St Luke's
Hospice Plymouth

Advanced Care Planning during the COVID-19 pandemic

Having advanced care planning conversations with our patients is always important, but the current COVID-19 pandemic has shone a spotlight on the unwanted consequences of not undertaking this planning. This applies to people dying from both COVID and non-COVID related conditions.

If we do not ask our patients about their wishes and what really matters to them, then we risk missing the opportunity to help them achieve a good death.

However, it should be recognised that these can be challenging conversations, which can create anxiety in the initiator, and need to be thought out and planned to enable them to be undertaken with compassion and sensitivity.

What is Advanced Care Planning (ACP)?

ACP is a proactive, ongoing process that aims to identify and document an individual's goals of care, producing a statement of wishes, much like a birth plan.

It should seek to share decision making and explore concerns, both with the patient and their family or loved ones.

Why is ACP important?

For the individual, it can ensure that their end of life wishes are met, allowing them the best possible death. It is much less distressing to have these discussions when the person is well.

For families and loved ones, it sets expectations and reduces the burden of crisis decision making. This in turn can ease the grief experienced by the bereaved.

For the wider healthcare system, avoiding unplanned and unwanted admissions can ease the strain on services, especially when resources are limited.

How is ACP undertaken?

Successful advanced care planning all comes down to communication. During the current pandemic, a lot of clinical interactions are taking place via telephone or video, which adds the to challenge. Guidance is available to support these consultations.

Health care professionals need to frame the conversation in a positive manner and to build their own bank of phrases to work with. Some opening examples could include:

"Have you been thinking about how COVID might affect you?"

"If I needed to make a decision about your care, what would you want me to know about your wishes?"

"Do you have any strong feelings about what you would or wouldn't want to happen to you?"

Consideration should be given to the individuals current health status (including frailty and co-morbidities) and the ceiling of treatment they are likely to be offered if admission takes place.

See our advice for difficult decisions for more information.

How is an ACP conversation recorded?

There are a multitude of ACP documents available to record these conversations, both electronic and paper versions, and an individual is free to choose the format that feels appropriate to them. The most important part is ensuring a copy is shared with all providers likely to be involved in their care. This can be done via templates on clinical systems such as Systmone and EMIS, through Devon Doctors Adastra End of Life register (email ddooh.eol@nhs.net for access), and by patient held copies.

Is it legally binding?

An advanced statement of wishes is not legally binding, it provides guidance to those involved in a person's care, but clinical judgement should be applied to how to interpret and follow it. It can be altered by the individual whenever they wish.

What is an Advanced Decision to Refuse Treatment?

An ADRT (previously known as a living will) allows an individual to refuse a specific treatment in specific circumstance e.g. someone with Motor Neurone Disease may wish to refuse a PEG tube for feeding if they become unable to swallow.

It is a legally binding document and only comes into effect when the individual loses capacity.

Where does the TEP form fit in?

The Devon Treatment Escalation Plan and Do Not Resuscitate Decision Record (TEP) is a familiar document to health care providers across the county and is often the first port of call when rapid decision making needs to take place.

Although it is essential that a TEP is completed to document the ACP conversation, TEP alone does not cover all the elements required to ensure a complete care plan.

What about Lasting Power of Attorney?

Many people have an LPA for health and welfare in place who can be consulted in the decision making process if an individual has lost capacity. An LPA cannot be established once someone has lost capacity, so it is helpful to encourage people to consider it at an early stage.

Whose responsibility is it to have ACP conversations?

Advanced care planning is everyone's responsibility and we all have a role to play in helping our patients to plan their future care to enable them to achieve what is important to them at the end of their lives.