LAST DAYS OF LIFE CARE PLAN

Section 1: Initial Assessment

Recognition of Dying

Recognizing a person is dying is complex, irrespective of diagnosis or history.

Reversible causes for the person's condition should be assessed and managed (use Health Professional's Information Sheet for guidance).

Where the MDT recognizes a person is in their last hours or days of life, they must ensure that the person, their relative, or friend have the opportunity to understand the possibility that death is imminent.

The following should be considered:

Physical Health (SENIOR CLINICIAN TO COMPLETE)

Has an Advance Care Plan, Advanced Directive been completed?	☐ Yes	☐ No
and has this been reviewed by the clinical team?	☐ Yes	☐ No
Is this the preferred place of care for the person?	☐ Yes	☐ No
Is this the most appropriate place of care for the person?	☐ Yes	☐ No
If no, has an alternative place of care been discussed with the person, relative, family or friend?	☐ Yes	☐ No
If the person is to transfer to another appropriate care setting, has this been organised according to organisational policies and procedures?	☐ Yes	☐ No
To support communication, has written information been given to the relative/friend such as "What to Expect When Someone is Dying"?	☐ Yes	☐ No
Is the General Practice Team/ARC facility aware the person is dying?	☐ Yes	☐ No

Comments:

Awareness of Person's Changing Condition

Family and Mental Health

First language - consider need for interpreter (contact no):

The person is able to take a full and active part in communication:	☐ Yes	☐ No
The person is aware that they are dying:	☐ Yes	☐ No
The relative, family spokesperson or friend* is able to take a full and active part in communication:	☐ Yes	☐ No
The relative, family spokesperson or friend* is aware that their relative, family member or friend* is dying:	☐ Yes	☐ No

Record outcome of the shared discussion between health professionals and with the person, relative, family or friend*

Last Days of Life Care Plan Commenced

Date care plan commenced: _____ Time care plan commenced: _____

Name of senior clinician/lead health practitioner (record name below)**	**Name of nurse (record name below)**
Print:	Print:
Signature:	Signature:
Next of Kin/Key Spokesperson/EPOA (please circle and record name below)	**Relative, family or friend* of those present for discussion (record names(s) below)**
Name:	Name:
Relationship:	Relationship:

This care plan may be discontinued after discussion with the MDT. If this care plan is discontinued please record here:

Date discontinued: _____ Time discontinued: _____

Reasons why this care plan was discontinued by MDT Team:

The person is aware of changing focus of care	☐ Yes	☐ No
The relative, family or friend* is aware of changing focus of care:	☐ Yes	☐ No

Signature

All personnel completing the care plan please sign below.

You should also have read and understood the 'Health Care Professional Information' on a separate sheet.

Name (print)	Full Signature	Initials	Professional Title	Date

Note:
*** Included in this list is also advocate and carer.**
**** Senior clinician refers to most senior clinical doctor or nurse practitioner appropriate to that care setting, eg in ARC this would be general practitioner or nurse practitioner, in acute care setting it would be registrar or consultant.**

The clinical team have up to date contact information for the relative, family or friend* as documented below

Family and Mental Health

1st contact name: _____

Relationship to person: _____

Tel no: _____

Mobile no: _____

When to contact:

- ☐ At anytime
- ☐ Not at night time
- ☐ Staying with person overnight

2nd contact name: _____

Relationship to person: _____

Tel no: _____

Mobile no: _____

When to contact:

- ☐ At anytime
- ☐ Not at night time
- ☐ Staying with person overnight

- ☐ **Next of kin (this may be different from above)**
- ☐ **or Enduring Power of Attorney (EPOA)**
- ☐ **or family spokesperson**

Name: _____

Contact details: _____

Name: _____

Contact details: _____

The relative, family or friend* has had a full explanation of the facilities and support available to them:

- ☐ Yes
- ☐ No

and written information has been given:

- ☐ Yes

☐ No

Comments:

Base Line Information

Physical Health

Conscious state:	☐ Conscious ☐ Semi-conscious ☐ Unconscious	Hygiene needs assessed:	☐ Yes ☐ No
Alertness:	☐ Fully alert ☐ Confused ☐ Delirious	Mouth moist and clean:	☐ Yes ☐ No
In pain:	☐ Yes ☐ No	Other symptoms or distress (eg oedema, itch):	☐ Yes ☐ No
Agitated:	☐ Yes ☐ No	Dyspnoea:	☐ Yes ☐ No
Able to swallow:	☐ Yes ☐ No	Respiratory tract secretions:	☐ Yes ☐ No
Nauseated:	☐ Yes ☐ No	Vomiting:	☐ Yes ☐ No
Continent (bladder):	☐ Yes ☐ No	Continent (bowels):	☐ Yes ☐ No

