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University Health Board

**mnda**  
motor neurone disease  
association  
cymdeithas  
clefyd motor niwron

**WE ARE  
MACMILLAN.  
CANCER SUPPORT**

# My health

# My care

# My decisions

This care plan contains information about me:

**my** life,

**my** values,

and thoughts about **my** future care.



## Advance Care Planning in North Wales My Health, My Care, My Decisions My Advance Care Plan

### Professional Authorship:



This advance care plan is the creation of a collaborative in North Wales made up of a wide range of contributors who have all brought a range of skills, experience and perspectives to the project.



In no particular order, these professionals include:



**Local Authority Social Care Professionals** Out of Hours medical providers  
**General Practitioners** Palliative Care Consultants **Palliative Care Nurse Specialists** Chronic Disease Nurse Specialists **Dementia Specialists** Health and Local Authority service managers **Chaplaincy** District Nurses **Voluntary Service Providers** Care Home Professionals **Hospice Professionals** Medical and Care of the Elderly Specialists **Neurological Disease Professionals**

### Acknowledgements:

Thanks to the many patients and professionals who have reviewed versions of this document before the pilot phase. The comments received have helped develop the document.

Thanks to NHS Gloucestershire for kindly allowing us to include text they had originally developed into section five of this advance care plan.

Macmillan Cancer Support in partnership with BCUHB endorse Advance Care Planning in North Wales.



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## Updating and Sharing my Advance Care Plan:

I have discussed and agreed to update my Advance Care Plan with:

<b>Name</b>	
<b>Their Role</b>	

## The dates for updating my Advance Care Plan are detailed here:

<b>Review Date</b>	<b>My Signature</b>

## I have shared my Advance Care Plan with the following people:

<b>Name</b>	<b>Their role</b>

# How to use this Advance Care Plan

This Advance Care Plan is **your** document. Filing it in is entirely optional.

Only fill in the sections or parts that **you feel are useful for you.**

# Betsi Cadwaladr University Health Board Advance Care Plan

## Section 1 - How to use this Advance Care Plan



This advance care plan is **your** document, and we want you to use it in whichever way works best for you.

That said, we would encourage you to try and use the following guidelines. The guidelines are designed to help you to record information in a way which allows the professionals involved in your care to easily understand and respect it – and that's got to be a good thing!

### Any questions?

If there is something in this advance care plan you don't understand, or would like to discuss before putting your thoughts on paper, or if you have any other question **then please ask your healthcare professional.**

## Sections

This advance care plan is made up of several different sections **but you don't have to use them all.**

It is designed so that each section works well on its own and also as part of a bigger, more comprehensive document when used with the other sections.

We would encourage you to aim to use as many sections as you feel comfortable with because that gives the best opportunity to consider as many different issues which might be important in your future care.

### Don't rush!

Take your time to complete the parts you want to - perhaps over a few weeks or months. You may want to think about some of the questions, or discuss them with others before putting your thoughts on paper, so don't rush!

**Mr Jones** jumped into his plan as soon as he received it. Within two days he had added a few comments to each page of every section, and felt very satisfied. In the following year he had another stroke, this time much larger, and he became confused and unable to speak. Unfortunately the doctors looking after him didn't get much help from his advance care plan. The thoughts he had written down weren't always very clear and were sometimes incomplete. This made it difficult to understand. His family and carers were also unable to help much because he hadn't discussed the document and his wishes with any of them.

**Mrs Phillips** approached her advance care plan in a different way. To start with she asked her community nurse to help her fill it in. Because they knew each other well it made it easier for them to discuss lots of difficult situations and then write down Mrs Phillips wishes on paper. They didn't write in the plan for two weeks after their initial chat, which gave Mrs Phillips some time to think through her wishes in more detail and to discuss them with her daughter and with a close friend. Then, they started by completing two sections. Over the next six months, Mrs Phillips had completed three more sections. She was happy with what she had written because the advance care plan had helped her to think about her priorities if her health became worse so that she could make difficult decisions for herself. She was also confident that those caring for her would find it helpful if she wasn't able to make the decisions herself.

