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

Patient Identifier Label

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Multidisciplinary Prompts for the Care of Patients at the End of Life – *see page 2 for further details*

Instructions for completion	*All HCP's must add their details at page 3*	*All sections must be completed*	*Document or tick as appropriate*	*For dates use dd/mm/yyyy and times use 24 hours clock*

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Consultant or GP	Print name		Signature		Date and time	
Doctor completing plan	Print name		Signature		Date and time	

Recognition that the patient is dying: medical decisions *tick when completed*		*Initial, Date, and Time*
Has it been a multidisciplinary decision that the patient may be in the last days of life?	☐	
Have reversible causes of deterioration been excluded?	☐	
Has the ceiling of ward based supportive care been discussed with the patient and /or family?	☐	
Has a DNACPR decision been documented?	☐	
Has the ReSPECT form been completed	☐	
If yes, has this been this discussed with patient and those important to the patient?	☐	
The senior clinician should discuss the rationale for starting the individual end of life care plan, what to expect and the estimated prognosis.	☐	
The senior clinician should discuss the need for hydration and nutrition.	☐	

Wishes *document*	
Document relatives wishes regarding notification of deterioration / death	
Contact details of person to call	
Document the patient's and those important to the patient's preferred place of death	

Document the name/s of relatives communicated with *add name and relationship*			
Name	*Relationship*	*Name*	*Relationship*

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For actual document see Trustdocs ID: Trustdocs ID: 10560

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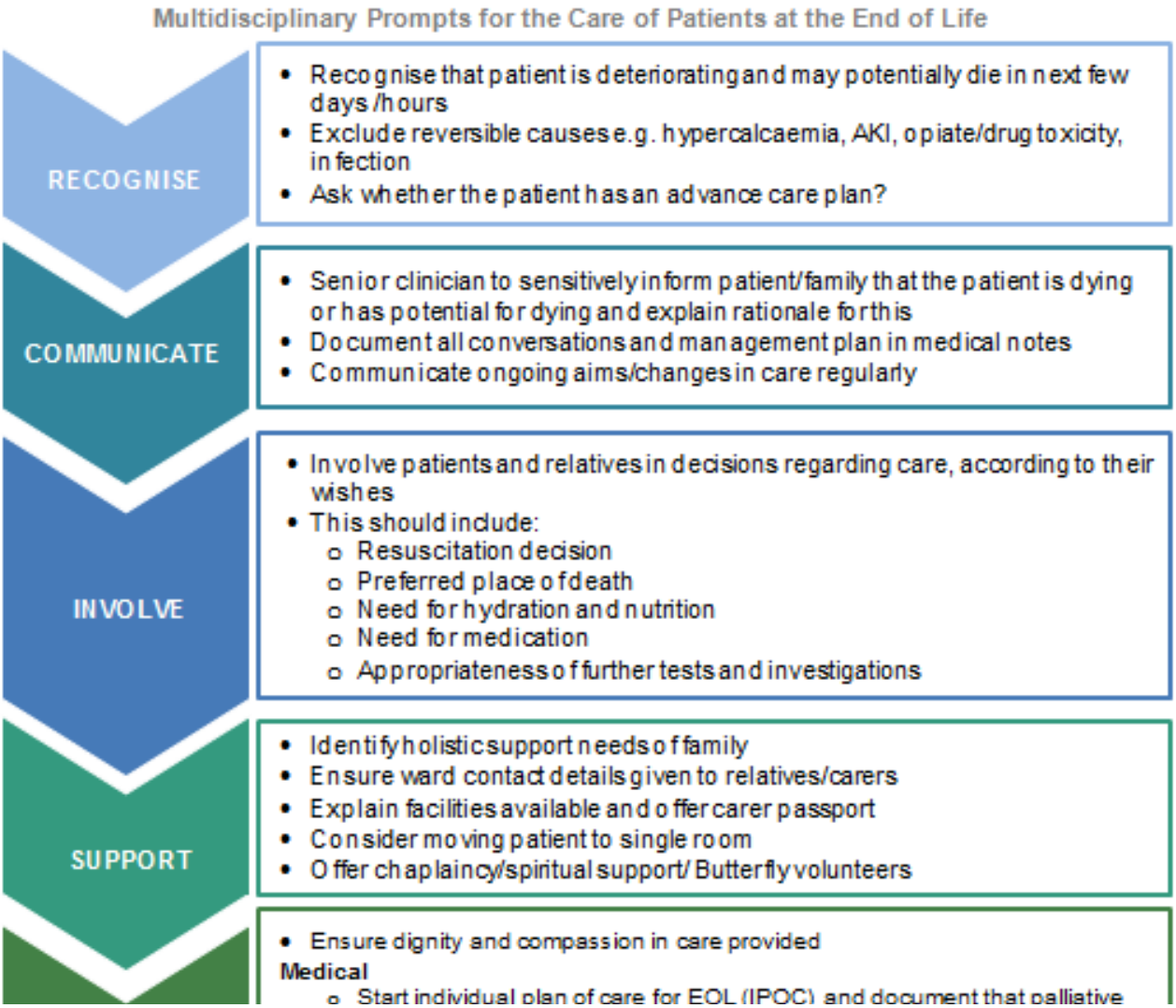

