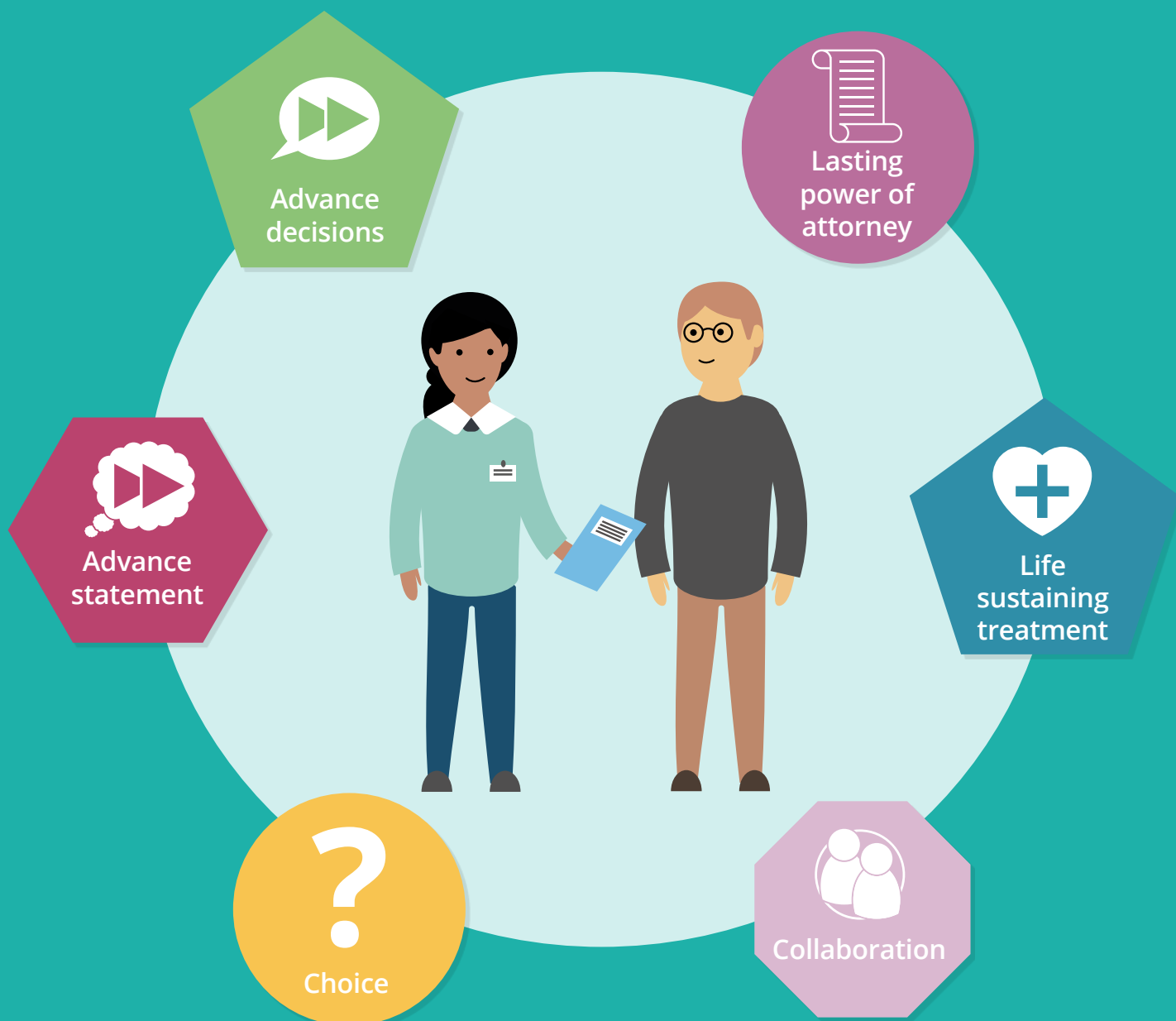


Advance care planning

A quick guide for registered managers of care homes and home care services



Advance care planning can make the difference between a future where a person makes their own decisions and a future where others do

Advance care planning offers people the opportunity to plan their future care and support, including medical treatment, while they have the capacity to do so.

Not everyone will want to make an advance care plan, but it may be especially relevant for:

- People at risk of losing mental capacity – for example, through progressive illness.
- People whose mental capacity varies at different times – for example, through mental illness.

Introducing advance care planning

Managers and care staff have an important role to play in supporting people to consider advance care planning, and should receive training to enable them to do so.

