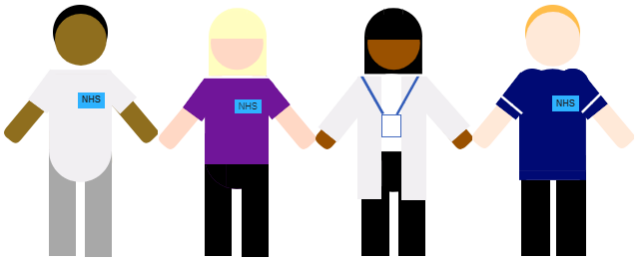
Oxford Health
NHS Foundation Trust

Patient guidance: palliative care plan

Please use this guide to complete your care plan



Community services

Palliative care plan

Palliative care is given to people with life-limiting conditions and helps them to live as well as they can for as long as they live.

It may be helpful if you take your care plan with you, for example, if you go to hospital. You can share it with your doctors and nurses if you wish, so that they are aware of your preferences and needs.

Page one: what do you understand about your condition?

You may have discussed the progression of your illness following recent conversations with your GP or medical team. You may not have taken all this information in and may like to discuss this further with the healthcare professional involved with your care.

Page one: if you are unable to communicate your wishes regarding your treatment and care

You may not always be able to make decisions due to loss of capacity. You may become muddled or confused if you have an infection or it may be because of the progression of your illness. You may wish to choose someone you trust to speak for you at this time.

If you have nominated an attorney for health and welfare (LPA) then you need to write their name on page one in the 'people important to you' section of your care plan.

Page one: do you have any of the following documents?

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

This only relates to resuscitation should your heart stop/you stop breathing, not to any other treatment. Your doctor or specialist nurse will discuss this in more depth and there is also written information available.
This document will be completed by your doctor or advanced nurse practitioner. The DNACPR form should be kept with you. Ideally at home it should be placed in a Lyons 'message in a bottle' in the fridge door so that everyone knows where it is. The bottle contains stickers for the front and fridge door to alert services that you have a form in place. It is for guidance only and is not legally binding.

Advance Decision to Refuse Treatment (ADRT)

This is a legally binding document and refers to the refusal of medical treatment, for example if you do not wish to have antibiotic therapy or cardiopulmonary resuscitation (CPR). You can complete this document yourself. It must be signed, dated and witnessed . If it includes the refusal of CPR, words such as 'even if at risk to my life' must be included.

Advance statement

This is a statement that expresses your wishes. It is not legally binding but health professionals should follow it (if practical to do so). If you have already written one then a copy of it can be put in your care plan.

Electronic Proactive Care Plan (ePCP)

Your GP will agree the care plan with you and complete this electronically, a copy is usually printed out and given to you to be kept with your medical notes at home. The plan will discuss treatment options and may include your preferred place of care.

Some of this information may also be included in your palliative care plan. Your GP will share the information with Out of Hours GPs (111 service) and the ambulance service.

Lasting Power of Attorney (LPA)

This can only be made when you have the capacity to make decisions and relates to financial affairs and/or your health and welfare. Your nominated attorney (s) can then make decisions in your best interests (as long as these are practical and achievable). The health care professional and GP may ask to see this document.

Please ask a healthcare professional for help to complete any of the above documents.

Page two: what are your current needs, preferences, wishes, goals and choices?

These questions allow you and your family to explore what is important to you from both a health and wellbeing perspective. Think about your current health, such as whether you have pain or difficulty breathing: what concerns you most and what is more tolerable.

Think about your social situation and whether you would benefit from further support or assistance with housing needs or finances. Consider who you would like to involve in your care and where you would like your care to take place.

You may want to reflect on important aspects of your life, such as food and drink preferences, types of clothes you like to wear, music preferences or whether you like a bath or a shower. You can say who you would like to visit you or be consulted about your care.

Do you have any goals that you want to achieve: small goals like improving your fatigue levels or mobility, getting out into the garden or going to the pub? You may have larger goals, such as moving house or getting married.

You may wish to be referred to the hospice team for specialist symptom control, for example pain and other symptoms. You may be eligible to attend a day centre (offered by some hospices) or receive home visits.

Page two: what matters most to you?

Are you worried or concerned about what is happening to you, do you have unanswered questions or are you anxious about something else?

You may be worried about your spouse, partner or family and the effect your illness is having on them.

Remember that physical symptoms and psychological and spiritual distress go hand in hand and improving any one aspect of your health may improve others; for example if you are less anxious you may also have less pain.

There may be a specific person known to you that you would like to talk to. If you would like to talk to a chaplain your health care professional can arrange this.

You may also benefit from seeing a psychologist for support.

Page two: when decisions about your care and treatment need to be made is there anything you would like discuss?

You may currently receive interventions to help monitor or treat your health condition. It may be helpful to discuss the ongoing benefits of these interventions if they start to become less effective or become more burdensome. For example you may have blood tests or intravenous treatments for a chest infection.

Page two: you may want to talk about what you want to happen if you became less well.

