

Patient name

Hospital number

Date of Birth

Ward

**PERSONALISED CARE FRAMEWORK FOR THE**

**LAST DAYS OF LIFE**

**MEDICAL CARE PLAN**

Care 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**

**Does the patient have:**

**A lasting power of attorney for health and welfare? O Yes O No If yes, Who?..............................................**

**An advance care plan? O Yes O No**

**An advance decision to refuse treatment? O Yes O No**

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| **Recognition of dying hasbeen discussed with family/NOK:**  **Please ensure family are aware that EOLC nurses will be informed and offer booklet titled “information for relatives and friends**  **of those close to the end of their life” (in purple EOLC resource box)**   |  |  |  | | --- | --- | --- | | **Name** | **Relationship to patient** | **Date & Time** | |  |  |  | |
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**The following professionals MUST be informed that this care plan has started:**

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| **Professionals** | **Contact Number** | **Signature** | **Date/Time** |
| **GP (Completion Essential)** | **By: Fax O Phone O Email O** |  |  |
| **EOLC nurses**  **Families should be aware the EOLC CNS**  **Team are available to offer support and**  **Advice to ward staff** | **Blp 1266**  **Ext 5190 (24 hr answerphone)** |  |  |
| **Chaplaincy**  Available 24hrs / 7 days a wk | **Ext 4271 (24hr answerphone)**  If urgent bleep duty chaplain  via switch 24 hrs a day |  |  |

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 the **end of life care nurse specialists on bleep 1266** or the **palliative care team on bleep 1293 or OOHs call ext 2113.**

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| **Recognise**  **Recognition that the patient is dying** | |
| This can be difficult and the decision should be made after assessment of the patient, by the most senior clinicians (**registrar or above** and senior nurses) caring for the patient.  **Why do you consider that the patient is dying?**  **Have you considered reversible causes for the patient’s deterioration?** | **Document who is involved in making the decision (must include the senior clinician who assessed the patient):**  **…………………………………………………………………………………………………………………………..**  **…………………………………………………………………………………………………………………………..**  **Document diagnoses and relevant clinical features:**  **……………………………………………………………………………………………………………………………**  O Bedbound O Comatose O Semi-comatose  O Unable to take tablets O Unable to take more than sips of fluid  O Reduced peripheral perfusion O Cheyne-Stokes respiration  O Respiratory tract secretions O Other……………………………………………………………..  **Document whether reversible causes have been considered:**  **……………………..…………………………………………………………………………………………………..**  **……………………………………………………………………………………………………………………………** |
| **Communicate**  **Sensitive communication with the patient and family** | |
| Deafness, loss of vision and cognitive impairment should all be considered.    Ensure pts have hearing and visual aids and allow extra time or approach from a particular side to help communication. | **Does the patient have any impairment that should be taken into account when communicating?** **O Yes O No**  **If yes, state how can communication with the patient can be aided**  **………………………………………………………………………………………………………………………….** |
| **Capacity is decision specific and should not be a barrier to ongoing communication with the patient.**  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 taken in their best interests.  **Capacity can fluctuate** especially at end of life and should be **reviewed** and documented on a regular basis. **The dying person should continue to be involved in day to day decisions** regarding food, drink and personal care as well as treatment decisions. | **Has recognition of dying has been discussed with the patient O Yes O No**  **If “No” please give reason (eg unconscious, patient’s wishes)**  **………………………………………………………………………………………………………………………….**  **Explain to the patient and/or those important to them what is happening and the reasons why you think the person is dying**.  You may need to explain the difficulty in making an accurate prognosis and uncertainty of timescales. Explain that the EOLC nurses will be made aware so that they can offer support.  **Document evidence that communication has taken place and with whom. Signpost to dated entries in medical notes.**  **……………………………………………………………………………………………………………………………** |
| **DNACPR status (including ReSPECT and Treatment escalation discussions)** | |
| If not already in place, discuss sensitively with the patient, if appropriate, and those important to them. | **Date of Documentation of DNACPR .............................................**  **Documentation must be on the appropriate DNACPR form in the medical notes.**  **Ensure DNACPR has been countersigned by consultant O Yes O No** |
| **Involve**  **What is important to the patient** | |
| This enables the dying person’s EOL care plan to be patient centred and goal specific.  e.g. Symptom control, particular requests. Include any specific cultural & spiritual needs that are important to them.    If the patient is unable to communicate this, ask people important to the patient, what their wishes and priorities may be. | **Ask and document what is important to the patient.**  **…………………………………………………………………………………………………………………………**  **…………………………………………………………………………………………………………………………**  **…………………………………………………………………………………………………………………………**  **…………………………………………………………………………………………………………………………** |

