NHS Lanarkshire Care Homes Protocol Group

Roles and Responsibilities for Anticipatory Care Planning for Care Home Residents

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Anticipatory Care Planning for Care Home Residents
Roles and Responsibilities

This document is intended to give guidance regarding the roles and responsibilities of those professionals involved in anticipatory care planning for care home residents. Those involved are mainly care home staff, general practitioners, colleagues in secondary care and community nurses.

The guidance relates to general anticipatory care planning and, where appropriate, the completion of formal patient-held anticipatory care plans.

The broad term anticipatory care planning encompasses all aspects of discussing and planning future care for a patient taking into account the patient's wishes when these can be ascertained. Anticipatory care planning includes advance statements (including issues such as preferred place of care and resuscitation preference), legal advance directives and patient-held anticipatory care plans.

When considering anticipatory care planning, professionals may wish to refer to the SPICT tool which provides guidance on poor prognostic indicators and care home staff may also wish to refer to prognostic indicator guidance prepared by the care home liaison nurses.

Triggers for Initiating Discussions

It is important to be aware of the main trigger points for initiating anticipatory care planning discussions because having the discussions at the right times can lead to more fruitful discussions.

The main triggers for initiating discussions are as follows: -

- At the time of general review of their situation when they are well and stable, e.g. at the time of annual GP review or 6 monthly review by care home staff
- When there has been a change in their situation, e.g. following discharge from hospital or following a significant illness
- When the future can be acknowledged, e.g. when discussing a patient's hopes and fears for the future or if the patient is considering making or amending a will
- When the patient asks

However, it has to be borne in mind that there are occasions when anticipatory care planning discussions are not appropriate, e.g. as part of a form-filling tick box exercise or if the patient is unable or unwilling to have the discussions.

Care Home Staff

Care home managers should encourage their staff to engage in training in relation to anticipatory care planning.

Nursing staff, senior carers or key workers in care homes have the main role in discussing anticipatory care planning for the residents in their care homes. This is particularly important for the formal patient-held anticipatory care plans.

Care home staff should use the resident's six-monthly review as a trigger to initiate discussion of anticipatory care planning and they should also be aware of other triggers to initiate discussion.

Care home staff should ensure that the outcome of such discussion is forwarded to the practice for sharing with the wider health care system. For patients who hold a formal anticipatory care plan, a copy of the ACP should be forwarded to the practice.

Similarly, in the event of a resident being admitted to hospital, care home staff should ensure that the outcome of anticipatory care discussions and the formal anticipatory care plans are conveyed to hospital nursing staff.

General Practitioners

Practices have a role in encouraging their care home colleagues to have anticipatory care planning discussions with the residents or their representatives.

As part of the care home local enhanced service, practices will be carrying out initial assessments and annual reviews of their care home patients. These routine assessments can be used as a trigger for discussions.

General practitioners should be involved in anticipatory care planning discussions in cases where those discussions are more complex.

General practitioners are responsible for the completion of Adults with Incapacity (Scotland) Act section 47 forms for those patients who lack capacity under the terms of the Act.

In addition, general practitioners are also responsible for the completion of Do Not Attempt Cardiopulmonary Resuscitation forms when appropriate.

Practices are responsible for sharing anticipatory care planning information via the electronic Key Information Summary with appropriate consent.

Secondary Care

There are situations in which secondary care professionals will be involved in anticipatory care planning discussions and decisions. In particular, specialist nurses in renal disease, respiratory disease and heart failure have a key role in anticipatory care planning in end stage disease in their area of expertise.

In addition, there will be circumstances when anticipatory care planning decisions are made during emergency hospital admissions in relation to treatments which are considered futile, burdensome or against the patient's wishes. Such decisions may be the subject of a hospital anticipatory care plan or treatment escalation and limitation plan. Although such plans lapse on discharge from hospital,

the decisions should still be communicated to care homes and to general practice as these decisions may subsequently be included in the patient-held ACP.

When such discussions have taken place, secondary care colleagues have a responsibility to ensure that the outcome of such discussion is communicated clearly and promptly in writing to both care home staff and general practice. In some instances, it may be helpful to inform the home and practice of the outcome of the anticipatory care planning discussions by telephone prior to written communication.

