MY CARE PLAN

To support a person who is thought to be in the last days and hours of life.
It is a template to demonstrate meeting the 5 key priorities for care of the dying person.
(ref: 'One Chance to get it Right' Report, DOH 2014)

GP'S – WHAT ARE WE ASKING YOU TO DO?

Page 10 Please complete the **MDT assessment** and **medical management plan (page 10).** This communicates to all that you are leading and planning the medical care for someone who is thought to be dying. These sections are really important and need to be completed.

MDT assessment – this is where you document why you think that the person is thought to be in the last days and hours of life. For example: current condition, reasons for deterioration, current symptoms, are they eating and drinking?

Medical management plan – this is where you guide a person's care from a medical perspective. Consider the following:

- Nutrition and hydration
  - Can they still eat and drink despite being high risk aspiration? The aim is quality of life and may involve a best interest discussion/decision.
  - Do they need subcutaneous fluids with a planned review?
  - Please document decision making specifically around this subject and any conversations that you may have had with carers and family members (may be documented as a best interest discussion)

- Medication review
  - Are they still able to take oral medications?
  - Are all medications relevant at this point?

- Do you still want to monitor observations, blood sugars etc.?

- ICD insitu? If yes would it be appropriate to deactivate the shock

- DNACPR decision made? If CPR is of no clinical benefit is this recorded in the medical notes and has a regional form been completed to communicate this decision?

- Consider preferred place of care and any advance care planning that may have been completed previously or conversations about future care that may have been shared with you.

The above should be discussed with the dying person (if appropriate) and those important to them to ensure good communication.

Page 11 Asks you to **prescribe pre-emptive medication** in line with local guidance (in symptom management section of folder) and best practice.

Page 11 Asks who has been involved in the assessment and planning and who this has been discussed with. Please fill in if you have had these discussions.

Page 11 Asks the **senior doctor** responsible for care **to sign**. This is a requirement of My Care Plan and in line with the 5 key priorities as set out in the 'One Chance to get it Right' report.

Care UK form needs completing and faxing – who will do this?