Norfolk and Norwich University Hospitals NHS Foundation Trust

Individual Plan of Care (IPOC) for End of Life (EOL) for Adults

Patient Details / Label

Recognise → Communicate → Involve → Support → Plan and Do

	Please identify role clearly, sign. date & time.

B

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Patient Identifier Label

Ward:

By creating this plan those named below have **recognised that the patient may be in the last days or hours of life, with all reversible causes being excluded, and following discussions with patient and/or family**, which should be documented in the medical notes prior to this plan.

This plan should be developed as part of a multidisciplinary approach and should follow the Five Priorities for EOL care - Recognise, Communicate, Involve, Support, Plan and Do (Trustdocs ID: 10560). Should you require further information on these priorities or assistance on completing this plan, please contact the Specialist Palliative Nurse advice line on 5052/3227.

If **clinical support** is required out of hours (5pm-9am) please call the Specialist Palliative Care Telephone Advice Service on **0330 158 8011** and **select option one**. Alternatively, the Palliative Medicine Consultant on call for emergencies can be reached via switchboard.

Consultant in charge of care	Name		Signature		Date & Time	

Relatives and carers involved in planning	• Names • Relationships • Preferences regarding being called about deterioration or death (e.g. overnight)	

The need for this plan should be reviewed daily.

If this IPOC is no longer appropriate to use (for example, patient recovery) please sign below to indicate its cessation and that relatives/carers have been updated.

Doctor discontinuing IPOC	Name		Signature		Date & Time	

Section One: Mental Capacity Assessment and Advance Planning Documents

MENTAL CAPACITY ASSESSMENT RECORD

Decision Required: Does the patient have capacity to take part in their own end of life care planning as laid out in this document?

STAGE 1	YES	NO
Does the person have an impairment of, or disturbance in the functioning of the mind or brain? *(if yes, state below)*	☐	☐
If 'No' the patient cannot be deemed to lack capacity		

STAGE 2: Due to the condition(s) in stage1, can the person:	YES	NO
Understand information about the decision?	☐	☐
Retain and recall the information discussed?	☐	☐
Weigh up that information to come to a decision?	☐	☐
Communicate their decision via any means?	☐	☐

If no to any, provide details below (*please continue in clinical notes if required*)

How has the person been helped to try and make a decision themselves?

This person does/does not have the capacity to make the decision at this time
(delete as appropriate)

Where the patient lacks capacity, decisions have been made and documented in line with best interests ☐

Name	Signature	Grade	Date	Time

The following documents should be used to inform and guide care planning, where the patient lacks the capacity to do so. Any LPA for Health & Welfare must be consulted when completing this IPOC.

	Details of Relevant Advance Care Planning Documents
☐ ReSPECT Form ☐ Advance Decision to Refuse Treatment/Advance Statement ☐ Lasting Power of Attorney for ☐ Health & Welfare and Document checked ☐ Wishes for tissue donation ☐ Donation of body to medical science	

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Section Two: Medical Plan

Doctor completing plan	Name		Signature		Date & Time	

The plan for routine observations, oxygen, blood tests and IV treatment:

Routine medications rationalised Yes ☐ No ☐

Any routine medications to continue Yes ☐ No ☐

Transdermal patches prescribed for analgesia should continue.
Do not stop regular opioids without first discussing with Specialist Palliative Care Team.

Anticipatory medications protocol prescription on EPMA		*Tick when prescribed*
Pain	eGFR >60 use Morphine	☐
	eGFR 30-60 use Oxycodone	☐
	eGFR <30 use Alfentanil	☐
Nausea and Vomiting	Antiemetic (e.g. Levomepromazine)	☐
Respiratory Secretions	Hyoscine Butlybromide	☐
Breathlessness	Opioid (as per eGFR) / midazolam	☐
Agitation	Midazolam	☐

Has it been explained to patient / NOK that these may cause drowsiness? Yes ☐ No ☐

Have you discussed use of syringe driver(s) with patient / relatives or carers? Yes ☐ No ☐

If no, please comment……………………………………………………………………………………………

Mouth care bundle prescribed on EPMA.. Yes ☐ No ☐

If no, please comment……………………………………………………………………………………………

Diabetic patients: stop all oral antidiabetic medications. If the patient is taking insulin, please discuss with the diabetes inpatient specialist team via Alertive and record advice. (End of life diabetes guidance – Trust docs.)

Summary of the plan for eating & drinking.

Summary of plan for clinically assisted nutrition & hydration (e.g. subcutaneous fluids, PEG/NGT feed plan)

Section Three: Spiritual and Psychological Needs

Healthcare Professional completing plan	Name		Signature		Date & Time	

Holistic Support of Patients

What is the Preferred Place of Death (PPOD)?

NNUH ☐ Home ☐ Care Home / Nursing Home ☐ Hospice ☐ Other ☐

If other, please state:

If not NNUH, please refer urgently to the Integrated Discharge Team

Does the patient follow any organised religion or have any spiritual beliefs? Yes ☐ No ☐

If yes, please specify………………………………………………………….

Would they like to see a member of the spiritual health care team? Yes ☐ No ☐

Referral date:…………………………………. Time:…………….

Are there any other steps we can take to support their beliefs?

Identified psychological / comfort needs

Ways we can adjust the caring environment to meet the needs and wishes of the patient

Holistic Support of Those Important to the Patient

Document any cultural or spiritual needs of those important to the patient:

Would they like to see a member of the spiritual health care team? Yes ☐ No ☐

Referral date:…………………………………. Time:…………….

Would they like to use the Chapel or its garden as a place for peace and reflection? Yes ☐ No ☐

What are the psychosocial / comfort needs of those important to the patient?

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Section Four: Nursing Plan

Supporting the Patient

Doctor/Nurse/HCA completing plan	Name		Signature		Date & Time	

	Tick when complete
Palliative Care Rounding commenced	☐
Mouth care tray provided	☐
Those important to the patient supported / educated to provide mouthcare if they wish to	☐
Feeding recommendations and food/drink preferences clearly displayed	☐
Pink end of life border put on Ward View	☐
Syringe driver icon put on Ward View if appropriate	☐

Supporting Those Important to the Patient

	Tick when complete
Written information about the dying process offered	☐
Carer's Passport provided	☐
Carers leaflet provided	☐
Ward contact details provided.	☐
Ward meal offered to main carer	☐
Shown where to access food and drink	☐
Shown location of toilets and washing facilities	☐
Overnight facilities and comfort pack offered where available	☐
Butterfly Volunteers offered	☐

Section Five: Care After Death

Nurse caring for the patient at time of death to complete below. If the patient has planned to donate their body to medical science, please call the bereavement office as soon as possible for guidance.

Practitioner verifying death	Name		Signature		Date & Time of Death	

Registered nurse on duty	Name		Signature		Date & Time	

Name of NOK notified of death……………………………….Time of NOK notified of death ………………

Bereavement Booklet been provided to NOK ☐ *Tick when complete*

Care after death procedures performed as per Trust Guideline ☐ *Tick when complete*

Notes prepared for collection by the bereavement office ☐ *Tick when complete*

Patient's property sent to the mortuary (including valuables) If not, please document below

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