My Care Wishes – Personalised Shared Care Plan

Version 20 Feb 2020

This care plan is for you to record your preferences about how you would like to be cared for should you become less well. This form should always be available to you and your care team.

Information About You

Name	GP Surgery GP Name
Date of Birth	Diagnosis
NHS Number	Other medical conditions (relevant to your current care)
Address Postcode	Allergies
Contact Tel. Home: Contact Tel. Mobile:	Frailty Score
1. Next of Kin/Family Carer Name: Relationship: Telephone home: Telephone mobile:	2. Next of Kin/Family Carer Name: Relationship: Telephone home: Telephone mobile:

Care Plan Discussion - Who is Helping You With This Care Plan?

Family member or friend involved in this discussion	Name: Relationship: Telephone:
Do you have a Registered Lasting Power of Attorney for Health and Welfare?	Name: Telephone (if not already given):
Health or Social Care professional involved in this discussion eg. Nurse, Senior Carer, Carer, Physiotherapist	Name: Role: Telephone:

Your General Care Needs

Who Supports you?	Name: Relationship: Telephone:
Care Agencies involved	Name(s) Telephone:
What is important for your care team to know how to care for you? e.g. Communication Eating and drinking Swallowing difficulties/Risk based Feeding Moving and Handling, include equipment Skin Care eg Continence, pressure area care, pressure relieving equipment Equipment e.g. Oxygen	

Your Urgent Care Needs

As you become less well and need further treatment, if possible **where would you most like to be cared for?**	**Circle your preference** Usual Place of Residence Hospital Other:

Some situations may benefit from urgent active care (such as sudden bleeding/severe anaemia etc.) Do you have a preference to how your needs might be managed? If you do have a preference, please tick (✓) the circle below that applies to you, knowing that in all situations comfort and symptom control will always be a priority.

Maximum Active Care	**Treat potentially reversible life threatening conditions early**	**No Further Active Treatment**
I would like to be actively treated in all situations.	I might like treatment in some circumstances such as sudden bleeding, severe anaemia, worsening kidney function, chest infection.	I am likely to decline further active treatment, including antibiotics for infection/hospitalisation for urgent care.

Emergency Plan Should Your Carer Become Unwell

What action should be taken should your family carer become unwell?	Action:

Your Final Days

If you become less well and you are not expected to recover, what is the most important thing for you?	
Where would you most like to spend your final days?	**Circle your preference** Usual Place of Residence: Other:
Do you have a signed and dated DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form?	**YES** **NO**
Do you have 'Just in Case' medications? (To be used should you have new or worsening symptoms for which you require urgent medication)	**YES** **NO**

Your Additional Comments

Do you have any special requests, preferences, or other comments? e.g. faith, spiritual needs, music, pets, favourite possessions	
Are there any additional comments from other people you are close to? (please name)	

Consent to Share This Information With Your Care Team		**Review Date**
Your Signature/Registered Lasting Power of Attorney for Health and Welfare	Signature Name Date	
Health or Social Care professional eg. Nurse, Senior Carer, Carer, Physiotherapist	Signature Role Date	

Directory of Key Contacts

To help in co-ordination and delivery of end of life care, make a note of contact details for local services and professionals who you may need to call upon.

Would staff please add appropriate numbers marked with * as a priority		
Contact	**Details**	**Additional Information**
Local GP Surgery	*	
District Nurses	0300 123 2425	
Early Intervention Team (EIT)	West Suffolk 0300 123 2425	When telephoning, ask for 'EIT' 24/7 availability
Reactive Emergency Assessment Community Team (REACT)	Ipswich and East Suffolk 0300 123 2425	When telephoning, ask for 'REACT' 24/7 availability
Out of Hours GP Provider	111	Available when normal GP surgery is closed (1830-0830)
Specialist Palliative Care Team: • Community Palliative Care nurses	*	
St Elizabeth Hospice	01473 707044 (community secretaries available 0900-1900 weekdays 0800 56 70 111 (One call palliative care advice line)	For referrals and office hours contact for community teams. 24/7 availability to patients, families and health and social care staff. *N.B. These services are able to assist with the management of patients at home/care home.*
St Nicholas Hospice Care	01284 702525 01284 766133	For all clinical services 0900-1700 Mon – Fri. This number will also direct you to the clinical mobile number for 0900-1600 weekend and bank holiday support Main reception number, and for all clinical support outside the above times
Hospital (l ocal)	West Suffolk: 01284 713000 Ipswich: 01473 712233	
Care agency		
Pharmacy		
Marie Curie (Nurse link)		
Advocacy Services – Independent Mental Capacity Advocate (IMCA)		
Social Services		
Equipment Store		
Benefits Advice		
Dementia Intensive Support Team (DIST)	West Suffolk - 01284 733260 Ipswich and East Suffolk – 01473 891733	Monday – Friday 0900-1700
Age UK Suffolk – Information and advice	01473 351234	Monday – Friday 0900-1630
Suffolk Family Carers – Information line	01473 835477	Mon, Weds & Thurs 0900-1700 Tues 0900-1930 Fri 0900-1600
Other		

