Documentation

Dignified Death

Guidence for End of Life Care in Critical Care Units

North of England Critical Care Network

Guidance on Documentation

Contents

All decisions should be discussed with the patient (if possible) and or relative / carer, allowing them to have an input into their care.

DD1: MDT Decision / Diagnosis of Dying

This document identifies what interventions are appropriate for the patient on an individual basis and allows for comment to justify the decision. The decision should not be made alone and it should be a multi-disciplinary discussion involving ITU consultant, parent team consultant and nursing staff.

The form also prompts the question of DNACPR decision, sign posting completion of documentation alongside the question of “Is the patient in the last few hours / days of life” sign posting them to the End of Life Guidelines.

This form should be review daily and if any changes then a new form completed with details.

Name: Hospital Number: Date:

MDT Decision / Diagnosing Dying

	YES	NO
Would Intravenous therapy be an appropriate treatment?		
If NO-why?		
Would enteral nutrition be an appropriate treatment?		
If NO-why?		
Would oral antibiotics be an appropriate therapy?		
If NO-why?		
Would intravenous antibiotics be an appropriate therapy?		
If NO-why?		
Would physiotherapy be an appropriate therapy?		
If NO-why?		
Would blood transfusion be an appropriate treatment?		
If NO-why?		
Would cardiovascular support with inotropes be an appropriate therapy?		
If NO-why?		
Would non-invasive ventilation be an appropriate therapy?		
If NO-why?		
Would invasive ventilation be an appropriate therapy?		
If NO-why?		
Would renal replacement therapy be an appropriate therapy?		
If NO-why?		
Would it be appropriate to defibrillate a "shockable" dysrhythmia in a monitored patient?		
If NO-why?		
Would CPR be an appropriate treatment?		
If NO-why?		
IS THIS PATIENT FOR A CARDIAC ARREST CALL?		
If **NO**, please complete a **DNACPR** form and file in the notes with discussion with the patient / family		
IS THE PATIENT IN THE LAST FEW DAYS / HOURS OF LIFE?		
If **YES** – commence **GUIDELINES FOR END OF LIFE CARE** If **NO** – review form daily or if the clinical condition alters or the patient views are changed		

Signature	Print Name	Position	GMC
Date	Time	Review Date	Time

Decisions reviewed: reconfirmation/cancelled/changed –if changed complete new form

Signed	Print Name	Date	Time

DD2: Initial Assessment

If the decision has been made that the patient is in the last few hours / days of life the initial assessment should be completed outlining the plan of care for the patient. As outlined earlier the focus changes from treatment to symptom control. Any specific considerations can be recorded on this assessment allowing the care to be individualised to the patient.

Name: Hospital Number: Date:

Initial Assessment (joint assessment by doctor and nurse)

DIAGNOSIS & BASELINE INFORMATION

Diagnosed as in last few days / hours of life by : (Name)

DOB:	**M/F:**	**Ethnicity:**

At the time of assessment is the patient:

	Y	N
In pain		
Agitated		
Vomiting		
Dyspnoeic		
Restless		
Distressed		
UTI problems		

	Y	N
Able to swallow		
Continent (bladder)		
Catheterised		
Continent (bowels)		
Constipated		
Aware		

	Y	N
Confused		
(Record below which is applicable)		
Conscious		
Semi-conscious		
Unconscious		
Intubated		
Respiratory Support		
Ventilated		
CPAP		
BIPAP (NIV)		
Face Mask		
Other:		

Experiencing respiratory tract secretions		
Experiencing other symptoms (e.g. oedema, itch) ……		