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| **Where is the patient’s preferred place of care (PPC)** | |
| Even very ill patients may be able to be discharged for EOLC at:   * Home / relative’s home * Nursing Home * Residential Home * Community hospital closer to home * Hospice (complex palliative care needs only)   Contact the **discharge team (ext 4292)** or **EOLC team (blp 1266)** for urgent advice  **Consider:**   * **Rapid Discharge Home to Die** section   *(in purple EOLC folder)*   * **CHC Fast Track** folders on ward**.** | **Where is the patient’s usual residence?**  **………………………………………………………………………………………………………………………….**  **Could discharge for EOLC in the community be appropriate for this patient?**  **O Yes O No**  **If no, please state why not *(must complete)*:**  **…………………………………………………………………………………………………………………………..**  **If yes, where is their preferred place of care?**  Please discuss with the patient/those important to them whether they would like the possibility of receiving EOLC in a different setting to be explored and if so, to where (of the possible options).    **……………………………………………………………………………………………………………………………** |
| **Support**  **What needs do the dying person and their loved ones have** | |
| Ask the patient (or loved ones) what gives the patient value and meaning to their life and where they turn to for support in times of crises. This may include religious, spiritual or cultural groups as well as own community, friendship groups and pets.  Ask loved ones about their needs for support and/or information. Ascertain what support network they have available, what other pressures they face (eg other dependents), and what more can be done to help | **Conversation had with: O Patient O Family**  **Patient’s religion:………………..………………………… Practising: O Yes O No**  **Patient’s Needs identified:**  **……………………………………………………………………………………………………………….**  **What is important to loved ones? What other pressures / support do they** **have?**  **………………………………………………………………………………………………………………………….**  **…………………………………………………………………………………………………………………………..**  Please inform the pt / family that the hospital chaplaincy team:   * offers support to people of all faiths and of none * have access to leaders of other faiths and denominations * are available to spend time with people whatever their needs * the chapel is accessible 24hrs a day for prayer or for quiet reflection (staff   ID badge required at night). |
| **Plan & Do**  **Consider all the investigations, interventions and treatments the patient is having** | |
| **Review investigations, interventions or treatments that won’t promote comfort, dignity and peace** | **Document what has been stopped and why:**  **………………………………………………………………………………………………………………………......**  **Document what is being continued and why.**  **…………………………………………………………………………………………………………………………….** |
| **Decide treatment escalation plan** | |
| All patients should be medically reviewed regularly to check they are comfortable and not distressed.  **Pts not receiving physical obs should have comfort observations taken regularly**  **What should happen if the observations are abnormal?**  Cardiac investigations unit should be alerted immediately re: deactivating ICD (for more advice see purple EOLC folders) | **Document which of the following should be carried out:**     |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Heart rate | **O Yes** | **O No** | BP | **O Yes** | **O No** | | Respiratory rate | **O Yes** | **O No** | Temperature | **O Yes** | **O No** | | O2 saturations | **O Yes** | **O No** | Blood sugar | **O Yes** | **O No** | | Bloods | **O Yes** | **O No** | **Comfort observations** | **O Yes** | **O No** |   **Document who should be contacted if the observations are abnormal or the patient needs urgent review.**  **…………………..………………………………………………………………………………………………………**  **Does the patient have an Implantable Cardiac Defibrillator (ICD)? O**  **Yes**  **O** **No**  **Date of deactivation** .......................... |

