OA Reablement Service	OA Day Care	OA Residential Care	Domiciliary Services	DMH Day Services	DMH Supported Living	DMH Residential Services	EIA'd
x	x	✓	x	x	x	x	✓

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PERSON CENTRED ADVANCED CARE STATEMENT

To assist the service user, if requested, in planning for their future care.

INTRODUCTION

This document has come from the need to ensure a consistent approach throughout Cumbria Care.

The Initiative that leads this comes from and has been developed under the North East Strategic Health Authority end-of-life clinical innovation team; this is the first framework in the UK to integrate the principles of making care decisions in advance.

What is *Deciding right*?

All care decisions must come from a shared partnership between the professional and the child, young person or adult. *Deciding right* provides the principles by which all health organisations can set their policies to encourage this partnership around care decisions made in advance for people who may lose capacity in the future.

These principles:

- Enable individuals and organisations to be compliant with the law, national guidelines and health targets
- Centre care decisions on the individual rather than the organisation
- Strongly endorse the partnership between the patient, carer or parent and the clinician (shared decision making)
- Are based on the Mental Capacity Act and the latest national guidelines
- Recognise the individual with capacity as key to making care decisions in advance
- Identify the triggers for making care decisions in advance
- Create regional documentation for use in any setting that is recognisable by all health and social care professionals
- Minimise the likelihood of unnecessary or unwanted treatment
- Introduce emergency health care plans as an important adjunct in specialist care settings to tailor care to the individual with complex needs
- Create principles and documentation suitable for all ages (children, young people and adults)

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PROCEDURE

This document may be used by other services as appropriate.

1. The Person Centred Advanced Care Statement (also known as PCACS) can help the service user plan for their future care. It gives the service user an opportunity to think about, talk about and have recorded their preferences and priorities. The service user does not need to complete the advanced statement unless he / she wishes to.

2. If there are any doubts about the service users mental capacity to complete any part of the P15 statement then further advice must be sought.

3. When a service user is unable to make decisions for themselves (unless arrangements are already in place) the manager / supervisor must request that a best interest meeting is held.

4. Minutes of any best interest meetings must be held on the service user file under section named confidential.

5. Staff must regularly give the service user the opportunity to discuss and think about making a person centred advanced care statement.

6. The person centred advanced care statement booklet will be held with the service user file until required. This must be held on the service user file behind the front sheet and must be recorded on the P14 person centred care plan front sheet (part 1).

7. Service users must be consulted as to whom they wish to discuss and / or complete their person centred advanced care statement with.

8. Staff should be open to any discussions the service user instigates about their future advanced care. It may be at the point when the person centred advance care statement is introduced that discussions around the following may occur:

    - Wishes and preferences
    - Whom the service user wishes to be involved in their future care
    - Advanced decision to refuse treatment (ADRT)
    - Do not attempt cardio pulmonary resuscitation (DNACPR)
    - Making sure the list of contacts is up to date
    - Lasting power of attorney

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9. The person centred advanced care statement must be reviewed inline with the person centred care plan and only when a change is needed should it be amended. The service user can request changes to the statement at any time.

10. Any concerns regarding the increasing decline in a service user's general condition may indicate or trigger the need for the service user to be added to the Six Steps End of Life Care Register. The register can be used to monitor the service users decline in health over a period of time.

11. In accordance with the North West End of Life Care Model, where the service user is known to have a life limiting disease or is moving towards the end of their life the following end of life care model points should be considered:

Advancing disease – A timeframe of one year or more.

- Review of the person centred care plan
- Implement the P15 Person centred advanced care statement
- The person is placed on Six Steps End of Life Care Register and information shared with the general practice
- Information shared with the service users approval

Increasing decline – A timeframe of approximately six months.

- Review of the person centred care plan
- Review the P15 Person centred advanced care statement
- ADRT (Advanced decision to refuse treatment)
- EHCP (Emergency health care plan)
- DNACPR (Do not attempt cardiopulmonary resuscitation)
- Consider specialist input

Last days of life – A time frame for the last few days.