Similarly, in the event that a Do Not Attempt Cardiopulmonary Resuscitation form has been completed in hospital, it is the responsibility of secondary care colleagues to ensure that the form is sent to the care home with the patient and that this decision has been communicated clearly and promptly in writing to both care home and general practice. Again, in some instances, it may be helpful to inform the home and practice of the outcome of resuscitation status discussions by telephone prior to written communication.

Community Nursing

Given the increasing number of elderly patients being managed at home in the community, community nurses have an increasing role in the care of such patients.

Although many elderly patients on the community nurses' caseload would be suitable to engage in anticipatory care planning discussions, the community nurses have a particular responsibility for anticipatory care planning discussions with those patients who are care managed.

It is important that such discussions take place at an early stage in order that as many patients as possible can be involved in anticipatory care plans while they still retain capacity.

By increasing the number of anticipatory care planning discussions in the community, an increasing proportion of new care home residents should have anticipatory care plans in place by the time they require care home admission.

As with other professional groups, community nurses should communicate the outcome of their discussions to their GP practice colleagues so that this can be communicated via the electronic Key Information Summary and, in the event that a patient is admitted to a care home from the community, the anticipatory care plan should accompany the patient to the care home where the key points should be reviewed.

Local Authority

In addition to Local Authority residential care home staff, other Local Authority colleagues can have a role in anticipatory care planning and in the reporting of anticipatory care planning.

Increasingly, home care staff in the community will have a role in promoting anticipatory care planning discussions prior to admission to a care home. When such discussions take place, Local Authority staff should ensure that the patient's anticipatory care planning wishes are recorded and

communicated with relevant colleagues, e.g. GPs for sharing on the electronic Key Information Summary.

In addition, Local Authority colleagues involved in care home contract and quality monitoring have a role in ensuring that care homes accurately report the numbers of up-to-date anticipatory care plans.

Independent Sector

In addition Independent Sector care home staff, other Independent Sector colleagues can have a role in anticipatory care planning.

Increasingly, Independent Sector home care staff in the community will have a role in promoting anticipatory care planning discussions prior to admission to a care home. When such discussions take place, Independent Sector staff should ensure that the patient's anticipatory care planning wishes are recorded and communicated with relevant colleagues, e.g. GPs for sharing on the electronic Key Information Summary.

Advocacy

There are a number of advocacy services available across Lanarkshire. Legislation, including the Mental Health [Scotland] Act 2015 and the Adult Support and Protection [Scotland] Act 2007, refers to the duty to involve or to consider the use of advocacy for those who are affected by mental health disorders.

Advocacy services help people, particularly those who are most vulnerable in society to:

- access information and services
- be involved in decisions about their lives
- explore choices and options
- defend and promote rights and responsibilities
- speak out about issues that matter to them

Information about local advocacy services can be found by contacting the Scottish Independent Advocacy Alliance. Alternatively, both North and South Lanarkshire Councils have contact details of local advocacy services on their websites.

Communicating with Family

Although this document stresses the importance of communication between relevant professionals involved in anticipatory care planning for care home patients, careful communication with the patient and with family is also important.

Indeed, in 2014, the Court of Appeal found in favour of a relative who complained that a DNA CPR order had been placed on his mother without her knowledge. The ruling observed that "since a DNACPR decision is one which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement. There need to be convincing reasons not to involve the patient." The ruling also noted that "The duty to consult … involves a discussion, where practicable, about the patient's wishes and feelings that is better undertaken at the earliest stages of the clinical relationship so that decisions can be reviewed as circumstances change. That

involves an acknowledgement that the duty to consult is integral to the respect for the dignity of the patient."

Where a care home resident has capacity, he or she should be involved in anticipatory care discussions.

Where a patient lacks capacity but has a formal legal proxy, i.e. welfare attorney or welfare guardian, the legal proxy should be involved in anticipatory care discussions, taking into account the patient's views, expressed while still capable.

Where a patient lacks capacity and there is no formal legal proxy, it is wise to involve family members and relevant others in discussions regarding anticipatory care planning. This includes discussions regarding treatments which, for some, may be futile or burdensome.

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