

## The differences between general care planning and decisions made in advance

**Advance care planning (ACP) is a process of discussion between an individual and their care providers irrespective of discipline.**

The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others. This may lead to making an advance statement, an Advance Decision to Refuse Treatment (ADRT), a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision, or other types of decision (such as making a Lasting Power of Attorney).

With the patient's permission, all of those concerned with the patient's care and well-being should be kept informed of any decisions which impact upon the patient's care. All care requires an ongoing, continuing and effective dialogue between the patient, carers, partners and relatives. This is essential to inform general care planning, and is necessary to elicit any decisions the patient wishes to make in advance, and to check whether those decisions have changed. However, general care planning is not the same process as making decisions in advance. This leaflet clarifies the differences between general care planning, and three decisions that can be made in advance: advance statements, ADRT and DNACPR decisions.

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	General Care Planning	Advance Care Planning (ACP) - advance statement	Advance Decisions to Refuse Treatment (ADRT)	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
<b>What is covered?</b>	Can cover any aspect of current health and social care.	Can cover any aspect of future health and social care.	Can only cover refusal of specified future treatment. May be made as an option within an advance care planning discussion.	Only covers decision about withholding future CPR.
<b>Who completes it?</b>	Can be written in discussion with the individual who has capacity for those decisions. or Can be completed for an individual who lacks capacity in their best interests.	Is written by the individual who has capacity to make these statements. May be written with support from professionals, and relatives or carers.  Cannot be written if the individual lacks capacity to make these statements.	Is made by the individual who has capacity to make these decisions. May be made with support from a clinician.  Cannot be made if an individual lacks capacity to make these decisions.	Completed by a clinician with responsibility for the patient. Patient consent is sought only if an arrest is anticipated and CPR could be successful.  Can be completed for an individual who does not have capacity if the decision is in their best interests.
<b>What does it provide?</b>	Provides a plan for current and continuing health and social care that contains achievable goals and the actions required.	Covers an individual's preferences, wishes, beliefs and values about future care to guide future best interests decisions in the event an individual has lost capacity to make decisions.	Only covers refusal of future specified treatments in the event that an individual has lost capacity to make those decisions.	Documents either - that CPR cannot be successful and should not be attempted - an individual's advance decision to refuse CPR.
<b>Is it legally binding?</b>	No - advisory only.	No - but must be taken into account when acting in an individual's best interests.	Yes - legally binding if the ADRT is assessed as complying with the Mental Capacity Act and is valid and applicable. If it is binding it takes the place of best interests decisions about that treatment.	Yes - if it is part of an ADRT. Otherwise it is advisory only, i.e. clinical judgement takes precedence.
<b>How does it help?</b>	Provides the multidisciplinary team with a plan of action.	Makes the multidisciplinary team aware of an individual's wishes and preferences in the event that the patient loses capacity.	If valid and applicable to current circumstances it provides legal and clinical instruction to multidisciplinary team.	Makes it clear whether CPR should be withheld in the event of a cardiac or respiratory arrest.
<b>Does it need to be signed and witnessed?</b>	Does not need to be signed or witnessed.	A signature is not a requirement, but its presence makes clear whose views are documented.	For refusal of life sustaining treatment, it must be written, signed and witnessed and contain a statement that it applies even if the person's life is at risk.	Does not need to be witnessed, but the usual practice is for the clinician to sign.
<b>Who should see it?</b>	The multidisciplinary team as an aid to care.	Patient is supported in its distribution, but has the final say on who sees it.	Patient is supported in its distribution, but has the final say on who sees it.	Clinical staff who could initiate CPR in the event of an arrest.

## For further information

### **[www.endoflifecareforadults.nhs.uk](http://www.endoflifecareforadults.nhs.uk)**

- Advance Care Planning - A guide for health and social care staff
- Advance Decisions to Refuse Treatment - A guide for health and social care professionals
- Planning for Your Future Care - A guide for patients
- Practical Guidance for Best Interests Decision Making and Care Planning at End of Life

### **[www.resus.org.uk/pages/dnar.pdf](http://www.resus.org.uk/pages/dnar.pdf)**

- Decisions relating to cardiopulmonary resuscitation

### **[www.ncpc.org.uk/publications](http://www.ncpc.org.uk/publications)**

- The Mental Capacity Act in Practice
- Good Decision Making - The Mental Capacity Act and End of Life Care

### **[www.dca.gov.uk/legal-policy/mental-capacity/publications.htm](http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm)**

- Mental Capacity Act - Information booklets

### **<http://www.publicguardian.gov.uk/mca/code-of-practice.htm>**

- Mental Capacity Act - Code of Practice

### **[www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)**

- Concise Guidance to Good Practice - Advance care planning

Acknowledgements - produced with the help and support from Simon Chapman (National Council for Palliative Care) and Prof. Claud Regnard (St. Oswald's Hospice and Newcastle hospitals NHS Trust, Newcastle).

Sheila Joseph, National End of Life Care Programme.

Published 2010.