Support sheet 3

National End of Life Care Programme

Improving end of life care

Advance Care Planning

Advance Care Planning (ACP) is a process of discussion between an individual and their care provider irrespective of discipline. The difference between ACP and more general planning 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 of the individual's condition. It is recommended that with the individual's agreement this discussion is documented, regularly reviewed and communicated to key persons involved in their care.

Key elements

- The ACP process is voluntary and should not be as a result of external pressure
- The result of the ACP process may be a statement of an individual's wishes, preferences, beliefs and values. This may include a choice for a preferred place of care
- All health and social care staff should be open to any ACP discussion instigated by an individual
- Staff will require the appropriate training to enable them to communicate effectively and understand any legal or ethical issues involved
- Discussions focus on the views of the individual although they may make a request for a carer, friend, partner or relative to be involved
- ACP requires that the individual has the capacity to discuss and understand the options available to them and agree what is then planned
- Should an individual wish to make an advance decision to refuse treatment (ADRT) this should be done following the appropriate guidance.
- The wishes expressed during ACP are not legally binding but should be taken into account when professionals are required to make a decision on a person's behalf
- If there is no record of ACP or ADRT then decisions will be made in a persons Best Interests

Further information

http://www.endoflifecareforadults.nhs.uk
http://www.e-elca.org.uk

Published April 2010