Advance Care Planning Australia
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Subject - Disability	Level 1 skills / knowledge	Expected behaviour for case study
Case study Jose is 26 years old and has muscular dystrophy. Jose lives with his parents and younger brother. His parents have been his long-term carers. Jose was admitted to hospital with abdominal pain and suspected pancreatitis. Jose is non-invasive ventilator dependent and has a PEG tube for nutrition. Jose wants to discuss his care preferences, as there has been discussion about interventions for Jose's pancreatitis. Jose is concerned that his mother may not be able to follow his preferences for care, as she wants him to stay alive with all interventions.		
Communication with the person / Family / Carers	Can explain advance care planning and provide general information	Jose initiates a conversation with the healthcare professional (HCP) about appointing a substitute decision-maker (SDM) and wants to know if he can only nominate one person. HCP is aware of what the SDM laws are for where he works and can provide a valid answer.
	Recognises triggers and risk factors where advance care planning may assist and can refer to others	HCP recognises Jose's health status and admission to hospital are trigger points for advance care planning (ACP) discussions. HCP shares with the treating team Jose's desire to discuss ACP and consideration of Jose's preferences when treatment decisions are considered.
	Has reflected on personal values and preferences and can differentiate between clinician and consumer agenda	HCP recognises that the perception of quality is individual and reflects on their values that would influence their own decision-making. HCP is able to focus on Jose who is accepting of his quality of life, even though he has many physical restrictions.
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 recognises that there are many people involved in Jose's care including his parents, community care, GP, respiratory team, cardiac team, GIT, dietitians, physio and OT etc. HCP recognises that Jose may want to continue advance care planning discussions with his other team members such as his GP.
	Able to recognise and discuss when treatment interventions may not match stated preferences for care	HCP can discuss with Jose how an advance care plan and appointing a SDM can provide a guide for decision-making if he cannot speak for himself and that this may reassure Jose.
	Aware of and utilises appropriate methods for documentation of discussion	HCP documents the discussion and encourages Jose to speak to his parents and the healthcare team.
Communication over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP identifies the need for Jose and his parents to discuss Jose's preferences for care and documents this discussion.
	Recognises triggers to review ACP	HCP identifies trigger to consider ACP and appointing an SDM include: Jose's admission

		to hospital; his co-morbidities; Jose's desire to clarify his preferences for care.
	Able to recognise deterioration and loss of capacity and discuss same with team.	HCP recognises that Jose is currently able to speak for himself but given the triggers, Jose may want to consider documenting his preferences.
Ethical	Recognises there may be conflict between the goals of the person, the SDM and the health care team	HCP recognises the potential for differing perspectives between the family, Jose and the treating team. HCP encourages Jose to speak to his family about his preferences.
	Informs the team of the existence of advance care directives	HCP identifies to the team that there is no SDM appointed and recommends the healthcare team continue to have an ACP discussion with Jose.
	Able to explain to the person that they are eligible to guide the medical team regarding interventions	HCP explains to Jose the advantages of ACP and appointing an SDM, if he is not able to speak for himself.
Legal	Able to assess the person's ability to participate in discussion and follow direction	HCP explores Jose's understanding of his health status and why he was admitted to hospital. HCP encourages Jose to continue advance care planning discussions post discharge with his GP and community care team.
	Aware of relevant documents and requirements for workplace	HCP is aware of ACP and SDM related documents for own area and can locate these for Jose.
	Able to put in the medical record system an alert that there is an advance care directive	HCP is aware of how to include the discussions and if completed any ACP alerts in the local system.

Points of assessment / discussion	Jose's capacity to make an ACD, managing potential family conflict, acceptance of Jose's choice to choose between treatment options and appoint an SDM.
Method of assessment	MCQs regarding role of SDM and appointing one SDM, how to manage a family meeting. Reflection regarding choice of intervention over quality.