Individual Plan of Care and Support

for a Person in the Last Days and Hours of Life

Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life

Section 1 – Recognition, Assessment and Communication

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| MEDICAL CLINICAL RECOGNITION OF DYING AND CEILINGS OF CARE (to be completed by GP if available otherwise leave blank)**Name Signature Date Time** |

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| **ANTICIPATORY PLANNING (to be completed by either the GP or nurse)**Are Mastercall aware? Have the anticipatory medications been authorised? Is there a valid DNACPR? |

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| **RECOGNITION OF DYING (to be completed by the nurse)** |
| What changes have you seen that make you believe that the person is now in the last days or hours of life? |
| Which doctor have you discussed this with, on which date and at what time did the discussion take place?  |
| What decision have you and the doctor named above made with regards to reversible causes for the change in condition and the likelihood that the person is now dying? |

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| **PREFERENCES AND WISHES FOR CARE** |
| What are the dying person’s wishes for care? (Place of care, environmental, music, windows etc) |
| What are the patient’s spiritual or religious or **cultural** needs at this time? |
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| **COMMUNICATION** |
| What have you explained to the person and family about the current clinical situation? |
| What have you agreed with the person and family about the level of intervention / support that is needed? |
| Please record here what you have explained to the person and family about the benefits and burdens of food and fluids?Please record here what you have explained to the person and family about the use and purpose of the anticipatory medications and possible use of syringe pump? |
| What have you explained about who to contact and how to contact them in the event of help being needed or when the person dies?**Please give the patient/carer the leaflet ‘Care and Support in the Last Days of Life’ and indicate here that this has been done.** **Assessing Nurse: Name Signature Designation Date Time** |

Section 2 – Individual Plan of Care

**Care Plan 1. Assessment of and Care Plan for Symptoms**

**Some common symptoms:**

**Remember:**

* **To monitor for ongoing Long term Conditions related symptoms, eg; Parkinson’s Disease, glycaemic control, heart failure and take steps to manage them**
* To look out for swallowing difficulties and review route of medication administration
* To document the **rationale** for doses of medication given
* To exclude reversible causes of symptoms
* To document the ABSENCE **or** PRESENCE of symptoms
* Refer to Palliative Care Pain and Symptom Control Guidelines and the symptom control algorithms
* Consult Specialist Palliative Care Team if needed ext 4215

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| * Pain
* Nausea/ Vomiting
* Breathlessness
* Noisy Breathing
* Agitation
* Confusion
* Constipation and urinary retention
* Alcohol and/or tobacco withdrawal
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**! Syringe Pump !**

If a syringe pump is commenced please indicate here that you have given the McKinley T34 leaflet to the patient/family

**The patient’s individual needs regarding symptom control:**

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| **Date** | **Time** | **Assessment of Care Needs** | **Intervention**  | **Print, Signature and Designation** |
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**1. Assessment of and Care Plan for Symptoms (Continued)**

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**Care Plan 2. Assessment of and Care Plan for Nutrition and Hydration**

**Remember:**

* To exclude reversible causes of reduced oral intake EG swallowing difficulties / dirty mouth
* To respect the dying person’s wish to eat and drink even at risk of aspiration
* To encourage the family to help with feeding if they so wish
* **You will need a plan if the patient has clinically assisted nutrition (EG PEG feeding)**
* To review nutrition and hydration at every visit

**Have you considered the following?**

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| * The position needed to aid oral intake for

**as long as** possible* Risk assessment for feeding at risk
* Plan for favourite food and fluids
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**The patient’s individual needs regarding nutrition and hydration:**

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**2. Nutrition and Hydration (Continued)**

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**Care Plan 3. Assessment of and Care Plan for Personal Care**

**Have you considered,**

**Remember:**

* **That existing care plans are valid if still appropriate to needs, there is no need to duplicate**
* To complete a moving and handling assessment if needed
* That family may want to participate in providing care – ensure that you have explained HOW to give mouthcare if you are delegating to family or REACH
* That position change is crucial for pressure sore prevention and also to counteract stiffness
* To ensure that the dying patient’s favourite products are used
* **Oral assessment will need to be completed daily**

**assessed and planned for the following?**

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| * Personal hygiene – including hair, nails,

 eyes and shaving* Elimination needs
* Maintaining skin integrity
* Need for communication aids
* Environment
* Detailed mouth care plan

**The patient’s individual needs regarding personal hygiene** |

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| **Date** | **Time** | **Assessment of Care Needs** | **Intervention Required** | **Print, Signature and Designation** |
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**3. Personal Care (continued)**

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**Care Plan 4 Assessment of and Care Plan for Psychological and Emotional Needs**

**You should consider the following;**

**Remember to make time for psychological support**

* ‘How are you feeling today?’
* ‘Is there anything that normally helps you to cope at difficult times?’
* ‘Is there anyone that you feel you need to see?’
* What matters most to you today?
* ‘Would it be helpful for you to talk to a chaplain or a leader from your community?”

