The Conversation Project

A toolkit of good practice to support and enhance advance care planning in the care homes in BaNES

'Advance care planning can make the difference between a future where a person makes their own decisions and a future where others do'

NICE 2019

Kind and compassionate conversations help to share what matters most to residents, families and carers about their care towards the end of life

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The following people and organisations have provided valuable contributions to this resource

Advance Care Planning Nurse Specialist BaNES
BaNES CCG
BaNES Council
BaNES Frailty Nurse Specialist
Care Home Managers BaNES
Community pharmacist
District Nurses
Dorothy House Hospice Care
GP representatives
RUH Palliative Care Team
SWAST ambulance services

Created with the kind support and contributions from the Care Home Managers and their colleagues in BANES

Introduction

Advance care planning helps us know what is important to our residents, their families and carers and how they wish to be cared for as they approach the final phase of their lives.
This guidance has been created following consultation from care home managers and key community staff in order to provide a practical resource that supports advance care planning in care homes.
Advance care planning is often referred to as 'planning ahead' in relation to information directed to residents and their families.

Contents

1. Starting the conversations

Multidisciplinary Team Approach

Working together as an multi-disciplinary team; care home manager, nurse and GP is a valuable way to address advance care planning. It is preferable that the care home staff approach the resident and family initially and set up a meeting together with the GP at a convenient time

Good conversations support good end of life care

- Consider starting 'planning ahead' conversations early. Some people find this best introduced on admission to the care home
- Consider sending an introductory letter (suggestions over page) and 'Planning ahead' leaflet- inviting a conversation to take place with the resident (if able) and family or next of kin
- Some residents and family may decline the conversation initially, so consider offering the opportunity to talk at a future time, adopting an 'open-door' approach
- The conversation can be started by the care home manager, nurse or GP, but best undertaken as a shared multi-professional approach. It can then be continued by an appropriate confident member of the care home team
- Preparation for the conversation is important with the family and/or resident to ensure that they are expecting this conversation and to check whether the resident has the capacity to be involved?
- Consider an appropriate place to have this confidential conversation and a convenient time and date for those who need to be involved

This leaflet- 'Planning ahead- A guide for patients, families and carers' helps introduce advance care planning and can help people consider the things they may wish to ask prior to any meeting

Additional planning ahead leaflets can printed from www.Ruh.nhs.uk Go to 'For GPs', click advance care planning

Examples of introductory letters

Many care home managers and nurses find sending an introductory letter and 'Planning Ahead' leaflet to the resident's family or carers a valuable way of introducing planning ahead.
Below are examples of letters that you may like to use, copy to your own letter head.

Dear …… and family

I would like to invite you as a family, to discuss an advance care plan for ……to help us provide the right support for them.

I would be grateful if you could contact the nursing team at ……at your earliest convenience, to arrange an appointment as you are integral to the process.

In implementing advance care planning it is our aim understand what is important to your loved one at this time in their life, to support your loved one with comfort and dignity in their preferred place of care and to reduce inappropriate hospital admissions in the final years of life. We also wish to understand what is important to you so that we can support you at this time.

Please feel free to contact……, and we will be happy to discuss any concerns you may have and explain our care

I look forward to hearing from you soon.

Dear

Here at ……. we are wishing to engage the resident and families of our residents in discussions about planning ahead.

Planning ahead allows us to ensure that we have considered well in advance the care a person would like prior to any change in their condition or as they approach the final phase of their lives.

This time may be (insert as appropriate) (in the days and weeks to come) or (many months or years away), but we wish to ensure that we have offered residents and families an opportunity to talk this through. If we know the wishes of our residents and their families we can then provide care as you and your family would wish for.

Many people welcome this opportunity to discuss decisions and wishes for the future.

Please be aware that decisions that are made are reviewed regularly and that decisions and plans can be changed as time goes by.

We would be grateful if you could contact us, so that we can agree a convenient time to discuss this in person or by telephone, we have included a leaflet for further information.

