Brighton and Sussex University Hospitals NHS Trust

HISTORY SHEET

CONSULTANT:

Surname (BLOCK CAPITALS):

Patient name:

Hospital no:

NHS no:

DOB:

Affix patient label

DATE & TIME

CLINICAL NOTES
Each entry to be signed with printed name, designation & bleep number included

REMEMBER THE FIVE PRIORTIES FOR THE CARE OF DYING PATIENTS:

1. The possibility (that a person may die within the next few days or hours) is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

BELOW AND OVERLEAF ARE COMPREHENSIVE SUGGESTIONS FOR WHAT TO INCLUDE IN YOUR EVALUATIONS AND DISCUSSIONS WITH DYING PATIENTS, AND THE PEOPLE THAT MATTER TO THEM, IN ORDER TO APPROACH AND ACHIEVE THE 5 PRIORITIES.

Care of the dying

PRIORITY 1: RECOGNISE

REMEMBER TO CONSIDER:

- Any potentially reversible causes if the person unexpectedly deteriorates. A doctor must assess if the change is potentially reversible, or if the person is likely to die within a few hours or days

REMEMBER TO DOCUMENT:

- Who has been involved in the multiprofessional assessment of the patient, including the senior doctor and nurse
- How you have reached the conclusion that the person is now likely to be dying in hours to days
- What the new goals of treatment and care are

REMEMBER TO DOCUMENT name, relationship and contact details of people identified as most important to dying person

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PRIORITY 2: COMMUNICATE

REMEMBER TO CONSIDER:

- The most appropriate team member to talk to the patient, based on their competence and confidence plus rapport with the patient
- If the patient would like anyone with them when having conversations with clinicians and making decisions
- The cognitive status of the patient and any specific speech, language or communication needs
- Any cultural, religious, practical or spiritual preferences

REMEMBER TO DOCUMENT:

- The current level of understanding of the patient that they may be nearing death and how much information they would like to have about their prognosis
- That you have provided accurate information to the patient (and those who matter to them) about their likely prognosis, explaining any uncertainty and how that would be managed
- If you have not explained that death is expected, you must state why you have not done so
- That you have provided the opportunity to talk about any fears and anxieties and to ask questions about care in the last days of life (unless they do not wish do, which you should also document)
- That you have established whether the person has an advance statement, advance decision to refuse treatment or Lasting Power of Attorney for health and to personal welfare
- That you have provided information on how the patient and those people who matter to them can contact their care team and offered further opportunities for discussion.

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PRIORITY 3: INVOLVE

REMEMBER TO CONSIDER:

- Any cultural, religious, practical or spiritual preferences

REMEMBER TO DOCUMENT:

- That you have informed the patient (and those who matter to them) who the senior clinicians are responsible for their care
- How much the patient wishes to be involved in decisions about their treatment and care. If they are unable to do so, state why not (e.g. unconscious)
- If any attempts to involve the patient have been declined by them
- To what extent the patient wants the people who matter to them to be involved in decisions about their care, and that you have explored the views of those people about ongoing treatment and care
- That you have listened to the concerns and answered questions raised by the patient and the people who matter to them
- If you need to make decisions in best interests, which domain(s) capacity is impaired in, and, how you have reached best interests decisions (including any IMCA involvement and consultation of Advance Decision or Power of Attorney documents)
- Your discussion involving the patient (and the people who matter to them) to the extent that they wish, about specific de-escalation of treatment decisions e.g. discontinuation of antibiotics, ICD deactivation, withdrawal of NIV or dialysis, DNACPR
- Your discussion involving the patient (and the people who matter to them) to the extent that they wish, about their goals and wishes for care, current and anticipated needs including symptom control, place of care and needs for care after death, if any are specified

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PRIORITY 4: SUPPORT

REMEMBER TO DOCUMENT:

- You have explored the specific needs of the people who matter most to the dying person, including needs for information, psychological, cultural, practical, spiritual and religious needs
- How you have addressed or involved others to address those needs as far as is practically achievable
- You have discussed their views about the patient's needs and care when dying
- You have explained the usual changes to be expected in the dying phase
- You have provided additional written information on what they can expect in the dying phase
- You have provided information on visiting hours, refreshment and other facilities they can use
- Who should be the first person to contact if they are not visiting the hospital
- The preferences of when they would like to be contacted, or not, if not visiting the hospital

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PRIORITY 5: PLAN AND DELIVER AN INDIVIDUALISED PLAN OF CARE

REMEMBER TO CONSIDER:
- Prescribe appropriate symptom control medication, consulting the online prescribing guidance and review appropriateness of any existing medication
- Consider if referral to the Specialist Palliative Care Team is required

REMEMBER TO DOCUMENT THE CARE PLAN FOR:

- *NEW GOALS OF CARE*

CLINICAL INTERVENTIONS AND TREATMENTS including:
- Plans for specific interventions which should start, stop or be modified (e.g. vital sign monitoring, blood tests, discontinuation of non essential medication, withdrawal of specific treatments, start symptom control medication, use of the symptom observation chart)

PHYSICAL & PSYCHOLOGICAL SYMPTOMS including:
- Assessment of current symptoms (including pain, breathlessness, agitation/anxiety/ delirium, respiratory secretions, nausea, vomiting, mouth care and other specific symptoms), and how these will be addressed
- Any anticipated symptoms and how these could be addressed
- Include pharmacological and non pharmacological interventions which could be utilised

HYDRATION AND NUTRITION including:
- If a “Nil by Mouth” order is deemed essential, document why and the senior decision maker responsible for this, plus the review plan
- The ability and desire to drink and the plan for how they will be supported with oral intake
- If use of clinically assisted hydration is indicated, or if the reduction/discontinuation of its use is appropriate and why
- Include your assessment of the need for clinically assisted hydration, and the preferences of the patient regarding this
- Document the details of your discussion re: potential risks and benefits of clinically assisted hydration
- If capacity for decision making is impaired, the discussion and best interests decision making regarding clinically assisted hydration
- If clinically assisted hydration is to be used, the plan for delivery (e.g. IV, SC, other routes) and review plan
- The ability and desire to eat
- If use of clinically assisted nutrition is indicated, or if the reduction/discontinuation of its use is appropriate and why
- If capacity for decision making is impaired, the discussion and best interests decision making regarding feeding, and the possible use of clinically assisted nutrition

Continue overleaf

Care of the dying

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PRIORITY 5: PLAN AND DELIVER AN INDIVIDUALISED PLAN OF CARE

BROADER HOLISTIC NEEDS including:

- Discuss and document spiritual, cultural, religious and practical needs and how these will be addressed
- Referrals to other services (e.g. spiritual care team)

CARE AT TIME OF DEATH including:

- The preferred place of death
- Any specific care needs immediately before or after death and how these will be met (e.g. any religious or cultural requirements)

REVIEW PLAN including:

- When the team will review the patient and care plan
- The completion of a holistic assessment at least every 24 hours
- Symptom control and hydration and nutrition needs

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ONGOING REVIEW OF THE DYING PERSON

ONGOING REVIEW OF DYING PATIENT

Remember to consider:

- Talk to the multi-professional team
- Talk to the patient if possible
- Talk to the people who matter to the person who is dying. Are there any concerns with the care being given?
- Review medication use and the symptom control observation chart
- Consult the nursing care plan
- Review the patient
- Are the patient's hydration and nutrition needs addressed?
- Have the symptoms or holistic needs changed for the dying person?
- Are the holistic needs of the people who matter to the dying person addressed?
- Do you need to refer to the specialist palliative care team?

Remember to document:

- If the person is still thought to be dying
- Your assessment and any necessary changes to the care plan
- Details of any conversations
- Review plan

Care of the dying