Case study example:

Stephen is a 65 yr old gentleman with mild learning disabilities (LD) who lives within an ISL placement supported by direct care staff

Stephen has a diagnosed Lung cancer with brain metastases, treatment with Dexamethasone is ongoing, however the dose was decreased resulting in swallowing problems. The LD SALT then became involved in his care alongside his carers and healthcare professionals i.e. GP, Macmillan CNS, SALT and Community Nurse LD.

Recommendations from SALT and ongoing input were around food / fluid textures, posture when eating / drinking and offering medications which are becoming increasingly difficult as Stephens illness progresses and he is more fatigued.

During your first visit Stephen's carers advise you that Stephen has expressed to his social worker and care team that he wishes to remain at home to the end of his life however there is no record available to you that shows any advance care planning discussions have been held with Stephen.

- **What Deciding right information and documents might help in recording discussions with Stephen about his**
- **future care and where he would like this to be?,**
- **Who needs to be involved in the discussions?**
- **Whilst considering Stephens diagnosis and current deterioration discuss and complete the Deciding Right documentation which you feel is appropriate.**
- **Who would this documentation need to be shared with and how can it be shared?**
- **Think about Stephens capacity and his ability to give consent – what needs to be considered prior to and**
- **during completion of the Deciding Right documentation?**

6 Weeks later:

Stephen's condition has now deteriorated further, he was recently admitted to hospital during the night on the advice of the out of hours GP service for treatment of possible dehydration, on Stephens admission his carer discussed that Stephen had expressed he did not wish to be taken to hospital and that this had been previously recorded in his notes, after several hours medical staff agreed that Stephens hospital admission was not appropriate and he was subsequently discharged.

Since his discharge home Stephen has again expressed that he does not wish to be admitted to hospital anymore as he feels there is no benefit to him being in hospital, he now talks openly about dying and frequently says that he wishes to remain at home until the end of his life.

- **As a Group:**
- **Consider and complete the Deciding right documentation you feel would best support Stephen to have his expressed**
- **preferences and wishes met at the end of his life**

- **In your discussions include:**
- **Who may need to be involved in the discussions and completion of the documents**
- **Think about the professionals involved in Stephens care and decided who would need to have access to the completed**
- **documents / information, how would these be shared?**
- **What needs to be considered in terms of Stephens capacity and how would this be documented?**