Phyllis Tuckwell Hospice Care
...because every day is precious

Patient Name:
Known As:
NHS number:
DoB:
Allergies:

Priorities for Care and Key Planning for the person in the dying phase

- The priorities for care and key planning at home are integral to the person's individual plan of care.
- This framework for care and key planning at home can be initiated as and when appropriate by the visiting professional delivering care. As the Key Worker, this would usually be initiated by the District Nurse.
- As each area is discussed, this can be documented by the relevant professional involved in the person's care with **each entry dated and signed** (with printed name and role clearly stated).
- Priorities are to be reviewed and documented in the clinical records, including the shared communication record where needed
- The Mental Capacity Act 2005 must be adhered to when formulating an individualised plan.
- The Lasting Power of Attorney (LPA) for Health and Welfare (if appointed) must be consulted regarding health decisions if the person does not have capacity to make specific decisions about health related issues.
- The name of the Lasting Power of Attorney (LPA) for Health and Welfare will need verification and this information needs to be shared between the relevant professionals involved in care delivery.
- Sharing information to support direct care is essential between registered and regulated health and social care professionals involved with the person's care. (7th Caldicott Principle)

Principles

Recognise*:* The possibility that a person is in the dying phase and this is clearly communicated. Decisions made and actions taken are in accordance with the person's individual needs and wishes and these are regularly reviewed with decisions revised accordingly. **Always consider reversible causes, e.g. infection, dehydration, hypercalcaemia.**

Communicate: Sensitive communication takes place between professionals and the dying person, alongside those identified as important to them. Communication between the professionals involved in the person's care is essential for co-ordinated care delivery.

Involve: 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.

Support: The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Plan & Do: An individual plan of care, which includes food and drink, symptom control, psychological, social and spiritual support, is discussed, agreed, co-ordinated and delivered with compassion.

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Recognise	
The GP / Doctor and a Registered Nurse have identified that the person's health is deteriorating and that the person is now in the dying phase of their illness.	**Name of GP / Doctor and Name of Registered Nurse involved with this decision / assessment:** _____ Date: _____ / _____ Date: _____ _____ Date: _____ / _____ Date: _____
Communicate	
The person has been reviewed by the person's usual GP/Dr within this illness and had discussions with interprofessional team and patient and family checking their understanding and wishes.	Date of this review and name of GP/Dr: Additional information:
The person's resuscitation status has been reviewed. Family / significant other are aware. **DNACPR/ReSPECT (original copy) is in the home.**	Specify where DNACPR/ReSPECT kept:
GP is in agreement that an appropriately trained Registered Nurse can verify the person's expected death?	Date this was agreed and name of GP: Name of Registered Nurse involved in the discussion:
All reversible causes for the deterioration have been assessed?	Date of the assessment and name of GP involved:
A medical review of non-essential medicines and interventions carried out?	Date of this medicine review and name of GP/Dr: Additional information:
As indicated: Anticipatory medicines prescribed with Instruction & Administration Charts in the home? MAR charts for stat doses and stock level charts?	Specify:
If applicable, has there been a review/discussion with patient and family about internal cardiac device? **Please state deactivation plan and date.**	Specify action plan or NA if no device:

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Priorities for Care and Key Planning for the person in the dying phase

The person is aware they are now in the dying phase.	Date of initial discussion:
Preferred Place of Care discussed *(Discuss and document individual care needs and wished and personalised goals in the care plan).*	Outline of discussion: State Preferred Place of Care: State Preferred place of death if different:
Is there an Advance Care Plan (ACP), funeral plan, a PACe document and ReSEPCT, Advance Decision to Refuse Treatment (ADRT)?	Explore and document wishes and preferences and where the documents can be found: Date reviewed.
Is there a LPA for health the relevant documents to be been seen by the HCP.	Record date seen by HCP: Health and Welfare LPA: □
Capacity to consent to arrangements about care?	Review and document:
Family members / LPA are aware that their relative is dying and of what to expect both in and out of hours?	Date of initial discussion: Ongoing review:
Family, carers, significant others / LPA have contact details for care, advice and support in & out of working hours).	Check and review:
Update the Out Of Hours GP, District Nurse, Ambulance Service (via the IBIS care plan), Hospice Care at Home / Clinical Nurse Specialist as required and as relevant.	Details of updates:

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If illness due to an industrial illness, documentation in the home by GP of discussion with coroner about the plan of care post death.	Date letter written: Name of family /LPA member updated with plan:
Involve	
Include the person in decisions about their treatment and care to the extent that they wish to be involved. Consent to involve family members / significant other / LPA in decisions about treatment & care to the extent that the person wishes.	Ongoing review. Names of those involved:
Assess and discuss ability to take food and drink considering related symptoms where clinical assisted hydration would benefit.	Ongoing review and document care plan accordingly.
Support	
The emotional, psychological, spiritual needs of the person are explored and respected.	Ongoing review. Offer access to supportive services. Link with Advance Care Plan.
The needs of family members/significant other are explored, preferences discussed and concerns or questions addressed.	Ongoing review. Referral to supportive services offered: If so which organisation/department: ……...date referred: ……..
Plan and Do	
Individual needs that are identified e.g. physical, psychological, symptom control, are addressed with a documented plan that is reviewed at each visit. Involve specialist palliative care team as appropriate.	Ongoing review