STANDARD OPERATING PROCEDURE FOR COMPLETION OF ANTICIPATORY CARE PLAN SUMMARY (ACP) AND CLINICAL FRAILTY SCALE (ROCKWOOD)

Completion of Electronic Anticipatory Care Plan Summary and Clinical Frailty Scale (Rockwood)
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Name of Reporting Group: ACP / Frailty Steering Group
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Target Audience: Older People and Primary Care Teams and Older Adult Mental Health Teams

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1. Introduction

Anticipatory Care Planning (ACP) has been identified as a national priority in Scotland to support the delivery of the 2030 vision for Health and Well Being Outcomes linked with Health and Social Care Integration. ACP responds to the challenge of providing care for a population with increasing prevalence of complex needs, long term conditions and multiple morbidities through appropriate interventions to optimise personal outcomes and quality of life.

What is Anticipatory Care Planning?

ACP is a person centred, proactive, "Thinking Ahead" approach requiring health and social care professionals to work with individuals, carers and their families to have the right conversations to plan ahead for any changes in their health or social care needs. ACP aims to put the needs and preferences of people at the centre of decisions about their care and to communicate and record this information effectively.

An ACP is a dynamic record that should be developed over time through evolving conversations, collaborative working and shared decision making.

The Benefits of ACP:

- Promotes person-centred care
- Improves the possibility for personal choice
- Empowers people to make difficult decisions
- Supports people to live in their preferred place of care
- Prepares individuals' and their families to manage on-going health issues

Who may benefit from an ACP?

- People who frequently attend Emergency Departments and Acute Assessment Units
- People with long term conditions such as COPD, Cardiac, Neurological conditions
- People diagnosed with Dementia
- Nursing / Residential care home residents and those in Intermediate Care Units
- People with a Clinical Frailty Score of 5 and above
- People discharged after an unscheduled admission to hospital
- People who are housebound through ill health
- People heavily dependent on carers (paid or unpaid)

Since 2015 different initiatives to introduce ACP into practice have been tried and tested across NHSGGC Board area with varying levels of success. It has emerged that no single

service can deliver this agenda independently; ACP requires a whole systems approach in order to improve quality of life and ensure positive outcomes are achieved.

A standardised approach has been agreed across the 6 HSCPs within NHSGGC Board area to obtaining and summarising key information from a person's ACP/ Personal Plan on an Electronic ACP Summary sharing this with GPs and other relevant practitioners involved in their care. In exceptional circumstances an editable PDF document using the same information fields will be the mode of sharing this information.

2. Scope

This Standard Operating procedure applies to all HSCP staff and to partner organisations with access to Clinical Portal who undertakes assessment within the Older People and Primary Care Services.

3. Purpose

The main objectives of ACP are to empower people to have greater awareness, control and choice regarding how their long term condition is managed and to reduce the number of unscheduled attendances and admissions to hospital. In addition ACP aims to:

- support staff to summarise key aspects of an evolving conversation between the person, their carer, their family and the practitioner
- identify collaborative interactions and produce a management plan that anticipates and addresses significant changes in a person's health and wellbeing
- record and support shared decision making and actions that could be taken to address the anticipated issue in the best possible way
- share consented information on the appropriate platform with relevant health and social care professionals
- provide ACP information to patients /clients and their families
- increase the number of people with sufficient information in their plan to allow ACP summaries currently held on clinical portal to be populated
- increase the number of completed ACP summaries shared with GPs and other relevant staff e.g. Scottish Ambulance Service
- provide information that is easily transcribed to eKIS

The national "Let's think ahead – My ACP" remains the gold standard for starting and recording views, concerns, preferences, goals and interventions and it is from this document's "My Summary" section that information is taken to populate the Electronic ACP

Summary currently available on Clinical Portal. It is acknowledged a person may have an alternative personal plan that reflects these views and as such information should be summarised from this and populated onto the Electronic ACP Summary on Clinical Portal.

