









West Dunbartonshire



Having Anticipatory Care Planning Conversations - A Guide For Staff

Anticipatory 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 Anticipatory 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 (call 0141 353 6504 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 ACP Summary to record any discussions or decisions that are made during an Anticipatory Care Planning conversation. You can access this via Clinical Portal, or complete the interactive PDF version.

How to use the ACP Summary and DISCUSS topics

Review | Rev Interventions Special Notes Current Health Frailty Score
Please select Frailty Score* from list: 0 - Not Applicable
If frailty assessment is not applicable, please select "0 - Not Applicable **Problems** My views about admissions / views about Gender M F CHI: treatment and Date of Birth: interventions GP / Practice details Is Next of Kin also Carer? Yes No **Decisions** Special Notes (Communication rrent Heatth Problems/significant Diagnoses
enview of health issues and diagnoses. Baseline functional and clinical status to help clini ndity detentoration – e.g. baseline 02%, 6-CIT score, level of mobility, current or planned attments. needs) Significant Diagnosis (capacity) Anticipatory Medication At Home Continence / Catheter Equipment At Home Adults with ving and Han Moving and Handling Էկսոր Mobility Equipment At Hom Incapacity Yes No Notes e.g. Guardian's details Adults with Incapacity / Legal Powers Power of bes the individual have a Combined Pow Attorney (financial and welfare)? ses the individual have a Continuing of Attorney (financial and welfare)?
Does the individual have a Continuing
Power of Attorney (finance and property)?
Does the individual have a Welfare Power Attorney 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)?

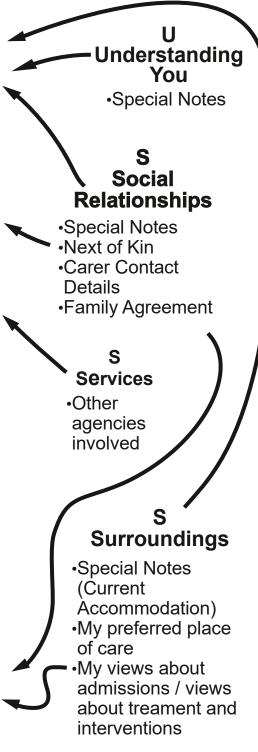
Is an Adult with Incapacity Section 47 held? C **CPR** Date of Appointment
Paperwork Verified by
Professional
Date Verified My views about admissions / views about treatment and interventions Resuscitation
Whilst fixee conversations can be helpful to plan future care, they should be held sensitively and appropriately. They are not mandatory.

Has DNACPR been discussed?

If YES, is a DNACPR Form in place?

Yes No Resuscitation

If YES, where is the documentation kept in the home? Refer to GP for further discussion re DNACPR? This is a copy of the PDF version on the ACP Summary.
The sections are identical to those on Clinical Portal.



DISCUSS for Staff - July 2022 - B&W ACPSupport@ggc.scot.nhs.uk