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| * Are there any non-verbal signs of low mood
* Are any verbal cues about fears/anxiety given
* Is there any unfinished business

**The patient’s individual needs regarding psychological and spiritual needs** |  |

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| **Date** | **Time** | **Assessment of Care Needs** | **Intervention Required** | **Print, Signature and Designation** |
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**4 Psychological and Emotional Needs (Continued)**

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**Care Plan 5 Assessment of and Care Plan for Needs of Family, Carers and Those Close to the Dying Person**

**Have you considered the following?**

**Remember:**

* To make time to talk to carers and family at each visit
* To listen to and acknowledge concerns or fears and document them
* Is additional support; e.g. Palliative Care Respite Team or REACH needed?

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| * Is there evidence of low mood or anxiety?
* Are there religious and spiritual needs for the family?
* Enabling participation in care if requested
* What physical needs do the family have?

**The family’s individual needs**  |  |

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**5 Needs of Family, Carers and Those Close to the Person (continued)**

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**Section 3** – **MULTI-PROFESSIONAL COMMUNICATION SHEET**

**THERE MUST BE A REVIEW OF THIS PATIENT, EITHER FACE TO FACE OR VIA A TELEPHONE CALL BETWEEN THE DOCTOR AND THE NURSE, EVERY 72 HOURS**

**This page should ONLY be used :**

* For recording the outcome of a GP review
* For Specialist Nurses to record their assessments and advice
* Any significant event NOT covered in the care plan

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| **Where to get further advice and support:** |
| **In Hours Advice** | **Out of Hours Advice** |
| **Specialist Palliative Care Team is available to contact 7 days a week 8.30 – 4.30.****Tel: 0161 419 4215****Macmillan Community Weekend Mobile:****07809 312 146** | **24 Hour Advice Line:****St Ann’s Hospice Tel: 0800 970 7970** |

**This** document has been adapted from **a consensus document developed by the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Palliative and End of Life Care Working Group to allow the documentation of care in the last days of life. It will be evaluated and may be subject to amendment in light of the results of that evaluation.**

**Date of issue:** **JUNE 2019 Status: Version 1.0**

**Section 4**  – **CARE AFTER DEATH**

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| **SECTION 4 CARE AFTER DEATH** |
| **Verification of Death** |
| Time of the death: …………………………………………………………………Date of death: ……… / ……… / ………**Verified by doctor** 🞏 **Verified by senior nurse** 🞏Date / time verified: ………………………………………**Details of healthcare professional who verified death**Name: ……………………………………………………………………………………………… (please print)Signature: ……………………………………………………………………………………… Comments: ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………Persons present at time of death: ………………………………………………………………………………………………………………Relative or carer present at time of death: **Yes** 🞏 **No** 🞏If not present, have the relative or carer been notified **Yes** 🞏 **No** 🞏Name of person informed: ……………………………………… Relationship to the patient: ……………………………………Is the coroner likely to be involved: **Yes** 🞏 **No** 🞏GP: …………………………………………… Doctor: …………………………………………… Tel No: ………………………………… |
| **Relative or Carer Information** | **The relative or carer can express an understanding of what they will need to do next and are given relevant written information*** Conversation with relative or carer explaining the next steps

 * Information given regarding how to collect the death certificate and make appointment with registrar

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| **PHCT**  | **The primary health care team notified of the patient’s death****GP** Yes 🞏 No 🞏 **DN** Yes 🞏 No 🞏 **SPCT** Yes 🞏 No 🞏**REACH**  Yes 🞏 No 🞏 **PC Respite Team**  Yes 🞏 No 🞏 |
| **Healthcare professional signature: ……………………………………………………….****Date: ………………………………………. Time: ………………………………………….** |
| ***Care after death*** ***MDT progress notes******- record any significant issues not reflected above.*** |
| ***Date*** |  |
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