Greater Manchester, Lancashire and South Cumbria
Strategic Clinical Networks

FINAL DRAFT: Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life

Date of issue: 20th June 2014

Date for review: TBC

Status: Final Draft Version 1.0

Prepared by: This is a consensus document developed by the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Palliative and End of Life Care Working Group to allow the documentation of care in the last days of life. It will be evaluated and may be subject to amendment in light of the results of that evaluation.

Name: Preferred Name: DoB: NHS Number: Unit Number:

Current Place of Care:

Name DoB NHS Number	LABEL

Purpose of Document

Aim/Purpose

This Care Plan is to be used to record the individualised care delivered to the dying person in the last days and hours of their lives and support their families, carers and those close to them. Communication, compassion and kindness as well as clear documentation are key to delivering good clinical care in all circumstances and meeting the needs of that person and their family, carers and those close to them.

Priority outcomes of care in the last days and hours of life include[1]:-

1. Recognition of dying

The possibility that a person may die, within the next few days or hours, is a multi-professional decision and should be communicated clearly by professional staff to the person who is dying, if possible, and those identified as important to them. The decision must be made with the most senior competent doctor available (each local area to complete grade) responsible for the person's care in consultation with the most senior registered nurse on duty (locality to specify band –hospital/ hospice or community). The competency of professionals relates to the clinical decision making and delivery of care in the last days and hours of life. Once the multi-professional team has concluded that the person is in the last days or hours of life then decisions made and actions taken should be in accordance with the person's needs and wishes.

This document can then be used to record the assessments made and the care delivered. This decision should ideally be made by the team who is supporting this person and within normal working hours. Where the decision is made out of hours, the care plan must be reviewed by a doctor within their usual care team who has the necessary competencies at the next available opportunity.

2. Sensitive communication

Communication should take place between staff and the person who is dying, and those identified as important to them. This may also be supported by a 'Patient and Relative Diary'

3. Involvement in decision making

Multi-professional teams are responsible for involving the dying person, and those identified as important to them, in the decisions about treatment and care – to the extent that the dying person wants and is able to.

4. Needs of families and others close to the dying person

The needs of families and others identified as important to the dying person are anticipated, actively explored, respected and addressed as far as possible. This includes both in the last days of life and onwards after a person has died.

5. Individual plan of care

Individuals who are dying must be cared for with respect and dignity and their needs anticipated and managed by competent professionals able to deliver and manage this care. Care should be delivered in response to each person's actual needs. An individual plan of care, which includes food and drink, symptom control, psychological, social and spiritual support, should be agreed, co-ordinated and delivered with compassion.

The care of the dying person must be regularly reassessed and reviewed by a Doctor who is competent to undertake this reassessment, at least every three days or sooner if there is an unanticipated change. Regular review should also be undertaken by the multi-professional team as often as required for the benefit and compassionate care of the dying person and their family and those close to them. The outcomes of these regular reviews should be communicated sensitively to person who is dying, and those identified as important to them.

Information about the guidance

The guidance offered here for professionals should underpin the clinical documentation of the holistic care for the dying person and should clearly document the individual assessments made and the care delivered to each individual person and their family, carers and those close to them based on their needs.

This guidance will include prompts to aid clinical management. Assessment should be on an individual basis depending on the dying person's needs and the needs of their family and those close to them. The prompts are <u>not to be ticked</u> but <u>to be considered</u> and then the outcomes documented within the text of the document.

[1] [1]TheNHS England Leadership Alliance for the Care of Dying People Interim Statement – March 2014

Name	
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Section 1: *Initial* Medical and Nursing Review Regarding Care in the Last Days of Life

Have you considered the following:

- Documenting team discussions and decision-making re: prognosis of a few days or hours for this person
  - Underlying diagnosis and other clinical conditions
  - Reversible causes of deterioration have been treated effectively or excluded
  - Assessment of mental capacity regarding any specific decisions and date/time of when assessment was made (Operating within the legal framework provided by the Mental Capacity Act 2005 and its Code of Practice)
- Informing other key professionals involved in the dying person's care
- Reviewing of benefits and burdens of investigations and other observations
- Assessing need for appropriate early warning scores
- Clinical levels of intervention/ ceilings of care
- Senior clinical handover from In-hours to Out of Hours regarding this individualised care plan
- Do Not Attempt Cardiopulmonary Resuscitation (DNA-CPR) decision documentation completed with reasoning and discussion with the dying person or family
- Implantable Cardiac Defibrillator (ICD) in situ and possible deactivation

Consider Specialist Palliative Care Referral if needed
Consider additional Specialist opinion if needed

Clinical Review and Multi-disciplinary Team Assessment					
Date	Time		Designation	Print Name	Signature

Agreement by competent Senior Doctor responsible for Person (consultant /GP): yes/no
Name of Senior Clinician and Grade??