Having 'planning ahead' conversations

Conversation starters and phrases

These are some ideas for starting conversations about planning ahead. You may already have some you like to use

- Doing the right thing: *'It is important to us that we provide the right care for you and for that reason we would really like to know your wishes….If you were to become unwell what would you like us to do?'*
- Seek Permission: *'Are you the sort of people who like to know what is going on?'*
- Reflect back: *'You know that they have not been so well recently…'*
- Fishing questions: *'Have you thought about a time when… you/they may not be as well as you/they are now?'*
- Focusing on key issues: *'Can you tell me what is the most important thing for you about planning ahead?'*
- Focus on the emotion: *'Am I right in thinking that you feel worried about the future?'*
- Framing difficult questions as universal or general: *'Some people like to make their thoughts/wishes known and to make plans in advance… and then get on with living'*
- Hypothetical questions: *'Sometimes it is helpful to think about the what if's'*

Be brave enough to start a conversation that matters

Having conversations

- Adopt a kind and compassionate manner and approach
- Check what the resident and family understands about any health concerns or change in condition and how they feel things are now
- Go at the pace of the resident and family
- Take time to listen and check their understanding as the conversation progresses
- Ensure that it is understood that any plan will be regularly reviewed and can be adjusted accordingly
- Offer to meet again or answer any questions should they have worries or concerns
- Don't feel that a complete plan needs to be made in one conversation- often it takes several conversations and through developing of an open, trusted relationship

Talking to families/carers

Consider the needs of the family and carers

- What are the family/carers thoughts and expectations of the future- are they realistic and appropriate?
- What are their feelings about future care such as medical interventions and hospital care?
- Have they recognised that their family member has deteriorated? Families may not always recognise the subtle changes over time that we see
- How much support do they need at this time?
- What worries or concerns do they have about their family member?
- Do they have different cultures, faiths and beliefs that are important to them now?

Remember to consider

- The family may not have experienced a family member dying before
- If they have , what has their experience of dying and bereavement been? This may affect their thoughts and concerns now
- Is there a great dependence on the person who is dying that may impact on their bereavement?

What might be helpful to the family and carers

- Understanding whether your resident has the capacity to make and be involved in decisions about their care
- Talking about whether their family member had ever expressed thoughts about care towards the end of their life before they lost capacity to say
- Making Lasting Power of Attorney for Health and Welfare early
- Support and guidance that sometimes decisions to support planning ahead may take time to work through
- Some families need and want to be guided by staff as to what is appropriate care for someone nearing end of life
- Being kind and compassionate and listen to their worries and concerns
- Understanding who supports them, such as other family, friends
- Communicating clearly with the family when we think their loved one is dying or sick enough to die. Families may wish to do things differently if they know their loved one does not have long to live

2. Advance care planning- explanation of terms

Understanding advance care planning

Advance care planning (ACP) is used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care. It can include thoughts about their future care, their medical care and management, any particular personal wishes and anything that people would want their family to know if they are ever in a situation where they are unable to say for themselves. ACP discussions should inform ongoing care for the person

Remember that people with capacity are able to change their minds about their wishes and preferences at any stage of their lives

Advance decisions to refuse treatment (ADRT)

An Advance Decision to Refuse Treatment (ADRT or living will) is a decision an individual can make to refuse a specific treatment in relation to a specific condition, should they loose capacity in the future. This is a legal decision if it meets certain requirements and needs to be signed and witnessed. It MUST be adhered to by healthcare professionals and therefore it is helpful if healthcare professionals see it and include in medical notes.
Helpful websites:
www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/
www.mydecisions.org.uk

Treatment Escalation Plan- TEP

Treatment Escalation Plans record the recommended emergency medical treatment plans for a person. They focus on what treatments may or may not be helpful for a person, such as antibiotics, artificial feeding, resuscitation or ventilation of the lungs.
TEP's are for clinical guidance and do not replace the clinical judgement of a medical professional in a given situation, but they do support and guide appropriate management.
A GP records on the patient electronic health records that a TEP exists to support information sharing with other healthcare professional.
Not all urgent care clinicians have access to all of the electronic health record and therefore the urgent care team need to know that the person has a TEP should they be called.
It is important that the TEP travels with the person should they attend hospital or other appointments.

