First name: ..... DOB: .....

Last name: ..... Gender: .....

Religion: .....

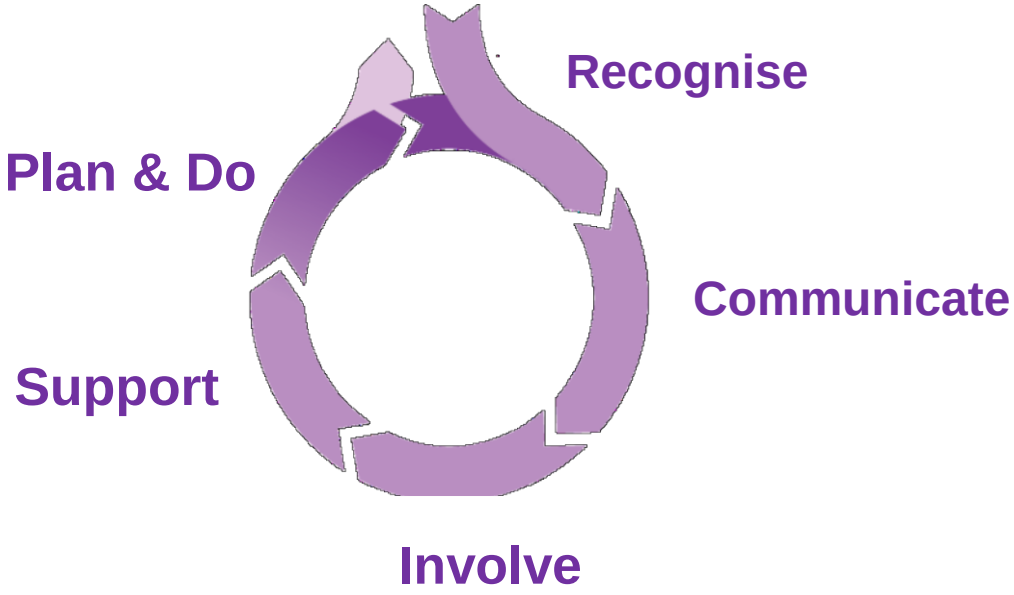
Address: .....

.....

NHS no: .....

Lancashire Care NHS
NHS Foundation Trust

Individual Plan of Care and Support for the Dying Person



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Each individual must have an individual Plan of Care according to their needs. The plan should be discussed openly with the person and those identified as important to them. This plan must be reviewed in accordance with the person's needs.

The care of the dying person will be led by the patient's Consultant in hospital, GP in community, hospice physician in the Hospice as well as a lead responsible nurse.

The principles of the Mental Capacity Act (2005) and its Code of Practice apply.

Current Place of Care:
If the patient is transferred to a different setting, keep photocopy and send original with patient

Date of issue: February 2017 **Date for review:** February 2020 **Status:** version 2.0

Prepared by: Adapted by LCFT and based on consensus document developed by ELHT, the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Palliative and End of Life Care Working Group. Utilises resources made available by the Leadership Alliance for the Care of Dying People on NHSIQ. The document will be evaluated and may be subject to amendment in light of the results of that evaluation

Supporting Health and Wellbeing

AUTHORS: Sue Metters, Nicola Collins, Anne Lloyd & Margaret Fishwick, March 2015

Patient details

Patient's name: ..... NHS no: .....

Aim/Purpose of Document

- This 'Individual Plan of Care and Support for the Dying Person' allows the documentation of individualised care provided for the dying person in the last days and hours of life as well as support offered to their families and those important to them.
- It aims to reflect the approach to care of the dying person and the 5 Priorities of Care described in the 'One Chance to Get It Right' report.
- The focus should be on the care provided and the outcomes for patients and their families.
- Communication, compassion and kindness, as well as staff having the required knowledge, skills and experience are essential to deliver good clinical care and to meet the needs of each dying person and their family.
- Clear documentation is important to ensure relevant information is shared within teams and across care settings.
- Whilst this document offers suggestions for the holistic care of the dying person, these suggestions are not exclusive.
- Assessment and care should be on an individual basis depending on the dying person's needs and the needs of their family and those close to them.
- The prompts are not to be ticked but to be considered and then the outcomes documented within the text of the document.
- All staff should ensure that they have the necessary knowledge and skills to provide care for patients who might be in the last days and hours of life.

ADVICE LINE FOR HEALTH CARE PROFESSIONALS:

- 24 hour Specialist Palliative Care Helplines:

  Blackburn with Darwen: Contact Telephone Number 07730639399 (Based at East Lancs Hospice)

  Central Lancs: Contact telephone number 01772 629171 – ask for the advice line (based at St Catherine's Hospice).

For patients and carers, please contact telephone district nursing service at any time, day or night for advice or support. Contact numbers are available of the information provided.

Patient details

Patient's name: ..... NHS no: .....

PERSONALISED NURSING CARE PLAN FOR THE DYING PERSON
Community Nursing Services

This care plan should be implemented following discussion with all relevant health professionals/patient/family/carers involved in …….care.
Key points to consider;

- All reversible causes of deterioration in condition must have been considered
- Do Not Attempt Cardio-Pulmonary Resuscitation is in place: Yes/ No
- All unnecessary interventions/medication are discontinued
- Ensure family/carers are aware of contact details and provide information leaflets as required to support family/carers
- Preferred priorities of care (PPC)/advance decisions/lasting power of attorney are considered
- Anticipatory medication is prescribed as appropriate for symptom control
- Consider if nicotine replacement therapy would be required

ALL THE ABOVE TO BE CLEARLY DOCUMENTED WITHIN THE ATTACHED DAILY CARE RECORD

Patient Specific Information

DIAGNOSIS: .....

.....

SPIRITUAL AND CULTURAL NEEDS: .....

.....

PREFERRED PRIORITIES FOR CARE: .....

.....

Expected Clinical Outcome:

WE WILL ENDEAVOUR TO MAKE ..... AS COMFORTABLE AND WELL CARED FOR AS POSSIBLE.

Any Other Patient Wishes: *i.e. pets in room etc?*

.....

Initial Assessment and Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

1. Recognise the possibility that the person may die within the next few days or hours

Points to consider:

- Document decision-making re: likely prognosis of a few days or hours for this person
  - Underlying diagnosis and other clinical conditions
  - Reversible causes of deterioration have been treated effectively or excluded
- Review benefits and burdens of:
  - Investigations and observations, incl. Early Warning Score
  - Treatments
  - DNA-CPR decision
- Is Implantable Cardiac Defibrillator (ICD) in situ and what is decision regarding deactivation?

Consider additional Specialist opinion and/or Specialist Palliative Care Referral if needed

Date	Time	Document decision process, discussions and outcome	Printed name, Designation, & Signature

Agreement by patient's Consultant or GP: yes/no	**Name of Consultant or GP:** _____ **Signature:** _____ **Date:** _____

Patient details

Patient's name: ..... NHS no: .....

Initial Assessment and Individual Plan of Care

2. Communicate and Involve

Document discussions you have had with the patient and family:

- Current clinical situation and recognising clinical uncertainties or recognising dying
- Agree aims and expectations of care, including:
  - Active treatment aimed at symptom care
  - Nutrition and Hydration
  - Symptoms control including syringe pump if needed
- Explore patients preferences for care, including place of care and wishes re: organ/tissue donation
- Document who was present for discussion

Explain and provide:

- Provide name and contact details of nurse and doctor responsible for leading the care of the dying person and their family
- Explain likely referral to coroner at time of death if this is necessary and anticipated
- Ask for and document key contacts for dying person and family
- In community setting – ensure the family know who to contact when the patient dies

