Name:
Date of Birth:
Address:
NHS Number:

gofal lliniarol CYMRU – WALES palliative care

All Wales Guidance: Care Decisions for the Last Days of Life

This document forms part of the patient's confidential clinical record. (See context for its use on the previous page.)

Mae'r ddogfen hon ar gael yn y Gymraeg hefyd. / This document is also available in Welsh.

Clinical assessment:

Do the clinical team agree that the patient is in the last days of life? Yes ☐ No ☐

Document changes that make the team think that this person is now dying:

Important:

If the patient is **NOT** in the last days of life, Care Decisions Guidance should **NOT** be used - see page 4.

Have reversible causes of deterioration been considered? Yes ☐ No ☐

Comments:

What is the main medical condition likely to be responsible for this deterioration?

Person centred focus - patient understanding and priorities:

Patients should be given opportunities to discuss and plan their individualised care.

Is the patient aware that they are deemed to be in the last days of life? Yes ☐ No ☐ *OR*

Patient is unable (for clinical reason) to discuss* ☐ Patient states they do not want to discuss* ☐

Document any discussions with the patient about their awareness of dying (so others can build on/avoid duplication).

Record <u>what matters most to them</u> including any priorities, needs or concerns they have/are known to have had, taking into account their capacity to make decisions. *

**Involve and discuss, as appropriate, with those important to the patient – see page 4*

Important holistic information about the patient:

Note any key medical, nursing, social or other important information which may affect, or needs to be taken into account, when providing individual patient care. These may include: disability e.g. hearing, sight, mobility; language; race, culture, religion and belief; sexual orientation; gender identity, their important relationships; anxiety, mental health; and any caring roles they usually undertake. *For more practical guidance about these see the Care Decisions 'Considering Diversity Appendix'.*

NB It is statutory duty that Welsh speakers are enabled to speak their mother tongue. Welsh language preferred ☐

Patient's preferred place of care:

Where is the preferred place of care for this patient in the last days of life?

Is this currently being achieved? Yes ☐ No ☐ No preference or unable to express ☐

If no, why not?

Name: Date of Birth: Address: NHS Number:	**Responsible consultant / GP** …… **Completing HCP (initials)** …… **Date** ……

Advance Care Planning (ACP) and Future Care Planning (FCP): *Refer to national/local guidance*

Has the patient expressed wishes and preferences in an Advance Care Plan? Yes ☐ No ☐ Don't know ☐
If yes, how have these views been taken into account?

Has the patient completed an Advance Decision to Refuse Treatment (ADRT)? Yes ☐ No ☐ Don't know ☐
Is there a registered Lasting Power of Attorney (LPA) for Health and Welfare? Yes ☐ No ☐ Don't know ☐
Is there a Future Care Plan (FCP) in place? Yes ☐ No ☐ Don't know ☐

Has the patient expressed a decision on the organ donor register? (Can check on: 03000 20 30 40) Yes ☐ No ☐
Has the patient opted in ☐ or opted out ☐ or have they nominated an appointed representative ☐ ?

If the patient **hasn't opted out** please discuss tissue donation with patient / next of kin. If tissue donation is a possibility please refer to national Referral Centre for tissue donation on 0800 432 0559.
Action:

Medical management plan:

Document agreed medical management plan, particularly with regard to ACP/FCP, further investigations, escalation of care and interventions which may be considered.

Hydration decisions:

Document any discussions and decisions regarding hydration (including the risk/benefit of oral fluids and/or the use of parenteral fluids) with the patient / those important to them.

Nutrition decisions:

Document any discussions and decisions about nutrition (including artificial feeding via PEG/NG tube) with the patient / those important to them.

CPR Status – Natural Anticipated and Accepted Death (NAAD): *Refer to All-Wales DNACPR policy*

Document any discussion with patient and those important to them about allowing natural death to occur, and complete appropriate forms (refer to fuller entries in patient record if necessary).

