UT COMPLIANCE

A TRADING NAME OF UNIQUE TENDERS LIMITED

POLICY DOCUMENT

Advance Care Planning Policy

UT Compliance

DOMICILIARY CARE

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CONFIDENTIAL DOCUMENT

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1. Scope

1.1 Purpose

This Advance Care Planning (ACP) Policy establishes the framework for supporting service users to make informed decisions about their future care and treatment. Advance care planning is a voluntary process that enables individuals to articulate their values, preferences, and wishes regarding future care, ensuring these are documented, communicated, and respected even if they later lose the capacity to make or communicate decisions. This policy aligns with the NHS England Universal Principles for Advance Care Planning, the Mental Capacity Act 2005, and CQC Fundamental Standards.

1.2 Application

This policy applies to all individuals involved in providing or supporting domiciliary care services at , including:

- All employees, including care workers, supervisors, and management who engage with service users
- Agency staff and temporary workers providing care
- Volunteers who interact with service users
- Contractors and third-party providers involved in care delivery
- Service users, their families, carers, and advocates participating in the ACP process

1.3 Services Covered

This policy applies to all aspects of domiciliary care where advance care planning may be relevant:

- Personal care and daily living support, respecting individual preferences for routines, personal boundaries, and levels of support
- Health and medical management, including preferences for treatment interventions, pain management, and emergency care
- End-of-life care, including preferred place of care and death, symptom management, resuscitation preferences, and spiritual or cultural needs
- Emergency care planning, including use of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms
- Coordination with healthcare professionals, hospitals, and other care providers

1.4 What is Advance Care Planning?

Advance care planning is a voluntary process of person-centred discussion between an individual and their care providers about preferences and priorities for future care. It is not a single event but an ongoing conversation that may result in:

- An Advance Statement of wishes and preferences (not legally binding but must be considered)
- An Advance Decision to Refuse Treatment (ADRT) – legally binding when valid and applicable
- Appointment of a Lasting Power of Attorney (LPA) for Health and Welfare

- A ReSPECT form documenting recommendations for emergency care and treatment
- A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision

1.5 Policy Ownership and Review

This policy is owned by the Registered Manager () who has overall accountability for ensuring ACP practices comply with legal, regulatory, and best practice requirements. The policy is reviewed annually or following significant legislative changes, regulatory updates, or organisational learning.

2. Legal and Regulatory Framework

operates within a comprehensive legal framework governing advance care planning:

Legislation/Regulation	Requirements
Mental Capacity Act 2005	Establishes the legal framework for decision-making for people who lack capacity. Enshrines the five principles of capacity assessment. Provides legal basis for Advance Decisions to Refuse Treatment and Lasting Powers of Attorney. Requires best interests decisions when a person lacks capacity.
Mental Capacity Act Code of Practice	Statutory guidance on implementing the Mental Capacity Act. All professionals must have regard to the Code. Provides detailed guidance on capacity assessment, best interests decisions, and advance care planning.
Health and Social Care Act 2008	Establishes the regulatory framework for health and social care. Sets standards for quality, person-centred care ensuring service users' preferences are respected and documented.
Care Act 2014	Promotes individual wellbeing and emphasises person-centred care. Requires local authorities and providers to consider individuals' views and wishes. Supports individuals to be involved in decisions about their care.
CQC Regulation 9 (Person-Centred Care)	Mandates that care is designed to meet individual needs and preferences. ACP is a key mechanism for ensuring care reflects what matters most to the person. Requires care to reflect preferences for end-of-life care.
CQC Regulation 11 (Need for Consent)	Requires consent to be obtained before care is provided. Supports individuals to make informed decisions about their care. Advance Decisions must be respected where valid and applicable.
CQC Regulation 12 (Safe Care and Treatment)	Requires providers to assess risks to health and safety. ACP helps ensure care in emergencies aligns with the person's wishes and clinical appropriateness.
CQC Regulation 17 (Good Governance)	Requires accurate, complete, and accessible records. ACP documentation must be maintained and shared appropriately.
CQC Regulation 20 (Duty of Candour)	Requires openness and transparency. If an ACP or advance decision is not followed and harm results, the duty of candour applies.
Equality Act 2010	Ensures all individuals have equal access to ACP discussions regardless of protected characteristics. Requires reasonable adjustments for those with disabilities to participate in planning.

Human Rights Act 1998	Article 8 (right to private and family life) supports autonomy in healthcare decisions. Article 3 (freedom from degrading treatment) relates to end-of-life dignity.
UK GDPR and Data Protection Act 2018	Governs secure handling of sensitive ACP information. Requires appropriate consent for sharing information. Provides individuals with rights over their personal data.
NHS England Universal Principles for ACP	National guidance setting out best practice for advance care planning. Emphasises voluntary, person-centred approach. Aligned with ReSPECT process and other local tools.