Are there any specific communication needs to consider for patient, their family and those close to them? E.g. interpreter required, deafness, anxiety

Date	Time	Document decision process, discussions and outcome	Printed name, Designation, & Signature

Initial Assessment and Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

Continued: Communicate and Involve

Family/Carer contact details:	
Relation:	**Relation:**
Name:	**Name:**
Telephone:	**Telephone:**
Other info:	**Other info:**
Lasting Power of Attorney for Health and Welfare Contact details:	
Relation:	**Relation:**
First name:	**First name:**
Telephone:	**Telephone:**

Patient details

Patient's name: ..... NHS no: .....

Initial Assessment and Individual Plan of Care

3. Support the Needs of Family and those important to the Dying Person

Points to consider:

- Assess and review needs of the family and those close to them
- Listen to and acknowledge their concerns of fears
- Explore their own religious and spiritual needs
- In hospital: explain facilities, consider side room
- In community: offer additional care, such as night sits or Hospice @ Home
- Enable to participate in care if requested

Date	Time	Document decision process, discussions and outcome	Printed name, Designation, & Signature

Patient details

Patient's name: ..... NHS no: .....

Patient details

Patient's name: ..... NHS no: .....

Initial Assessment and Daily Review of Plan of Care

Plan & Do – Develop and Review Individual Plan of Care

4.1 - Assess Symptoms

Points to Consider:

- Common symptoms in dying patients: pain, nausea + vomiting, breathlessness, noisy breathing, agitation, dry mouth
- Anticipatory prescribing of PRN medications for specific potential symptoms
- Review ongoing benefit and burden of existing medications and other treatments such as Oxygen
- Consider use of T34 Syringe Pump if required to manage patient's symptoms
- Consider Specialist Palliative Care Referral or advice if needed

4.2 - Nutrition / Hydration

Points to Consider:

- Assess nutrition and hydration needs
- Consider benefit and burden of clinically assisted nutrition/ hydration
- Record clinical decision re: stopping/ starting and continuing clinically assisted nutrition and hydration

Provision of Care:

- Support oral fluids and food as dying person is able
- Respect the dying persons choice to eat and drink even if at risk of aspiration while trying to minimise the risk of aspiration
- Provide regular mouth care
- Consider nicotine replacement therapy if appropriate

4.3 - Maintain Quality Personal Care

Points to Consider:

- Review nursing interventions and update any existing nursing care plan to ensure it meets the patient's current needs
- Reviewing bowel and bladder function
- Considering catheterisation for comfort and support
- Manual handling assessment
- Hygiene needs – including hair care, shaving and oral care Availability of communication aids e.g. spectacles, hearing aids
- Skin integrity
  - Considering the need for pressure relieving and other equipment needs

Care planned initiated by (signature): ..... (Print): .....

Date .....

Patient details

Patient's name: .... NHS no: ....

Initial Assessment and Individual Plan of Care

Plan & Do – Develop individual plan of care

Regular Review of Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

If MDT feels the dying person is no longer in the last days of life due to improvement in condition, then use appropriate care plan and document the reasons for the decision making and who it has been discussed with.

The care of the dying person will be led by the patient's Consultant in hospital, GP in community, hospice physician in the Hospice and a lead responsible nurse.

Regular Re-Assessment and Reviews:

- Regularly review person to make sure plan of care remains appropriate and respond to change in condition, needs and preferences.
- Consider which decisions require immediate action and those that can be discussed and agreed with senior clinician and multi-professional team responsible for person's care as soon as possible.
- **Medical:**
  - The patient's Consultant (in hospital), GP (in community), hospice physician (in hospice) has overall responsibility for the patient.
  - The dying person must be regularly reassessed and reviewed by a Doctor who is competent to undertake this assessment, at least every three days or sooner if there is an unanticipated change or need.
- **Nursing:**
  - The nurse leading the care for the patient should communicate with the patient and family on a daily basis, checking their understanding and ensuring that any emerging concerns are addressed.
  - The Nurse leading the care of the dying person should be documented every shift.
  - The regular nurse review should occur at least every 4 hours in hospital and every 12 hours in the community.
  - The reviews should be guided by the 5 priorities and the Individual Plan of Care for this patient.