Senior Doctors signature:

Name	
DoB	LABEL
NHS Number	

Section 2: *Initial* Medical and Nursing Communication with the Dying Person and Family

The goals of care must be discussed wherever possible and agreed with the dying person, their families and those close to them, by the multi-professional team caring for the dying person, and clearly documented.

2.1 Key information for the dying person, their family and those close to them:

- **Have you considered the following:**
  - Include dying person as far as possible
  - Documenting who was present for discussion
  - Dying person and family questions and concerns
  - Reviewing and re-evaluation plans
  - Key contacts for dying person and family
  - Name of nurse responsible for leading the care to be given to the dying person and the family and contact details
    - Offering a leaflet/ information sheet for dying person and families (to be addressed locally)
  - Facilities available in the environment being used
  - Offering and explaining 'Patient and Family Diary'
- Provide an explanation of assessment:
  - Current clinical situation/ dying person's condition
  - Agreeing aims and expectations of care being provided
  - Levels of intervention/ Treatment Limitations
  - Recognising clinical uncertainties re: care and interventions
  - Nutrition and Hydration
  - Symptoms and medication required
  - Using syringe pump if required
- Discussing likely referral to coroner at time of death if this is necessary and anticipated

Are there any specific communication needs to consider for patient, their family and those close to them? E.g. interpreter required, deafness, anxiety

Senior Clinician Communication with the Dying Person and Family					
Date	Time		Designation	Print Name	Signature

Name	
DoB	LABEL
NHS Number	

2.2 Discussions re: preferences of care

- Dying person's understanding and wishes re: care
- Where does the person wished to be cared for in the last days of life?
- Considering rapid discharge from inpatient care if person wishes
- Considering capacity issues and best interest decisions if required
- Reviewing any Advance Care Plan/Advance Decision to Refuse Treatment (ADRT) documentation and following its contents when it is valid and applicable (within the terms of the Mental Capacity Act (2005) and its Code of Practice)
- Identifying and involving those who hold Lasting Power of Attorney (LPA) for Health and Welfare if required (under the legal framework provided by Mental Capacity Act (2005) and its Code of Practice)
- Wishes re: organ/ tissue donation
- If moved between care settings, considering any emergency planning

Senior Clinician Communication with the Dying Person and Family					
Date	Time		Designation	Print Name	Signature

Family/Carer contact details:	
Relation:	**Relation:**
First name:	**First name:**
Telephone:	**Telephone:**
Lasting Power of Attorney for Health and Welfare Contact details:	
Relation:	**Relation:**
First name:	**First name:**
Telephone:	**Telephone:**

Name	
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NHS Number	

Section 3: *Initial* Multi-disciplinary Team Assessment Regarding Care in the Last Days of Life

3.1 Assess Symptoms

Have you considered the following:

- Pain
- Nausea/ Vomiting
- Breathlessness
- Noisy Breathing
- Agitation
- Confusion
- Dry mouth
- Constipation and urinary retention
- Documenting absence or presence of symptoms
- Reviewing of existing medications, current symptoms and medication/treatment options
- Potential side effects of medications
- Medications to prescribe or stop and reasoning
- Assessing oxygen
- Anticipatory prescribing of medications for specific potential symptoms
- Reviewing route of medications if swallowing difficult and consider subcutaneous injections and use of McKinley T34 Syringe Pump (explanation to dying person/those close to them)
- Ensuring syringe pump recording chart & care plans are utilised
- Checking all medicines/equipment is available as soon as needed
- Prescribing guidance (local links)

Refer to Network Palliative Care Pain and Symptom Control Guidance
Consider Specialist Palliative Care Referral if needed

Assess Symptoms Regularly					
Date	Time		Designation	Print Name	Signature

Name	
DoB	LABEL
NHS Number	

3.2 Nutrition/ Hydration

Have you considered the following:

- Current situation managing oral diet and fluids including offering of regular drinks
- Support that must be required to sustain food and drink orally
- Nutrition and hydration assessment at every review
- Mouth Care - Considering oral moisture gels/ lip salves
- Dying persons favourite flavour/foods
- Supporting oral fluids and food as dying person is able
- Difficulties swallowing
- Risk of aspiration
- Benefit of formal SALT Assessment
- Considering clinically assisted nutrition/ hydration (including safety risks versus benefits)
- Recording of clinical decision re: stopping/ starting and continuing clinically assisted nutrition and hydration
- encouraging the family to help with oral intake if they wish
- Respecting dying persons choice to eat and drink even if at risk of aspiration
- Best interest decision to be made if dying person lacks capacity regarding nutrition and hydration

Consider additional Specialist opinion if needed

Nutrition/ Hydration					
Date	Time		Designation	Print Name	Signature

Name	
DoB	LABEL
NHS Number	

3.3 Maintain Quality Personal Care

Have you considered the following:

