Advance Care Planning

1. Background

The Mental Capacity Act 2005 enables individuals to plan ahead for situations where they may be unable to make important decisions about their care and medical treatment in the future. Advance Care Planning is the voluntary process of discussing and planning ahead for care in the future and whilst this generally happens in the context of a terminal illness or life-limiting condition, people can choose to plan ahead at any time. Following the introduction of the Mental Capacity Act 2005, it is likely that health and social care professionals will be faced more and more frequently with Advance Care Planning scenarios.

2. Objectives

The aim of this policy is to ensure that:

- Abbeyfield staff have the knowledge and skills to support residents with Advance Care Planning;
- Where a resident has made decisions about their future care and treatment, their decisions are respected and acted upon; and
- Abbeyfield provides care and support for residents which complies with relevant legislation and current best practice.

3. Scope

All staff, agency staff and volunteers involved in the care and support of residents.

4. Policy

All Abbeyfield The Dales staff will provide person-centred care and support and will always treat residents with sensitivity and respect and in accordance with their wishes. Staff will support residents who wish to plan ahead for their future care and treatment and where residents have already made decisions about their future care and treatment, they will ensure that their wishes are recorded, respected and acted on.

4.1. Advance Care Planning (ACP)

An important aspect of caring for people is to discuss with them their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future. These discussions need to be handled with skill and sensitivity. The outcome of the discussions should be documented, regularly reviewed, and communicated to other relevant people, subject to the resident's agreement. This is the process of Advance Care Planning (ACP).

An ACP discussion includes:

- The individual's concerns and wishes.
- Their important values or personal goals for care.
- Their understanding about their illness and prognosis; and
- Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.

The discussion may lead to:

- An Advance Statement (a statement of wishes and preferences).
- An Advance Decision to Refuse Treatment (ADRT).
- The appointment of a Lasting Power of Attorney for Health & Welfare; and
- Referral to an advocacy service.

All or any of these can help inform those who are involved with the resident's care, health and wellbeing should they individual lose capacity to make their own decisions. Advance Care Plans will normally be made in partnership with the healthcare team when a person enters the end-of-life phase, unlike Advance Statements, ADRTs and Lasting Powers of Attorney which can be made at any time.

The most used type of Advance Care Plan is called the Preferred Priorities for Care (PPC) document. Although individuals can decide what they want to include in an Advance Care Plan, the PPC contains several questions which can help with what to include.

The My Future Wishes Advance Care Plan (S:\ATD\Resident) must be scanned on to the residents' care plan on the Person Centred care digital system. The contents should be documented within the Death and Dying care plan on the Person-Centred care digital system.

4.2. Advance Statement

This is a summary term embracing a range of written and/or recorded oral expressions, by which people can, if they wish, write down or tell people about their wishes or preferences in relation to future treatment and care, or explain their feelings, beliefs and values that govern how they make decisions. They may cover medical and non-medical matters and are often included with an Advance Care Plan. An Advance Statement is not legally binding but should be used when determining a person's best interests in the event they lose capacity to make those decisions**,** these should be documented within the Death and Dying care plan on the Person-Centred care digital system.

4.3. Advance Decision to Refuse Treatment (ADRT)

An ADRT, previously known as an Advance Directive and sometimes called a 'Living Will', allows people to give instructions about refusing specific medical treatments should there ever come a time when they are unable to make decisions for themselves or to communicate them to others. It comes into force when the person loses capacity and, provided it is deemed to be valid and applicable at that time, it is legally binding.

An ADRT 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 decision was written.

An ADRT cannot be used by a resident to:

- Refuse treatment if they still have the capacity to give or refuse consent.
- Refuse basic care that is essential to keep them comfortable, such as washing or bathing.
- Refuse food or drink by mouth (although it can be used to refuse feeding by tube).
- Refuse the use of measures designed solely to maintain comfort – for example, painkillers (which relieve pain but do not treat the underlying condition);
- Demand specific treatment.
- Refuse treatment for a mental disorder if the resident is detained under the Mental Health Act 1983; or

- Request something that is against the law, such as euthanasia or assisting a resident in taking their own life.

If the resident wishes to refuse life-sustaining (sometimes called lifesaving) treatment in the future, the decision needs to be:

- Written down.
- Signed by the resident; and
- Signed by a witness **(not a member of staff)**

If the resident wishes to refuse life-sustaining treatments in circumstances where they might die as a result, they need to state this clearly in the ADRT.

New residents may have an ADRT in place before admission. If this is the case and the resident has agreed that it remains an accurate reflection of their wishes, the existence of the ADRT should be recorded in their care plan and a copy given to the GP and any other health care professional involved in the resident's care so that their wishes are known.

If the resident does not already have an ADRT but wishes to make one, they must be advised to seek the advice of a medical professional who 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 ADRT should be recorded in the care plan and a copy given to the medical professionals and others involved in the resident's care.

The family or representative of the resident should, with the resident's agreement, be told of the ADRT and its contents.

