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Future Care Planning

Future Care Planning

CHC Learning Forum – 14th March 2024

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Learning Outcomes

By the end of this session, participants should be able to answer the following questions:

- What is Future Care Planning?
- Who should be involved in Future Care Planning?
- What should a plan look like?
- How can we share plans?
- Where can I get more information and further support?

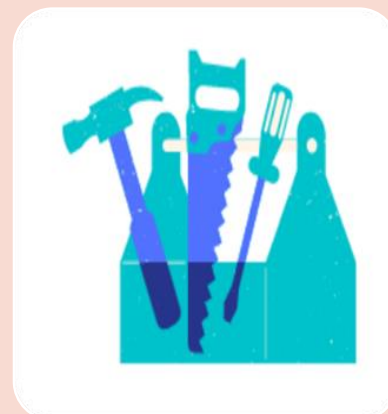
What is Future Care Planning?



An opportunity to think about what is important.



A guide to help people understand who you are and what matters to you.



A tool to help you feel in control about the decisions that affect you.



A safety net, in case you are not able to communicate your wishes later on.

What Future Care Planning is **NOT**:



A Legal Document
It is a guide to wishes and preference, not legal instruction.



Set in Stone
It can be changed and updated easily, and as often as needed.



A “Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)” Form
This is a separate document (and conversation).



Mandatory
It is completely voluntary, however we think it is a great idea!

A Little Bit of Context ...



Who is Future Care
Planning for?

Everyone should have one!



Who should be
involved?

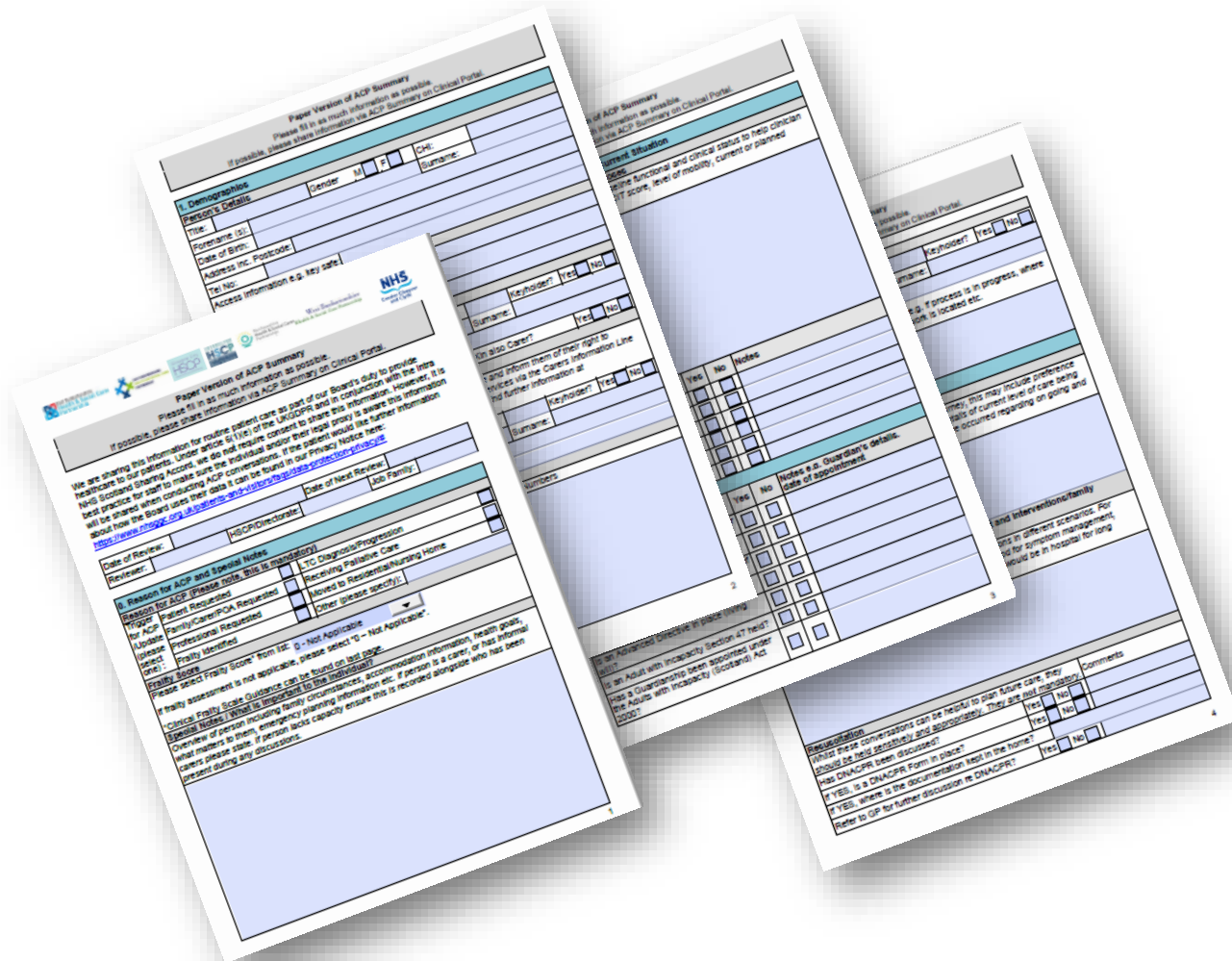
Everyone!

