Hospital Anticipatory Care Plan (HACP)

Suitable for patients with irreversible chronic respiratory failure and/or multiple co-morbidities
Other forms are available on FirstPort. (Advanced Malignancy, Cardiology, Frailty, Liver Disease, General Surgery, Orthopaedics and Renal).

Patients who may benefit from an HACP when admitted to hospital include those with:

- Severe frailty, completely dependent for ADLs
- Progressive / end stage organ failure with or without multiple co-morbidities
- Advanced cancer (not receiving potentially curative treatment)
- Progressive incurable illness e.g. Dementia, MS, MND in the final stages of their illness
- Refractory abnormal observations e.g. GCS <5, BP <60 systolic, Sats <85% where the diagnosis of dying has been confirmed and documented.

- HACP should be used concurrently where a DNACPR order is being put in place.
- HACP should be used when making a Palliative Care referral.

Discussion with the patient and their family (wherever possible) regarding this Plan is important. Consideration should be given to the issue of mental capacity¹. Information in an existing ACP / KIS / Palliative Care Summary should be used. Thereafter, having assessed the patient, including prognosis, indicate the agreed decision(s) by ticking the relevant box:

FOR FULL ESCALATION, INCLUDING CPR

DO NOT ATTEMPT CPR²

Now consider and indicate the most appropriate care option(s) below (circle YES / NO). Changes can be made at any time later if necessary.

ROUTINE BLOOD TESTS
ARTERIAL BLOOD GAS ANALYSIS
ANTIBIOTICS
PREDNISOLONE
NON-INVASIVE VENTILATION (BiPAP)
TRANSFER TO HIGH DEPENDENCY UNIT
ICU / POSSIBLE MECHANICAL VENTILATION
OTHER (please state) .................................................................

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

¹ Information in an existing ACP / KIS / Palliative Care Summary should be used.
² The decision(s) made in the Plan should only be changed if the patient's mental capacity returns.
The Plan has been discussed with the patient YES / NOT POSSIBLE
Capacity issues have been addressed and documented in the Hospital Notes YES
Discussion about prognosis and management is ongoing YES / NOT POSSIBLE
Name of family member / designated other with whom this has been communicated:

Guidance Notes

1) The Hospital ACP will be used when there is acute deterioration in the patient’s principal condition, especially if the illness trajectory is one of steady decline despite optimal medical management and/or the acute presentation has the potential to become a life-threatening crisis. Its provisions will be guided by a consultant. A standard DNACPR form should still be completed. This form is not a replacement even although reference to CPR is made.

2) Ethics The 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.
   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 undertreatment.

3) IMMEDIATELY REVERSIBLE PROBLEMS SHOULD 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 Palliative Care Nurse Specialist during normal office hours, or the Duty Doctor at St Andrews Hospice at all other times. (01236 766951).

5) Consultation
   a. Family presence should be encouraged and supported in patients who are severely ill.
   b. 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. You should consider whether the patient has mental CAPACITY to be involved in and make decisions (refer to Adults with Incapacity (Scotland) Act (2000)). Impairment of capacity does not preclude use of the 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. The intervention list in disease-specific HACP is not a “menu” but a prompt. 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. He / she carries ultimate responsibility for its provisions.

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 regularly 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.