- Reviewing bowel and bladder function
- Considering catheterisation for comfort and support
- Manual handling assessment
- Mouth care
- Hygiene needs – Hair care and shaving
- Maintaining Privacy & Dignity
- Skin integrity
  - Considering the need for pressure relieving and other equipment needs
  - Documenting pressure/ Waterlow score
- Determining frequency of re-positioning (using existing documentation) – documenting/discussing with carers
- **CHECKING PATIENT AND FAMILY DIARY REGULARLY**

Quality Personal Care					
Date	Time		Designation	Print Name	Signature

Name LABEL DoB NHS Number

3.4 Identify Psychological, Spiritual and Religious Needs of Dying Person

Have you considered the following:

- Concerns/fears
- Faith
- Belief
- Values
- Cultural needs
- Considering chaplaincy/ religious leader support
- Considering any specific needs before death or at death
- Documenting specific actions required
- Referring for additional support as needed
- **CHECKING PATIENT AND FAMILY DIARY REGULARLY**

Local contact numbers for spirituality teams

Identify Spiritual Needs of Dying Person and Family					
Date	Time		Designation	Print Name	Signature

Name

DoB LABEL

NHS Number

3.5 Identify Support Needs of Family, Carer and those Close to the Person

<u>Have you considered the following:</u>

- Assessing and reviewing needs of the family and those close to them
- Concerns or fears
- Low mood of family or those close to the dying person
- Religious and spiritual needs
- Equipment and care support at home (if required)
- Key providers of care
- Explaining facilities if not in usual place of residence
- Considering side room if an inpatient Documenting specific actions required
- Contact numbers updated
- Documenting any concerns or worries that family may have
- Enabling to participate in care if requested
- Any other support required
- **CHECKING PATIENT AND FAMILY DIARY REGULARLY**

Identify Support Needs of Family

Date	Time		Designation	Print Name	Signature

Name

LABEL

DoB

NHS Number

Section 4: *Regular Review* of Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life

The care of the dying person must be regularly reassessed and reviewed by a Doctor who is competent, to undertake this assessment, at least every three days or sooner if there is an unanticipated change. Regular review should also be undertaken by the care team as often as required for the benefit and compassionate care of the dying person and their family and those close to them.

- Reviewing regularly to identifying changing needs
- Person undertaking the daily review needs to seek or have access to a senior clinician able to undertake assessment and management
- Nurse leading the care per shift to be documented
- Regular and proactive communication
- Consider linking the ongoing review to the individual initial assessment for this dying person, their family and those close to them using Initial Assessment Sections
- Continue to operate within the legal framework provided by the Mental Capacity Act 2005 and its Code of Practice

Consider ongoing review with regard to initial assessment?
Consider Specialist Palliative Care Referral if needed

CHECKING PATIENT AND FAMILY DIARY REGULARLY

If MDT feels the dying person is no longer in the last days of life due to improvement in condition, then use appropriate care plan and document the reasons for the decision making and who it's been discussed with.

On-going Multi-disciplinary Notes - Senior Clinician and Nursing Review						
Date	Time	Section	Review Care Plan	Designation	Print Name	Signature

Name

LABEL

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NHS Number

Section 4. *Regular Review* Continuation Sheet

On-going Multi-disciplinary Notes - Senior Clinician and Nursing Review						
Date	Time	Section	Review Care Plan	Designation	Print Name	Signature

Name

DoB

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Section 5. Record of Care After Death

Date of Death	**Time**
Those Present – family **Name:** **Name:**	 **Relationship:** **Relationship:**
Healthcare professional: **Name:**	 **Role:**

If not present, family informed of death

Date Contacted: **Time contacted:**
Name: **Relationship:** **By Whom:**

Date Contacted: **Time contacted:**
Name: **Relationship:** **By Whom:**

Verification of Death

Time of person's death verified **Date:** **Time:**
Details of healthcare professional who verified death
Name **Signature** **Role**
Comments……

Certification of Death
Cause of Death written on Death Certificate:
1a
1b
1c
II

Death Certificate Completed **Cremation part 4 completed**

Referral to Coroner Yes/ No Comments ……

Preferred Place of Death achieved: ……(This can be localised)

ICD/Cardiac Pacemaker in situ: Yes/No

Care after Death
Persons wishes/ Carer or family involvement/ Funeral arrangements/ Care of body/ Cultural needs/Burial or Cremation
Signature **Date**

Relatives and Carer Information

Signature **Date**

Bereavement Booklet

Require referral to bereavement services……

Signature **Date**

Removal of Equipment (in community) arranged **Yes/No** **Details……..**

Organisation Information
GP Informed
Other Services Involved **Signature** **Date** **Time**

Name DoB NHS Number

LABEL

Where to get further advice and support:	
In Hours Advice	**Out of Hours Advice**
Specialist Palliative Care Team: (This can altered locally)	24 Hour Advice Line: (This can altered locally)