Advance Care Planning

in a Care Home Setting

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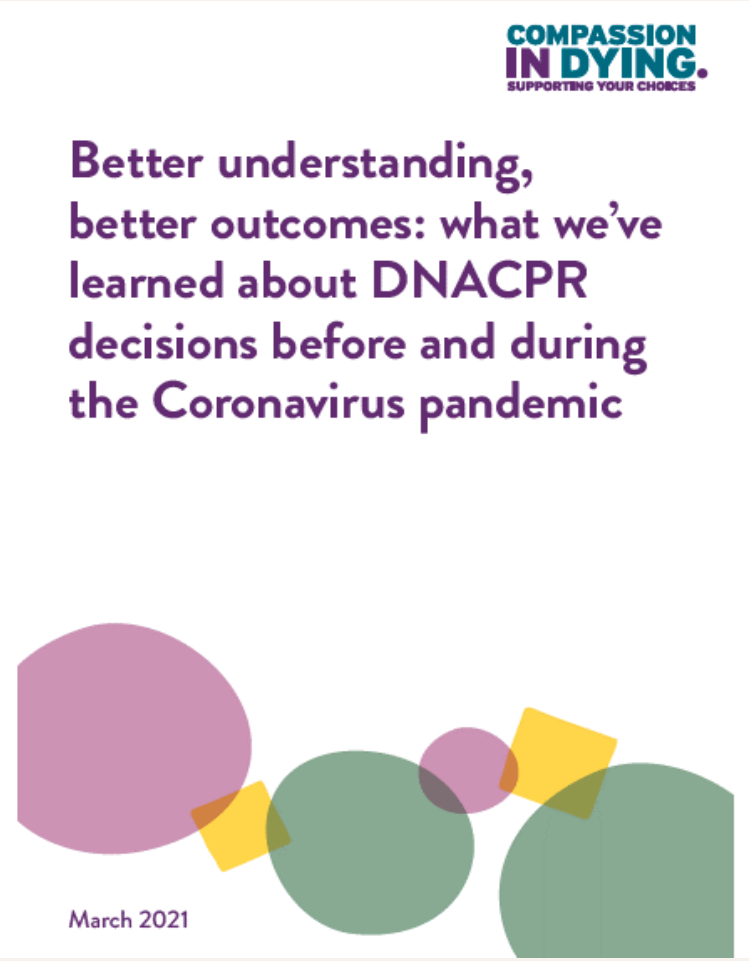
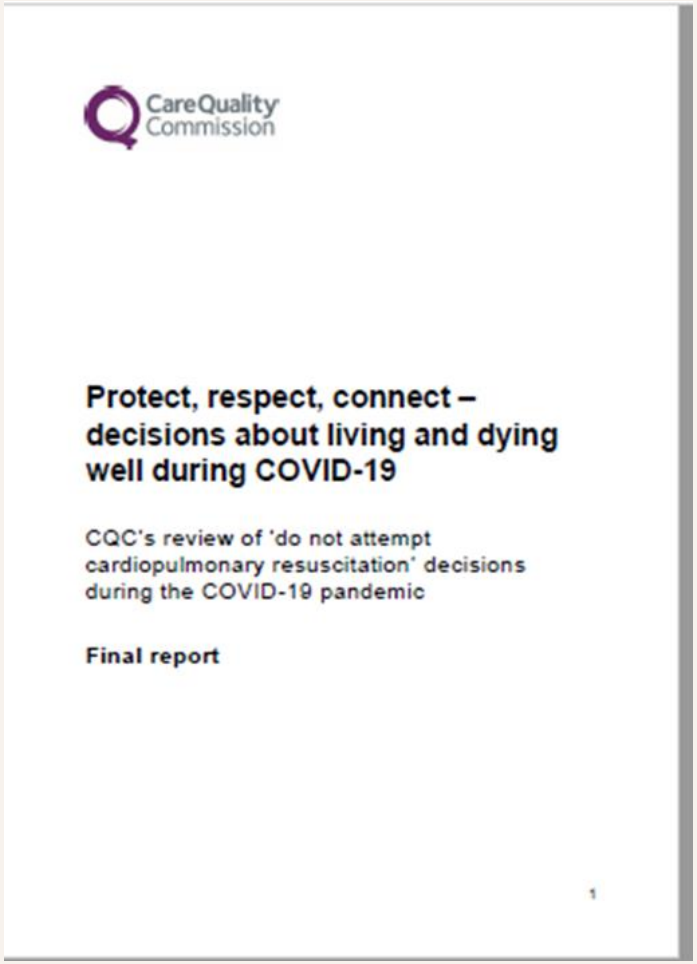
Our Purpose

Working together to enable the delivery of a supportive, responsive service.

