Advance Care Planning

Information and Guidance for Professionals to Support Completion of an Advance Care Plan

Gateshead Primary Care Trust
South Tyneside Primary Care Trust
Sunderland Teaching Primary Care Trust

Working together with partnership organisations
**Professional Guidance**

**Purpose of Advance Care Plan [ACP]**

Advance care planning is an ongoing process of discussion about preferences and choices of care and future needs that takes place between a patient and their care provider, and this may or may not also include family or friends. It is about providing opportunities, picking up on cues from patients, providing prompts and responding to where the patient leads these discussions allowing them to set the agenda and the pace.

With the agreement of the patient, this discussion should be recorded in a patient held document, regularly reviewed and communicated to key persons involved in their care.

If a patient wishes, the ACP should be an integral part of the assessment of need, the plan of care and of the regular care plan review. The process of ACP will usually take place in the context of an anticipated deterioration in the individual’s condition in the future.

In the event of the patient losing capacity to make choices and/or ability to communicate wishes to others, preferences written into an advance care plan can influence decisions in the patient’s best interests.

“All people approaching the end of life, and their carers, should be entitled to:

- Have their needs assessed by a professional or professionals with appropriate expertise;

- Have a care plan which records their preferences and the choices they would like to make. The care plan should be reviewed as their condition changes;

- Be involved in decisions about treatments prescribed for them, including the option to say ‘no’ to treatments they do not wish to have prescribed; and,

- Know that systems are in place to ensure that information about their needs and preferences can be accessed by all relevant health and social care staff with their permission.” (DH, 2008)
Assessment of Capacity in Making a Valid Decision

The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made.

**The person assessing capacity should ask the following questions:**
- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Do they understand the likely consequences of making, or not making, this decision?
- Can they understand and process information about the decision? And can they use it to help them make a decision?

*Where there is doubt*, the assessor must be able to show that it is more likely than not that the answer to these questions is ‘*no*’.

**Does the person have capacity for this decision?**

**YES**

*Ask the patient*

It is important to acknowledge the difference between:

- Unwise decisions, which a person has the right to make and decisions where there is inability to weigh up the information about a decision.

**NO**

The person has previously made an **advanced decision** to refuse medical treatment while they had the capacity to do so.

*And / OR*

There is a lasting Power of Attorney for Health and Welfare

Who can be the decision maker?

**The decision-maker to consider**

- the person’s past and present wishes and feelings and in particular, any relevant written statements made by him when he/she had capacity
- the beliefs and values that would be likely to influence his decision if he/she had capacity, and
- the other factors that he/she would be likely to consider if he/she were able to do so.

**The decision-maker has a duty to take into account the views of the following people where it is practical and appropriate to do so:**

- Anyone the person has previously named as someone they want to be consulted
- Anyone involved in caring for the person
- Anyone interested in their welfare (for example, family carers, other close relatives, or an advocate already working with the person)
- An attorney appointed by the person under a Lasting Power of Attorney, and
- A deputy appointed for that person by the Court of Protection.

If there is no-one to speak to about the person’s best interests, in some circumstances the person may qualify for an Independent Mental Capacity Advocate (IMCA).
**Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?**

Examples of an impairment or disturbance in the functioning of the mind or brain include the following:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- The long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and the symptoms of alcohol or drug use.

**Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?**

A person is unable to make a decision if they cannot:

- Understand information about the decision to be made (the Act calls this ‘relevant information’)
- Retain that information in their mind (the person must be able to hold the information in their mind long enough to use it to make an effective decision)
- Use or weigh that information as part of the decision-making process, for someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision
- Communicate that decision (by talking, using sign language or any other means).
Prompts that you may find helpful to initiate the ongoing discussions around advance care planning:

- What do you understand about your illness?
- How do you feel things are at the moment?
- How do you see the future?
- Who is helping to look after you?
- Have you had any particular thoughts about your care and where it should take place now or in the future?
- If you become more ill where would you like to be looked after?
- What would your family think about your choices?
- Are you aware of what services could be provided for you?
- What elements of care are important to you?
- Are there any aspects of your future care that you would like to avoid? (consider DNAR)

The Process

- Initiation of discussion by patient or professional
- Time for consideration by patient
- Completion of document with patient
- Complete summary document
- Dissemination of information to other professionals
- Register plan with data base
- Review plan with patient (no longer than 6 months)
- Further sharing of review
- Further ongoing reviews
- Complete after death analysis and register with database
References


NHS South of Tyne and Wear is committed to raising the standard of written information for patients, their carers, people who use the NHS and the general public.

This information can be made available in another format or language on request. Please contact the Communications and PR Team Tel: 0191 529 7118   E-mail: mopil@sotw.nhs.uk