When to persist?

If the patient indicates at any stage that they do not want to think more about their future care, it is normally appropriate to move on to something else. However, there are some circumstances when it may be appropriate to gently 'push' a bit further whilst acknowledging to the patient that this is difficult for them:

- If the patient has young children, and no spouse who would automatically take over their care;
- If the patient is the main carer for a disabled relative or partner.
- If the patient is likely to lose mental capacity in the near future e.g. from a brain tumour
- If an acute complication is likely, which would require an urgent decision in which the patient may not be able to participate e.g. acute haemorrhage, cardiac arrest?

Involving others

If the patient clearly does not wish to discuss further, consider asking about involving others in decisions:

I appreciate you may not wish to dwell on this, but we would always want to do the right thing for you. Is there someone else [like your husband/wife/partner] you would like us to involve if you aren't able to make decisions for yourself?

Resources

Further information, forms and all other resources are available on-line from:

http://wales.pallcare.info

This leaflet was written for healthcare professionals. It was devised and written by Dr Ian Back, Palliative

Communication Skills in Advance Care Planning (ACP)

A short Introduction

wales.pallcare.info

Prepare — *Prepare the ground*

How to Start

There is no 'magic' to advance care planning; its foundation lies in listening to the patient and using good communication skills (e.g. the Cardiff Six Point Toolkit). We can all give patients the opportunity to plan for their future. This leaflet contains some suggestions which may help you.

Gain permission to have 'a chat'; ensure the patient feels comfortable - both physically and has time to talk to you.

Encourage the patient to reflect on their condition

Have you thought about how things are going?

You haven't been so well over the last few months [weeks]?

Explore understanding of prognosis

Explore the patient's understanding of their terminal illness (find out what they know, what they want to know? Often exploring the patient's understanding can involve discussing bad news or breaking bad news)

Are you aware that this [heart failure] is a condition that tends to get worse over time?

Ask — *Ask if they wish to discuss Advance care Planning*

Introduce the idea of planning ahead

Doctors and nurses always want to do their very best for you, and it is helpful for them to know what you would want in the future.

Some people find it is helpful to think about the future; there may be things you want to plan for, or choices you would like to discuss about treatment when (or if) things get worse.

If they haven't already given you a clue, ask whether they want you to continue

Do you think this (planning) is something you would like to discuss some more?

Explain what sort of things they may want to discuss

Some people want to think about making provision for their family, or there may be some treatments you would not want to happen to you, such as an operation. Or there may just be some wishes you want to express, such as not wanting to go back into hospital.

Based on the reaction so far, choose what you do next:

- Stop if the patient does not want to continue (see below). Offer the opportunity to discuss at a later date if the patient wants.
- Offer a written information leaflet, and more time to consider.
- Offer another person to follow up the discussion e.g. the palliative care nurse / specialist nurse in clinic.
- Continue with discussion, perhaps using the Record of Advance Care Planning form