Advance Care Planning
Record of Advance Care Plans & Preferences

ACP A

Name:		NHS no:	
Address:		Date of birth:	
Postcode:		Hospital no:	
GP and practice:			

This form is to record advance care plans& preferences of a person with mental capacity for the decision. The decisions recorded here are not legally binding, but should inform clinical decisions made on behalf of the person

Date:

MEDICAL BACKGROUND

Medical condition(s) relevant to this advance statement

1 INVOLVING OTHERS IN DECISION MAKING

*Have you appointed a **Lasting Power of Attorney for Health & Welfare?***

Name(s): Tel no(s):

*If not, is there **someone you would like to be consulted** if the clinicians ever have to make treatment decisions on your behalf?*

Name(s): Tel no(s):

2 DEPENDENTS

*Do you have anyone **dependent** on you for their care (e.g. children, partner or elderly relatives)?*

Record who, what relationship, and age:

If so, have you made any plans for their care if you are unable to look after them?

Record brief details:

3 TREATMENT & CARE PREFERENCES / PLACE OF CARE

*Have you ever made a **"Living Will"** – either an **Advance Decision to Refuse Treatment** (ADRT) or a **written advance statement of your wishes/preferences** about medical treatment?* Please Select

If so, what does it say and where is it kept? (Is a copy available in the medical records?)

If not already covered by the above –

*Do you have **preferences about where you would like to be cared for** if you become less well, including when you are nearing the end of your life? You can include several options/preferences:*

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3 TREATMENT CARE PREFERENCES (contd.)

*Some people wish to set a limit, or a 'ceiling', to their treatment. Are there any **treatments or interventions** you would **not** want in some circumstances?* (⇨ optionally use next page)

Is there anything you are worrying may happen in the future? (e.g. difficulty breathing, being left alone)?

4 CARE AROUND LAST DAYS OF LIFE – PREFERENCES OR WISHES / PLACE OF DEATH

*This section contains some questions about your **care around the last days of your life**:*

*Do you wish to express a **preference about where you would like to be cared for** when you are dying? You can state several options/locations that are acceptable to you.*

*Do you have any **religious or spiritual needs** for care around the time of death?*

*Have you **made a will**?*

Please select

*Would you like your organs or tissues to be considered for **donation**?*

Please select

Have you considered your "digital legacy" e.g. on-line content on WhatsApp, Facebook, Paypal, Ebay, smartphone photos? Further information on this is available for example at: https://digitallegacyassociation.org/)

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<u>OPTIONAL</u>: Use this page to record more details of your views about specific medical treatments or interventions. Consider filling in with a clinician

*Consider adding possible treatments specific to the medical background e.g. dialysis for advanced kidney disease.

***If a person has a clear understanding of their preferences and wishes to refuse treatments under specific conditions, they can complete an Advance Decision to Refuse Treatment (ADRT), making such refusals legally binding. See www.wales.nhs.uk/afcp for an All-Wales ADRT form and guide**

"Some people wish to set a limit, or ceiling, to the care they receive.
If the following treatments were medically appropriate, how would you feel about these interventions?"

Treatment(s)	*Would want clinicians to consider*	*May want it if it were primarily to maintain dignity or comfort*	*Not under any circumstances*	*Comments*
Antibiotics for a serious (life-threatening) infection	☐	☐	☐	
Intravenous hydration (a fluids 'drip')	☐	☐	☐	
Admission to hospital (what if fell& you broke your wrist, for example?)	☐	☐	☐	
Admission to an Intensive Care Unit	☐	☐	☐	
A mechanical ventilator (to help with breathing)	☐	☐	☐	
An endo-tracheal tube used in order to perform the above	☐	☐	☐	
Nasogastric, gastrostomy, or other feeding tubes introduced to feed	☐	☐	☐	
Attempted Cardio-pulmonary Resuscitation (CPR)	☐		☐ Request a DNACPR form	
Other…	☐	☐	☐	

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Emergency situations

Although life-threatening emergencies are very uncommon, you may wish to consider how you would like others to respond if a sudden life-threatening event should occur at home, for example a large haemorrhage/bleed. Which would be your priorities?

	Comments
To get to hospital a.s.a.p. to receive active treatment i.e. a 999 emergency ambulance	☐
To control pain or other symptoms as quickly as possible, wherever that may be	☐
To stay at home if at all possible	☐
To put the wishes, views & preferences of partner/carer first	☐
Other priority…	☐

ADDITIONAL INFORMATION

*Would you like to record **any other preferences, views, or choices** about your healthcare? If you need prompts, then consider looking at the What Matters Most at the end of life charter https://www.whatmattersconversations.org/*

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If appropriate, has a **DNACPR** (Do Not Attempt Cardiopulmonary Resuscitation) form been completed? (https://www.wales.nhs.uk/DNACPR for All-Wales DNACPR policy and resources). Yes ☐

Does the person consent to share this information with other healthcare professionals?	Select
Does the person consent to record this information in their computerised healthcare record?	Select
Has the person discussed this information with those close to them/family?	Select
Permission to discuss this information with those close to them/family if appropriate?	Select

Please record (by ticking) all who have been informed:

- GP ☐
- District Nurses ☐
- Out-of-Hours primary care service ☐
- Hospital teams(s) ☐
- Specialist Palliative Care Team ☐
- Ambulance Service (WAST) ☐
- Others: ☐

Where is this document kept?
e.g. where in the house, such as Message in a Bottle in Fridge, etc.

If the information on this form needs to be updated or changed, please strike through all pages of this form, and ensure that you inform **ALL** those listed above.

Signature of patient (optional)	**Print Full Name & Contact Information**	**Date**
Signature of care professional helping with the form	**Name & Contact**	**Date**
GMC/NMC/HCPC Number:		