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| **Symptom Control** | |
| **Consider and address possible symptoms**  **Could these symptoms be reversible?**  Eg confusion caused by opioid toxicity or abdominal pain and restlessness caused by urinary retention/rectal loading.  Consider current medication in particular long term analgesia. **Seek advice from palliative care if needed (blp 1293).** | **Document all current symptoms:**   |  |  |  | | --- | --- | --- | | O Pain (location) ……………………………………………………………………………………….. | | | | O Confusion | O Restlessness | O Breathlessness | | O Nausea &/or Vomiting | O Resp Tract secretions | O Dry mouth | | O Dry mouth | O Urinary retention | O Constipation |     **Have current medications been rationalised? O Yes O No**  *See rationalising medications guidance in EOLC folders*  **Have anticipatory medications been prescribed? O Yes O No**  *Refer to anticipatory prescribing guidance (page 5 of PCF)*  **If no, give reasons why? ……………………………………………………………………………………..** |
| **Nutrition and Hydration** | |
| Check for any difficulties which may increase the risk of aspiration, e.g. impaired swallow, and reduced consciousness.  When discussing with the dying person, and those important to them, the risks and benefits of clinically assisted hydration for someone who is in the last days of life the following guidance from NICE may be useful to draw upon:   * It is uncertain whether giving clinically assisted hydration will prolong life or extend the dying process or that withholding clinically assisted hydration will hasten death. * Whilst clinically assisted hydration may relieve distressing symptoms or signs related to dehydration, it may cause or exacerbate other problems   (NG31, 2015)  **This decision should be reviewed daily (continue in medical notes).**  Assess, preferably daily, the dying person's mouth, and review the need for lubricants, mouth care or antifungal prescriptions.  **Any decisions regarding the use or withdrawal of artificial nutrition and hydration should be communicated with either the patient (if able) or those important to them, including relevant factors and reasons for the decision.** | **Is the patient able to drink?**  **O Yes**  The benefits of eating and drinking for comfort should be discussed acknowledging any associated risks. They should be supported to eat and drink and regular mouth care should also be provided to keep the patient’s mouth moist, free of debris and reduce the risk of infection.  **O No**  They are currently unable to drink and eat due to their physical condition and should receive regular mouth care to keep their mouth moist, free of debris and reduce the risk of infection.    If the person has distressing symptoms or signs that could be associated with dehydration, such as delirium or thirst, and oral hydration is inadequate, a ***therapeutic trial*** of clinically assisted hydration may be considered.  **Is a trial of artificial hydration currently appropriate? O Yes O No**  For people being started on clinically assisted hydration:   * Monitor at least every 12 hours for changes in the symptoms or signs of dehydration, and for any evidence of benefit or harm. * Continue with clinically assisted hydration if there are signs of clinical benefit. * Reduce or stop clinically assisted hydration if there are signs of possible harm to the dying person, such as fluid overload, or if they no longer want it.   For people already receiving clinically assisted hydration or nutrition(enteral or parenteral) before the last days of life:   * Review at least daily the risks and benefits of continuing and discuss with the person and those important to them.   **Is continued artificial hydration currently appropriate? O Yes O No O N/A**  **Is continued artificial nutrition currently appropriate? O Yes O No O N/A**  **………………………………………………………………………………………………………………………........**  **……………………………………………………………………………………………………………………………...** |
| **Name of doctor completing this form:** | |
| **Name: Signature:** | |
| **Grade: Bleep no: Date/Time:** | |

**Daily Reviews to be written in the medical notes**

*In the event that the personalised care framework for last days of life is discontinued please document the reasons why in the patient’s medical notes and . Please strike through and sign each page of the PCF.*

**ANTICIPATORY PRESCRIBING AT END OF LIFE GUIDANCE**

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:

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| **Symptom** | **Medication** | **Notes** |
| Pain | Morphine Sulphate 2.5-5mg SC PRN | Caution in renal failure\* and the frail elderly. For patients already taking opioid analgesia the dose will need to be adjusted. See below for detailed guidance. Oxycodone 1-2mg SC PRN may be useful in pts with renal impairment showing signs of opioid toxicity. |
| Nausea and vomiting | If appropriate, continue with normal antiemetic given via SC route or use Levomepromazine 6.25mg PRN | NB Levomepromazine has sedative effect. Please see below for more detailed guidance on nausea management. Alternative Haloperidol 1mg PRN (maximum dose 5mg/24hrs). *Levomepromazine & Haloperidol contraindicated in Parkinson’s disease.* Seek further advice from HPCT blp 1293 |
| Restlessness | Midazolam 2.5-5mg SC PRN | If frank delirium use an antipsychotic rather than midazolam alone. Always consider reversible causes, i.e urinary retention and rectal loading. |
| Respiratory tract secretions | Glycopyrronium 200 mcg SC PRN (max 1.2 mg in 24 hrs) | Causes less sedation than Hyoscine Hydrobromide. If using Hyoscine Hydrobromide use 400mcg prn SC (max 2.4mg in 24hrs). |
| Breathlessness | Morphine Sulphate 1.25-2.5mg SC PRN | Low dose of opioid often helpful even if patient on a higher dose of opioid for pain |

