

# Future Care Planning

## An Introduction



# A Little Bit of Context ...



Who is Future Care  
Planning for?

Everyone should have one!



Who should be  
involved?

Everyone's business!

# 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 is 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 Form” (DNACPR)

This is a separate document (and conversation).



## Mandatory

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

# Future Care Planning



# What are the conversation triggers?

If we think about the people you support...

Who or what situation would trigger the conversation?



People

Condition



Setting



Person  
Carer/POA  
Health & Social Care  
Community  
3<sup>rd</sup> Sector

New Diagnosis  
Change to condition  
Additional Health Conditions

Hospital admission /discharge  
New Living Arrangement  
End of Life Care

# MORE than the LAST BREATH

## The SPECTRUM of PALLIATIVE CARE

### LIVING with LIFE LIMITING CONDITIONS (INCLUDING ADVANCED FRAILTY +/- DEMENTIA)

FOCUSSING on HOLISTIC NEEDS and LIFE QUALITY



CHECK we KNOW...

What MATTERS to ME...



Start FUTURE CARE PLANNING



Are PRESCRIBED DRUGS still needed? STOP unnecessary or harmful medication

Are patient and family aware FOCUS is on GOOD PALLIATIVE CARE?



Consider RESUSCITATION STATUS

### PERIOD of DECLINE and INDICATORS of DECLINE \*

Can be HOURS, DAYS, MONTHS or YEARS

DECREASING

- Activity
- Mobility
- Function



MEDICAL/NURSING REVIEW to look for reversible causes of decline

INCREASING need for carer support

Choice of no further active treatment

Low mood

increasing confusion or delirium

incontinence recurrent infections

fatigue

stage 3/4 pressure sores

ADVERSE EVENTS? eg. fall or hospital admission



INCREASING SYMPTOMS or COMPLICATIONS of underlying illnesses



POWER of ATTORNEY - in place and DOCUMENTED?

Review FUTURE CARE PLAN with patient + family

Request JUST in CASE medication



LIAISE with GP or nurse

MEDICINES BETTER CRUSHED? (where allowed) or other form

Resuscitation DISCUSSED and RECORDED

loose? DECREASING ORAL INTAKE and WEIGHT LOSS

### LAST DAYS or HOURS

STOP monitoring/medicines

Has 'just in case' drugs

Family supported and updated?

GP or nurse courtesy call



In place?



Doing what matters

Recognise possible SIGNS of ACTIVE DYING

- L**ETHARGY - weak, bed-bound, increasingly sleepy
- A**LTERED MENTAL STATE - confused, restless, agitated
- S**KIN CHANGES - pale, blue, mottled, cold hands or feet
- T**ABLETS and oral intake diminished or stopped
- B**REATHING CHANGES - rattly, rapid, intermittent

\* Gold standards Framework 2011



This poster and plain text version

# Things we can talk about ...

How can we help you make informed decisions? Could someone make decisions on your behalf?

What you would like to happen and what you would not?

Who is important to you and who can give you support?

What do we mean by CPR? Is this appropriate for you?

What matters to you?

How do we create an appropriate space for care?

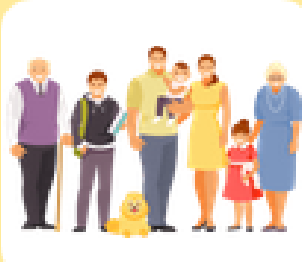
What services support you now or in the future?