- Be sensitive – some people may not want to talk about or have an advance care plan.
- Check whether the person already has an advance care plan in place.
- Remember that everyone is different – their wish for knowledge, autonomy and control will vary.
- Be ready at any time to explain the purpose of advance care planning, and discuss the advantages and challenges.
- Remember that people may make choices that seem unwise – this doesn't mean that they are unable to make decisions or their decisions are wrong.



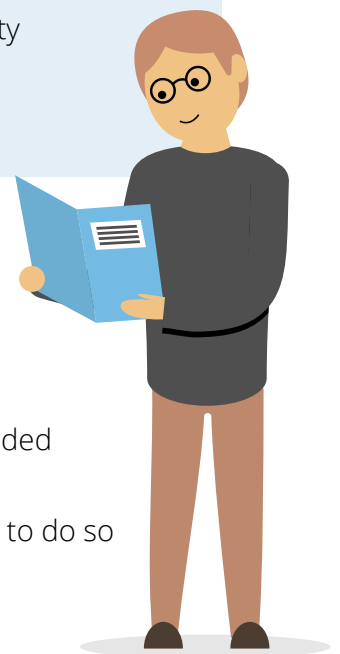
The Mental Capacity Act provides a number of ways for people to plan their care and support in advance. Care staff should find out about:

- **Advance statements...** are not legally binding but should be considered carefully when future decisions are being made. They can include any information the person considers important to their health and care.
- **Lasting power of attorney...** involves giving one or more people legal authority to make decisions about health and welfare, and property and finances.
- **Advance decisions...** are for decisions to refuse specific medical treatments and are legally binding.

Providing information

Give people written information about advance care planning in a way that they can understand, and explain how it is relevant to them. If someone has recently been diagnosed with a long-term or life-limiting condition that may affect their ability to make decisions in the future, make sure they have information about:

- their condition. Support them to ask healthcare staff for more information if needed
- the process of advance care planning
- how they can change the decisions they have made while they still have capacity to do so
- how decisions will be made if they lose capacity
- services that can help with advance care planning.



Helping people decide

Help the person make an informed choice about whether to make an advanced care plan. It should be entirely their decision. An advance care plan can cover areas such as the person's thoughts on different types of care, support or treatment, financial matters, and how they like to do things (for example shower rather than bath). As part of this process:

Together with the person (and their carer or family if they wish), think about anything that could stop them being fully involved and how to make their involvement easier.

Offer to discuss advance care planning at a time that is right for them.

Make sure you have up-to-date information about the person's medical condition and treatment options to help the process and involve relevant healthcare staff if needed.



If the person decides to go ahead

Developing advance care plans

If the person decides that they want to create an advance care plan:

- Ask them if they want to involve their family, friends or advocates and if so, make sure they are included.
- Help them consider whether involving a healthcare professional could be useful
- Take into account the person's:
 - history
 - social circumstances
 - wishes and feelings
 - beliefs, including religious, cultural and ethnic factors
 - aspirations
 - any other factors they feel are important.
- Help them think about how their needs might change in the future.

Communication support

The person may need help to communicate during these discussions. Support might include: communication aids, advocacy, interpreters, specialist speech and language therapy support, or involving family members or friends.

Recording and sharing advance care plans

During the conversation, record the discussion and any decisions made and check that the person agrees with your notes. Give them a written record of their advance care plan, which they can also take to show different services. In addition:



Ask if the person consents for their plan to be shared with relevant people. If they consent, ensure the plan is shared and transfer the plan if their care provider changes.



Review the advance care plan whenever treatment or support is being reviewed, while the person has capacity. Consider whether it would be helpful to involve a healthcare professional. Make any changes requested, including to any copies.



If the person is nearing the end of their life, ask if they would like to review their plan, or develop one if they haven't already.

Further information

[Decision-making and mental capacity](#) – NICE guideline, including [implementation resource](#)

[Mental Capacity Act Code of Practice](#) – available from Office of the Public Guardian

[Advance Care Planning: A Guide for Health and Social Care Staff](#)

– University of Nottingham. Includes more information on lasting power of attorney and advance decisions.

[Planning for your future care: a guide](#) – NCPC/University of Nottingham/National End of Life Care Programme. An information source for people considering advance care planning.

[My future wishes: Advance care planning for people with dementia in all care settings](#) – NHS England

[Advance planning and decision-making](#) – SCIE

[Advance decisions to refuse treatment](#) – NCPQSW, Bournemouth University

This content has been co-produced by NICE and SCIE and is based on NICE's guideline on decision-making and mental capacity.

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