Regular Review of Individual Plan of Care

If MDT feels the dying person is no longer in the last days of life due to improvement in

Patient details

Patient's name: ..... NHS no: .....

condition, then use appropriate care plan and document the reasons for the decision making and who it has been discussed with.

Domains to consider:

1. Recognise
- Are there any changes to the patient's condition?
- Are changes to the plan of care required?

2. Communicate and Involve
- Aim and expectations of care
- Explore any emerging concerns
- Explore preferences of care

3. Support family and those important to the dying person

4. Plan & Do

4.1 Symptoms
4.2 Nutrition and Hydration
4.3 Personal Care
4.4 Psychological, spiritual and religious needs

Date/ Time	Domain	Ongoing MDT notes	Printed Name Designation Signature

Patient details

Lancashire Care NHS
NHS Foundation Trust

Patient's name: .... NHS no: ....

Regular Review of Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

Regular Review of Individual Plan of Care

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Patient details

Patient's name: .... NHS no: ....

Regular Review of Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

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Patient details

Patient's name: .... NHS no: ....

Regular Review of Individual Plan of Care

Patient details

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Patient details

Patient's name: .... NHS no: ....

Regular Review of Individual Plan of Care

Patient details

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Lancashire Care NHS
NHS Foundation Trust

Patient details

Patient's name: .... NHS no: ....

Regular Review of Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

Regular Review of Individual Plan of Care

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4.1 Symptoms
4.2 Nutrition and Hydration
4.3 Personal Care
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Patient details

Patient's name: .... NHS no: ....

Regular Review of Individual Plan of Care

Patient details

Patient's name: ..... NHS no: .....

Record of Care After Death

Following the death of a patient on the Community Nursing caseload

At first notification that the patient has died the community nurse is to make contact at the earliest opportunity to offer condolences and to arrange a bereavement visit. Arrange collection of all equipment as needed. Advise that all medications to be returned to local pharmacy if indicated and/or denatured by the district nurses.

Ensure that all other disciplines involved with the patient's care are informed e.g. Marie Curie, Out of Hours team, Oxygen team.

At a mutually convenient time provide a bereavement visit. Provide time to talk through events, collect notes and any other non-loan store equipment. Ensure that all other returnable equipment has been collected and medication has been returned or disposed of and recorded as per policy.

Document bereavement visit and archive all home and office records as per Trust Record Keeping Policy.

If the carer and family require further bereavement support then provide contact details for support as per own locality area, to enable self-referral.

Blackburn with Darwen

East Lancs Hospice
Bereavement Support
01254 733407

Cruse Bereavement Care
0844 477 9400

Central Preston

Bereavement counselling

St. Catherines Hospice,

Bamber Bridge.

Nr. Preston.

Tel. 01772 629171

Cruse Bereavement Care
0844 477 9400

Chorley and South Ribble

Bereavement counselling

St. Catherines Hospice,

Bamber Bridge.

Nr. Preston.

Tel. 01772 629171

Cruse Bereavement Care
0844 477 9400

Priorities for Care in the Last Days and Hours of Life[1]

Each individual must have an individual Plan of Care according to their needs. The plan should be discussed openly with the person and those identified as important to them. This plan must be reviewed on a daily basis.
The care of the dying person will be led by the patient's Consultant in hospital, GP in community, hospice physician in the Hospice as well as a lead responsible nurse.
The principles of the Mental Capacity Act (2005) and its Code of Practice apply.

