Guidance in creating an individualised plan of care for people approaching the last days and hours of life

Refer to 'Guidance for doctors and nurses caring for people in the last days and hours of life' and the 'Fylde Coast Care of the Dying Person Algorithm'- attached.

Complete the pink checklist 'Individualised plan of care for people approaching the last days and hours of life' in discussion with the patient and their family- documenting fully in the clinical record.

This pink checklist MUST be inserted into the clinical record as a continuation of the chronological record of the person's care. Blank areas of continuation sheets should be scored out and signed as intentionally left blank.

Please fax a copy to the patient's GP to inform them of these discussions.

Please send a photocopy of the completed pink checklist with the patient when the patient moves between care settings. This is for information only. A new individualised plan of care will need to be completed for each new care setting using a new pink checklist.

Please send a copy of the completed pink checklist to FCMS by secure fax or email when a patient is moving into any new community 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. Provide an 'end of life care' diary if the family would like one.

North West End of Life Care Model

Version 1.10 July 2014
Review due July 2015

Approved by Health Records Committee .....

In response to a joint statement by the Leadership Alliance for the Care of Dying People 20 March 2014.The Alliance is a coalition of the national organisations to which the Liverpool Care Pathway for the Dying Patient review panel addressed its recommendations, joined by charities and others with a strong interest in care for dying people. The scope of the Alliance's work is England.

Guidance for Doctors and Nurses caring for people in the last days and hours of life

It is the responsibility of all clinicians to ensure that all people who are dying receive good end of life care and document the individualised plan of care in the patient's clinical record

The core elements of this care are:

- Regular assessment and management of symptom control including anticipatory prescribing of medication to control symptoms.
- Comfort measures delivered in a compassionate and timely manner.
- Effective and empathic communication with the dying person (where possible) and their families and carers.
- Provision of psychological, social and spiritual support to the dying person and family and carers as needed.
- Provide dignified and respectful care at all times including after death.

Care for the Dying Person: Good Practice Guidance

- If the person is felt likely to die in the next few days the views of the person, their family/ carers should be sought about their view of the current situation. The inherent uncertainty in predicting death should be conveyed. The possibility that end of life may be approaching should be communicated sensitively to the person (where possible and appropriate) and to family and/or carers.
- This communication should be fully documented in the patient's clinical record in order to ensure that clinical staff are aware of the discussion.
- Review the appropriateness of cardiopulmonary resuscitation. Where possible discuss this with the dying person. If the dying person lacks capacity or, where the dying person has capacity but agrees to discussion with the family/carers, ensure that this discussion takes place and document the outcome of the discussion in the clinical record.
- Recognition of dying is complex and should be considered by the senior clinician (doctor or nurse) who best knows the dying person, following a face to face assessment, in consultation with the person (where possible), family/carers and other members of the multi- professional team. Pre-emptive discussion should take place prior to weekends and can be included as part of the prospective management plan for the dying person. This can be used to inform a clinical decision by a covering clinician.

An individualised plan of care for people approaching the last days and hours of life must be made:

- Take into account the dying person's wishes and family/carers views when developing the individualised plan of care.

- The plan of care must be discussed with other members of the multi-disciplinary team, with the dying person and their family/carers, documented in their clinical record and reassessed regularly.

- Anticipatory prescribing for symptoms of pain, respiratory tract secretions, agitation, nausea and dyspnoea must be completed.

- If required, the use of a syringe pump should be discussed with the dying person (where possible) and family/carers before it is commenced.

- Review clinical interventions including nursing observations to ensure they are in the best interests of the dying person.

- Review hydration and nutrition and document a clear plan on how this will be supported appropriately.

- Provide psychological, spiritual and social care.

- In Blackpool Teaching Hospitals /Trinity Hospice-identify the named consultant responsible for the dying person's care and a named member of staff each day that will be responsible for communicating with the person and family/carers to address any concerns they have about end of life care.