To improve care for residents by having the opportunity to prepare and support their plans for end of life whilst continuing to live their life fully.

Feedback from the population & CQC





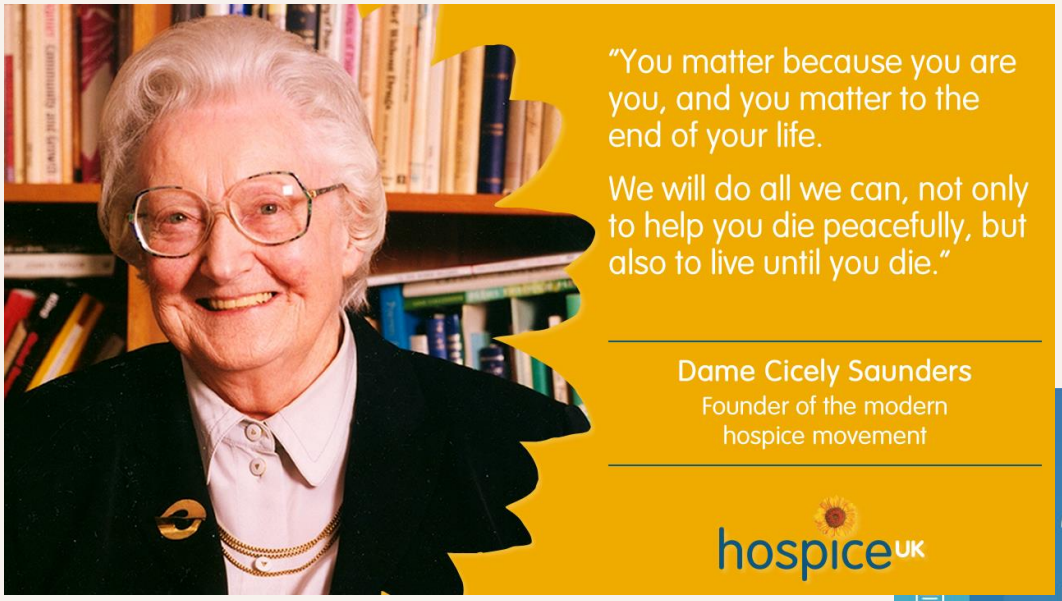
CQC Report

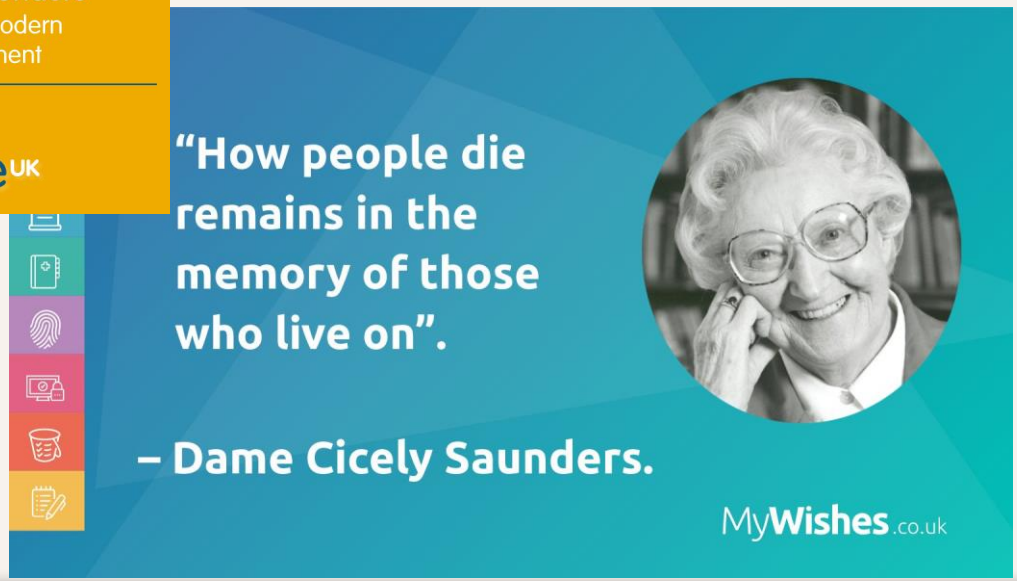
- The CQC report provides a system wide review. It brings a detailed set of recommendations
- Good training and support can help us learn from this feedback and ensure everyone has access to personalised advanced care plans appropriate to their needs.

