Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

# 'Getting it right for me' Personalised Care Plan

Name:
NHS/Hospital No:
Address:

Date of birth:

**To the patient / carer,**

This is the second part of your care plan where we record the issues that are impacting you the most at present. A Registered Nurse will assess your physical, spiritual, social and psychological needs and develop a plan with you to reduce any symptoms or causes of anxiety or distress.

We hope that you will feel part of the process of planning and delivering your care but if your circumstances change or if you have any questions, please ask to speak with the Doctor or Nurse named on the front of this document. If you want to feedback about any element of your care, please contact us or ask to speak to the PALs team on 01296 316042

**The Chief Nurse**

**To the clinician:** This second part of the care plan compliments the patient held record of their needs and preferences at this time.

Please refer to the patient held record in completing this assessment

Please use this care plan to record a compete assessment of the patient's physical, psychological, social and spiritual needs. It is designed to be used in support of a safe and compassionate multidisciplinary process of care for patients who have been identified as being near the end of life.

Each individual must have an individual care plan according to their needs. The plan should be discussed openly with the person and those identified as important to them. This plan must be reviewed whenever the patient's condition changes or at least weekly. **If the patient is discharged from hospital, this plan should go home with the patient and a copy of this document must be placed in the patient's clinical notes**

Responsible GP/ Consultant for your care:

Signature: Date:

Designation:

Name of assessing clinician:

Signature: Date:

Designation:

# Nursing Assessment

This part of the document is designed to provide the assessing RN and the wider care team with a person centred care plan for people identified as being in their last days and hours of life, to ensure we achieve the national five priorities of care. We will:


- ✓ You should **assess** each aspect of the patient's needs. Where one or more is not applicable, please say why in the care plan
- ✓ Some core assessment tools are included with this bundle however you should ensure that you add in any other assessments documents where indicated (for e.g. bedrails, falls, etc).
- ✓ Where the patient's condition changes, **record** your re-assessment of need and ensure the care plan actions are updated as required.
- ✓ For each aspect of the care plan, you should **evaluate** the outcomes of the care in the continuation notes in the patient record.
- ✓ Please ensure that the care plan is **reviewed daily.**
- ✓ Any record of care given whether nursing, therapy or medical should be written in the continuation notes within the patient's folder. **Do not make duplicate entries in the patient notes**
- ✓ Remember that communication with the patient, their carers or family members is vitally important. **All conversations must be recorded in the notes**
- ✓ Please ensure that you offer a copy of the Trust information on end of life care and bereavement to all family members/carers, and ensure that they have been made **aware of the support on offer**

| | |
|---|---|
| **Date of first assessment** | |
| **Name** | |
| **Signature** | |

| | |
|---|---|
| **Date of re-assessment** | |
| **Name** | |
| **Signature** | |

# Nursing Assessment (1)

| **Category**<br>Please assess each category of need. If any category is not applicable please record why | **Assessment**<br>Please use the relevant assessment tools included in this care plan | **Plan of action**<br>Please ensure that all actions prescribed are person centred, specific, measureable, achievable, realistic and timed. Ensure you discuss each aspect of this plan of care with the patient or carer |
|---|---|---|
| **Pain management**<br>If the patient has pain, ensure background analgesics are prescribed as per BHT guidelines.<br>Consider use of a syringe driver for persistent pain and give breakthrough medication as clinically indicated. A pain assessment tool and copy of the decision support tool has been included towards the rear of the care plan | **Baseline assessment** | |
| | **Review assessment** | |
| **Breathing & circulation**<br>If the patient is breathless consider using a fan or postural changes and medication to relieve distress.<br>**You should only be recording regular observations (i.e. NEWS) if clinically indicated and in the patients best interests** | **Baseline assessment** | |
| | **Review assessment** | |

