Unit 58: Understand Advance Care Planning

Unit reference number: A/503/8135
Level: 3
Unit type: Optional
Credit value: 3
Guided learning hours: 25

Unit summary

The aim of this unit is to give learners an understanding of the principles of and approaches to advance care planning.
Learning outcomes and assessment criteria

To pass this unit, the learner needs to demonstrate that they can meet all the learning outcomes for the unit. The assessment criteria outline the requirements the learner is expected to meet to achieve each learning outcome.

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<th>Learning outcomes</th>
<th>Assessment criteria</th>
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<tbody>
<tr>
<td>1 Understand the principles of advance care planning</td>
<td>1.1 Describe the difference between a care or support plan and an Advance Care Plan</td>
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<td></td>
<td>1.2 Explain the purpose of advance care planning</td>
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<td>1.3 Identify the national, local and organisational agreed ways of working for advance care planning</td>
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<td>1.4 Explain the legal position of an Advance Care Plan</td>
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<td>1.5 Explain what is involved in an ‘Advance Decision to Refuse Treatment’</td>
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<td>1.6 Explain what is meant by a ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) order</td>
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<td>Learning outcomes</td>
<td>Assessment criteria</td>
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</table>
| **2** Understand the process of advance care planning | 2.1 Explain when advance care planning may be introduced  
2.2 Outline who might be involved in the advance care planning process  
2.3 Describe the type of information an individual may need to enable them to make informed decisions  
2.4 Explain how to use legislation to support decision making about the capacity of an individual to take part in advance care planning  
2.5 Explain how the individual’s capacity to discuss advance care planning may influence their role in the process  
2.6 Explain the meaning of informed consent  
2.7 Explain own role in the advance care planning process  
2.8 Identify how an Advance Care Plan can change over time  
2.9 Outline the principles of record keeping in advance care planning  
2.10 Describe circumstances when you can share details of the Advance Care Plan |
| **3** Understand the person-centred approach to advance care planning | 3.1 Describe the factors that an individual might consider when planning their Advance Care Plan  
3.2 Explain the importance of respecting the values and beliefs that impact on the choices of the individual  
3.3 Identify how the needs of others may need to be taken into account when planning advance care  
3.4 Outline what actions may be appropriate when an individual is unable to or does not wish to participate in advance care planning  
3.5 Explain how individual’s care or support plan may be affected by an Advance Care Plan |
Unit content

What needs to be learned

Learning outcome 1: Understand the principles of advance care planning

Difference between a care or support plan and an Advance Care Plan

- A care or support plan identifies and meets the day-to-day and general needs of individuals, covering any aspect of health and/or social care.
- Advance Care Plans:
  - clarify an individual’s wishes in relation to end of life care, support and treatment, for example preferred place of death, funeral arrangements, and specific requests for their care as they are dying and following death
  - consider the context of deterioration expected in the individual's condition in the future
  - consider the individual’s loss of capacity to make decisions and/or ability to communicate their wishes to others
  - is a process of discussion between an individual and people who provide care.

The purpose of advance care planning

- To clarify individual's wishes, needs and preferences in relation to end of life care, support and treatment.
- Based on the value of 'open awareness' and 'autonomy'.
- Deliver care to meet identified needs.
- To support individuals at any age or stage of health.
- Contribute to understanding and sharing individual’s values, life goals, and preferences regarding end of life care, support and treatment.
- Can lead to an individual making an advance statement, an Advance Decision to Refuse Treatment (ADRT), a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision and appointing a Lasting Power of Attorney.

