A guide to Advance Care Planning

Covering the following areas with useful links included:

- Advance Statement- future wishes;
- Advance Decision to Refuse Treatment;
- Appointment of a legal advocate- Lasting Power of Attorney
- Anticipatory Clinical Management Plan (Emergency Care and Treatment Plan)
- Recording and sharing the information
- Starting ACP conversation

Overview

Advance Care Planning (ACP) is a discussion between an individual and their care provider(s).

It is to make clear an individual's wishes and preferences about their future care and treatment.

It is made when a person has capacity to be used only when a person lacks capacity to make their wishes known.

It is a voluntary and ongoing process that should be regularly reviewed.

With the individual's agreement, discussions should be documented, regularly updated and shared with key people involved in their care. This may include family and friends at the individual's wish.

An advance care planning discussion may result in one or more outcomes:

- Statement of Preferences and Wishes;
- Advance Decision to Refuse Treatment;
- Appointment of a legal advocate- Lasting Power of Attorney

Advance Statement - future wishes

This is a record of an individual's values, beliefs, wishes and preferences regarding future care and treatment. This information is not legally binding but it is to be taken into account when a person lacks capacity and best interest decisions are being made. It may also be used to nominate a person/people to speak on the individual's behalf (a nominated spokesperson can inform best interest decisions but they cannot legally make decisions on the individual's behalf).

Generic templates can be downloaded here:

https://www.dyingmatters.org/sites/default/files/preferred_priorities_for_care.pdf

http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/ACP%20Resources/Advance_Care_Plan_May2020_editable.pdf

Advance Decision to Refuse Treatment (ADRT):

An adult has the legal right to say in advance that they want to refuse specific treatments should they lose this decision-making capacity in the future. It is recommended that individuals wishing to make these decisions get advice from healthcare professionals involved in their care and treatment.

An advance decision to refuse treatment is valid if:

- the treatments to be refused are clearly specified and the circumstances in which they are to be refused clearly explained
- nothing has been said or done by the individual that would contradict the ADRT since it was made

If it refers to life sustaining treatment it must:

- be in writing
- signed and witnessed
- state clearly that the decision applies even if life is at risk.

Further information can be found here: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf. On page 7&8 of this guide there is a check list to assess whether an ARDT is legally binding and Appendix 1 offers a sample ADRT form.

Lasting Power of Attorney (LPA):

Lasting Power of Attorney is a legal document that allows an individual to appoint one or more people to make decisions on their behalf should they lose capacity.

There are two types of LPA;

- health and welfare- this involves decisions about an individual's care and treatment; it must be stated whether or not this includes giving or refusing consent to life-sustaining treatment. It can only be used when the individual lacks capacity
- property and financial affairs- once it is registered, with the individuals permission, it can be used while they still have capacity as well as when they lose capacity

Making a lasting power of attorney:

- The documents need to be signed by the individual, the attorneys and witnesses
- The signed documents need to be registered with the Office of the Public Guardian (this can take up to 10 weeks).
- It costs £82 to register each one (exemptions or reduced rates may apply).

Validity of a LPA:

An LPA is only valid if it has been registered with the Office of the Public Guardian (OPG). To check its validity the document will bear a stamp from the OPG or go online and request to search the OPG register.

Further information can be found here: https://www.gov.uk/power-of-attorney

Anticipatory Clinical Management Plan (Emergency Care and Treatment Plan)

This is a very specific type of ACP that summarises the emergency care aspect of a wider Advance Care Planning process. It gives recommendations for a person's treatment in an emergency including decisions around resuscitation and the level of care that is felt most beneficial or wanted by them- whether this is comfort care at home or in a care home; supportive care that can be delivered on a general hospital ward or active treatment including critical or intensive care.

These recommendations are developed through discussions with the person and their GP or treating clinical team; where the person lacks capacity the discussions will take place with their family or advocate. There is no blanket approach to making these recommendations; they should be made on an individual basis weighing up risks, burdens and benefits to that person and valuing their wishes far as is practicable.

This information needs to be made accessible to professionals who are required make immediate decisions in a crisis such as the out of hours GP or the paramedic.

If the recommendation is that the person is not for resuscitation then this information is recorded on a form that is recognisable to all healthcare professional in the area and kept with the person at all times.

A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form is one aspect of emergency care planning and if someone has one of these it is useful to know if other recommendations have been discussed and documented.

More information on decisions relating to cardiopulmonary resuscitation and be found here: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

In some areas the DNACPR form has been replaced by a ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment) This records all information concerning emergency care planning including resuscitation status. It also records the existence of other relevant ACP documents (Advance statement, LPA, ADRT) and where to find them.

Further information on the ReSPECT process can be found here: https://www.resus.org.uk/respect/health-and-care-professionals/

Recording and Sharing

When ACPs have been made it is important that those who are involved in the individual's care know where they are kept. Key information might also be stored on an individual's electronic health or care records.

The Advance Statement document 'My Future Wishes Advance Care Plan' has a back page that may be completed with key information. This can be detached and given to the GP for uploading onto an electronic system such as enhanced Summary Care Record or Electronic Palliative Care Coordination System (EPaCCS).

http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/ACP%20Resources/Advance_Care_Plan_May2020_editable.pdf

NB. an individual may have both paper and electronic ACP records in existence; any updates must be replicated across all formats.

Starting ACP Conversations

The Alzheimer's Society has worked with people affected by dementia (including family carers) to develop a resource pack which can help support people start conversations about their future wishes.

The pack covers 4 topics:

- What's important to me?
- Lasting Powers of Attorney and Wills
- Medical Decisions
- My Care Preference

The pack can be downloaded here:

http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/Alzheimers%20resource/My%20Future%20Wishes%20Care%20Pack%20PDF%20READ%20VIEW.pdf