EnCOP

Enhanced Care for Older People

Enhancing Care for Older People Webinar Series. Session 13

End of Life Care in Frailty and Dementia: Advance Care Planning

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Experiences of Financial Planning in Later Life

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Housekeeping

- Please ensure microphones are muted and during presentation cameras are turned off.
- The event will be recorded and shared.
- The webinar recording and presentation will be circulated and uploaded on to the website following the event.
- If you have any questions during the session then please use the chat facility. We will attempt to address questions, if we can't then we will follow up after the event.
- Please also use the chat facility to inform us of any technical issues as this will be monitored closely throughout by one of the EnCOP team.
- Occasionally you may have difficulty seeing or hearing video clips that are played, this will usually be due to your own device or software settings and not something we can influence during the webinar session. Please be assured all content will be shared following the event so you will have an opportunity to view afterwards.
- If you need to take a break at any time throughout the session please feel free to do so.

Session aims and linked EnCOP Competencies

- **Aim:** To enhance or develop knowledge and understanding about advance care planning in frailty and dementia, including consideration of financial arrangements

Linked EnCOP Domains:

A. Values, attitudes and Ethics
C1: Partnership working and communication with older people , families and friends
C2: Interprofessional and interorganisational working, communication and collaboration
D2: Ageing Well : Assessing, planning, implementing and evaluating care and support
D4: Ageing Well: Promoting & supporting holistic physical health and wellbeing with older people
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D7: End of life care: Older people and frailty – recognition, assessment and care planning

Advance Care Planning for AHSN session

Advance Care planning

Voluntary process of discussion between an individual and their care providers to make clear the individual's wishes regarding their ongoing care in the context of anticipated deterioration of their health with loss of capacity to make decision or communicate wishes in the Future.

Why is it important?

It is to make clear a person's wishes in anticipation of a deterioration in the their condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.

Not Just at end of life …..

Advance Care Planning (ACP)

- What kind of things do people want to tell us about their wishes and preferences for their future care ?
- Watch this film to hear why it is important for some local people to let us know what they want
- **Is it that time already**
- Can you identify any circumstances that may be triggers to discussions about future care ?

Choosing where to be cared for

- For many people, deciding where and how they would like to be cared for is one of the most important decisions they can make
- May be triggered by:
- A new diagnosis
- Increase in care needs/loss of independence
- Recent hospital admission
- Loss of someone close
- Film clip highlights

Deciding Right: A North-East initiative for making care decisions in advance https://northerncanceralliance.nhs.uk/deciding-right/

Covers all care settings

Key Points : Individuals have the right to make decisions in advance about their care and for that to happen as a shared partnership with health and social care professionals

. Individuals who lack capacity to make specific decisions have the right to have decisions made in their best interests in the way required by the Mental Capacity Act

. Health and social care professionals have a duty to follow national legislation and guidance. They also need clear instructions about what the individual wants to happen.

Deciding right empowers the individual and the professional to make the right decisions

- **More information is available, including detailed guidance, in Your life, Your choice.**

Deciding Right

- **Successfully planning care in advance**
- **Requires:**
- Putting the individual at the centre of the dialogue
- Good communication skills
- A professional who never assumes what an individual should know or discuss
- Clear documentation of the decision-making

Deciding right forms
(underpinned by the Mental Capacity Act 2005)

Advance Statement (AS)

Advance Decision to Refuse Treatment (ADRT)

Emergency Healthcare Plan (EHCP)

DNACPR

Setting up a Power of Attorney

Taking care of legal matters can appear complex

Types of Power of Attorney

There are 3 different types of power of attorney: lasting power of attorney (LPA), enduring power of attorney (EPA) and ordinary power of attorney.

LPAs came into force in October 2007. Before that, people made EPAs. It's no longer possible to make an EPA, but an EPA made before October 2007 remains valid.

An ordinary power of attorney allows someone to look after your financial affairs for a temporary period. It will end if you lose mental capacity to make decisions.

Lasting Power of Attorney (LPA)

This includes:

- health and welfare LPA
- property and financial affairs LPA

Health and welfare LPA

A health and welfare LPA gives your attorney the power to make decisions about your daily routine (washing, dressing, eating), medical care, moving into a care home and life-sustaining medical treatment. It can only be used if you're unable to make your own decisions.

Property and financial affairs LPA

A property and financial affairs LPA gives your attorney the power to make decisions about your money and property. This includes managing your bank or building society accounts, paying bills, collecting your pension or benefits and, if necessary, selling your home.

Once registered with the Office of the Public Guardian, it can be used immediately or held in readiness until required.

Enduring Power of Attorney (EPA)

An EPA deals only with property and financial affairs, not with personal welfare issues.

Planning ahead with dementia

Planning ahead for your future care and treatment is important. That can be a difficult and emotional experience particularly when trying to come to terms with your diagnosis and what this means for you and your family.

No one can say when the right time is for each person to start planning their future, but it is always worth thinking about as early as possible in the dementia journey.

This allows time to discuss options and make sure that people know what your wishes are

It is never too early to begin talking

Being able to communicate your wishes and to understand fully your options can become more difficult as a dementia progresses, so it is important to discuss these while you are still able to.

Planning ahead can include financial and legal planning, care and treatment and plans for end of life.

It is always good to have a loved one or trusted friend to talk to about your plans.

Health and Social care professionals can provide more detailed individual advice on how best to plan for your future.

If you are thinking about making a will, you should contact a solicitor.

End of life care planning

Planning for end of life care can be emotionally very difficult

But, it is good to do so as early as possible so that carers, family and professional staff will know about individual wishes and preferences .

Having a plan for end of life care can provide comfort and support to family and carers in the last months and years of your life by relieving them from having to make certain difficult decisions on your behalf.

Best interest decisions

If a person can no longer make a decision for themselves,

those who are making decisions for them must do so in their best interests.

This ensures that their rights are respected; and the decision is the one which is best for the individual.

Best interest decisions should never be taken just to make things easier for carers or the professionals involved.

This entails arranging a Best Interests meeting and involving everyone who represents the person for whom a decision is being made

These decisions need to be written in the persons notes

Case Study

Bill 78 has had epilepsy since childhood. Diagnosed with mild Vascular Dementia one year ago occasional seizures and recent history of infections

Moved to a care home 3 months ago , emphatic that not want to go to hospital

Brother visits once a week and tells staff he has Enduring Power of Attorney (EPA finances)

Key Issues Emerging that we can act on

- Deciding right process – discussion when lucid
- Assess Capacity
- Advance statement of wishes and preferences
- Advance Decision to refuse Treatment

Case Study continued EHCP

Who decides when to start a conversation about what to do if an emergency occurs?

If it can be assumed that Bill has capacity for these decisions, only he can decide. In this case it is not the healthcare professional's job to make this decision and patients should never be burdened by questions delivered without warning or preparation. This can only be done as dialogue in which the professional checks what Bill understands and whether he wishes to know more.

If Bill is suspected of having an impairment or disturbance of mind or brain *and* a capacity test shows he does not have capacity, the EHCP must be discussed as part of a Mental Capacity Act best interests meeting.

When to start a conversation: Some events such as a recent crisis or a deterioration can prompt a dialogue, but the patient should remain in control of the information and discussion. Many patients will initiate the conversation by asking questions after or during such events, while some will ask questions much earlier while they are still well.

What if Bill does not want a conversation? Any dialogue includes respecting a patients wish not to have such a discussion and not to have an EHCP. Insisting on having this dialogue can be traumatic for some patients with long lasting effects. If Bill is clear this is too difficult to discuss, give him time- he may be able to discuss this later after some thought. In the meantime, an EHCP cannot be completed and emergencies will have to be decided by the clinicians present at the time.

Case Study Continued

Bill having more frequent seizures but has always stated he does not want to go to hospital

Had a further stroke

Swallowing difficulty especially fluids

GP suggests hospital admission for insertion of PEG feeding tube

More Complex decisions

- Assume Capacity unless proven otherwise
- ACP from before useful in ascertaining previous wishes and preferences
- Is there and Advance Decision to refuse Treatment or EHCP that still applies?
- Best interest decision meeting planned: Bills brother says he is the ultimate decision maker and wants Bill to go to hospital
- Due to Bills previous reluctance to go to hospital SLT conducted a swallowing test and advised a trial of dietary modifications including thickeners

Your role ….

Decisions relating to finance and property

Specialist Advice

- Wills
- Setting up and registering LPA
- We will hear about Barbara’s experience later

Funeral Planning

Although it can be difficult many people plan ahead for their funeral, which can include practical and spiritual wishes and how the service takes place.

Spiritual advisers may provide more help with this.

It is useful to let family and friends know your wishes as early as possible

This will help reduce any anxieties that they might have about this.

The Challenges

Impaired capacity eg in people with dementia (leaflet)	The discussion : Communication skills and who leads it	Voluntary process –some people not ready	Lack of consensus professionals and family
Too late ? No plans in place and no appointed LPOA	Sensitivity may lead to strong emotions	Cannot always plan for unexpected event	DNACPR

Thank you for listening

Any Questions ?

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Experiences of Financial Planning in Later Life

Mrs Barbara Dow, Lived Experience Expert

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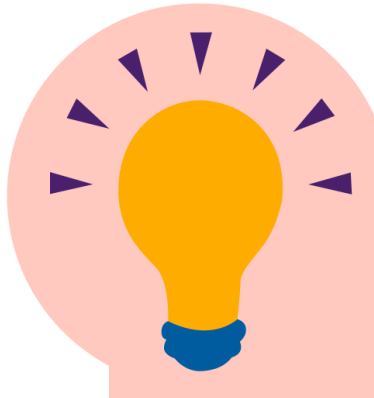
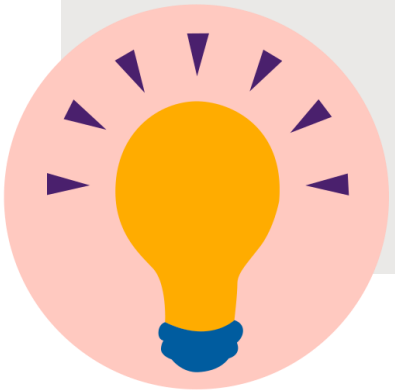


Consolidating Learning:

Reflection on the session & considering application to practice & what this means 'your people'

- Think about this session in relation to your own role
- How much of this was revision?
- What have you learned today ?
- How will this help you in your role ?
- Think about your EnCOP self–assessment; consider which performance indicators this session may relate to and how this can be used as part of your own development / competency achievement.



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Reminder of linked EnCOP domains

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Feedback about today's session and any future sessions you may like to see included in our webinar series….

All feedback welcomed; You may want to consider the following –

Was it easy to book onto the session?
Did you find the session went well in this online format ?
Was the content of the session relevant to your area of practice / job role?
Did you enjoy the session?

Thinking about future webinar's, which topics linked to older person's care would you be most interested in? Please put any suggestions in the chat.

Please comment in the chat today or feel free to email us: ghnt.encop@nhs.net

More information can be found within the Frailty icare website

www.frailtyicare.org

Our EnCOP pages are located in the workforce section

EnCOP Library of Learning & Development Resources can be found at:
EnCOP Assessment Toolkit Domains « I-Care (frailtyicare.org.uk)