NHS Lanarkshire

Hospital Anticipatory Care Plan

CHI no .....
First name ..... DOB ..... /..... /.....
Last name ..... Sex: ☐ M ☐ F
Address .....
.....
.....
or attach addressograph label here

TREATMENT ESCALATION / LIMITATION PLAN, SUITABLE FOR PATIENTS WITH FRAILTY AND /OR MULTIPLE CO-MORBIDITIES

Other forms are available on First Port (At Point of Admission, Advanced Malignancy, Cardiology, COTE, Dementia, Liver Disease, Orthopaedics, Renal, Respiratory and Surgery).

The Hospital ACP is indicated when one or more of the following applies:

- The patient is unstable with the possibility of deterioration.
- He / she has severe frailty / is completely dependent for ADLs / has progressive / end stage organ failure / multiple co-morbidities / advanced cancer.
- He / she has specific wishes regarding medical interventions.
- Treatment limitation in the event of a crisis / deterioration would be in the patient's best interests and would avoid harm.

- **Discussion with the patient** and their family, welfare attorney or important others regarding this Plan is strongly advised. DNACPR discussions in isolation are potentially unhelpful. If a discussion is not possible, the HACP should be completed if it is in the patient's best interests to do so, and it would potentially harmful not to do so.
- Consideration should be given to the issue of **mental capacity.** The provisions of the AWI Act (Scotland) 2000 apply.
- An HACP should be completed prior to making an **ICU or Palliative Care referral.**
- Information in an **existing ACP** / KIS / Palliative Care Summary should be used.

An HACP must be used concurrently when a DNACPR order is being put in place

GOALS OF CARE It is often helpful to write down the **treatment aims** in your own words:

.....

Immediately **reversible problems should be addressed.** Management should **always include symptom control** if the patient is in pain, nauseated, breathless or distressed.

TREATMENT ESCALATION / LIMITATION PREFERENCES

FOR FULL ESCALATION, INCLUDING CPR ☐

DO NOT ATTEMPT CPR | **ESCALATE / LIMIT TREATMENTS using options below** ☐

ROUTINE BLOOD TESTS	YES / NO	NIL BY MOUTH (if yes, document reason in Hospital Notes)	YES / NO
ABG ANALYSIS	YES / NO	PROCEDURES / INVESTIGATIONS (state)	
IV ACCESS	YES / NO	.....	YES / NO
IV FLUIDS (with time limit if appropriate)	YES / NO	TRANSFER TO HDU	YES / NO
SUBCUT. FLUIDS	YES / NO	TRANSFER TO ICU / POSSIBLE MECHANICAL VENTILATION	YES / NO
IV A'BIOTICS (with time limit if appropriate)	YES / NO	OTHERS	
ORAL ANTIBIOTICS	YES / NO	.....	YES / NO
COMFORT FEED	YES / NO	.....	YES / NO
BLOOD TRANFUSION	YES / NO		

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Person completing this document

Signature:..... **Print in Capitals:**.....

Position:..... **Date:**.....

Authorised by (consultant responsible)..... **Initials and date**.....

Date of commencing **this** HACP .....

This HACP is .... (please circle) NEW / UPDATE on a previous HACP

- **Capacity issues have been addressed and documented in the Hospital Notes** **YES**
- **The Plan has been discussed with the patient / family / POA** **YES / NOT POSSIBLE**
- **Discussion about prognosis and management is ongoing** **YES / NOT POSSIBLE**
- **Name of family member / designated other with whom this has been discussed:**
  .....

Guidance Notes

Aims The HACP is designed:

1a. to provide CONTINUITY OF CARE and good communication especially for on-call staff out of hours.

1b. to provide information about, as well as appropriate limitations to, interventions which are likely to be FUTILE AND / OR BURDENSOME OR CONTRARY TO THE PATIENT'S WISHES. Interventions in these categories are unethical.

1c. to MINIMISE HARM due to overtreatment or undertreatment.

1d. to provide for shared decision-making as much as possible in the context of acute or acute-on-chronic illness.

Consultation

2a. The treatment Plan will, where at all possible, have been discussed and agreed with the patient, and / or their family / carers or legally appointed representative. The record of all discussions / decisions requires to be documented separately in the Hospital Notes. This includes reasons for "NOT POSSIBLE".

2b. Futile interventions need to be discussed with the patient / family only if they are designated in law to be life-saving e.g. surgical operation, CPR. If they are in this category, but are considered futile, the reasons for not offering this intervention still need to be discussed.

2c. You should consider whether the patient has MENTAL CAPACITY to be involved making decisions. Refer to Adults with Incapacity (Scotland) Act (2000)). Complete an AWI Section 47 form if necessary. Impairment of capacity does not preclude use of the HACP if it is in the patient's best interests to put one in place.

2d. There may be an existing Anticipatory Care Plan (ACP) (refer to Palliative Care Register, or Key Information Summary (KIS)). Existing ACP provisions should be respected and honoured, though its provisions may need to be updated.
2e. The provisions of the HACP may be initiated by trainee doctors or senior charge nurses but will be guided by and are the responsibility of the lead consultant.

Ethics and medico-legal issues

3a. The HACP is not a binding advanced directive.

3b. The HACP does not provide for the withdrawal of any treatment.

3c. The medico-legal requirements for HACP are identical to those that apply to DNACPR. NHSL medical directors recommend that an HACP should always be used along with a DNACPR. DNACPR without an HACP is associated with a 3-fold increase in patient harms.

Practice

4a. A standard DNACPR form should still be completed. The HACP form is not a replacement for the DNACPR even although reference to CPR is made.

4b. The intervention options list in each disease-specific HACP is not a "menu" but a prompt. Careful consideration should be given to other interventions or procedures that may not be listed but are either appropriate or inappropriate.

4c. The relevant consultant / senior clinician must review and sign the plan within 24 hours of its completion. He / she carries ultimate responsibility for its provisions.

4d. The HACP should be placed at the front of the patient's hospital record, along with the DNACPR order.

4e. The Plan should be reviewed regularly during an admission. Do not make multiple entries on to a plan - replace the existing one with an updated fresh one.

4f. The plan only applies to the current admission. At the time of any subsequent admission a new HACP should be completed. Any old Plan should have OBSOLETE written across it in block capitals with date and initials.

4f. If / when the patient is discharged HACP decisions should be referred to in the discharge summary and communicated to the GP. If possible, its provisions should be recorded in the Key Information Summary. Where appropriate a copy may be provided to the patient / GP for future use.