**Advance Care Planning (ACP) v7** (Regnard C, Randall F. 25 Feb 2008)

ACP is a process of discussion between an individual and their care providers irrespective of discipline. If the individual wishes, their family and friends may be included. With the individual’s agreement, discussions should be documented, regularly reviewed and communicated to key persons involved in their care (Advance Care Planning: a Guide for Health and Social Care Staff).

This algorithm should be used in conjunction with national guidance on ACP (www.endoflifecareforadults.nhs.uk)

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**Are you the right person to do this?**

- *No*  
  - If you are uncertain or lack knowledge of the patient’s clinical condition or their reaction to their illness, do not proceed.  
  - Ask a colleague who does have this knowledge to lead the ACP discussion.

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**Does the patient have an impairment of mind or brain?**

- *Yes*  
  - Assess the patient’s capacity using the four tests in the Mental Capacity Act.  
  - If the patient does not have capacity for advanced planning, then the clinical team will need to make choices based on the patient’s best interests as defined in the MCA.  
  - If they have capacity for advance planning, continue the ACP.

- *No*  
  - Ask the patient if they want to change their previous priorities for care.  
  - Ask permission to see any documentation if this is available.

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**Is this the first ACP discussion in this patient?**

- *No*  
  - Review the situation regularly.  
  - Check again when the patient’s circumstances change and the patient wishes to discuss future care.

- *Yes*  
  - Many patients with early or slowly progressing disease, and some with advanced disease, will not wish to discuss end-of-life care. However, they should still receive the opportunity to discuss other aspects of their future care.  
  - Ensure that the ACP discussion and documentation do not include questions or statements about end-of-life care.

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**Does the patient want to discuss their future care?**

- *No*  
  - Do not use an ACP document to record this decision.  
  - Discuss with the patient the option of completing an Advance Decision to Refuse treatment (ADRT) according to the Mental Capacity Act.

- *Yes*  
  - Many patients with early or slowly progressing disease, and some with advanced disease, will not wish to discuss end-of-life care. However, they should still receive the opportunity to discuss other aspects of their future care.  
  - Ensure that the ACP discussion and documentation do not include questions or statements about end-of-life care.

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**Is the patient ready to discuss end-of-life care?**

- *No*  
  - Ask open questions, eg. (from Preferred Priorities for Care, 2007 www.endoflifecareforadults.nhs.uk)  
    - Q. In relation to your health, what has been happening to you?  
    - Q. What are your preferences and priorities for your future care?  
    - Q. Where would you like to be cared for in the future?  
  - Allow the patient to control the flow of all information, ie. if they do not want to discuss an aspect of their future care, defer that question to another time.

- *Yes*  
  - Do not use an ACP document to record this decision.  
  - Discuss with the patient the option of completing an Advance Decision to Refuse treatment (ADRT) according to the Mental Capacity Act.

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**Does the patient want to refuse future treatment?**

- *No*  
  - Review the situation regularly.  
  - Check again when the patient’s circumstances change and the patient wishes to discuss future care.

- *Yes*  
  - Many patients with early or slowly progressing disease, and some with advanced disease, will not wish to discuss end-of-life care. However, they should still receive the opportunity to discuss other aspects of their future care.  
  - Ensure that the ACP discussion and documentation do not include questions or statements about end-of-life care.

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**Does the patient want this discussion documented?**

- *No*  
  - Document only that the discussion has taken place.  
  - Review the patient’s advance priorities - when the patient requests a review OR  
    - when the patient’s circumstances change

- *Yes*  
  - Write the priorities for care in the patient’s records. If specific documentation is used, do not use one that is restricted to end-of-life for a patient who does not want to discuss this aspect of their care.  
  - Ask the patient if and to whom they want copies given, eg. care teams, family.  
  - Write to all professionals to tell them the discussion has taken place and where copies are to be kept. Give the original to the patient to keep.  
  - Document the date of all subsequent changes.