DNACPR- Do not attempt cardio pulmonary resuscitation

DNACPCPR decisions are not legally binding like 'Advance Decision to Refuse Treatment' but these important decisions guide healthcare professionals judgement and actions

The following is aimed at supporting conversations with residents and families who may require further discussions and a better understanding of resuscitation decisions

- A DNACPR does not stop all other treatments that a person may need to improve a person's symptoms and wellbeing, just cardio pulmonary resuscitation
- Cardiopulmonary arrest means that the person's heart and breathing has stopped.
- It is sometimes possible to restart the heart and breathing with an emergency treatment called cardiopulmonary resuscitation (CPR). CPR can include repeatedly pushing down very firmly on the person's chest, using electric shocks to try to restart the heart and performing 'mouth-to-mouth' breathing. If the heart has stopped as part of the natural dying process, CPR will not be effective.
- DNACPR is a medical decision based on a doctor's assessment as to whether CPR is clinically appropriate taking into consideration a person's health and underlying medical problems. The DNACPR decision should be communicated with the resident and family as appropriate.
- CPR can be undignified and success rates are very low. The process of CPR can result in broken ribs and the person can survive but may be very unwell following and there is a high risk that they will not return to their previous state of health
- CPR will not be used if a person has said in advance that they do not wish to receive it and/or the medical team decides that it is not medically appropriate

Helpful website:
www.compassionindying.org.uk/making-decisions-and-planning-your-care/planning-ahead/dnar-forms/

Statement of wishes

An advance statement or statement of wishes is a term used as part of an advance care planning. An advance statement of wishes can include aspects of care the person wishes others to know should they loose capacity to tell themselves. This can include preference for place of care. Although not legally binding they would inform any 'best interest decision' and are a very important part of a person's care planning.

Helpful website: www.nhs.uk/conditions/end-of-life-care/advance-statement/

Lasting power of Attorney (LPA)

This is a legal document that lets an individual 'donor' appoint one or more people 'attorneys' to help make decisions on a person's behalf if they are not able to make decisions for themselves. There are two types; 'health and welfare' and 'property and financial'. People choose to make either or both.
An LPA needs to be registered at the Office of Public Guardians to allow it to be used. It can only be used once it is registered and comes into force if the individual concerned does not have mental capacity

Helpful websites: www.lastingpowerofattorney.service.gov.uk/home

Wills

A will is the only way to make sure a person's money, property, possessions and investments go to the people and causes that a person cares about.
Note: If a person is not married or in a civil partnership, their partner will not have the right to inherit if they do not have a will.
For a will to be valid it must be in writing, signed by the individual, and witnessed by two people, a person must have the mental capacity to make the will and understand the effect it will have. A person must have made the will voluntarily and without pressure from anyone else.

Helpful websites:
www.gov.uk/make-will
www.citizensadvice.org.uk/family/death-and-wills/wills/
www.ageuk.org.uk/information-advice/money-legal/legal-issues/making-a-will/

3. Documentation- care plans, wishes and preferences

Different organisations and homes will have their own care plans and documentation

- A comprehensive care plan provides a highly personalised care approach
- Review the care plan monthly or if there is a change in a person's condition or circumstance
- Ensure that the care plan is accessible to all care staff to inform care as end of life approaches

Any care plan should include the following:

Contacts and those who support and represent the best interests of the resident

- Next of kin and family's contact details- keep updated as end of life approaches
- Identify who is important to the resident, who advocates for them and supports their plan of care and document their contact numbers
- Lasting Power of Attorney for Health and Welfare and Lasting Power of Attorney for Finances. In both cases the home should have a copy of all LPA documents
- Ask whether they have made a will

Medical background and support from healthcare professionals

- Health or social care professionals involved in the residents care eg. GP, DN
- Medical diagnosis, underlying conditions and allergies leading to regular GP review
- Frailty score and frailty assessments over time. Consider Continuing Health Care Fast Track application for care funding if rapidly deteriorating conditions apply
- Treatment escalation plan and decisions around ongoing medical management.
- Symptom management and 'Just in case medications' as end of life approaches

Care Needs

- Statement of wishes and preferences including preferred place of care
- Particular wishes – music, environment, pets, photos, personal belongings
- Who they would like involved in their care
- Hopes and plans- any key goals or events
- Spiritual care and knowing what is important to the person. Consider what gives their life meaning, sharing life stories, involving family or those important in their lives
- Specific requests and how would they like to be cared for as they are dying
- Cultural and religious beliefs and any relevant contacts
- Decisions about their funeral plans and desire for cremation or burial

Plan of care should the person become acutely unwell

- Completed Treatment Escalation Plans- TEP
- Whether any future medical intervention is desired or is deemed appropriate
- Whether future hospital care is desired or appropriate and reasons for – see section 6
- Understanding actions around avoiding admission if not in the resident's best interests
- Who the person would like contacted if they become unwell

A copy of the care plan should be shared with the family or next of kin

Care plans and documentation……. continued

What the person would like to happen as they approach the final stage of their life and as they are dying

- Where and how would the person wish to be cared for when the person is dying?
- Who would they like involved in their care?
- Include the wishes of the family or carer
- Any particular cultural, spiritual or religious desires?
- Any particular requests- music, temperature of the room, position of the bed, familiar things around them?

