Advance Care Planning Australia
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Subject – Palliative care	Level 1 skills / knowledge	Expected behaviour for case study
Case study – building on PCC4U case study Michelle is 38 years old and lives with her partner Peter. They have 2 children aged 9 and 12. Michelle has metastatic breast cancer to lung, liver and bones. Michelle is at home being cared for by her husband and family with the support of community services including GP, home nursing and palliative care team. Michelle's condition is deteriorating and she is sleeping most of the time. There has been an advance care directive (ACD) completed and Peter has been appointed as the substitute decision-maker (SDM)		
Communication with the person / Family / Carers	Can explain advance care planning and provide general information	Healthcare professional (HCP) asks Michelle and Peter if there is an advance care directive (ACD) and/or appointed a substitute decision-maker (SDM). HCP is aware of the potential for further deterioration of Michelle's condition and the possible need for a SDM.
	Recognises triggers and risk factors where advance care planning may assist and can refer to others	HCP states the triggers are 1) Michelle has advanced disease and 2) Michelle is deteriorating and sleeping most of the time. HCP prompts Michelle and Peter to locate and review advance care directive.
	Has reflected on personal values and preferences and can differentiate between clinician and consumer agenda	HCP reflects on own values of life prolonging treatment versus quality of life when living with a terminal illness. HCP listens to Michelle's desire to remain at home for as long as possible and for no further active cancer treatment. HCP suggest this preference is included in her advance care directive.
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 encourages Michelle and Peter to talk about the decision to stop treatment with the oncology service, the GP and other team members involved in Michelle's care.
	Able to recognise and discuss when treatment interventions may not match stated preferences for care	Peter states to HCP he would like Michelle to continue treatment. HCP encourages Michelle and Peter to discuss plan of care with GP and oncology team.
	Aware of and utilises appropriate methods for documentation of discussion	HCP together with Peter and Michelle review current ACD and if needed encourages Michelle to change ACD content.
Communication over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP recognises Michelle would like to stop active cancer treatment and discusses with Michelle and Peter that the focus of the care has to be on what Michelle wants
	Recognises triggers to review ACP	HCP recognises Michelle's change in preferences for care is a trigger to review the ACD.

	Able to recognise deterioration and loss of capacity and discuss same with team.	HCP encourages Michelle and Peter to discuss with the GP and community care team her preferences for care as a priority.
Ethical	Recognises there may be differing perspectives between the goals of the person, the SDM and the health care team	HCP recognises the need to review the ACD and encourages Michelle and Peter and the healthcare team to discuss possible changes.
	Informs the team of the existence of advance care directives	HCP discusses with palliative care team that Peter is the appointed SDM
	Able to explain to the person that they are eligible to guide the medical team regarding interventions	HCP advises Peter and Michelle that documenting any change in ACD will guide decision-making
Legal	Able to assess the person's ability to participate in discussion and follow direction	HCP encourages Michelle to be part of the decision-making when she is able whilst recognising Peter's role of decision-making if Michelle is not able to communicate her preferences.
	Aware of relevant documents and requirements for workplace	HCP assists Michelle with updating her ACD by providing her with relevant documents to be completed.
	Able to put in the medical record system an alert that there is an advance care directive	HCP advises the team of the existence of the reviewed ACD and adds an alert to the medical record system.

Points of assessment / discussion	Understanding need to review preferences for treatment as condition progresses. Managing family discussions. Role of SDM
Method of assessment	MCQ re triggers for review and role of SDM. Reflection on how to manage family discussions and advocacy for patient.