



Having Future Care Planning Conversations - A Guide For Staff

Future Care Planning helps us make care and treatment plans that respect people's wishes and preferences. We use the word "DISCUSS" to help everyone remember the different topics that are part of Future Care Planning.

You might not think it is appropriate to discuss some of these topics right now, or you might think other staff may be better at explaining some of these issues. That is okay. Make sure you refer people for further conversation with relevant services.

What could we "DISCUSS"?

D Decisions

We should talk to people and those that matter to them to check they understand everything that we are talking about. We may need to provide additional information or change the way we communicate to help them understand. We also need to think about capacity and involve any Power of Attorney. If they do not have a Power of Attorney we should suggest this and offer them more information (www.nhsggc.scot/planningcare).

I Interventions

We should talk to people and those that matter to them about things we could do to help them, as well as things they might not like to happen. We would also talk to them about treatments that we don't think would be good for them.

S Social Relationships

We should talk to people and those that matter to them about what kind of informal support friends, family members of neighbours currently give. We should discuss if there is any additional support these unpaid carers may need and possibly refer them to Carer Support Service (visit www.nhsggc.scot/carers for more information). We should involve carers in these conversations, however if the person has capacity then it is up to them to decide what we can share with others. We should ask the person who they want to be involved in these discussion, and if there is anyone who they do not want involved.

C CPR

Cardiopulmonary Resuscitation (CPR) is a process which tries to restart someone's heart. In most cases it will not be successful. We should talk to people and those that matter to them about whether this might be appropriate for them and how they feel about it.

U Understanding You

We should talk to people and those that matter to them about what makes them happy and brings comfort. This might be things like religion or faith, but could also involve how they like to spend their time and the "little things" that bring them joy.

S Surroundings

We should talk to people and those that matter to them about where they would like to receive care and treatment. This could be short or long term treatment. We may also need to talk to them about where they would like to receive end of life care. This might be at home, hospital, a hospice or a nursing or residential home.

S Services

We should talk to people and those that matter to them about services that may already help them in their day to day life, or other services that could be useful. This might be a clinical service like district nurses, or a social care service like homecare. It could also be support services like Carer Support Services or local community support.

Where to document this discussion?

You can use the Clinical Portal Summary to record any discussions or decisions that are made during an Future Care Planning conversation. You can access this via Clinical Portal, or complete the interactive PDF version.

How to use the Summary and DISCUSS topics

This is a copy of the PDF version on the Summary. The sections are identical to those on Clinical Portal.

I Interventions

- Special Notes
- Current Health Problems
- My views about admissions / views about treatment and interventions

D Decisions

- Special Notes (Communication needs)
- Significant Diagnosis (capacity)
- Adults with Incapacity
- Power of Attorney

C CPR

- My views about admissions / views about treatment and interventions
- Resuscitation

We are sharing this information for routine patient care as part of our Board's duty to provide healthcare to our patients. Under article 6(1)(e) of the UKGDPR and in conjunction with the Intra NHS Scotland Sharing Accord, we do not require consent to share this information. However, it is best practice for staff to make sure the individual and/or their legal proxy is aware this information will be shared when conducting Future Care Planning conversations. If the patient would like further information about how the Board uses their data it can be found in our Privacy Notice here: <https://www.nhs.uk/patients-and-visitors/faq/data-protection-privacy>

Date of Review:	Date of Next Review:
Reviewer:	HSCP/Directorate:
	Job Family:

0. Reason for Plan and Special Notes

Reason for Plan (Please note, this is mandatory)

Trigger for plan	Patient Requested	Long Term Condition Diagnosis/Progression
(please select one)	Family/Carer/POA Requested	Receiving Palliative Care
	Professional Requested	Moved to Residential/Nursing Home
	Frailty Identified	Other (please specify):

Frailty Score

Please select Frailty Score* from list: 0 - Not Applicable
If frailty assessment is not applicable, please select '0 - Not Applicable'.

*Clinical Frailty Scale Guidance can be found on last page or scan this QR code

Special Notes / What is important to the individual?