What would the person wish to happen after they have died

- Has the resident or family expressed whether they would like a funeral or a cremation?
- Has the resident or family expressed any cultural wishes or religious beliefs that need recognising?
- Have they expressed any wishes regarding funeral planning?
- Do their NOK or family know whether the resident has expressed any particular wishes?

Review of care plans

It is good practice to review the plan of care and adjust as necessary. This should be done;

- If circumstances change
- Monthly or more frequently as end of life approaches
- At the request of the resident or their next of kin

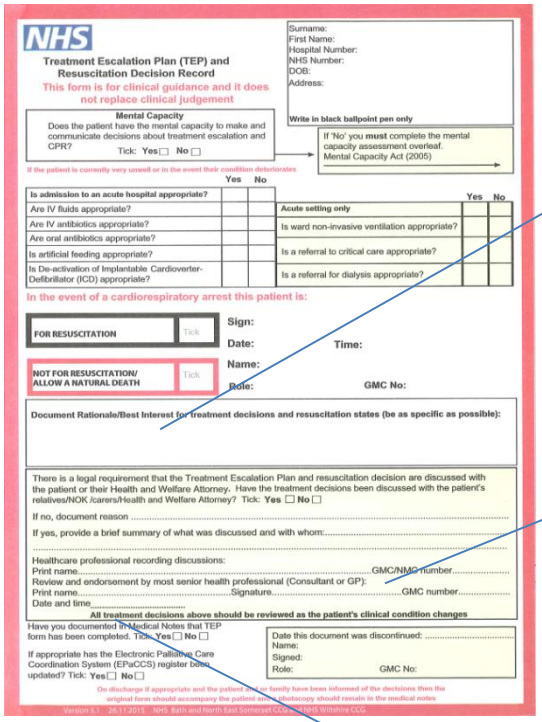
Storage of care plans

Any advance care plans are the property of the resident but should be kept with the notes and made available to any visiting healthcare professional involved in the resident's care

4. Treatment Escalation Plans- TEP

Guidance on the completion and signing of TEPs

- It can be completed by a senior community nurse or matron, hospice nurse such as Dorothy House Nurse Specialist, palliative care consultant, GP or hospital consultant
- If completed by a nurse it needs to be countersigned by the GP at the earliest practicable opportunity
- TEPs accompanying residents on discharge from hospital are still applicable once the resident is in the community- inform the GP that the resident has a TEP
- The GP needs to know that the resident has a TEP (they do not need to redo it), they will document this in the residents' notes and on the electronic medical record which is coded to ensure that out of hours care is aware that a TEP exists
- Only the original is valid- not a photocopy
- Store the TEP in the front of the residents notes, it is the property of the resident


NHS

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

This form is for clinical guidance and it does not replace clinical judgement

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Address:

Write in black ballpoint pen only

Mental Capacity
Does the patient have the mental capacity to make and communicate decisions about treatment escalation and CPR? Tick: Yes ☐ No ☐

If 'No' you must complete the mental capacity assessment overleaf. Mental Capacity Act (2005)

If the patient is currently very unwell or in the event their condition deteriorates

	Yes	No
Is admission to an acute hospital appropriate?		
Are IV fluids appropriate?		
Are IV antibiotics appropriate?		
Are oral antibiotics appropriate?		
Is artificial feeding appropriate?		
Is De-activation of Implantable Cardioverter-Defibrillator (ICD) appropriate?		

Acute setting only	Yes	No
Is ward non-invasive ventilation appropriate?		
Is a referral to critical care appropriate?		
Is a referral for dialysis appropriate?		

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION Tick

NOT FOR RESUSCITATION/ ALLOW A NATURAL DEATH Tick

Sign:
Date: Time:
Name:
Role: GMC No:

Document Rationale/Best Interest for treatment decisions and resuscitation states (be as specific as possible):

There is a legal requirement that the Treatment Escalation Plan and resuscitation decision are discussed with the patient or their Health and Welfare Attorney. Have the treatment decisions been discussed with the patient's relatives/NOK /carers/Health and Welfare Attorney? Tick: Yes ☐ No ☐

If no, document reason .....

