

# Advance Care Planning by phone or video

This framework has been designed to support GPs to have advance care planning conversations with patients by phone or video, in the context of COVID-19. It is a tool to help you have honest and open conversations. It is not a script.

You can use existing appointments or touchpoints, such as wellbeing calls, as an opportunity to initiate advance care planning conversations. Sections in *italics* offer ways to start conversations and ask questions about your patient's wishes. You can use some or all of them, or you may wish to use your own words.

## Starting the conversation

### Explain why you are calling

- ✓ *I'm giving you a call because of what's going on with coronavirus. Because of your [particular health condition], if you were to get the virus we think you could become very unwell.*
- ✓ *I want to find out more about what's important to you and the type of care you would want if you become ill. Understanding what matters to you means that we can care for you better.*

### Check-in with them

- ✓ *How are you doing with all this?*
- ✓ *Have you been thinking about how coronavirus might affect you?*

## Understanding what matters to the person

- ✓ *What is important to you in your life?*
- ✓ *Is there anything you want us to know if you become very unwell with coronavirus [or your health condition] and need urgent care?*
- ✓ *Is there anything you don't want to happen to you?*
- ✓ *Where would you like to be cared for?  
[If at home] Is there anyone who could help to care for you at home?*
- ✓ *Who are the important people in your life that you'd like to be involved?*
- ✓ *Who could we talk about your care with if you become too unwell to tell us what your wishes are? Do you think they understand what matters to you? Please explain that the relative won't be able to make decisions.*

## Explaining treatments

This section provides information to explain what different treatments involve, and how likely they are to be helpful. Please consider factors such as the person's pre-existing health conditions and/or frailty, and local guidance when having conversations about treatment options. This will help ensure that the information given is accurate and appropriate for that person as an individual.

Remember that critical care will not be appropriate for some people. If unsure, you can talk to secondary care colleagues.

If the person is unlikely to benefit from critical care, framing the conversation as 'protecting' them may be useful.

For example:

✓ *I understand that this might be a worrying time for you, but I'd like to talk with you about how we can make sure you're **protected** from invasive treatment if you were to get coronavirus. In your situation, this kind of treatment might not work or could leave you with a worse quality of life.*

### Explaining treatments and outcomes in hospital and critical care

The Royal College of Physicians' critical care guidelines have useful patient-facing information, including what happens in critical care and expected outcomes following critical care. You can read them [here](#).

## CPR

If someone wants to refuse CPR, or you believe that CPR is likely to be futile or not in the person's best interests, you should complete a DNACPR form or the ReSPECT process (more details on the next page).

You should explain what CPR entails and why you think it is unlikely that it would be successful for that particular person. You must always discuss DNACPR with the person and/or the important people to them, unless doing so is likely to cause the patient "physical or psychological harm". Compassion in Dying's [factsheet](#) includes patient-facing information to explain CPR and DNACPR decisions.

# Recording wishes

Please follow local protocols for recording wishes. A range of tools are included below, not all of which are used in every locality.

If you are based in London, make sure you record all decisions about your patients' treatment and care in a Coordinate my Care (CMC) record. This will mean it can be accessed by NHS colleagues providing emergency care including community nurses, hospital teams, out-of-hours doctors, specialist nurses, London Ambulance Service and NHS 111.

Remember to get consent from the patient before creating a CMC record.

## Recording the person's preferences about their care, including where they would like to be cared for:

### ✓ An Advance Statement

An Advance Statement includes anything that is important to someone in relation to their health or wellbeing, such as their daily routine and what is important to their quality of life. Your patient can complete this on their own if they choose. It should be uploaded to their medical record, and added as an attachment to their CMC record if they have one. You can find an Advance Statement form [here](#) or an online version [here](#).

### ✓ A Coordinate My Care (CMC) record (London-based)

CMC is an urgent care plan which contains information about the patient, their diagnosis and medication, key contact details of their regular carers and clinicians, and their personal preferences across a range of possible care circumstances.

### ✓ A MyCMC plan

Patients can create their own CMC record, called a [My CMC](#) plan, online. Once they have filled in their details, they need to book a telephone appointment with their GP or nurse, who will add clinical details and recommendations, and upload their plan to the CMC system.

## Recording CPR decisions

If someone wants to refuse CPR, or you believe that CPR is likely to be futile or not in the person's best interests:

✓ you should complete a DNAR form or complete the ReSPECT process

✓ the patient can make an Advance Decision to Refuse Treatment detailing this refusal (more details below)

The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express decisions, including CPR decisions. Not all areas use ReSPECT. Please check local guidance.

## Recording the patient's wish to refuse treatment

### ✓ An Advance Decision to Refuse Treatment

An Advance Decision to Refuse Treatment (ADRT, also called Advance Directive or Living Will) allows a person to write down any treatments they don't want to have in the future, including CPR, in case they later become unable to make or communicate decisions. An ADRT is only used if the person loses capacity to make the treatment decision in question. If it meets certain requirements it is legally binding and healthcare professionals must follow it. You can find an ADRT form [here](#) or your patients can complete one online [here](#).

# Sharing a completed Advance Decision to Refuse Treatment

## You should:

- ✓ Scan and upload a copy to the person's medical records
- ✓ Add the relevant SNOMED code: Advance care planning 816301000000100
- ✓ Add as an attachment to the person's CMC record, if they have one

## The patient should:

- ✓ Share with important people (family/friends) and any other healthcare professionals involved in their care, such as the local ambulance trust, consultant and out of hours team

## Giving a trusted person authority to make health decisions

### ✓ Lasting Power of Attorney for Health and Welfare

A Lasting Power for Attorney for Health and Welfare (LPA) allows someone to give a person they trust the legal power to make decisions if they lack capacity to make decisions for themselves. An LPA must be made and registered with the Office of the Public Guardian (OPG). There is a cost involved. They do not need to use a solicitor. The forms are available here, and an online version is here. It may take longer than usual to register the forms due to COVID-19.

Compassion in Dying has developed online information to help people make decisions about treatment for COVID-19:

W [www.compassionindying.org.uk/coronavirus](http://www.compassionindying.org.uk/coronavirus)

Compassion in Dying's free nurse-led information line supports people to make the decisions that are right for them:

T 0800 999 2434

## Thank you to the GPs who supported the development of this publication:

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This resource has been developed in response to the needs of our GP partners in light of COVID-19. It will be reviewed regularly, so if you feel it could be improved or adapted to better suit your needs, please get in touch.

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## We can help you prepare for the end of life. How to talk about it, plan for it, and record your wishes. Have any questions? Talk to us.

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