# Personalised Care Plan for the Last days of Life

# Guidance for Nurses

1. Decision that patient is dying is a MDT decision that has been agreed with the patient's named consultant.

2. Ensure that the medical team have documented plan of care including:

    - medicines they wish to prescribe or stop and for what purpose
    - if any IV medications are to stop
    - if IV/SC fluids are to start or stop
    - if artificial nutrition is to stop
    - what has been said to patient and family and by whom

3. Document all conversations you have with the patient and family about this plan of care. Offer "Coping with dying leaflet" and “Supporting in the last hours or days of life”.

4. At the beginning of each shift and throughout the day ensure those caring for the patient understand the expectations of the patient where appropriate, and the family about this plan of care.

5. If the patient is able to take oral fluids offer drinks at least hourly. If the family wishes to help with this, encourage them to do so. Document any and all attempts to offer fluid.

6. The family may wish to continue to give sips even when the patient is unable to swallow, and this needs to be discussed sensitively, explaining why it is no longer safe to do so.

7. Offer regular mouth care, at least hourly, especially for patients who are unable to take oral fluids. If families wish to assist with this please show them what to do and encourage them. However, continue to monitor mouth care and document all attempts including when unable to provide mouth care and why.

8. If the patient is able to eat then offer at acceptable regular intervals as appropriate. If only taking mouthfuls then offer 2 hourly. If family wish to assist, encourage them to do so. Please document all offers of food and what is taken or not.

9. Ensure patient is offered general personal care throughout the day and night. Document what is offered and accepted.

10. Review symptom control hourly:

- Pain - if the patient is taking oral analgesia ensure this is adequate and controlling pain. If not ask a doctor to review and/or refer to palliative care team. If the patient is unable to swallow but in pain give s/c analgesia as prescribed and document in the care plan. If not adequate ask the doctor to review as above.

- Nausea - if not a problem review every 4 hours by asking patient. If already a symptom review 1hrly and give anti-emetic as prescribed. If remains nauseous then ask the doctor to review and/or refer to the palliative care team.

- Agitation - look for possible causes, pain, urinary retention, requiring repositioning, mental distress. If remains distressed despite any interventional care then give appropriate medication as prescribed and document this in the care plan. If unsure or no medication prescribed ask the doctor to review and/or refer to the palliative care team.

- Respiratory secretions - these may occur as death becomes more imminent. Hyoscine hydrobromide can be helpful to dry these secretions. Hyoscine hydrobromide can also cause sedation which may be helpful if the patient is restless or unsettled. An alternative is Glycopyrronium which is less sedative. If you are unsure ask the doctor to review and/or refer to the palliative care team.

Please ensure that you explain to the family any and all interventions, including the giving of medication.

**Remember- for patient and family this may be their first and only experience of this situation. Sensitive and careful explanation of the care plan will assist in how we all cope with such a difficult and emotional time.**