Catheterised:	☐ Yes ☐ No	Skin integrity:	☐ Yes ☐ No

Braden Score: _____

Interventions in the Best Interest of the Person at this Moment in Time

Physical Health (SENIOR CLINICIAN TO COMPLETE)

	Currently not being taken/or given	Discontinued	Continued	Commenced
Routine blood tests				
Intravenous antibiotics				
Blood glucose monitoring				
Recording of routine vital signs				
Oxygen therapy				

4.1 Implantable Cardioverter Defibrillator (ICD) is deactivated:

☐ Yes

☐ No

☐ No ICD in place

Contact the person's cardiologist. Refer to local/regional policy/procedure. Written information given to the person, relative, family or friend.

Medication

Physical Health (SENIOR CLINICIAN TO COMPLETE)

Current medication assessed and medications no longer essential for comfort discontinued:

- [ ] Yes
- [ ] No

Medication prescribed on an "as required" prm basis for all of the following five symptoms which may develop in the last few days of life:

- [ ] **Pain**
- [ ] **Agitation**
- [ ] **Respiratory tract secretions**
- [ ] **Nausea/vomiting**
- [ ] **Dyspnoea**

Anticipatory prescribing will ensure that there is no delay in responding to a symptom. Refer to algorithms at end of care plan.

A syringe driver is available:

- [ ] **Already in place**
- [ ] **Is available if required**

If a syringe driver is to be used explain the rationale to the person, relative, family, friend*. Not all people who are dying require a syringe driver.

A four hourly checklist should be in place to monitor the use of a syringe driver.

Provision of Food and Fluid

Physical Health (SENIOR CLINICIAN TO COMPLETE)

A person should be supported to take fluid and foods by mouth for as long as is safe and tolerated:

Is clinically assisted (artificial) nutrition required:

- [ ] Not required
- [ ] Discontinued
- [ ] Continued

If clinically assisted (artificial) nutrition is already in place please record the route:

- [ ] NG
- [ ] PEG/PEJ
- [ ] NJ

- [ ] TPN

This review is discussed with the person where possible and appropriate and with the relative, family, or friend:

- [ ] Yes
- [ ] No

Is clinically assisted (artificial) hydration required?

- [ ] Not required
- [ ] Discontinued
- [ ] Continued

If clinically assisted (artificial) hydration is already in place please record the route:

- [ ] IV
- [ ] SC
- [ ] PEG/PEJ
- [ ] NG

This review is discussed with the person where possible and appropriate and with the relative, family or friend*:

- [ ] Yes
- [ ] No

Comments:

Personalized Care Needs: Spiritual and Cultural

Spiritual Health

Ethnicity:

Which ethnic group or groups does the person identify with: _____

It is best practice to ask the person the ethnic groups they identify with.

You can gain important information at this time, for example, someone's cultural affiliations that may be important in addressing the goals related to personalizing care.

The person is given the opportunity to discuss what is important to them at this time, eg their wishes, feelings, faith, beliefs, values and culture.

The relative, family spokesperson or friend* is given the opportunity to discuss what is important to them at this time, eg their wishes, feelings, beliefs, values and culture.

Comments:

Conversations could include identification of specific customs, traditions or cultural practices that are important to the person, relative, family or friend at death and after death.

Religious tradition identified, please specify:

_____

Person's minister/priest/spiritual advisor:

Name: _____

Phone по: _____ Date/time: _____

Contacted:

- ☐ Yes
- ☐ No
- ☐ N/A

Support of the facility spiritual advisor:

Name: _____

Phone по: _____ Date/time: _____

Contacted:

- ☐ Yes
- ☐ No
- ☐ N/A

The person and their family, family, or friends* are aware of the facility cultural support (if available):

- ☐ Yes
- ☐ No
- ☐ N/A

After Death Care Practices

Spiritual Health

Are there any specific care practices that the person, family, family or friend* want staff to be aware of? Including wishes regarding tissue/organ donation?

