Advance Care Planning Australia

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Subject - Dementia	Level 1 skills / knowledge	Expected behaviour for case study
Case study Trevor has been the main carer for his mother, Joan 81 years old who has advanced dementia on a background of osteoarthritis and recent pneumonia. Joan was admitted to a residential aged care facility 3 months ago and is experiencing another chest infection that is likely to be aspiration pneumonia and a decision of whether to go to hospital is discussed. Joan is responsive but does not have capacity. There are no other children and Joan's husband is deceased.		
Communication with the person / Family / Carers	Can explain advance care planning and provide general information	Healthcare professional (HCP) discusses with Trevor and Joan if a substitute decision-maker (SDM) has been appointed and if any advance care directives (ACD) have been documented. HCP is able to explain what a SDM and ACD is.
	Recognises triggers and risk factors where advance care planning may assist and can refer to others	HCP recognises that the triggers for ACD and SDM discussion include: admission to a residential aged care facility, and diagnosis of pneumonia, another chest infection and dementia.
	Has reflected on personal values and preferences and can differentiate between clinician and consumer agenda	HCP can reflect on what care they might choose for their own mother but is able to differentiate this from what Joan wants and requires.
Communication with the team	Recognises that the team involves health professionals across all settings and all have a role in advance care planning discussions	HCP identified the team might include the geriatrician, social worker and GP along with any other family members.
	Able to recognise and discuss when treatment interventions may not match stated preferences for care	HCP recognises Trevor is unsure about having to make a decision for Joan regarding admission to hospital to treat a chest infection. HCP asks Trevor what Joan would have wanted to guide him with the decision-making.
	Aware of and utilises appropriate methods for documentation of discussion	HCP documents the discussion with Trevor including clarifying if there was an ACD, and a SDM appointed and the options for care.
Communication over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP focuses Trevor on what his mother would have wanted if she could speak for herself and supports his decision. HCP asks if there are any other supports for Trevor, e.g. siblings.
	Recognises triggers to review ACP	HCP guides Trevor in identifying that Joan's health status has deteriorated and consideration for the medical interventions that Joan would have wanted is required.
	Able to recognise deterioration and loss of capacity and discuss same with team.	HCP identifies that Joan no longer has capacity to make her own decisions and that implementation of any advance care

		preferences is now required.
Ethical	Recognises there may be differing perspectives between the goals of the person, the SDM and the health care team	HCP recognises the change in the goal of care may be difficult for Trevor to accept initially. HCP focuses discussion with Trevor on Joan and what she would have wanted.
	Informs the team of the existence of advance care directives	HCP clarifies there is no ACD but that Trevor was appointed SDM. HCP reviews the documentation provided by Trevor re. SDM and ensures there is a copy with Joan's medical record.
	Able to explain to the person that they are eligible to guide the medical team regarding interventions	HCP advises Trevor that as there is no ACD he could reflect on previous discussions with his mother to help guide his decision-making. Healthcare team are able to explain options for Joan's care.
Legal	Able to assess the person's ability to participate in discussion and follow direction	HCP includes Joan in discussions but as she lacks capacity Trevor is required to make the decisions.
	Aware of relevant documents and requirements for workplace	HCP is aware of the validity of SDM documents provided by Trevor.
	Able to put in the medical record system an alert that there is an advance care directive	HCP is able to state process for recording of SDM for the setting.

Points of assessment / discussion	Assessing capacity for people with dementia, negotiating change of goals care, supporting the SDM.
Method of assessment	MCQ on types dementia, triggers for discussion. Reflection on changes in goals of care and advocating for person's preferences for care.