Patient name:
Hospital No:
NHS No.
D.O.B:

or affix patient ID sticker here

Brighton and Sussex University Hospitals NHS Trust

HAVE YOU RECOGNISED YOUR PATIENT MAY DIE IN THE COMING HOURS OR DAYS?

ENSURE YOU:

- HAVE CONSIDERED POTENTIALLY REVERSIBLE CAUSES WHICH MAY BE APPROPRIATELY TREATED
- HAVE COMMUNICATED WITH THE PATIENT AND THOSE IMPORTANT TO THEM
- AIM TO INVOLVE A SENIOR DECISION MAKER (SpR/CONSULTANT)
- DOCUMENT CPR STATUS AND TREATMENT ESCALATION PLAN
- ASSESS SYMPTOMS AND PRESCRIBE APPROPRIATE MEDICATION
- ASSESS NEED FOR CLINICALLY ASSISTED HYDRATION AND NUTRITION
- CONSIDER IF DISCHARGE IS FEASIBLE IF PREFERRED PLACE OF CARE IS HOME
- CONSULT 'PALLIATIVE CARE' TAB ON TRUST INTRANET FOR FURTHER GUIDANCE

THEN:

DOCTORS

COMPLETE INDIVIDUALISED CARE PLAN (ICP) FOR THE DYING PATIENT OVERLEAF

NURSES

ONCE ICP COMPLETED USE SYMPTOM OBSERVATION CHART & DAILY CARE PLAN FOR THE DYING PATIENT

DOCTOR

NAME: _____ GRADE _____

SIGNATURE:_____ BLEEP _____

DATE : ___/___/_____ TIME ____:_____

NURSE

NAME: _____ GRADE _____

SIGNATURE:_____

DATE : ___/___/_____ TIME ____:_____

FURTHER GUIDANCE IS AVAILABLE ON PALLIATIVE CARE INTRANET PAGE AND VIA MICROGUIDE APP

⇒ **All patients recognised as dying must have pre-emptive medication prescribed PRN for control of common symptoms**

⇒ **If PRN not controlling symptoms (≥ 3 doses in any 24 hour period) consult on line guidance and seek advice on whether a regular subcutaneous infusion (syringe pump) is appropriate**

			Pain	*Dyspnoea*
Pain/Breathlessness: 1st line **Morphine**	2.5mg	sc	1 hourly	4 hourly
2nd line **Oxycodone**	1.25 – 2.5mg	sc	1 hourly	4 hourly
(If known severe renal failure eGFR<30ml/min: **Alfentanil**) *discuss with Palliative Care Team first	0.2mg	sc	1 hourly	4 hourly
Nausea: **Haloperidol**	1.5mg	sc	4 hourly	
Distress from anxiety: **Midazolam**	2.5-5mg	sc	1 hourly	
Distress/agitation from delirium: **Haloperidol**	1-2.5mg	sc	4 hourly	
Respiratory secretions: **Glycopyrronium**	0.2mg	sc	4 hourly	

- **If patient on existing regular opioids or other symptom control medication consult on line guidance for conversions and advice on starting a regular subcutaneous infusion (syringe pump)**
- Review and discontinue non-essential medication. For essential medication which cannot be taken orally (e.g. anti-epileptics) see online guidance
- **FOR COMPLEX SYMPTOM MANAGMEMENT / TREATMENT RESISTANT SYMPTOMS CONSULT PALLIATIVE CARE TEAM OR A PHARMACIST**

Prescribing guidance	**See "palliative medicine"+"care of the dying" – sections 14 & 15 online prescribing guidelines**
Hospital Palliative Care Team (M-F 9-5)	**ext** 3021 **Bleep:** 8420
RSCH (OOH) = Martlets Hospice -	01273 964164
PRH (OOH) = St Peter & St James Hospice -	01444 471598
Medicines Information Service ext.	8153 / 8566

Patient First

Patient care is our top priority

FURTHER GUIDANCE IS AVAILABLE ON PALLIATIVE CARE INTRANET PAGE AND VIA MICROGUIDE APP

INDIVIDUALISED CARE PLAN FOR A DYING PERSON

Patient name:
Hospital No:
NHS No.
D.O.B:

or affix patient ID sticker here

Goal: To facilitate dying with dignity and comfort for the patient while providing carers with support. To ensure sensitive communication about the deterioration in the patient's condition
PLEASE REVIEW THIS PLAN DAILY

PRIORITY 1: RECOGNISE

Which members of the MDT have been involved in the recognition of dying phase and what is the condition(s) now thought to be irreversible and contributing to the dying phase?

PRIORITY 2: COMMUNICATE

Document who the patient identifies as most important to them and their contact details. Share understanding of expectations of dying phase eg symptoms, timeframe and document here.

PRIORITY 3: INVOLVE

Make sure the patient knows which senior clinicians are leading their care. Involve the dying person and those important to them in decisions about treatment and care including food, drink and physical symptoms.

PRIORITY 4: SUPPORT

Identify, explore and respect the needs of those the dying person identifies as important to them and meet them as far as is possible.

