

Personalised Care Plan for the Last Days of Life

Patient name
Hospital number
Date of birth
NHS number

Medical Care Plan

(Medical plan to be discussed and agreed with nursing staff)

Following assessment and agreement that all reversible causes for current condition have been considered; the multi-professional team has agreed that the patient is dying.

Remember to apply the principles of the Mental Capacity Act 2005

Recognition of dying has been discussed with the patient (where appropriate) and family/NOK including:

Name:	Relationship to Patient:	Date & Time:

Consultant:	Ward:	Date:
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Name: DOB: Hosp No: NHS No:

PERSONALISED CARE PLAN FOR THE LAST DAYS OF LIFE

This guidance is to aid the care of patients thought to be dying within the next few days. The patient's care should be individualised to their specific needs. If advice is needed at any stage, contact a senior member of the team or the palliative care team on 8102 (8115 out of hours).

Recognition that the patient is dying	
<p>This can be difficult and the decision should be made by the most senior clinicians (nurses and doctors) caring for the patient.</p> <p>Why do you consider the patient is dying?</p> <p>Have you considered reversible causes for the patient's deterioration?</p>	<p>Document who is involved in making the decision:.....</p> <p>.....</p> <p>Document diagnoses and relevant clinical features:</p> <p>Diagnoses</p> <p>.....</p> <p><input type="radio"/> Bedbound <input type="radio"/> Comatose</p> <p><input type="radio"/> Semi-comatose <input type="radio"/> Unable to take tablets</p> <p><input type="radio"/> Unable to take more than sips of fluid</p> <p><input type="radio"/> Reduced peripheral perfusion</p> <p><input type="radio"/> Cheyne-Stokes respiration</p> <p><input type="radio"/> Respiratory tract secretions</p> <p><input type="radio"/> Other.....</p> <p>Document whether reversible causes have been considered:</p> <p>.....</p>
Sensitive communication with the patient and family	
<p>Explain what is happening and the reasons why you think the person is dying.</p> <p>Discuss prognosis (and the difficulty making an accurate prognosis).</p> <p>Discuss priorities for care, including place of care if appropriate. Even very ill patients may be discharged home, if they and their family wish, using the Rapid Discharge Home to Die Pathway.</p>	<p>Document the conversation, including all the issues covered (use continuation sheet if needed):</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
Consider all the investigations, interventions and treatments the patient is having	
<p>Stop investigations, interventions or treatments that won't promote comfort, dignity and peace</p> <p>Discuss with the patient and/or family.</p>	<p>Document what has been stopped and why:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Document what is being continued and why.</p> <p>.....</p> <p>.....</p> <p>Document that this has been discussed with the patient and/or family:</p> <p>.....</p>
Decide DNACPR status	
<p>Discuss sensitively with the patient and family if appropriate</p>	<p>Document DNACPR on the appropriate form in the notes</p>

Name: DOB: Hosp No: NHS No:

Decide treatment escalation plan	
<p>All patients should be medically reviewed regularly to check they are comfortable and not distressed.</p> <p>Should the patient be having observations of heart rate, BP, respiratory rate temperature, oxygen saturations, blood sugar?</p> <p>What should happen if the observations are abnormal?</p> <p>Does the patient have an Implantable Cardiac Defibrillator (ICD)? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Document which (if any) observations should be made:</p> <p>Heart rate <input type="radio"/> Yes <input type="radio"/> No</p> <p>BP <input type="radio"/> Yes <input type="radio"/> No</p> <p>Respiratory rate <input type="radio"/> Yes <input type="radio"/> No</p> <p>Temperature <input type="radio"/> Yes <input type="radio"/> No</p> <p>Oxygen saturations <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood sugar <input type="radio"/> Yes <input type="radio"/> No</p> <p>Document who should be contacted if the observations are abnormal.</p> <p>Should a PEWS call be triggered? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Record action to be taken to deactivate ICD</p>
Patient preferences and advance decisions	
<p>Does the patient have:</p> <p>An advance care plan? <input type="radio"/> Yes <input type="radio"/> No</p> <p>An advance decision to refuse treatment (ADRT)? <input type="radio"/> Yes <input type="radio"/> No</p> <p>An expressed wish for organ/tissue donation? <input type="radio"/> Yes <input type="radio"/> No</p> <p>A lasting power of attorney for health and welfare? <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Record actions to be taken:</p>
Symptom management	
<p>Consider and address possible symptoms For example, pain, shortness of breath, nausea, vomiting, restlessness, confusion, urinary retention, dry mouth etc.</p> <p>Consider whether any of these symptoms are reversible, for instance confusion caused by opioid toxicity or abdominal pain and restlessness caused by urinary retention.</p> <p>Seek advice from senior colleagues and the palliative care team if needed.</p>	<p>Document current symptoms:</p> <p><input type="radio"/> Pains (including sites of pain)</p> <p><input type="radio"/> shortness of breath</p> <p><input type="radio"/> nausea</p> <p><input type="radio"/> vomiting</p> <p><input type="radio"/> restlessness</p> <p><input type="radio"/> confusion</p> <p><input type="radio"/> urinary retention</p> <p><input type="radio"/> dry mouth</p> <p><input type="radio"/> respiratory tract secretions</p> <p><input type="radio"/> other.....</p> <p>Prescribe medications on drug chart which may be required PRN and give reasons for use.</p>
Feeding and fluids	
<p>All patients who are able to take sips of fluid should be offered drinks.</p> <p>If a patient's swallowing is impaired they are at risk of aspiration pneumonia. They may still choose to take sips and this should be reviewed on an individual basis to maximise overall comfort.</p> <p>Consider the possible benefits and burdens of artificial hydration and nutrition</p>	<p>Document any discussion with the patient and family relating to feeding and fluids:</p> <p>Artificial hydration and nutrition, document all relevant factors, the decision reached and the reasons for the decision.</p>