An ADRT can be superseded or withdrawn 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 themselves 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 service, who will contact the relevant practitioner and feedback information to other staff as needed. The ADRT 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 ADRT is to apply. The ADRT 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 an ADRT when there is no reason to believe the resident has changed their mind can result in legal action against the relevant medical professional.

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

The ADRT should be reviewed with the resident at least once a year to ensure the content continues to reflect their preferences and wishes. Any changes must be recorded and witnessed by an independent person.

4.3.1. Deprivation of Liberty Safeguards

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

If a resident has a valid ADRT 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.

4.4. Do Not Attempt to Cardiopulmonary Resuscitation

Cardiopulmonary resuscitation (CPR) is an emergency treatment used to restart a person's heart and breathing if they stop, called a cardiopulmonary arrest. Cardiopulmonary arrests can happen unexpectedly but can also happen as part of the natural process of dying. The aim of CPR is to keep the person alive while a correctable cause of the cardiopulmonary arrest is identified and treated.

An ADRT may stipulate that a resident does not want resuscitation. A DNACPR form (also called a DNR or DNAR), is a document issued and signed by a doctor, which tells healthcare professionals and others involved in the individual's care not to attempt CPR in the event of a cardiopulmonary arrest. This can also be documented in the form of a ReSPECT form, (ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment). A DNACPR or ReSPECT form documents either that CPR cannot be successful and should not be attempted, or an individual's advance decision to refuse CPR. It only relates to CPR and not other types of treatment (unless specifically refused in an ADRT) or treatment to ensure the individual is comfortable and pain-free. The form is designed to be easily recognised and verifiable, allowing healthcare professionals to make decisions quickly about emergency treatment.

Decisions about CPR should be recorded on a standard form that is used, recognised and accepted across geographical and organisational boundaries. The Resuscitation Council (UK) (RC (UK)) publishes model forms for recording DNACPR decisions and these, together with guidance notes for completing the form, can be accessed on the RC (UK) website.

A DNACPR or ReSPECT form is not legally binding unless it is part of an ADRT.

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 life-saving treatment that they need.

Where a resident has a DNACPR or ReSPECT in place, this must be scanned on to the residents care plan on the Person Centred care digital system .and all staff involved in the care of the resident should be made aware. 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 and respond to their comments or concerns.

A resident's DNACPR / ReSPECT wishes should be visible and made know to all health professionals in whatever setting they work in. It is important that a DNACPR should be contained in the care notes that travel with a resident should they ned to go to hospital for whatever reason.

4.5. Organ & Tissue Donation

Organ donation means taking healthy organs and tissues from one person for transplantation into another. The NHS Organ Donor Register (ODR) is a secure database that records people's decision around whether or not they want to be an organ and tissue donor when they die.

Individuals can choose which organs they want to donate, and whether they want to include their eyes and tissues, by ticking the specific box on:

- the NHS Organ Donor Register, or
- by letting family/friends/carers know what they want to donate.

It is important to know if a resident wants to be an organs and tissue donor so that their wishes can be acted on and an organ donor card is one way of letting others know about their wishes. An organ donor card can be downloaded and printed from here: Donor Card.

Relatives will always be consulted about any donations, even if the resident has joined the ODR, and relatives can overturn the decision so it is important that the resident's wishes are clearly understood.

Healthcare professionals decide which organs and tissue are suitable for donation but donors must be no more than:

- 80 years old for cornea donation; or
- 60 years old for heart valves and tendons donations.

There is no age limit on bone and skin donations and other organs.

Individuals can change their mind and withdraw their name from the ODR at any time.

4.6. Lasting Power of Attorney (LPA)

An LPA is a statutory form of power of attorney created by the Mental Capacity Act 2005 (England and Wales). Anyone who has the capacity to do so may choose a person (an attorney) to take decisions on their behalf if they subsequently lose capacity. An LPA can cover financial decisions, or health and welfare decisions, or both, and it needs to be registered with the Office of the Public Guardian (OPG). An LPA which covers health and welfare decisions will invalidate an ADRT. However, the person who has power of attorney can refer to the ADRT for guidance. If the LPA only covers property and finance, the ADRT remains valid.

Where a resident has a registered LPA, a copy of the LPA document should be held on file by the service.

5. Finance, Value for Money & Social Value

Abbeyfield The Dales has a duty of care to understand and respect the wishes of residents.

6. Supported Appendices

Model DNACPR / Respect form
My Future Wishes Advance Care Plan (S:\ATD\Resident)

7. Linked Policies

Care Planning and Key Working (C008P)
Consent to Personal Treatment and Care (C009P)
End of Life Care (C012P)
Mental Capacity Act (C015P)
Deprivation of Liberty Safeguards (MCA DOLS) (C010P)

8. Legislation/Regulation

Mental Health Act 1983
Mental Capacity Act 2005
Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)
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

www.resus.org.uk

Age UK Factsheet 72: Advance decisions, advance statements and living wills