My Advanced Care Plan

Patient's Name:
NHS Number:
General Practitioner:
GP's Contact telephone number:
Registered Nurse/Key worker responsible for care:
Contact telephone number:
Out of Hours District Nurses contact telephone number: 0300 3300 254 **Out of Hours GP contact telephone number: 111**
Advanced Care Plan Commenced by **Name:** **Signature:** **Band:** **Date:**

Signature Sheet

Patient name_____ DOB: _____ NHS No _____

All those completing this care plan, please sign below

Name (Print)	Full Signature	Band/Role	Date
Advanced Care Plan Commenced by	**Name:**	**Signature:**	
	Date:	**Band:**	

Advanced Care Plan

Patient name_____ D.O.B_____ NHS No _____

Likes to be called	
Address **Post code**	
Telephone number	
Diagnosis	
Allergies	

Family /carer contact details 1st contact	**2nd contact**
Name _____	Name_____
Relationship to patient_____	Relationship to patient _____
Address _____	Address _____
Postcode _____	Postcode _____
Contact number _____	Contact number _____
Alternative contact number _____	Alternative contact number _____
Any communication barriers _____	Any communication barriers _____
When to contact Day ☐ Night ☐ Anytime ☐	When to contact Day ☐ Night ☐ Anytime ☐

Has the person identified a preferred place of care?	Yes ☐ No ☐ If yes, please state
Resuscitation status	DNACPR in place Yes ☐ Date in place:

Advanced Care Plan Commenced by Name: **Signature:**

Date: **Band:**

Advanced Care Plan

Patient name _____ D.O.B. _____ NHS No _____

Specific communication barriers identified. How can communication be supported? *(Consider hearing, vision, speech, learning disabilities, confusion, language barriers)*	
Do you or your family have any specific wishes relating to your religion/ faith or spirituality?	
Does the patient have an identified Lasting Power of Attorney for health and welfare?	Yes ☐ No ☐ Name: _____ Contact details_____
Has the patient identified individuals who they would like health and social care professionals to consult regarding care/treatment decisions? (This is a baseline assessment and mental capacity should be reassessed as appropriate).	Yes ☐ No ☐ Name: _____ Contact details_____ Name: _____ Contact details_____ Name: _____ Contact details_____
Does the patient have the mental capacity to make decisions about their care and treatment at the present time? **If they have not then any changes made to treatment should be supported by a best interests approach.**	Yes ☐ No ☐ Date and time made ……. If no, ensure assessment is documented
Advanced Care Plan Commenced by Name: **Signature:** **Band:** **Date:**	

Advanced Care Plan

Patient name_____ D.O.B_____ NHS No _____

Do you have any advance care plans in place? Yes ☐ No ☐ If yes, have the plans been used to inform any best interest decision making? Yes ☐ No ☐	
What do you understand about your condition/ treatment plan?	
If possible ask the family or carers "What do you understand about _____'s condition?"	
What is important to you? **(**Consider fears / feelings / practical issues / financial issues / issues about their care / spiritual/religious needs)	
If possible ask the family and carers "What is important to you (Consider fears / feelings / practical issues / financial issues / issues about their care / spiritual/religious needs)	
Do you have any specific wishes regarding your care after death e.g. organ donation, funeral arrangements?	Yes ☐ No ☐ If yes, please state
Do you have any specific nutritional or hydration needs?	
Advanced Care Plan Commenced by Name: **Band:**	**Signature:** **Date:**

Advanced Care Plan

Patient name_____ D.O.B_____ NHS No _____

Current symptoms on commencement of Advanced Care Plan:

If your condition deteriorates in the future, have you got any specific wishes relating to:

Hospital admissions
Ongoing blood tests and investigations
Medications
Oxygen
Management of pacemakers or implanted defibrillator.

Are there any other concerns you have about your care you would like us to know about?

This has been discussed with ……

…….

Relationship …….

Date ……Time……..

Advanced Care Plan Commenced by Name: **Signature:**

Band: **Date:**

Advanced Care Plan

Patient name_____ D.O.B_____ NHS No _____

Pre-emptive medications prescribed		
Pain	Yes ☐	No ☐
Nausea/vomiting	Yes ☐	No ☐
Agitation	Yes ☐	No ☐
Respiratory Tract Secretions	Yes ☐	No ☐
Breathlessness	Yes ☐	No ☐
Others ……..	Yes ☐	No ☐

Do you have any specific care needs that you would like to discuss,

Consider

- Personal care
- Mobility
- Mouth care
- Skin integrity and pressure area management
- Bowel and bladder management
- Environment preferences e.g. music, lighting, privacy.

