Future Care Planning Checklist

As from the beginning of June 2025, the Future Care Plan has been updated on Clinical Portal with additional questions. These include a question on **Power of Attorney (PoA) Confirmation and Treatment Escalation Plans (TEPs).**

Where an 'old' version of the Summary is still active and you are updating and existing plan (you will know this because it will still be called the "Anticipatory Care Plan Summary" at the top of the document), we would ask that you close the 'old' version (you might wish to note any information that requires to be transferred) and create a new form, so we can capture the new information.

You will find the 'close' button at the end of the form. Please note that once you close, you can no longer edit.

Topic	Descriptor	Check
Frailty Score	Has the frailty score been added? (For a consistent approach to screen for frailty use Rockwood Clinical Frailty Scale app) Does the clinical information / context of the person's life reflect the score? The amount of information required is unique to the person and their circumstances e.g. level of frailty, services, condition etc. Level of information in relation to frailty score: 0-3 = low level | 4-6 = moderate level | 7-9 = high level. Would also expect more detail for people receiving palliative care, people residing in care/nursing homes and those living with a learning disability. If no score – add a reason to 'special notes' why e.g. under 65	☐
Special Notes	**What is important?** Provide a brief outline to give context to the person - is there anything important to note e.g. spiritual/culture, passions, important people, values, health goals. What's the impact of their health condition on their daily living? Does the person have a caring role, children at home to be looked after or pets to be taken care of? **Communication Needs** - Refer to any communication difficulties a person has e.g. alternative formats of information, interpreter requirements, supporter present, and impairments. Or add 'no known communication needs' **Services provided** - This might include social services, 3rd sector and community organisations e.g. home care, condition specific organisations, faith organisations, a family support network. Who is going in and when. **Housing Access** – Is there a key holder? Door entry key codes to note and any access issues? Living arrangements (do they… live on own / with family, in a care home / supported accommodation etc.). **Person/Family Understanding** – Who is involved e.g. family members / supporter?	☐ ☐ ☐ ☐

	Does the person and/or family members understand the current situation - the illness / its impacts, their role (family) and the decisions made? e.g. "family are very supportive of the plan". **Risk and Protocols –** anything to note / behaviour management e.g. Herbert Protocol – Dementia. Manage someone's breathing or reduce anxiety.	☐ ☐
Agencies Involved	Contact names and numbers for key agencies e.g. clinical services, social work, home care, day centres, carer services, condition specific organisations, support workers, hospice, and community providers. Add to Special Notes - any detail on support provided e.g. home care 3 x daily / 5 days per week, input from Marie Currie Hospice Community Team, attends day centre twice per week (record this in special notes), befriending service from Epilepsy Scotland, Macmillan ICJ, Dementia Post Diagnostic Link workers involved.	☐
NOK	Ensure ALL details recorded e.g. name, number, address etc. Avoid 'as above' or 'as patient' add full address e.g. patient might move into care home.	☐
Carer (unpaid)	This relates to unpaid carers such as family, friends or neighbours. If ticking that the carer is the same person as NOK, the form will prepopulate with above, if not, you need to add all details. Are there any other people who provide a caring role (additional information can be detailed under special notes)? Are they coping? Note if no-one is providing a caring role e.g. family lives a distance away or no carer/family can be noted. Consider whether someone does not see themselves as a carer but is providing a caring role. Relatives of those in care homes might still have a caring role – decision-making; social activities; providing/ purchasing items.	☐
Clinical Management Plan	**Current Diagnosis** – list conditions and health issues, any recent hospital / recurring admissions, medication. Avoid using acronyms / state any clinical information in full. **Baseline Stats** – general stats e.g. blood pressure, oxygen levels for any relevant conditions. Any condition specific information e.g. cancer stages, kidney disease level, dementia stage, addictions – e.g. alcohol consumption. **Treatment Plans** - ongoing treatment plans for relevant conditions (**not** general views on hospital admission). e.g. diabetes treatment; oxygen therapy; just in case medication; medication, cancer treatment planned, smoking caseation support. **Other useful information** – allergies, nutritional needs, mobility issues. Addiction information - this may include alcohol, cigarette or substance misuse. If none, can add – "no known addictions" "no known allergies" etc.	☐ ☐ ☐ ☐

