Advance Care Planning Australia

BE OPEN | BE READY | BE HEARD

Subject – Primary Care Community	Level 1 skills / knowledge	Expected behaviour for case study
Case study Michael is a 70 year old man with chronic obstructive pulmonary disease (COPD) who lives with his wife Cherry and they have 3 adult children. Michael and Cherry are attending his general practice as part of his chronic disease plan. Michael has not had an advance care planning discussion before with a healthcare professional.		
Communication with the person / Family / Carers	Can explain advance care planning and provide general information	Healthcare professional (HCP) raises advance care planning with Michael and asks if he has thought about who would speak for him if he could not speak for himself. Michael thought they would just ask his wife. HCP follows up with Cherry and asks if she would know what Michael would want if he collapsed. Cherry says she is not sure.
	Recognises triggers and risk factors where advance care planning may assist and can refer to others	HCP recognises the triggers as being the review of the chronic disease plan, and the diagnosis of COPD, and that the wife is present for the review.
	Has reflected on personal values and preferences and can differentiate between clinician and consumer agenda	HCP has reflected on their own preferences for care and the need to discuss these with their substitute decision-maker (SDM). HCP is alert to the fact that Cherry and Michael have not discussed the role of the SDM or Michael's preferences for care. Considers the need for Cherry and Michael to discuss values and preferences for health care.
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 identifies the need to involve Michael, Cherry, and other family if needed as well as the GP, and other allied health team involved in the care e.g. physio and OT. HCP refers to GP to follow-up and have a case management meeting if needed.
	Able to recognise and discuss when treatment interventions may not match stated preferences for care	On discussing with Michael and Cherry, it is clear that they have not identified values and preferences. HCP recognises the importance of stating and possibly documenting preferences for care. HCP provides written and other multimedia resources on these issues.
	Aware of and utilises appropriate methods for documentation of discussion	HCP documents discussion and resources provided in the medical record along with need for follow-up discussion to encourage completion of advance care directive and if needed appointing an SDM.
Communication	Identifies what the person wants to achieve from the advance care	HC identifies to Michael the benefits of an ACD and appointing and SDM. Michael agrees to discuss his

over time	planning discussion	values with his SDM and his GP.
	Recognises triggers to review ACP	HCP explains to Michael that the ACD, once completed ideally it would need review at least every 12 months if not before. HCP is also able to identify other triggers such as admission to hospital, chest infection, if Cherry becomes unwell.
	Able to recognise deterioration and loss of capacity and discuss same with team.	HCP assesses Michael as being well and able to speak for himself at this time. HCP is aware that the chronic COPD that Michael experiences puts him at risk of not being able to speak for himself at some stage in the illness.
Ethical	Recognises there may be differing opinions between the goals of the person, the SDM and the health care team	HCP states to Michael the benefits of writing down preferences for care, such as if the situation is stressful, having preferences written down can guide the SDM. This would reduce the risk of confusion from differing opinions.
	Informs the team of the existence of advance care directives	HCP is aware of the need to make sure the GP, community health team, and the local acute hospital are provided with a copy of any completed documentation.
	Able to explain to the person that they are eligible to guide the medical team regarding interventions	HCP can advise Michael and Cherry of the role of a SDM and having written advance care information can guide decision-making.
Legal	Able to assess the person's ability to participate in discussion and follow direction	HCP is able to assess Michael's insight to his health status and whether he is able to communicate his decision and the rationale.
	Aware of relevant documents and requirements for workplace	HCP is aware of the documents relevant for Michael to complete in the area in which he lives.
	Able to put in the medical record system an alert that there is an advance care directive	If documentation is completed HCP is aware of how to ensure other healthcare team members know to access it.

Points of assessment / discussion	Advance care planning discussions should be part of routine care. Understanding triggers for initiating and reviewing advance care plans. Clarifying what has been discussed and what needs further thought regarding values and preferences. Identifying the role of the SDM.
Method of assessment	MCQ re. trigger points and how to clarify values and preferences and how to locate relevant documents.