3. Definitions of Key Terms

The following terms are used throughout this policy:

Term	Definition
Advance Care Planning (ACP)	A voluntary process of person-centred discussion enabling individuals to explore, consider, and express their values, wishes, and preferences for future care, particularly for times when they may lack capacity to make or communicate decisions.
Advance Statement	A written statement of the person's wishes, preferences, beliefs, and values regarding future care. Not legally binding but must be taken into account in best interests decisions.
Advance Decision to Refuse Treatment (ADRT)	A legally binding decision made by an adult with capacity to refuse specific medical treatment in future circumstances when they lack capacity. Must meet specific validity requirements. Also known as a Living Will or Advance Directive.
Lasting Power of Attorney (LPA) for Health and Welfare	A legal document allowing a person (donor) to appoint one or more attorneys to make decisions about their health and personal welfare when they lack capacity. Must be registered with the Office of the Public Guardian before use.
ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	A process creating a summary of agreed recommendations for a person's clinical care in emergency situations. Not legally binding but provides clinical guidance. Includes CPR recommendations.
DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)	A clinical decision recorded in advance that CPR should not be attempted if the person's heart or breathing stops. Does not affect other treatment. May be incorporated into ReSPECT.
Mental Capacity	The ability to make a specific decision at a specific time. A person lacks capacity if they cannot understand, retain, use or weigh information, or communicate their decision. Capacity is decision-specific and time-specific.
Best Interests	The principle under the Mental Capacity Act that decisions made for a person who lacks capacity must be in their best interests, considering their past and present wishes, beliefs, values, and other relevant factors.
End-of-Life Care	Care provided in the final months, weeks, and days of life, focusing on comfort, dignity, and quality of life. Includes symptom management, emotional and spiritual support.

Treatment Escalation Plan (TEP)	A plan documenting which treatments and interventions are appropriate for an individual, providing guidance particularly for out-of-hours and emergency situations.
Preferred Priorities for Care (PPC)	A document enabling people to record their preferences for end-of-life care, including preferred place of care and death.
Cardiopulmonary Resuscitation (CPR)	Emergency treatment including chest compressions and artificial ventilation attempted when a person's heart or breathing stops. Success rates vary depending on circumstances.
Donor (LPA)	The person who creates a Lasting Power of Attorney, granting authority to their chosen attorneys.
Attorney (LPA)	A person appointed under a Lasting Power of Attorney to make decisions on behalf of the donor when they lack capacity.
Valid and Applicable (ADRT)	An ADRT is valid if made by an adult with capacity, not withdrawn, and made voluntarily. It is applicable if it relates to the treatment in question and circumstances that have arisen.

4. Policy Statement

4.1 Commitment

is committed to supporting every service user's right to make informed decisions about their future care. We believe advance care planning is a fundamental aspect of person-centred care, empowering individuals to express what matters most to them and ensuring their wishes are known and respected. We recognise that ACP is always a voluntary process and individuals must never feel pressured into having these conversations or making decisions.

4.2 Core Principles

adheres to the following principles aligned with the NHS England Universal Principles for ACP:

- Voluntary Process: ACP is always voluntary. People must not feel forced or rushed, nor denied the opportunity for these discussions in future
- Person-Centred: ACP conversations start with exploring what matters to the person – who and what are important to them, their values, beliefs, and what quality of life means to them
- Respecting Autonomy: Each person's right to make their own decisions is respected, including the right to decline treatment
- Supported Decision-Making: People are supported to make their own decisions with accessible information and appropriate support
- Inclusive of Others: Family, friends, and carers may be involved if the person wishes, but the person's right to choose who to involve is respected
- Ongoing Process: ACP is not a one-off event. Conversations and plans can be revisited and updated as circumstances change
- Clear Documentation: All ACP outcomes are documented clearly and shared appropriately so they can be accessed when

needed

- Cultural Sensitivity: Personal values, beliefs, and culture are respected throughout ACP discussions

4.3 Service User Rights

Service users have the right to:

- Have the opportunity to discuss their wishes for future care
- Decline to participate in advance care planning
- Change their mind and update their preferences at any time while they have capacity
- Have their valid Advance Decision to Refuse Treatment respected
- Appoint an attorney under a Lasting Power of Attorney
- Have their cultural, spiritual, and religious needs considered
- Have their ACP information kept confidential and shared only with their consent or as required by law

5. Roles and Responsibilities

Clear allocation of responsibilities ensures effective implementation of advance care planning:

Role	Responsibilities
All Staff	Understand the principles of ACP and their role in supporting it. Recognise opportunities to initiate ACP conversations sensitively. Respect and implement documented preferences. Report any concerns about ACP implementation. Complete mandatory ACP training.
Registered Manager ()	Overall accountability for ACP policy implementation. Ensure staff are trained in ACP principles and practice. Oversee quality of ACP documentation and processes. Ensure ACP information is shared appropriately with other providers. Lead on complex ACP situations and escalations. Report to CQC as required.
Duty Manager	Day-to-day operational support for ACP implementation. Support staff in handling ACP discussions and documentation. Ensure ACP information is accessible when needed for care decisions. Escalate complex situations to Registered Manager.
Care Coordinators	Lead ACP discussions with service users where appropriate. Ensure ACPs are documented in care plans and accessible. Coordinate with healthcare professionals on clinical aspects of ACP. Arrange reviews of ACPs when circumstances change. Liaise with families and attorneys as appropriate.
Safeguarding Lead ()	Ensure ACP processes include appropriate safeguards. Advise on situations where there may be concerns about coercion or undue influence. Support staff in complex situations involving capacity and best interests.
Data Protection Officer ()	Ensure ACP records are handled in compliance with data protection law. Advise on appropriate sharing of ACP information. Oversee secure storage and appropriate access controls.
Health and Safety Officer ()	Assess any health and safety implications of implementing ACP preferences. Advise on safe implementation of care preferences.

6. Procedures

6.1 Initiating Advance Care Planning Discussions

ACP can be initiated at any time, though earlier is generally better. Staff should be alert to opportunities:

1. Identifying Opportunities: ACP may be appropriate during care plan reviews, following a change in health status, following a hospital admission, when a service user raises concerns about the future, or when a diagnosis is made that may affect future capacity.
2. Assessing Readiness: Not everyone is ready to have ACP conversations. Staff should sensitively explore the person's readiness without pressure. If someone declines, this should be respected and revisited at a later time.
3. Capacity Assessment: Before initiating ACP discussions, assess whether the person has capacity to engage in the conversation and make relevant decisions. Follow Mental Capacity Act principles.
4. Creating the Right Environment: Choose a comfortable, private setting. Allow adequate time. Check if the person wants anyone else present.
5. Starting the Conversation: Begin by exploring what matters to the person – their values, beliefs, what gives their life meaning. Do not start with questions about specific treatments or death.

6.2 Conducting ACP Conversations

ACP conversations should explore:

- What matters most to the person – people, activities, routines, beliefs
- What quality of life means to them
- Their understanding of their current health situation and what may happen in future
- Preferences for where they would like to be cared for and, if relevant, where they would prefer to die
- Who they would like involved in their care and decision-making
- Any specific treatments they would or would not want in particular circumstances
- Spiritual, religious, or cultural needs
- Practical matters such as care of pets, notification of specific people

6.3 Understanding Specific ACP Documents

Staff must understand the different types of ACP documentation:

Advance Decision to Refuse Treatment (ADRT):

- Legally binding if valid and applicable
- Must be made by an adult (18+) with capacity
- If it refuses life-sustaining treatment, it must be in writing, signed, witnessed, and include a statement that it applies even if life is at risk

- Healthcare professionals must follow a valid and applicable ADRT

Lasting Power of Attorney for Health and Welfare:

- Must be registered with the Office of the Public Guardian before it can be used
- Attorneys can only act when the donor lacks capacity
- Attorneys must act in the donor's best interests
- The donor may or may not have given authority to refuse life-sustaining treatment

ReSPECT Form:

- Creates a summary of agreed recommendations for emergency care
- Not legally binding but provides clinical guidance
- Should be kept with the person and taken to hospital if admitted
- Staff must know where to find ReSPECT forms for each service user and understand their content

6.4 Documenting Advance Care Plans

All ACP discussions and outcomes must be documented clearly:

- Record the date, participants, and summary of discussions in the care plan
- Document specific preferences and wishes clearly and accessibly
- Record whether formal documents exist (ADRT, LPA, ReSPECT) and where they are located
- Flag ACP information prominently so it is not missed
- Store copies of formal documents securely with appropriate access
- Share ACP information appropriately with other providers involved in care (with consent)

6.5 Reviewing Advance Care Plans

ACPs should be reviewed regularly:

- At regular care plan reviews (at least annually)
- Following significant changes in health status
- After hospital admissions or other significant events
- When the person indicates they wish to review their plan
- Following changes in personal circumstances (relationships, living situation)

6.6 Implementing Advance Care Plans

When implementing ACP in daily care and emergency situations:

- Ensure all staff providing care know about and can access ACP information

- Integrate ACP preferences into daily care delivery
- In emergencies, locate and follow ReSPECT/DNACPR forms while calling for help
- Communicate ACP information to paramedics, hospital staff, and other healthcare professionals
- If an ADRT exists, ensure healthcare professionals are aware of it
- Contact the LPA attorney if decisions need to be made and the person lacks capacity

