

# Advance Care Planning

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# Advance Care Planning

Is a process of discussion between a patient and those who provide care for them.

The aim is to enable an individual to express their views, preferences and wishes about their future care, so that these can be taken into account should they lose capacity to make their own decisions in the future.

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# A process of discussion

## A voluntary process of discussion

- Not everyone will wish to have such a discussion
- It is important to respect autonomy and choice

## The discussion may include:

- An individual's understanding of their illness and prognosis
- Their concerns
- Their important values or personal goals for care
- Preferences for types of care and treatment that may be beneficial in the future & the availability of these

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# What?...Who?...Where?...Why?

What actually triggers “talking about dying” in your experience?

Who do patients actually choose to talk to about death and dying?

Where do people choose to do this?

Why do people want to talk about death and dying?

What is the result of talking about death and dying?

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# Triggers for initiating or reviewing ACP conversations

- The patient initiates the conversation
- Diagnosis of a progressive life limiting illness
- The diagnosis of a condition with a predictable trajectory, which is likely to lead to a loss of capacity
- A change or deterioration in condition
- A routine or planned clinical review

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# Outcomes of creating opportunities for talking about ACP

For **many** people this will lead to more conversations over time, that reveal elements of their wishes and hopes for their future care (to be shared with more people; family, wider h&sc professionals)

For a **few** this will result in making choices clear and writing them down. This might lead to comprehensive and legal documentation

For **some** their choice will be to never discuss their future care wishes

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# ACP might involve an individual...

Opening the conversation

Exploring the options

Identifying wishes and preferences

Deciding to refuse a specific treatment in advance

Identifying individuals to be consulted on their behalf

Letting people know their wishes

Appointing someone to make decisions for them using a LPA

# Statement of wishes & preferences

Statement reflecting an individual's feelings, beliefs and values in relation to future treatment or care. May cover medical or non medical issues.

May be written by the patient or recorded by a professional or carer

Not legally binding but according to MCA must be taken into account when making decisions for a patient who lacks capacity

Preferred Priorities of Care is an example of a **Statement of wishes & preferences** designed for people with life limiting illness

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# Advance decision to refuse treatment

Previously known as Living will or Advance Directives

An advance decision must relate to refusal of a specific treatment in specific circumstances

It must be written signed and witnessed if it relates to refusal of life-sustaining treatment. It must also include a statement such as '*even if my life is at risk*'

It is legally binding

It will only come into effect when the individual has lost capacity to give or refuse consent.

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# Lasting Power of Attorney (LPA)

An individual with capacity can appoint a person/s (“attorney”) to make decisions on their behalf if they subsequently lose capacity (LPA has replaced Enduring Power of Attorney)

**There are 2 types of LPA:**

health and welfare

property and financial affairs

An individual can make an LPA of one type or both

An attorney may be appointed to make all or specific health and welfare decisions, as well as property & financial decisions on behalf of the donor

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# Summary of advance care planning

- Advance care planning is a voluntary process of discussion and review to support individuals choice
- To support an individual who has capacity to prepare for a time when they might lose capacity
- ACP is dependent on having timely conversations (picking up on cues and initiating conversations) some of which may be difficult

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