Disclaimer: These are intended only as good practice prompts. Use your clinical judgement.

Top Tips for Clinicians

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Subject	**Advance Care Planning - MY FUTURE WISHES** (April 2020)
Top Tip 1	**What is an Advance Care Plan (ACP)** A discussion in which a person ***may*** choose to express some views, preferences, wishes about future care. • Their concerns/important values or personal goals for care/understanding about their illness/ prognosis • Their preferences for types of care or treatment that maybe beneficial in the future and their understanding of the availability of these **(Advance decisions to refuse treatment)** • Carer emergency care plans • **Do Not Attempt Resuscitation (DNAR)** • **Emergency Care Plans (ECP)** • Lasting Power of Attorney (LPA) **Differences between ECP and ACP** • ECPs - concise, relevant, rapidly accessible clinical recommendations for use in an emergency • ACPs - detailed, often completed by the patient and may focus specifically on end of life care • The two plans are complementary , they may be developed together or completion of one may prompt consideration of the other **RECORD ALL PLANS ON THE ACP TEMPLATE (PART OF EPaCCs)**
Top Tip 2	**Who to focus on – Care Homes and Housebound: Dementia /Frailty/Palliative codes** **Ask yourself the 'Surprise Question': Would I be surprised if this person died in the next 12 months?** **IF THE ANSWER IS NO THINK ACP / ECP / DNAR / GSF / Gold Line** 1. DEMENTIA: a study of nursing home deaths found most people with dementia were given a prognosis of more than 6 months, but 71% of people died within less than 6 months 2. FRAILTY: 25% of people with severe frailty die each year **Local data: of those living in a Care Home (3,286), 1,962 DO NOT have a RESUS status recorded** (52% in AWC, 70% in City and 63% in Districts) **Searches to help you identify the groups which may benefit from ACP discussions** 1. Clinical Reports >Data Quality Toolkit >Deaths (those on EOL/Palliative Register with ACP elements missing) 2. Clinical Reports >Data Quality (10720) >CCG BFD&AWC >Care Homes (those in a Care Home or Housebound with Severe Frailty/Dementia /EOL without DNAR)
Top Tip 3	**Who should undertake ACP (My Future Wishes ACP)?** • ACP is a discussion between a patient & those who provide care for them eg nurses, doctors, care home manager or family members and can be undertaken irrespective of discipline • **Discussions about refusal of treatment or DNA CPR and ECP need to be had with a suitably qualified practitioner and there may be a need to consider the Mental Capacity of the patient in the discussions** • Where patients have severe Dementia, and may lack the capacity to make decisions on their own, it is then about 'Best Interest 'discussions
Top Tip 4	**Resources: New Bradford Advance Care Plan** **FOR PATIENTS** • Compassion in Dying – Advance Decisions and Lasting Power of Attorney for Health and Welfare • The National Council for Palliative Care – Difficult Conversations • Dying Matters – Starting end of life care conversations with people affected by dementia **FOR CLINICIANS** (Access to My Future Wishes ACP document) Also on ACP Template • Palliative Care – Bradford, Airedale, Wharfedale and Craven – Advance Care Planning
Info	Mental Health in Older People 'A Practice Primer' Youtube – Depression in older people