COMMUNICATION

	Y	N
The patient is able to take a full and active part in communication		
If NO –why?		
First Language:	**Interpreter Y/N –Contact Number:**	
Does the patient have:	**Y**	**N**
An Advanced Care Plan		
An Advanced decision to refuse treatment (ADRT)		
Does the patient have the capacity to make their own decisions at this moment in time?		
If **NO** - Consider the support of an IMCA –please document below.		
Name:	Contact details:	
The relative/carer is able to take a full and active part in communication		
If **NO** –why?		
The patient is aware that they are dying?		
Comment:		
The relative or carer is aware that they are dying.		
Comment		
Specialist Nurse for Organ Donation has been contacted?		
Comment		
Explored preferred place of death – if wish to go home refer to **Discharge Home to Die Guidelines**		
Comment		

Contact information:

1st Contact:	**At any time**		**Not at Night-time**	
Relationship	**Telephone**		**Mobile**	
2nd Contact:	**At any time**		**Not at Night-time**	
Relationship	**Telephone**		**Mobile**	

N:O:K: - if different from above.

Name:	**Contact Number:**

Name: Hospital Number: Date:

FACILITIES

The relative/ carer have had a full explanation for the facilities available to them and have been given the visitor information. (Car parking / beverages / accommodation)	**Y**	N

Comment:

SPIRITUALITY

The opportunity is given to patient / carers discuss what is important to them. (wishes, feelings, faith, values, organ donation) These are respected as far as practically possible.	Y	N

Comment:

Religion identified:	Chaplaincy Service offered:		

External support:	Name:	Contact No:	Date:

Comment:

Needs now:

Needs at death:

Needs after death:

MEDICATION

The patient has medication prescribed on a prn basis for the following symptoms which may develop in the last hours of life.		**Y**	**N**
Pain		Comment:	
Agitation			
Respiratory tract secretions			
Nausea / vomiting			
Dyspnoea			

Ensure the following is explained:

- **The patient is only receiving medication that the MDT agrees is beneficial at the time.**
- **Anticipatory prescribing in this manner will ensure that there is no delay in responding to a symptom if it occurs.**
- **Medicines for symptom control will only be given when needed, at the time and just enough and no more than is needed to help the symptom.**
- **That when new medication is commenced (especially via infusion) rationale for this will be explained.**

Comment:

Name: Hospital Number: Date:

Current Interventions

The patient's current interventions has been reviewed by the MDT and discussed with the patient, relatives/carer.	**Y**	**N**

Comment

	Currently not being taken / or given / or in place	**Discontinued**	**Continued**	**Commenced**
Routine Blood Tests				
Intravenous Antibiotics				
Blood Glucose Monitoring				
Recording of routine vital signs				
Oxygen therapy				
Physiotherapy				
I.V. vasoactive medications				
Electronic Monitoring /alarms				
Renal Replacement Therapy				
NG tube (gastric secretions)				
Current ventilatory support				

Current ventilator support:

Changes:

Silence alarms (remember apnoea alarm)

Comment:

Has patient has a DNACPR in place	YES		NO	
This has been explained and discussed with patient, relative or carer.	YES		NO	

Please complete the appropriate associated documentation according to the policy and procedure.
Comment:

Implantable Cardiovertor Defibrillator (ICD) is deactivated	YES		NO	
This has been explained and discussed with patient, relative or carer.	YES		NO	

Contact patient's cardiologist. Refer to the ECG technician and refer to local/regional – policy and procedure
Comment

Nutrition

The need for clinically assisted (artificial) nutrition is reviewed by MDT	YES		NO	

Comment:

Decision discussed with patient / relative / carer.	YES		NO	

Name: Hospital Number: Date:

Hydration

The need for clinically assisted (artificial) hydration is reviewed by MDT	YES		NO	

Comment:

Decision discussed with patient / relative / carer.	YES		NO	

Skin Care

The patient's skin integrity is assessed	YES		NO	

Risk Assessment score:				
Existing Pressure damage	YES		NO	
Mattress in use / type				
Frequency of positional changes				

Comment:

Explanation of Care

A full explanation of plan of care is explained to the patient.	**YES**		**NO**	

Comment:

A full explanation of plan of care is given to the relative / carer	**YES**		**NO**	

