Patient Name:_____

DOB:_____ NHS No:_____

Sussex Community NHS
NHS Foundation Trust

CARE PLAN FOR THE DYING PERSON

(ADULTS)

Author : EOLC Steering Group

Review Date : March 2019

Patient Name:_____

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Initial Assessment Documentation	Date	Time	Signature
Ensure a doctor has assessed and agreed that the person is likely to die within a few hours or days			
Communicate clearly and sensitively that death is expected soon to the person (if conscious and appropriate), family and those important to the person and the focus of care is now on comfort			
Ensure that signed DNACPR is available and at the front of the patients notes together with any Advance decision to refuse treatment (ADRT) completed previously			
Review any previous documentation/discussions of persons wishes and preferred place of death			
Ensure the name and contact details of the GP and community team responsible for the persons care are made known to the person, family and carers (informal and formal)			
Ensure contact numbers for key family members are recorded			
Ensure Anticipatory medications have been ordered and are available			
Scan and send DNACPR to SeCamb dnacpr.secamb@nhs.net			

SIGNATURE LOG			
PRINT NAME	SIGNATURE	PRINT NAME	SIGNATURE

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RECOGNISE	INVOLVE	PLAN AND DO
Consider potentially reversible cause of symptoms and take prompt action in accordance with persons wishes Develop and document plan of care according to current wishes and circumstances Regularly review person and respond to changes in condition, needs and preferences	Involve the dying person to the extent they wish to be: In day to day decisions about food, drink, personal care and clinical treatment decisions Find out and respect the extent to which individuals wish their family and those important to them to be involved in decision making and information sharing Identify a key patient representative who can disseminate information with the patients consent to family and friends	Ensure an individual plan of care is agreed to meet the needs of the dying person and documented so that consistent information is shared amongst those important to them Pay attention to symptom control including relief of pain and other discomforts Pay attention to the persons physical, emotional, psychological, social, spiritual, cultural and religious needs
COMMUNICATE	**SUPPORT**	**AFTER CARE**
Use clear and understandable language in all forms of communication Adapt communication to best meet the needs of the person and those close to them Check the understanding of information that is being communicated and document this Provide additional written support if appropriate about the clinical changes that may occur at end of life	Recognise that families and carers have their own needs and offer emotional support and signpost to supportive services as required Listen to and acknowledge their needs and wishes even if it is not possible to meet them all Where a dying person lacks capacity, explain the decision making process to those supporting the dying person and involve them as much as possible	Inform GP and other involved clinicians and carers Follow local procedure for verification of expected death Offer emotional support and signpost to supportive services Offer local bereavement booklet

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SYMPTOM OBSERVATION CHART

RECORD OBSERVATIONS AT EACH CONTACT OR AT LEAST FOUR HOURLY ON INPATIENT UNIT

DATE								
TIME								
CONSCIOUS LEVEL								
A=Awake S=Semi conscious U=Unconscious								
PAIN – Reported or Observed	3							
	2							
	1							
	0							
NAUSEA	3							
	2							
	1							
	0							
VOMITING	3							
	2							
	1							
	0							
BREATHLESSNESS	3							
	2							
	1							
	0							
RESPIRATORY SECRETIONS	3							
	2							
	1							
	0							
DRY MOUTH	3							
	2							
	1							
	0							
AGITATION	3							
	2							
	1							
	0							
OTHER – PLEASE SPECIFY	3							
	2							
	1							
	0							
SIGNATURE								
ROLE								

3	Symptom present – Does not resolve with current medications/intervention	Review of the patient and Care plan for any single symptom score of 3
2	Symptom present – Requires Medication/intervention	Care Plan continues, If 3 consecutive symptom scores of 2 are present (for any symptom) A review is required of the patient and the care plan
1	Symptom present – Resolves Spontaneously	Care Plan continues, consider adaptations
0	Symptom absent	Care Plan continues

Adapted from BSUH/Symptom observation chart for the dying person

Patient Name:_____

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PAIN

- Consider other underlying causes e.g. constipation, retention of urine, pressure damage.
- Review medication and ensure anticipatory prescribing and a signed authority is in place.
- Consider underlying causes psychological/spiritual.
- Consider non-pharmalogical management of pain.
- If pain is reported or observed, assess intensity and severity of pain (use pain scale 0-10).
- Identify site and what coping strategies the person is using to help alleviate it.
- Discuss with GP or CNS if appropriate and consider possible sensitivities.
- Consider using syringe driver to give appropriate analgesia if person unable to take oral medication.
- Encourage patient, family or those important to the patient to alert team if symptoms /concerns persist

Liaise with Multidisciplinary Team when score on Symptom observation chart is 3 or reaches 2 on 3 consecutive occasions

