

# Advance Care Planning



Northern Cancer Alliance

## Conversations and Triggers.....

### What is advance care planning

Advance care planning is a process of discussion to allow patients the opportunity to express their views, preferences, and wishes about their future care if they are unable to make their own decisions at some point in the future. It is a voluntary process and no one is under pressure to become involved in any of these steps. Deciding Right documents are available to record the discussion.

### What would trigger a discussion of future wishes with my patient?

- Diagnosis of life limiting condition or recurrence
- Marked deterioration in condition or declining performance status
- Recent admission to hospital
- **Patient may ask you!** about the future, death or dying- don't be frightened to have this conversation
- Consider Communication skills training

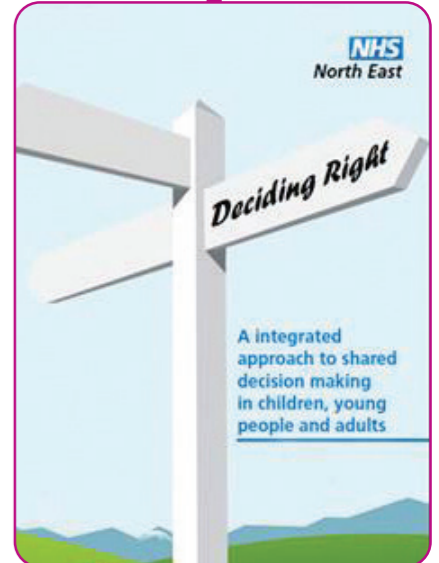
### How do I communicate effectively?

- Use active listening and open ended questions
- Respond to cues
- Acknowledge, empathise, reflect and summarise
- Use non-verbal communication i.e. eye contact
- Check understanding at all times
- Be open and honest
- Consider Communication skills training

### What types of things should we talk about?

- The type of care they would like towards end of life
- Where they would like to die
- How long they would want doctors to treat them
- Funeral arrangements, care of any dependents, how they would like to be remembered
- Worries about being ill and dying
- Organ and tissue donation

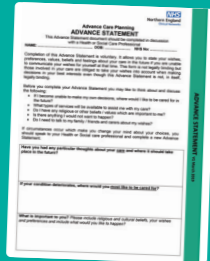
### Deciding right



## Documents..... Which one to use?

### Preferences and wishes identified

- Any religious or spiritual beliefs
- Preferred place of death
- Individual preferences/ likes and dislikes
- Concerns or solutions about practical issues
- Who should be kept informed of care plans/ decisions



**CONSIDER ADVANCE STATEMENT (non-legally binding)**

### Refusal of specific treatments discussed

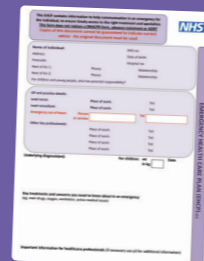
- Strong views held about specific medical treatments patient does not want to have
- Patients may want to refuse a treatment in some circumstances but not in other



**CONSIDER ADVANCE DECISION TO REFUSE TREATMENT (legally binding)**

### Planning for anticipated emergencies

- Plan for when a crisis or emergency may be anticipated.
- May be useful for setting limits to escalation of treatment or a need to make clear that the patient should receive all possible treatments
- Invaluable for individuals with complex physical, mental or cognitive disabilities



**CONSIDER EMERGENCY HEALTH CARE PLANS (non-legally binding)**

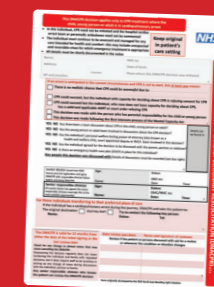
### Identification of Named individuals to be involved in care decisions

Patient may wish to 'name' someone or even more than one person to be legally consulted with about their care and make decisions on their behalf when they are unable to do so themselves

**CONSIDER LASTING POWER OF ATTORNEY (Property and Financial Affairs/ Health and Welfare. Consider a 'will'. Legally Binding)**  
[www.gov.uk/government/organisations/office-of-the-public-guardian](http://www.gov.uk/government/organisations/office-of-the-public-guardian)

### DNACPR

This is a medical decision but discussion must take place with the patient and/or family. A second opinion can be sought if disagreement occurs



**Advisory Note - non legally binding**

### Sharing of documents

How do I find these documents when I want to use them? Where can I go for help?

Access to Deciding Right regional documents:  
[www.northernalliance.nhs.uk/deciding-right/deciding-right-regional-forms](http://www.northernalliance.nhs.uk/deciding-right/deciding-right-regional-forms)