

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

*Patient Identifier Label*

**Ward**

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

<b>Instructions for completion</b>	<i>All HCP's must add their details at page 3</i>	<i>All sections must be completed</i>	<i>Document or tick as appropriate</i>	<i>For dates use dd/mm/yyyy and times use 24 hours clock</i>
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<b>Consultant or GP</b>	Print name		Signature		Date and time	
<b>Doctor completing plan</b>	Print name		Signature		Date and time	
<b>Recognition that the patient is dying: medical decisions</b> <i>tick when completed</i>						<i>Initial, Date, and Time</i>
Has it been a multidisciplinary decision that the patient may be in the last days of life?					<input type="checkbox"/>	
Have reversible causes of deterioration been excluded?					<input type="checkbox"/>	
Has the ceiling of ward based supportive care been discussed with the patient and /or family?					<input type="checkbox"/>	
Has a DNACPR decision been documented?					<input type="checkbox"/>	
Has the ReSPECT form been completed					<input type="checkbox"/>	
If yes, has this been this discussed with patient and those important to the patient?					<input type="checkbox"/>	
The senior clinician should discuss the rationale for starting the individual end of life care plan, what to expect and the estimated prognosis.					<input type="checkbox"/>	
The senior clinician should discuss the need for hydration and nutrition.					<input type="checkbox"/>	
<b>Wishes</b> <i>document</i>						
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						
<b>Document the name/s of relatives communicated with</b> <i>add name and relationship</i>						
<i>Name</i>	<i>Relationship</i>	<i>Name</i>	<i>Relationship</i>			

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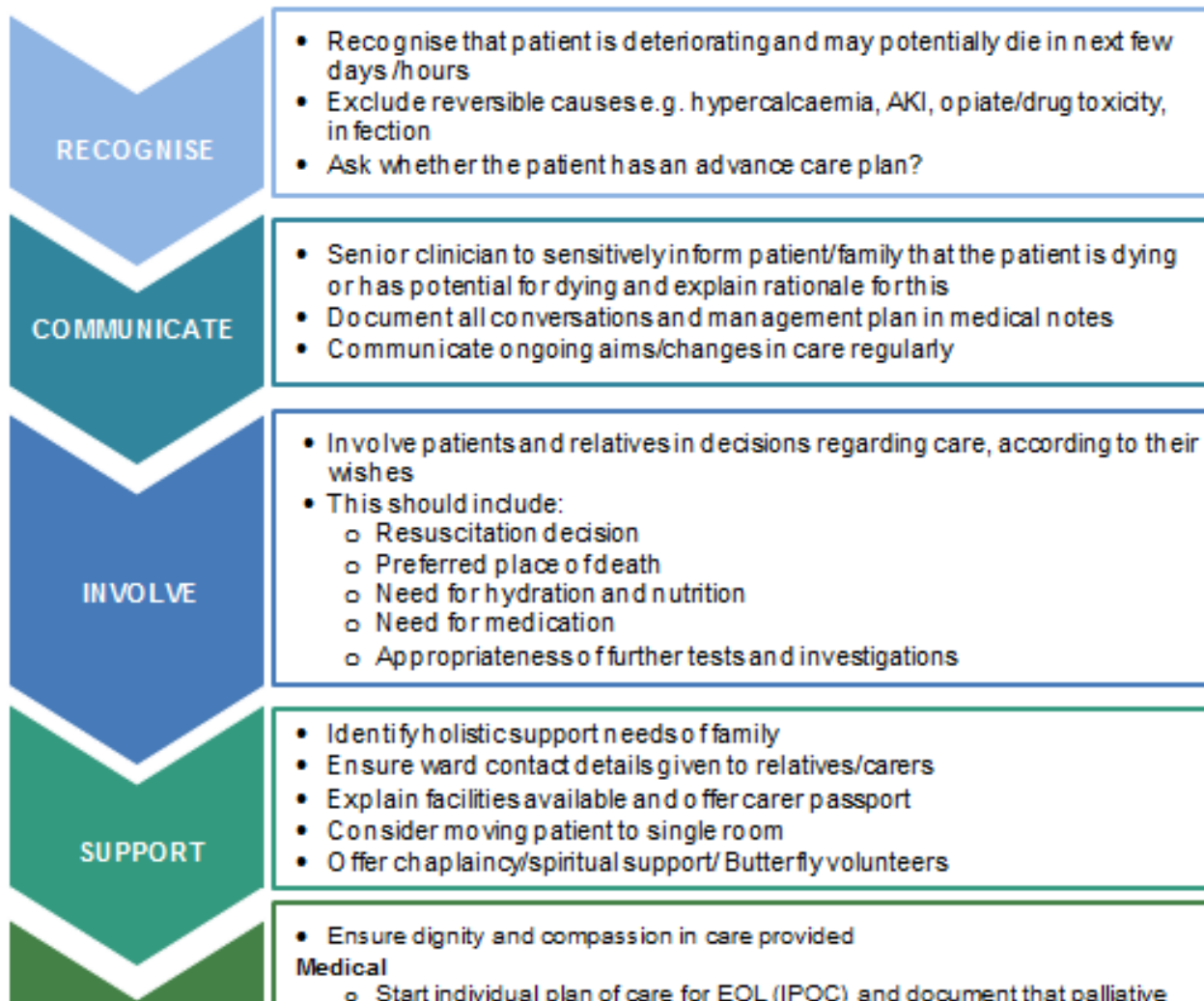
For actual document see Trustdocs ID: [Trustdocs ID: 10560](#)