"For older people and people with other serious mental health or long-term conditions, it has never been more important for decisions to continue to be made on an individual basis according to the person's wishes.

Where the person lacks the capacity to engage with the process then it is essential that best interest guidelines are followed, with the involvement of family members or other appropriate individuals.

Quotes


"You matter because you are you, and you matter to the end of your life.
We will do all we can, not only to help you die peacefully, but also to live until you die."
Dame Cicely Saunders
Founder of the modern hospice movement
hospice UK


"How people die remains in the memory of those who live on".
– Dame Cicely Saunders.
MyWishes.co.uk

Vision of Good EOL Care

- Identify and enable the resident to prioritise their concerns as early as possible.
- Recognise and value the contribution from family and loved ones alongside the resident and supporting them through their care
- Seek the resident's wishes and aspirations to best understand their needs.
- Inform the resident and family / loved ones throughout, enabling them to make the right decisions together.
- Treat the resident and family / loved ones with respect and dignity throughout their care
- Enable the resident to have control to make decisions.
- At all times seek to deliver the right care, at the right time, in the right place.
- Enable the resident to help themselves through appropriate guidance, advice and support.
- When death is imminent and expected:

Enable the resident to die peacefully with symptoms managed and wishes met.

DNACPR only means DNACPR

Reasons for DNACPR decision?

- DNACPR is in accordance with sustained wishes of the resident
- DNACPR is unlikely to be successful eg: residents who are expected to die from incurable illness and CPR would be futile
- There is uncertainty about the successful outcome of CPR who following discussion about benefits v burdens decide on DNACPR
- For individuals where a DNACPR decision has been made there should be evidence of that decision …a ReSPECT form or an ADRT

What is end of life care?

- End of life care is support for people who are in the last months or years of life" (NHS Choices, 2015)

- "Likely to die within the next 12 months" (General Medical Council, 2010)

- "Would you be surprised if this resident were to die in the next few months, weeks, days?"

(Gold Standards Framework, 2011)

What do you understand by the terms 'palliative care' and 'end of life care'?

There are a number of terms used when describing the care people may need as they approach the end of life.

There is a lot of overlap and often different terms are used to mean the same thing, so it can be confusing.

Who are we talking about?

End of Life is an umbrella term used when people with life limiting illness are recognised as being in the last few …

months - weeks - days - hours - minutes ...of life

The main reasons for recognising End of Life is to ensure that these individuals and their families receive appropriate care, which means …**assessing current needs**, **anticipating future needs**, **planning ahead**, **coordinating care** & **good communication** with residents, families and professionals.

Common chronic long term conditions

- COPD
- Renal failure
- Dementia
- Heart failure
- Motor neurone disease
- Cancer
- …Frailty

…Frailty

- An emerging theme of end of life care practice
- Recognised by the General Medical Council as a person with "general frailty and co-existing conditions that mean they are expected to die within 12 months"
- Frailty very common in residents over 85 who have long term conditions or co morbidities and so creates the 'Surprise Question' (Keeble, 2015)

How do you recognise end of life?

There are 3 triggers:

1. The 'surprise question'

"Would you be surprised if this person died in the next 12 months?"

2. General indicators of decline
3. Specific clinical indicators related to certain conditions

The focus is upon anticipating likely needs rather than working out exact time remaining

Gold Standards Framework Prognostic Indicator Guidance 2011

Proactive Identification Guidance (PIG)