Recognition of likelihood of dying

- The possibility that a person may die, within the next few days or hours, is a ***multi-professional decision***. It should involve the Consultant responsible for the patient's care (in hospital) or the patient's GP (in community) and the senior registered nurse on duty. The Consultant may delegate this decision to a ST3 or above whom they deem to be competent and the decision should be reviewed by the patient's Consultant/GP at the next available opportunity.
- All professionals must carefully consider which decisions need to be made immediately to ensure the person's comfort and safety, and which can and must wait for review by the senior doctor who has responsibility for the person's treatment and care.
- If potentially reversible causes are identified, take prompt action to treat these, provided this is in accordance with person's wishes (or best interests, if lacks mental capacity).
- If likely to die very soon, communicate this clearly and sensitively to the person (if conscious and have not indicated they would not wish to know) and family and those important to the person.
- Take into account the person's views and preferences, and develop and document a plan of care.
- Regularly review the person to make sure plan of care remains appropriate and respond to any change in condition, needs and preferences.

Sensitive communication

- Remember that open, honest and sensitive communication is critically important.
- Use clear, understandable and plain language – verbally and in all other forms of communication.
- If needed, provide additional support to help the dying person understand information, communicate their wishes or make decisions.
- Remember that communication is two-way. Listen to the views of the person and those important to them, do not simply provide information.
- Be sensitive, respectful in pace and tone of communication, and take account of what the dying person and those important to them want, and feel able, to discuss at any particular point in time.
- Check the other person understands the information that is being communicated, and document this.

[1] 'One Chance to get it Right', June 2014, Leadership Alliance for the Care of Dying People

Involvement in decision making

- Involve the dying person to the extent they wish to be:
  - in day to day decisions about food, drink and personal care
  - in clinical and treatment decisions.
- Find out, and respect, the extent to which individuals wish their families and those important to them to be involved in decision-making.
- Tell the person, and those important to them, who is the senior doctor who has responsibility for their treatment and care, and who is the nurse leading their care.
- Where it is established that the dying person lacks capacity to make a particular decision, that decision or action taken on their behalf must be in their best interests. Involve them as far as possible.

Support - Needs of families and others close to the dying person

- Remember that families and those important to the dying person, including carers, have their own needs which can be overlooked at this time. This includes both in the last days of life and onwards after a person has died.
- Recognise that they may be physically and emotionally tired, anxious or fearful.
- Ask about their needs for support or information, and meet these as far as possible.
- Listen to, and acknowledge their needs and wishes, even when it is not possible to meet all of them.
- Where a dying person lacks capacity, explain the decision-making process to those people who are supporting the dying person and involve them as much as possible.

Plan & Do - Individual plan of care

- Develop an individualised plan of care and treatment to meet the dying person's own needs and wishes, and document this so that consistent information is shared with those involved in the person's care and is available when needed.
- Pay attention to symptom control, including relief of pain and other discomforts.
- Pay attention to the person's physical, emotional, psychological, social, spiritual, cultural and religious needs.
- Support the person to eat and drink as long as they wish to do so.
- Refer to specialist palliative care and other relevant services if the person and/or situation require this, and ring for advice if unsure about anything.

ADVICE LINE FOR HEALTH CARE PROFESSIONALS:

- 24 hour Specialist Palliative Care Helplines:

  Blackburn with Darwen: Contact Telephone Number 07730639399 (Based at East Lancs Hospice)

  Central Lancs: Contact telephone number 01772 629171 – ask for the advice line (based at St Catherine's Hospice)

  For patients and carers – please contact your district nursing team using the telephone numbers provided on your information leaflets.

For patients and carers, please contact telephone district nursing service at any time, day or night for advice or support. Contact numbers are available of the information provided.

Please note:

This document is for use of LCFT staff only. Other providers might adopt this document, but LCFT will not accept any liability or responsibly for the care delivered by non-LCFT staff. Providers adopting the document must be aware of the 'One Chance to Get It Right' report, including the Priorities for Care of the Dying Person and the expectations of service providers and employers outlined within that report.