File in Section 4

Plan of Care for people approaching the last days and hours of life

Abbreviations used in this document to be listed here with the full description:
GP - General Practitioner
MDT - Multi-disciplinary Team
FCMS - Fylde Coast Medical Services

Write patient details or affix Identification label

Hospital Number:
Name:
Address:

Postcode:
Date of Birth:
NHS Number:

This is to be used when commencing an individualised plan of care and does not replace documentation in the clinical record.
This form must be inserted into the clinical record in chronological order as a record of the patient's care.
If the patient is in the Acute Trust the form must be signed by a senior doctor (ST3 or above) and countersigned by the consultant at the earliest opportunity.

Priority 1
The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
(To be completed by a senior member of the clinical team taking into account the views of the multi-professional team involved with the patient)

	Initial and date
Evidence that this person is dying has been considered and documented in the clinical record	
Reversible causes for the change in the person's condition have been considered and documented in the clinical record	
The dying person's wishes regarding the following have been documented in the clinical record	
• Ceilings of treatment/Advance Decision to Refuse Treatment	
• Preferred place of care including preferred place of death	
• People that they wish to be involved in discussions about care	
• Wishes around organ / tissue donation (as appropriate)	

Priority 2
Sensitive communication takes place between staff and the dying person and those identified as important to them.
(To be undertaken by a senior clinician, the dying person where appropriate and/or family/carers nominated by the person to act on their behalf)

Key areas covered in conversation around end of life with dying person have been documented in the clinical record
Outstanding concerns have been identified by dying person or nominated individual and documented in the clinical record

PLEASE ENSURE MDT REVIEW OF INDIVIDUALISED PLAN OF CARE EVERY 3 DAYS AS A MINIMUM

Patient NHS Number: _____	Patient Name: _____	Patient Date of Birth: _____

Continuation of Plan of Care for people approaching the last days and hours of life

Priority 3 **The dying person and those identified as important to them are involved in decisions about treatment and care to the extent that the dying person wants. If the person lacks capacity all care/treatment given in the persons best interest,** *(Communication plan agreed with dying person, family/carers and Healthcare team-* **Each meeting to be documented in patient clinical record**)
Documentation of names of people nominated by dying person to be involved Is there a Lasting Power of Attorney for Health and Welfare in place YES/NO, if yes who is nominated
Documentation of frequency of meeting e.g. daily, when there is a change
Likely timing of meetings; morning, during ward round, lunch time
The name of the senior doctor (Consultant in the Acute Trust) and senior nurse responsible for leading care for the dying person is communicated to the patient and family.

Priority 4 **The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.**
A summary of this conversation is in the clinical record
Relevant information leaflets have been offered
Referral for further support (e.g. Chaplaincy)

Priority 5 **An individualised plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.**
1. A care plan around hydration documented in clinical record 2. A care plan around nutrition documented in clinical record 3. A care plan around symptoms documented in clinical record 4. A care plan about concerns raised documented in clinical record 5. Other resources to provide additional psychological, social and spiritual support where appropriate
Confirmation of decision made and appropriate documentation in the clinical record: **Name (Senior Doctor)** **Name (Consultant – Acute Trust only)** **Name (Senior Nurse)** **Signature** **Signature** **Signature** **Date** **Date** **Date**

- **Please fax a copy to the patient's GP to inform them of these discussions.**
- **Please send a copy to FCMS by secure fax or email when a patient is moving into any new community care setting. A new form will need to be completed for each new care setting.**
- **Please give the patient and their family an information leaflet around end of life care and any other leaflets pertinent to their circumstances.**