Frimley Health and Care

What is an Advance Care Plan?

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What is an Advance Care Plan?

Advance care planning is a voluntary process of discussion about your future care between you and those who provide your care, for example a nurse, doctor, care home manager or a family member. It is a non-legally binding document to record your preferences and wishes for your future. You can decide who you want to involve in this conversation; it is good to involve those important to you, including family and carers, but your right to choose who to involve will be respected and supported.

Your Advanced Care Plan booklet should be held by you, but it should be discussed with your health care professionals so that when you become ill and have need of care and treatment all those involved in supporting you know your wishes. A copy of this booklet should be kept with your health records.

Advance care planning is as important for Children & Young People and their families. Information and the Advance Care Plan document can be found on the Children and Young People Advance Care Plan website: cypacp.uk/

For more information please see the 'Frimley Advance Care Plan' leaflet

When to start an Advance Care Plan

An Advance Care Plan can be instigated at any time by an individual or their healthcare professional. However, it may be triggered by an event such as:

- The death of a family member or close friend
- A new diagnosis of a life limiting disease
- A change in the progress of an existing health condition
- New treatment options to consider
- The need to consider a different care setting
- A change in personal circumstances (e.g. retirement)
- A change within your family

How do I make and Advance Care Plan?

Your healthcare professional may have already suggested making an Advance Care Plan, however, you do not need to wait for someone to ask you.

Your Healthcare professional can talk with you about your wishes and thoughts, and help you understand the different medical options available to you. You may also wish to discuss your Advance Care Plan with those close to you. This will make them aware of your wishes, and help to make sure that people around you know what you would like to include.

What should it include?

Your Advance Care Plan should include anything that is important to you in relation to your future care. These can range from very serious decisions to more day-to-day things. This can help with an understanding of who you are as a person by letting them know what is important to you, your likes and dislikes and your feelings and wishes about different things.

Things to consider including:

- Where you would like to be cared for
- Any religious or spiritual beliefs that you would like to be respected
- Whether you would like to appoint someone to make decisions on your behalf if you are no longer able to (a lasting power of attorney)
- The names of those people you would like to involve in discussions about your care and treatment
- The types of treatment you would like to receive, or not receive
- Medications you would like to continue or stop and not receive

  Examples of medications to stop/not receive:

  - ☐ Medications used with renal dialysis
  - ☐ Chemotherapy
  - ☐ Antibiotics
  - ☐ Artificial nutrition and hydration including tube feeding

- Examples of medications to start/continue:

  - ☐ Medication that can make you feel comfortable, e.g. medication for pain or nausea

Benefits of advance care planning

- Help everyone, irrespective of age or state of health to begin to think about their future
- Improves end of life care by enabling a person's wishes to be fulfilled
- Help you, your family, carers and health professionals understand what is important to you
- Provides an opportunity for you to discuss and record your wishes in writing
- Ensure that your priorities will be considered and respected as guiding principle
- Enables you views and wishes to be respected if you cannot make decisions
- An understanding of where you would like to receive your care and treatment

Can I change my mind?

Your feelings and preferences may change over time; it is advisable to review your plan regularly to ensure it still reflects your wishes. You can either complete a new Advance Care Plan booklet or sign and date any alterations and let your health care professional know about the changes.

Everybody involved in these conversations understands that these conversations change over time. The conversation should not routinely be a one-off event. Even when the urgency of an emergency situation requires an immediate conversation, further opportunity to discuss, review and update your wishes will be offered.

Take your Advance Care Plan to all your healthcare appointments and please tell them if you have made any changes.

The Advanced Care plan maybe in conjunction with the ReSPECT conversation.

What is ReSPECT?

ReSPECT

a Recommended Summary Plan for Emergency Care and Treatment

Your health care professional may suggest that the information in your Advance Care Plan be summarised in **ReSPECT**, a **Recommended Summary Plan for Emergency Care and Treatment**. This can be stored in your NHS computer records so all health professionals can be aware of your wishes. This may include GP, ambulance services, district nurses, hospitals, care homes, domiciliary care staff, specialist teams involved in your care, out of hour's services, and those important to you who may be contacted in an emergency.

The **ReSPECT** process allows you and your healthcare professional to create a summary of personalised recommendations for your clinical care in a future emergency in which you do not have capacity to make or express choices. This is intended to respect both your preferences and clinical judgement. Clinical recommendations recorded include a recommendation on whether or not Cardiopulmonary Resuscitation (CPR) should be attempted.