- Review the person centred care plan
- Review the P15 Person centred advanced care statement
- Consider specialist input
- Review end of life medication
- Check the service users preferred contacts

First days after death – A timeframe for the first few days

- Follow the D11 Cumbria Care death procedure
- Obtain the verification and certification of death
- Relatives / friends etc being given information on what to do following a death
- Register the death if appropriate

- Contact the funeral director if appropriate

Bereavement – A timeframe of one year or more

- Offer information about support and bereavement services if required

The right to refuse treatment

1. An advanced decision to refuse treatment (ADRT) is a written refusal of specified future treatment made by an adult over the age of 18 and who has capacity in regard to making decisions about their future care.

2. The service user may wish to complete an advanced decision to refuse treatment (ARDT).

3. Any advanced decision to refuse treatment that the service user requests must be discussed with those who the service user has specifically requested. This may be the family, friend and / or G.P.

4. Any ADRT must be signed and dated and it must be very specific with exactly with the exact details about what the individual is refusing to be treated for. E.g. "I do not want resuscitated only if I go into renal failure. The ADRT is legally binding.

5. The original advanced decision to refuse treatment (ADRT) form must be held on the service user file behind the front sheet. A copy must be given to the service user's GP.

6. A service user may also wish to talk about emergency treatment such as resuscitation. The service user has the right to refuse cardiopulmonary resuscitation (DNACPR) in the event of an emergency.

7. "Do not attempt cardiopulmonary resuscitation (DNACPR) form" can only be completed following discussion with the GP present. The form must be signed and dated. This is a clinical decision that can only be signed by a Doctor.

8. Where a DNACPR form is in place it can be printed off in colour or black and white but the Doctor must complete and sign the document in order to be valid.

   Please note: Photocopies of the completed signed forms are not valid.

   The **DNACPR** form must be placed on:

Older Adults Residential - the service users file and filed behind the front sheet and the P14 front sheet must be completed.

A note must also be added to the advanced care statement and the p14 person centred care plan.

9. It is important that the service user is encouraged to inform the person/s whom they wish to be involved in their future care about a DNACPR.

10. Where a DNACPR form is in place Cumbria Care must ensure that the Emergency Health Care Plan (EHCP) form and The End of Life Care Alert Notification Form is completed by the Doctor. The End of Life Care Alert Notification must be used to alert the emergency services (Ambulance Service) that there is a DNACPR in place for that individual. Cumbria Care should keep the original file

11. The EHCP and the End of Life Care Alert Notification Form will inform the Ambulance service that in the event of a medical emergency in the Cumbria Care establishment there is a DNACPR in place.

12. A copy of the EHCP and the End of Life Care Alert Notification Form must be held on the service user file behind the front sheet.

13. When Cumbria Care is required to call the emergency services for a service user who has a DNACPR form in place, the medical crew MUST be given the ORIGINAL DNACPR form. Having had the Alert Notification Form they will be aware that there is a DNACPR form in establishment but may not be aware of who it is for.

14. The emergency crew **WILL** resuscitate if they are not provided with the DNACPR original form.

15. The emergency crew will take the DNACPR form and related documents to hospital with the service user. This will stay with the service user. If the service user returns to the Cumbria care establishment after a stay in hospital the DNACPR form and related documentation (including the care plan) must come back with them. It is imperative that the supervisor on duty must make every effort to ensure that this form is handed back to them for safe keeping and filed appropriately.

16. All forms can be downloaded on the following website and by following the route below: http://www.nescn.nhs.uk/commom-themes/deciding-right/

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- Google
- Then type in North East Strategic Network
- Then click on Deciding Right
- Then click on Deciding right forms
- Scroll down to see all the forms

17. The above forms including the advanced statement must be reviewed in line with the person centred care plan or when changes occur. Only at the request of the service user must these forms be amended, and only by a medical professional. The DNACPR must be reviewed every 12 months at most.

In order to effectively implement this procedure the manager must ensure all care staff are given training on the procedure and the documentation involved. Once care staff have been given training on the procedure this must be documented on the staff training