Name of doctor completing this form:	Signature:
Grade:	Bleep no:
Date/Time:	

Continuous day to day evaluations to be written in medical notes

GUIDANCE ON THE CARE OF THE DYING AND USE OF THE PERSONALISED CARE PLAN

- Diagnosing dying should be a multi-professional decision.
- The decision to use a Personalised Care Plan for the Last Days of Life should be made by the most senior available clinician responsible for the patient's care (Consultant or SpR).
- If possible, patients should be given the opportunity to discuss the care they wish to receive at the end of their life.
- Families should be given a clear explanation that the patient is dying before starting to use the Personalised Care Plan for the Last Days of Life. Following this verbal explanation written information should also be given.
- Patients who are able to take food and drink will be offered, encouraged and helped to do so. When a patient is unable to take food or drink, the risks and benefits of artificial hydration and nutrition will be assessed daily (taking account of the views of the patient and family).

SYMPTOM CONTROL GUIDANCE

Medications

Patients who are thought to be dying should usually be prescribed medication for the relief of pain, nausea, vomiting, restlessness and respiratory tract secretions, unless there are contraindications. This means that symptoms can be controlled without delay even if they arise overnight.

Examples of appropriate medication for anticipatory prescribing:

Symptom	Medication	Notes
Pain	Morphine 2.5-5mg SC PRN	For patients already taking opioid analgesia the dose may need to be adjusted; caution in renal failure
Pain on movement	Ketorolac 30mg PRN (max 90mg in 24h)	Would replace oral NSAID – do not give concurrently. Caution if risk of gastrointestinal bleeding. Does not mix with midazolam.
Nausea and vomiting	Levomepromazine 6.25mg SC PRN (max 25mg in 24h)	Higher doses may be used as an antipsychotic but 6.25mg - 12.5mg over 24h is usually sufficient to control nausea and vomiting
Restlessness	Midazolam 2.5-5mg SC PRN	If frank delirium use an antipsychotic rather than midazolam alone
Respiratory tract secretions	Hyoscine hydrobromide 400mcg SC PRN (max 2.4mg in 24h)	Can also cause sedation which may be helpful if the patient is restless or unsettled. An alternative is glycopyrronium 200mg SC PRN (max 1.2mg in 24h) which is less sedative.

Consider using a syringe driver for patients who need regular SC medication for the control of pain or other symptoms. Ask for advice if needed.

Advice and guidance are available from:

- Senior members of the team looking after the patient
- The hospital intranet – under Palliative Care. Includes symptom control guidance and Rapid Discharge Home to Die Pathway.
- The Palliative Care Handbook (“Green Book”) – Advice on clinical management, Wessex Palliative Physicians. 7th edition (2010)
- The Hospital Palliative Care Team on 8102: Facilitator in EoLC on 2457.
- Palliative Care Service out of hours on 8115 or via switchboard.

Each individual deserves the best end of life care we are able to provide.

We only have one chance to get it right.

Supporting care in the last hours or days of life

Information sheet to be given to the family following discussion

As the end of life approaches it can be difficult to estimate how much time is left, but this may now be as short as hours or days.

We will do our best to make sure that is as comfortable and well cared for as possible.

It can be difficult to take lots of information on board at a time like this, but we will do our best to explain things to you simply and clearly. If you have questions or just want to talk things over with one of the doctors, nurses or chaplain, let us know.

Medication

Taking tablets and other medication usually becomes more difficult as it becomes harder to swallow safely. We will stop any medication that is not helpful. We will make sure that injections are available if needed, for instance to control pain, sickness, breathlessness and other symptoms. They will only be given if and when needed, just enough and no more than is needed to help the symptom.

Reduced need for food and drink

We will offer help and support with eating and drinking for as long as possible. However as part of the dying process, most people gradually lose interest in food and drink. When a person stops eating and drinking it can be hard to accept even when we know they are dying.

Sometimes fluids given by a drip may be offered, but a drip will only be recommended where it is helpful and not harmful.

Good mouth care is very important to relieve dryness. If you would like to help with this, let us know.

Comfort

We will offer help with personal care regularly. However, we recognise that it is important for you to have time and space just to be together. This is sometimes a difficult balance to achieve so please let us know if we need to do things differently, for whatever reason.

Feel free to share as much of the physical care as you want, or if you prefer, support by spending time together, sharing memories and news of family and friends.

We understand this may be all very unfamiliar to you. Please let us know if there are any questions that occur to you, no matter how insignificant you think they may be or how busy we may seem.

We want to provide the best care we can.



We can be reached during daytimes on:.....

Night time:.....

Other information or contact numbers (e.g. palliative care nurse / district nurse):

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This space can be used for you to list any questions you may want to ask:

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