- [ ] Yes
- [ ] No

Comments:

Checklist

MDT, the person, relative, family or friend recognise and agree that person is dying and have been communicated with regarding plan of care:

- [ ] Yes
- [ ] No

The person, relative, family or friend have agreed to the place of care:

- [ ] Yes
- [ ] No

Initial assessment complete:

- [ ] Yes
- [ ] No

The person, relative, family or friend have been given opportunities for further discussion about the plan of care and are aware this plan of care will be regularly reviewed in consultation with them:

- [ ] Yes
- [ ] No

Comments:

Section 2: Ongoing Assessment of the Goals of Care

Date: _____ Day: _____

Undertake a MDT review of the current care plan. If at any time there is a change in relation to any of the following:

- Improved conscious level, functional ability, mobility, ability to perform self-care.
- Concerns expressed regarding management plan from either the person, relative, family or friend or MDT member.

This care plan will be reviewed in its entirety daily.

When each goal is assessed mark with an 'A' if it has been 'achieved! If interventions are required, mark a "IR" and enter that change on the "Interventions Required Sheet" pg 7.	400	800	1200	1600	2000	2400
	If using this in community enter visiting times below					
The person:						
Is pain free						
Is not agitated						
Has no respiratory tract secretions						
Is not breathless						
Is not nauseated						
Is not vomiting						
Has no urinary problems						
Has no bowel problems: Bowels last opened _____						
Has no other symptoms (Record symptom here as applicable)						
Medication and route remain appropriate						
Food and fluid have been provided as appropriate (see question 6 of page 5)						
Has a moist and clean mouth						
Skin integrity is maintained, Braden score _____						
Personal hygiene needs met						
Receives their care in a physical environment adjusted to support their individual needs						
Personalised care needs met (see questions page 5)						
Relatives, family or friends*						
Personalised care needs met (see questions page 5)						
Other care needs _____						
Signature of the registered nurse per shift:	Night	Morning		Afternoon		Night

Interventions Required Sheet

Please record intervention required on this sheet.

What occurred?		Interventions taken		Was intervention effective?		If no, what further intervention was taken?	Initials
				Yes	No		
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				

Progress Notes

Date/Time	Record significant events/conversations/medical review/significant changes to the person/visits by other specialist teams, eg palliative care/second opinion if sought/person and/or relative, family or friend concerns. A summary should be entered each shift.	Print name and signature and role

Section 3: Care After Death

Date of person's death: _____

Time of person's death: _____

- [ ] Burial
- [ ] Cremation

Details of healthcare professional who verified death:

Name: _____ (please print)

Signature: _____

Comments: _____

Family present at time of death: _____

Persons present at time of death: _____

If not present, has the relative, family or friend* been notified:

- [ ] Yes
- [ ] No

Name of person informed: _____

Name of Funeral Director: _____

Relationship to the person: _____

Telephone no: _____

The person is treated with respect and dignity whilst care is undertaken. Universal precautions and local policy and procedures including infection risk are adhered to. Spiritual, religious cultural rituals/needs met. Organisational policy followed for the: • management of ICDs • storage of the person's valuables and belongings. Are valuables left on the person (if requested): ☐ Yes ☐ No	

The relative, family or friend can express an understanding of what they will need to do next and are given relevant written information. Conversation with relative, family or friend explaining the next steps. Written information is given such as: 'What to Expect When You are Grieving' leaflet given: ☐ Yes ☐ No Information given regarding how and when to contact the funeral director (if appropriate) to make an appointment regarding the death certification and person's valuables and belongings where appropriate: ☐ Yes ☐ No Discuss as appropriate the following: viewing the body/ the need for a post mortem/the need for removal of cardiac devices/the need for a discussion with the coroner: ☐ Yes ☐ No Confirm wishes regarding tissue/organ donation discussed: ☐ Yes ☐ No Information given to families and family on child bereavement services where appropriate: ☐ Yes ☐ No	
A private space is available for family. Arrangements for blessing room/bed space made as appropriate: ☐ Yes ☐ No	

Prayer are offered in respect of cultural needs of family: ☐ Yes ☐ No	
The medical team and/or general practice teams/ARC that supports the person in their usual place of residence are notified of the person's death: ☐ Yes ☐ No	
The person's death is communicated to appropriate services across the organisation: ☐ Yes ☐ No	