URN:

Name:

Date of Birth:

Address:

ADDRESSOGRAPH

CONSULTANT/ GP			
CARE SETTING			
DATE			

Personalised Care Record for the expected last days of life Part 2 - Care

This care record is designed to support best possible clinical care at the end of life in accordance with the person's needs and wishes.

It is a multi-organisational document to be used by all professionals and is to be shared with the person, their family and carers. Each organisation should comply with their own policies and procedures.

If there is any content that you would like more information on, please contact the professionals that are currently providing care.

Name ..... **DOB** ..... **URN** .....

Guidelines for staff

This replaces all other nursing and medical documentation excluding medication charts.

1. This care record is designed to record the communication and collaboration between the multi-professional team, individual adult patients and their family / carers.
2. If you require any additional support and advice please contact the Specialist Palliative Care Team Jersey Hospice Care (JHC) on 01534 876555.
3. For guidance on symptom management at the end of life please refer to local guidelines for symptom management. Available on JHC website and HCS intranet.
4. In the community this document should stay with the patient and be adapted to their needs and wishes.
5. In hospital the document is held in the nursing notes and replaces existing nursing documentation and should be adapted to the patient's needs and wishes.
6. On discharge from hospital the document must be photocopied, the original is to be transferred with the patient and the copy filed in the patient's medical notes.

Health Care Professional Record

All people involved in decision making and delivery of care, please complete and sign below

Full Name (Print)	Signature	Initials	Designation	Date

Name ..... **DOB** ..... **URN** .....

Health Care Professional Record

All people involved in decision making and delivery of care, please complete and sign below

Full Name (Print)	Signature	Initials	Designation	Date

Name ..... **DOB** ..... **URN** .....

Personalised Care Plan for last days of life

..... is now thought to be approaching the last days of his / her life and requires individual holistic care focused on comfort and dignity. Use only the following symptom control care plans that your patient needs.

Agreed Goals:

- Ensure compassionate, person centred communication with the person (when possible), and with family and / or significant others
- Ensure the person is included when possible. If the person lacks capacity for a decision ensure this is documented and how this conclusion was reached. Please note capacity is decision and time specific
- Ensure frequent updates are given to the family and / or significant others concerning the person's condition
- To provide care for these last days that reflects his / her individual and specific needs
- To promote care that ensures his / her safety, wellbeing and dignity
- To promote his / her involvement and that of the family / significant others, if they so wish, in the planning of care
- Ensure effective handover of the person's condition, including any changes in planned care to all relevant staff

Guidance for the use of the Symptom and Care Chart

- For adults, this chart supersedes the National Early Warning Score Observation chart when it is no longer deemed appropriate by the medical team
- For use by the multi-professional team
- Observations to be recorded at each contact in a community setting or at least **4 hourly** in an in-patient setting
- To be completed **hourly** or earlier if any symptom is **severe / distressing or moderate**
- All symptoms should be scored 0-3 and appropriate action taken in line with the guidance
- Please ensure this Symptom and Care Chart is used in conjunction with the Personalised Care Record
- Ensure inappropriate interventions have been discontinued

Key for Care/Goal Codes

1. Mouth Care
2. Skin Integrity
3. Bowel and Bladder Care
4. Eating and Drinking
5. Pain
6. Nausea and Vomiting
7. Agitation and Anxiety
8. Respiratory Secretions
9. Breathlessness
10. Other Symptoms

Name ..... **DOB** ..... **URN** .....

1. Mouth Care

- Offer and support the patient to eat and drink for as long as they want / or are able to
- Maintain good, regular mouth care to promote the patient's comfort; consider use of soft toothbrush
- Ensure anticipatory prescribing of oral care preparations (e.g. BioXtra gel®)
- Consider using ice cubes / pops to relieve dry mouth where appropriate
- Ensure the family / significant others are aware of the importance of mouth care and how they can support this
- Explain the symptoms of dry mouth or cracked lips do not necessarily mean the patient is thirsty, and this may be related to mouth breathing
- Record on Symptom and Care Chart

Date	Personalised Care Plan	
	Goal: **Action Plan:** **Anticipated outcome:**	**Completed by:** **Review date:**
	Goal: **Action Plan:** **Anticipated outcome:**	**Completed by:** **Review date:**
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Name ..... **DOB** ..... **URN** .....

