ADVANCE CARE PLANNING (ACP) - PATIENT HELD DOCUMENT – PROFESSIONALS

BACKGROUND:

All people with serious life limiting illnesses who are thought to be in their last year of life, including the frail elderly, should have the opportunity to discuss and record their preferences, choices and wishes for care at the end of their lives . They have the right to be involved in decisions about treatments prescribed for them including the option of saying 'no'.

WHAT IS THE DOCUMENT:

This ACP document is designed to aid discussions between patients, families and health and social care professionals. It aims to help identify and understand the wishes and preferences of the patient. It does not have legal status; it's simply a guide to areas people may want to consider discussing. The booklet is a patient held record. It is not suitable for those who have cognitive impairment and lack capacity to make these decisions in advance.

ADVANCE CARE PLANNING – Is not usually a one off conversation. It is a process which patients may choose to engage with at different levels over time. It is important to offer support in decision making in a timely manner and at a pace appropriate to the individual.

We recommend if you use the ACP document that you explain its purpose to the patient and ask them to look at it with those important to them, such as a family member, to give them time to consider the information and if they would like to use the document. Arrange to see them again to discuss further and document as appropriate.

The written document can then be kept with the patient and it can be shown to anyone they wish to share it with at appropriate times eg - to a health care professional who hasn't met them before or ambulance services.

There is a template (Advance Care Plan Template) within the patients Systm1 electronic record where information known about patients preferences and choices can be recorded by the health professional who has helped the individual with the document (or at any other time important discussions occur).

Health and Care professionals with access to the Systm1 record will be able to view this information to help inform best interest care and treatment decisions if a patient has lost capacity to make their wishes and preferences known .

It is envisaged that information placed on the template will be reviewed at regular intervals (for example, as part of a GSF meeting), to ensure care is being aligned as far as possible with these preferences, and to review preferences and decisions.