If yes, provide a brief summary of what was discussed and with whom: .....

Healthcare professional recording discussions:
Print name..... GMC/NMC number.....
Review and endorsement by most senior health professional (Consultant or GP):
Print name..... Signature..... GMC number.....
Date and time.....

All treatment decisions above should be reviewed as the patient's clinical condition changes

Have you documented in Medical Notes that TEP form has been completed. Tick: Yes ☐ No ☐

If appropriate has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Tick: Yes ☐ No ☐

Date this document was discontinued: .....
Name:
Signed:
Role: GMC No:

On discharge if appropriate and the patient and/or family have been informed of the decisions then the original form should accompany the patient and a photocopy should remain in the medical notes

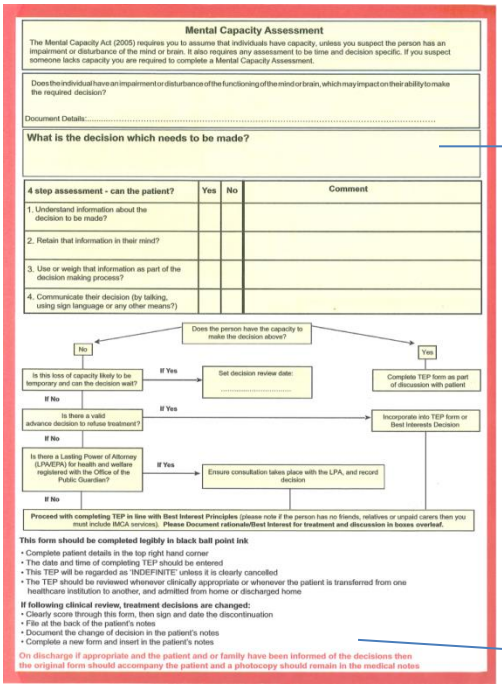
Version 5.1 26.11.2015 NHS Bath and North East Somerset CCG and NHS Wiltshire CCG

Summary of communication with patient
State clearly what was discussed and agreed.
If not discussed with the patient state the reason why.
It is good and recommended practice to discuss treatment decisions with every patient but if this would cause distress without any likelihood of benefit for the patient or if the patient lacks capacity this should be recorded.

The senior responsible medical clinician- GP or hospital consultant must countersign, add date, time and their GMC number

Summary of communication with family or friends
If the patient does not have capacity their relatives, friends or an IMCA must be consulted and may be able to help by indicating what the patient would decide if able to do so.
If Lasting Power of Attorney (LPA) for health and welfare exists - ensure this is valid. Then their appointed welfare Attorney can help make decisions in the persons best interests.

The existence of a TEP does not deny a resident from any other treatment that may be in the patients best interest for treatment or symptom control purposes



Mental Capacity Assessment

The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain. It also requires any assessment to be time and decision specific. If you suspect someone lacks capacity you are required to complete a Mental Capacity Assessment.

Does the individual have an impairment or disturbance of the functioning of the mind or brain, which may impact on their ability to make the required decision?

Document Details:.....

What is the decision which needs to be made?

4 step assessment - can the patient?	Yes	No	Comment
1. Understand information about the decision to be made?			
2. Retain that information in their mind?			
3. Use or weigh that information as part of the decision making process?			
4. Communicate their decision (by talking, using sign language or any other means?)			

Does the person have the capacity to make the decision above?

No → Is this loss of capacity likely to be temporary and can the decision wait? If Yes → Set decision review date: ..... If No → Is there a valid advance decision to refuse treatment? If Yes → Incorporate into TEP form or Best Interests Decision. If No → Is there a Lasting Power of Attorney (LPA/EPA) for health and welfare registered with the Office of the Public Guardian? If Yes → Ensure consultation takes place with the LPA, and record decision. If No → Proceed with completing TEP in line with Best Interest Principles (please note if the person has no friends, relatives or unpaid carers then you must include IMCA services). Please Document rationale/Best Interest for treatment and discussion in boxes overleaf.

Yes → Complete TEP form as part of discussion with patient

This form should be completed legibly in black ball point ink

- Complete patient details in the top right hand corner
- The date and time of completing TEP should be entered
- This TEP will be regarded as 'INDEFINITE' unless it is clearly cancelled
- The TEP should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, and admitted from home or discharged home

If following clinical review, treatment decisions are changed:

- Clearly score through this form, then sign and date the discontinuation
- File at the back of the patient's notes
- Document the change of decision in the patient's notes
- Complete a new form and insert in the patient's notes

On discharge if appropriate and the patient and or family have been informed of the decisions then the original form should accompany the patient and a photocopy should remain in the medical notes

Mental capacity

If there is any reason to doubt capacity of the patient, a Mental Capacity Assessment must be completed.