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

Patient Name:_____

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BREATHLESSNESS

- Identify and treat reversible causes of breathlessness in the dying person eg pulmonary oedema or pleural effusion
- Consider non-pharmacological management of breathlessness in the last days of life (hand held fan, repositioning, alternative therapies, relaxation techniques, alleviate anxieties)
- Do not routinely start O^2 to manage breathlessness, only offer O^2 therapy to people known to have symptomatic hypoxemia.
- Consider use of pharmacological interventions if appropriate (opioids, benzodiazapines or a combination of both)
- Encourage patient, family or those important to the patient to alert clinician if symptoms /concerns persist.
- Acknowledge changes in breathing patterns associated with dying and share with the patient and those important to them

Liaise with Multidisciplinary Team when score on Symptom observation chart is 3 or reaches 2 on 3 consecutive occasions

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

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NAUSEA AND/OR VOMITING

- Assess for likely causes of nausea and vomiting in the dying person
- Discuss the options for treating nausea and vomiting with the dying person and those important to them
- Consider non pharmacological methods for treating nausea and vomiting
- Have anti-emetics have been used in the past and establish success and effectiveness.
- Consider bowel related causes and positioning
- Consider cause, current medication and side effects.
- Discuss with GP and multidisciplinary team as appropriate.
- Ensure access to vomit bowls, tissues.
- Encourage patient, family or those important to the patient to alert team if symptoms /concerns persist.

Liaise with Multidisciplinary Team when score on Symptom observation chart is 3 or reaches 2 on 3 consecutive occasions

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

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AGITATION

- Explore the possible causes of anxiety, delirium and agitation and treat any reversible causes
- Observe for verbal/non-verbal signs of agitation
- Check for physical symptoms (Bladder, Bowel, Pain, Positioning, Toxicity, Environmental) that may be contributing to agitation
- Seek specialist advice if standard medication does not manage anxiety
- Encourage patient, family or those important to the patient to alert team if symptoms /concerns persist.

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RESPIRATORY SECRETIONS

- Ensure anticipatory prescribing and signed authority in place.
- Assess the likely causes of noisy respiratory secretions in the dying person
- Reassure the dying person and those important to them that, although the noise can be distressing, it is unlikely to cause discomfort
- Consider a trial of medication to treat noisy secretions if they are causing distress.
- Monitor for improvements and side effects of medications
- Encourage patient, family or those important to the patient to alert team if symptoms /concerns persist

Liaise with Multidisciplinary Team when score on Symptom observation chart is 3 or reaches 2 on 3 consecutive occasions

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MOUTH CARE

- Maintain good oral hygiene.
- Mouth pain –Discuss with GP to prescribe appropriate medication.
- Observe for signs of thrush.
- Encourage the use a soft tooth brush.
- Relieve a dry mouth with ice cubes, frozen fruit, lemonade or tonic water as appropriate and taking in patient preference.
- Consider tinned, unsweetened pineapple which can cleanse the mouth and help with dryness.
- Offer food and fluids as long as the patient is able.
- Communicate with patient, family or those important to the patient.
- Encourage patient, family to alert clinician if symptoms /concerns persist important to the patients.

Liaise with Multidisciplinary Team when score on Symptom observation chart is 3 or reaches 2 on 3 consecutive occasions

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BOWEL AND BLADDER CARE

- Ensure dignity at all times.
- Acknowledge patient preferences.
- Communicate with patient, family or those important to the patient.
- During the latter stages of a terminal condition a full bladder (or bowel) can cause agitation and restlessness.
- Skin care is part of continence management (utilise SCFT assessment tools for bowel and pressure area care)
- Barrier creams, repositioning and constant re-evaluation are the cornerstone to preventing skin deterioration.
- Care is more often aimed at maintaining comfort and dignity and relieving symptoms with minimal interference.
- Collaborative approach between continence and palliative care.
- Assess need for continence equipment and identify source.

Liaise with Multidisciplinary Team when score on Symptom observation chart is 3 or reaches 2 on 3 consecutive occasions

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COMMUNICATION

- Good communication in EoLC involves both the dying person and those important to them
- Establish the communication needs and expectations of those entering the last days of life
- Establish the current level of understanding of the clinical situation
- Establish the dying persons cognitive status and any specific communication needs
- Identify what is important to the dying person and those important to them
- Explore and address any stresses the dying person may be experiencing.
- Identify and address any religious/spiritual wishes the patient may have.
- Continue to explore the understanding and wishes of the dying person and those close to them, and update documentation accordingly
- Support patient and family and those important to the patient to fulfil any wishes as is able

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

Patient Name:_____

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SPIRITUALITY

- Identify what is important to the patient, family and those whom are important to the patient.
- Identify and address any stresses the patient may be experiencing.
- Communicate with patient, family or those important to the patient.
- Identify and address any religious wishes the patient may have.
- Support patient and family and those important to the patient to fulfil any wishes as you are able

