**Booklet**

**Future Feeding Planning**

Patient Name: ………………………………..

DOB: ……………………………………………………

NHS Number: ………………………………………..

Diagnosis: ………………………………………………

Where Process Completed: …………………………………….

Completed by: …………………………………………………………

Date Process Commenced: ………………………………………..

Date Completed: …………………………………………………………

**Form of decision: Statement of wishes**

 **ADRT (See separate form)**

 **Best Interests Decision**

**Date com­pleted:** Click here to enter text.

**Summary of decision (delete as required)**

* **To not have a feeding tube and to eat and drink at risk.**

***OR***

* **To have a feeding tube and be made nil by mouth when swallow becomes unsafe**

***OR***

* **To have both a feeding tube and continue with some oral intake for quality of life under guidance of a Speech and Language Therapist. This oral intake may be safe or unsafe.**

**Professionals involved in/aware of this decision:**

**Dr responsible for care:** ……………………...… (Sign) ……………………………… (Name)

**Dietitian:** ……………………...… (Sign) ……………………………… (Name)

**Speech Therapist:** ……………………...… (Sign) ……………………………… (Name)

**Psychologist:** ……………………...… (Sign) ……………………………… (Name)

**Patient signature (if has capacity):**

…………………………………………… (Sign) …………………………………………… (Name**)**

**Power of Attorney for Health and Welfare Representative:**

…………………………………………… (Sign) ……………………………………………(Name**)**

**Guidelines for completion**

This document has been prepared for and published by the Royal Hospital for Neuro-Disability.

**IMPORTANT NOTE: It is the independent responsibility of any other organisation that elects to use these tools as part of their clinical decision making/records keeping to ensure that they are used appropriately and in accordance with their own processes, the law and good practice, and to obtain further clinical and/or legal advice as necessary*.***

PLEASE REFER TO ‘Future Feeding Planning Pathway’ FOR GUIDANCE/INSTRUCTIONS ON COMPLETING THIS PROCESS.

This booklet should be completed by the multi-disciplinary team including suitably qualified Dietitian and Speech & Language Therapist. It is not designed to be completed in one go.

This process should be started as soon as possible, as appropriate, ideally in a non-emergency situation to allow reasoned clinical decision making. The decision made should be kept under review.

**Please note this booklet is not a legally binding document, it is designed to help guide and support decisions and wishes with regards to future feeding options – the Booklet can be used as an informal Statement of Wishes.** If a patient wishes to complete an ‘Advanced Decision to Refuse Treatment’ (ADRT), this is a legally binding decision.

Once the process is completed, copies should be made and distributed as appropriate – see suggested list on final page of booklet.

**Section 1 – Legal Documentation**

**Does patient already have any of the following relevant to this decision:**

**Advanced Decision to Refuse Treatment? Yes** [ ] **No** [ ]

**Statement of wishes? Yes** [ ] **No** [ ]

**Lasting Power of Attorney for Health and Welfare? Yes** [ ] **No** [ ]

Does this cover life-sustaining treatment? **Yes** [ ]  **No** [ ]

**Court Appointed Deputy for Personal Welfare? Yes** [ ]  **No** [ ]

Does this cover decision making re: artificial feeding? **Yes** [ ] **No** [ ]

Summary of content of legal documentation (attach copies):

Click here to enter text.

**If Power of Attorney for Health and Welfare or Court Appointed Deputy (covering this decision) is in place, who holds this?**

|  |  |  |
| --- | --- | --- |
| **Names** | **Relationship to patient** | **Date authorised** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

If Advanced Decision to Refuse Treatment in place that is relevant to this decision, it may not be appropriate to progress further with the Booklet – consider discussing the ADRT with the patient as they have the right to change their decision. Document the decision on the front of the Booklet and place a copy of the ADRT in the medical notes.

If they have an existing best interests decision, the robustness of this should be reviewed and an MDT decision made about whether to proceed further with this process.

**Section 2 – Patient education sessions and Capacity Assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Session Date** | **Assessors****Names & Title** | **Summary of session** | **Resources/methods used to support capacity** | **Summary and Conclusion of Assessors** |
| Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Does patient have capacity?**

 **Yes** [ ]  **No** [ ]

|  |
| --- |
| **If the patient does have capacity:**What is their current decision?Click here to enter text.Document this at front of this booklet. You do not need to continue with the following sections. Turn to the final page of the booklet for guidance on distributing this information.**Offer the patient the opportunity to complete an Advanced Decision to Refuse Treatment (ADRT) - this is a legally binding document.**  |

|  |
| --- |
| **If the patient does not have capacity**: Continue with the booklet, move on to Section 3 |

**Section 3 – Family/NOK/LPA Discussion & Education**

**Independent Mental Capacity Advocate (IMCA) required?**

**Yes** [ ]  Continue to Section 4 **No** [ ]  Continue with Section 3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date & time** | **Attending Health Professional/s** | **Attending relative/NOK/LPA** | **Topics discussed** | **Family feedback/comments** | **Actions** |
| Click here to enter a date.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Section 4: Summary of Best Interests Meeting**

**Note**: If the patient has a Lasting Power of Attorney for Health & Welfare (LPA) or Deputy which covers life sustaining treatment then the person named in the LPA (or Deputy) is ultimately the final decision maker. If there is no LPA/Deputy in place then it is the lead medical doctor who has the final decision. In either case the decision should be made in the best interests of the patient. Please note: if there is an irreconcilable dispute about what is in the patient’s best interests, then further legal advice should be sought.

Summarise the key points from the meeting below and complete detailed minutes (including pros and cons of the options discussed).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Meeting** | **Attendees** | **Summary of MDT view** | **Summary of****Patient view (Section 2 & any previously expressed relevant views)** | **Summary of Relative(s)/LPA/IMCA view (Section 3)** | **Decision:** |
| Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter a date. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Once booklet and supporting evidence fully completed, we suggest this paperwork is compiled into a pack of documentation and distributed as follows:**

**Pack of documentation:**

|  |  |
| --- | --- |
| * Completed booklet
 | [ ]  |
| * Decision summary form
 | [ ]  |
| * Minutes from any best interests/family meetings
 | [ ]  |
| * Copy of Lasting Power of Attorney for Health form (if applicable)
 | [ ]  |
| * Copy of ADRT (if applicable)
 | [ ]  |
| * Photo of Talking Mats (if applicable)
 | [ ]  |
| * Copy of yes/no questions form (if applicable)
 | [ ]  |
| * Any other relevant evidence pertinent to the decision
 | [ ]  |

**Distribute to the following as appropriate:**

* Medical notes
* Patient care plan
* GP
* Consultant
* Social worker
* Patient and/or family member or carer
* Funding authority

**This decision should be reviewed annually by the MDT or more frequently if clinically indicated (e.g. decreased swallow safety, decreased ability to meet nutrition/hydration needs orally).**

**The annual review can take the form of an MDT discussion with relevant parties. This can then be documented on the Annual Review form and filed in the pack of documentation.**