National, local and organisational agreed ways of working for advance care planning

- Working practices to follow for ensuring that the individual is respected.
- Approaches to introducing and carrying out advance care planning.
- Ways of working to ensure privacy and dignity are maintained.
- Data protection, recording, reporting, confidentiality and sharing information.
- Actions to take if an individual requests that they would like to make or change their will.
- Ensuring that practitioners, family/carers are aware if an individual has made a living will.
- Action to take when an individual lacks capacity to make decisions about their care or treatment.
- Working practices to follow for ensuring how the personal property of the deceased person will be kept secure, and to whom it may be released.
- Practices to follow for the removal of medical equipment from deceased individual.
What needs to be learned

The legal position of an Advance Care Plan

- Not legally binding.
- Good practice determines that wishes set out in an Advance Care Plan are adhered to.
- Healthcare team will try to follow individual’s wishes and take the document into account when deciding what is in their best interests.

An ‘Advance Decision to Refuse Treatment’

- An Advance Decision to Refuse Treatment:
  - legally binding as long as it meets the legal requirements of the Mental Capacity Act 2005
  - makes others aware of individual’s wishes if, at a later date, they are not able to make decisions themselves
  - can be made by anyone over 18 who is able to make decisions for themselves
  - must be reviewed regularly to ensure it meets individual’s changing and current wishes.

‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) order

- Document:
  - stating that an individual does not want to have cardiopulmonary resuscitation (CPR)
  - issued and signed by a doctor
  - not legally binding
  - provides guidance on the action to take or not take if the individual has a cardiac arrest or dies suddenly.

Learning outcome 2: Understand the process of advance care planning

When advance care planning may be introduced

- Can be determined at any stage of life but generally following diagnosis of a serious/life-limiting illness.
- Voluntary and not mandatory process.
- Can be introduced by healthcare team.
- Individual can start process themselves.

Who might be involved in the advance care planning process

- The individual.
- Family/carers/friends.
- Healthcare professionals.
- Doctors/GP.

Information an individual may need to enable them to make informed decisions

- Options available.
- Priorities.
### What needs to be learned

- Service options and availability.
- Timescales involved.
- Who is involved.
- Cost and time implications.
- Implementation/achievement time.
- Risk involved.

### Using legislation to support decision making about the capacity of an individual to take part in advance care planning

- The Mental Capacity Act 2005:
  - protects and empowers individuals who may lack the mental capacity to make their own decisions about their care and treatment
  - applies to people aged 16 and over
  - states that capacity involves being able to make a particular decision at the time it needs to be made
  - an individual is deemed to lack capacity if they are unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain
  - if an individual lacks capacity, an assessment of capacity, as set out in section 2 and section 3 of the Mental Capacity Act 2005, must be carried out.

### Individual’s capacity to discuss advance care planning and influence on the process

- Level of understanding and comprehension at that moment in time.
- Willingness and ability to be involved.
- Capability to process information provided.
- Level of involvement determined by capacity.
- Approach to rational decision making.
- Awareness of the need to discuss advance care plan.

### Informed consent

- Individuals are given clear and easy to understand information to help them make the right decision for their healthcare.