# Nursing Assessment (2)

| **Category**<br>Please assess each category of need. If any category is not applicable please record why | **Assessment**<br>Please use the relevant assessment tools included in this care plan | **Plan of action**<br>Please ensure that all actions prescribed are person centred, specific, measureable, achievable, realistic and timed. Ensure you discuss each aspect of this plan of care with the patient or carer |
|---|---|---|
| **Eating and drinking**<br>The patient should be supported to eat and drink as long as they wish. Use modified diet and fluids if this alleviates symptoms or makes eating and drinking more comfortable. Commencing IV or SC fluids is a clinical decision made with reference to specialist input and in the best interests of the patient taking into account the patient's views or the views of those speaking for them | **Baseline assessment** | |
| | **Review assessment** | |
| **Nausea and vomiting**<br>If the patient has nausea or vomiting ensure antiemetics are prescribed as per BHT guidelines which can be found towards the rear of the care plan. If unable to swallow, consider the use of a syringe driver with breakthrough medication as clinically indicated. | **Baseline assessment** | |
| | **Review assessment** | |

# Nursing Assessment (3)

| **Category**<br>Please assess each category of need. If any category is not applicable please record why | **Assessment**<br>Please use the relevant assessment tools included in this care plan | **Plan of action**<br>Please ensure that all actions prescribed are person centred, specific, measureable, achievable, realistic and timed. Ensure you discuss each aspect of this plan of care with the patient or carer |
|---|---|---|
| **Elimination**<br>Monitoring of bowel movements and urinary output is a clinical decision made in the best interests of the patient and in support of active treatment. Consider use of interventions to promote patient comfort (for e.g. suppositories to relieve constipation or catheters to relieve retention) | **Baseline assessment** | |
| | **Review assessment** | |
| **Personal hygiene**<br>Manage hygiene needs in line with patient preference and your assessment of care. | **Baseline assessment** | |
| | **Review assessment** | |

# Nursing Assessment (4)

| **Category**<br>Please assess each category of need. If any category is not applicable please record why | **Assessment**<br>Please use the relevant assessment tools included in this care plan | **Plan of action**<br>Please ensure that all actions prescribed are person centred, specific, measureable, achievable, realistic and timed. Ensure you discuss each aspect of this plan of care with the patient or carer |
|---|---|---|
| **Skin and pressure area care**<br>You should have an up to date Waterlow Assessment and ensure that pressure areas are supported as indicated by that assessment. Please use the BHT Waterlow Assessment chart that has been included towards the rear of this care plan | **Baseline assessment** | |
| | **Review assessment** | |
| **Secretions**<br>Once postural changes have been tried, refer to BHT guidelines for appropriate medication to treat excess secretions. A copy of the BHT decision support tools for treating secretions can be found towards the rear of this care plan | **Baseline assessment** | |
| | **Review assessment** | |

# Nursing Assessment (5)

| **Category**<br>Please assess each category of need. If any category is not applicable please record why | **Assessment**<br>Please use the relevant assessment tools included in this care plan | **Plan of action**<br>Please ensure that all actions prescribed are person centred, specific, measureable, achievable, realistic and timed. Ensure you discuss each aspect of this plan of care with the patient or carer |
|---|---|---|
| **Agitation**<br>If the patient is agitated, assess to exclude reversible causes (for e.g. retention of urine).<br>Consider medication as clinically indicated and once all reversible causes have been eliminated<br>A copy of the BHT decision support tools for treating agitation can be found towards the rear of this care plan | **Baseline assessment** | |
| | **Review assessment** | |
| **Spiritual and / or psychological well being**<br>Ensure to ask the patient how you can best support them in meeting any spiritual or religious needs. Contact details for the Chaplaincy team can be found at the end of this document.<br>Consider using the 'Distress Thermometer' which can be found towards the rear of the care plan to help the patient express their own care needs | **Baseline assessment** | |
| | **Review assessment** | |