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

Patient Name:_____

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EATING AND DRINKING

- Support the dying person to drink if they wish and are able to. Check for any difficulties, such as swallowing problems or risk of aspiration.
- Discuss the risks and benefits of continuing to eat and drink with the dying person and those involved with the dying persons care.
- Encourage people important to the dying person to help the patient with eating and drinking, provide any necessary aids and give them advice on drinking safely
- Assess daily the dying persons hydration status and review the need for clinical assisted hydration, respecting the persons wishes and preferences.
- If appropriate discuss the risks/benefits of clinical assisted hydration with the dying person and those important to them.
    - Clinical assisted hydration may relieve distressing symptoms of dehydration, but may cause other problems.
    - It is uncertain if giving clinical assisted hydration will prolong life or extend the dying process
    - It is uncertain if not giving clinical assisted hydration will hasten death

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

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ADDITIONAL SYMPTOMS

DATE	CARE PLAN	REVIEW DATE	SIGNATURE

Patient Name:_____

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Please use the above as key prompts for Care Planning at the end of life. This is not an exhaustive list but can be used to guide your care planning along with the symptom assessments in the previous pages

Date	Care Plan	Signature

Patient Name:_____

DOB:_____ NHS No:_____

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CARE PLAN

Date	Evaluation	Signature

Patient Name:_____

DOB:_____ NHS No:_____

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ONGOING EVALUATION

Date	Evaluation	Signature

Patient Name:_____

DOB:_____ NHS No:_____

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CONFIDENTIAL EOLC HANDOVER FORM

Please contact relevant nursing teams before considering hospital admission–unless it is a medical emergency

CIRCLE YES/NO as relevant

Alerts/Risks : DNACPR in house: YES / NO

PATIENT DETAILS	**CARERS DETAILS**	**GP DETAILS**
Name:	Name:	Name:
DOB:	Relationship:	
Address:	Address:	Address:
Tel :		
NHS No:	Tel :	Tel :
Key Code	Alternate Tel :	
COMMUNITY NURSING TEAM	**EVENING OVERNIGHT TEAM**	**SPECIALIST/HOSPICE CONTACT**
Team :	Team :	Provider :
Named Nurse:		CNS :
Address:	Base:	Address:
Tel :	Tel :	Tel :
Fax:	Fax:	Fax:
Hours:	Hours:	

ACUTE HOSPITAL : TEL :

HOSPITAL TEAM: FAX :

CONSULTANT:

Reason for referral :

Patient Name:_____

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MEDICAL INFORMATION

Diagnosis:

Is patient aware: Yes No Carer/family aware: Yes No

Advance directive/care plan: Yes No Location:

Patient consent to share information: Yes No

ANTICIPATORY MEDICINES

Anticipatory medicines & community script in house: Yes No N/A
Current Symptoms:

Pain Yes No
Anxiety Yes No
Nausea Yes No
Secretions Yes No
Breathlessness Yes No
Syringe driver equipment in place: Yes No N/A

END OF LIFE CARE

Is imminent death anticipated: Yes No

Patients preferred place of care:

Is there a signed DNACPR form in the house: Yes No If no – Why :
Location of DNACPR:
Discussion with GP & Nursing teams around verification of death: Yes No
Family/carer aware of plan? Yes No
Cultural/Spiritual/religious needs:
Care of the body after death:

One Call please fax

Community Nurses: YES NO
GP: YES NO
Evening/Overnight Team: YES NO
Hospice Team: YES NO
OOH Provider: IC24.nespn@nhs.net. YES NO
South East Coast Ambulance: YES NO

INITIAL NURSE ASSESOR

Name:

Signature:

Date/Time:

Patient Name:_____

DOB:_____ NHS No:_____

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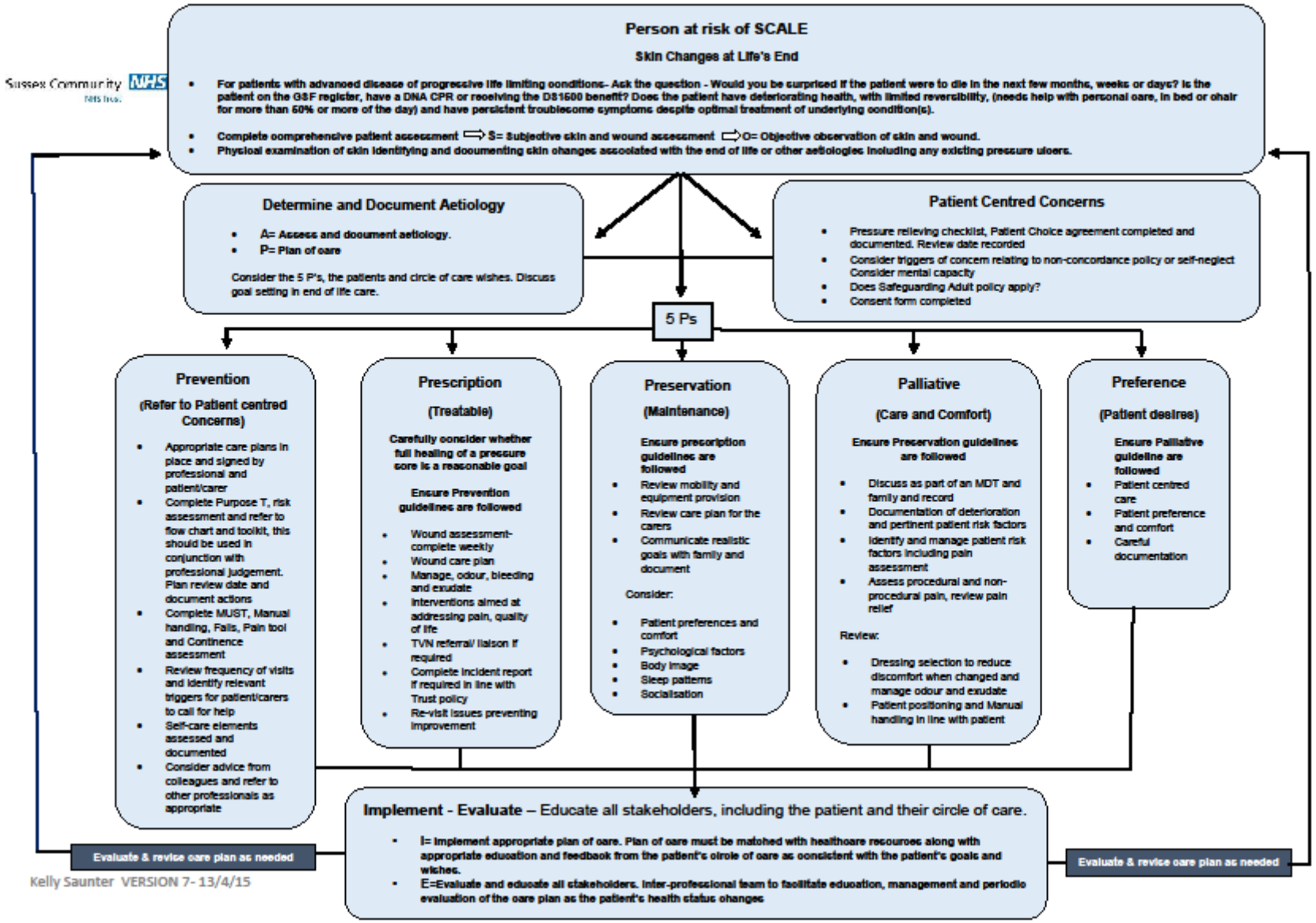

Patient Name:_____

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CARE PLAN FOR THE DYING PERSON (ADULTS)

INFORMATION FOR STAFF

The care plan for the dying person is an individualised, person centred integrated care plan designed for use with patients in the last weeks and days of life.

The care plan incorporates the priorities of care for the dying patient and aims to improve end of life care for people in their last days of life by communicating respectfully and involving them, and the people important to them, in decisions and by maintaining their comfort and dignity.

The care plan will help to assess and manage common symptoms for the dying patient and will allow for clear care plans to be accessible to all clinicians caring for the patient. In order to ensure completeness a paper copy should be left in the patients' home (yellow folder) or with their inpatient notes and all clinicians should record any activity with the patient in it.

The Care Plan for the Dying Person is available within SystmOne as a template and combined set of care plans. It is also available within SystmOne as a Word document, which can be printed for the patient from the Communications and Letters section of the record. If you complete the SystmOne template first, the information which has been entered into the template will pull through onto the Word document ready to be printed.

This paperwork is designed to become the core documentation relating the patient during the active dying phase, and should be used for all patients that are assessed as being in their last days of life.

RESOURCES

Verification of Expected Death Policy – PULSE

Allow a Natural Death Policy – PULSE

McKinley Syringe Driver Policy and Standard Operating Procedure – PULSE

Palliative Adult Network Guidelines (PANG) - http://book.pallcare.info/

Skin Changes at End of Life – SCALE – PULSE

Preparing to say Goodbye Booklet
http://www.sussexcommunity.nhs.uk/downloads/services/pallitive_care/palliativecare_bh_eolcbooklet.pdf

Planning Future Care -
http://www.sussexcommunity.nhs.uk/Downloads/Services/endoflife_care/advance-care-plan.pdf

There is also a great deal of information available in your locality – please source as required.