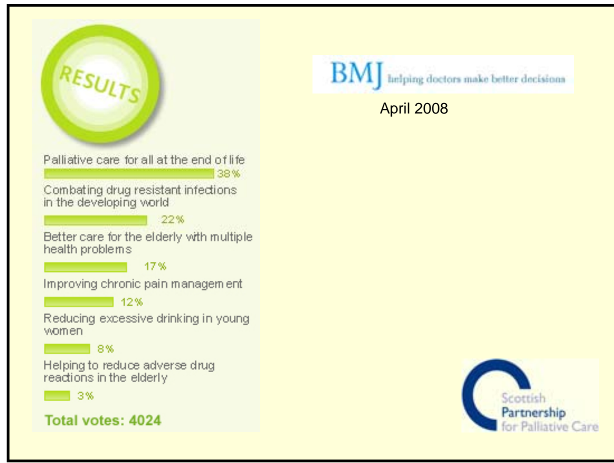

Recommendation 1 ......optimum cardiological management and palliative care.

1.1 ....on primary care supportive and palliative care register.

1.2 .....actively monitored by primary care team.............if additional advice, assessment or care from the specialist heart failure nursing service........

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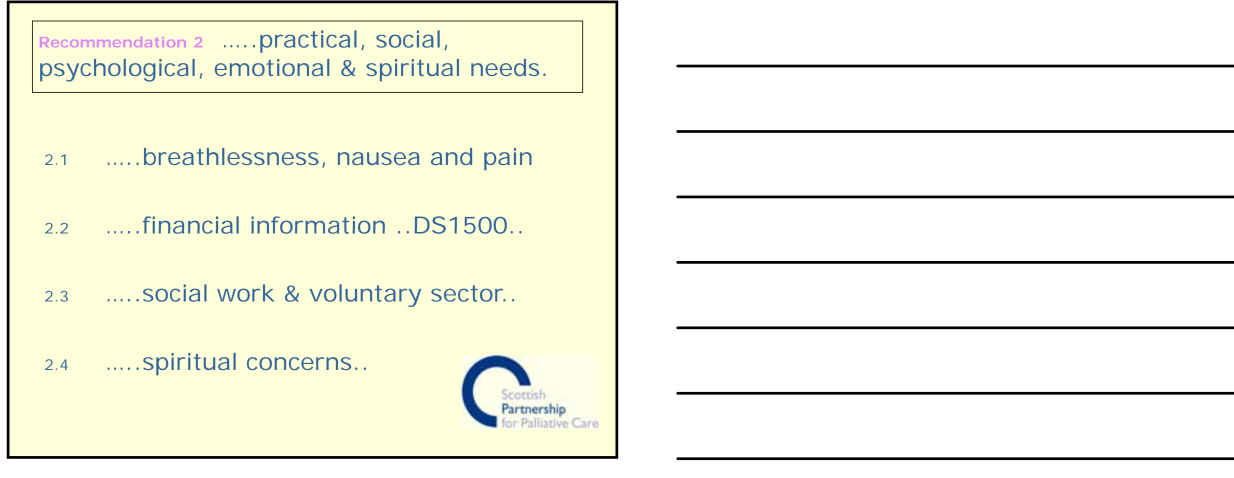
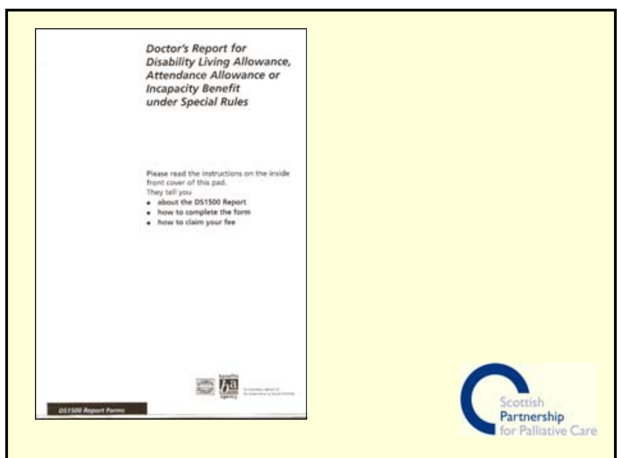
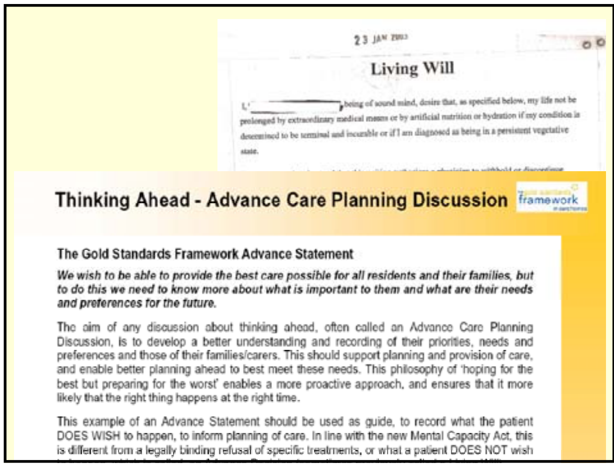
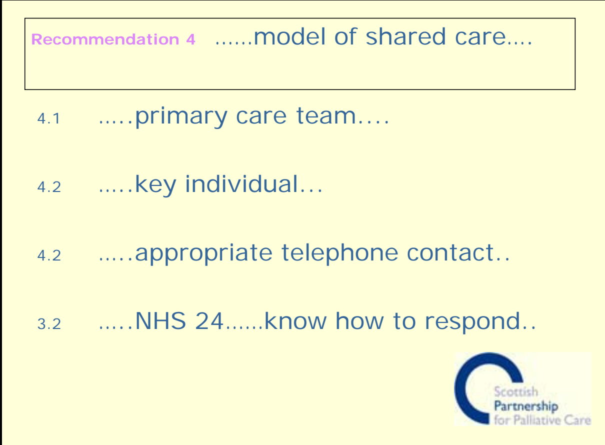



