Advance Care Planning Australia

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Subject – Aged care	Level 1 skills / knowledge	Expected behaviour for case study
Case study Yuri 78 years, widowed, with no noticeable cognitive impairment. He has numerous health issues: diabetes, obesity, a leg ulcer and poor mobility. Yuri has three children (Mirra, Lydia and Moriz) and lives with his daughter, Mirra. Yuri assumes that Moriz, who is the youngest of his children, as the male in the family will be his substitute decision-maker (SDM). Moriz sees his father only on special occasions organised by Mirra such as birthdays. Lydia lives interstate. Yuri was admitted to hospital with a chest infection and a recent fall which has further limited his mobility. Yuri is slowly recovering and will be able to be discharged shortly.		
Law	Explains that a person is presumed to have decision-making capacity unless there is reason to suggest otherwise	HCP assesses that Yuri is aware of his health status and that Yuri is able to state his rationale for his decision-making. Therefore, HCP determines Yuri has the capacity to appoint Moriz as the SDM and documents the information used to determine capacity.
	Recognises and locates relevant advance care planning documents and identifies the person's substitute decision-maker	HCP able to locate and provide relevant SDM documents for the family. HCP can register the SDM paperwork once completed so that it is associated with Yuri's medical record.
	Demonstrates appropriate processes to add an advance care planning document alerts on local systems	HCP is aware of and completes the workplace process for sharing ACD documents and need for alerts.
Communication - with the person / family / carers	Explains advance care planning and can provide general information about it	The healthcare professional (HCP) asks Yuri if he has an ACD. HCP can explain the hierarchy of the person responsible in that state/territory and provide information about how to appoint a substitute decision-maker (SDM).
	Recognises trigger factors where advance care planning may assist a person and can refer to others	HCP can recognise triggers which are 1) the chest infection 2) the fall 3) Yuri's age 4) comorbidities. HCP is also aware that the person responsible hierarchy would not direct decision making to son, so Yuri needs to appoint Moriz as SDM.
	Initiates an advance care planning discussion	HCP identifies that an advance care planning discussion with Yuri is appropriate.
	Reflects on their personal values and preferences and	HCP reflects on their own family relationships and can identify there is variety in how families

	can differentiate between these and consumer agenda	relate with each other. HCP is able to direct Yuri as to how he can appoint Moriz to be SDM and encourages Yuri to discuss this with all family members.
Communication - with the team	Identifies the contribution of all health professionals and care workers in a person's advance care planning discussions	HCP recognises the role of the community health care team, the GP and practice nurse in following up any ACP discussions commenced in hospital and encourages Yuri and Mirra to discuss the ACP with the community services.
	Recognises and discusses when treatment interventions may not match stated values and preferences for care	HCP informs the team that Yuri would like to appoint Moriz as his decision-maker even though the daughter is the main carer. HCP encourages family to discuss Yuri's preferences for healthcare.
	Is aware of processes to receive, store and share advance care planning documents	HCP provides Yuri with written information (in relevant language if required) regarding the role of the SDM.
Ethics	Recognises that there may be different perspectives between the goal of the person, the substitute decision-maker and the healthcare team	HCP clarifies that Moriz is the SDM. HCP encourages Mirra, Moriz and Yuri to have ongoing conversations about Yuri's preferences for care.
	Explains to the person with sufficient capacity that they can guide the healthcare team regarding interventions	HCP able to explain the role of the SDM to the family.
Communication - over time	Identifies what the person wants to achieve from the advance care planning discussion	HCP clarifies with Yuri the appointment of the son as SDM, can explain why officially appointing Moriz is required, and suggests that Yuri talk to all his children about his values and preferences. HCP provides written information about the role of the SDM and making ACPs.
	Recognises triggers to review advance care planning documents	HCP explains to Yuri that he can review his ACP and/or SDM if the situation changes and suggests they should talk with the community services about Yuri's ACP when he comes home.
	Recognises the loss of decision-making capacity and discusses this with the healthcare team	Yuri appears to have capacity - HCP can state how the assessment is made i.e. able to describe current health status, understands treatment options and is able to explain why the son should be the decision maker.
	Informs the team of the	HCP advises the hospital team when the

	existence of any advance care planning documents.	appointment of the SDM is completed and registers this in the medical record. HCP encourages Yuri to copy the document and share it with his family and his GP, upload it to 'My Health Record' and makes suggestions as to how to make the form available.

Points of assessment / discussion	Cultural differences between families. Respect for what the person prefers. Differing perspectives between the family. Advocating for the person.
Method of assessment	MCQ re. assessing cultural determinants of care, running a family meeting. Reflection on how to advocate for people.