Advance Care Planning Australia
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Subject – Rural	Level 1 skills / knowledge	Expected behaviour for case study
Case study Margaret is 48 years old and is living with relapsing remitting multiple sclerosis (MS). Margaret lives in Albany, WA, a coastal town with her husband and her 15-year-old son. Margaret is experiencing fatigue, urinary incontinence and is unable to mobilise independently. Margaret has recently returned home following a hospital admission to Perth (400km away) following a recent exacerbation. Healthcare professional is reviewing Margaret at home.		
Communication with the person / Family / Carers	Can explain advance care planning and provide general information	Margaret raises the issue of the distance between her house and the hospital with the healthcare professional (HCP). Margaret identified that she would prefer to stay close to home and not have to keep going to Perth. HCP introduces advance care planning to Margaret and provides written and multimedia information.
	Recognises triggers and risk factors where advance care planning may assist and can refer to others	HCP is able to state the triggers and risk factors for Margaret are: the diagnosis of MS, recent exacerbations and Margaret's concerns about distance to Perth. HCP suggests further discussion with the specialist and GP may help inform Margaret's thinking.
	Has reflected on personal values and preferences and can differentiate between clinician and consumer agenda	The HCP reflects on personal values regarding optimal care versus being close to home. HCP focuses on the potential pathway for Margaret and the possibility of further deterioration and increased dependence and considers what this might mean for Margaret in terms of care in the local town. Identifies Margaret's preference at this point is to stay home with her husband and son.
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 is aware that Margaret requires assistance from allied health for home adjustments, equipment and maximising independence. HCP liaises with teams in Perth and Albany regarding Margaret's preferences for care and that the team could continue further advance care planning discussions.
	Able to recognise and discuss when treatment interventions may not match stated preferences for care	HCP identified Margaret's desire to remain at home. HCP highlights the need for Margaret to discuss and appoint a substitute decision maker (SDM) and clarify her preferences for care with the SDM so that Margaret is not transferred to Perth inappropriately. Margaret needs to be clear on when if ever she would want to be transferred to Perth. Margaret also needs to recognise the situation maybe unforeseen and the SDM may have no choice but to agree to transfer to Perth.
	Aware of and utilises appropriate methods for documentation of discussion	HCP documents discussion with Margaret including advice re. appointing an SDM, and clarification of preferences.
Communication over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP is aware that Margaret wants to minimise the trips to Perth and the main reason for appointing the SDM is to support this decision. HCP explains that the situation maybe unforeseen and the SDM may have no choice

		but to agree to transfer to Perth.
	Recognises triggers to review ACP	HCP identifies the need to review the ACP again and that a trigger for review maybe that Margaret experiences further deterioration or there may be a change in husband's health.
	Able to recognise deterioration and loss of capacity and discuss same with team.	HCP able to recognise that there may be further relapses or other health issues that may require transfer to Perth and suggests Margaret talk to her GP about potential health issues.
Ethical	Recognises there may be conflict between the goals of the person, the SDM and the health care team	HCP recognises the desire of Margaret's husband to care for Margaret and Margaret's desire to remain at home. HCP also recognises that Margaret's care needs may increase to beyond what can be provided at home and suggests that she continue to review her advance care plans and discuss health needs with the healthcare team.
	Informs the team of the existence of advance care directives	HCP discusses with the team Margaret's desire to stay at home, and that discussions about appointing a substitute decision maker and identifying preferences for care have started.
	Able to explain to the person that they are eligible to guide the medical team regarding interventions	HCP discusses with Margaret the need to appoint an SDM and discuss her care preferences for care. HCP can inform Margaret of the advantage of having an SDM and the need to discuss with them her preferences for care particularly related to transfer to Perth.
Legal	Able to assess the person's ability to participate in discussion and follow direction	HCP recognises that Margaret is aware of her health status, and currently abilities and preference to stay at home, and can provide a rationale for her decision-making and so is assessed as being able to complete advance care planning documentation.
	Aware of relevant documents and requirements for workplace	HCP is aware of local documents required to appoint an SDM and / or documenting preferences for care and can locate these.
	Able to put in the medical record system an alert that there is an advance care directive	HCP considers best options for communicating with care team the discussions held with Margaret.

Points of assessment / discussion	People may feel the options for care may be limited because of access to local services. Choices may therefore not align with HCP. Need to advocate for patient and carers. Need for consideration of all options so the person can make informed decisions. Ethical dilemma if care is limited because of location of care
Method of assessment	MCQ regarding triggers for discussion, advocating for pt. in MDT discussions. Reflection on ethics of care.