**Remember what this advance care plan is for**

Many people find that working through an advance care plan is a good way to think about what would be important to them if their health was to change in a way which was well considered rather than rushed. In this way it can allow you to think about more of the aspects of what makes you 'You', and what is important to you, than you're sometimes able to do if your health deteriorates quickly and have to make decisions quickly.

Jim had advanced lung disease and needed oxygen at home. When he got a chest infection his breathing tended to get worse quickly. When this happened his son often panicked and phoned for an ambulance and before he knew it he was in hospital on a busy ward. Whilst Jim was grateful for the care he received it wasn't really what he wanted. He missed his dog when he was in hospital and didn't sleep very well.

He had wondered if there were any other ways of dealing with these episodes but didn't have the courage to question his doctors and carers because he thought he might seem ungrateful.

Jim was given an advance care plan by his community nurse. Over the coming few months he worked through it, asking questions he had previously wanted to but not felt able to. He discovered that there were services and treatments which could be quickly provided for him whilst still at home which might avoid having to go into hospital. He knew that home treatment might not be able to provide all the fancy tests he sometimes had in hospital but he also knew he could be at home with his dog, and sleep in his own bed and this was much more important to him. Deep down he knew his health was steadily deteriorating and that in the next few years he may even die from his lung disease. But he was happy that his priorities and values were at the centre of his plan.



## How to update or correct your advance care plan

Keeping your plan up to date is important. Your plan is a document which you can change or add to whenever you like. We've tried to make it as easy as possible for you to change parts of your document.

### Really simple changes

If the change is a simple change and if there is enough spare room in the section then you could just cross out the old entry and add in the new entry. But only do this if there is enough space to make the change without causing confusion to anyone who may have to understand your wishes.

Section 2 – About Me	
<b>My Details</b>	
Name	<i>Fred Jones</i>
Address	<del>72 <i>Owain Street</i> <i>Rhyl</i> <i>Denbighshire</i></del> <i>23 Seaview Road</i> <i>Prestatyn</i> <i>Denbighshire</i>
Date of Birth	<i>1<sup>st</sup> January 1935</i>
Hospital Number	<i>G1234567</i>

Me 2

### Slightly bigger changes

If there is not enough room, or if the change is more complicated, then put a line through the section you want to change, and enter your new wording on the 'additional comments and

Section 2 – About Me	
<b>My Details</b>	
Name	<i>Fred Jones</i>
Address	<del>72 <i>Owain Street</i> <i>Rhyl</i> <i>Denbighshire</i></del> <del><i>23 Seaview Road</i> <i>Prestatyn</i> <i>Denbighshire</i></del> <i>see correction page at end of this section</i>
Date of Birth	<i>1<sup>st</sup> January 1935</i>
Hospital Number	<i>G1234567</i>

Me 2

### Complicated changes or multiple changes

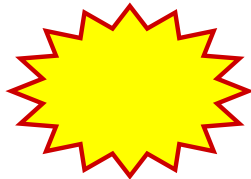
If the change is more complicated, or if there are lots of changes, then ask your healthcare professional and they'll send you a blank version so that you can start again.

## Sharing your advance care plan

This advance care plan is **your document**. That means that it is up to **you** if any of it is shared.

We recommend that you share parts of your plan, because it will make it easier for those people looking after you to respect your wishes. Only share your plan with those people that might need to know about parts of it.

Pages we feel are important to share are identified with this icon:



If you do not wish to share your Advance Care Plan (ACP) we recommend that you inform those important to you of its existence and whereabouts.

This advance care plan is **your** document. Filing it in is entirely optional.

Only fill in the sections or parts that **you feel are useful for you.**

## About Me

### My details

Name:

Address:

Telephone number:

Date of birth:

NHS Number:

### My main healthcare professional

The professional who acts as your first point of contact and coordinates your care - for example nurse, social worker, doctor.

This may change over time and may need to be updated.

Name:

Address:

Telephone Number:

Their role:

### My GP

Name:

Address:

**People important to me**

For example names, relationship to you, contact details and addresses if you wish.