GP guidance and process to Gold Standards Framework

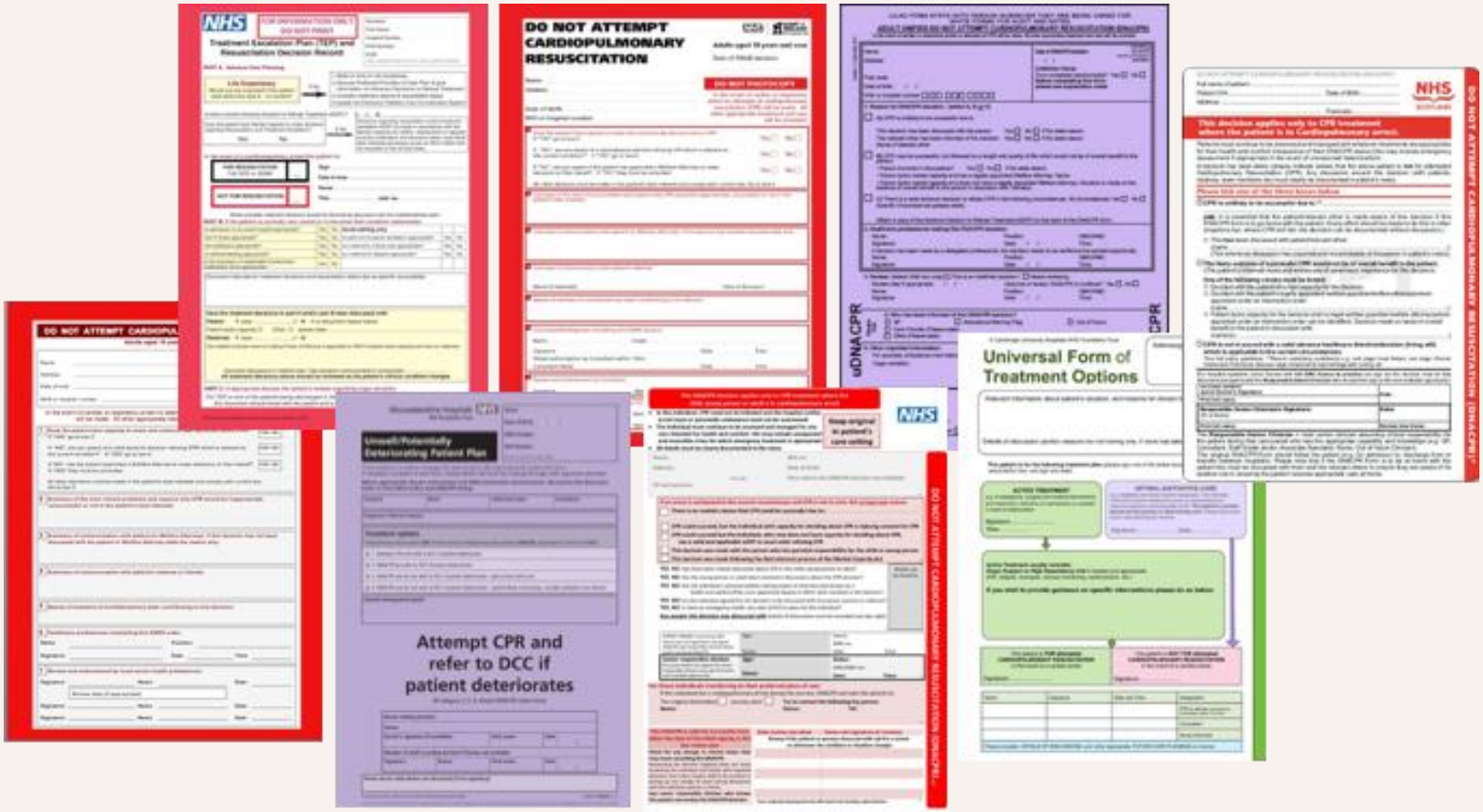
http://www.goldstandardsframework.org.uk/pig

Advance Care Planning is....

- A journey and a conversation that takes place over the course of time
- A *voluntary process* about planning ahead for possible healthcare decisions
- Enables residents and their advocates to communicate wishes, views and preferences about care including refusal of treatment
- It is an incremental process usually made in the context of an anticipated deterioration in a person's condition before losing mental capacity

- https://www.youtube.com/watch?v=bYy4q8R9kro

Background


DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION
Universal Form of Treatment Options
Attempt CPR and refer to DCC if patient deteriorates