Name of relative(s) / Carer (s) present	**Relationship to patient**
Names of Healthcare professional present:	**Position**

Comment:

Communication log commenced and left at the patient's bedside	**YES**		**NO**	

Comment:

The patient's primary health care team / GP practice is notified that the patient is dying.	**YES**		**NO**	

Comment:

Please sign on completion of the initial assessment

Signature

Doctor's Name:		**Nurse's Name:**	
Position:		**Position:**	
Signature:		**Signature:**	
Bleep:		**Extension Number:**	
Date:		**Date:**	
Time:		**Time:**	

DD3: On-going assessment of the plan of care

This document allows all aspects of care to be assessed and any interventions recorded. The planned care should be assessed at least 4 hourly, if not more frequently on commencement of the End of life Guidance.

A full assessment should be undertaken and care reviewed if:

- There is **improved** conscious level, vital signs, functional ability, oral intake, mobility, ability to perform self-care.
- There are concerns expressed regarding management plan form patient, relative / carer or the team.
- It is **24 hours** since last full MDT assessment

Name: Hospital Number: Date:

ONGOING ASSESSMENT OF THE PLAN OF CARE

UNDERTAKE A MDT ASSESSEMENT & REVIEW THE CURRENT CARE PLAN IF:

Improved conscious level, vital signs, functional ability, oral intake, mobility, ability to perform self-care

AND / OR

Concerns expressed regarding management plan from patient, relative /carer or team

AND / OR

It is 24 hours since last full MDT assessment

PLANNED CARE SHOULD BE ASSESSED **AT LEAST 4 HOURLY**

	ASSESSMENT	COMMENT
A	The patient has pain	Verbalised by the patient if conscious, pain free on movement. Observe for non-verbal clues. Consider need for positional change. Use pain assessment tool if appropriate. Consider PRN analgesia for incident pain
B	The patient is agitated	Patient does not display any signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity
C	The patient does has respiratory tract secretions	Consider positional change. Discuss symptoms and plan of care with relative / carer. Medication to be given as soon as symptom occurs
D	The patient does have nausea	Verbalised by the patient if conscious
E	The patient is vomiting	Give medication as prescribed
F	The patient is receiving planned respiratory support	Monitor for signs of distress/ breathlessness. Amend the mode of basic or advanced respiratory support given as appropriate. Explain to the relative / carer.
G	The patient does have urinary problems	If catheterised is it patent and draining
H	The patient does have bowel problems	Monitor constipation / diarrhoea. Monitor skin integrity.
I	Medication is administered safely	Monitoring sheet for infusions. The patient is only receiving medication that is beneficial at this time.
J	The patient is receiving fluids as planned	The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration / distress. Consider IV therapy if in the patients best interest – if in place monitor and review rate / volume. Discuss with relative / carer
K	The patient is moist and clean	Adhere to mouth care policy. Relative / carer involved in care giving as appropriate.
L	The patient skin integrity is maintained	Assessment, cleansing, positioning, use of special aids (mattress / bed). Frequency of repositioning according to patients individual needs
M	The patients personal hygiene needs are met	Skin care, eye care, change of clothing according to individual needs. Relative / carer involved in care giving as appropriate.
N	Appropriate physical environment	Side ward if available. Well-fitting curtains, sufficient space at the bed side, silence / music, light / dark, nurse call bell available
O	Psychological well-being maintained	Staff just being at the bed side can be seen as a sign of support. Respectful, verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of communication log. Spiritual / religious / cultural needs – consider use of the chaplaincy team.
P	Relative / Carer well-being maintained	Just being at the bedside can be seen as a sign of support and caring. Consider spiritual / religious / cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative / carer. Listen and respond to worries / fears. Consider physical

TIME / DATE:

Code	Yes	No	Comment
A			
B			
C			
D			
E			
F			
G			
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J			
K			
L			
M			
N			
O			
P			

SIGN:

Name: Hospital Number: Date:

TIME / DATE	Code	Yes	No	Comment	SIGN:
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	P				

Comment

DD4: Daily Assessment

The documentation of the full MDT assessment to be completed daily and plan of care identified.