# Nursing Assessment (6)

| **Category**<br>Please assess each category of need. If any category is not applicable please record why | **Assessment**<br>Please use the relevant assessment tools included in this care plan | **Plan of action**<br>Please ensure that all actions prescribed are person centred, specific, measureable, achievable, realistic and timed. Ensure you discuss each aspect of this plan of care with the patient or carer |
|---|---|---|
| **Care after death**<br>Staff must find out from the dying person, their family and those important to them, the details of any cultural or religious-specific requirements about what constitutes respectful treatment of the body after death.<br>As soon as possible after the death of the person, and depending on the family's wishes, a health care professional should attend the person to ensure their body is appropriately cared for according to Trust policy and the immediate practical and emotional needs of those present are attended to. | **Baseline assessment** | |
| | **Review assessment** | |
| **Support for those closest to the patient**<br>Assess and address (if possible) the needs of families and those important to the dying person, and offer information about access to other sources of help and support.<br>Family or important others who wish to participate in caring for the dying person must be supported by staff to do so, e.g. by showing them simple practical techniques, but assumptions must not be made about their ability or wish to do so | **Baseline assessment** | |
| | **Review assessment** | |

# Assessment tools and guidance

This section contains Trust approved assessment tools and symptom management guidance for staff to use in meeting the needs of patients approaching the end of life.

The tools contained in this section should be used to support the development of person centred aims for each aspect of the care plan and referred to when reviewing progress against the plan.

**Distress Thermometer**
The Distress Thermometer is a tool that the patient can use to talk to clinicians about their distress. It has a scale on which the clinician or the patient can circle the level of distress and indicate the parts of life in which there are problems. The Distress Thermometer can be used to help establish if the patient requires supportive services such as chaplains, social workers, counsellors, and others.

**Waterlow Assessment**
The Waterlow Assessment chart should be completed for every patient as per existing BHT policy and appropriate measures put in place to maximise patient comfort and reduce harm

If you have any questions about the assessment tools or guidelines contained in this section of the care plan, please contact the Specialist Palliative Care team.

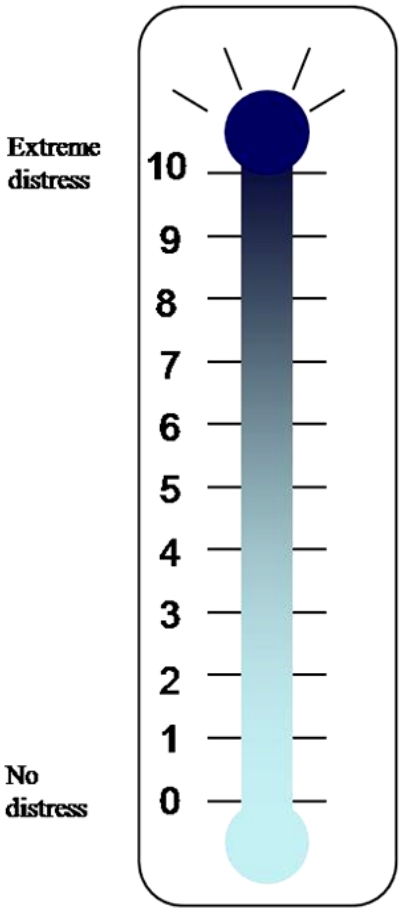
**Abbey Pain Scale**
The Abbey Pain Scale is best used as part of an overall pain management plan and is designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.
The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

**Wong and Baker Pain Scale**
The Wong Baker Facial Grimace tool may be used to establish how much pain the patient is in and how debilitating it is. It provides visual cues that may be used by the assessing clinician or the patient to indicate their level of pain

**Symptom management protocols**
The decision support algorithms at the end of the document are part of the Trust approve guideline for good end of life care. A full range of anticipatory medicines should be prescribed according to the standards laid down.