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

Suggested actions for patients with frailty score 5-6

- Undertake a medication review
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti-hypertensives should be used with caution
- Start new medication at low dose with very gradual increments
- Use personalised goals when applying disease-based guidelines e.g. for diabetes, hypertension and CKD
- Avoid over treating hypertension & diabetes
- Screen for falls and refer to local healthcare team if required
- Check for postural hypotension if falling
- Consider need for calcium/vitamin D if housebound

- Refer to community matron if 3 or more long-term conditions
- Discuss with local healthcare team at multidisciplinary meeting
- Generate a personalised shared care & support plan outlining treatment goals and management plans for urgent care
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Consider whether an increase in social care is required

West
Nursing and therapy services (including Community matron) referral no: 0300 1232425
Geriatrician referral no: 01284 713299

East
Geriatrician hotline referral no: 07930 181236 (Mon-Fri, 0900 – 1700)

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Suggested actions for frailty score 7-9

- Undertake a medication review
- Aspirin, warfarin, opiates, anti-cholinergics, antidepressants, ACE inhibitors and anti-hypertensives should be used with caution
- Start new medication at low dose with very gradual increments
- Use personalised goals when applying disease-based guidelines e.g. for diabetes, hypertension and CKD to avoid overtreatment
- Screen for falls and refer to local healthcare team if required
- Check for postural hypotension if falling
- Consider need for calcium/vitamin D if housebound
- Ask about memory problems and refer on if indicated
- Consider whether an increase in social care is required

- Refer to community matron if 3 or more long-term conditions
- Discuss with local healthcare team at multidisciplinary meeting
- Generate a personalised shared care & support plan outlining treatment goals and management plans for urgent care
- Consider referral to geriatric medicine if significant complexity, diagnostic uncertainty or challenging symptom control
- Consider referral to Old Age Psychiatry if complex cognitive or behavioural problems
- Discuss the patient's preferences for end of life and complete a DNACPR form if appropriate
- Consider entering patient onto the GSF register

Nursing and therapy services (including Community matron) referral no: 0300 123 2425

Geriatrician referral no: 01284 713299

My Care Wishes – Information Sheet

Version 2 Feb 2020

What is My Care Wishes?

If you are living with a long term or life limiting illness, you may be managing well with the support of your family and/or care team. However, there may be times when you become less well.

It is helpful for your family and care team to know what you would like to happen when you become less well so that the right action is taken.

It is especially helpful to consider what you would like to happen **in an urgent situation**, as you may be too unwell at that time to make a decision. Some treatments can be given in your home, such as taking tablets. Other treatments can only be given in a hospital.

How do I record My Care Wishes?

You should be given the opportunity to have a discussion with a health or social care professional so that if you become less well you know what to expect and can plan your care. This is your personalised shared care plan. The discussion should involve those persons who support you; this could be your family, your friends or your Registered Lasting Power of Attorney for Health and Welfare. If you change your mind about how you would like to be cared for, you should discuss this with the person who knows you best to record the changes.

A health care professional should assess your mental capacity prior to you completing your care plan.

Further information about mental capacity can be found at https://www.suffolk.gov.uk/mca

Who can see My Care Wishes?

My Care Wishes records important information about you, which can be shared with your care team so that the care you receive reflects your wishes.

Where should I keep My Care Wishes?

Your personalised shared care plan should be kept in the yellow My Care Wishes folder. This folder should be with you wherever you go, so that it is always available in the event of an emergency. There is a location sticker in the folder for you to state where you keep your folder at home. The sticker should be placed either on the back of your front door, or your fridge.

Other documents in the yellow My Care Wishes folder

It is important that all the information about your wishes are kept together

DNACPR – Do Not Attempt Cardiopulmonary Resuscitation

This form records a decision about whether there should be an attempt to start cardiopulmonary resuscitation should your heart suddenly stop, or your heart stops as you come to the natural end of your life. It is best practice that you, your family and your GP discuss this decision. Cardiopulmonary resuscitation will only be given if the doctor believes it is clinically appropriate. This will depend on your current state of health and other underlying medical problems.

Directory of Key Contacts

You are likely to have a number of health and social care professionals in your care team. You may also have different organisations who support you. The directory of key contacts records all these contact details.

Clinical Frailty Scale

If you are living with a long term or life limiting illness, you can be assessed for your level of frailty. This assessment helps to identify your health needs so that actions are taken to improve your wellbeing.

Further Information

If you are a healthcare professional, further information can be found at
https://wwwwestsuffolkccg.nhs.uk
https://ipswichandeastsuffolkccg.nhs.uk