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.

Prompts are provided, but if you need more detaills on what to consider in achieving these 5 priorities, see comprehensive guidance on palliative care team info-net pages.
Consider if you need to refer to the specialist palliative care team.
If you are unsure if the person is likely to be dying, or if the person and/or those important to them raise concerns, a senior clinician must review the person, the goals of care and the care plan.

Care of the dying

EXAMPLE

EXAMPLE INDIVIDUALISED CARE PLAN FOR A DYING PERSON

PRIORITY 1: RECOGNISE

Remember: State the names and positions of multiprofessional team involved in assessment of patient and recognition of dying phase, (including senior doctor and nurse), the diagnosis and condition now thought to be irreversible and contributing to dying phase.

Lead Consultant: Dr A N Other
Senior Nurse: Ward Manager K James
Others present: Dr AL Ternative (FY1)

Advanced COPD with Type II respiratory failure.
Congestive cardiac failure.
Type II diabetes, insulin controlled.

Further to previous documentation, it is now apparent that Mrs Person is approaching the end of her life due to advanced COPD and Type II respiratory failure (with requirement for NIV). This more acute deterioration is on a background of short months of accelerating decline and several hospital admissions in the last year.
It is expected that she will die from this within a short number of days.

Remember to document name, relationship and contact details of people identified as most important to the dying person.

MR ANY PERSON (HUSBAND) - 01273 123 456 - first contact at all times, including overnight
MR OTHER PERSON (SON - in DENMARK) - 00 45 6022 6035

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PRIORITY 2: COMMUNICATE

Remember: Open, honest and sensitive communication is key. Involve the patient as much as they want in decisions about their care, explore their concerns, wishes and preferences; document their understanding about information communicated. Apply principles of MCA if patient lacks capacity for decision making. Confirm any Advance Decision documents or LPA. Document what has been explained to the patient (and those important to them) about the recognition of dying. If not explained you must say why.

I have spoken with both Mrs Person and her husband today (with her permission).

They both have a good understanding of the advanced nature of her COPD and consequent heart failure. She has expressed a desire not to recommence non invasive ventilation, and understands that without this, her respiratory failure is expected to worsen, resulting in her death. We have had a detailed discussion about her wishes and preferences for care in her final days, detailed below, with the focus on comfort care. Given this, she would also wish to discontinue antibiotics and understands with without those, she may die sooner than if any infection were treated.

She is aware that she is likely to die in a short number of days, and is likely to become increasingly drowsy and unable to communicate in that time, but currently has been able to participate fully in discussion about her wishes, reflecting what she and her husband have been discussing at home for some time now.

Mrs Person's main concern is that she remains comfortable in the final phase of her life. Previously she was supported by her husband at home, but given her recent accelerating decline, she has stated that she wishes to remain in hospital where access to support and care for both herself and her husband can be achieved.

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PRIORITY 3: INVOLVE

Remember: Ensure the dying person and those important to them know which senior clinicians are leading their care and document this. Involve the dying person and people who matter to them (as much as the patient wishes) in decisions about treatment and care, plus day to day decisions about food, drink and personal care. Listen to their views and concerns and document questions answered. Apply principles of MCA if patient lacks capacity for decision making.

Mr and Mrs Person have been informed that Dr Other and Ward Manager James are the senior clinicians leading her care.

Whilst able to do so, she wishes to continue to be fully updated and included in decisions about her treatment and care and day to day decisions.

She wishes for that inclusion to be extended to her husband at all times.

In addition to that already detailed, Mrs Person is happy to have frequency of BM monitoring adjusted and insulin regime modified.

I have also spoken with her Husband, Mr Any Person, separately with permission. He supports his wife's wish not to receive further ventilation or antibiotics and to stay in hospital until her death. He understands the expected prognosis is likely in the region of short days. He agrees that hospital is the right place to care for his wife, (after discussing the options of returning home), since they have been struggling to cope prior to admission. His main concern is that her breathlessness is controlled and that she is comfortable. I have talked in more detail with him about the pros and cons of clinically assisted hydration when Mrs Silversmith becomes unconscious and unable to swallow.

He is happy to be contacted at home at any time and knows the arrangements for visiting. He will update their Son who is in Denmark and I have suggested he visit as soon as possible.

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PRIORITY 4: SUPPORT

Remember: Explore and document the holistic support needs (including spiritual, religious, cultural, practical) of people who matter most to the dying person. Detail what you have explained about what to expect in dying phase and further written information you have provided. Provide contact details of clinical team and ward.