### Own role in the advance care planning process

- Supporting and reassuring individual and their family/carers.
- Supporting healthcare team.
- Explaining process, responding to questions and uncertainties.
- Monitoring the condition of the individual.
- Reporting/recording changes to individual’s wishes.
- Liaising with individual/family/carers/healthcare team.
<table>
<thead>
<tr>
<th>What needs to be learned</th>
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<tbody>
<tr>
<td><strong>How an Advance Care Plan can change over time</strong></td>
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<tr>
<td>• Change of views/wishes.</td>
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<tr>
<td>• Change to wellbeing.</td>
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<td>• Deterioration in capacity.</td>
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<tr>
<td>• Inclusion of relatives/carers’ views.</td>
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<tr>
<td>• Death or loss of someone key to the Advance Care Plan.</td>
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<td>• Advancement of treatments.</td>
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<tr>
<td><strong>The principles of record keeping in advance care planning</strong></td>
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<tr>
<td>• Records to be stored securely.</td>
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<tr>
<td>• Completed fully and legibly.</td>
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<tr>
<td>• Use of guidance in relation to content of Advance Care Plan.</td>
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<td>• Confidentiality protocols to be maintained.</td>
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<td>• Only shared if individual agrees to disclosure.</td>
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<td>• Nothing recorded should be used in decision making until the individual can no longer make decisions.</td>
</tr>
<tr>
<td><strong>When details of the Advance Care Plan can be shared</strong></td>
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<tr>
<td>• If individual agrees.</td>
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<td>• When the condition of the individual deteriorates, and the Advance Care Plan is necessary.</td>
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<tr>
<td><strong>Learning outcome 3: Understand the person-centred approach to advance care planning</strong></td>
</tr>
<tr>
<td><strong>Factors an individual might consider when planning their Advance Care Plan</strong></td>
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<tr>
<td>• Their current health and mental wellbeing.</td>
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<td>• Their priorities.</td>
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<tr>
<td>• Past/other experiences of healthcare.</td>
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<tr>
<td>• Family/carer involvement and wishes.</td>
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<td>• Service availability.</td>
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<td>• Appointing a Lasting Power of Attorney.</td>
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<tr>
<td>• Completing an Advance Decision to Refuse Treatment (ADRT) and a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision.</td>
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<tr>
<td><strong>Importance of respecting the values and beliefs that impact on the choices of the individual</strong></td>
</tr>
<tr>
<td>• Respecting each person as an individual.</td>
</tr>
<tr>
<td>• Each individual has their own identity, needs, wishes, choices, beliefs and values.</td>
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<tr>
<td>• The choices made are important to the individual.</td>
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</tbody>
</table>
**What needs to be learned**

- Person-centred way of working.
- Individual feels in control; they have planned using their values and beliefs.
- Concerns about practical issues relevant only to that person, e.g. home life, partners, pets.

**How the needs of others may need to be taken into account when planning advance care**

- Individual’s preference or wish for others’ views will vary.
- Individual chooses what is to be taken into account, as long as they have capacity.
- Needs of others taken into account in liaison with individual.

**What actions may be appropriate when an individual is unable to or does not wish to participate in advance care planning**

- Refer to person named to speak for individual.
- Refer to power of attorney.
- If no advance care plan, healthcare practitioners must act in the individual’s best interests at all times.

**How individual’s care or support plan may be affected by an Advance Care Plan**

- Key to healthcare delivery.
- Must be referred to.
- Works in conjunction with care and support planning, service and delivery.
- Best interests.
- Changes made to Advance Care Plan should be taken note of and implemented.
Information for tutors

Suggested resources

**Books**


**Websites**

<table>
<thead>
<tr>
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<tr>
<td><a href="http://www.dyingmatters.org">www.dyingmatters.org</a></td>
<td>Dying Matters provides information and resources to increase awareness and discussions about end of life care.</td>
</tr>
<tr>
<td><a href="http://www.ncpc.org.uk/publication/planning-your-future-care">www.ncpc.org.uk/publication/planning-your-future-care</a></td>
<td>This National Council for Palliative Care guide aims to explain advance care planning to the public. It outlines the different options available to people when planning for their end of life care.</td>
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</table>
Assessment

This guidance should be read in conjunction with the associated qualification specification for this unit.

This unit is internally assessed. To pass this unit, the evidence that the learner presents for assessment must demonstrate that they have met the required standard specified in the learning outcomes and assessment criteria, and the requirements of the assessment strategy.

To ensure that the assessment tasks and activities enable learners to produce valid, sufficient, authentic and appropriate evidence that meets the assessment criteria, centres should follow the guidance given in Section 8 Assessment of the associated qualification specification and meet the requirements from the assessment strategy given below.

Wherever possible, centres should adopt an holistic approach to assessing the units in the qualification. This gives the assessment process greater rigour and minimises repetition, time and the burden of assessment on all parties involved in the process.

Unit assessment requirements

This unit must be assessed in accordance with the Skills for Care Assessment Principles.

Learners can enter the types of evidence they are presenting for assessment and the submission date against each assessment criterion. Alternatively, centre documentation should be used to record this information. This unit must be assessed in accordance with the Skills for Care Assessment Principles.