Advance Care Planning

Guidance for Clinicians

Why?

- Advance care planning can help patients and families express their concerns and wishes and achieve better quality of care.
- ACP can reduce crisis consultations and admissions.
- Patients who are identified at EOL **and** are involved in decision making
- opportunities are more likely to live longer meaningful lives, offering them a sense of hope and purpose.
- The ACP process helps people explore coping with on going changes, helping them to reframe, refocus from loss and dependency and set realistic and achievable goals.
- ACP is satisfying for clinicians and highly appreciated by patients.

When?

- As soon as you feel/think the patient **may** be in the last year of life.
- Use prognostic indicators (GSF)
- Recurrent admissions, falls, infections not fully clearing, weight loss….
- Decision taken to stop life prolonging treatments e.g. dialysis, radio/chemotherapy

How?

- Patient cues, reflect on recent events to commence conversation
- Practice some key phrases (see SAGE & THYME below)
- Read body language
- Use pauses
- Active listening, reflections, para phrasing, gentle exploration, open questions, educated guesses, clarifying & summarising.

Remember

1. Not everything needs covering in one go
2. It is good practice and more effective to encourage and enable family participation. Planning ahead for this helps things along.
3. Ensure that all decisions are recorded on the Electronic Palliative Care Coordination (EPaCCS) template.
4. People's feelings and decisions may change in time as their health or circumstances change.

SAGE & THYME®

for Advance Care Planning & End of Life Care Conversations

SETTING	Create a time and place to talk.
ACKNOWLEDGE/ASK	"I'm aware that you have been in hospital again / I've seen a change in your condition. I wonder what thoughts you have about the future?"
GATHER	Gather all of their thoughts / concerns – not just the first few.
EMPATHY	"You have been through a lot / You have a lot to think about."
&	
TALK	"Who supports you?" "Who can you talk to?"
HELP	"How do they help?"
YOU	"What do YOU think would help?"
ME	"Is there something that you would like ME to do?" Consider suggesting a written ACP.
END	"We have started to discuss these important issues; we can talk again next time we meet." "Is it ok to leave it there today?"

Suggested script to use when introducing the Advance Care Planning document to patients:

'The document will help you plan ahead with the help of those closest to you and those of us helping you with your care. It is designed to guide you through some useful and important decisions you may wish to make.

The document is a good way to record information about what is important to you. Although it is not legally binding or a replacement for good communication with you, it should be used as a guide if you are not able to communicate clearly at any time.

You can review and change it at any time.

Have a look at the document in your own time and with your family or anyone else you feel should be involved in supporting you.
If you would like to ask me to help you or need me to explain anything to you in more detail we can arrange a good time to do this together.'