4. Process

- Person is identified as benefiting from ACP
- Engage in person centred, proactive conversation introducing the person to the National ACP workbook or alternative appropriate resource
- Encourage person to complete this with support of carer and /or family capturing the individuals situation, health conditions and personal goals
- On completion seek consent from the person / carer / family where appropriate to gather a summary of this plan and share it with services involved in their care
- If consent is obtained gather a summary of this information and record on the NHSGGC Clinical Portal Electronic Anticipatory Care Plan Summary – in exceptional circumstances the editable PDF document
- The NHSGGC Clinical Portal Electronic Anticipatory Care Plan Summary will be electronically sent to the person's GP as soon as the Summary is saved or updated
- Review at predetermined junctures and time scales e.g. annually or when significant changes occur; updates following review can be completed by anyone, not necessarily by the practitioner or team who initiated the ACP
- Update the Clinical Portal if the person shares even the smallest piece of information that may support communication of wishes in terms of their care plan

5. Completion of Clinical Portal Anticipatory Care Plan Summary

See appendix: Clinical Portal – ACP Summary User Guide

A summary can be obtained from the "My ACP" summary or alternative personal plan such as Post Diagnostic Support Plan or Carers Emergency Plan. When consent is given to share, this information should be extracted and transcribed onto the Electronic ACP Summary on Clinical Portal.

DUMMYPATIENT, Eforms Three
BORN 27-Feb-1988 (31y) GENDER Female
OHCP 3333333333_CHI

Anticipatory Care Plan Summary

Last updated by Eleanor McColl on 07-Oct-2019 16:36 (v. 1)

0. Consent and Special Notes

Patient Consent	Yes	Date of consent	07-Oct-2019

This Patient has a DNACPR

Review

Date of Review	07-Oct-2019
Reviewed by	Alan Thompson
Date of Next Review	05-Oct-2020

Special Notes / What is important to the patient? Neque porro quisquam est qui dolorem ipsum quia dolor sit amet, consectetur, adipisci velit

1. Next Of Kin / Carer

Next of Kin

Title	Mr
Forename(s)	Richard
Surname	Fraser
Gender	Male
Address (inc postcode)	123 High Street, GLASGOW
Telephone Number(s)	0141 324 5432
Relationship	Husband
Keyholder	Yes

Is Next of Kin also the Carer? No

DUMMYPATIENT, Eforms Three -
3333333333_CHI (OHCP)

cfc4ec20-fc8f-4102-9758-d544d39b20aa

Carer

Title	Miss
Forename(s)	Jane
Surname	Fraser
Gender	Female
Address (inc postcode)	345 High Street, GLASGOW
Telephone Number(s)	0141 546 7654
Relationship	Daughter
Keyholder	Yes

Other Agencies Involved

Other Agencies Involved	Contact Numbers
Home Care Services	0141 324 2576

Use a person centred approach to capturing the person's situation, current issues including management plan if there is one and what matters to them, who matters to them and why it matters.
There are a number of drop down option in this section

2. Summary of Clinical Management Plan / Current Situation

Current Health Problems / Significant Diagnoses	Neque porro quisquam est qui dolorem ipsum quia dolor sit amet, consectetur, adipisci velit

Essential Medication and Equipment

Oxygen Therapy	Yes	Oxygen therapy notes	—
Anticipatory medication at home	Yes	Anticipatory medication notes	1. XYZ 2. XYZ
Continence / Catheter Equipment at home	Yes	Continence / Catheter Equipment notes	—
Syringe Pump	Yes	Syringe pump notes	—
Moving and handling equipment at home	—		
Mobility equipment at home	Yes	Mobility equipment notes	1. Internal stair lift 2. Bathroom rails 3. Raised toilet seat

There are a number of drop down boxes in this section.

3. Legal Powers

Does the individual Yes

have a Combined Power of Attorney (financial & welfare)?

Is POA in use? Yes

Name & Address of Combined POA

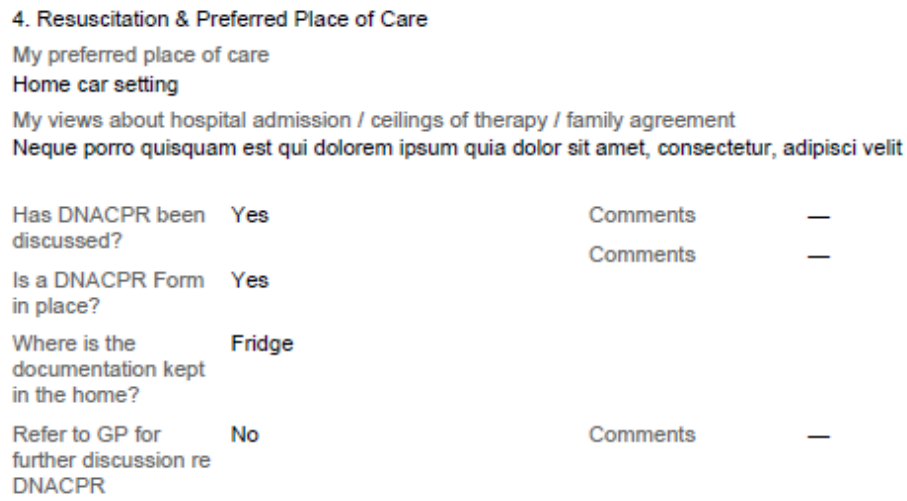
Name	Address	Part of POA Held
Ms Jane Fraser	345 High Street, GLASGOW	Both - Finance & Welfare

