Guide to Advance Care Planning

Covering the following areas with useful links included:

- Statement of Preferences and Wishes;
- Advance Decision to Refuse Treatment;
- Appointment of a legal advocate- Lasting Power of Attorney
- Recording and sharing the information
- Starting ACP conversations

Overview:

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 know.

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

Statement of Preferences and 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 the guide there is a check list to assess whether an ARDT is legally binding

Appendix 1: offers a sample ADRT form

Lasting Power of Attorney (LPA):

There are legal processes /documents that allow 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

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 statement of preference and wishes 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

The ReSPECT form asks the individual to record the existence of relevant ACP documents and where to find them.

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

Starting ACP Conversations

Alzheimer's Society developed a resource pack which can help support people start ACP conversations.

The pack includes a folder and 4 topic cards. The topics covered are:

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

The folder can be downloaded here:
http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/Alzheimers%20resource/Alzheimers%20UK%20A5%20Folder%20WEB%20Pilot%20Final%20(003).pdf

The topic cards can be downloaded here:

http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Care%20Planning/Alzheimers%20resource/Alzheimiers%20A5%20folded%20cards%20WEB%20Pilot%20Final%20(003).pdf