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Norfolk & Norwich University NHS Foundation Trust (NNUH) Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust (QEH) Norfolk Hospice Tapping House	• IPOC must be reviewed **daily** to ensure it remains appropriate. • The Registered Nurse / Doctor / HCP's must sign serving as the record of accountability. • Nurses must also complete the Palliative Care Rounding document *and* the Clinical Risks Assessment Booklet. • Care Guidance Sheets support symptom control at EOL
Norfolk Community Health and Care NHS Trust (NCH+C)	• Registered Nurses, working within in-patient settings must sign this for each shift and community staff each visit, as this serves as the record of accountability.

All HCP's must enter specimen signature and initials below

Print Name	Signature	Initials	Designation	Ward/Department

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This individual plan of care supports the provision of dignity, comfort, sensitive communication and compassionate care in the last days or hours of life and will replace the Patient Care Record and Nursing Assessments and Plans of Care documents **If the patient lacks capacity his/her Next of Kin (NOK), Welfare Lasting Power of Attorney (LPA) or Independent Mental Capacity Advocate (IMCA) must be involved and supported to achieve a best interests decision regarding end of life choices**	
Mental Capacity Assessment (MCA)	

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Assess Mental Capacity

See (Trust Doc 10830)
Establish the involvement the patient wishes to have in decision making.

Establish who the patient wants involved in decisions and document details of

Mental Capacity Assessment Record

Decisions required

Stage 1	Yes	No
Does the patient have an impairment of, or disturbance to the functioning of the mind (If 'yes' please give details below)	☐	☐

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If 'No' the patient cannot be deemed to lack capacity

Stage 2	Yes	No
Can the person:		
1. Understand information about the decision	☐	☐
2. Retain and recall the information discussed?	☐	☐
3. Weigh up that information to come to a decision?	☐	☐
4. Communicate their decision by any means?	☐	☐

For those without capacity, please document all practicable steps that have been taken, without success, to enable the person to make a decision themselves.

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		Initial, Date, and Time
Does patient have an LPA?	☐ Yes ☐ No *If yes detail who that is*	
Name of person completing MCA assessment *print name*		

	Action *please tick all that apply and complete as appropriate*	*Initial, Date, and Time*
Advance Care Plan (ACP)		
Does the patient have an (ACP)? Discuss personal wishes identified that need to be addressed, including care needs after death	☐ Yes ☐ No *If yes document key actions to achieve ACP below* Please include details of any advance decision to refuse treatment or ReSPECT form	
Organ Donation		
Contact details for organ donation		
Donate Body to medical science	If patient wishes to donate their body to medical science e.g. University of East Anglia Patient Has the patient brought all relevant paperwork? ☐ Yes ☐ No	

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	Staff	Death documentation must be completed as soon as possible e.g. the 1st available shift. It is imperative that the paperwork is completed in 24 Hours
Medical decisions		
Doctor to document that routine observations can be discontinued	Unnecessary tests/observations stopped?	☐ Yes
	Document any tests or observations that are to be continued	*Document below*
	Is patient diabetic ☐ Yes ☐ No	*if yes see guidelines under pink poppy Icon*
	Medications have been rationalised? Remember to inform patient and those important to the patient of any medication changes.	☐ Yes