Consider using a syringe driver for patients who need regular SC medication for the control of pain or other symptoms. Doses should be based on the PRN use in the preceding 24 hours.

**PAIN**

**Morphine Sulphate -** For patients already taking oral morphine sulphate give morphine sulphate via syringe driver, dose =total oral morphine dose inlast 24 hours divided by 2. PRN dose = 1/6th of syringe driver dose.

**Oxycodone -** Limited accumulation of metabolites in renal failure compared with morphine, may be useful in patients with renal impairment showing signs of opioid toxicity\*. Syringe driver dose = totaloral oxycodone dose inlast 24 hours divided by 2. PRN dose = 1 – 2mg if opioid naïve or otherwise 1/6th of syringe driver dose.

**Transdermal patches** – Leave patch on (dose unchanged) and prescribe PRN opioid. Convert PRN analgesic requirements into syringe driver over 24 hours, to be given concurrently with patch. Would not recommend commencing patch at end of life.

**NAUSEA AND VOMITING** Assess most likely cause:

**Gastric stasis/intestinal stasis:**  *(In complete bowel obstruction refer to green book p32)*

* Metoclopramide\*\* Syringe driver - 30 – 60mg over 24 hours, PRN dose 10mg

**Drugs/Endogenous toxins:**

* Haloperidol\*\* Syringe driver – 2.5 – 5mg over 24 hours, PRN dose 1 mg
* Metoclopramide\*\* (dose as above)
* Levomepromazine – Syringe driver – 6.25 – 25mg (higher dose may cause sedation), PRN dose 6.25mg. Contraindicated in Parkinson’s Disease

**Raised intracranial pressure:**

* Cyclizine – Syringe driver 150mg over 24 hours

**Advice and guidance are available from:**

* Senior members of the team looking after the patient
* The Palliative Care Handbook (“Green Book”) – Wessex Palliative Physicians. 8th edition (2014)
* The Hospital Palliative Care Team (mon-fri 9am-5pm) bleep 1293 or OOHs via hospice ext 2113
* Spiritual Care guidance in folders on every ward.

**Implementing the *Medical* Care Plan**

* Diagnosing dying should be a multi-professional decision.
* The decision to use a Personalised Care Framework for the Last Days of Life should be made by the most senior available clinician responsible for the patients 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 Framework for the Last Days of Life. Following this verbal explanation written information should also be offered.
* So as to promote the Five Priorities for Care of the Dying Patient, best practice states that the Personalised Care Framework for the Last days of Life should ideally be started by the patient’s own team who know the patient, and after all of the priorities have been addressed. At weekends, any patients newly identified as in their last days of life should be seen as a priority by a senior clinician (SpR or consultant on call) and the Personalised Care Framework commenced if appropriate. In the event of a patient being identified overnight as dying, the Personalised Care Framework should not be commenced however it can be used to help guide medical care planning (including the prescription of anticipatory medications and the need for artificial hydration and nutrition) and the patient referred to either their own team or the day team on call as a priority with a view to commencing the Personalised Care Framework for Last Days of Life in the morning.
* 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).

**Advice and guidance can be obtained from**

* The purple EOLC folders and resource files available on each ward
* The EoLC nurse specialists blp 1266, ext 5190
* Microguide - under End of Life Care for all EOLC documentation and 5 priorities of care
* The Palliative Care Handbook (“Green Book”) – Advice on clinical management, Wessex Palliative Physicians. 8th edition (2014) available in EOLC ward purple boxes
* The Hospital Palliative Care Team (mon-fri 9am-5pm bleep 1293) or OOHs via the hospice on ext 2113
* Spiritual Care Guidelines on Microguide or in spiritual folders on each ward

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

**We only have one chance to get it right.**