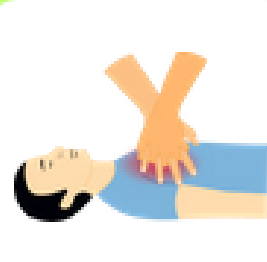
**D**  
Decisions



**I**  
Interventions



**S**  
Social Relationships



**C**  
CPR



**U**  
Understanding

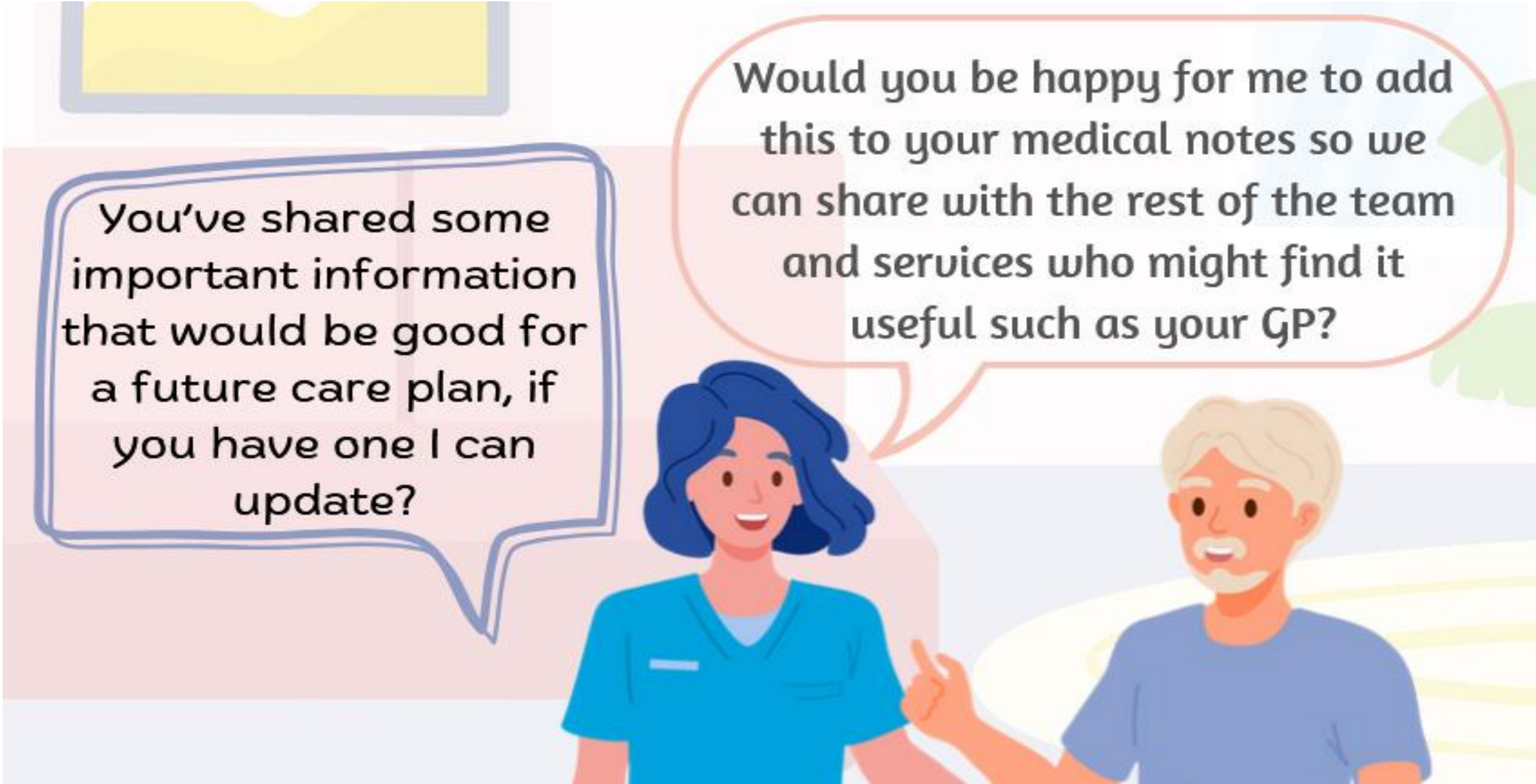


**S**  
Surroundings



**S**  
Services

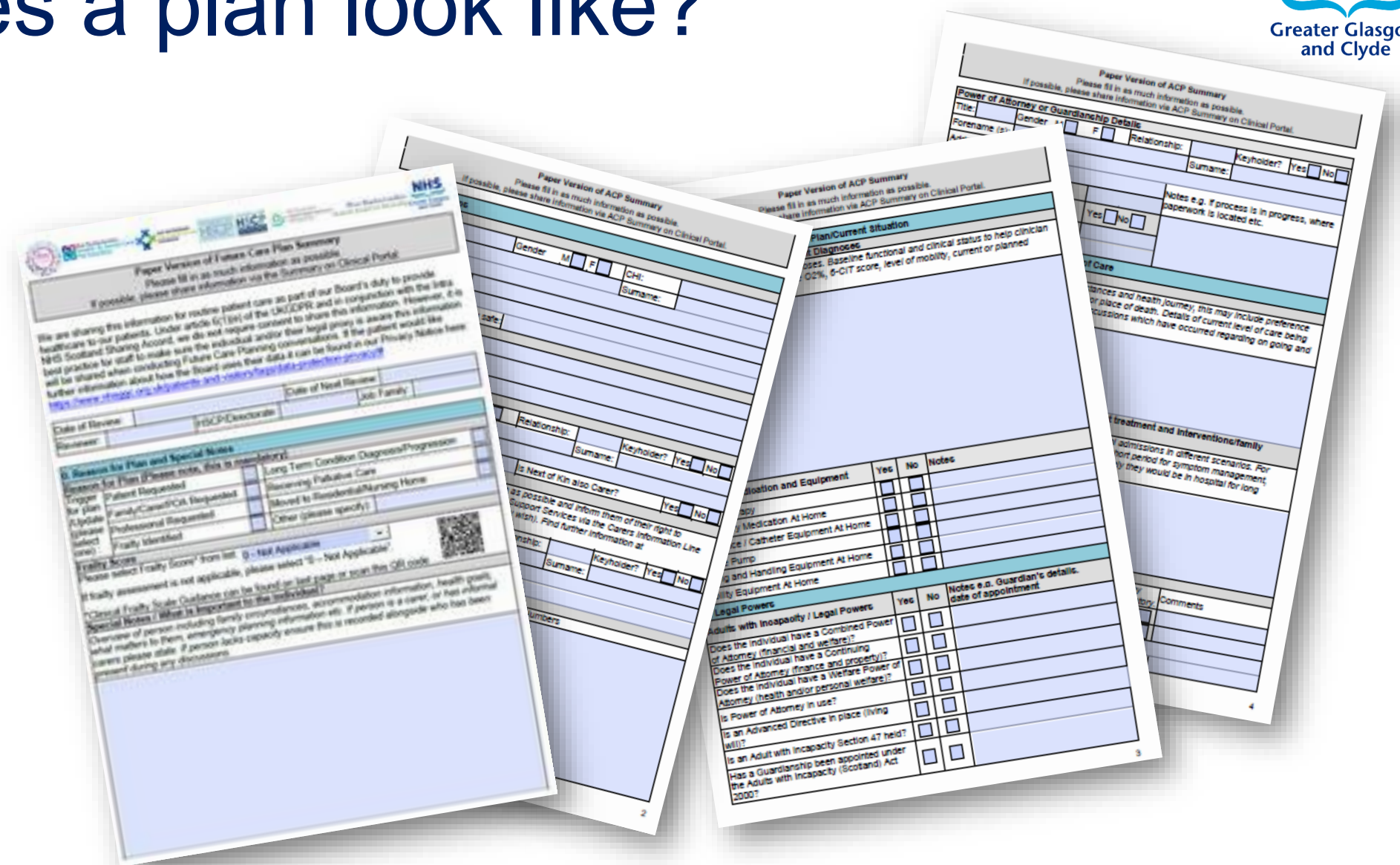
# Start The Conversation ...

An illustration of a healthcare professional with dark blue hair, wearing a blue scrub top, standing next to a patient with grey hair and a beard, wearing a blue t-shirt. They are in a hospital room with a bed and a window in the background. Two speech bubbles are present: one from the healthcare professional and one from the patient.

You've shared some important information that would be good for a future care plan, if you have one I can update?

Would you be happy for me to add this to your medical notes so we can share with the rest of the team and services who might find it useful such as your GP?

# What does a plan look like?



[Interactive PDF Summary](#)

Focus less on what it looks like...

# And more on what it will tell you ...

Where do they wish to be cared for, views on hospital, what about treatments?



What is important and why?



What services are involved?



Who is important to them, what is their role?



Information about their health conditions, medication, baselines, treatment plans, risks?




What do they know about their health? Goals to aim for?

# ACP Example's

- ❑ [Alan Fulton](#) - An older man who cares for his wife.
- ❑ [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](#).
- ❑ [Sophie Morrow](#) - A young woman with autism.
- ❑ [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.



# Think. Talk. Plan.



## Useful Resources



Greater Glasgow  
and Clyde

Think. Talk. Plan.



[www.nhsggc.scot/planningcare](http://www.nhsggc.scot/planningcare)

[FCP Website](http://www.nhsggc.scot/planningcare)



Future Care  
Planning Resources

[FCP Resources](#)



[FCP SWAY](#)



Future Care Planning  
Share Point

[NHSGGC FCP  
SharePoint](#)



[Previous Events  
Recordings](#)