**In case of emergency please contact**

Name:

Relationship:

Address:

Their telephone number:

**My values and beliefs**

You may wish to write down values that are particularly important to you. For example how you like to be addressed, your preferred language, your religious beliefs and important ceremonies, attitudes to life or ways of living your life that have always been important to you.

**My responsibilities**

Complete this if you feel you have responsibilities to care for those important to you. Include relatives, friends, pets etc.

Name(s) and addresses:

Key contact details (e.g. school, nursing home etc):

Designated guardian(s): name(s), contact details:

Other information (continue on the 'Additional Information' pages at the end if you don't have enough room):

**My wishes regarding my home life if I become unwell**

I would like the following people to be told that I have become unwell and / or admitted to hospital and for them to be given information about me on request:

I **do not** want the following people told that I have become unwell or admitted to hospital:

Other people I wish to be informed that I am not at home - for example district nurses, home care worker, regular visitors, milkman etc:

I have asked the following person to do this:

Name:

Contact details:

I have asked the following person to be responsible for the security of my home:

Name:

Contact details:



### My pets


I have the following pets:

I have asked the following people to look after my pets:

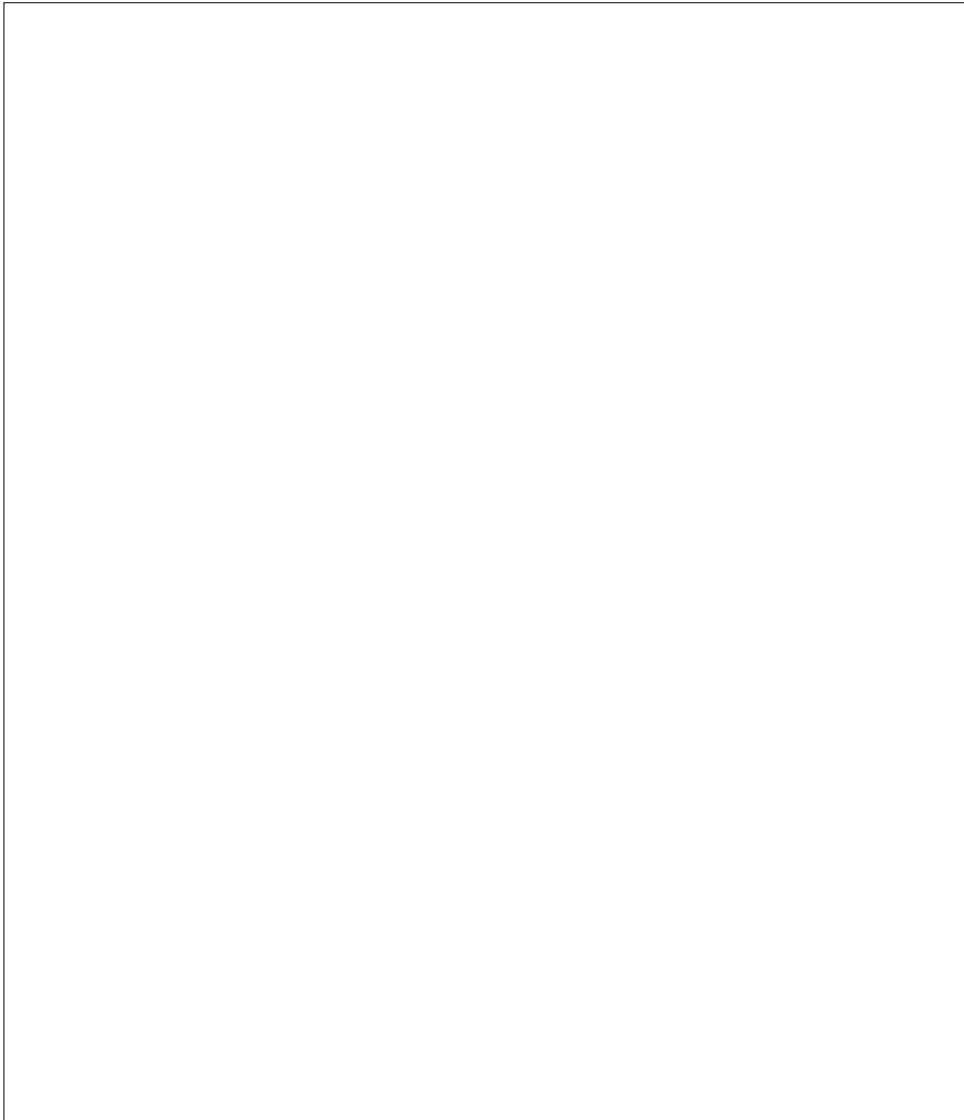
Information about my pets:

### My internet presence:

Think about your Facebook page, electronically stored photographs, music etc.  
Have you nominated an individual who will manage your electronic presence if you are unable to do this yourself?

 [www.deadsocial.org](http://www.deadsocial.org)

**Additional information or changes to this section**



This advance care plan is **your** document. Filling it in is entirely optional.

Only fill in the sections or parts that **you feel are useful for you.**

# My Health

### My Health History

You may wish to use this section to record key aspects about your medical condition(s), for example:

- Dates (year) of operations/ diagnoses
- When key treatments were given
- Allergies - name of substance and type of reaction

Any medications you have a known allergy to?

### My Priorities for Future Care

If you have thought about and discussed your wishes with others, it means they are far more likely to be achieved. Although this is not legally binding, it can be helpful for others making decisions on your behalf if you are unwell. For example:

- If your health changes, how much information would you like to receive?
- Is there anything you would ideally like to avoid happening to you?
- If you become more poorly, where and how would you prefer to be cared for?
- Have you thought about where you would like to be cared for at the end of your life?



### Discussions with healthcare professionals

You may find it helpful to record and date discussions you have had with your doctor, nurse or specialist.

For example this might be about what to expect in the future, or which treatments would or would not benefit you. Although this is not legally binding, it can be helpful for others making decisions on your behalf if you are unwell.

### Additional pages which may be of interest

With some medical conditions it can be helpful to record specific information about your preferences if certain things were to happen. For example:

- somebody with chronic kidney disease might want to write down their thoughts about dialysis
- somebody with cancer might have some thoughts to write down about chemotherapy

Ask your health care professional for more information if you think this may help you explain your wishes.

### Making legally binding arrangements for your future . . .

It is important to remember that the preferences you have recorded here are not legally binding - although those caring for you will try to respect the wishes you have recorded, they do not necessarily have to.

If you feel strongly about ensuring certain treatments **do not** happen to you, you can either appoint someone you trust to make decisions on your behalf (a Lasting Power of Attorney for Health and Welfare), or you can write an 'Advance Decision to Refuse Treatment'. An 'Advance Decision to Refuse Treatment' is legally binding upon healthcare professionals, so long as it applies to the circumstances in question.

If an Advance Decision to Refuse Treatment or Lasting Power of Attorney are of interest to you then more details can be found in the next section - 'If I cannot make decisions for myself'.

Additional information or changes to this section

**Important!**

If you write on this page we suggest you share it with others.



This advance care plan is **your** document. Filling it in is entirely optional.

Only fill in the sections or parts that **you feel are useful for you.**

## **If I cannot make decisions for myself**

This section of your Advance Care Plan (ACP) provides information about:

- Advance Decisions to Refuse Treatment (ADRT)
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) Orders
- Lasting Power of Attorney (LPA) for Health and Welfare

**Because these processes can be complicated, this section provides information only.**

If, after reading the information, you would like to know more, or would like to complete the paperwork involved, then please let your healthcare professional know.

They will help you to find more information. They will also help you arrange completion of the necessary paperwork if you wish to proceed.

## Making an Advance Decision to Refuse Treatment

You may foresee a situation where you lose the capacity to give consent to, or decline, certain treatments.

You may be concerned that, in those circumstances, doctors and nurses would assume your consent to certain treatments.

An example might be:

I am worried that if I had a severe stroke with little chance of recovery doctors and nurses would keep me alive by feeding me through a tube into my stomach.

If this prospect was unacceptable to you, it would be possible to state this in advance.

This would be an Advance Decision to Refuse Treatment.

Doctors and nurses would then be **legally bound** to respect your wishes.

