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Patient label/details

**Personalised Care Framework for the last days of life**

**WARD BASED CARE**

 **Patients suspected or confirmed to have COVID 19**

**This guidance incorporates the 5 Priorities of Care for the Dying Person, and is to aid the care of suspected or confirmed COVID 19 patients who are believed to be in their last days of life. The patient’s care should still be individualised to their specific needs. Please apply the principles of the Mental Capacity Act (2005). As visiting is likely to be restricted it is vital that all discussions with loved ones are documented fully in medical notes.**

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| **Does the patient have… (information which may aid decision making)** |
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| --- | --- | --- | --- |
| A lasting power of attorney for health and welfare  | O | Community or hospital DNACPR | O |
| An advance decision to refuse treatment | O | Treatment Escalation Plan (TEP) | O |
| An Advanced Care Plan | O | SYSTM1 / Summary Care Record checked | O |

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| **Recognise - Recognition that the patient is dying (INCLUSION CRITERIA)** |
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| Senior clinician supporting this decision: ………………………………  | Document diagnosis: ……………………………………………………………  |
| (ST4 or above)Reversible causes considered (tests/scans reviewed) | O | COVID 19: suspected O confirmed OPatient deteriorating despite optimal treatment | O |
| Patient unlikely to survive Completed DNACPR form (signed by Spr/cons) | OO | Patient comfortable (if not despite Anticipatory meds contact HPCT bleep 1293 for telephone advice) | O |
| Consultant / Med SpR in agreement with proposed management | O | Patient/family/carers aware that patient is expected to die and proposed management plan | O |

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| **Communicate & Support - Sensitive communication with the patient and family and support offered** |
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| NOK / carer informed (Name): | Discussion: Face to face O Over telephone O |
| Relationship to patient:Confirm 1st contact telephone number:Night call: Yes O No O | Date and time: …………………………………………………………..Is loved one able to visit Yes O No O |
| Issues identified: any other family members ill / self isolating, multiple bereavements, what is their support network? …………………………………………………………………………………………………………...………………………………………………………………………………………… |

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| **Involve – Ascertain from patient / carers / loved ones what is important to the patient. Has the patient expressed escalation wishes?** |
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| Agreed priority of care: ……………………..………………………………………………………………………………………………………………………..................... |

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| **Plan & Do - Consider the investigations, interventions and treatments the patient is having *(agreed with nursing staff).***  |
| What is being continued and why: (this may include but not limited to oxygen therapy, ABX, hydration, dexamethasone, comfort observations, mouth care, Anticipatory meds)…………………………………………………….……………………..……………………………………………………………………………………………………………………………….What has been stopped and why: (this may include but not limited to medicines, Abx, artificial hydration, physiological observations)…………………………………………………………………………………………………………………………………………………………………………………………………………….

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| **MEDICAL TEAM**Ensure relevant family aware of prognosis  | O | Document what nutrition / hydration is appropriate |  O |
| Telephone and inform GPClear escalation plan in notesValid DNACPR in notes | OOO | ………………………………………………………………………………..If present should IV access be replaced if lostCan the patient take oral medications | Y / NY / N |
| **Anticipatory Prescribing (Guidance below)**Pre-printed (PCF COVID 19) anticipatory drug chart reviewed & signed  | O | Current meds rationalised (including any duplicated PRNS)  | O |
| Patient Label/details**NURSING TEAM (in conjunction with daily nursing goals)** |
| Offer EOL info booklet to relatives if present | O | Inform chaplaincy | O |
| Support patient to eat & drink as able | O | Complete comfort observations & daily nursing goals | O |
| Mouth care equipment available at bedside Refer patient to EOLC team blp 1266 / ext 5190 | OO | Inform cardiac investigations unit immediately if patient has an implantable cardiac defibrillatorPlease ensure compassion rose accompanies all deceased patients to mortuary | OO |

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| **Name of doctor & nurse completing this form:** |
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| --- | --- |
| **Doctor Name, Grade & Bleep:** | **Nurse Name, Band** |
| **Signature:** | **Signature:** |
| **Date & Time:** | **Date & Time:**  |

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**GUIDANCE**

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| * Covid 19 EOLC resource files on each ward (Clear folder with red sleeve)
 | * End of Life Care team Blp 1266, Hospital Palliative Care Team (HPCT) Blp 1293 or OOHs via hospice ext 2113
 | * Palliative Care Handbook “Green book” – Advice on clinical management, Wessex Palliative Physicians. 9th edition (2019) in EOLC purple resource box
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**ANTICIPATORY PRESCRIBING GUIDANCE AT END OF LIFE (specific for COVID 19)**

**Nursing staff should offer oral medications in 1st instance if patient able to take**

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| **Symptom** | **PRN Medication** | **Regular medications and Notes** |
| Breathlessness / Pain   | **Morphine Sulphate**\* 2.5-5mg PO PRN (Oramorph liquid 10mg/5ml)**Morphine Sulphate**\*1.25-5mg SC PRN | Adjust dose for patients already taking opioid analgesia. **\*Caution in renal failure and the frail elderly, consider oxycodone instead if significant renal impairment or signs of opioid toxicity.****Oxycodone**: IR (immediate release) 1-2mg PO PRN or Oxycodone 0.5-2mg SC PRN Transdermal patches – Leave patch on (dose unchanged) and prescribe PRN opioid. Commencing patch at EOL not recommended.**O2 therapy:** may continue if providing psychological benefit for patient/ family even if clinical benefit unclear. Avoid the use of fans. |
| Breathlessness / Anxiety | **Lorazepam** 0.5-1mg Sublingual PRN | Maximum dose 4mg in 24 hrsCaution in elderly – always start at lowest dose |
| Breathlessness / delirium | **Midazolam** 2.5-5mg SC PRN | Maximum dose 30mg in 24hrs. Please alert HPCT if requiring >30mg/24hr. **Always consider reversible causes**, i.e urinary retention and rectal loading. |
| Agitated delirium | **Levomepromazine**12.5mg SC PRN | Please seek advice from specialist palliative care if requiring more than 50mg/24hrs. Caution in Parkinson’s Disease – please consider midazolam in Parkinsons or those at high risk of seizures**Always consider reversible causes** ie urinary retention, constipation |
| Respiratory tract secretions | **Glycopyrronium** 200 mcg SC PRN  | Maximum dose 1.2mg in 24hrsIf not syringe driver available: glycopyrronium 400mcg SC BD |
| Nausea / Vomiting | **Cyclizine** 50mg PO/SC PRN | Maximum dose 150mg in 24hrs. Avoid in heart failure. Refer to “green book” or specialist palliative care for alternatives |

**Parkinson’s / Anti seizure medications:** Parkinson’s medsshould be converted to patches and anti-seizuremedication continued where possible. Route of administration may need to be changed.

**Continuous subcutaneous infusions (csci):** If requiring 3 or more PRN doses in 24hrs consider csci. PRN dose of analgesia should be adjusted so that it is 1/6th of 24hr hour dose in infusion

**IF USING COVID 19 PCF ANTICIPATORY MEDICATIONS CHART, PLEASE ATTACH TO PATIENT’S STANDARD DRUG CHART AND ENSURE THERE ARE NO DUPLICATIONS**