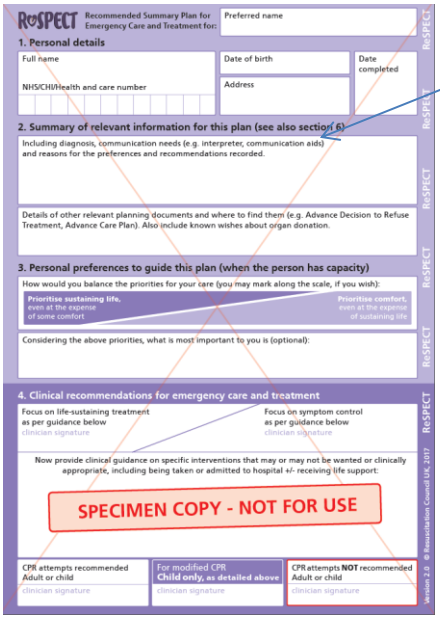
The assessment of mental capacity is only in relation to the decisions made at the time of completing the form. If capacity changes, the form (including capacity) must be reviewed and documented.

Clearly document any Best Interest Decision in relation to the Treatment Escalation Plan and Resuscitation Decision.

If following clinical review treatment decisions are changed:

- Clearly score through this form, then sign & date the discontinuation.
- File at the back of the resident's notes.
- Document the change of decision in the notes.
- Complete a new form and insert in the front of the resident's notes

TEP and Resuscitation Decision Review A fixed review date is not necessarily required if the person's condition is unchanged; national guidance states that the TEP is considered as 'indefinite' unless clearly cancelled. However it is good practice and required by CQC that any TEP decisions are reviewed regularly (yearly), whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another and admitted from home or discharged home.



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name | Date of birth | Date completed

NHS/CHI/Health and care number | Address

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort ... Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below clinician signature

Focus on symptom control as per guidance below clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

SPECIMEN COPY - NOT FOR USE

CPR attempts recommended Adult or child clinician signature

For modified CPR Child only, as detailed above clinician signature

CPR attempts NOT recommended Adult or child clinician signature

ReSPECT Resuscitation Council UK, 2017 version 2.2

Recommended Summary Plan for Emergency Care and Treatment form- ReSPECT

ReSPECT Please note

Some residents who have come from others areas may have different TEPs, such as the ReSPECT form which is being introduced in Bristol and other areas.

For further information see www.respectprocess.org.uk

If your resident has a ReSPECT form or an alternative TEP inform your visiting GP as they may wish to transfer to the current red- bordered TEP form used in BANES.

All TEPs support the residents's care and are valid documents that support and guide appropriate care.

5. Sharing information

It is important that any information that supports a person's advance care plan goes with the resident as they are transferred between different places of care

On receiving a resident from hospital/community/hospice ask

- What do the hospital/community/hospice staff know about the person's condition?
- Why were they admitted to hospital/hospice and what has happened during their admission?
- Is their likely prognosis known or has there been recognition that the patient may be in the last few weeks or months of their lives?
- Have any conversations about planning ahead taken place?
- Are the wishes of the patient and their family known, do they have a 'My wishes' leaflet?
- Do they have a 'This is Me' document?
- Request that their existing TEP is reviewed or that they are transferred to the home with a new community TEP
- If they are new to the care home, request a community TEP and ensure they know to put the correct address of the care home on it.
- Relay the above information to the GP, if not already known

On transfer to hospital/hospice for assessment, appointments or for admission

- Transfer the resident to any hospital assessment, appointment or for admission with relevant information about their advance care plans and TEP
- A photo copy of the TEP can be kept in the residents' notes but the original needs to go with the resident
- Include information regarding SBARD- see section 6
- Include a detailed history of their medical status, current medication and allergies
- Send with any other information that supports the resident's care especially important if the person is not able to tell someone themselves

The Red Bag Scheme

The Red Bag scheme aims to provide a prompt, safe and efficient transfer of care when a resident moves between a care home and other clinical settings. The red bag stays with the resident from the time they leave to go to hospital until they return to their care home.