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## Multidisciplinary Prompts for the Care of Patients at the End of Life



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

Author/s: Palliative Care Team

Approved by: PPPG

Available via Trust Docs

Version: 11.2

Author/s title: Palliative Doctors and Nurse

Date approved: 16/12/2020

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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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Mental Capacity Assessment Record	
Decisions required	
<b>Stage 1</b>	Yes      No
Does the patient have an impairment of, or disturbance to the functioning of the mind (If 'yes' please give details below)	<input type="checkbox"/> <input type="checkbox"/>
.....	
.....	
If 'No' the patient cannot be deemed to lack capacity	
<b>Stage 2</b>	Yes      No
Can the person:	
1. Understand information about the decision	<input type="checkbox"/> <input type="checkbox"/>
2. Retain and recall the information discussed?	<input type="checkbox"/> <input type="checkbox"/>
3. Weigh up that information to come to a decision?	<input type="checkbox"/> <input type="checkbox"/>
4. Communicate their decision by any means?	<input type="checkbox"/> <input type="checkbox"/>
For those without capacity, please document all practicable steps that have been taken, without success, to enable the person to make a decision themselves.	

**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



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		<i>Initial, Date, and Time</i>
Does patient have an LPA?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes detail who that is</i>	
Name of person completing MCA assessment <i>print name</i>		

<b>Action</b>		<i>Initial, Date, and Time</i>
<i>please tick all that apply and complete as appropriate</i>		
<b>Advance Care Plan (ACP)</b>		
Does the patient have an (ACP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes document key actions to achieve ACP below</i> Please include details of any advance decision to refuse treatment or ReSPECT form	
Discuss personal wishes identified that need to be addressed, including care needs after death		
<b>Organ Donation</b>		
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 <input type="checkbox"/> <input type="checkbox"/> 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
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**Medical decisions**

Doctor to document that routine observations can be discontinued	Unnecessary tests/observations stopped? <span style="float: right;"><input type="checkbox"/></span>
	Yes
	Document any tests or observations that are to be continued <span style="float: right;"><i>Document below</i></span>
Is patient diabetic	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>if yes see guidelines under pink poppy icon</i>
Medications have been rationalised? <span style="float: right;"><input type="checkbox"/></span>	Yes
Remember to inform patient and those important to the patient of any medication changes.	

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<b>Action</b>		<i>Initial, Date, and Time</i>
<i>please tick all that apply and complete as appropriate</i>		
<b>Shared decision making</b>		
<b>Hydration</b>		
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 <a href="#">Trustdocs Id 11887?</a>	Document plan to maintain hydration as appropriate <i>Detail below</i>	
	Discuss any decision to stop artificial fluids <i>Detail below</i>	
	Discuss any decision to commence artificial fluids <i>Detail below</i>	
	Prescribe 2 hourly mouth care regularly <input type="checkbox"/> <i>Detail below</i>	
	Nurses to provide an mouth care tray <input type="checkbox"/> <i>Detail below</i>	

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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 needs	Document any discussion regarding stopping feeds <span style="float: right;"><i>Detail below</i></span>
	Discuss with patient/NOK risks/benefits of eating <span style="float: right;"><i>Detail below</i></span>

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

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Start a syringe driver if more than 2 anticipatory doses administered in 24 hours <u>Trustdocs Id</u> <u>9883</u>	Syringe driver required? <div style="float: right;">                     Yes <input type="checkbox"/> No <input type="checkbox"/> </div>	
	Syringe Driver discussed with patient and those important to patient. <i>If yes detail any discussion</i> <div style="float: right;">                     Yes <input type="checkbox"/> No <input type="checkbox"/>  <i>Detail below</i> </div>	
	Document time and date syringe driver commenced <div style="text-align: right; font-size: small;"> <i>Detail below                      dd/mm/yyyy,                      and 24 hour clock)</i> </div>	

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

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Ensure those important to the patient are aware of facilities available for them:	Ward contact details provided	Yes <input type="checkbox"/>	
	Car parking facilities	Yes <input type="checkbox"/>	
	Access to food and drink	Yes <input type="checkbox"/>	
	Location of toilets and washing facilities	Yes <input type="checkbox"/>	
	Overnight facilities	Yes <input type="checkbox"/>	
	Offer carer's passport	Yes <input type="checkbox"/>	
	Consent obtained for Butterfly Volunteer to visit	Yes <input type="checkbox"/>	
<i>Other please state</i>			

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



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

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<b>Recognise → Communicate → Involve → Support → Plan and Do</b>	
<b>All Health Care Professionals (HCPS) should document daily</b>	
<ul style="list-style-type: none"><li>• <b>Daily assessment of symptoms and anticipatory medications</b></li><li>• <b>Prescribe / amend syringe driver if &gt; 2 anticipatory doses administered</b></li><li>• <b>Daily review of hydration needs</b></li><li>• <b>Document any patient / relative concerns daily</b></li></ul>	Initial and use staff type sticker and Date <i>dd/mm/yyyy</i> and Time <i>24 hours</i>



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