Advanced Decisions to Refuse Treatment

1. Background

This policy has been developed to ensure Abbeyfield The Dales (ATD) staff understand what is meant by an Advance Decision to Refuse Treatment and that where a resident has made an advance decision about their care or treatment, their decision is respected and acted upon.

2. Objectives

ATD is committed to providing services that enhance the quality of life for older people and developing services that will meet the needs of future generations. This commitment is based on the Mission and Values of ATD. ATD will also comply with all relevant and current legislation.

The aim of this policy is to ensure that as a resident's condition deteriorates, they are close to death or dying, staff continue to treat residents and their family sensitivity, with respect and in accordance with resident's wishes.

3. Scope

All staff, including bank staff, agency staff and volunteers working or assisting within the home.

4. Policy

4.1. Definition

Every adult with mental capacity has the right to agree to or refuse medical treatment. A 'living will' makes advance wishes clear and can include specific refusals of treatment called an 'Advance Decision to Refuse Treatment'. The resident's wishes will then be clear if they lose capacity, i.e. they become too ill to control their care.

An advance decision may provide:

- Direction and advice on the care the resident would like to refuse;
- A basis for discussion with medical professionals and others about the resident's wishes, choices and concerns; and/or
- Advice for family, friends and attorneys about the wishes of the resident at the time the directive was written.

Advance decisions cannot provide a direction for euthanasia or lawful authorisation for anyone to end a life.

New residents may have an advance decision in place before admission. If this is the case and the resident has agreed that the advance decision remains an accurate reflection of their wishes, the existence of the advance decision should be recorded in their care plan and a copy given to the GP and any other health care professional involved in their care so that their wishes are known. Frequently expressed wishes may be taken as an advance decision and should be documented in the care plan as such and the responsible medical professional informed.

If the resident does not already have an advance decision but wishes to make one, the medical professional, informed by senior staff, must ensure that the resident has the mental capacity to make one, is not being encouraged or influenced by a third party to do so and

understands the implications of making such a decision. As above, the existence of the advance decision should be recorded in the care plan and a copy given to the medical professional and others involved in the resident's care.

The family of the resident should, with the resident's agreement, be told of the advance decision and its contents.

Advance decisions can be superseded by clear and competent decisions at any time. If there are any doubts as to the capacity of the resident, then the professional must assure him/herself of the resident's capacity by means of a medical professional's assessment. Requests of this nature should be referred to the senior management of the home, who will contact the relevant practitioner and feedback information to other staff as needed. The advance decision must be reviewed at the time the person is ill or becomes incapacitated and it is the medical professional's responsibility to make decisions of this nature.

The resident must express in clear terms under what circumstances or situations the advance decision is to apply. The advance decision may be a statement which, whilst not refusing any particular treatment, specifies a degree of irreversible deterioration after which no life sustaining treatment should be given or it may name another person with a Lasting Power of Attorney for Health & Welfare who should be consulted at the time a decision has to be made. It may be a clear instruction refusing some or all medical procedures or it may combine a request, refusal and the nomination of a representative under a Lasting Power of Attorney for health & Welfare.

Competent adults have the right to refuse any medical treatment, even if refusal results in their death. An informed and competently made refusal is legally binding upon the medical professional. Failure to respect such an advance refusal when there is no reason to believe the resident has changed their mind can result in legal action against the relevant medical professional.

All advance decisions should be witnessed by an independent person. Where appropriate advocacy services can be contacted. Staff must never witness advance decisions or act as attorney for a resident.

4.2. Advance Care Planning (ACP)

Advance care planning (ACP) has been described as the process of discussion between an individual, their care providers and often those close to them, about their future care. The discussion may lead to:

- an advance statement (a statement of wishes and preferences)
- an advance decision to refuse treatment
- the appointment of a Power of Attorney for Health & Welfare referral to an advocacy service
- referral to an advocacy service.

All or any of these can help inform care providers should the individual lose capacity. These terms supersede previous phrases such as 'living wills' and 'advance directives'.

Advance decisions to refuse treatment only come into force if an individual loses capacity. The presence of an ACP document or an advance decision to refuse treatment does not override the decision of a competent individual.

Following the introduction of the Mental Capacity Act, it is likely that health and social care professionals will be faced more and more frequently with advance care planning scenarios.

4.3. Resuscitation

An advance decision may stipulate that a resident does not want resuscitation. It should be noted that resuscitation refers only to cardiopulmonary resuscitation (known as DNACPR). A note should be added to the care planning records that the resident is 'not for cardiopulmonary resuscitation' (sometimes called 'do-not-attempt cardiopulmonary resuscitation' or DNACPR) and the responsible medical professional informed.

The resident and their family must be assured that an advance decision refusing resuscitation does not mean that no treatment will be given. The resident will still receive the best possible care and any other lifesaving treatment that they need.

The DNACPR form to register the resident's decision may be obtained from registered healthcare professionals such as the residents GP or hospital.

Further general information on how to get the form completed, record and store the form and general processes is on the Resuscitation Council (UK) website: www.resus.org.uk.

Staff should be aware of the resident's expressed wishes and support should be given to them in dealing with this situation. Should staff have professional concerns around a particular aspect of a resident's advance decision, then this should be discussed with their line manager who will formally record their comments and concerns.

4.4. Deprivation of Liberty Safeguards

The existence of an advance decision could conflict with a request for an authorisation to deprive the person of their liberty.

If a resident has a valid advance decision which is applicable to some or all of the treatment that is the purpose for which a standard authorisation for a deprivation of liberty has been requested, then a standard authorisation could not be given.

5. Finance, Value for Money & Social Value

N/A

6. Supported Appendices

N/A

7. Linked Policies

Autonomy & Choice (R003P)
Advocacy & the Duty to Consult (R001P)
End of Life Care (C012P)
Consent to Treatment and Personal Care (C009P)
Mental Capacity Act (C015P)
Deprivation of Liberty Safeguards (MCA DOLS) (C010P)

8. Legislation/Regulation

Mental Health Act 2007
Mental Capacity Act 2005

Section 20 regulations of the Health & Social Care Act 2008
Essential Standards of Quality and Safety
Outcome 2: Consent to care and treatment
Regulation 9: Person Centred Care
Regulation 11: Need for Consent

9. Review

Every 3 years, subject to any regulatory or legislative updates.

10. Procedure/Guidance

N/A