# Screening for distress

**1.** Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.




**2.** Please tick WHICH of the following is a cause of distress.

**Practical Problems**
- ☐ Childcare
- ☐ Housing
- ☐ Money
- ☐ Transport
- ☐ Work/School

**Family Problems**
- ☐ Dealing with partner
- ☐ Dealing with children
- ☐ Dealing with family problems
- ☐ Dealing with friends

**Emotional Problems**
- ☐ Depression
- ☐ Fears
- ☐ Nervousness
- ☐ Sadness
- ☐ Worry
- ☐ Anger
- ☐ Numbness

**Spiritual/Religious Concerns**
- ☐ Loss of faith
- ☐ Relating to God
- ☐ Loss of meaning or purpose of life

**Physical Problems**
- ☐ Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Tiredness
- ☐ Sleep
- ☐ Feeling swollen
- ☐ Getting around
- ☐ Bathing / Dressing
- ☐ Sexual
- ☐ Appearance
- ☐ Breathing
- ☐ Appetite
- ☐ Eating
- ☐ Mouth sores
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Passing urine
- ☐ Fevers
- ☐ Night sweats
- ☐ Hot flushes
- ☐ Skin dry / itchy
- ☐ Nose dry / congested
- ☐ Tingling in hands / feet
- ☐ Change in taste

**3.** Then rank your top 4 most distressing i.e. 1= most distressing etc:

## WATERLOW (2005) Pressure Ulcer Prevention Risk Assessment

Buckinghamshire Healthcare NHS
NHS Trust

Patient label

| | | Score | date | date | date | date |
|---|---|---|---|---|---|---|
| **Build/weight for Height** | | | | | | |
| Average-BMI 20-24.9 | 0 | | | | | |
| Above average-BMI 25-29.9 | 1 | | | | | |
| Obese-BMI >30 | 2 | | | | | |
| Below average- BMI-<20 | 3 | | | | | |
| **Continence** | | | | | | |
| Complete/catheterised | 0 | | | | | |
| Urinary incontinence | 1 | | | | | |
| Faecal incontinence | 2 | | | | | |
| Urinary + faecal incontinence | 3 | | | | | |
| **Skin Type Visual Risk Areas** | | | | | | |
| Healthy | 0 | | | | | |
| Tissue paper | 1 | | | | | |
| Dry | 1 | | | | | |
| Oedematous | 1 | | | | | |
| Clammy, pyrexia | 1 | | | | | |
| Discoloured category 1 | 2 | | | | | |
| Broken / Spots category 2-4 | 3 | | | | | |
| **Mobility** | | | | | | |
| Fully | 0 | | | | | |
| restless/fidgety | 1 | | | | | |
| Apathetic | 2 | | | | | |
| Restricted | 3 | | | | | |
| Bed bound e.g. traction | 4 | | | | | |
| Chair bound e.g. wheelchair | 5 | | | | | |
| **Age / Sex** | | | | | | |
| Male | 1 | | | | | |
| Female | 2 | | | | | |
| 14-49 | 1 | | | | | |
| 50-64 | 2 | | | | | |
| 65-74 | 3 | | | | | |
| 75-80 | 4 | | | | | |
| 81+ | 5 | | | | | |
| **Subtotal from left side** | | | | | | |
| **Total Score** | | | | | | |
| **Initial of Nurse** | | | | | | |

| | | Score | date | date | date | date |
|---|---|---|---|---|---|---|
| **Tissue Malnutrition** | | | | | | |
| Terminal Cachexia | 8 | | | | | |
| Multi-organ failure | 8 | | | | | |
| Single organ failure (resp, cardiac, renal) | 5 | | | | | |
| Peripheral Vascular Disease | 5 | | | | | |
| Anaemia > Hb8 | 2 | | | | | |
| Smoking | 1 | | | | | |
| **Neurological Deficits** | | | | | | |
| Diabetes, MS, CVA | 4-6 | | | | | |
| Motor/Sensory | 4-6 | | | | | |
| Paraplegia | 4-6 | | | | | |
| **Medication** | | | | | | |
| Cytoxic, Long term steroids, anti-inflamatory (score 1 pt each - max of 4) | 1-4 | | | | | |
| **Major surgery/Trauma** | | | | | | |
| Orthopaedic spinal | 5 | | | | | |
| On table >2hrs # | 5 | | | | | |
| On table >6hrs # | 8 | | | | | |
| # scores can be discounted after 48 hrs provided pt is recovering normally | | | | | | |
| **Malnutrition screening tool (MUST)** | | | | | | |
| **A**- Has the patient lost weight recently? YES-go to **B** NO-go to **C** UNSURE go to **C** & score 2 | | | | | | |
| **B**- Weight loss score | | | | | | |
| 0.5-0.5kg | 1 | | | | | |
| 5-10kg | 2 | | | | | |
| 10-15kg | 3 | | | | | |
| >15kg | 4 | | | | | |
| Unsure | 2 | | | | | |
| **C**-Patient eating poorly or lack of appetite | | | | | | |
| Yes | 0 | | | | | |
| No | 1 | | | | | |
| Unsure | 2 | | | | | |
| **Subtotal from Right side** | | | | | | |

