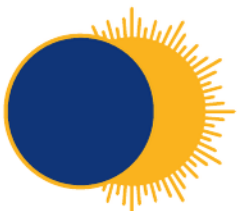




# My advance care plan



Royal Hospital for  
Neuro-disability

## Introduction

Advance care planning describes the conversation between you, your family, friends and carers about your future wishes and priorities for care. Although it is not legally binding, an advance care plan provides a helpful format for others to know your wishes in the event you are unable to tell them yourself.

This advance care plan booklet is for you to:

- think ahead and tell others what is important to you in relation to your values, care and treatment
- write down what you would want healthcare professionals, family and friends to know if you were no longer able to tell them yourself
- have a chance to think about the care you want towards the end of your life

The booklet can be completed by family, friends, loved ones or carers if you cannot do so yourself. It can be completed over a period of time and you can make any changes at any point if your wishes change. If you are completing this booklet on someone else's behalf, it is important to share what you think they would want known as their wishes and preferences to the best of your knowledge.

It is advised that you discuss the medical treatment sections with your doctors before you complete them. Your medical team will then take this information into consideration when deciding your future medical treatment.

This form:

Has been completed in the persons best interests

Has been completed by the person it concerns

**Person completing form:**

**Relationship:**

## My details

Name  Date of birth  /  /

NHS number

Have you completed an advanced care plan in the past?  Yes  No  Unknown

If yes, please provide details:

I have an Advanced Decision to Refuse Treatment  Yes  No

(if yes, a copy is to be placed on RHN Electronic Mental Capacity System)

I have a Lasting Power of Attorney (LPA) for health and welfare  Yes (please provide details below)  No

Name

Relationship   No, but I would like one

Phone number

Address

I have a LPA for property and financial affairs  Yes (please provide details below)  No

Name

Relationship   No, but I would like one

Phone number

Address

I have a Court Appointed Deputy for personal welfare  Yes (please provide details below)  No

Name

Relationship   No, but I would like one

Phone number

Address

[Redacted address field]

I have an Independent Mental Capacity Advocate (IMCA)

Yes (please provide details below)

No

Name

Relationship

Phone number

Address

No, but I would like one

[Redacted address field]

## Relationships

My preferred first point of contact:

Name

Relationship

Phone number

Address

[Redacted address field]

I understand that my preferred contact person has no legal status in clinical decision-making, but they will be consulted and informed.

The important people in my life include:

Full name	Relationship	Date of birth
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Family members involved in Advance

Full name

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Healthcare professionals involved in Advance Care Planning discussions:

Full name

Role


My care should **not** be discussed with the following people:

Full name

Relationship


## About Me

### Key information about me

Please let us know about yourself and the things that are important to you:

## My health

When people ask me about my condition, this is what I tell them:

These are the things that make my life worth living:

## My religion

My faith or belief is:

- No religion    Christianity    Islam    Judaism    Hinduism    Sikhism    Buddhism  
 Other (please specify):

I would like to talk to someone about my faith or beliefs    Yes    No

## My spiritual and cultural values

If nearing death, I would like the following religious or spiritual rituals, or the following customs and practices:  
(eg do you have any practices or traditions that are important to you?)

## My future lifestyle choices

How I would like to spend my spare time here:

(eg music you listen to, the sorts of books you like to read, any social activities you'd like to try)

The things I'd most like to do in the future:

If there was one thing I'd like to do before I die, it would be:

## Statements of wishes and care preferences

My future clinical care will be reflected in a Treatment Escalation Plan decided with my doctors, in consultation with statements that I have expressed in this Advance Care Plan.

I would like someone to help me discuss my future with my family and friends  Yes  No  
If yes, who might that be?

The elements of care important to me now, and which I believe still will be in the future, include:  
(eg good communication, dignity, comfort, pain relief, presence of loved ones)

Where I would like to receive care, if possible:  
(eg the RHN, your own home, hospital, a nursing home)

Where I would like to receive care, if possible, if my condition deteriorates:  
(eg the RHN, your own home, hospital, a nursing home)

I would like the following people to visit me if I am nearing death:  
(You could also mention people you wouldn't like to see)

If I am nearing death, I would like my family and friends to know and remember the following:

If I am close to death, these things are important to me:  
(eg, loved ones present, religious or cultural practices, music, to be comfortable and pain free)

If my health deteriorates, I might worry about:

If my health deteriorates, I **wouldn't** want  
(eg feeding tube, ventilation, to go to hospital)

If my health deteriorates, I **would** definitely want

**If given a choice, I would prefer:**

- medications that allow me to stay alert but might not completely relieve my pain
- medications that relieve my pain but might make me drowsy

**If given a choice, I would prefer:**

- surgical procedures that may extend my life but leave me with impaired mobility and discomfort
- no surgical procedures, whereby I live for a shorter period with an improved quality of life

Some treatments are life sustaining. This means without them the person would die. Some people do not want these life sustaining treatments to continue if their condition or quality of life deteriorates. Some people want their life sustaining treatment to continue as long as possible regardless of their functional ability or quality of life.

