Advance Care Planning during the COVID pandemic

What is Advance Care Planning?

Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness. (International Consensus Definition of Advance Care Planning 2017)

- Advance care planning (ACP) conversations can be done at any time. However, triggers for offering a conversation about ACP could include diagnosis of a life limiting illness, recognition of increasing frailty or admission to a care home.
- ACP is a voluntary process, which patients can decline when offered. It may also be a series of conversations rather than covering everything at once.
- Most ACP will lead to a non-legally binding plan outlining the patient's wishes that can be used to guide and inform future care, including decisions taken the person's best interest.
- Some patients may wish to appoint a lasting power of attorney (LPA) for health and welfare and/or finances. If patients have specific treatment they wish to refuse they may also wish to complete an Advance Decision to Refuse Treatment (ADRT) which is legally binding. More information about LPAs and ADRTs can be found in the resources below.

What is the difference between Advance Care Planning and Anticipatory or Emergency Healthcare Plans?

- Advance care planning is done with patients who have capacity to express their wishes for their future care and may consider the patients general goals and preferences as well as some specific decisions, for example DNACPR decisions.
- Anticipatory clinical management plans, also known as emergency healthcare plans are based on specific scenario(s) and set out what treatment should be offered and what the goals of care should be. For example if patient X develops an infection they should be treated with oral antibiotics but not with intravenous antibiotics and would not be transferred to hospital.
- Anticipatory clinical management plans can be made for patients with and without capacity to make decisions about their medical treatment. If the patient does not have capacity then the principles of best interest's decision making should apply, including involving those important to the patient.

Recording Advance Care Plans and Anticipatory Clinical Management Plans

- Advance care plans and anticipatory clinical management plans can be recorded in many paper formats as a patient or carer held record, for example the preferred priorities for care document. Many patients or carers may find this helpful but it is not mandatory.

Dr Rachel McDonald, community palliative medicine consultant

- Advance care plans and Anticipatory clinical management plans also need to be recorded in the person's medical records.

- It is vital that any relevant EPaCCS (electronic palliative care co-ordination systems) codes, for example preferred place of death and DNACPR status, are entered into EMIS when advance care plans or anticipatory clinical management plans are recorded. These codes will allow this information to be pulled through into Cheshire Care Record, which is available to other healthcare professionals the patient may encounter. There is an EPaCCS template in EMIS to facilitate use of any relevant codes.

- If after ACP discussions you would not be surprised if the person was in the last year of life consider adding to the practice Gold Standards Framework list

Considerations during the Pandemic

- It is more important than ever to consider and offer ACP for frail and vulnerable patients

- While the ongoing pandemic may well be a factor in patient's preferences and clinical decision making there should not be blanket approaches or decisions for patients who fall into certain groups, for example care home residents. Advance care planning and any anticipatory clinical management plans should be done on an individualised basis.

- It may well be necessary to have discussions with patients and/or those important to them over the phone or via video consultation. Tips for remote ACP can be found here http://www.cheshire-epaige.nhs.uk/wp-content/uploads/2020/06/FINAL-Guidance-Notes-for-remote-Advance-Care-Plans-V1.4.pdf

Useful Resources

- Preferred priorities for care document https://www.dyingmatters.org/sites/default/files/preferred_priorities_for_care.pdf

- Links to multiple resources to support ACP are available on the Cheshire e-paige http://www.cheshire-epaige.nhs.uk/document-library/?top-category=advance-care-planning-dnacpr

- Multiple resources on the Macmillan website to support ACP and difficult conversations https://www.macmillan.org.uk/coronavirus/healthcare-professionals

- Top tips for identifying patients who may benefit most from ACP http://www.cheshire-epaige.nhs.uk/wp-content/uploads/2019/05/TOP-TIPS-identifying-patient-ACP-2019-002.pdf

- Tips for ACP for G.Ps http://www.cheshire-epaige.nhs.uk/wp-content/uploads/2018/11/ACP-Tips-for-General-Practitioners.pdf

- Creating COVID-19 relevant ACPs in care homes https://www.ec4h.org.uk/wp-content/uploads/2020/05/Creating-Covid-19-relevant-ACPs-in-Care-Homes-7-steps-to-ACP-implementation-Guidance-v1.1.pdf

Dr Rachel McDonald, community palliative medicine consultant