

British Heart Foundation, Marie Curie and NHS Greater Glasgow and Clyde working together to provide better palliative care for heart failure patients.

Use of Caring Together Medical Anticipatory Care Plan

This medical anticipatory care plan template has been specifically designed by the Caring Together Programme Team to support health care professionals in their assessment of supportive and palliative care needs of patients and carers living with advancing heart failure. The medical anticipatory care plan template has been developed and implemented by Caring Together as part of an integrated care model which includes specific referral criteria and core components.

Patients are referred if they meet the following **clear and concise referral criteria**:

- Have advanced heart failure (New York Heart Association classification categories III or IV)
- Have distressing or debilitating symptoms despite optimal medical therapy
- Have supportive or palliative care needs that may include a combination of physical, social, emotional, spiritual or psychological needs
- Further supplementary considerations are taken into account by clinicians referring patients, including the number of admissions in the last year and the surprise questions.

Patients who meet the referral criteria receive a **comprehensive assessment**:

- a cardiological review in outpatient or in-patient settings as appropriate
- a holistic assessment which looks at the physical, social, psychological and spiritual aspects of care is undertaken in order to address unmet patient and caregiver needs and inform future care planning and onward referral to other services.

Each patient is **assigned a care manager**, who acts as their main point of contact for information and support. Care managers are responsible for leading and co-ordinating patients' care. They work closely with a patient's GP, cardiologist, district nurse and the wider multidisciplinary team to make sure they are getting the support they need.

An individualised medical anticipatory care plan is developed (**using this template**) for each patient in partnership with lead clinician, patient and carer, which includes concise information on the patient's medical and palliative care needs. Anticipatory care plans are developed in partnership with the individual, family and carers, on how those needs can be met. Care plans are shared with the all involved in the care of the patient including unscheduled care providers.

Caring Together's **multidisciplinary approach** across the acute, community and out-of-hours care teams enables us to deliver consistent and coordinated services to patients and their carers in all care settings. The programme has also supported **joint learning** and increased awareness between health and social care professionals working across acute and community settings.

Caring Together is currently undertaking an independent evaluation. Implementation of tools outside such an integrated care model is undertaken at implementing organisation's own risk.

TEMPLATE



Caring Together Programme

Caring Together Medical Anticipatory Care Plan Summary

Patient Details:

Name:

DOB/CHI/Hospital Number:

Address:

NOK/Main Carer Details: (please insert both if NOK is different from main carer)

Name:

Contact:

Power of Attorney/Guardianship Insitu:

Yes/No

Diagnosis: **ADVANCED HEART FAILURE**

Priorities of Care:

- | | |
|------------------------------|-----------------------------------------------|
| 1. Current Place of Care: | Home/Hospital/Hospice/Care/Nursing Home/Other |
| 2. Preferred place of care: | Home/Hospital/Hospice/Care/Nursing Home/Other |
| 3. Preferred place of death: | Home/Hospital/Hospice/Care/Nursing Home/Other |

Resuscitation Status:

Cardiac Device Status:

Active/Deactivated/Not Applicable

Ceiling of Therapy:

ITU etc with Yes/No

Consultant:

Care Manager:

Professional Services to be considered if condition or situation changes:

- | | |
|----------|------------------|
| 1. Name: | Contact Details: |
| 2. Name: | Contact Details: |

Emergency contact details

Cardiology

Palliative care

Cardiac Physiology (Mon-Friday 9-5)

NB: A detailed summary of the key components of this Medical ACP summary are contained within the attached Medical Anticipatory Care Plan.

Date Completed:

Review Date:



Caring Together Programme

DEPARTMENT OF MEDICAL CARDIOLOGY
Clinic Title

Hospital Name
Hospital Address 1
Hospital Address 2
Town/City
Postcode

Consultant:
Dr XXXXX

Caring Together Medical Anticipatory Care Plan

Patient and Main Carer Details

NAME: DOB: CHI/Hospital Number:

ADDRESS:

NOK Details (*Relationship*):

Main Carer Details (*Relationship*):

Care Manager Details:

Diagnosis List:

Current Medications:

Changes to medications

Medications to stop:

Medication intolerance:

Device details: Applicable / Not applicable

Medical and Symptom Management Considerations:

Name

CHI

Priorities of Care

Current Place of Care:

Preferred place of care: 1.
2.

Device Status if appropriate:

DNA / CPR Status:

Intensive Care Referral: Not Appropriate

Central line access: Not Appropriate

Appropriate maximal medical therapy:	Inta-aortic Balloon Pump (IABP)	YES / NO
	IV Inotropes	YES / NO
	IV Diuretics	YES / NO
	SC Diuretics	YES / NO
	Oral medications	YES / NO

Transfer to hospital in the event of acute deterioration: Avoid if at all possible

Key Professional Services Currently Involved:

NAME - Consultant Cardiologist GRI

NAME – Care manager

NAME - GP

NAME - Other Consultant

Key Professional Services to be considered if condition or situation changes:

Significant Conversations

Patients Understanding of current situation:

Carers Understanding of current situation:

Helpful/Emergency Contact Numbers:

Cardiology GRI:

HFLN

DN

Consent

Has patient agreed to sharing their personal details with other professionals (including for use in ePCS and KIS):

Yes / No / NA

Has carer agreed to sharing their personal details with other professionals:

Yes / No / NA

Has next of kin agreed to sharing their personal details with other professionals:

Yes / No / NA

This Medical ACP has been agreed by:

Consultant Cardiologist (Dr XXXXX)

Sec: xxxxx – Telephone Number
Email Address

Signature:

Date:

Care Manager (Print Name):

Signature:

Date:

All components of this Medical ACP have been discussed and agreed with the patient and family members (where applicable).

Date Completed:

Review Date: Weekly
Recommend as appropriate

This patient has attended a heart failure and supportive care clinic.

This patient has met the criteria for Caring Together and should be considered for entry onto the appropriate palliative care registers

For further information on the Caring Together Programme:

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www.mariecurie.org.uk/caringtogether

www.bhf.org.uk/caringtogether

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