ReSPECT Policy

Date approved: xxx 2021
Review date: xxx 2022
Version 1.0

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DRAFT ReSPECT Policy

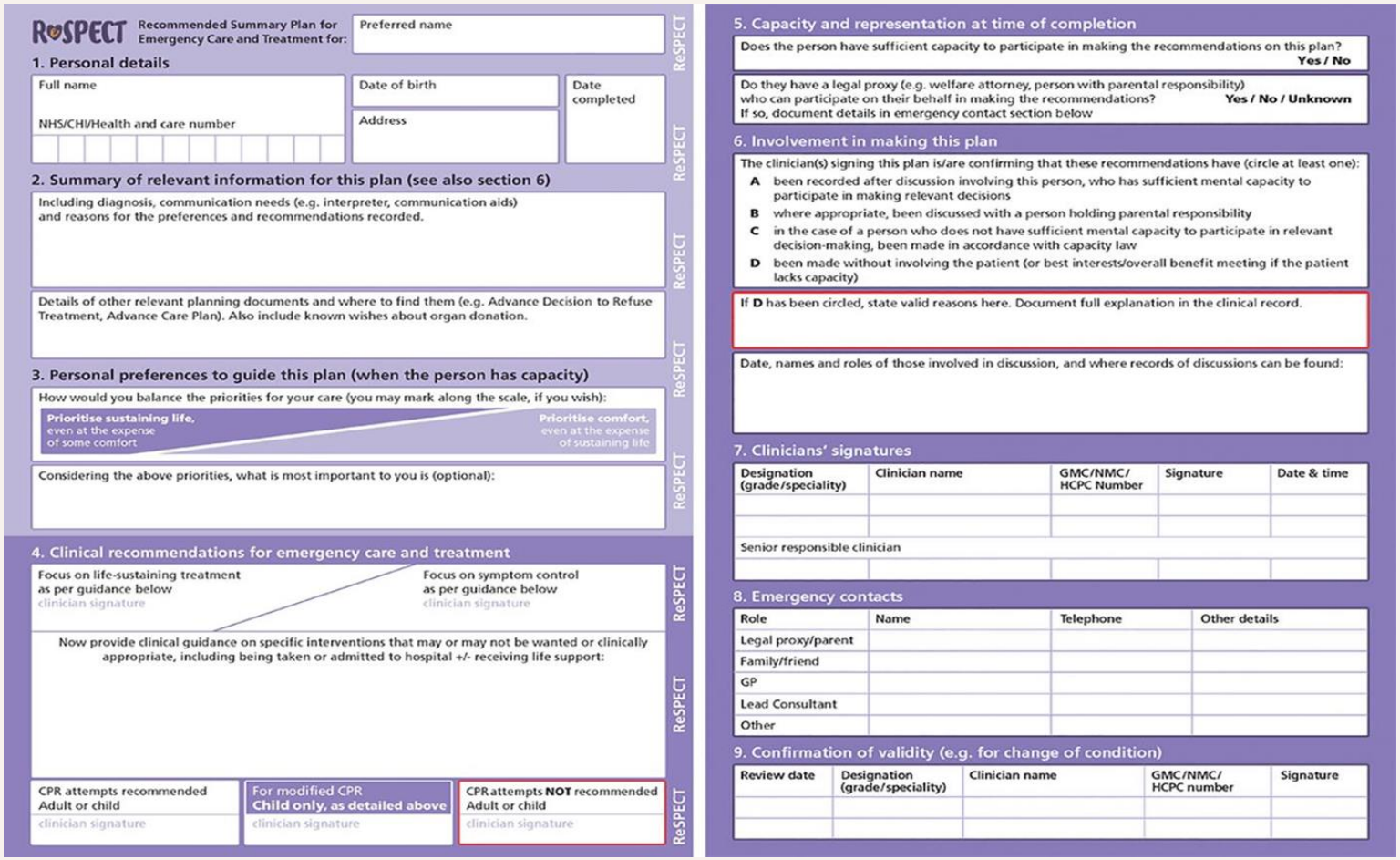
Policy Lead
- Deirdre Brunton, Clinical Audit and End of Life Care Lead

Policy Readers
- xxx

Consulted with
- xxx, Sirona Care and Health (external)

ReSPECT Forms

https://www.youtube.com/watch?v=SdkncGjihG0



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child
clinician signature

For modified CPR **Child only, as detailed above**
clinician signature

CPR attempts **NOT** recommended Adult or child
clinician signature

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend			
GP			
Lead Consultant			
Other			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

Capacity

The term ‘capacity’ refers to the ability to make a decision about a particular issue at the time the decision needs to be made or to give consent to a particular act.

