ACP

Anticipatory Care Planning in Care Homes
I am mostly speaking about care homes but as GP’s we have all spoken to patients who are vulnerable about their wishes more over last 3/12

Triggers for ACP should be
- Recurrent hospital admissions
- New diagnosis of life limiting illness
- Vulnerable patient/family
- Residential care resident
- Frequent OOH contacts
• Very important at all times but even more so in Covid 19
• Important to consider patient’s individual wishes and what they feel is important to them
• Does not need to be decided there and then but can we worked on over time
• In my care homes (usually) the nurses do some discussion re what is important to the patient on admission and then ACP began at the 4 week meeting
• Why do I feel it is important?
• Please ensure it is documented what each patient would like to happen if they become seriously ill with Covid19 and what they would not like to happen (i.e. admission/stay at home) and that it is clearly documented in both the care home and on KIS.
• Having a DNACPR in place and/or a VOD is does not constitute an ACP and should not result in nursing or medical staff assuming the patient is not for admission in event of illness.
• As we know treatment of Covid19 is supportive and in the majority of cases should be possible in the care home. In the care home we can provide personalised care by staff who know the patient, just in case medications and oxygen.
• Discussions with patients and their families can be difficult and there is a RED-MAP tool (next slide) to help if you felt a tool might be helpful it is attached.
**RED-MAP** is a 6-step approach to conversations about planning care, deteriorating health and dying developed in Scotland and with SPICT partners in the UK and internationally. It is suitable for all care settings.

**Ready:** Can we talk about your care and what Coronavirus might mean for you?

**Expect:** What do you know? What do you want to ask? What worries you?

**Diagnosis:** What we know is…. What we don’t know is… What we are not sure about is…

**Matters:** What matters to you? What is important to you and your family if you get very unwell?

**Actions:** What we can do to help is…. This does not work or help when/if/because…..

**Plan:** Let’s make a plan for good care for you and your family.

– Each step in RED-MAP is important, as is the order of the steps.
– Suggested phrases are adapted to the person or family, place of care and context of the discussion.
– Always refer to the person by name when talking with their family or a close friend.
– If talking with people by phone: check you have the right person; ask if it is a good time; speak slowly in shorter sentences; keep checking what’s been understood and how people are.
– Ask for help and support from colleagues, senior staff or a specialist. Seek a second opinion, if needed.
ACP

1. **INVOLVE THE PERSON, FAMILY AND OTHER IMPORTANT PEOPLE**
   - Discuss by phone or video chat to reduce spread of infection
   - What matters to your dad?
   - Phone next of kin power of attorney

2. **THINK AHEAD WITH ANTIPHYTARY CARE PLANNING**
   - If you were to become seriously unwell, due to an infection such as the coronavirus, how would you like to be cared for?
   - What things would be important if you were more seriously unwell and might die?
   - We can care for you well here.
   - Hospital admission is unlikely to help, and may not be available.
   - Share plan with GP practice

3. **MORE UNWELL: REASSESS**
   - Consider cause for deterioration - is it reversible?
   - Stop unnecessary medications
   - Review regularly
   - WE NEED TO TALK ABOUT DYING
   - We can still care compassionately with PPE
   - Prescribe 'just in case' medication - in case of deterioration

4. **CARING AT THE END OF LIFE**
   - We're here to help
   - More complex care for elderly
   - Palliative care services
   - Social, spiritual, psychological

5. **SEEK HELP FROM COLLEAGUES AND EXPERTS**
   - Ask for help and support
   - Call on expertise

6. **CARE CONTINUES AFTER DEATH**
   - Phone family and explain death certificate
   - Look after yourself
   - Could be your own voice, again.
ACP tools for recording ACP

- Templates for recording decisions
- NHS Lothian ACP document is what I use in care home for clear documentation
Making a plan: Anticipatory Care Planning questions for residents

There are changes in health that do sometimes happen in frail older people. Please tell us which option is closest to how you think you would like to be cared for. We will use this information to help us make a Care Home Anticipatory Care Plan for you.

1. If you had a sudden illness (such as a stroke or a heart condition), how do you think you would like to be cared for?
   a) Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.
   b) Contact a family member close friend, if possible, to talk about whether or not to send you to hospital, before phoning for an urgent (999) ambulance.
   c) Send you to hospital for tests and other treatments, if this is going to be of benefit to you.

2. If you had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how do you think you would like to be cared for?
   a) Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.
   b) Contact a family member close friend, if possible, to talk about whether or not to send you to hospital.
   c) Send you to hospital for tests and other treatments, if this is going to be of benefit to you.

Intensive care treatment does not help people who are already very frail and in poor health from underlying health problems. It is better to care for them in other ways.

3. If you were not eating or drinking because you were now very unwell, how do you think you would like to be cared for?
   a) Keep you comfortable, clinically assess you, treat any pain or other symptoms, and care for you in your care home.
   b) Contact a family member close friend, if possible, to talk about whether or not to send you to hospital.
   c) Send you to hospital for tests and other treatments, if this is going to be of benefit to you.

If we think you have a serious fracture (such as a hip fracture) we would usually send you to hospital for treatment, as that would be the best way to care for you.