An Advance Decision to Refuse Treatment must:

- state precisely what treatment is to be refused
- set out the circumstances when the refusal should apply
- will only apply at a time when the person lacks capacity to consent or to refuse a specific treatment.

If you are thinking about making an advance decision, you are perfectly entitled to write your own. However, because they must be very specific it is best to talk to a healthcare professional who knows you well.

**Important!**  
If you have an ADRT we suggest you share it with others.

## Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR) Order

Cardiopulmonary Resuscitation (CPR) is the term given to the emergency attempts taken to restart a person's heart or breathing when either stop.

CPR may include:

- 'mouth to mouth' breathing
- up and down compressions on the chest
- electric shocks to try and restart the heart
- putting a tube into the windpipe to artificially inflate the lungs.

Some people may not wish to have CPR if their heart or breathing stops. If the professionals providing your healthcare know this then they will respect your wishes. If they are unsure about your wishes they may decide to attempt CPR.

### Why might somebody not want CPR?

The commonest reason is when somebody has a serious health condition or generally poor health. We know that CPR is less likely to be successful in people with serious health problems. And where CPR is successful in restarting your heart and breathing, in these circumstances, it is more likely to be associated with long-term complications and may not result in a full recovery.

If you have an illness which is causing your health to deteriorate and which may eventually lead to your death, you may have decided that when your heart and breathing stops you want to have a 'natural death' and so do not want anyone to attempt CPR.

We have a form to complete if you do not want to be given CPR. The form will be respected by all of the health professionals who work for the NHS in Wales.

### What if I change my mind?

If you have completed a DNA-CPR form, but have now changed your mind, it is important to let the healthcare professionals looking after you know straight away so that they can discuss this with you. Changing your mind does not necessarily mean you will receive CPR if your heart or breathing stops. CPR will only be attempted if the doctors in charge of your care believe it is appropriate to do so, and that there is a likelihood of success.

**If you need more information about DNA-CPR**

Your doctor or nurse can provide you with more information about cardiopulmonary resuscitation (CPR) if you are worried about what it means for you.

**If a DNA-CPR form has been completed for you**

It helps to make sure those important to you are aware.

1. If you have a completed DNA-CPR form then we will share this information with others on your behalf such as your GP, out-of-hour medical services etc **if you give us permission to do so.**
2. It is a good idea to keep your completed DNACPR form with you.

**Important!**

If you have a DNACPR form it is vital to let others know where it is.

## Lasting Power of Attorney for Health and Welfare

A correctly completed Lasting Power of Attorney (LPA) is a legally enforceable document, covered by the Mental Capacity Act 2005, which allows you to plan in advance for others to make decisions on your behalf if you are unable to do so for yourself.

There are two types of Lasting Power of Attorney (LPA):

- **Health and welfare** - allows the person you have appointed to make decisions on treatment, care, medication, etc.
- **Property and financial affairs** - allows the person you have appointed to make decisions about paying bills, dealing with the bank, collecting benefits, etc.

Some people complete one of the two types of LPA, and others complete both. Decisions about your healthcare can only be made by somebody you have appointed under an LPA if it is a health and welfare LPA, and then only if you cannot make the decision for yourself.

An LPA has to be completed using an official 'Lasting Power of Attorney form' which can be downloaded from the DirectGov website: [www.direct.gov.uk/mentalcapacity](http://www.direct.gov.uk/mentalcapacity)

A lasting power of attorney has to be registered with the Office of the Public Guardian before it can be used. There is a charge for this.

Your completed Lasting Power of Attorney form must also be signed by somebody who can certify that they have spoken to you privately, and that you understand the powers you are giving away to somebody else if you lose capacity to make decisions for yourself. This person cannot be a member of your family - most people use a solicitor or another professional who understands the Mental Capacity Act, and that person may charge you a fee to undertake this.

A person appointed by a Lasting Power of Attorney for Health and Welfare to make decisions on your behalf can only do so **if you are unable to do so for yourself**.

