning documents	ensures she is aware that she can update the ACD at any time. HCP encourages discussion of her preferences for care with her community support team.
	Informs the team of the existence of any advance care planning documents	HCP documents the discussions about ACD with Dianne to encourage further follow up post A&E discharge.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP recognised and can explain to Dianne the delirium she experienced earlier may happen again and that a SDM may help guide the healthcare team in their decision-making if she is again not able to speak for herself.

Points of assessment / discussion	Ethical dilemma of providing care for someone not able to speak for themselves and not knowing their preferences and the young age of the person. Understanding informed decision making over potential depression and capacity assessment. Understanding the involvement of the team.
Method of assessment	MCQ regarding assessment of capacity and role of the MDT. Reflection on informed consent and can people refuse dialysis.