Overview of person including family circumstances, accommodation information, health goals, what matters to them, emergency planning information etc. If person is a carer, or has informal carers please state. If person lacks capacity ensure this is recorded alongside who has been present during any discussions.

1. Demographics

Person's Details

Title:	Gender	M	F	CHI:
Forename (s):	Surname:			
Date of Birth:				
Address inc. Postcode:				
Tel No:				
Access Information e.g. key safe:				

GP / Practice details

GP/Practice Name:	
Address inc. postcode:	
Telephone No:	

Next of Kin

Title:	Gender	M	F	Relationship:	Keyholder?	Yes	No		
Forename (s):	Surname:								
Address inc. Postcode:									
Tel No:									
Is Next of Kin also Carer?								Yes	No

Carer

All staff have a duty to identify carers as soon as possible and inform them of their right to support. Carers can be referred to local Carer Support Services Contact details of local carers services can be found at www.nhs.uk/carers (carers can also self-refer if they wish).

Title:	Gender	M	F	Relationship:	Keyholder?	Yes	No
Forename (s):	Surname:						
Address inc. Postcode:							
Tel No:							

Other Agencies Involved

Organisation / Main Contact	Contact Numbers

2. Summary of Clinical Management Plan/Current Situation

Current Health Problems/Significant Diagnoses

Overview of health issues and diagnoses. Baseline functional and clinical status to help clinician identify deterioration - e.g. baseline O2%, 6-CIT score, level of mobility, current or planned treatments.

Essential Medication and Equipment	Yes	No	Notes
Oxygen therapy			
Anticipatory Medication At Home			
Continence / Catheter Equipment At Home			
Syringe Pump			
Moving and Handling Equipment At Home			
Mobility Equipment At Home			

3. Legal Powers

Adults with Incapacity / Legal Powers	Yes	No	Notes e.g. Guardian's details, date of appointment
Does the individual have a Combined Power of Attorney (financial and welfare)?			
Does the individual have a Continuing Power of Attorney (finance and property)?			
Does the individual have a Welfare Power of Attorney (health and/or personal welfare)?			
Is Power of Attorney in use?			
Is an Advanced Directive in place (living will)?			
Is an Adult with Incapacity Section 47 held?			
Has a Guardianship been appointed under the Adults with Incapacity (Scotland) Act 2000?			

Power of Attorney or Guardianship Details

Title:	Gender	M	F	Relationship:	Keyholder?	Yes	No
Forename (s):	Surname:						
Address inc. Postcode:							
Tel No:							
Date of Appointment	Notes e.g. if process is in progress, where paperwork is located etc.						
Paperwork Verified by Professional	Yes	No					
Date Verified							
Name of Verifier							

4. Preferred Place of Care & Resuscitation

My preferred place of care

Depending on the person's own circumstances and health journey, this may include preference about long term care, place of treatment or place of death. Details of current level of care being provided by informal carers and/or any discussions which have occurred regarding on going and future care they might be able to provide.

My views about hospital admission/views about treatment and interventions/family agreement

Where possible please give details regarding hospital admissions in different scenarios. For example, people may be willing to be admitted for a short period for symptom management, however would be unwilling to be admitted if it was likely they would be in hospital for long periods.

Treatment Escalation Plan (TEP)

TEPs help plan and manage any sudden deterioration in Acute settings. If one exists, please fill out the information below. Please note past TEP documentation is available on Clinical Portal.

Date of TEP Creation	Level of Escalation	Ward Based
		High Dependency Unit (HDU)
Hospital of Admission		Intensive Care Unit (ITU/ICU)

Resuscitation

Whilst these conversations can be helpful to plan future care, they should be held sensitively and appropriately. They are not mandatory.

Has DNACPR been discussed?	Yes	No	Comments
IF YES, is a DNACPR Form in place?	Yes	No	
IF YES, where is the documentation kept in the home?	Yes	No	
Refer to GP for further discussion re DNACPR?	Yes	No	

U Understanding You

- Special Notes

S Social Relationships

- Special Notes
- Next of Kin
- Carer Contact Details
- Family Agreement

S Services

- Other agencies involved

S Surroundings

- Special Notes (Current Accommodation)
- My preferred place of care
- My views about admissions / views about treatment and interventions