Last Days of Life Care Plan Personalised For:

………………………………

Patient likes to be known as: ……………………….

Preferred place of death (if known): ....

Your named care team:
District Nurse: Name……..…………………… Signature……………………
GP: Name……..………………………………. Signature……………………

Family Contact Details	
If the patient's condition changes, who should be contacted first?	**1st Contact:** Name: …………………………………………………….. Relationship: ………………………………………………. Tel No: ……………………………………………………. Mobile No: …………………………………………………..
If the patient's condition changes, when should they be contacted?	At any time: ☐ Not at night time: ☐
If the first contact is unavailable, who should be contacted?	**2nd Contact:** Name: …………………………………………………….. Relationship: ………………………………………………. Tel No: ……………………………………………………. Mobile No: …………………………………………………..
When should they be contacted?	At any time: ☐ Not at night time: ☐

Name of patient:………………………. NHS number………………………DOB…………........
Name of person completing (PRINT)…..……………... Signature……….…………… Date………

Care plan to be used in conjunction with 'Guidance to professionals for care in the last days of life' and 'Symptom Control Guidance', Note: these can be printed from the Palliative Care Template (EPaCCS) on Systm1

Recognition that the patient is dying	
This can be difficult and the decision should be made by the most senior clinicians (nurses and doctors) caring for the patient.	**Document who is involved in making the decision:** …………………………………………………………… …………………………………………………………… …………………………………………………………… **Document diagnoses and relevant clinical features:** **Diagnoses:** …………………………………………………… …………………………………………………………… Bedbound ☐ Comatose ☐ Semi-comatose ☐ Unable to take more than sips of fluid ☐ Reduced peripheral perfusion ☐ Cheyne-Stokes breathing ☐ Respiratory secretions ☐ Other: ………………………………………………………...
Have you considered reversible causes for the patient's deterioration?	All reversible causes for patient deterioration have been considered ☐ Document details of any relevant considerations: …………………………………………………………… ……………………………………………………………

Sensitive communication with the patient and family	
Explain what is happening and the reasons why you think the person is dying. **Discuss prognosis** (and difficulty making an accurate prognosis). **Discuss priorities for care** (including preferred place of death, if appropriate) **Specific communication needs / issues** **The patient is aware they are dying:** ☐ Yes ☐ No ☐ Lacks capacity ☐ Declines discussion	**Document the conversation, including all the issues covered** (use continuation sheet if needed): …………………………………………………… …………………………………………………… …………………………………………………… …………………………………………………… …………………………………………………… …………………………………………………… …………………………………………………… …………………………………………………… ……………………………………………………

Name of patient:………………………… NHS number………………………DOB……….......
Name of person completing (PRINT)…..……………….. Signature……….…………. Date………

The family are aware the patient is dying: ☐ Yes ☐ No **Name of family member or carer discussion took place with:** ……………………………………………………………… **Date & time conversation took place:** ………………………………………………………………	……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ………………………………………………………………

Stop investigations, interventions or treatments that will not promote comfort, dignity and peace eg blood glucose monitoring, fragmin injections **Does the patient have an Implantable Cardiac Defibrillator (ICD)?** ☐ Yes ☐ No If yes, follow ICD deactivation guidance	**Document what has been stopped and why:** ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… **Document what is being continued and why:** ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ………………………………………………………………

Name of patient:……………………………… NHS number………………………….DOB…………........
Name of person completing (PRINT)…..……………….. Signature………….……….…… Date………

DNA CPR	
Decisions to be discussed sensitively with the patient and family.	Form completed and in notes: ☐ Yes ☐ No

Patient preferences and advance decisions- please also refer to any information already recorded in the Palliative Care template (EPaCCS) on System1	
Does the patient have: Advance care plan/statement of wishes and preferences: ☐ Yes ☐ No Advance decision to refuse treatment: ☐ Yes ☐ No Expressed wish for organ / tissue donation: ☐ Yes ☐ No Lasting power of attorney for health & welfare: ☐ Yes ☐ No If Yes: Name: ……………………………………………… Tel No: …………………………………………… Mobile No: ………………………………………	**If yes, record any actions to be taken:** …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… **If no, are they able to express any preferences for their care in their last days?** …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… ……………………………………………………………………