What does a plan look like?

Focus less on what it looks like...

...and more on what it tells you!

- **What** is important? (wishes, preferences, not just about treatment)
- **Why** is this important? (motivations, goals, putting the person and their decisions in context)
- **Who** is important? (NOK, Legal Guardians, key staff)
- **Where** they wish to be treated? (Hospital? Care Home? Both?)
- **How** are they at the moment? (current medical issues, treatments, prognosis etc.)

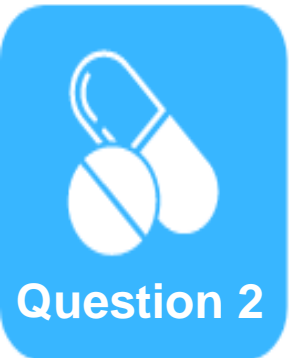


3 Questions

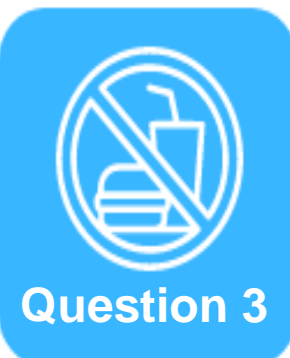
3 Scenarios



If your relative/friend **has a sudden collapse** (such as a stroke or a heart condition,) what would you think your relative/friend would wish to happen?



If your relative/friend **had a serious infection** that was **not improving** with an antibiotic tablet or syrup, what do you think your relative/ friend would wish to happen?



If your relative/friend **was not eating or drinking** because they were now **very unwell**, what do you think your relative/friend would want to happen?



Keep them comfortable, treat any pain or other symptoms and **care for them at home.**



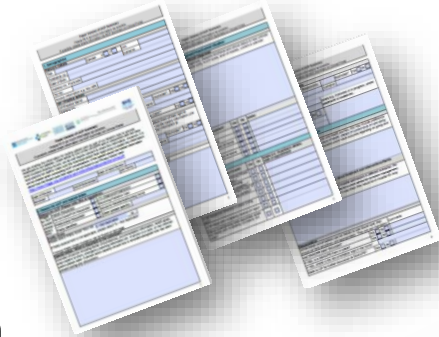
Contact NHS24/GP (or family) to help decide whether to send them to hospital instead of dialling 999.



Send them to hospital for investigations and treatment such as drips and treatment into vein.

Options for Sharing

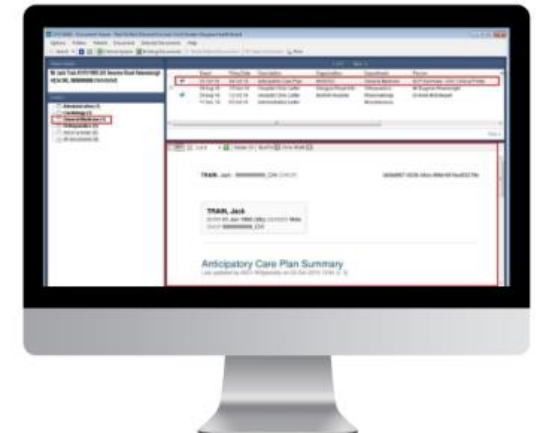
Staff, residents and family should all be involved in the conversation, and complete a plan. This information should be saved in the PDF (alongside any other paperwork the Home uses).



Depending on the arrangements either the Home will directly upload or CHLN/other services may be involved in uploading the document to Clinical Portal.