Name: Hospital Number: Date:

MDT Daily Full Assessment

DIAGNOSIS & BASELINE INFORMATION

Diagnosed as in last few days / hours of life by : (Name)

At the time of assessment is the patient:

	Y	N
In pain		
Agitated		
Vomiting		
Dyspnoeic		
Restless		
Distressed		
UTI problems		

	Y	N
Able to swallow		
Continent (bladder)		
Catheterised		
Continent (bowels)		
Constipated		
Aware		

	Y	N
Confused		
(Record below which is applicable)		
Conscious		
Semi-conscious		
Unconscious		
Intubated		
Respiratory Support		
Ventilated		
CPAP		
BIPAP (NIV)		
Face Mask		
Other:		

Experiencing respiratory tract secretions		
Experiencing other symptoms (e.g. oedema, itch)		

CURRENT INTERVENTIONS

	Currently not being taken / or given / or in place	Discontinued	Continued	Commenced
Routine Blood Tests				
Intravenous Antibiotics				
Blood Glucose Monitoring				
Recording of routine vital signs				
Oxygen therapy				
Physiotherapy				
I.V. vasoactive medications				
Electronic Monitoring /alarms				
Renal Replacement Therapy				
NG tube (gastric secretions)				
Artificial Nutrition				
Artificial Hydration				
Current ventilatory support				

Changes:

Silence alarms (remember apnoea alarm)

Comment:

PLAN OF CARE

Plan:

Name: Hospital Number: Date:

EXPLANATION OF CARE

Patient in the last hours/days of life?	**YES**		**NO**	

IF **YES** continue with End of Life Guidelines
If **NO** discontinue End of Life Guidelines – review DNACPR

A full explanation of plan of care is given to the relative / carer	**YES**		**NO**	

Name of relative(s) / Carer (s) present	**Relationship to patient**
Names of Healthcare professional present:	**Position**

Comment:

Communication log completed	**YES**		**NO**	

Comment:

Please sign on completion of the initial assessment

SIGNATURE

Doctor's Name:		**Nurse's Name:**	
Position:		**Position:**	
Signature:		**Signature:**	
Bleep:		**Extension Number:**	
Date:		**Date:**	
Time:		**Time:**	

DD5: Communication Log

Communication is an important aspect of care for patient and / or relative / carer. The use of a communication log can improve the communication between the healthcare professionals and the family. The aim of the log is to record all communication of relevant information pertaining to the care of the patient, and also can be used by the family to write down any questions they may have. It should be recognised that the death of a loved one is a stressful time and the ability to retain and or process information can be altered. The use of the log allows the family to read the information that has been given to them allowing them to process what has been said in their own time. It also allows other members of the family to be aware of exactly what has been said. Another aspect of the communication log is that it can be used as a tool for the family to ask any questions, as they can write them down as they think of them and also they may find it difficult to voice the questions they would like answering.

You matter because you are you, you matter to the last moment of your life and we will do all we can to let you die peacefully.
Dame Cicely Saunders

Patient Name:

Communication Log

The purpose of the communication log is to improve communication between the healthcare professionals and the family.

How to use it:

Healthcare professionals:

- Record any conversations / discussions that you have with the patient, relative or carer.
- Do not use medical terminology

Patient / relative / carer

- Used to recap information that you have just been given, helps you to process it in your own time
- Allows other family members to see what has been said
- Allows you record any questions you may like to ask but slipped your mind or that you didn't want to voice.

The document will be kept by the bedside allowing ease of access.

This is not to replace face to face communication but to be used to augment the communication process.

Date	Comment	Sign

Date	Comment	Sign

Date	Comment	Sign

Date	Comment	Sign

Date	Comment	Sign