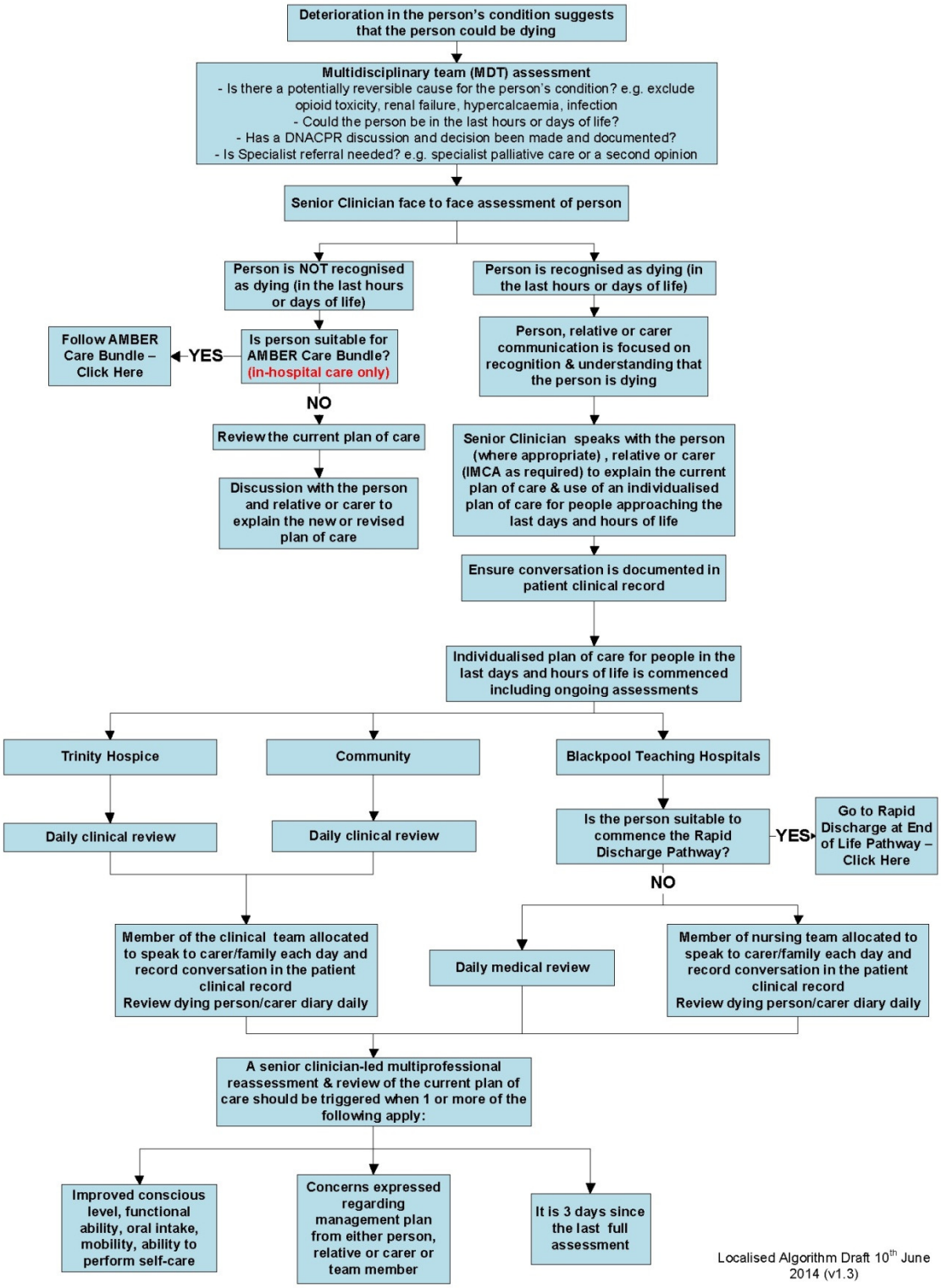
- In Blackpool Teaching Hospitals/Trinity Hospice- four hourly nursing assessments, daily medical review and 3 day MDT reassessments are the minimum requirements and are mandatory. The dying person should be reviewed more frequently if required.

- In the community-daily assessment and 3 day MDT reassessments are the minimum requirements and are mandatory. The dying person should be reviewed more frequently if required.

- Ensure the clinical record is completed fully. Regular review of symptom control, comfort measures, communication, and psychological, social and spiritual care are required elements in an individualised plan of care for people in the last days and hours of life.

North West End of Life Care Model

Fylde Coast Care of the Dying Person Algorithm



Localised Algorithm Draft 10th June 2014 (v1.3)