COMPASSION IN DYING.
SUPPORTING YOUR CHOICES

Advance Care Planning by phone or video

This framework has been designed to support GPs to have advance care planning conversations with patients by phone or video, in the context of COVID-19. It is a tool to help you have honest and open conversations. It is not a script.

You can use existing appointments or touchpoints, such as wellbeing calls, as an opportunity to initiate advance care planning conversations. Sections in ***italics*** offer ways to start conversations and ask questions about your patient's wishes. You can use some or all of them, or you may wish to use your own words.

Starting the conversation

Explain why you are calling

- ✓ *I'm giving you a call because of what's going on with coronavirus. Because of your [particular health condition], if you were to get the virus we think you could become very unwell.*
- ✓ *I want to find out more about what's important to you and the type of care you would want if you become ill. Understanding what matters to you means that we can care for you better.*

Check-in with them

- ✓ *How are you doing with all this?*
- ✓ *Have you been thinking about how coronavirus might affect you?*

Understanding what matters to the person

- ✓ *What is important to you in your life?*
- ✓ *Is there anything you want us to know if you become very unwell with coronavirus [or your health condition] and need urgent care?*
- ✓ *Is there anything you don't want to happen to you?*
- ✓ *Where would you like to be cared for?*
  [If at home] Is there anyone who could help to care for you at home?
- ✓ *Who are the important people in your life that you'd like to be involved?*
- ✓ *Who could we talk about your care with if you become too unwell to tell us what your wishes are? Do you think they understand what matters to you?* Please explain that the person won't be able to make decisions.

Explaining treatments

This section provides information to explain what different treatments involve, and how likely they are to be beneficial. Please consider factors such as the person's pre-existing health conditions and/or frailty, and local guidance when having conversations about treatment options. This will help ensure that the information given is accurate and appropriate for that person as an individual.

If someone wants to refuse critical care or you believe that critical care might do more harm than good, you should have a conversation with them about this. If you are unsure about whether critical care is likely to benefit a particular patient, you can talk to secondary care colleagues.

If the person's individual needs and situation mean they are unlikely to benefit from critical care, framing the conversation as 'protecting' them may be useful.

For example:

✓ If appropriate and based on an individual conversation about the person's wishes and needs:

*I understand that this might be a worrying time for you, but I'd like to talk with you about how we can make sure you're **protected** from invasive treatment if you were to get coronavirus. In your situation, this kind of treatment might not work or could leave you with a worse quality of life. Can we talk about your hopes and priorities for your health and care?*

Explaining treatments and outcomes in hospital and critical care

The Royal College of Physicians' critical care guidelines have useful patient-facing information, including what happens in critical care and expected outcomes following critical care. You can read them here.

CPR

For any patients at risk of having a cardiac arrest it is important to discuss CPR, explaining what CPR involves and the potential outcomes for that patient. It is important to understand whether a person would want to be resuscitated.

If you believe that CPR is likely to be futile or not in the person's best interests and you make a decision that CPR should not be attempted, you must explain this to them (or their family if they lack capacity). You should also record this clinical decision in their medical notes and on any shared care records that exist in your area. More information on how to do this is overleaf.

Compassion in Dying has developed online information to help people make decisions about treatment for COVID-19:

W www.compassionindying.org.uk/coronavirus

Compassion in Dying's free nurse-led information line supports people to make the decisions that are right for them:

T 0800 999 2434

Recording wishes

It is important that you follow your local protocol for recording a patient's preferences and clinical decisions. A range of tools are included below, not all of which are used in every area.

> If you are based in London, make sure you record all decisions about your patients' treatment and care in a Coordinate my Care (CMC) record. This will mean it can be accessed by NHS colleagues providing emergency care including community nurses, hospital teams, out-of-hours doctors, specialist nurses, London Ambulance Service and NHS 111. Remember to get consent from the patient before creating a CMC record.