Nutrition & Fluids	
All patients should be offered drinks / nutrition as appropriate. If a patient's swallowing is impaired, they are at risk of aspiration pneumonia. Patients may choose to take sips. This should be offered in a safe form (thickened / subcutaneous) and reviewed on an individual basis to enable overall comfort. **Consider the possible benefits and burdens of artificial hydration and nutrition.** **Complete Care plan 1**	**Document any discussion with the patient and family relating to feeding and fluids:** …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… ……………………………………………………………………

Name of patient:………………………… NHS number………………………DOB……….......
Name of person completing (PRINT)…..……………….. Signature…….…………… Date………

Symptom Management	
Consider and address possible symptoms: For example, pain, shortness of breath, nausea, vomiting, restlessness, confusion, urinary retention, dry mouth. **Consider whether any of these symptoms are reversible:** For example, confusion caused by opioid toxicity or abdominal pain and restlessness caused by urinary retention.	**Document current symptoms:** ☐ Pains (Care Plan 2) ☐ Restlessness/agitation/confusion (Care Plan 3) ☐ Respiratory tract secretions (Care Plan 4) ☐ Breathlessness (Care Plan 5) ☐ Nausea / vomiting (Care Plan 6) ☐ Elimination (Care Plan 7) ☐ Broken/vulnerable skin (Care Plan 8) ☐ Dry mouth (Care plan 9) ☐ Emotional distress (Care plan 10) ☐ Wound care needs ☐ Other …………………………………………………………………… **Prescribe medications which may be required (see professional and symptom control guidance).** **If symptoms are uncontrolled seek additional advice if needed** **<u>If a symptom is identified, please complete a care plan</u>**

Religion & Spirituality	
Patient is given the opportunity to discuss what is important to them, including faith, feelings, beliefs, wishes and values.	**Religious tradition or spiritual beliefs:** …………………………………………………………………………… ……………………………………………………………………………
Offer support of chaplaincy team / religious leader.	**Chaplaincy team / religious leader support accepted:** ☐ Yes ☐ No
Identify any specific needs at death or after death eg if a death certificate will be needed urgently	**Specified Needs at death / after death:** …………………………………………………………………………… ……………………………………………………………………………

Privacy & Dignity	
Personal preferences for care discussed **If patient requires help with Personal cares – complete care plan 11**	**Personal preferences:** …………………………………………………………………………… ……………………………………………………………………………

Name of patient:………………………… NHS number………………………DOB…………........
Name of person completing (PRINT)…..……………….. Signature……….…………… Date………

Summary of above	
Explanation of above plan of care given to: **Patient:** ☐ Yes ☐ No **Family:** ☐ Yes ☐ No	**By whom:** …………………………………………………………………

Information and explanation of facilities	
"Supporting care in the last hours or days of life" information sheet or 'End of Life Care guide (Macmillan booklet) to be offered to relative / carer.	**Information sheet given:** ☐ Yes ☐ No OR **End of Life Guide given:** ☐ Yes ☐ No

Care of family / friends	
Name / Relationship: ………………………………………. ………………………………………. **Specific needs identified, e.g. health, language, cultural, young children.** **Complete Care plan 12**	**Information:** **Carers information** …………………………………………………………………………… …………………………………………………………………………… ……………………………………………………………………………

Record any other information relevant to this patient and their family/friends here
……… ……… ……… ……… ……… ……… ……… ……… ………

Name of patient:………………………… NHS number………………………DOB……….….....
Name of person completing (PRINT)…..………………... Signature……….………… Date………

Review of Care Plan:

- **This care plan must be agreed with the multidisciplinary team**
- **Complete this review every third day.**

Do the MDT agree that this patient is still dying?

☐ Yes ☐ No 1st Review date ……………………..