Name: Date of Birth: Address: NHS Number:	**Responsible consultant / GP** …… **Completing HCP (initials)** …… **Date** ……

Cultural, spiritual and religious support for patient and those important to them:

Consider the individual needs of the patient and those important to them. The Diversity Appendix offers practical advice. Discuss any particular priorities which may affect individual patient care. Document actions to be taken:

Individual plan of care

Update existing nursing care plans and risk assessments
Refer to Symptom Assessment Chart

Focus on measures to increase patient comfort. Stop interventions no longer providing symptomatic benefit.
Document decisions on the following:

- Monitoring of vital signs (e.g. NHS Early Warning Scores in hospital setting)
- Regular blood tests
- Monitoring blood sugar levels*
- Other:
- Investigations or appointments
- Management of Implantable Cardiac Device*
- Stopping VTE prophylaxis

Update existing nursing care plans and risk assessments in line with the above decisions.
In particular, address the following important aspects of care in the last days of life:

- Mouth care
- Skin
- Bladder/bowel
- Communication
- Environment - Privacy/Single room
- Symptom assessment
- Anticipatory medication
- Blood sugar level management*
- Hydration
- Nutrition

Symptom Control

- Rationalise current regular medication.
- Assess the patient for symptoms likely to occur in the last days of life (including pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions).
- Document findings on the Symptom Assessment Chart.
- Prescribe anticipatory medication with individualised indications for use, dosage and route of administration.
- Refer to the Care Decisions Symptom Control Guidance, if needed.

*Refer to local/national guidance such as:

- Care Decisions Diabetes Management Supplement or EOLC Diabetes UK Clinical Care Recommendations (2021)
- All Wales Operational Document for Deactivation of ICD (guidance) (2019)

Ongoing review

Update existing nursing care plans and risk assessments

Continue to monitor **at least daily** for signs and symptoms, for example pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions. Liaise with senior clinician if any concerns.

- Carry out regular symptom review, and discuss with senior colleagues if needed.
- Maintain frequent two-way communication with the patient (if they are able) and those important to them, taking into account that patient priorities may change over time.
- Discuss patient progress (and any changes) with the multi-disciplinary team.
- Consult your local Specialist Palliative Care Team for further advice if required.

Name:

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Address:

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Responsible consultant / GP .....

Completing HCP (initials) .....

Date .....

Understanding and priorities of those important to the patient:

With the patient's consent, those important to the patient should be given opportunities to discuss and help plan the patient's care. Offer information (including written material) about the role they can play to be involved and support care at this time.

Do those important to the patient understand the patient is dying? Yes ☐ No ☐ *OR*

Patient has no important people/does not want anyone informed ☐

Name of key individual to be involved / kept informed:

Relationship to patient:

Document discussion held with those important to the patient. Consider the following:

What support do they have? What are their needs and concerns at this time?

Are they aware how to access facilities, practical help or additional support, at home, in hospital or other setting?

Are they aware of bereavement support available, if needed?

If at home, do they know what to do when the person dies? **Document agreed plan:**

Verification of expected death: Refer to local policy for further guidance if needed

Can verification of death be carried out by a suitably trained healthcare professional (other than a GP or hospital doctor) according to the management of an 'expected death'? Yes ☐ No ☐

Medical Examiner / Coroner:

Will the death meet the statutory regulations to refer to the coroner? Yes ☐ No ☐

Document reason and discussions with team and those important to the patient:

If referring to coroner, have you let next of kin know? Yes ☐ No ☐ N/A ☐

Does next of kin know what will happen after death (including scrutiny from Medical Examiner)? Yes ☐ No ☐

NB. For cultural/religious reasons, urgent death certificates and particular care of body may be needed by some families.)

IMPORTANT:

- If the clinical situation improves and the patient is **no longer deemed to be in the last days of life,** then the clinical team should discuss an alternative medical management plan. Care Decisions guidance should **no longer be used**. This should be indicated by drawing a line through each page, signed and dated.
- Please complete and return a Case Review sheet for each patient after death.

Identify responsible healthcare professionals: Ensure responsible clinician identified in box above

Healthcare professional (HCP) completing the document:

Print Name: Role: Date:

Signature:

Discussed with senior clinical decision maker and plan agreed:

Print Name: Role: Date consulted: