NHS Lanarkshire

Name.....

CHI number.....

Patient information label here

Hospital Anticipatory Care Plan (HACP)

At the point of hospital admission

The Hospital ACP is indicated in the following circumstances:

- When a patient has severe frailty, progressive organ failure, multiple co-morbidities or advanced / end stage cancer.
- The patient is likely to be in the last year of life.
- The patient (or legally appointed representative) has specific wishes regarding end-of-life care.
- Treatment limitation in the event of a crisis / deterioration would be in the patient's best interests and would avoid harm.
- When DNACPR is considered appropriate and is about to be documented.

Does the patient have Capacity?

YES ❑ NO ❑

If not, then the provisions of the Adults With Incapacity Act (Scotland) 2000 apply. Discuss with next of kin, welfare attorney or important others and document accordingly

Are any of the following active or already in place?

Community ACP / eKIS ❑
Advance Refusal of Treatment ❑

If so, refer to it before completing this Care Plan

Having assessed the patient, including prognosis, now indicate their resuscitation status / preference by checking the relevant box:

FOR FULL ESCALATION, INCLUDING CPR ❑
DO NOT ATTEMPT CPR ❑

If the patient is 'DNACPR', now indicate the most appropriate care option:

Standard ward based care * ❑

HDU level of care and possibility of NIV, CPAP, inotropes, etc. ❑

Consider ITU referral and possible mechanical ventilation ❑

For end of life care. Symptomatic and comfort measures only

*Specific investigations, interventions or treatments which are considered appropriate or inappropriate e.g. IV fluids / antibiotics, surgical procedure, transfer for imaging (state clearly; if none, state "NONE").

APPROPRIATE .....

INAPPROPRIATE .....

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Discussion and documentation

This plan has been discussed with: PATIENT Yes❑ No❑
FAMILY / CARERS Yes❑ No❑
RECEIVING SPECIALTY Yes❑ No❑

All discussions should be documented in the patient's admission record. If discussion has not been possible for any reason this should also be recorded. Refer to the Guidance Notes below prior to completing this section.

Person completing this document

…….. (Signature) …… (Print Capitals)

…… (Position ……. (Date) ……. (Time)

Consultant Responsible …… (Initials and date) ……

Guidance Notes

1) This form is relevant at the time of a specific acute admission – if appropriate it can be replaced by a condition specific HACP advanced malignancy, cardiology, dementia, frailty /COTE, liver disease, surgery, orthopaedics, renal, respiratory – available on First Port) once the patient is admitted.
2) *Ethics* HACP is not a binding advanced directive. It does not provide for the withdrawal of any treatment. It may need to be reviewed and modified as the clinical situation evolves. It is designed:
   a) to provide CONTINUITY OF CARE and good communication especially out of hours and/or if the patient deteriorates further.
   b) 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.
   c) to MINIMISE HARM due to overtreatment or under-treatment.
3) Immediately reversible problems should always be identified and addressed e.g. pneumothorax in COPD, acute confusion in previously alert patient.
4) Management should ALWAYS INCLUDE SYMPTOM CONTROL if the patient is in pain, nauseated, breathless or distressed, irrespective of the diagnosis. Where necessary refer to the Palliative Care Guidelines for help with management: http://www.palliativecareguidelines.scot.nhs.uk/ and prescribe appropriately. Further advice can be obtained from the Macmillan nurse (Ext 4656) or the duty doctor at St Andrews hospice. (Phone 01236 766951). Active consideration should be given to the need for spiritual care.
5) *Consultation a*) Family involvement should be encouraged and supported in patients who are severely ill.
   b) The treatment plan will, where possible and appropriate, have been discussed and agreed with the patient, family / carers or legally appointed representative. You should consider whether the patient has capacity to make these decisions (refer to the Adults with Incapacity (Scotland) Act 2000). Complete an AWI Section 47 form if necessary. Impairment of capacity does not preclude use of HACP.
   c) The provisions may already have been documented in an earlier Anticipatory Care Plan (ACP), Palliative Care Register, or Key Information Summary (KIS). Refer to these.
   d) In general, futile treatments do not need to be discussed with the patient / family unless they are designated in law to be life-saving e.g. surgical operation, CPR.
   e) The medico-legal requirements for HACP are identical to those that apply to DNACPR. The substance of discussions/ decisions requires to be documented separately in the hospital notes.
   f) The relevant consultant / senior clinician must review and sign the plan within 24 hours of its completion.
6) *Availability and continuity* a) The HACP should be placed at the front of the patient's hospital record, along with the DNACPR order (if there is one).
   b) The Plan should be reviewed during an admission. The plan only applies to the CURRENT admission. At the time of any subsequent admission a new HACP should be completed. The old one should have OBSOLETE written across it in block capitals with date and initials.
7) 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.