The differences between general care planning and decisions made in advance

Advance care planning (ACP) is a process of discussion between an individual and their care providers irrespective of discipline.

The difference between ACP and planning more generally is that the process of ACP is to make clear a person’s wishes and will usually take place in the context of an anticipated deterioration in the individual’s condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others. ACP may lead to making:

- An advance statement
- An Advance Decision to Refuse Treatment (ADRT)
- A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision
- Other types of decision, such as appointing a Lasting Power of Attorney.

With the person’s permission, all those concerned with their care and wellbeing should be kept informed of any decisions which impact upon care. All care requires an ongoing, continuing and effective dialogue between the individual, their carers, partners and relatives. This is essential to inform general care planning, and is necessary to elicit any decisions the person wishes to make in advance, and to check whether those decisions have changed.

However, general care planning is not the same process as advance care planning. This chart clarifies the differences between general care planning, and three decisions that can be made in advance: advance statements, ADRT and DNACPR decisions.
## The differences between general care planning and decisions made in advance

<table>
<thead>
<tr>
<th>General Care Planning</th>
<th>Advance Care Planning (ACP) – advance statement</th>
<th>Advance Decisions to Refuse Treatment (ADRT)</th>
<th>Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is covered?</strong></td>
<td>Can cover any aspect of current health and social care.</td>
<td>Can cover any aspect of future health and social care.</td>
<td>Can only cover refusal of specified future treatment. May be made as an option within an advance care planning discussion.</td>
</tr>
<tr>
<td><strong>Who completes it?</strong></td>
<td>Can be written in discussion with the individual who has capacity for those decisions. or Can be completed for an individual who lacks capacity in their best interests.</td>
<td>Is written by the individual who has capacity to make these statements. May be written with support from professionals, and relatives or carers. Cannot be written if the individual lacks capacity to make these statements.</td>
<td>Completed by a clinician with responsibility for the person. Consent is sought only if an arrest is anticipated and CPR could be successful. Can be completed for an individual who does not have capacity if the decision is in their best interests.</td>
</tr>
<tr>
<td><strong>What does it provide?</strong></td>
<td>Provides a plan for current and continuing health and social care that contains achievable goals and the actions required.</td>
<td>Covers an individual’s preferences, wishes, beliefs and values about future care to guide future best interests decisions in the event an individual has lost capacity to make decisions.</td>
<td>Only covers refusal of future specified treatments in the event that an individual has lost capacity to make those decisions.</td>
</tr>
<tr>
<td><strong>Is it legally binding?</strong></td>
<td>No – advisory only.</td>
<td>No – but must be taken into account when acting in an individual’s best interests.</td>
<td>Yes – legally binding if the ADRT is assessed as complying with the Mental Capacity Act and is valid and applicable. If it is binding it takes the place of best interests decisions about that treatment.</td>
</tr>
<tr>
<td><strong>How does it help?</strong></td>
<td>Provides the multidisciplinary team with a plan of action.</td>
<td>Makes the multidisciplinary team aware of an individual’s wishes and preferences in the event that the person loses capacity.</td>
<td>Makes it clear whether CPR should be withheld in the event of a cardiac or respiratory arrest.</td>
</tr>
<tr>
<td><strong>Does it need to be signed and witnessed?</strong></td>
<td>Does not need to be signed or witnessed.</td>
<td>A signature is not a requirement, but its presence makes clear whose views are documented.</td>
<td>For refusal of life sustaining treatment, it must be written, signed and witnessed and contain a statement that it applies even if the person’s life is at risk.</td>
</tr>
<tr>
<td><strong>Who should see it?</strong></td>
<td>The multidisciplinary team as an aid to care.</td>
<td>The person is supported in its distribution, but has the final say on who sees it.</td>
<td>Clinical staff who could initiate CPR in the event of an arrest.</td>
</tr>
</tbody>
</table>
For further information

National End of Life Care Programme

- Capacity, care planning and advance care planning in life limiting illness
- Advance Decisions to Refuse Treatment: a guide for health and social care professionals
- Planning for your future care and Preferred Priorities for Care (PPC) documentation and resources
- Thinking and planning ahead – learning from each other: a volunteer training programme about advance care planning
- Practical guidance for best interests decision making and care planning at end of life
- Guidance documents to support the national information standard ‘End of Life Care Co-ordination: Core Content (ISB 1580)’, which was approved in March 2012.

www.endoflifecareforadults.nhs.uk

e-Learning

e-ELCA contains over 150 sessions on all aspects of end of life care, including a course of sessions focusing on advance care planning. e-ELCA is free to access for health and social care staff.

www.e-lfh.org.uk/projects/e-elca

Mental Capacity Act

- Mental Capacity Act Code of Practice
- Information booklets and additional guidance

www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

National Council for Palliative Care

- The Mental Capacity Act in Practice
- Good Decision Making – The Mental Capacity Act and End of Life Care

www.ncpc.org.uk/publications

Resuscitation Council (UK)

- Decisions relating to cardiopulmonary resuscitation – Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing

www.resus.org.uk/pages/dnar.htm

Royal College of Physicians

- Concise Guidance to Good Practice – Advance care planning

http://bookshop.rcplondon.ac.uk/details.aspx?e=267

Advance Decisions to Refuse Treatment

- Information and guidance

www.adrt.nhs.uk

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