The GP Practice will receive a copy automatically and can upload to KIS.



Resources

Think.



Talk.



Plan.



Helping you plan for the future.

www.nhsggc.scot/planningcare | [@NHSGGC_ACP](https://twitter.com/NHSGGC_ACP)

ACPSupport@ggc.scot.nhs.uk.

**Training
& Events**



NHS
Greater Glasgow
and Clyde



Keep up to date with all the latest developments from the Anticipatory Care Programme.

Click here to sign up to our mailing list.

You can unsubscribe at any time by emailing ACPSupport@ggc.scot.nhs.uk

**Could you be an
Future Care Planning
Champion?**



**Future Care
Planning Resources**

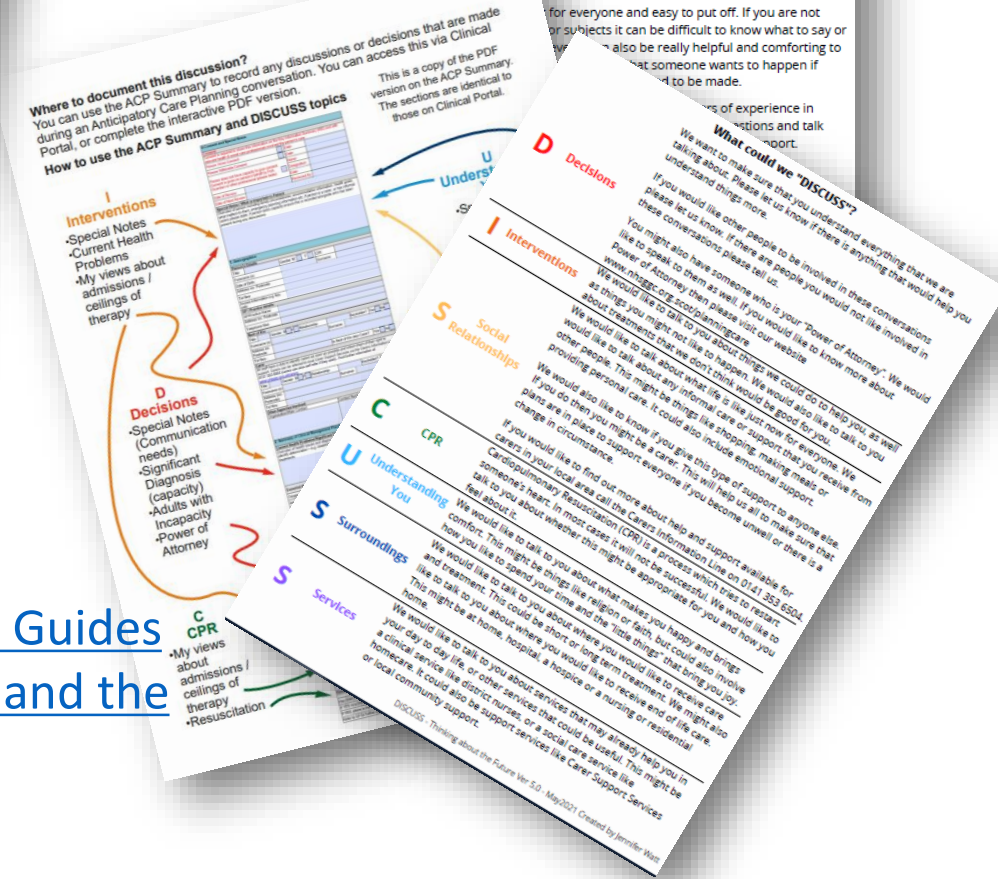
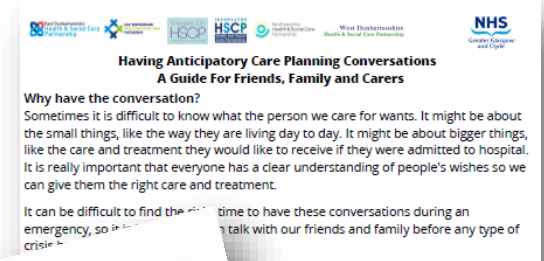


FOLLOW
us on  **@NHSGGC_ACP**

helping you plan for the future



Useful Documents



[Interactive PDF Summary](#)

[DISCUSS Guides for Staff and the Public](#)

Training Resources

Future Care Planning e-Module

Intro What? Who? Why? When? How? Where? Progress

Think. Talk. Plan.



