York Teaching Hospital NHS
NHS Foundation Trust

Information and Guidance for Professionals

to support completion of an Advance Care Plan

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Advance care planning (ACP) is an on-going process of discussion about preferences and choices of care and future needs. This is something which 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 the patient. This then informs the discussions allowing the patient to set the agenda and the pace. With the consent of the patient, this discussion should be recorded in a patient held document. It can be 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.

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
- Review plan with patient (no longer than 6 months)
- Further sharing of review
- Further on-going reviews

Prompts that you may find helpful to initiate the on-going 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 DNACPR)

Terms explained:

Advance statement: This is a statement of wishes and preferences, values and beliefs. It is useful when taking into account 'best interest' decisions on behalf of someone ensuring their wishes are voiced.

Advance decision to refuse treatment: This is a decision to refuse a particular treatment or type of care. It must be in writing, signed and witnessed and is legally binding under the Mental Capacity Act 2005.

Lasting power of Attorney (LPA) property and affairs: This allows a person over the age of 18 to nominate someone to make decisions about the patient's money and property.

Lasting power of Attorney (LPA) personal welfare: This allows a person to be nominated to make decisions regarding the patient's healthcare. This includes decisions to refuse or consent to treatment. These decisions can only be taken on the patient's behalf if they lack capacity. All LPA's must be registered with the Office of Public Guardian to be valid. Further information can be found at www.publicguardian.gov.uk

Mental capacity act (2005): This provides a statutory framework to empower and protect vulnerable people who are unable to make their decisions. It makes it clear who can take decisions, in which situations and how they should undertake this. It enables people to plan ahead for a time when they may lose capacity.
Further information can be found at www.justice.gov.uk/guidance/mca-info-leaflet.htm