People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

National Guidance

End of life care includes the care and support given in the final weeks and months of life, and the planning and preparation for this. For some conditions, this could be months or years.
While Clair Fisher was on a work trip to the Cayman Islands a couple years ago, she had to fly to Florida for an emergency surgery. She would soon learn that the cause of her pain was advanced cancer. Clair now spends her time focusing on how she can live and die well. As part of what she calls her retirement project, Clair is advocating for early intervention to hospice, the benefits of working during a terminal illness, and breaking down the taboos of talking about death and dying.
Advance Care Planning includes:

DNACPR

ADRT

Lasting Power of Attorney

Organ donation

Digital Legacy

Advance Care Plan

Anticipatory Care Plan

Part of normal life planning
13 Dec • Written By Clare Fuller

Just a Normal Part of Life Planning

In this blog I aim to normalise Lasting Power of Attorney decision making and place it in the context of general life planning. I will touch on why LPAs aren’t in place for the vast majority of us and end, as ever, with a call to action.

There are two types of LPA, one covers Health and welfare and the other Property & Finance, details of which are covered more in blog 1 and blog 2 Business LPAs form a third category, however whilst drafting a Business LPA requires specific thinking and questioning the application follows the same process as the Property and Finance LPA (LP1F)
<table>
<thead>
<tr>
<th>Progressive disease potentially last year of life</th>
<th>Deteriorating – months to weeks (CHC Fast Track)</th>
<th>Last days of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider DNACPR</td>
<td>Fast Track Continuing Health Care</td>
<td>Anticipatory medications and chart</td>
</tr>
<tr>
<td>LPA</td>
<td>DNACPR (&amp; alert)</td>
<td>Complete Last Days of Life Care Plan</td>
</tr>
<tr>
<td>ADRT</td>
<td>Update ACP</td>
<td>Check valid DNACPR and alert</td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>Ceiling of treatment</td>
<td>Recheck carer needs and bereavement risk</td>
</tr>
<tr>
<td>Preferred place of care/death</td>
<td>Assess family and carer risk factors for bereavement</td>
<td>Use Priorities for Care of the Dying Person</td>
</tr>
<tr>
<td>Anticipate future care needs: e.g. ICD, respiratory support, dialysis</td>
<td>Act upon agreed care plans</td>
<td></td>
</tr>
<tr>
<td>Assess family and carers needs: signpost</td>
<td>DNACPR</td>
<td></td>
</tr>
<tr>
<td>Check patient is on GP Palliative Care Register</td>
<td>Check GP is aware of patient &amp; is on palliative register</td>
<td></td>
</tr>
<tr>
<td>Consider CHC application</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Needs based coding
Progressive disease, potentially in the last year of life.

- Consider DNACPR
- Preferred place of care/death
- LPA
- Assess family and carer’s needs: signpost

- Anticipate future care needs, e.g. ICD, respiratory support, dialysis
- Advance Care Plan
- Check patient is on GP Palliative Care Register
- ADRT
- Consider CHC application
Deteriorating – months to weeks (CHC Fast Track)

Fast Track Continuing Health Care

- Anticipate future care and develop MDT treatment plan for last for patients with an ICD/respiratory support/dialysis.
- DNACPR (& email to Ambulance Service, Out of Hours)

- Begin /update Advance Care Plan
- Ensure there is a clear ceiling of treatment documented and shared with appropriate teams (Treatment Escalation Plan)
- Assess family and carer risk factors for bereavement.
- Check GP is aware of patient & is on palliative register
Last days of life

Anticipatory medications and chart

Check valid DNACPR and alert

Use Priorities for Care of the Dying Person

Complete Last Days of Life Care Plan

Recheck carer needs and bereavement risk
Recognition
  Confidence
    Process
      No universally agreed national processes
      No system intra operability
About us

We are a group of independent charities, research organisations and health and social care bodies.

We are helping to drive a movement to encourage lifelong 'What matters' conversations. Our aim is to get people talking about what is important to each of us.

Having regular 'What matters' conversations enables personal wishes to be heard. That way, when we become ill or are dying, planning is easier. Those around us will know what we want and can respect our wishes. This will help us to live well to the very end of our lives.

How this initiative came about is discussed in Julian Abel’s blog. Please click here

You may be interested in a short article:

Advance care planning re-imagined: a needed shift for COVID times and beyond
Clare is a Registered Nurse with 30 years' experience in End-of-Life Care (EoLC). Clare has worked in hospices, the community, and acute sectors as a Clinical Nurse Specialist and at a regional level as a Consultant Nurse for the Gold Standards Framework. Clare is a CQC Specialist Advisor for EoLC and a Lasting Power of Attorney Consultant.

Clare delivers EoLC service analysis & recommendation, support in preparation for CQC inspection & EoLC education including:

- Managing Care in the Last days of Life
- National policy and quality drivers
- Recognition & Prognostication
- Grief and Bereavement
- Advance Care Planning
- Communication Skills
- DNACPR
- VoED

Contact clare@cfullerconsultancy.co.uk to find out more.

Clare founded www.speakformelpa.co.uk specialising in:

- Lasting Power of Attorney consultancy and drafting
- Advance Care Planning education
- Raising public awareness about planning ahead

Contact: clare@speakforme.lpa.co.uk

CFuller Consultancy Ltd
Clare Fuller RGN MSC

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