Helping you plan for the future.

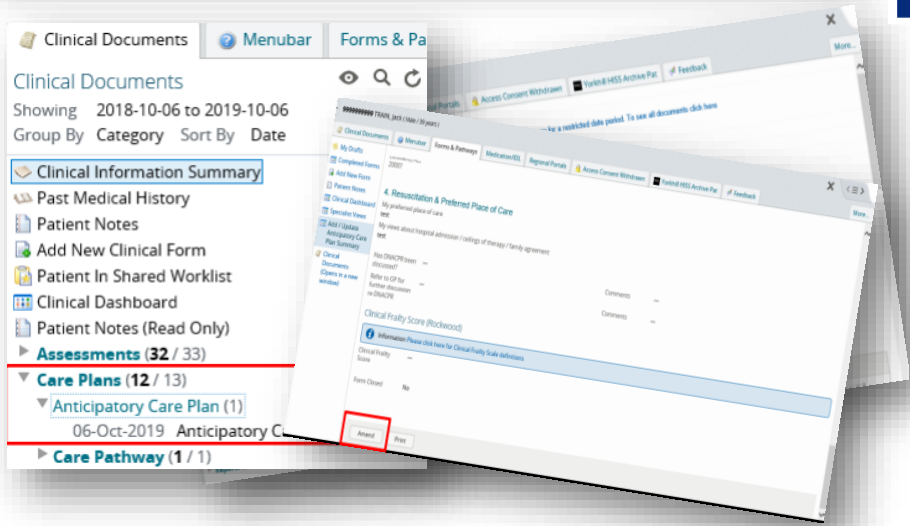
Future Care Planning:
What you need to know

Click the 'Next' button to continue ➡

There are links to other websites embedded in this module. They will be in a different colour and underlined. If you are viewing this on a web browser, please **right click** on these links and select "open in a new tab".

Next

Online E-module (available to all)



Case Study Part 1: Meet Morag

Conversation

1. What are key areas you would wish to cover on a first visit?
2. Who else would you involve in the conversation and at what stage?
3. Suggest questions you could ask or statements from Morag to explore more which would open up or keep the conversation going?
4. How would you evidence that a good conversation has taken place.
5. Are there any barriers or challenges in supporting Morag with ACP?

Guide to updating ACPs on Clinical Portal



Future Care Planning – The Big Picture Session

Summary Example Library

- ❑ [Alan Fulton](#) - An older man who cares for his wife.
- ❑ [Monica Hill](#) - A lady with breast cancer receiving support from a local hospice.
- ❑ [Elizabeth MacDonald](#) - An older lady with COPD.
- ❑ [Ali Malik](#) - A young adult transitioning between child and adult palliative care services. You can also view an example of a [Child and Young People Acute Deterioration Management \(CYPADM\) form](#).
- ❑ [Jacqueline Morrow](#) - A parent carer with a daughter on the autistic spectrum.
- ❑ [Sophie Morrow](#) - A young woman with autism.
- ❑ [Margaret Quinn](#) - An older lady living with dementia.
- ❑ [Paul West](#) - A middle-aged man recovering from cancer.
- ❑ [Tom Williams](#) - A Care Home Resident.

Meet Alan

Alan is 81 years old and cares for his wife Molly who has dementia. Recent changes to his health and how he will manage in the future has initiated the ACP



Meet Monica

Monica is 53 years old and is living with Breast Cancer. Monica wishes to manage her condition so she can stay well. Maintaining a good quality of life is important to



Meet Ali

Ali is 20 years old, he has very clear views about his future in relation to his condition (Muscular Dystrophy) and wishes to be involved with decisions on his care and treatment.



Sophie lives with her mum. She was diagnosed with Autism at 13 years and also has a moderate learning disability. Recently she has been admitted to hospital with recurring epileptic seizures.



Important Links



Future Care Planning

Future Care Planning Website	<u>Planning for Care - NHSGGC</u>
Future Care Planning	<u>Training Hub</u>
Future Care Planning	<u>Documents and Resources</u>
Future Care Planning	<u>Latest News</u>
Future Care Planning	<u>Become a Champion</u>
Future Care Planning Email	<u>ACPSupport@ggc.scot.nhs.uk</u>
Future Care Planning X	<u>@NHSGGC ACP</u>
Carer Information and Support	<u>Carers - NHSGGC</u>

Any questions?