	Mental Health Overview: - Emotional Mental Health and Spiritual - This could be information which relates to both positive and negative emotional mental health e.g. depression and/or anxiety. Or patient 'coping well'. - Psychiatric Conditions - This may include historical diagnosis e.g. Bi-polar, chronic depression. - Neurological Condition - This question includes people living with dementia, those who have epilepsy or conditions such as Motor Neuron Disease. This may include historical diagnosis.	☐
Medication and Equipment	Answer yes or no for all. Where yes, add brief details in comment box. Something to consider is the use of an Implantable Cardioverter-Defibrillator (ICD) and decisions to keep activated or deactivate the device at end of life. It is worth checking what they would wish to do.	☐ ☐
POA/Guardianship	Ensure ALL questions answered yes / no. If no POA/Guardian recorded, evidence of POA/ Guardianship conversations can be added to special notes. Most people should be signposted to this information. The plan now asks you to verify that you have seen the PoA registration certificate. Advance Directive (or 'Living Will') – relates to a legal document to refuse treatment – add further comments in clinical notes. You will find this document under 'Patient Preferences'. NOTE: sometimes a TEP form is saved under legal notes/living will, so best to check that the living will is a living will and not a Treatment Escalation Plan.	☐ ☐
Preferred Place of Care / Future Treatment Plans	Discussion regarding Preferred Place of Care (PPC) – with the person (and relatives). These conversations relate to Long Term Place of Care, not hospital admission views. Record what is the person's / family understanding of their decision? What are the person's motivations for this, is it feasible – e.g. equipment available, safety issues - how do the family feel about this. In some cases, Preferred Place of Death (PPD) might be discussed by person/relatives, if appropriate – record. Note that PPC and PPD might be different places. Check if they are the same place. If not, then record both separately. Note any refusal of treatment (and why if given).	☐ ☐
Views on Hospital Admission	Person's views on hospital admissions and note family understanding. If they decline hospital admission, state reasons why – what is the motivation for decision? Or note circumstances when acceptable and when not. If refusal, a statement could be added 'not for hospital admission under any circumstances'	☐

	Consider discussing specific scenarios related to their condition – when is admission appropriate or not.	
Treatment Escalation Plan (TEP)	This question is a new addition to the Future Care Plan. You will find information about a patient's TEP under Patient Preferences in the document tree on Clinical Portal. Complete as appropriate.	☐
DNACPR	Note decision yes / no, use comment box for: Any comments in relation to conversation on DNACPR, this should include family understanding. If referral to GP for further discussion ticked, can use comment box to note person/family agreement for referral. Follow this up with an email referral to practice as back up. You can use the frailty score as guide: 1-5: might not be any reason to discuss / person may bring up 6/7: staff should begin conversation and initiate plan 8-9: the conversation is vital and outcome noted/updated.	☐
Key Information Summary (if you can)	Does the information on plan match information on KIS and vice versa – can missing information be added?	☐
Close Form box**!**	The only time we would ask you to do this is where an 'old' version is still in use – see opening paragraph at the top of the first page. If a new version exists e.g. post June 2025, then do not close the form.	

What Makes a Good Plan

Things to remember…

Sometimes staff consolidate all the narrative information into the 'special notes' section instead of adding to each designated section, however please help your colleagues navigate the document and find the information they are looking for quickly by recording information under the appropriate headings.

- Special Notes - context to the person
- Clinical Notes - health Information: conditions/baselines/treatments
- Preferred Place of Care (can include death) - where they see themselves in the future
- Views on Hospital Admission - motivation for decision, any specific instructions

If this is the first Future Care Plan created for the person, add all your details which includes trigger for the plan. For new plans, avoid using the drop down 'review/update', it's more about establishing the reason for initiating the plan e.g. receiving palliative care / carer requested etc

When adding further information at a later date to an existing plan, e.g. updating health/status of the person, you then choose 'review/update'. Always click a new set of 'Review' boxes anytime you add/update information.

When completing a Future Care Plan on Clinical Portal that you remember to add those essential pieces of information such as **name ▪ address ▪ phone number ▪ relationship ▪ POA/AWI etc.**