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).		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	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.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP assists Michelle with updating her ACD by providing her with relevant documents to be completed.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	HCP advises the team of the existence of the reviewed ACD and adds an alert to the medical record system.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	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 trigger factors where advance care planning may assist a person 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.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion with Michelle is appropriate.
	Reflects on their personal values and preferences and can differentiate between	HCP reflects on own values of life prolonging treatment versus quality of life when living with a terminal illness. HCP listens to

	these and consumer agenda	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	Identifies the contribution of all health professionals and care workers in a person's 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.
	Recognises and discusses when treatment interventions may not match stated values and 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.
	Is aware of processes to receive, store and share advance care planning documents	HCP together with Peter and Michelle review current ACD and if needed encourages Michelle to change ACD content.
Ethics	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	HCP recognises the need to review the ACD and encourages Michelle and Peter and the healthcare team to discuss possible changes.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP advises Peter and Michelle that documenting any change in ACD will guide decision-making.
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 advance care planning documents	HCP recognises Michelle's change in preferences for care is a trigger to review the ACD.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	HCP encourages Michelle and Peter to discuss with the GP and community care team her preferences for care as a priority.
	Informs the team of the existence of advance care directives	HCP discusses with palliative care team that Peter is the appointed SDM.

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.

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