Do you consent to us sharing your health record with other health and social care professionals who provide you with care?	Yes ☐ No ☐ Unable to consent ☐

Advanced Care Plan Commenced by: Name: **Signature:**

Date: **Band:**

Advanced Care Plan

Personal Goals

Name _____DOB _____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review
1. To ensure that aims of my treatment and care are based on a clear rationale, regularly reviewed and understood by all those involved with my care.	a. Identify GP and responsible registered nurse/key worker and ensure that my family, carers and I am aware of who this is. b. Identify a clear treatment and care rationale and plan which is discussed and agreed with me or my advocates and the professionals caring for me and discussed with and explained to my family and carers, unless I have stated not to. c. Ensure this plan is reviewed at each visit or, if in inpatient unit, daily and changed according to any change in my condition or needs. d. Ensure I and my family and carers are aware of changes in my condition, medical management plan and care plan as appropriate e. Provide us with appropriate written information f. Provide us with information about services involved in my care and their contact numbers g. Ensure information about my care plan is shared with relevant services (including out of hours services) if I have consented to this. h. Ensure that my family, carers and I (if appropriate) know who to contact if further help and advice is needed at all times. i. Ensure my family and carers understand what to do in the event of my deterioration	Ongoing Any changes to be noted in Care Plan Evaluation and systm one.
Advanced Care Plan Commenced by Name: **Band:**		**Signature:** **Date:**

Advanced Care Plan
Personal Goals

Name _____ DOB_____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review
2. To feel supported and that my wishes and beliefs are at the centre of my care.	a. Listen to me. b. Offer me, my family and carers the opportunity to complete a Personal diary as part of my care plan. c. Ask me or my advocate(s) what is important and respond to my preferences and wishes appropriately. d. Provide appropriate explanations and information to ensure that I am, or my advocate(s) are able to make decisions about my care. e. Consider all aspects of my care. f. I am offered the opportunity and support to access spiritual / religious support as needed.	Ongoing Any changes to be noted in Care Plan Evaluation and systm one.
3. To ensure I am in the environment of my choice whenever possible	a. Offer me or my advocate(s) the opportunity to discuss my preferred place of care and wherever possible facilitate my care in this place b. Consider my personal preferences within the environment e.g. fragrance, lighting, privacy, photographs, music or sound c. Facilitate my family and carers being able to spend as much time with me as I/ they wish.	Ongoing Any changes to be noted in Care Plan Evaluation and systm one.
Advanced Care Plan Commenced by Name: **Band:**		**Signature:** **Date:**

Advanced Care Plan

Personal Goals

Name _____ DOB_____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review
4. To be comfortable and for any symptoms I am experiencing to be managed as well as possible. These may include: • Pain • Agitation • Fear • Nausea and vomiting • Breathlessness • Respiratory tract secretions	The nurses/ doctors will: a. Utilise appropriate assessment tools b. Monitor my condition for any signs of distress or discomfort c. Exclude any reversible causes of distress or discomfort e.g. urine retention, opioid toxicity, need for positional change d. Discuss with me or my advocates preferences for my treatment options e. Consider holistic treatment of my symptom needs e.g. using fan, positional changes, relaxation etc f. Provide me and my family/carers with information and explanations about medications or treatments which may be used g. Ensure medications are prescribed for use if needed should any symptoms occur - see medication guidelines. h. If a syringe pump is currently needed or maybe required in the future ensure equipment is available and if used, medication is given as required; doses based on previous medication use – see guidelines. i. In hospital, hospice or care home ensure symptoms are reviewed regularly. j. At home review regularly and ensure that I and/or my family and carers understand how to report any occurrence of symptoms so timely review can occur (i.e. provide contact numbers for all times) k. Ensure any medication required are administered in a timely manner, safely and appropriately	Ongoing Any changes to be noted in Care Plan Evaluation and systmone.