☐ Yes ☐ No 2nd Review date ……………………..

☐ Yes ☐ No 3rd Review date ……………………..

☐ Yes ☐ No 4th Review date ……………………..

Who was involved in decision / discussions?

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REVIEW:

Care plans should be individualised to ensure personalised needs are met.

Clinical staff responsible for patient should complete progress sheet at every intervention.

For example: Nutrition and Hydration Care plan '………………. has taken sips of pineapple juice with assistance'

Care plans should be reviewed as necessary.

Name of patient:………………………… NHS number………………………DOB……….…......
Name of person completing (PRINT)…..…………….. Signature……….………… Date………

Relative / Friend Communication Journal

Please feel free to use this space to record anything about yourself, your family and ……………………………..….. that you think staff may want to know. This could include care you have given, or any questions you may have for the staff.

Date / Time and Name	

Name of patient:………………………… NHS number………………………DOB……….......
Name of person completing (PRINT)…..……………... Signature……..………… Date………

Airedale NHS
NHS Foundation Trust

Bradford District NHS
Care Trust

TO BE COMPLETED AT THE TIME OF DEATH

Verification of Death Death is confirmed when all of the following criteria are met. Confirm all criteria with a √ in each box					
Circulatory		**Respiratory**		**Cerebral**	
No radial pulse present for one minute		No respiratory effort		No eye movement	
No carotid pulse present for one minute		Use stethoscope: No chest sounds for 1 minute		Use pen torch: Both pupils fixed and dilated	
Use stethoscope: No heart sounds heard for one minute				Use pen torch: both pupils not reacting to light	

Name of nurse verifying death: (PRINT)……………………….Job Title:………………………

In accordance with the Airedale NHS Foundation Trust / Bradford District Care Trust's (delete as applicable) guideline for the Verification of Expected Death, I have confirmed that all the above criteria are met and verify the expected death of the following patient.

Patient Name: ……………………………………….Date of Birth: ……………………………………….

NHS Number: ………………… Signature of Nurse verifying death: ………………………………..

Circumstances of Death		
Date of death: …………………………….	**Estimated time of death:** ……………………………….	**Time death verified:** …………………………………
Place of death:		
Has the coroner been informed? ☐ Yes ☐ No Reason: ………………………………………………………………………………………………		

Persons Present at time of death: If none, state NONE	
NAME	**CONTACT DETAILS**

FAX this form to the usual GP and phone or task practice so they can action as soon as possible. Inform if deceased is to be moved to Funeral Directors

Name of patient:………………………… NHS number………………………DOB……….........
Name of person completing (PRINT)…..……………….. Signature……….…………… Date………

Airedale NHS
NHS Foundation Trust

Bradford District NHS
Care Trust

Certification of Death (to be completed after Dr completes medical certificate of death if wished)

Cause of death:	
	1 a) ………………………………………………………………………………………
	1 b) ………………………………………………………………………………………
	1 c) ………………………………………………………………………………………
	2. ………………………………………………………………………………………

Care after death

Burial ☐ Cremation ☐

Funeral Director Name:

…………………………………………………………………….

Name of person body released to:

Print: ……………………………………………………………

Signature: …………………………………………………

Specific needs of patient / family (cultural etc):

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

Relative / friend given written information about the bereavement services and support:

☐ Yes ☐ No

Medical cause of death certificate given to:

………………………………………………………………………

Relationship: ……………………………………………………

Cause of death discussed: ☐ Yes ☐ No

Property returned to: ………………………………………….

………………………………………………………………………

Valuables returned to: ………………………………………..

………………………………………………………………………

GP Notified: ☐ Yes ☐ No

Community Team Notified: ☐ Yes ☐ No

Entered on SystmOne: ☐ Yes ☐ No

Please coordinate the return of Trust equipment to relevant teams e.g. nebulisers, monitors, syringe drivers

Name of patient:………………………… NHS number………………………DOB……….......
Name of person completing (PRINT)…..……………….. Signature……….………….. Date………