Doctor's Report for Disability Living Allowance, Attendance Allowance or Incapacity Benefit under Special Rules

Please read the instructions on the inside front cover of this pad.
They tell you
- about the DS1500 Report
- how to complete the form
- how to claim your fee

DS1500 Report Form


23 JAN 2003
Living Will
I, , being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary medical means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state.
Thinking Ahead - Advance Care Planning Discussion
framework
The Gold Standards Framework Advance Statement
We wish to be able to provide the best care possible for all residents and their families, but to do this we need to know more about what is important to them and what are their needs and preferences for the future.
The aim of any discussion about thinking ahead, often called an Advance Care Planning Discussion, is to develop a better understanding and recording of their priorities, needs and preferences and those of their families/carers. This should support planning and provision of care, and enable better planning ahead to best meet these needs. This philosophy of 'hoping for the best but preparing for the worst' enables a more proactive approach, and ensures that it more likely that the right thing happens at the right time.
This example of an Advance Statement should be used as guide, to record what the patient DOES WISH to happen, to inform planning of care. In line with the new Mental Capacity Act, this is different from a legally binding refusal of specific treatments, or what a patient DOES NOT wish


Recommendation 4 ......model of shared care....
4.1 .....primary care team....
4.2 .....key individual...
4.2 .....appropriate telephone contact..
3.2 .....NHS 24......know how to respond..
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! Please ensure this pan-Lothian Form follows the patient !
(e.g. on admission to, discharge from or transfer between hospitals)
NHS Lothian
Full name of patient:
Patient CHI/Hospital No:
Date of Birth:
Address:
Postcode:
DO NOT ATTEMPT RESUSCITATION (DNAR)*
A decision has been taken that the above patient is NOT for Cardio-Pulmonary Resuscitation (CPR). Any discussion around this decision (with patients, relatives, team members etc) must clearly be documented in patient's notes.
Please tick one of the four boxes below.
CPR is unlikely to be successful due to:**
(NB discussion with patient/proxy is not compulsory in this situation only).
This has been discussed with the patient/patient's proxy (name of proxy)
(Record details of discussion in patient's notes).
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Recommendation 5 ......arrangements for appropriate end of life care.....

5.1 .....Gold Standards Framework... Liverpool care pathway..

LIVERPOOL Care Pathway

5.2 .....safe cessation of unnecessary medication and implantable devices.

5.3 .....anticipatory prescribing....

Recommendation 6 ......Educational & training opportunities

6.1 .....Reciprocal opportunities

6.2 .....multiprofessional....

6.4 Advanced clinical communication education...

6.5 Training in spiritual care....

"Advanced clinical communication education..."

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Recommendation 7 ......research..

.....effective models of care..

.....symptom control and quality of life..

"Just in Case Box"

(Pain killer, sedative, anti sickness injections)

NHS Highland

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Recommendation 8 ...... resource implications...

.....reorganisation..to meet increasing need

.....resources to.......enable full implementation

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Thanks to:

Contributors and members of the working group

British Heart Foundation Scotland.

Scottish Partnership for Palliative Care