FOSS AGM – ACP + ReSPECT FORMS

As a result of the COVID pandemic we have all been forced to think about and discuss our own mortality a little more. It is really important for us all to do this – both think and discuss with our loved ones about dying and consider what is important to us.

Advance Care Plan – ACP

This is a document which details and sets out step by step considerations in planning your future care.

Advance Care Planning (ACP) can help you prepare for the future.

It gives you an opportunity to think about, talk about and write down your preferences and priorities for your future care, including how you want to receive your care towards the end of your life. Anything can be included. If it is important to you, record it, no matter how insignificant it may appear.

Advance Care Planning can help you and your carers (family, friends and professionals who are involved in your care) to understand what is important to you. The plan provides an ideal opportunity to discuss and record in writing your views with those who are close to you. It will help you to be clear about the decisions you make and it will allow you to record your wishes in writing so that they can be carried out at the appropriate time. Remember that your feelings and priorities may change over time. You can change what you have written whenever you wish to, and it would be advisable to review your plan regularly to make sure that it still reflects what you want.

The choice is yours as to whom you share the information with. This booklet has been designed in consultation with patients and carers to assist you with the planning and recording of your preferences and wishes. By recording your preferences in this booklet it will help

to ensure that your wishes are taken into account. Not all of the sections in the booklet need to be completed and you can take your time completing those that you wish to use but a good place to start the first section “Statement of your wishes and care preferences” on page 4

There are five parts in total

Statement of your wishes and care preferences page 4

Advance Decision making page 8

Putting your affairs in order page 14

Making a Will page 17

Funeral planning page 18

ReSPECT FORMS

A new national scheme was initiated in Sept 2020 to encourage patients and health care professionals to complete a Respect form together following an Advance Care Planning conversation. Respect stands for Recommended Summary Plan for Emergency Care and Treatment. These forms are used throughout the UK and therefore are recognised by all Health Care Professionals within the community and hospital settings such as GPs, District Nurses, Paramedics, Palliative Care teams, Hospital doctors and nurses.

Respect forms are held by a patient at home and are completed by a Health care professional following a discussion with that patient. These forms are used to plan and help guide the management of future medical care and end of life care. They help clinicians understand patient’s wishes and what is important to that person in

a future emergency in which they maybe unable to express or make choices. It then helps Health Care professionals or Care professionals respond to that emergency and make immediate decisions about that persons care and treatment.

That plan is recorded on a form – it looks like this……..

It includes personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that you would want or that you would not want or that would not help or be appropriate.

In other words it records what is most important to you. Is it more important for you to be kept comfortable and stay at home or is life sustaining treatment and intervention the most important to you at whatever cost of comfort?

You are able to consider and express your preference for if you would want to be taken to hospital and also where you would prefer to die.

Respect forms also include your thoughts and wishes regarding resuscitation in the event of a cardiac or respiratory arrest – meaning whether you would want people to try to restart your heart if it stops or if you stop breathing - sometimes known as DNAR or DNR – “do not resuscitate” order. You can also indicate if you do want to have active resuscitation.

Respect forms can be for anyone but these forms are particularly important for people who have complex health needs, people who are likely to be nearing the end of their lives or people who are at risk of sudden deterioration or a cardiac arrest. Your wishes on the form can be changed at any point as your preferences and circumstances and health change.

I strongly advise you to think about your own wishes for care at the end of your life and recommend that you have an advance care planning discussion with your family and also a health care professional to complete a Respect form that you can keep at home. This ensures you have considered and documented your own priorities and wishes for the final phase of your life and that we as health care professionals respect those wishes as much as we can.

Dr Anna Chiles