Score- 10+ At Risk 15+ High Risk 20+ Very high Risk Perform initial assessment within 6 hours of admission or on first visit. Reassess if condition changes or weekly for inpatients. If patient is long term every 1-3 months depending on age and underlying condition.

# Wong-Baker Facial Grimace Scale


The Wong Baker Facial Grimace tool may be used to establish how much pain the patient is in and how debilitating it is. The assessing RN should explain to the person that each face is for a person who has no pain (hurt) or some pain, or a lot of pain.

Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little bit more.
Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain.

If you use this tool to assess the patient's pain, you should record your assessment of the patient's pain at least four hourly and up to hourly if indicated by the patient's pain

**Please record your assessment in the continuation sheets in the patient's record**

If the patient's pain does not respond to the interventions described in the care plan, seek specialist advice from the Palliative Care team

# Abbey Pain Scale

**For measurement of pain in patients who cannot verbalise**

**How to use scale:** While observing the patient, score questions 1 to 6.

**Name of patient:**.....

**Name and designation of person completing the scale:**.....

**Date:** ..... **Time:**.....

**Latest pain relief given was** ..... at .....hrs.

**Q1. Vocalisation**
eg whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

**Q2. Facial expression**
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

**Q3. Change in body language**
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

**Q4. Behavioural change**
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

**Q5. Physiological change**
eg temperature, pulse or blood pressure outside normal limits,perspiring,flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

**Q6. Physical changes**
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002.

| 0-2 no pain | 3-7 mild | 8-13 moderate | 14+ severe |
|---|---|---|---|

If you use the Abbey Pain Scale to assess your patient's pain, you should do so every four hours and up to hourly if the patient's pain indicates. Record your assessment **in the continuation sheets in the patient's record as outlined** below.

1. Record the assessment date and time
2. Add scores from Q1-6 above
3. Record the total pain score and score description from the chart above
4. Record your assessment of what type of pain the patient may be experiencing using the phrases -
    a. Acute;
    b. Chronic; or
    c. Acute on chronic

If the patient's pain does not respond to the interventions described in the care plan, seek specialist advice from the Palliative Care team

## End of Life Care Symptom Control Guidelines

### SECRETIONS

**Are they a problem now?**

**YES**

1) Give hyoscine butylbromide (Buscopan®)* 20 mg s/c injection and consider syringe driver of 60 mg over 24 hours using water for injections or sodium chloride 0.9% as the diluent.

2) If symptoms persist, give further 20 mg boluses at a minimum interval of 4 hours and up to a maximum of two.

3) If not effective, consider other potentially treatable symptoms caused by, e.g.:
- Infection
- Heart failure
- Parenteral fluids

and manage appropriately.

4) If symptoms persist, seek advice from specialist Palliative Care Team via switchboard or Medicines Information on 01494 425 355.

**NO**

It has the potential to become a problem, therefore:

1) Prescribe hyoscine butylbromide (Buscopan®) 20 mg prn s/c - give 1 or 2 boluses at 4 hourly intervals. Do not repeat if ineffective.

2) If two or more prn doses have been required, consider syringe driver over 24 hours.

