NHS
Cheshire
Clinical Commissioning Group

COVID-19 COMMUNITY PREPAREDNESS

Advance Care Planning Top Tips for Care Homes

What is Advance Care Planning?

Advance Care Planning is a voluntary process of discussion about future care between an individual and their care providers. If the individual wishes, families and friends can be included in the discussion. The advance care plan should describe what is important to the person and how they wish to be treated once they lose capacity. Many care home residents and their families may already have had these discussions and have them documented in their notes.

What do we need to do now we have the threat of Coronavirus entering our care home?

The COVID-19 pandemic has a mortality rate of 3.4% on average according to the WHO, however, this mortality rate dramatically increases with increasing age to almost 15/100 patients aged 80 and over. With the number of cases rising and intensive care unit (ICU) reaching, or exceeding capacity, very difficult decisions will have to be made about who would benefit from ICU care; age will be one of the criteria.

It is anticipated that **ALL** Care Home residents will have a higher than average rate of death from coronavirus.

Therefore, it is more important than ever that each resident have a clinical plan which anticipates how they should be cared for if they become infected with COVID-19 or deteriorated due to another health condition.

Due to the enormous pressure on the NHS **we are asking for the support of care homes in initiating these discussions.**

Across Cheshire, there are a number of different forms that can record a clinical plan and maybe called different names e.g. Anticipatory Care Plan, Proactive Care Plan or Terminal Phase of Illness. (See example attached- Appendix 1)

Whatever form the Care Home and GP practices choose to use there are some common principles:

- **The residents should be supported to be involved** with 'planning for their future care' and their preferences documented. They may wish for their family of friends to be involved.

- Residents who are thought to lack capacity should have a **capacity assessment** that tests whether they are either unable to: understand the decision, or retain information to make a decision, or weigh up the pros and cons of a decision, or communicate their decision. This should be documented in a clinical plan

- If a person lacks capacity to contribute to the process, this must take place with their **legal proxy** (e.g. LPA/Welfare Attorney) if they have one, or otherwise with a close family member where at all possible. A plan can then be done in the person's best interest. The role of the LPA and family is to give an opinion of what they think the resident would have wanted if they had capacity

- Many residents will have had **DNACPR** orders completed and agreed. However these only relate to resuscitation. A clinical plan creates personalised recommendations for clinical care in a future emergency. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment

- It is important to understand that no residents or their families are able to demand treatments that healthcare staff do not believe would be likely to be beneficial or successful.

What do Care Home Staff need to do?

- Work with your **GP practices** to identify what plan you are going to use and which healthcare professionals will support you with this process. Your practices will be uploading care planning information onto a template called **EPaCCS** (Electronic Palliative Care Coordination System) so that the outcomes from these important discussions can be shared with other NHS staff

- Identify which members of Care Home staff will undertake the work and **plan an approach**. We recommend identifying those who are at highest risk (oldest + multiple medical problems) and start conversations with them first. Moving on to other care home residents thereafter.

- Explain to residents if they have capacity, or LPA's and families if they lack capacity, that coronavirus has a very high mortality rate in older people. It is important to stress that we 'Hope for the best, but plan for the worst'. The aim is to try to ensure that the resident has the **right care in the right place**, and avoid a hospital admission unless absolutely necessary. (You may find the table below useful.)

Age	Case Fatality Rate
≤ 9 years	0%
10 to 19 years	0.18%
20 to 49 years	0.32%
50 to 59 years	1.3%
60 to 69. years	3.6%
70 to 79 years	8.0%
≥80 years	14.8%

https://www.cebm.net/global-covid-19-case-fatality-rates/

- **Record** the person's preference for treatment when they become unwell. Make sure this is recorded somewhere prominent in their notes and everyone knows where to find this and ensure the GP practice is also aware of their preferences.

- Some residents or their families/LPA's may already have an **advance care plan** or end of life care plan in place to assist you in the discussion. It is necessary to check if the plan is still appropriate at this time in view of the situation with COVID-19.

- Some residents may have made an **Advance Directive to Refuse Treatment (ADRT) or 'living will',** which is a legally binding document and describes the specific treatments the resident does not want to have if they lose capacity. For examples See Compassion in Dying (https://compassionindying.org.uk/library/advance-decision-pack/)#

- As you may be working with healthcare professionals who do not know your residents use the Clinical Frailty Score (See Appendix 2) to describe what the capability of each resident was 2 weeks ago. If this is a new resident check with their family or carers. Please be aware that this scale is not suitable for people with physical or learning disabilities.