Advanced Care Plan Commenced by Name: **Signature:**

Band: **Date:**

Advanced Care Plan

Personal Goals

Name _____ DOB _____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review
5. To receive hydration and nutrition to meet my needs	a. Support me to take fluid and food as long as I desire and am able to tolerate b. If I am unable to swallow consider the need for clinically assisted hydration. Any decision should if possible be taken in consultation with me and/or my family and carers (See guidance) c. If I am receiving clinically assisted hydration or nutrition ensure I receive this as prescribed	Ongoing. Any changes to be noted in Care Plan Evaluation and systm one.
6. To maintain all my personal care needs	a. Ensure all my personal care, including skin care, eye care, bladder and bowel function, changing of clothing, is provided in accordance with my wishes. b. Provide information and explanations to family and carers and if appropriate advise them about how to provide my personal care c. Maintain my hygiene needs if in my own home and if I wish instigate a referral to social services for care provision	Ongoing. Any changes to be noted in Care Plan Evaluation and systm one.
7. To keep my mouth moist and clean	a. Assess my mouth care needs – see guidance b. Provide regular mouth care as I require – see guidance c. Provide information and explanations to my family and carers and if appropriate advise them about how to provide mouth care	Ongoing. Any changes to be noted in Care Plan Evaluation and systm one.
Advanced Care Plan Commenced by Name: **Band:**		**Signature:** **Date:**

Advanced Care Plan

Personal Goals

Name _____ DOB_____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review
8. To maintain my comfort and prevent pressure damage of my skin	The nurses will: a. Assess potential pressure damage and provide me with pressure relieving aids as assessed and appropriate. b. Change my position as required. c. Monitor my skin for any signs of skin damage and treat appropriately d. Ensure my carers/family are made aware of appropriate skin care they can provide for my comfort. e. Refer onto specialist services as appropriate.	Ongoing. Any changes to be noted in Care Plan Evaluation and systm one.
9. For my family and carers to feel supported.	The nurses will: a. Provide information to my family about Carers support available. b. Listen to my families and carers worries and concerns and respond to these appropriately. c. Provide them with written information as required and appropriate. d. In hospital/ hospice/ care home, explain facilities and support available. e. At home, ensure they have contact numbers and know how to get support day and night.	Ongoing. Any changes to be noted in Care Plan Evaluation and systm one.
Advanced Care Plan Commenced by Name: **Band:**		**Signature:** **Date:**

Advanced Care Plan

Personal Goals

Name _____ DOB_____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review
10.		
11.		
Advanced Care Plan Commenced by Name: **Band:**	**Signature:** **Date:**	

Advanced Care Plan

Personal Goals

Name _____ DOB: _____ NHS No_____

Personal Need	Key actions for people involved in my care	Frequency of review	Signed/Band/Date
12.			

Care plan discussed and agreed by patient	Yes ☐	No ☐	N/A ☐	Signature	Date	Time
Care plan discussed and agreed by family or carer	Yes ☐	No ☐	N/A ☐	Signature	Date	Time
Health Professional	Designation			Signature	Date	Time

Advanced Care Plan Commenced by Name: **Signature:**

Band: **Date:**

Advanced Care Plan

Care Plan Evaluation

Name_____ DOB_____ NHS No_____

Time/date	Problem number	Evaluation comments	Signature and designation

Advanced Care Plan Commenced by Name: **Signature:**

Band: **Date:**

Advanced Care Plan

Care Plan Evaluation

Name_____ DOB _____ NHS No_____

Time/date	Problem number	Evaluation comments	Signature and designation

Advanced Care Plan Commenced by Name: **Signature:**

Band: **Date:**

Advanced Care Plan

Care Plan Evaluation

Name_____ DOB _____ NHS No_____

MY diary & MY family/carer's diary

Please feel free to write any comments or observations about any part of yours or your relative's care or changes in condition

Date & time		Your name and relationship

Advanced Care Plan Commenced by Name: **Signature:**

Band: **Date:**

Patient Advice and Liaison Service (PALS)

Compliments, comments, concerns or complaints: we want to hear from you.

PALS and Complaints Department
Humber NHS Foundation Trust
Trust Headquarters
Willerby Hill
Beverley Road
Willerby
HU10 6ED

PALS can be contacted on:
Tel. 01482 303966
Email. pals@humber.nhs.uk

Complaints can be contacted on:
Tel. 01482 303930
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www.humber.nhs.uk