COGNITIVE DECLINE PARTNERSHIP CENTRE

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Start2Talk

PLANNING AHEAD COMMUNITY AND HOME CARE TOOLKIT

Advance Care Planning (ACP) continuum of practice model

Planning ahead can be assisted by a wide range of professionals across the community, home care and health sectors. To create sustainable systems which support early planning, services need to develop systematic ways of engaging with clients and care partners to increase the likelihood that their wishes will be known and adhered to.

Planning ahead includes planning across a range of financial, health and personal issues including preparation of wills, power of attorney (financial), nomination of substitute decision makers (SDM) for personal and health care , advance care planning (ACP) and lifestyle planning e.g. accommodation, support services, work and driving.

This tool can provide a useful means of evaluating specifically the ACP component of planning ahead in home care and community services. It is important that staff also have the knowledge and are empowered to prompt and encourage their clients in in other areas of planning ahead or provide information and referral to other professionals who can assist.

Describing ACP practices on a continuum allows assessment of how routinely or systematically ACP is undertaken. Mapping against key ACP action areas allows an assessment of current practice and opportunities for improvement. It is important to understand the categories overlap and are not mutually exclusive. Additional tools are available in the community and health professionals section of the Start2Talk website at www.start2talk.org.au

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ADVANCE CARE PLANNING (ACP) CONTINUUM OF PRACTICE MODEL

Highly systematic → **No system in approach**

	A	B	C	D
ACP initiation	Planning information, including ACP is discussed when the person first accesses home care or community services	ACP is not raised directly but may be included in general discussions with the individual or their family	Some written ACP information may be given but there is no discussion initiated by staff	There is no ACP information given or discussion initiated by staff
Scope	Identifies substitute decision maker, personal values, care and treatement preferences in possible future scenarios. Discusses wide range of issues relevant for extended period of incapacity	Some discussion of care and treatment preferences in possible future scenarios	No discussion of treatment preferences in possible future scenarios until near end of life	No discussion of future wishes other than funeral arrangements
Person centred	Organisation respects the autonomy of the client and wherever possible supports them to be involved in decision making	Organisation respects autonomy of the client to a degree but little attention is given to factors that support the client making decisions	Organisation is unsure about what 'autonomy' means and tends to think once a person has dementia they have no capacity.	Organisation defaults to the substitute maker making all the decisions or alternatively does not involve the substitute decision maker at all.
Follow-up	Systematically includes ACP discussion in initial care interview and at regular client reviews. Refers to ACP in later care or treatment decisions	ACP may be mentioned at the initial care interview but is not done systematically and often does not happen	No follow up initiated by staff. They will respond if resident or family raise ACP issues	No follow up initiated by staff. Discussion occurs only in response to serious illness or conflict
Documentation	ACP discussions and directives are recorded and placed on the client's file. With the client's permission copies are sent to the local hospital's medical records unit and their GP	ACP discussions are recorded on the client's file but copies are not routinely sent to the hospital medical records unit or their GP	There is no specific ACP documentation. Any discussion that may occur is only written in the client's care notes.	There is no documentation at all of ACP discussions or the individual's care preferences
Training	All staff including non-clinical staff receive training in ACP. Training involves a practical component and mentorship and review over time is provided	Some staff have received practical training in ACP. Refresher training and mentorship is not provided	Some staff have attend external ACP training, but it is not reinforced in the agency training	Staff are not trained in ACP
Organisational leadership	Management and other senior staff see ACP as a priority and are strong role models and champions. Clear policies and staff training are provided	Management is interested in developing ACP and is making an effort to develop policies. No consistent approach or training yet	Management has some understanding of ACP but does not see it as a priority and is too busy to attempt to find out more	Management does not understand what ACP is about and is not really interested in finding out about it

Advance Care Planning Continuum of Practice has been adapted with permission from Shanley Et Al Understanding how advance care planning is approached in the residential aged care setting: A continuum model of practice as an explanatory device *Australasian Journal on Ageing*, Vol 28 No 4 December 2009, 211–215