MY ADVANCE CARE PLAN

(insert photo here)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Telephone number** |  |
| **Address** | . | **Date of birth** |  |
| **Postcode** |  | **NHS number** |  |
| **Any distinguishing features in the event of unconsciousness** |

**My Advance Care Plan for the end of my life includes:**

* **My Advance Decision to Refuse Treatment** (ADRT). This is legally binding if valid and applicable (please see page 7 and 8 of [Advance-Decisions-to-Refuse-Treatment-Guide.pdf (england.nhs.uk)](https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf))
* **My Advance Statement of Wishes**(ASW) - This gives information about other matters which are important to me. (Although this is not legally binding, the Mental Capacity Act 2006 requires clinical decision makers to give due consideration to this document)

***(When applying this document, please consider the Refusals in the context of the Wishes if there is doubt about applicability or validity)***

# MY ADVANCE DECISION TO REFUSE TREATMENT (ADRT)

#  *(If you would prefer to have all treatments available, leave the following sentence in place and delete the rest* *of the* *page*

#  Please see the first sentence in my advance statement of wishes*)*

**I refuse the following treatments:** *(the following are suggestions only, please add or delete as you need. You can also be more detailed if you wish, for example by adding ‘life-extending’ in front of antibiotics and/or major surgery. NB if you wish to refuse blood products for religious reasons, please seek advice from your church)*

* cardiopulmonary resuscitation (CPR)
* clinically assisted artificial nutrition and hydration
* artificial ventilation
* antibiotics
* renal dialysis
* major surgery
* blood products

**I confirm that these refusals of treatments are to apply even if my life is at risk or may be shortened as a result**

**Circumstances in which the refusals apply**

In any situation in which I have been assessed as not having the mental capacity to make the specific decisions required when diagnosed with the following conditions: *(Delete any that you do not want to apply and add any others you do want to apply. You may wish to include the stage in a progressive disease when they would apply)*

* **In the later stages of a terminal illness:** If it is acknowledged that I am dying, regardless of whether a firm diagnosis has been made.
* **Dementia**: Once I have lost capacity
* **Brain Injury or Damage**: If I have a brain injury or damage from any cause from which I am unlikely to recover
* **A permanent vegetative or minimally conscious state**
* **Disease of the Central Nervous System**: If I have a progressive disease of the central nervous system such as, but not limited to, Motor Neurone Disease, Parkinson’s Disease, Multiple Sclerosis.

**Circumstances in which refusals do not apply***(delete if not applicable and add any other circumstances you wish)*

I **would** accept the treatments listed if they were considered essential for comfort or symptom relief

I **would** accept the treatments listed in the case of an unexpected and sudden collapse, pending diagnosis

**MY ADVANCE STATEMENT OF WISHES** *(the following are suggestions only, please delete or add as you prefer)*

# I wish to live as long as possible and would accept any treatment that my clinical team consider might extend my life

* I would prefer not to be hospitalised if I am at the end of life because of frailty or a life limiting illness (even an unexpected or acute one). If I cannot be cared for at home, I would prefer to be moved to a hospice
* If do not wish to die in my own home and would like to be transferred to a hospital/hospice/care home if death seems near
* I would prefer to receive palliative care at home, focused on alleviating pain, distress and distressing symptoms, even if such treatment might hasten death
* I would be prepared to accept some level of pain if it meant that I could communicate with loved ones and carers.
* I would want as much pain relief or sedation as needed to control symptoms even if this render me unconscious
* I would like the needs and wishes of family caring for me to be considered, as well as my own, when making clinical decisions, even about where I am cared for.
* I would prefer not to require my partner or family members to clean up my excreta and to that end would prefer to be catheterised once I cannot get out of bed to urinate.
* I would prefer to be looked after by my family, even if personal care is needed.
* I would prefer to have only female carers
* I would accept paid carers to look after me
* I would be happy/not happy to be enrolled into any research programme consistent with this plan

# I WOULD LIKE THE FOLLOWING PEOPLE TO BE INVOLVED IN DECISIONS ABOUT MY CARE

I would like the people named below to be consulted when a decision is being made on my behalf. I understand that this does not give them legal decision-making authority unless they also hold Lasting Power of Attorney for Health and Welfare that is valid and applicable for the specific decision to be made. I give my consent for them to be contacted by telephone, email, Skype/Zoom (or similar).

I would like it to be made clear to them that, whilst I wish them to be consulted when possible, they do not bear final responsibility for decisions about accepting or refusing interventions (unless they also hold Lasting Power of Attorney for Health and Welfarethat is valid and applicable for the specific decision to be made). I would like ………………………………………….. to be contacted in the first instance.

|  |
| --- |
| **Name** |
| **DOB** |  | **Relationship** |  |
| **Address** |  | **Telephone number** |  |
| **Postcode** |  | **Email address** |  |

|  |
| --- |
| **Name** |
| **DOB** |  | **Relationship** |  |
| **Address** |  | **Telephone number** |  |
| **Postcode** |  | **Email address** |  |

|  |
| --- |
| **Name** |
| **DOB** |  | **Relationship** |  |
| **Address** |  | **Telephone number** |  |
| **Postcode** |  | **Email address** |  |

# MY DECLARATION AND SIGNATURE

The decisions and preferences set out reflect my wishes. They have been made at a time when I have mental capacity and I can make them. These decisions are my own and have not been made under the influence of other people.

|  |  |
| --- | --- |
| **Name** |  |
| **Signature** |
| **Date** |  |

**WITNESS**

I confirm this Advance Decision to Refuse Treatment was signed in my presence.

|  |
| --- |
| **Signature** |
| **Name** |  | **Date** |  |
| **Address** |  | **Postcode** |  |
| **Telephone number** |  | **Email address** |  |

# GP DETAILS and DECLARATION *(this is not a legal requirement but may make the document more effective in practice)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Telephone number** | . |
| **Address** |  | **Postcode** |  |
| **Declaration***I have discussed the matters contained in this document with …….and I am satisfied that they have the capacity to make and understand the decisions in it.***Signature****Date** |