7. Training and Development

7.1 Initial Training

All new staff receive mandatory induction training covering:

- Principles of advance care planning and person-centred care
- Mental Capacity Act principles and capacity assessment
- Different types of ACP documents (ADRT, LPA, ReSPECT, DNACPR) and their legal status
- How to sensitively initiate and participate in ACP conversations
- Documentation requirements and where to find ACP information
- Confidentiality and information sharing

7.2 Ongoing Training

Staff receive ongoing development including annual refresher training on ACP and end-of-life care, communication skills workshops for sensitive conversations, updates on changes to legislation, guidance, or local tools, and reflective practice sessions to share learning from ACP experiences.

7.3 Competency Assessment

Competency is assessed through observation of ACP discussions, review of ACP documentation quality, supervision discussions, and feedback from service users and families. Staff who need additional support receive targeted training and mentoring.

8. Monitoring and Review

8.1 Monitoring Framework

monitors ACP implementation through:

- Audits of care plans to assess whether ACP opportunities have been explored and documented
- Review of ACP documentation quality and accessibility

- Feedback from service users and families about ACP experiences
- Staff feedback on ACP training and confidence
- Analysis of incidents where ACP preferences were not followed

8.2 Quality Indicators

Key performance indicators include:

- Percentage of service users offered the opportunity to discuss ACP
- Percentage of service users with documented ACP preferences
- Percentage of ACPs reviewed in the past 12 months
- Staff training completion rates
- Service user and family satisfaction with ACP process

8.3 Policy Review

This policy is reviewed annually by the Registered Manager, considering audit findings, feedback from service users and families, staff feedback and training evaluations, legislative and guidance changes, and incidents or complaints related to ACP. Lessons learned are incorporated into policy updates and training.

9. Reporting Concerns

9.1 Staff Duty to Report

Staff must report any concerns about ACP implementation, including situations where ACP preferences are not being followed, concerns that a person may have been coerced into making an ACP decision, concerns about capacity to make ACP decisions, missing or inaccessible ACP documentation, and disagreements between family members or between family and healthcare professionals about ACP.

9.2 Reporting Channels

Concerns should be reported to the Duty Manager or Registered Manager (). Anonymous reporting is available for those who prefer it. Serious concerns about capacity or coercion should be escalated to the Safeguarding Lead. External reporting to CQC is available if internal concerns are not addressed.

9.3 Whistleblowing Protection

Staff who raise concerns about ACP practices in good faith are protected under the Public Interest Disclosure Act 1998. No staff member will suffer detriment for raising genuine concerns.

10. Related Policies

This policy should be read in conjunction with:

- Mental Capacity and Best Interests Policy
- Consent Policy
- End-of-Life Care Policy
- Person-Centred Care Policy
- Safeguarding Adults Policy
- Data Protection and Privacy Policy
- Complaints Policy
- Accessible Information and Communication Policy
- Equality, Diversity and Human Rights Policy

Document Control

Policy Title	Advance Care Planning Policy
Version	2.0
Policy Owner	Registered Manager ()
Approved By	

Appendix A: Advance Care Planning Discussion Record

ADVANCE CARE PLANNING DISCUSSION RECORD

SECTION 1: SERVICE USER DETAILS	
Name:	
Date of Birth:	
Date of Discussion:	
Location:	

SECTION 2: PARTICIPANTS IN DISCUSSION
Who was present? (include relationship to service user):

SECTION 3: CAPACITY ASSESSMENT
Does the service user have capacity to participate in ACP discussions? ? Yes ? No
If No, describe the basis for this assessment and who else was consulted:

SECTION 4: WHAT MATTERS TO THE PERSON
What matters most to them? (people, activities, values, beliefs, quality of life):

SECTION 5: CARE PREFERENCES
Preferred place of care if health deteriorates:
Preferred place of death (if discussed):
Other care preferences or wishes:

SECTION 6: FORMAL ACP DOCUMENTS

Does the person have any of the following? (tick all that apply):	
? Advance Decision to Refuse Treatment (ADRT)	? Lasting Power of Attorney (Health & Welfare)
? ReSPECT Form	? DNACPR Form
? Written Advance Statement	? None of the above
Location of documents:	

SECTION 7: AGREED ACTIONS AND NEXT STEPS

SECTION 8: RECORD COMPLETED BY			
Staff Name:		**Job Title:**	
Date:		**Signature:**	

Date for review of this ACP discussion:

Policy Approval & Review

APPROVED BY	SIGNATURE
	No signature on file
REVIEW DATE	NEXT REVIEW DATE
1 January 1970	**17 February 2027**