- Ensure that the healthcare professional with clinical responsibility makes a plan that is specific to the potential needs of the resident:
  A) **care or treatments to be considered** (e.g. antibiotics for a chest infection)
  B**) care or treatments that are not recommended** (e.g. not for invasive ventilation).

  If a person has an **LPA for (health and welfare)** it's important to know if it is registered and includes making decisions about **life sustaining treatment**. When talking to residents families ensure that you document which person you spoke to by name, rather than just stating 'daughter'

- Make sure that the wording used is appropriate for all community, ambulance and acute hospital staff to read, understand and be guided by. **Good communication is key** with the person, relative and care home staff alike.

- Make sure records include those involved in discussing this plan and essential emergency contacts.

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FAQ

1. What happens if a resident or family member demands that DNACPR is undertaken or that a hospital admission is required?

The first course of action is to ensure that the resident/family/LPA understand what is being recommended and why. This is a highly emotional time for everyone and people are frightened. Explain that we are aiming to try to protect people from harmful situations, and care for them in the right way.
From a legal perspective, health services only need to offer treatment and care that is clinically indicated. Residents/families/LPA cannot demand treatment that is not clinically required.

2. I am worried that the conversation will upset the resident or their family.

Before starting any conversation, look through the resident's notes to see whether this kind of discussion has already taken place and what has been decided. This may be very helpful.

These conversations can be upsetting, but people are often relieved that a plan is in place and they have an opportunity to talk about things that are worrying them. It is far better to have this conversation early rather than be forced to do it in an emergency.

3. Where can I get help?

Contact: EoLP 01270 310 260 or www.eolp.org.uk

For:

- Coaching and support in starting conversations,
- Advice on documenting these in residents care plans including best interest decisions,
- Advice on sharing advance care plans across system e.g. Ambulance and Out of Hours.

For resources, see EPAIGE: www.cheshire-epaige.nhs.uk

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Enter practice details here (& print on green paper)

Anticipatory and Terminal care plan

(to be placed alongside the Lilac DNACPR form, clearly identifiable in the records)

Patient Name ……Care Provider/unit ……

This form should be used for information for care provider staff, and any on-call or visiting professional when making management decisions, and for the purposes of death confirmation in the event of a death out of hours. It forms a summary of any Advanced Care plan if available.

The above named patient is a registered patient. **I can confirm that I have had discussions with key health professionals, nursing staff, the family (where possible), and the patient themselves (where appropriate) and make the following suggestions based on Best Interest and MCA guidance:-**The patient is suffering from a palliative, terminal, degenerative or non-curable illness and as such the focus of care should be on symptomatic control rather than proactive disease investigation and management: *YES / NO*

(Please list the relevant diagnoses)

……

1. The patient is best managed at this care home, with an emphasis on symptom control, dignified care, familiar staff and surroundings, and maintaining comfort and pain control. *YES / NO*

   (*this should be discussed in advance with the patients next of kin (if possible) and nursing staff)*
   Please note any exceptions to this plan……

2. In the event of a sudden deterioration, should the patient be admitted to hospital? **note: this may not apply to suspected fracture/trauma or uncontrolled bleeding.* *YES / NO*

   (if symptoms/illness cannot be controlled in care home, this should be at the discretion of the assessing doctor)

3. In the event of a treatable acute condition which may accelerate deterioration (e.g. UTI, resp. tract infection), should the patient be actively treated to alleviate symptoms? *YES / NO*

4. Preventative, prophylactic medications and interventions should be withheld to allow nature to take its course and allow a natural death *YES / NO*

5. In the event of a cardiac arrest, should attempts to resuscitate this patient be made? *YES / NO*

   (*this should be discussed in advance with the patients next of kin (if possible) and nursing staff, and an appropriate "Lilac" DNACPR form be in place. Further information regarding this decision should be outlined in the DNACPR form)*

6. In the event of the natural death of this patient, I would, as the regular GP, be comfortable classifying the death as "expected", and permit nurse verification of death where possible. *YES / NO*

GP Name: Signature: Date / /

Nurse/Senior Carer Name: Signature: Date / /

NOK/RPR/IMCA name: Signature: Date / /

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Appendix 2

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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