Recording the patient's treatment and care preferences

- **An Advance Statement**

  An Advance Statement includes anything that is important to someone in relation to their health or wellbeing, such as their daily routine and what is important to their quality of life. Your patient can complete this on their own if they choose. It should be uploaded to their medical record. You can find an Advance Statement form here or an online version here.

- **A coordinate My Care (CMC) record (London-based)**

  CMC is an urgent care plan which contains information about the patient, their diagnosis and medication, key contact details of their regular carers and clinicians, and their personal preferences across a range of possible care circumstances.

- **A MyCMC plan**

  Patients can create their own CMC record, called a My CMC plan, online. Once they have filled in their details, they need to book a telephone appointment with their GP or nurse, who will add clinical details and recommendations, and upload their plan to the CMC system.

- **ReSPECT**

  ReSPECT is a process that creates personalised recommendations for a person's clinical care and treatment in a future emergency, should they be unable to communicate this themselves.

  The ReSPECT plan is created through conversations between a person and their healthcare professional. The resuscitation status of the person is included in this conversation and a decision is made in the context of their broader clinical care. The plan is recorded on a form including their personal priorities for care and agreed clinical recommendations. A ReSPECT form is a clinical document. It is not legally binding. A person can have a ReSPECT and be "for CPR attempts recommended."

Recording a decision not to attempt CPR

If someone wants to refuse CPR or you believe that CPR is likely to be futile or not in the person's best interests you should have a conversation with them about this, making sure you establish a shared understanding of what outcomes are likely if CPR is attempted. You should then:

- Complete a DNACPR form if used in your area
- Complete the ReSPECT process if it has been adopted in your area. The decision about resuscitation should be made as part of the overall goals of care and treatment.
- Tell the patient they can make an Advance Decision to Refuse Treatment detailing this refusal (more details overleaf).

You must always discuss the DNACPR decision with the person (or someone close to them if they lack capacity), unless doing so is likely to cause the patient "physical or psychological harm".

Recording the patient's wish to refuse treatment

An Advance Decision to Refuse Treatment

An Advance Decision to Refuse Treatment (ADRT, also called Advance Directive or Living Will) allows a person to write down any treatments they don't want to have in the future, including CPR, in case they later become unable to make or communicate decisions.

An ADRT is only used if the person loses capacity to make the treatment decision in question. If it meets certain requirements it is legally binding and healthcare professionals must follow it.

You can find an ADRT form here or your patients can complete one online here.

Sharing a completed Advance Decision to Refuse Treatment

You should:

- Scan and upload a copy to the person's medical records
- Add the relevant SNOMED code: Advance care planning 816301000000100
- Add as an attachment to the person's CMC record, if they have one

The patient should:

- Share with important people (family/friends) and any other healthcare professionals involved in their care, such as the local ambulance trust, consultant and out of hours team

Giving a trusted person authority to make health decisions

Lasting Power of Attorney for Health and Welfare

Lasting Power for Attorney for Health and Welfare (LPA) allows someone to give a person they trust the legal power to make decisions if they lack capacity to make decisions for themselves.

An LPA must be registered with the Office of the Public Guardian before it can be used. There is a cost involved. They do not need to use a solicitor. The forms are available here, and an online version is here. It may take longer than usual to register the forms due to COVID-19.

Thank you to the GPs who supported the development of this publication:

Dr Nupur Yogarajah
Dr Justin Hayes
Dr P S Jarrett
Dr Jennie Parker

This resource has been developed in response to the needs of our GP partners in light of COVID-19. It will be reviewed regularly, so if you feel it could be improved or adapted to better suit your needs, please get in touch.

Published June 2020 v2

We can help you prepare for the end of life. How to talk about it, plan for it, and record your wishes. Have any questions? Talk to us.

181 Oxford Street, London, W1D 2JT

T 0800 999 2434
E info@compassionindying.org.uk
W www.compassionindying.org.uk
f www.facebook.com/compassionindying
@agooddeath