Capacity, care planning and advance care planning in life limiting illness. National End of Life Programme

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice


4. Use best interests decision if I can't decide for myself
3. I am allowed to make unwise decisions
2. Individuals supported to make their own decisions – Do all you can to support me
5. Use the least restrictive option for me
1.Presumption of capacity - I can make a decision
MENTAL CAPACITY ON ONE HAND

Lasting Power of Attorney (LPA)

- A LPA is a legal document that lets a 'donor' appoint one or more people to help them make decisions or to make decisions on their behalf.
- There are 2 types of LPA:
- health and welfare
- property and financial affairs
- An individual can choose to make one type or both
- A health and welfare LPA can only be used when an individual does not have capacity for that decision.

In the moment …

- …if an individual has capacity to make that specific decision then their wishes at that time, in the moment, is the most important factor

- …some people have capacity but lack the ability to communicate their wishes. It is the clinical team's responsibility to try all means possible to enable them to communicate.

- …if individuals lack capacity, ACP information & documentation would help inform the clinician & inform the decision making

Advance statements of wishes and preferences

- Statements reflecting an individual's feelings, beliefs and values in relation to future treatment or care. These may cover health or non-health related issues. These might include:- preferred place of care, preferred place of death, who they would like involved in discussions and/or in their care, including things they particularly don't want.

- Advance statements are not legally binding but according to MCA must be taken into account when making decisions for a resident who lacks capacity

Advance Decision to Refuse Treatment (ADRT)

- An advance decision must relate to refusal of a specific treatment in specific circumstances
- If it relates to refusal of life-sustaining treatment that must be clear
- ("even if my life is at risk") It must be written

and witnessed

- It is legally binding
- It will only come into effect when an individual has lost capacity to give or refuse consent.

Conditions when resuscitation can be discontinued

- The presence of a DNAR order or an ADRT that states the wish of the patient not to undergo attempted resuscitation.

A DNAR decision does not override clinical judgement of the event of reversible cause of the patient's cardiac/ respiratory arrest e.g. choking, anaphylaxis, or trauma

- The person is in the final stages of a terminal illness where death is imminent and unavoidable and CPR would be unsuccessful, but for whom no formal DNAR decision has been made

Cardiac Arrest Clinical Guideline (CG07)P3 version

What Matters Most Charter/ Advance Statement

- What matters most conversations are a voluntary process that can be discussed at any point in life
- Promote a culture of openness about living as well as possible for the whole of life, including living with life-limiting illness
- What Matters conversations are centred on individuals and their significant relationships rather than being owned by healthcare
- To enable living well until death

Four main principles for the health professional

- Seek to discover what matters most in life to this individual.
- Seek to discover what are the most important social connections for this person.
- Seek to discover in the event of illness, how health and social care decisions can be used to support what matters most to this person.
- Help individuals map what treatments would most likely to match their own individual needs and hopes. The process of Planning Ahead enables professionals to focus their care on what matters most to the individual.

https://www.whatmattersconversations.org/video-app

NICE Guidelines for RNs and Managers in Care Home setting

https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/advance-care-planning

https://www.england.nhs.uk/wp-content/uploads/2018/04/my-future-wishes-advance-care-planning-for-people-with-dementia.pdf

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What things might be most important towards end of life…