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	Action *please tick all that apply and complete as appropriate*		*Initial, Date, and Time*
Shared decision making			
Hydration			
Describe current hydration needs Discuss with patient / family Assess ability to take oral fluids Support the patient to drink if they wish and are able Decide whether clinically assisted hydration is appropriate Ensure regular mouth care is offered and given according to Trust policy for oral hygiene Trustdocs Id 11887?	Document plan to maintain hydration as appropriate	*Detail below*	
	Discuss any decision to stop artificial fluids	*Detail below*	
	Discuss any decision to commence artificial fluids	*Detail below*	
	Prescribe 2 hourly mouth care regularly ☐	*Detail below*	
	Nurses to provide an mouth care tray ☐	*Detail below*	

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Nutrition		
Follow guidance for 'at risk' feeding if appropriate Support patient to eat if they wish and are able Address any special dietary need**s**	Document any discussion regarding stopping feeds	*Detail below*
	Discuss with patient/NOK risks/benefits of eating	*Detail below*

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	Action *please tick all that apply and complete as appropriate*			*Initial, Date, and Time*
Medication				
Ensure anticipatory medications are prescribed as per Trustdocs Id 9883 as per flow charts	Drugs are prescribed for		*Tick if prescribed*	
	Pain	eGFR>60 use morphine	☐	
		eGFR 30-60 use Oxycodone	☐	
		eGFR<30 use Alfentanil	☐	
	Nausea and Vomiting	Levomepromazine	☐	
	Respiratory Tract Secretions	Buscopan (Hyoscine Butylbromide)	☐	
	Breathlessness	Opiate (as per eGFR)/midazolam	☐	
	Agitation	Midazolam	☐	
Syringe driver				

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Start a syringe driver if more than 2 anticipatory doses administered in 24 hours Trustdocs Id 9883	Syringe driver required?	☐ Yes ☐ No	
	Syringe Driver discussed with patient and those important to patient. *If yes detail any discussion*	☐ Yes ☐ No *Detail below*	
	Document time and date syringe driver commenced	*Detail below dd/mm/yyyy, and 24 hour clock)*	

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	Action *please tick all that apply and complete as appropriate*	*Initial, Date, and Time*
Patient Psychological / Spiritual Needs		
Psychological	Address and document psychological concerns if patient is conscious *Detail below*	
Spiritual Needs	Chaplaincy / faith support offered ☐ Yes ☐ Declined Referral made ☐ Yes	
Psychological / Spiritual needs of those important to the patient		
Assess religious, spiritual and psychological care needs of those important to the patient (inpatient units only)	Document any psychological concerns and support given *Detail below* Document children / young people or identifiable vulnerable adults needing support and actions taken? *Detail below*	
	Chaplaincy or other faith support offered? ☐ Yes ☐ Declined If yes tick if referral made ☐ Yes	
Facilities for those important to the patient		

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Ensure those important to the patient are aware of facilities available for them:	Ward contact details provided ☐ Yes Car parking facilities ☐ Yes Access to food and drink ☐ Yes Location of toilets and washing facilities ☐ Yes Overnight facilities ☐ Yes Offer carer's passport ☐ Yes Consent obtained for Butterfly Volunteer to visit ☐ Yes *Other please state*	

	Action *please tick all that apply and complete as appropriate*	*Initial, Date, and Time*
Care After Death - *this must be completed*		
Date and time of death	Date: Time:	
Doctor / Site Practitioner notified of death	Doctor / Site Practitioner has verified death? ☐ Yes	
Ensure those important to the patient are contacted and	Those important to patient contacted - *detail who was contacted.*	

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aware of the death as soon as possible (according to requests of those important to the patient).	Do those important to the patient wish to come to visit patient on the ward? If yes what arrangements have been made?	☐ Yes ☐ No *Detail below*
Provide Trust Bereavement booklet	Bereavement booklet provided?	☐ Yes ☐ No
Care after death procedures Trustdocs Id 1065	Care After Death Procedures performed?	☐ Yes
Contact the porters so the deceased patient can be moved to the mortuary	Notes sent with deceased patient? *If not detail why not*	☐ Yes ☐ No
	Document what has happened to patient belongings.	*Detail below*

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Recognise → Communicate → Involve → Support → Plan and Do	
All Health Care Professionals (HCPS) should document daily	
• **Daily assessment of symptoms and anticipatory medications** • **Prescribe / amend syringe driver if > 2 anticipatory doses administered** • **Daily review of hydration needs** • **Document any patient / relative concerns daily**	Initial and use staff type sticker and Date *dd/mm/yyyy* and Time *24 hours*

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