Is an Advanced directive in place (living will)? Yes

Is an Adult with Incapacity Section 47 held? Yes

Has a Guardianship been appointed under the Adults with Incapacity (Scotland) Act 2000? No

The person's wishes, preferences should be taken into account for example, where they wish to live or be supported. It is important to note the person's views may change over time and any changes can be made on a new or updated ACP Summary



4. Resuscitation & Preferred Place of Care

My preferred place of care

Home car setting

My views about hospital admission / ceilings of therapy / family agreement

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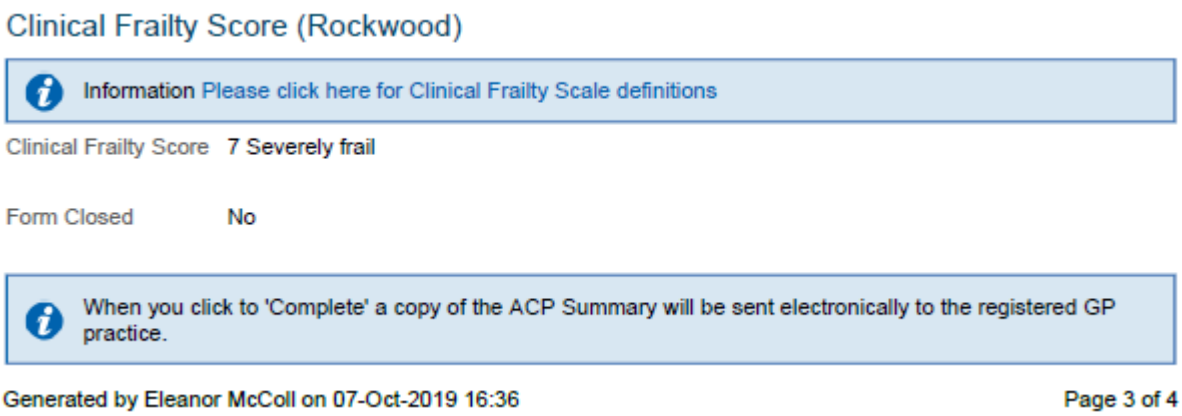
Has DNACPR been discussed?	Yes	Comments	—
Is a DNACPR Form in place?	Yes	Comments	—
Where is the documentation kept in the home?	Fridge		
Refer to GP for further discussion re DNACPR	No	Comments	—

The Clinical Frailty Scale (CFS) is a validated tool for people aged 65 years and over and is integral to the ACP summary. The CFS is an ordinal scale from 1 -9; 1 being independent and 9 end of life. It is a descriptor of levels of frailty and is applied following completion of clinical and social care assessments.



Clinical Frailty Score (Rockwood)

Information Please click here for Clinical Frailty Scale definitions

Clinical Frailty Score 7 Severely frail

Form Closed No

When you click to 'Complete' a copy of the ACP Summary will be sent electronically to the registered GP practice.

Generated by Eleanor McColl on 07-Oct-2019 16:36 Page 3 of 4

When the Electronic ACP Summary is completed or updated it will be sent automatically to the person's GP practice for their information and consideration of upload onto the Electronic Key Information Summary (eKIS). This may be printed if required. If the person resides in a Care Home this information should be sent with them in the "Red Bag" for unscheduled attendances / admissions to hospital.

6. Policy links:

- 2030 / Vision - https://www.gov.scot/publications/nursing-2030-vision-9781788511001/
- Health and Social Care Integration https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2016/12/health-social-care-delivery-plan/documents/00511950-pdf/00511950-pdf/govscot%3Adocument/00511950.pdf
- NHSGGC Moving Forward Together – http://www.movingforwardtogetherggc.org/moving-forward-together/
- NHSGGC eHealth Digital Strategy – https://www.nhsggc.org.uk/about-us/digital-as-usual/digital-strategy-outlook-2018-2022/
- National Anticipatory Care Plan Toolkit- https://ihub.scot/project-toolkits/anticipatory-care-planning-toolkit/anticipatory-care-planning-toolkit