Looking ahead

A document to inform future best interest decisions decisions about end of life for people living in care homes who lack capacity to engage in their future healthcare

This document has been produced to help care home staff open up discussions with families about resident care needs towards the end of life for people with dementia.

It aims to enable discussions between friends/family and the caring team (GPs, nurses, district nurses and care home staff) in order to inform any future best interest meetings. It is important wherever possible to involve the resident in these discussions, and to remember that people do not always lose the ability to communicate despite cognitive impairment. The ability of people with dementia to engage in discussions can vary from day to day or even throughout the day. Health and social care professionals need to assess the individual's capacity to be involved in end of life care discussions. Discussions in this document are based around the care the person themselves might have wanted at the end of life. Family/friends/staff who have this knowledge can collectively record their thoughts in this document. The questions in this document might help guide discussion.

This is not a legal document. However if a decision regarding future care needs to be made, the information in this document should be made available to decision makers.

Name of resident

Their date of birth

Their GP's name

Their District Nurse's name

Their next of kin who is point of contact

Name

Address and postcode

Telephone

Does anyone have Lasting Power of Attorney for their property and affairs? ☐ Yes ☐ No

If YES, please supply copy of document and provide their details here

Name

Address and postcode

Telephone

Does anyone have Lasting Power of Attorney for their personal welfare? ☐ Yes ☐ No

If YES, please supply copy of document and provide their details here

Name

Address and postcode

Telephone

Is anyone a Deputy of the Court of Protection? ☐ Yes ☐ No

If YES, please supply copy of document and provide their details here

Name

Address and postcode

Telephone

Is there any previous documentation such as an advance statement or an advance decision to refuse treatment (ADRT)? ☐ Yes ☐ No

If YES, please supply copy of document

1 Were there any particular wishes that your relative/friend/resident wanted to try to achieve while still able? If so, is there anything we can do to help with this?

2 Do you know of any specific worries that your relative/friend/resident talked about if their health started to decline towards the end of life?

3 Do you have any specific thoughts about where your relative/friend/residents might want to be cared for at the very end of life?

4 Do they have a particular faith or belief system that has been important to them? Would they like a minister/other to visit toward the very end of life?

5 Is there anything else not yet mentioned that is important for us to know? For instance: more personal touches that would mean a lot to you/your relative at the very end of their life; funeral details: burial/cremation.

There may be circumstances where a decision to transfer your relative/friend to hospital at the very end of their life is important (such as breaking a leg following a fall). However, in normal circumstances, it is perfectly possible for care home staff (alongside GP/district nurses) to manage the comfort measures at the end of life in the care home. Any further discussion can be documented below.

Summary of further discussion

Details of those present at the discussion

Name	Telephone
Name	Telephone
Name	Telephone
Name	Telephone
Name	Telephone

Care professional leading the discussion

Name

Signature **x** Date

Reviews

First review

Date of review

Names of those present at review

Summary of review

Second review

Date of review

Names of those present at review

Summary of review

Terms explained

Advance statement This is a statement of wishes, preferences, values and beliefs. It is useful when making 'best interests' decisions on behalf of someone who lacks capacity but is not legally binding. If you aren't able to make decisions for yourself, your advance statement will be taken into account when a decision is made in your 'best interests'.

Advance decision This is a decision to refuse treatment. It must be in writing if it relates to life sustaining treatment, signed and witnessed and is legally binding under the Mental Capacity Act 2005 if valid and applicable. This was previously known as a Living Will.

Deputy of the Court of Protection The Court of Protection makes decisions and appoints deputies to act on behalf of people who are unable to make decisions about their personal health, finance or welfare.

Lasting Power of Attorney (LPA) – property and affairs This allows you to choose someone else to make decision about how to spend your money and manage your property and affairs.

Lasting Power of Attorney (LPA) – personal welfare This allows you to choose someone to make decisions about your healthcare and welfare. This includes decisions to refuse or consent to treatment on your behalf and deciding where you live. These decisions can only be taken on your behalf when you lack the capacity to make the decisions yourself and must be taken in your best interests. All LPAs must be registered with the Office of the Public Guardian to be valid. Further information and forms can be found at **www.publicguardian.gov.uk**

Mental Capacity Act 2005 The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

Next of kin There is no legal definition of next of kin so people can choose who they want to designate such as a close friend. If no one has been chosen and the person lacks capacity to chose, the spouse or life partner will normally be treated as next of kin or the closest blood relative if there is no spouse or life partner.

Further information

Mental Capacity Act

www.justice.gov.uk/guidance/mca-info-leaflet.htm

Chapman S (2008) *The Mental Capacity Act in Practice: Guidance for End of Life Care*. London; National Council for Palliative Care.

Best Interest Guide

www.endoflifecareforadults.nhs.uk/publications/bestinterestseolguide

Advance Care Planning

www.endoflifecareforadults.nhs.uk/publications/pubacpguide

Regnard C (2012) *Deciding Right; An integrated approach to making care decisions in advance with children, young people and adults*. www.theclinicalnetwork.org

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