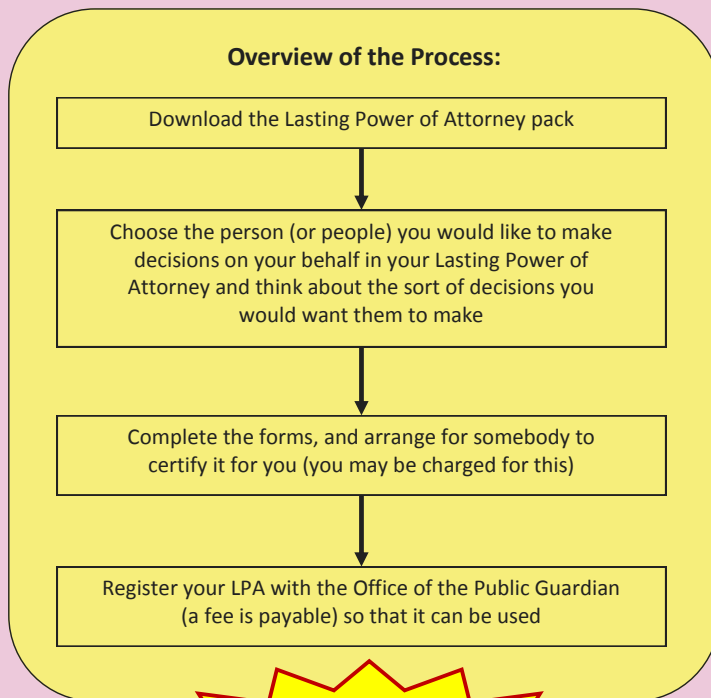
To make a decision about your healthcare the Lasting Power of Attorney must be a '**Health and Welfare**' type.

More information about making a Lasting Power of Attorney, including a Lasting Power of Attorney information pack, can be obtained from the DirectGov website:

 [www.direct.gov.uk/mentalcapacity](http://www.direct.gov.uk/mentalcapacity)

Completing a Lasting Power of Attorney can be complicated - although you don't have to seek legal advice we would encourage you to do so, but remember you will be charged by your solicitor for their advice.

Whether or not you seek legal advice, your LPA **must** be registered with the Office of the Public Guardian before it can be used, and a fee is payable for registration. Details are included in the Power of Attorney information pack.



**Important!**  
If you have an LPA Health and Welfare we suggest you share the fact with others.





This advance care plan is **your** document. Filling it in is entirely optional.

Only fill in the sections or parts that **you feel are useful for you.**

# Arrangements for after my death

**Introduction - Arrangements for after my death.**

Putting your affairs in order can greatly reduce the burden and anxiety for those you leave behind. You may wish to think about:

- Making a will
- Writing down your funeral arrangements
- Ensuring someone you can trust knows where to find your :
  - bank account details
  - pension details
  - insurance policies
  - passport
  - driving licence
  - birth / marriage certificate
  - morgage details
  - hire purchase agreements
  - solicitors contact details
  - tax office contact details
  - other important documents

It can be helpful if your wishes around tissue / organ donation are known:

I am a UK registered donor. My registration details are: \_\_\_\_\_

**If you live in Wales** and you have not registered a decision on organ donation, from 1st December 2015 you will be treated as having no objection to being an organ donor. This is called deemed consent.

If you **do not want** your organs donated then you may register your decision and / or tell your family / loved ones about your choices.

I have asked this person: \_\_\_\_\_

To be the person who will access the detailed information if required.

Their contact telephone number: \_\_\_\_\_

**Funeral Planning**

The person who has agreed to be responsible for making my funeral arrangements is:

---

My preferred funeral director is:

---

I wish to be buried / cremated / other (e.g. donation for medical science - specific arrangements will need to be made in advance, you can discuss this with your healthcare professional.)

---

I wish my funeral arrangements to be in accordance with my faith (please state):

---

I would like the venue to be:

---

I would like the following hymns, reading or music included:

---

---

---

I would like the following person(s) to conduct the service if possible:

---

Other details / information you would like to record (e.g. donations to charity, people you would like to be informed):

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---

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**Additional information or changes in this section**

**Managing my internet presence:**

Have you nominated an individual to manage your internet presence?