You may wish to stay at home if you become more unwell or prefer to go into a hospice or local community hospital. It is important to note, however, that a bed may not always be available.

Do you have any concerns about having care at home, such as the impact on your loved ones? We may be able to help you to stay at home by providing extra help from for example the district nursing service and planning night care.

It might be that you have symptoms that are difficult to manage, such as pain or nausea and vomiting. Specialist palliative care teams will be able to help with these, either by visiting you at home or perhaps through an inpatient stay at your local hospice.

Page three: is there anything else you would like to talk about?

Your nurse and/or GP can discuss any issues or concerns you or family may have, including any difficulties in taking medication: your medication may be changed from tablet to liquid form or some of your medication may be stopped.

If you have difficulties managing you medication you may like your tablets to be put in a dossett box. This is a box with tablets in individual compartments, filled by the pharmacist.

You may be concerned about your finances or unsure whether you have all the benefits you are entitled to or need help with travelling to appointments. Please refer to useful contacts for example, Age UK for transport support.

Other information
Page three: are any of the following in place?

Social or NHS funding: Formal care can be privately funded or funded through the council (social care) or the NHS depending on your condition and level of need.

Attendance Allowance or Personal Independence Allowance: You can apply for this benefit if you require any help with your activities such as washing and dressing. You may be eligible for the higher rate if your condition is advanced and you have a limited life span or if you need help night and day.

Anticipatory medication: Your doctor may prescribe medication that is given by injection; this is called *anticipatory medication* and may come in a jiffy bag. This can be kept somewhere safe until it is required.

Day care: You may require assistance with household tasks, personal care or other activities. Visits from a formal carer or a carer living with you may assist you to maintain your independence and quality of life.

Night care: You may require some help or support at night or if you have an informal carer they may require support and relief from caring.

If you would like help at night your district nurse or health care professional involved can refer you to a night sitting service such as Marie Curie or help you find private care.

Marie Curie is a free service. It can provide registered nurses and senior healthcare professionals to sit from 10pm until 6:30am for anyone with a palliative diagnosis, on a priority basis.

Are you registered as an organ/tissue donor?

If you want to donate your tissue after your death you will need to be on the NHS organ donation register.

It is very important that your family/close friends understand and support your decision because their support is needed for donation to go ahead.

Further advice and support contact details.

Community nurse team:

If you are no longer able to go out a community (district) nurse will visit you at home to take bloods or complete other health care tasks.

Clinical nurse specialist/hospice:

The hospital may refer you to the community specialist palliative care team, based at your local hospice.

A nurse will arrange to visit you at home and help you with any symptoms such as pain or breathlessness and psychological care.

Community matron:

If you need help with coordinating your care your GP or other clinicians involved may ask if you would like to be referred to a community matron, the community matron works alongside other community teams such as community nurses and therapists and can also help with symptom management.

Out of hours:

The Out of Hours service provides medical support when your GP surgery is closed. A paramedic or doctor will come out to visit you during the evening or overnight if necessary.

Hospital at Home:

The Hospital at Home team provide medical treatments at home such as IV treatments and are also available during the Out of Hour period. With your consent you will be added to their palliative care list by your key worker. The team consists of nurses and paramedics who work alongside the GP Out of Hours and Urgent Care services.

Other:

You may have someone else involved in your care such as a neighbour or care provider. You may want to put their details on your care plan.

Concerns and complaints

We aim to provide you with a high quality service at all times. However, if you have any concerns, complaints or comments about your experience of our service then please tell a member of the team or contact the Patient Advice and Liaison Service on freephone 0800 328 7971.

If you need the information in another language or format please ask us

Nëse ky informacion ju nevojitet në një gjuhë apo format tjetër, ju lutem na kontaktoni

আপনি যদি এই তথ্যাদি অন্য কোন ভাষায় বা মাধ্যমে (ফরমেট) পেতে চান তবে দয়া করে আমাদেরকে বলুন

જો તમને આ માહિતી બીજી ભાષામાં અથવા બીજા આકારમાં જોઇએ, તો કૃપા કરીને અમને પૂછો

यदि आपको यह जानकारी किसी दूसरी भाषा या आकार में चाहिए हो तो कृपया हम से पूछें

若您需要本信息的另一种语言或格式的版本，请与我们联系

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੀ ਦੂਜੀ ਭਾਸ਼ਾ ਜਾਂ ਸ਼ਕਲ ਵਿੱਚ ਚਾਹੀਦੀ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰ ਕੇ ਸਾਨੂੰ ਪੁਛੋ

اگر آپ کو یہ معلومات کسی دوسری زبان میں یا کسی دوسرے طریقے سے درکار ہوں تو برائے مہربانی ہم سے پوچھیں۔

Oxford Health NHS Foundation Trust
Trust Headquarters
Warneford Hospital
Warneford Lane
Headington
Oxford, OX3 7JX

Switchboard 01865 901 000
Email enquiries@oxfordhealth.nhs.uk
Website www.oxfordhealth.nhs.uk

This service is provided by our Older People Directorate.

OP 015.18