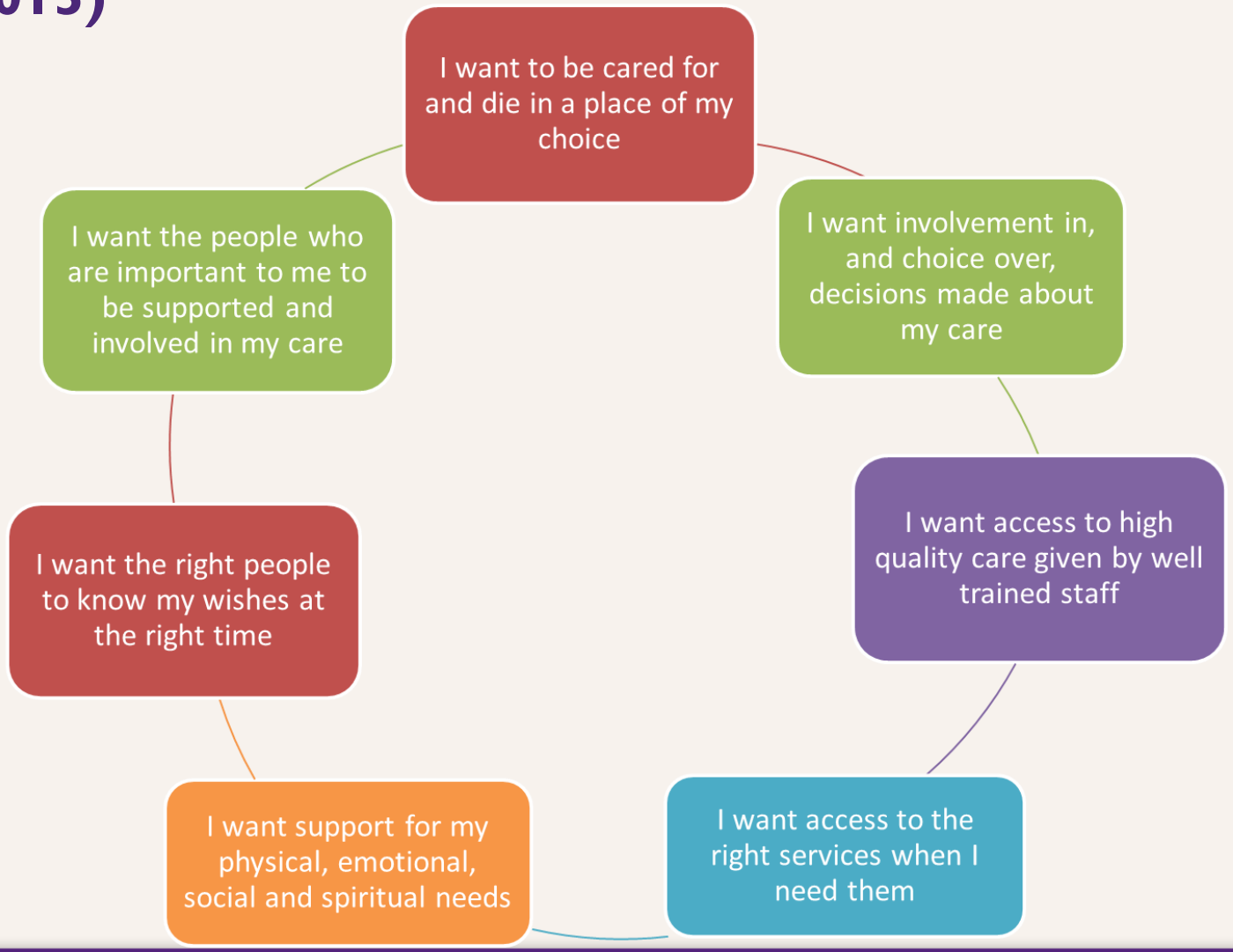
For the person approaching end of life?

For relatives and carers?

The Person and their family's needs

- To be able to express concerns and someone to listen
- Information and discussion
- Good symptom control
- To be in familiar surroundings with the people that are important to them
- Continuity of care & good team work
- Practical support and advice
- Access to expert services

What's important to me: A review of choice in end of life care.(2015)



Advance Care Planning In Care Homes - What Matters Most – Lead the Way!

Education

OPEN ACCESS

Advance care planning in nursing homes: new conversation and documentation tools

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► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjspcare-2021-003008).

For numbered affiliations see end of article.

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ABSTRACT

Although advance care planning (ACP) is highly relevant for nursing home residents, its uptake in nursing homes is low. To meet the need for context-specific ACP tools to support nursing home staff in conducting ACP conversations, we developed the ACP+intervention. At its core, we designed three ACP tools to aid care staff in discussing and documenting nursing home resident's wishes and preferences for future treatment and care: (1) an extensive ACP conversation guide, (2) a one-page conversation tool and (3) an ACP document to record outcomes of conversations. These

Key messages

What was already known?
- Uptake of advance care planning (ACP) is low in nursing homes; important barriers are insufficient knowledge and skills of care staff.

What are the new findings?
- Newly developed ACP tools.

What is their significance?
- Clinical: involve residents, their families and professionals in the ACP process while avoiding a 'tick-box' approach.
- Research: fill the gap of detailed

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Resources

- E-LFH Introducing Culture
- E-LFH Cultural Competence
- E-ELCA Introduction to care after Death (1)
- E-ELCA Providing personal care after death (2)
- ELFH Pain Management in the End-of-life Patient.

Faull C, Nicholson A (2012) Terminal Care and dying. Handbook of Palliative Care. Wiley- Blackwell Hoboken New Jersey.

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