Advance care planning in Residential and Nursing Homes- explanatory notes for GP practices and Care Home Staff

Advance Care Planning resulting in clear, written Advance care Plans should be done as soon as possible for new residents and completed for existing residents. The new digital Proactive Care Plans are the forms developed and approved by OCCG for this purpose.

The resident should be involved, wherever possible through a face-to-face discussion, and their wishes respected.

If a resident lacks capacity to be involved in any way with any advance care planning eg due to advanced dementia, then the principles enshrined in the Mental capacity Act (2005) should be used to guide a "Best Interest Decision":

Information to assist a Best Interest Decision should be completed by (in order of preference):
1) Person holding an active Lasting Power of Attorney for Health or Advance Decision to refuse Treatment for the resident
2) Next of kin
3) Close friend or other representative with best knowledge of resident
4) If resident has no-one to support or represent them: an Independent Mental Capacity Advocate (IMCA) as required by the Mental Capacity Act 2005

In a Best Interests Decision it should be noted that the final decisions regarding clinical care and direction of anticipatory planning rest with the GP and medical staff. In these cases, the purpose of this documentation and any related discussion is to try and reach a consensus agreement as to the best interests of the patient. This decision is based on a medical assessment as well as available evidence from next of kin or friends who knew the resident and feel that they are in a position to comment on the patient's likely wishes in a given situation.

Process of creating an Advance Care Plan:

1. Discussion with patient or their next-of kin/proxy- thinking ahead
2. Completion of a written care plan- the approved one in Oxfordshire is the digital Proactive Care Plan (dPCP) which should be completed by the patient's GP which will summarise the key plans.
3. A printed copy should be signed by patient and GP and filed at front of nursing records so that all key staff can find/see the form when required.
4. A copy of the plan should also be offered to the patient and/or their next of kin
5. An electronic version should be in the patient's computerised medical record in the GP practice which will ensure key features of the care plan will be available in the Oxfordshire Care Summary but the care plan can also be sent directly to the OOH service to:
6. Complete any DNAR form separately in usual way (having logged this in dPCP), ensure this is printed out on lilac paper and available in patient nursing record

Care planning should be done in collaboration with the patient or their relative. A quiet room should be made available so that the visiting GP and patient/relative can discuss these matters in private. There may be circumstances where the GP and relative are not able to meet face to face to do this or it is easier to collect patient/relative's views through the printed word.

Eg - the patient is very hard of hearing
- the patient lacks capacity to understand, contribute to or otherwise complete the form and the relative is not available in working hours

In situations where it is not possible to have a face-to-face discussion with a patient (eg extreme deafness) or, where patient lacks capacity, their next-of-kin (eg due to being unobtainable) the following sample Thinking Ahead document could be completed by the patient or their relative and returned to the GP so that their wishes can be incorporated into care planning. Care Homes should supply this form for new residents where requested and collect back and pass to requesting GP. A Word version of this form is available on the Care Homes section of the OCCG Intranet to complete electronically or to print out and on the OCCG website.

Please note that the lilac DNAR form will still also need to be completed where appropriate and should be kept in the care home resident's records so that it is easily available (along with the Proactive care Plan).

Sample form to consult about wishes in regard to advance care planning if a face to face discussion is not possible.

Insert practice letterhead.

THINKING AHEAD FOR RESIDENTS IN CARE HOMES

Name of Resident Date of Birth

Please could you help us plan your care by completing the questions below. You can ask your next-of-kin to help you complete this or complete it on your behalf if you prefer. We would hope to have the opportunity to discuss these matters with you in person but there may be times when it is easier for you to write this down here.

If a resident is unable to make their wishes known, the next-of-kin acting in the resident's best interests or person who has been given Lasting Power of Attorney to make welfare decisions on the resident's behalf could complete this. If the resident has an Advance Directive in place, this should be followed.

If you are filling this in on behalf of a resident, please answer the following:

Do you have a written and signed Advanced Directive? Yes/No
Do you have Lasting Power of Attorney for welfare for the resident? Yes/No

If you have answered Yes to either of these questions, please state your name and your relationship to the resident:

Please complete the questions below as soon as possible and return to a senior member of staff. It will be used to help inform a written care plan and a copy of this will be made available for you. Please feel free to ask to discuss further with your GP if preferred.

The medical and nursing care you receive in your care home is aimed at trying to prevent problems, ensuring symptoms are controlled and keeping you/your relative as comfortable as possible.

However, should you/your relative's condition deteriorate despite all the usual medical care, hospitalisation may be considered if more active/life-prolonging treatment is needed. This is not always in a patient's best interests if it prolongs suffering or if the experience is likely to cause distress due to unfamiliar surroundings, busy wards with constant noise and medical interventions without the benefit of improved quality of life following treatment.

If death is expected, most residents can receive all appropriate care while staying in this Care Home with the benefit of familiar surroundings, friendly faces and the peace and comfort of one's own room.

While any decision regarding hospitalisation is primarily the responsibility of the doctor in attendance, we would like to be able to take account of your views so please answer the following questions:

What elements of care are important to you/your relative as condition progresses?

What would you/your relative like to happen?

What would you/your relative not like to happen?

Would you/your relative prefer to avoid hospitalisation unless there would be a clear benefit?

Would you/your relative prefer to avoid attempts at resuscitation?

Do you have any special requests or arrangements?

Signed by…….
Date……

Please print name……..

If relative, please state relation to resident if not already provided above