Is there anything else about your health and care that it is important for us to know?
(Any specific illness or treatment that needs a plan such as epilepsy, diabetes or tube feeding)

We can share this information with the people who are close to you by sending them a copy.
If you DO NOT want this information shared with the emergency services, please tick here ☐

Resident’s name……………………………………………… Date………………………………
Other options

- Directly complete the ACP template on clinical portal
- My ACP document from Scottish Government
- 4 page PDF version of ACP (similar to KIS)
- HIS developed a Covid ACP for use in care homes
An essential ACP for those most vulnerable to coronavirus

Ask: 'If you were to become seriously unwell due to an infection such as the coronavirus, how would you like to be cared for?
Ask: 'Is there anyone that you would like to be involved in future decisions about your care, if you were to become unwell (e.g. a friend, family member or carer)?
Note: Specific care options e.g. ventilation in intensive care may not be available or appropriate. It may help to explore this further and consider whether comfort options such as symptom control would be a priority.

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<th>The things you would like:</th>
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<th>The things you do not want:</th>
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<th>Any other information around preferences for care:</th>
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<tr>
<th>Discussions about cardiopulmonary resuscitation:</th>
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<th>Is this person to have cardiopulmonary resuscitation?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>If NO, Is a DNACPR form completed?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<th>The people you would like to be involved in decisions about your care. (List names and contact info.)</th>
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<td>Do any of these people have power of attorney or welfare guardianship? YES/NO</td>
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<td>If so, what are their names?</td>
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<th>Other important contacts (next of kin / carer / neighbour):</th>
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<th>Key worker (social / health care worker/ mental health support/ others )</th>
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<tr>
<th>Name and contact details of Responsible Clinician (Consultant/ GP/ Other)</th>
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<tr>
<th>Name and designation of person who has led this ACP discussion</th>
<th>Date completed:</th>
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<th>Consent obtained to share in Key Information Summary (good practice but not mandatory)</th>
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<td>Yes</td>
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Please send this completed electronic word document to the GP practice so that the above information can be copied and pasted into the special notes section of the Key Information Summary.
ACP

- All tools now available on www.ec4h.org.uk
- Once the tools have been used to ask the right questions and document decisions, this needs to be transferred to KIS or clinical portal and make sure care home have this clearly documented in patients notes.
- Please populate the special notes and upload relevant coding to KIS and information like eGFR or usual saturations if relevant.
ACP difficult discussions

• Difficult times in particular at the moment during covid as families not able to routinely visit.
• Useful to reflect on what condition was like just before covid when they last saw their relative and how they had been 6/12 or 1 year before
  – How do they feel family member is/was
• What are their expectations? For e.g how did relative cope with last hospital admission/what do they think the benefits would be
• Listen to their concerns? Do they have concerns about care in care home
• DNACPR discussions can be difficult too- in care homes i do discuss with patients/relatives
Use of Oxygen in Care Homes
• CRRT in GGC have pulled together community resources
  – Community respiratory team
  – Secondary care respiratory nurses
  – Pulmonary rehab team
  – 8-6pm 7 days a week
• Previously they could provide an oxygen concentrator into care home with a few hours notice with a verbal request
• This was to help support patients with confirmed or suspected Covid 19 who were breathless/sats<85% and had not had any benefit from opiates and benzodiazepines
• Really was another form of palliation in the care homes that we had hoped would reassure families
• Felt to be useful
• Now all care homes in GGC have been offered oxygen concentrators by the CRRT/comissioning
• Majority have accepted this and it should be in place
• Means no delay getting these to patients as often patients can become very unwell very quickly
Advice for families
Visiting at end of life

- Not to visit if any symptoms of Covid 19
- Wash hands before they go to care home and on arrival
- Wear PPE
- Keep distance from staff
- After visit ask staff to help family doff PPE correctly and wash hands
- Should wash clothes at 60 degrees and have a shower when they go home
- Do not need to isolate unless they develop symptoms if they wore PPE
- Could use the knitted hearts if families are unable to visit
Caring for relatives at home with covid 19

- Limit contact - not too many people visiting/all at once
- Ideally 2 meters away
- Ideally main care giver would not be someone in a high risk category person
- Different bedroom and different bathroom
- Open windows
- If unwell should be fed in their room
- Clean surfaces
- Wash hands
- Wash clothes at 60 degrees or double bag and leave for 72 hours if can not do this
Support in caring for unwell family at home

- District nursing service
- Home care
- Marie Curie fast track (certain areas of Glasgow)
- Marie Curie nursing service
- Local voluntary organisations can support food and medication delivery
Other questions.....
• Top tips on home visiting with PPE
  – Make up bags – mask/apron/gloves/bag for disposal/gowns (we got from ‘for the love of gowns’)
  – Each have hard surface disinfection wipes in car
  – We use own equipment and clean
  – Take spares of everything
• Role of CRRT
  – Accept referrals for patients with COPD/asthma/bronchiectasis/ILD with or without covid 19 infection
  – Admission avoidance and early discharge
  – Either home visit or remote consultation