A Red Bag check list ensures that appropriate information is shared about the resident in the red bag on transfer to hospital to support ongoing care. The checklist includes: medical information, TEP, current medication and personal belongings.
A further check list is used by the hospital to ensure that the necessary information returns with the resident including their Discharge Letter. Advance care planning needs to be included in the transfer information

6. Advice and guidance- decisions about ongoing medical management

These decisions are made by GP's and nurses, but informed by the care staff who may know the resident very well and understands what their wishes are

Decisions around urgent care for people who are approaching the end of their lives in the next weeks and months

- For many residents decisions about their future medical management are made over time, however it is preferable that they are made as early as possible.
- If the resident is becoming more frail it becomes very important that these medical decisions are made in advance of a further change in a person's condition.

For decisions about a person's medical management ask;

1. Is your resident for all active treatment in all situations ?

- Have they ever expressed a desire to have or not have treatment for more urgent care, is this in line with their family's wishes and understanding?
- Is it deemed medically appropriate that they have all active management?

2. Would they like to be treated for potentially reversible conditions such as a urinary tract infection or chest infection?

- Some residents may benefit from active treatment for sudden bleed/severe anaemia, worsening kidney function or infection
- There are some situations where hospital assessment is likely to be necessary such as potential fractured bones, unexpected choking or difficulty swallowing or acute events such as seizures

3. Has the resident or their family with the person's best interests in mind, declined all further active treatment. Does the TEP reflect this and is this information known to the resident if able and next of kin, family or carer?

- In all cases where more active management is not deemed to be appropriate, all care is aimed at symptom management, comfort and support.

Advice and guidance- who and when to call for help

Do you need to call for advice and support?

For medical advice and guidance if the resident's condition deteriorates or in an emergency contact

- In normal working hours- phone the GP surgery
- In out of hours and weekends phone the Clinical Assessment Service Direct line on 0300 111 5818

Please see over page for information healthcare professionals will need to know when you make that phone call- SBARD

For symptom management guidance or advice regarding care towards the end of life

- Contact Dorothy House Hospice - 24 hour advice line 0345 0130 555
  Option 1 for the advice line 24 hours (access out of hours advice)
  Option 2 for the Clinical Co-ordination Centre (day time hours 7 days a week)

Would you like an opinion from elderly care specialists?

- Frailty Nurse specialist- For non urgent, non- emergency discussions about patient care and support- email n.aplin@nhs.net
- Falls Team 8 am- 6pm 7 days a week call 999 and say that the resident has fallen

www.bathandnortheastsomersetccg.nhs.uk/new-rapid-response-falls-service-launched-bnes

Has your resident been recently discharged from hospital or you feel that the elderly care team in the hospital could offer some advice?

- Phone the discharging ward via the hospital switchboard 01225 428331
- Frailty flying squad between 8am- 8pm seven days a week 07807477604 for any resident who are being transferred to hospital

Do you need to speak to the District Nurse Team for advice or to request a visit?

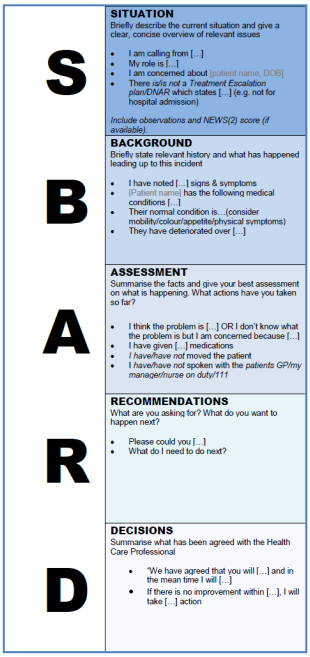
- Phone the District Nurse Clinical Co-ordination Centre 0300 241 0200
  Press 2 for the health Access Team /Professional Line

See separate flow chart which can be put by the phone

Advice and guidance – providing clear information

If you contact a health care professionals for advice or support, be prepared to give the following information using SBARD;

- Situation- explain who you are and what you are worried about. Explain if the resident has a TEP and an advance care plan
- Background-describe what has happened and why are you calling
- Assessment give the facts and what you have done so far
- Recommendations- what are you asking for and what do you expect to happen
- Decisions summary of what has been agreed



If an ambulance crew attends they will need;

