Advance Care Planning

A quick reference guide

Contents

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What is Advance Care Planning?

"Advance care planning can make the difference between a future where a person makes their own decisions and a future where others do."

- It's a conversation
- It's about a person's future wishes and priorities for care
    - This includes medical treatment
        - e.g. location of treatment, extent of treatment

Why is it important?

- For patients:
    - People are dying more and more of chronic disease.
        - This provides the opportunity to discuss future wishes ahead of a time when they might lose capacity
    - It improves quality of life.
- For families:
    - Increased satisfaction with the bereavement process
    - Reduced decision-making burden
    - Reduced conflict within the family / with professionals
- For professionals:
    - It reduces admissions and ED attendances, though it's not about stopping people coming to hospital or saving money
    - It helps other clinicians know how to help your patient
    - It helps us all to know that we're doing right by people when they can't speak for themselves.

How do I identify patients who might benefit from it?

- Prognostication is hard!
- Acknowledge the uncertainty inherent in this kind of thinking.
- There are tools that can help, e.g. SPICT.
    - Look back at the **number of unplanned hospital attendances** in the last 12 months.
    - Look for **poor or worsening functional status**.
    - Increasing dependence. Increasing carer burden.
- Ask yourself **the "surprise question"**. It's an intuitive question.
    - ***Would I be surprised if this person died in the next 12 months?***
        - If not, then they might benefit from discussing their preferences for the future.
- Discuss with the nursing staff.

How do I begin the conversation?

- It takes practice!
- Find the words that fit in your mouth.
    - Find a way that suits you.
- Be curious and inquisitive about the patient in front of you.
- ACP is not like another job on the list that can be ticked off!
    - It can take a long time, and is unlikely to be “finished” in one sitting.
    - Any benefits it has can be negated by trying to rush it.
    - Beginning the process is the important thing.
    - Share the task with the GP.
    - Give the patient and family a hard copy of the form to look at at home.

What should be covered?

- Does the patient have capacity to make decisions at the moment?
  - If not, is there an LPA (lasting power of attorney)?
  - If not, are there people who can help make a best interests decision?
- Try to **build a shared understanding**
  - Are you and your patient on the same page about where they are with their illness?
- **"What matters most to you?"**
- The RED-MAP framework for having ACP conversations in hospital can be really helpful.
  - Consider saving the PDF to your phone for reference.
- **Use the ACP document as a guide**.
  - It's a helpful guide, particularly if there's uncertainty.
- Consider the likely progress of the condition (even if uncertain).
- Think about medical and non-medical issues.
- Consider talking about unforeseen acute health problems.
  - This can be really hard!
  - The diagnosis may be unclear initially in the community, so focus on symptoms / presentations
    - e.g. breathlessness, chest pain, collapse, fall, unresponsive episode
  - Remember that things may change over time.

How do I document this information?

- ACP is a process, and it's easier to continue if it's clear where the conversation has got to.

- To find the paper ACP form on the intranet:
  - Home page → site index → geriatric medicine → advance care planning
  - If it's completed, you can scan and upload it as a Clinical Note on Lorenzo.

- Complete the Lorenzo ACP Summary:
  - Follows the format of the paper form
  - Gets automatically sent to the GP on discharge
  - Clinical note → create note → arrow to open the search pane → advanced search → "sth%adv%" → find. Add to favourites.

- Add an "Advance Directive" alert to Lorenzo:
  - Health Issues → Advance Directives tab → Record Advance Directive (left side of screen) → Choose type & care provider (consultant name), enter free text → Finish

- To create a Lorenzo pop-up alert that an ACP exists:
  - Health Issues → Record Alert (left side of screen)

- Add the patient to the ACP Register so it appears on Whiteboard:
  - STH Links (top of Lorenzo screen) → Registers → Advance Care Plan → Add current patient

- Don't forget when you're admitting a patient to ask about any ACPs they might have, and whether they're up-to-date and relevant to their wishes.
  - Places to look if there's an existing ACP:
    - SCR (double check this with the patient!)
    - "Docs" on E-Whiteboard / "Clinical Notes" on Lorenzo
    - Lorenzo pop-up

How do I share this information?

- For Advance Care Planning to be practical and useful, the written record has to be available to the people who might encounter that patient
  - e.g. out of hours GPs; District Nurses; paramedics; ED staff
- Once you've completed the paper form and the Lorenzo summary (or done as much as you're going to):
  - To distribute the Lorenzo ACP summary to the GP Collaborative and Single Point of Access (SPA) teams:

Distribute Advance Care Plan Summary via Lorenzo

Tick 2 boxes at top: *completed* ☐ *distribute* ☐
Click **next**
Select recipient type: *team members*
Next to recipient click [...]
Search under name: *ACP%*
Click →**find**
Select: *Other Teams /ACP distribution list*
Click **ok**
On the next screen click add
GP collaborative and SPA appear
Click **finish now**
This will immediately send to SPA and GPC

- Handover to the GP (ring them if time is pressing) and ask them to add the patient to the palliative care register (write it on the discharge letter).
- Ask the nursing staff to refer to the district nursing team.

Resources:

Gold Standards Framework on ACP

SPICT

Clinical Frailty Scale

Planning Your Future Care (printable leaflet aimed at patients)

What Matters Conversations (great website with videos, blogs and podcasts)

"When words fail us" discussion between Michael Rosen & Kathryn Mannix (BBC Word of Mouth podcast)

RED-MAP framework

MDTea podcast on ACP