**Syringe driver compatibilities**

For advice on syringe driver compatibilities contact:
- Specialist Palliative Care Team via Trust switchboard

or
- Medicines Information on 01494 425 355

*unlicensed indication

## End of Life Care Symptom Control Guidelines

### PAIN

**PATIENT IS IN PAIN**

**Is patient already taking oral morphine?**

**YES**

1) Give prn morphine dose s/c.

Divide total daily dose of oral morphine by two to get morphine dose for syringe driver over 24 hours. Use water for injection or sodium chloride 0.9% as diluent.

Prescribe prn dose of morphine which should be 1/6$^{th}$ of 24 hour dose in syringe driver.

2) Review after 24 hours and adjust syringe driver to give the same dose as the total dose needed in the previous 24 hours.

**NO**

1) Give morphine 2.5 - 5 mg prn s/c.

2) If needed repeat morphine 2.5 - 5 mg s/c after a minimum interval of 2 hours.

3) Review after 24 hours. If two or more prn doses have been needed, then consider a syringe driver over 24 hours. Start with the total dose needed in the previous 24 hours.

**PATIENT'S PAIN IS CONTROLLED**

**Is patient already taking oral morphine?**

**YES**

1) To convert a patient from oral morphine to a 24 hour s/c morphine infusion:

**Divide total daily dose of oral morphine by two**, e.g:

Zomorph® 30 mg 12 hourly **orally** = 60 mg/24 hours **orally** = 30 mg/24 hours s/c.

2) Prescribe prn dose of morphine which should be 1/6$^{th}$ of 24 hour dose in syringe driver, e.g.: morphine 30 mg/24 hours = prn dose of 5 mg s/c.

**NO**

1) Give morphine 2.5 - 5 mg prn s/c.

2) Review after 24 hours. If two or more prn doses have been needed, then consider a syringe driver over 24 hours.

**Syringe driver compatibilities**
For advice on syringe driver compatibilities contact:
- Specialist Palliative Care Team via Trust switchboard

or
- Medicines Information on 01494 425 355

**To convert from other opioids, or for any other advice if pain is not controlled, please contact the specialist Palliative Care Team via switchboard or Medicines Information on 01494 425 355.**

## End of Life Care Symptom Control Guidelines

### NAUSEA AND VOMITING

**Is this a problem now?**

**YES**

1) Give haloperidol 1.5 mg s/c injection stat.

2) Repeat dose every six hours, if needed (max. three times daily)

3) Review after 24 hours. If patient has needed two or more doses in 24 hours, consider starting a syringe driver to give 3 – 5 mg over 24 hours. The diluent to use is water for injection.

4) If symptoms persist despite the syringe driver, seek advice from specialist Palliative Care Team via switchboard.

**NO**

It has the potential to become a problem, therefore:

1) Prescribe haloperidol 1.5 mg s/c prn 6 hourly

**Syringe driver compatibilities**

For advice on syringe driver compatibilities contact:

- Specialist Palliative Care Team via Trust switchboard

or

- Medicines Information on 01494 425 355

## End of Life Care Symptom Control Guidelines

### RESTLESSNESS AND AGITATION

**Is this a problem now?**

**YES**

1) Give midazolam* 2.5 mg - 5 mg s/c injection and repeat as needed at a minimum interval of 1 hour. If doses >30 mg needed, seek advice from Palliative Care Team.

2) Review after 24 hours. If patient has needed 2 or more prn doses, consider syringe driver over 24 hours, starting at 10 – 15 mg with sodium chloride 0.9% or water for injection as the diluent. Continue to give prn doses if needed.

3) Adjust the dose in the syringe driver daily, according to prn doses which have been needed.

4) If symptoms persist, seek advice from specialist Palliative Care Team via switchboard or Medicines Information on 01494 425 355.

**NO**

It has the potential to become a problem, therefore:

1) Prescribe midazolam prn 2.5 mg – 5 mg s/c at a minimum interval of 1 hour to a max. dose of 30 mg/24 hours.

**Syringe driver compatibilities**

For advice on syringe driver compatibilities contact:

- Specialist Palliative Care Team via Trust switchboard

or

- Medicines Information on 01494 425 355

*unlicensed indication