Husband will visit when able and happy to be telephoned at any time. He wishes to contact Son and update him. Will confirm if Son would like further discussion with team on telephone if not able to visit.

He feels well supported emotionally and practically by neighbours and friends, who are helping with meals at home and transport.

I have explained the likely changes he can expect to see as death approaches and have provided him with the leaflet "What to expect when someone important to you is dying". I have also explained the details of the agreed care plan set out below.

Ward manager has explained visiting hours do not apply, plus where refreshments can be obtained. Ward telephone numbers and names of clinical team provided.

No outstanding holistic needs today (he will talk with the chaplain who is due to visit his wife). For continued daily assessment.

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PRIORITY 5: PLAN AND DELIVER AN INDIVIDUALISED PLAN OF CARE

Remember to define in the dying person's individualised plan of care: Goals of care, changes to any clinical interventions or treatments, management of pain and other physical symptoms, management of psychological/emotional, spiritual, cultural, religious, practical and other needs, plan for hydration and nutrition, place of care and review plan. Do you need to refer to the Specialist Palliative Care Team?

New goals of care:
To optimise comfort and dignity in final days of life. To stop distressing or potentially life prolonging interventions in line with Mrs Person wishes.

Clinical interventions and treatments:
To discontinue routine vital sign checking and routine blood tests.

To remove arterial line and discontinue ABGs.

To discontinue IVAbs and remove IV line (see priority 2 dicussion)

To continue oxygen for comfort.

Not to receive assisted ventilation. Ceiling of treatment is ward based comfort care.

DNACPR form already in place - previously discussed with patient and husband.

Current medication reviewed and adjusted.

PRN Anticipatory medication prescribed.

To follow guidance provided in notes for management of diabetes - once daily early pm monitoring of cBM and continue insulin at present; may require further reduction in dose of insulin. cBM 6-15 would be acceptable (unless symptomatic).

Use symptom observation chart for dying patient to monitor comfort and escalate if patient and care plan need early doctor review.

Support and information needs of those identifed as most important:
See details in Priority 4. Daily support to be offered by ward team.

Continued overleaf

Care of the dying

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PRIORITY 5: PLAN AND DELIVER AN INDIVIDUALISED PLAN OF CARE

Physical symptoms:
Priority is control of breathlessness. Commenced regular oral morphine sulfate regularly + prn today.

Anticipate that may have escalation of symptoms, or develop new symptoms of pain, worsening breathlessness, nausea, anxiety/distress, chest secretions, dry mouth and possibly oedema.

Regular mouth care products and PRN sc medication charted to allow management of above as needed.

If unable to swallow oral morphine sulfate, to convert to CSCI diamorphine (using online prescribing guideline).

We have discussed use of sedation for intractable symptoms or severe distress and Mrs Person would be in agreement with this if felt necessary.

Broader holistic needs including psychological/emotional, spiritual, cultural, religious, practical
To have distress and anxiety minimised. Feels safe in hospital and keen to ensure her husband's stress is minimised by her staying here. If required, medication to relieve anxiety/distress to be used. Has a Christian Faith. Has been an active part of her life. No specific wishes for care after death, but wishes to see Chaplain now - referred.

Support and information needs of those identifed as most important:
See details in Priority 4. Daily support to be offered by ward team.

Continued overleaf

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Do you need to refer to the Specialist Palliative Care Team?

Hydration and nutrition support:
Appetite poor and needs assistance with eating. Needs assistance and prompting to drink, with only moderate desire to drink.
Mouth currently clean and moist.

To continue to be supported maximally with oral intake as desired and able. Both aware this will be impossible if becomes too drowsy or unconscious. Mouth care essential and to be performed regularly using water and prescribed products. Clinically assisted nutrition not in place and not appropriate to commence.

Pros and cons of clinically assisted hydration discussed - could potentially worsen symptoms of heart failure (although not currently troublesome - to be monitored). Mrs Person would prefer not to recieve potentially life prolonging measures, but would consider subcutaneous clinically assisted hydration if would contribute to greater comfort - for ongoing daily review and discussion with patient/husband.

Additional wishes and needs:
None specified at this time.

Preferred place of death: Hospital, No additional needs for care at time of death or immediately after identified.

Review plan: For daily senior review, more frequent if required.

Dr AL Ternative
FY1
Bleep 3021

Care of the dying

EXAMPLE