Document

Document the patient's wishes

There are a variety of ways to record a patient's wishes.

1) The RACPaP (*Record of Advance Care Plans and Preferences*) is a form designed to help guide healthcare professionals through a general enquiry about all aspects of care preferences, and to record those wishes.

2) The *Preferred Priorities of Care* form asks broader questions, and can be completed by the healthcare professional (with the patient), or by the patient themselves.

3) *Planning Ahead* is a more comprehensive pack suitable for motivated patients and those who have approached you to make plans for their end-of-life care

4) Other forms such as the *GSF Thinking Ahead* form

Treatment plans for emergency situations e.g. haemorrhage may be made using an *Advance Emergency Treatment Plan*, which should be kept with the patient.

Advance Decision to Refuse Treatment

If a patient has a clear view about specific treatment(s) that they wish to refuse in specific circumstances, advise the patient about the option of making an *Advance Decision to Refuse Treatment* (ADRT), which is legally binding.

Lasting Power of Attorney

Advise the patient to contact a lawyer if they wish to specify someone to have the legal right to make decisions on the patient's behalf in case of mental incapacity.

Either of the above may incur significant cost.

DNA-CPR form

If the patient does not want to receive cardio-pulmonary resuscitation in the event of a cardio-respiratory arrest, you should - after discussion with the patient - complete a *DNA-CPR form* to be kept by the patient in their home.

RESOURCES

In addition to the subjects in italics above, there are many resources available on-line about:

- Advance Decision to Refuse Treatment (ADRT)
- Lasting Powers of Attorney

Share

Share with family and healthcare professionals

Encourage the patient to share their wishes with a family member.

This very important for two reasons: 1) to facilitate open discussion within the family about the patient's condition and prognosis; 2) to avoid surprises or disagreements if or when the time comes when the patient is unable to make decisions about their own care.

With the patient's consent, ensure that the advance care plan is available to other healthcare professionals when it is needed.

If appropriate, the original Advance Care Plan document(s) should be kept by the patient in their own home. If the patient has district nursing notes in the house, this may be the best place.

Consider any of the following:

1) Send a copy of the ACP document, or inform others that one exists (e.g. using the *Advance Care Planning communication form*):

- Primary care
- Hospital / Specialist Palliative Care teams
- Out-of-hours service
- WAST ambulance service

2) Update your computer records:

- GP computer system
- Canisc (oncology & Specialist Palliative Care teams)

3) In some circumstances (especially if the patient lives alone), consider other ways to alert attending professionals e.g. MedicAlert bracelet, or a Message in a Bottle.

Resources

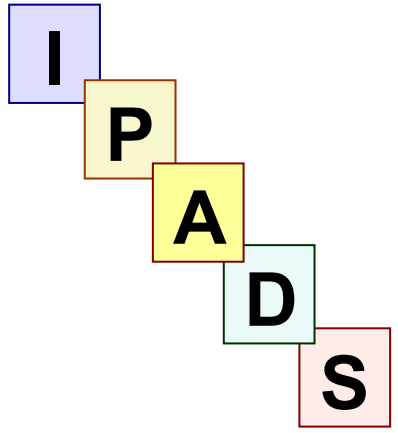
Further information, forms and all other resources are available on-line from:

http://wales.pallcare.info

This leaflet was written for healthcare professionals. It was devised and written by Dr Ian Back, Palliative Care Consultant in Cwm Taf LHB.

(w)IPADS

A Framework for Advance Care Planning (ACP)



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Identify — *Identify appropriate patients for ACP*

Opportunities for Advance Care Planning discussions should be actively sought by all healthcare professionals, working in primary or secondary care.

Advance care planning may be initiated by patient or relative at any time**.**

Triggers

Triggers for healthcare professionals to initiate Advance Care Planning may include:

1) At diagnosis, or shift of treatment focus, in a 'terminal illness' e.g. metastatic cancer, severe COPD

2) Multiple hospital admissions

3) "Would not be surprised if patient died in next 6-12 months"

See *End-of-Life Care Indicator Tools* for more guidance.

GP Palliative Care Register

In primary care, regular review of patients at GP Palliative Care meetings is a good opportunity to identify patients for whom ACP is appropriate.

Secondary care

During a hospital admission, especially if the patient is considered unlikely to survive, advance care planning should be undertaken by the secondary care team.

Secondary care also has an important role in identifying patients suitable for advance care planning, which may be best undertaken back in primary care. This may be at the time of discharge, or in out-patient clinics.

Communication with primary care is essential -

- Identify patients suitable for inclusion on the Palliative Care Register
- Change in focus of care e.g. curative to palliative, patient decision not to start dialysis
- Change in expected prognosis group (months, weeks or days cf. *Traffic lights*)
- Likely complications e.g. PEG tube for MND, deactivation of ICD

Prepare — *Prepare the ground*

Before starting any discussion about Advance Care Planning, ensure that the patient and/or family have been given the opportunity to understand the nature and prognosis of their illness through adequate discussion.

Where appropriate, prompt the patient to consider likely/ expected complications e.g. the need for PEG feeding in MND.

If the patient does not wish to discuss their condition or the prognosis, their wishes should be respected. It may still be possible to ascertain some of their wishes or preferences, so this should not prevent you from continuing to explore their views.

The *Communication Skills guide to starting ACP* may be helpful.

Does the patient have Mental Capacity?

For patients who do not have mental capacity to make such decisions, it may still be possible to pursue some form of advance planning with the family; consider the *RBID (Record of Best Interests Decisions).*

RESOURCES

- Communication skills guide to starting ACP
- RBID (Record of Best Interests Decisions) form

RESOURCES (TO IDENTIFY PATIENTS)

- End-of-Life Care Indicator Tools:
  - Welsh Palliative care Indicator Tool
  - GSF prognostic indicators
- Secondary to primary care communication
- Traffic lights

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

Introduce the subject of Advance Care Planning with the patient and/or family

It is important to tailor the way Advance Care Planning is raised with the patient and/or family to suit the patient's specific case.

You should check if the patient has already made his/her wishes known in any form.

The *Communication Skills guide to starting ACP* may be helpful.

A variety of *written information* is available for patients who wish to read more, and for those who wish to take it away and prepare their own advance care plan document.

Remember that Advance Care Planning will mean different things to different patients:

- recording a preference not to receive treatment
- making a will
- appointing a Lasting Power of Attorney
- recording a preference about staying a home
- an emergency treatment plan e.g. for seizures

Few patients will want everything.

If the patient does not wish to continue, their wishes should be respected; record a note to that effect in the medical records. Consider exploring the subject again at a later date, when the patient's condition worsens.

RESOURCES

- Communication skills guide to starting ACP

Written information leaflets and document packs for patients:

- ACP Introduction - a short, gentle introduction
- Planning for your future care - a guide for patients
- "Planning your Future Care Together" - a more comprehensive ACP pack
- Advance decisions, advance statements and living wills – factsheet by Age UK