Advanced Care Plan

Patient Name:	
Address	
DOB & CHI No:	

Please contact professional detailed below as soon as possible if person has an unscheduled admission.

Prepared By: **Name & Designation:**	Jill Nicholls, Heart Failure Specialist Nurse		
Signature:		**Date:**	
Practice / Service		**Tel No:**	

NOK: Relationship: Address: Contact:	**Ist contact** / Main Carer: Address: Contact:

Main clinical problem: Advanced Heart Failure, Aortic Stenosis and increasing confusion

Person has self-management plan? COPD ☐ Asthma ☐ Diabetes ☐ Anticipatory Medication ☐ None ☐ Other (specify)

Patients understanding of condition & principal areas of concern:

Family / Carer understanding of condition & principal areas of concern:

Single Shared Assessment **Completed** √ Required ☐

Key Professional / Services involved in person's care	Contact
Dr B	
DN Team	
HF Nurse	

Patient on Palliative Care / Intensive Care Register (circle which applies)	**Yes**	♥	No	☐
Has cardio-pulmonary resuscitation been discussed?	**Yes**	♥	No	☐
If Yes - Has a DNACPR form been completed?	**Yes**	♥	No	☐
If Yes - Where is it located ♥				
(AWISA) Adults With Incapacity Scotland Act completed?	Yes	☐	**No**	☐

Management Plan

Patient Name :	CHI No :

By communicating what the suggested management plan is for any anticipated changes in health status, patients should receive the best quality of care possible.

<table>
<tr><td colspan="2">Situation: (summary of current situation including social care and carers issues)</td></tr>
<tr><td colspan="2">Background: (summary of significant medical history)</td></tr>
<tr><td colspan="2">Assessment: (brief list of principle areas of concern / current problems and management)</td></tr>
<tr><td colspan="2">Recommendations: (treatment plan that reflects any anticipated deterioration and how it should be managed including alternative care options)</td></tr>
<tr><td colspan="2">Preferred place of care:</td></tr>
<tr><td colspan="2">Summary of discussion with patient / family / carer regarding care plan as detailed above:</td></tr>
<tr><td colspan="2">Key contact:
Name: ……….. Tel Number: ……………..</td></tr>
<tr><td colspan="2">I consent to information on this form being shared with relevant agencies involved in my / my family members' care:

<u>Patient</u>
Signature: Date:
<u>Relative</u>
Signature: Date:</td></tr>
<tr><td>Document on
Date:</td><td>Review Date:</td></tr>
</table>

11/12/09

A copy of the Advanced Care Plan should be retained by the person or their family / carer as appropriate