Your **ReSPECT** plan is created through conversations between yourself and one or more of the healthcare professionals involved in your care. It may be used across a range of health and care settings, including your own home, ambulances, a

care home, a hospice or a hospital. This allows professionals, such as ambulance crews, out-of-hours doctors, care home staff and hospitals to be able to make decisions about your emergency care and treatment if they have prompt access to your agreed clinical recommendations on a **ReSPECT** plan.

Your **ReSPECT** plan should be kept with you and be available immediately to health and care professionals who are faced with making immediate decisions in an emergency in which you have lost capacity to participate in making those decisions.

Other things to think about
Putting your affairs in order

Ensuring your paperwork and documents are up-to-date and easy to locate can save time and reduce anxiety for your family/next of kin if you are unable to attend to your affairs, or if you become ill, or suddenly die.

It is important to nominate someone you can trust who will be able to access these details if the need arises.

The checklist below can act as a reminder that you have thought about and recorded in a safe place the items detailed:

- ☐ Arrangements/documents relating to dependent children/adults
- ☐ Bank name/Account details (including debit/credit cards)
- ☐ Insurance policies
- ☐ Name and details of any health insurance

- [ ] Pension details
- [ ] Passport
- [ ] Documents relating to naturalisation or asylum status
- [ ] Birth/Marriage certificate
- [ ] Mortgage or landlord details
- [ ] Deeds of property
- [ ] Hire purchase agreements or information relating to other debts
- [ ] Will
- [ ] Other important documents/contacts e.g. solicitor
- [ ] Details of any funeral arrangements or preferences
- [ ] Addresses and contact number of family, friends and colleagues
- [ ] Tax office address and contact details
- [ ] Pets
- [ ] If access to computer required ability to access system
- [ ] Other important information

Some terms explained

- **Lasting Power of Attorney (LPA) Personal Welfare**

  This allows you (if you are over 18) to choose someone to make decisions about your health care and welfare. This includes decisions to refuse or consent to treatment on your behalf. These decisions can only be taken on your behalf when you lack capacity to make decisions yourself. This is legally binding document. All LPAs must be registered with the Office of the Public Guardian to be valid.

  www.lastingpowerofattorney.service.gov.uk/home

- **Advance Decision to Refuse Treatment**

  An advance Decision to Refuse Treatment (previously known as a Living Will or Advance Directive) is a legally binding document which allow you to make a decision to refuse a specific type of treatment.

  Sometimes you may want to refuse a treatment in some circumstances but not others. If so, you must specify all the circumstances in which you want to refuse a particular treatment.

  There are rules if you wish to refuse treatment that is potentially life sustaining, for example ventilation. An Advance Decision to refuse this type of treatment must be put in writing, signed and witnessed.

  An Advance Decision to Refuse treatment will only be used if at some time in the future you lose the ability to make your own decisions about your treatment.

  www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/

- **Allowing Natural Death** (Do Not attempt Cardiopulmonary Resuscitation (DNA CPR)

  As part of your **ReSPECT** discussion, your health care professional may discuss your wishes around Cardiopulmonary Resuscitation (CPR). This is an emergency treatment which tries to restart a person's heart or breathing when it has stopped suddenly i.e. interrupting the natural death process. CPR only works in certain situations. People who were previously well and who have specific types of cardiac arrest are much more likely to respond. In people with very serious, advanced illness only about one in a hundred who receive CPR will recover enough to leave hospital.

  The ultimate responsibility for the decision usually rests with the consultant in hospital or your GP at home or care home, although you, your family and or your healthcare proxy may be consulted as appropriate.

  If CPR is not appropriate this will not prevent you receiving other appropriate treatments for your comfort and dignity.

  www.resus.org.uk/respect/respect-healthcare-professionals

For Further information

Your Health Care Professionals involved in these conversations will be prepared and have most of the information you might need available. If they are not able to answer your questions during the conversation, they will seek further information or involve other colleagues as appropriate. A range of resources and relevant information are available to support you with your planning. This includes culturally appropriate resources, information being available in easy read versions and in different languages etc.

Information on advance care planning is available in a booklet called "Planning for your future" booklet produced by the NHS. You may be given a copy of the booklet by your health care professional as part of your discussion before completing an Advance Care Plan or you can download a copy from the NHS website.
www.nhs.uk/livewell/endoflifecare/documents/planning_your_future_care%5B1%5D.pdf

Advance Care Planning: www.nhs.uk/conditions/end-of-life-care/why-plan-ahead/

Planning ahead for your future treatment and care:
www.mydecisions.org.uk

Frimley Health and Care

If you require translated copies of this booklet, please email: frimleyicb.endoflifecare@nhs.net

Frimley Health and Care website: www.frimleyhealthandcare.org.uk

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