Contact details provided and plan to meet again:

PRIORITY 5: PLAN & DELIVER AN INDIVIDUALISED CARE PLAN

1) ***Goals of care*** *(eg dignity and alleviation of symptoms)*

2) ***Clinical interventions*** *(eg NEWS2, symptoms observation chart, blood sugar readings, MET calls)*

3) ***Management of physical symptoms*** *(eg individualised symptom plan)*

4) ***Management of broader holistic needs*** *(psychological, spiritual, cultural, religious and practical (eg parking permits or visiting times) needs)*

5) ***Management of hydration and nutrition*** *(eg assessment of ability to eat and drink, at risk oral fluids/food to person's thirst, need for clinically assisted hydration and/or nutrition)*

6) ***Other individualised care goals***

7) ***Preferred place of care***

PLEASE REVIEW THIS CARE PLAN DAILY

CLINICIAN AGREEING ABOVE INDIVIDUALISED CARE PLAN

Signature_____ Name_____ Grade_____ Date_____ Time_____

Symptom Observation Chart for the Dying Patient

Brighton and Sussex University Hospitals NHS Trust

Patient name:
Hospital No:
NHS No.
D.O.B:

or affix patient ID sticker here

Date patient was recognised as dying: ___/___/_____

Record observations at least 4 hourly

Month / Year	Date / Time																								Date / Time
Pain (reported or observed)	3												3												3
	2												2												2
	1												1												1
	0												0												0
Nausea	3												3												3
	2												2												2
	1												1												1
	0												0												0
Vomiting	3												3												3
	2												2												2
	1												1												1
	0												0												0
Breathless-ness	3												3												3
	2												2												2
	1												1												1
	0												0												0
Respiratory Secretions	3												3												3
	2												2												2
	1												1												1
	0												0												0
Agitation/ Distress	3												3												3
	2												2												2
	1												1												1
	0												0												0
Other, if present (state) _____	3												3												3
	2												2												2
	1												1												1
	0												0												0
Mouthcare - confirm given																									
HCA signature																									HCA
Registered nurse signature																									Reg Nurse
Doctor signature																									Doctor

3 = Symptom present, does not resolve with PRN medication	**Urgent doctor review of patient and care plan is required for any single symptom score of 3**
2 = Symptom present, requires PRN medication to resolve	**Care plan continues. If 3 consecutive symptom scores of 2 are present (for any symptom), urgent doctor review of patient and care plan is required**
1 = Symptom present	**Care plan continues, consider PRN medication**
0 = Symptom absent or controlled with CSCI	**Care plan continues**

Brighton and Sussex University Hospitals NHS Trust

ACTION AND EVALUATION OF SYMPTOMS

Patient name:
Hospital No:
NHS No.
D.O.B:

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SYMPTOM (What symptom?)	ACTION (What did you do?)	EVALUATION (Did your action help? If not, what other action have you taken?)
Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____
Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____
Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____
Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____
Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____	Signature: _____ Date/Time: _____

DAILY NURSING CARE PLAN FOR THE DYING PERSON

PREFERRED NAME _____

DATE ___/___/_____

Patient name:
Hospital No:
NHS No.
D.O.B:

or affix patient ID sticker here

GOAL : MEDICATION NEEDS REVIEWED BY DOCTORS & ADJUSTMENTS MADE AS NECCESARY		
DAY		
NIGHT		
GOAL : HOLISTIC ASSESSMENT COMPLETED & NEEDS OF PATIENT AND PEOPLE MOST IMPORTANT TO THEM MET (EMOTIONAL, SPIRITUAL, CULTURAL, PRACTICAL)		
DAY		
NIGHT		
GOAL : MOUTH CARE DELIVERED AND ORAL HYGIENE MAINTAINED		
DAY		
NIGHT		
GOAL : ORAL HYDRATION IS MAINTAINED & ASSISTANCE PROVIDED TO DRINK AS ABLE/DESIRED		
DAY	Oral hydration estimate: None☐, <500ml☐, 500-1000ml☐, 1000-1500ml☐ >1500ml ☐	
NIGHT	Oral hydration estimate: None☐, <500ml☐, 500-1000ml☐, 1000-1500ml☐ >1500ml ☐	
GOAL : ORAL NUTRITION MAINTAINED & ASSISTANCE PROVIDED TO EAT AS ABLE/DESIRED		
DAY		
NIGHT		
GOAL: MICTURITION/CATHETERS & BOWEL/STOMA CARE: COMFORT & DIGNITY MAINTAINED. APPROPRIATE CATHETER CARE AND URINARY SYMPTOMS MAINTAINED		
DAY		
NIGHT		
GOAL: HYGIENE, SKIN INTEGRITY AND COMPLICATIONS OF BEING IN BED: COMFORT AND DIGNITY MAINTAINED, APPROPRIATE PRESSURE AREA CARE ADDRESSED		
DAY		
NIGHT		

IF GOALS NOT MET DURING SHIFT PLEASE DOCUMENT WHY AND WHAT ACTION HAS BEEN TAKEN

CONTINUE DOCUMENTATION OVERLEAF IF REQUIRED

EVALUATION OF CARE GIVEN

Date & time		Sign/initial