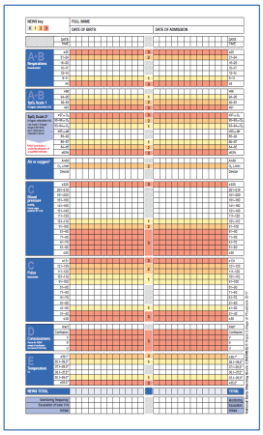
- The relevant information- follow SBARD
- See the TEP and advance care plan- they may not be aware that the resident has one or know what medical decisions have been made around further treatment and management of care.
- If the resident requires transfer to hospital include their original TEP

Please note In all situations where a patient has capacity and is able to communicate their wishes paramedic crews will respect their decisions

NEWS2 National Early Warning Score

This system helps staff recognise and respond to a resident who is deteriorating, thereby triggering a review, treatment and escalation of care.
This system allocates six measurements eg. respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and any new confusion.

Residents with a NEWS of 5 or more are at serious risk of clinical deterioration and a poor clinical outcome, and need urgent assessment and intervention.



Admission avoidance

For many residents admission to hospital- the journey, the challenges they may face in ED, being away from the people they know and the familiarity of their home can be very difficult.

Please follow guidance to prepare ahead to avoid unnecessary admissions to hospital.

For many residents who are nearing the end of life and dying, they are best cared for in the care home with staff who know them, but do feel that you can call for advice and support

Before phoning for medical advice

STOP, THINK and CHECK

- Is admission to hospital appropriate for your resident ?
- Does your resident have an advance care plan and a TEP?
- Do you need to call a health care professional? If yes:

Monday- Friday, 9-5: phone GP surgery

Out of hours: phone 0300 111 5818 and include;

S	**SITUATION** Briefly describe the current situation and give a clear, concise overview of relevant issues • I am calling from […] • My role is […] • I am concerned about [patient name, DOB] • There *is/is not* a *Treatment Escalation plan/DNAR* which states […] (e.g. not for hospital admission) *Include observations and NEWS(2) score (if available).*
B	**BACKGROUND** Briefly state relevant history and what has happened leading up to this incident • I have noted […] signs & symptoms • [Patient name] has the following medical conditions […] • Their normal condition is…(consider mobility/colour/appetite/physical symptoms) • They have deteriorated over […]
A	**ASSESSMENT** Summarise the facts and give your best assessment on what is happening. What actions have you taken so far? • I think the problem is […] OR I don't know what the problem is but I am concerned because […] • I have given […] medications • *I have/have not* moved the patient • *I have/have not* spoken with the *patients GP/my manager/nurse on duty/111*
R	**RECOMMENDATIONS** What are you asking for? What do you want to happen next? • Please could you […] • What do I need to do next?
D	**DECISIONS** Summarise what has been agreed with the Health Care Professional • "We have agreed that you will […] and in the mean time I will […] • If there is no improvement within […], I will take […] action

7. Just in case medication and anticipatory prescribing

Just in case medication

This medication should be available if it is expected that the resident's condition is deteriorating and there is a risk that they may experience symptom problems. They should not be ordered too far in advance as they may reach their expiry dates.

Medication prescribed for care in the last days of life should include medication for ;

- Pain or discomfort- consider morphine
- Nausea and vomiting consider cyclizine/levomepromazine
- Troublesome secretions- consider hyoscine butylbromide
- Agitation in the last few days of life consider midazolam

If the person is transferred from the Royal United Hospital

The following will apply

Patients will only be discharged with anticipatory Medications if they are assessed as being in the last few days or week of life.
The medications will be prescribed on the RUH prescription and authorisation to administer template. This authorises a registered nurse to administer the prescribed medication for up to 7 days.
A GP review will be required to prescribe and authorise anticipatory medications within 1 week of transfer to the care home


NHS
Royal United Hospitals Bath
Prescription and Administration Instructions

8. Additional Information

1. CHAT Bundle- community framework to support advance care planning
2. Treatment Escalation Plan in BANES
3. Example of ReSPECT form
4. Two leaflets to support planning ahead
   - Introducing planning ahead
   - My wishes
5. Supportive and Palliative care Indicator Tool (SPICT) 4 all
6. Rockwood Frailty Score
7. Advance care planning website www.ruh.nhs.uk
   Go to GP page and then click on 'The Conversation Project'

8. For Frailty pathway go to [www.**bit.ly/Frailtypathway**](http://www.bit.ly/Frailtypathway)
9. NICE guidance ACP for care homes
10. Key card to support words and phrases in conversations