If I was in that situation, I would want:

- treatments to continue regardless of my ability and quality of life
- treatments to stop to allow me to die if the following applied to me. Please provide examples (e.g. unable to communicate, unable to recognise your family, were more physically impaired, if you needed a ventilator or tracheostomy, etc.)

Additional thoughts and comments

## What I'd like to happen when I die

Organ donation is now automatic in the UK, would you like more information on how to opt out?

Yes  No

I have made a will  Yes  No

If **yes**, answer: my will is held by \_\_\_\_\_

If **no**, answer: I'd like to speak to someone about making a will  Yes  No

I have made funeral arrangements  Yes  No

I have a pre-paid funeral plan  Yes  No

If **yes**, answer: my pre-paid funeral plan is held by:

The type of service I would like to have – including funeral director, the type of service, where it would be held, music, flowers, and donations – would be:

When I die, I would like to be:

Buried  Cremated  Other (please specify): \_\_\_\_\_

Other details I would like, such as where to be buried, for my ashes to be inured or scattered:

## Signature of the person completing the Advance Care Plan (ACP)

Depending on your condition and capacity to make decisions, please fill out whichever of these sections is most relevant to you.

### A

I confirm that this is an accurate record of my healthcare preferences and will only be used when I am unable to express my preferences.

Print name

Date  /  /  Signature

Witness name

Date  /  /  Signature

I confirm that this is an accurate record of my healthcare preferences and will only be used when I am unable to express my preferences.

Print name

Date  /  /  Signature

Witness name

Date  /  /  Signature

**B**

If you are unable to physically sign this form, but have indicated agreement with this information verbally or by some other means, please can this box be ticked instead:

Witness name

Date  /  /  Signature

**C**

When this care plan has been completed in 'best interests', the signature of the person completing this booklet is required:

Witness name

Role

Date  /  /  Signature

Once complete, please share with the someone from the treating team. They will scan and upload the document to the electronic record so that health professionals can access as needed.

## Glossary of terms

### Advance Statement

An advance statement is a written statement that sets down your preferences, wishes, beliefs and values regarding your future care. The aim is to provide a guide to others who may have to make decisions in your best interest if you have lost the capacity to make decisions or to communicate them. It is not legally binding but professionals must make practical efforts to follow these wishes.

### Advanced Decision to Refuse Treatment

This is a legally binding document. An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision you can make now to refuse a specific type of treatment at some time in the future. For more information, a leaflet is available upon request.

It lets your family, carers and health professionals know your wishes about refusing treatment if you're unable to make or communicate those decisions yourself. You essentially make a decision for yourself, in the future, when you may no longer be able to make one at the time. The treatments you're deciding to refuse must all be named in the advance decision.

### CPR

CPR stands for cardio-pulmonary resuscitation. It's a lifesaving medical procedure which is prescribed for someone whose breathing and/or heart suddenly stops. It helps to mechanically pump blood from the heart by external compressions or electric shocks around the person's body when their heart can't.

### DNACPR

DNACPR stands for Do Not Attempt Cardio-Pulmonary Resuscitation. The DNACPR form is also called a DNACPR order. A DNACPR form is a document issued and signed by a doctor, which tells your medical team not to attempt cardiopulmonary resuscitation (CPR). For more information, a leaflet is available upon request.

### Lasting Power of Attorney

A Lasting Power of Attorney (LPA) is a legal document that lets you (the 'donor') appoint one or more people (known as 'attorneys') to help you make decisions or to make decisions on your behalf. This gives you more control over what happens to you if you have an accident or an illness and can't make your own decisions (when you 'lack mental capacity'). For more information, a leaflet is available upon request.

You must be 18 or over and have mental capacity (the ability to make your own decisions) when you make your LPA.

There are two types of LPA:

- health and welfare
- property and financial affairs

You can choose to make one type or both.

## Mental Capacity Act 2005

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions.

## Acknowledgements

The Royal Hospital for Neuro-disability would like to acknowledge the following in development of this Advance Care Plan booklet:

- Royal Trinity Hospice
- Gold Standards Framework
- ReSPECT
- [www.nhs.co.uk](http://www.nhs.co.uk)
- [organdonation.nhs.uk](http://organdonation.nhs.uk) (for more information and to opt out)





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