2. Skin Integrity

- Observe skin integrity by implementing appropriate support and positioning schedules according to comfort
- Record position on Symptom and Care Chart i.e. **L**eft, **R**ight, **B**ack
- Support the hygiene needs of the patient based upon their comfort
- Consider the use of aids e.g. slide sheets, pressure relieving mattress and ensure correct set up for weight / size of patient
- Discuss importance of comfort positioning with patient, family and significant others
- Consider issues of privacy and dignity e.g. side room, noise levels

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Name ..... **DOB** ..... **URN** .....

3. Bowel and Bladder Care

- Ensure privacy and dignity is maintained at all times
- Acknowledge patient preferences utilising appropriate continence aids for e.g. conveen
- Consider urinary catheter for retention and / or comfort
- Provide pads if weakness causes incontinence
- If available utilise a catheter care bundle for patients requiring catheterisation
- Monitor and support skin integrity
- If distressed by constipation consider bowel intervention
- Communicate with patient, family or significant others
- Record on Symptom and Care Chart

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Name ..... **DOB** ..... **URN** .....

4. Eating and Drinking

- The desire for food and drink may naturally decrease towards the end of life
- Offer and support the patient to eat and drink for as long as they want / or are able to
- Assess patient's swallowing ability and continue to support oral fluids if appropriate / tolerated
- Monitor for signs of distress or aspiration
- Communicate with the family and the significant others in order to recognise their understanding about potential risks associated with eating and drinking
- Continually review the appropriateness of any artificial hydration and nutrition
- Offer to discuss the benefits and burdens of artificial hydration and nutrition with patient and or family
- Liaise with the multi-professional team

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Name ..... **DOB** ..... **URN** .....

5. Pain

- Ensure anticipatory prescribing is in place at a dose appropriate to the person's regular analgesia
- Consider other underlying causes e.g. constipation, retention of urine, pressure damage
- Address psychological / spiritual causes if appropriate
- If a patient is already receiving regular analgesia ensure administration by an appropriate route
- If pain is reported or observed, assess intensity and severity of pain (use pain scale 0-10 if appropriate)
- Record on Symptom and Care Chart
- If a syringe pump is in place ensure regular checks are made in line with the Ambulatory Syringe Pump Policy
- Communicate with patient, family or significant others
- Obtain palliative care advice where needed

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Name ..... **DOB** ..... **URN** .....

6. Nausea and Vomiting

- Ensure anticipatory prescribing in place
- Ensure regular anti-emetic is prescribed by an appropriate route
- Consider bowel related causes
- Consider positioning of person
- Ensure access to vomit bowls, tissues if appropriate
- Offer regular mouth care (see care plan 1)
- Record on Symptom and Care Chart
- Provide explanations and information to patient, family or significant others as appropriate
- Obtain palliative care advice where needed

	Personalised Care Plan	
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Name ..... **DOB** ..... **URN** .....

7. Agitation and Anxiety

- Ensure anticipatory prescribing in place
- Exclude reversible causes if appropriate e.g. bladder retention, bowel pain
- Discuss with patient / family / significant others to try to ascertain likely cause
- Consider non-pharmacological options to manage symptoms and explain these options to patient, family or significant others as appropriate
- Discuss spiritual needs
- Ensure regular anxiolytic and / or antipsychotic is prescribed by an appropriate route
- Record on Symptom and Care Chart
- Obtain palliative care advice where needed

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8. Respiratory Secretions

- Ensure anticipatory prescribing is considered and in place early
- Provide understandable explanations of possible secretions and likely effectiveness of medication to family
- Re-position patient if necessary
- Give subcutaneous anti-cholinergic either as required or via a syringe pump
- Review with medical team
- Record on Symptom and Care Chart
- Obtain palliative care advice where needed

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9. Breathlessness

- Ensure anticipatory prescribing in place
- Consider use of a fan and open windows
- Consider re-positioning
- Consider relaxation techniques
- Consider use of pharmacological interventions if appropriate
- Address anxieties if appropriate
- Acknowledge changes with breathing patterns and discuss any concerns with the patient and family
- Record on Symptom and Care Chart
- Obtain palliative care advice where needed

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10. Other Symptoms

- For example: dry eyes, hiccups, itch
- Record on Symptom and Care Chart

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Name ..... DOB ..... URN .....

If the patient dies or the PCR is suspended please also document in part 1.

Ongoing Assessment / Multi-professional Care Record

Date	Time	Care/Goal Code (Pg.3)	Record of Action and Outcome	Signature

Name ..... DOB ..... URN .....

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Ongoing Assessment / Multi-professional Care Record

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