My care plan

Name: ……

NHS no: ……

Preferred name: ……

This document contains confidential information and should not be read without the consent of the person named above.

In partnership with:
South West Yorkshire Partnership NHS Foundation trust
Barnsley Hospital NHS Foundation Trust

Barnsley Hospital Quality in Care

BARNSLEY Hospice

With all of us in mind.

About your care

This care plan will help to support, guide and record your care. The doctors and nurses caring for you will have discussed and agreed it with you and/or those important to you. They will also have explained the changes in your condition. It is so important that we provide care which is right for you and supports your comfort and dignity. If you have any questions or concerns, please speak to your doctor or nurse.

Those caring for you in the last days of your life will always aim to:

- Provide care with respect, kindness, compassion and dignity.
- Discuss and record your wishes and preferences about your treatment and care if you choose and are able to do so.
- Provide the opportunity for your family and those important to you to be involved in discussions about your care unless you have previously stated you do not want this. However, they cannot give legal consent on your behalf.
- Provide care which is coordinated and with your permission, share key information about your care, treatment and preferences with other people involved.
- Ensure you know which senior doctor and registered nurse are responsible for your care.
- Involve you in any decision making. If you are concerned that the decision being made is not right, then you can request a second opinion.
- Regularly assess any changes in your condition and take appropriate action according to your needs.
- Ensure your family and those important to you have their own needs addressed.
- Encourage and help you to eat or drink if you are able and wish to do so. If you are unable to eat or drink a decision about giving fluid/food by a drip or tube will be considered by the nurses and doctors looking after you. Your preferences will be at the centre of this decision. They will consider what is best for your comfort and discuss this with your family and those important to you if appropriate.
- Give medicines promptly to help manage your symptoms (such as pain or sickness) if needed.
- Inform your family and carers how to seek help should you need it.
- Ask for specialist advice and help if needed.
- Respect any cultural or faith, wishes and beliefs you may have.

Recognition of the possibility that a person may die within the next few days or hours

People whose condition is changing and deteriorating, must be identified, promptly reassessed, pre-existing care and treatment plans consulted and care and treatment goals re-evaluated. This must be done in consultation with the person (where possible), their families and those important to them (where present or contactable) and other members of the team who may have information to contribute. It is important to consider at this point any specific features of their underlying condition(s).

Recognition that a person may be in the last days or hours of life, is complex and uncertain. Decisions about their treatment and care should be made by the senior responsible clinician in conjunction with the person and other members of the multidisciplinary team and in consultation with their family and carers. Any potentially reversible causes for the person's condition should be identified. This could include dehydration, infection, opioid toxicity, hypercalcaemia, renal failure.

If the doctor judges that the change in condition is potentially reversible, prompt action must be taken to attempt this provided that this is in accordance with the person's wishes or in their best interests, if it is established that they lack capacity to make the decision about treatment at that time.

If the doctor judges that the person is likely to be dying, taking into account the views of others caring for the person, a plan of care must be developed to meet the person's own needs and wishes. This should include how their care should be managed and any treatment preferences they may want to express.

The plan must include attention to symptom control and the person's physical, emotional, psychological, social, spiritual and religious need, support the person to eat and drink as long as they are able and wish to do so and ensure that their comfort and dignity are prioritised. There must be on-going review of the care plan.

The care plan must be clearly and sensitively communicated to the person (where possible) and those important to them.

Useful contact numbers

Community

Right Care Barnsley /Single Point of Access (SPA)	01226 644575
Crisis Response team Out of hours via SPA	
Community Palliative Care Service (Macmillan Service)	01226 644575
9am – 4.45pm Mon – Fri Sat, Sun & bank holidays	
Community Matrons 8.45am – 4.45 pm 7 days	01226 644575
Supportive Care at Home Service	01226 645281
I Heart, Out of hours GP Service	01226 242419
Community Equipment Stores	01226 645400
PalCall (Out of hours palliative care telephone advice service)	01226 244244

Barnsley Hospital

End of life care team (including fast track discharge)		01226 435489
8.30am - 4.30pm Mon - Fri		
Specialist Palliative Care Service	9am – 5pm, 7day service	01226 434921
Comfort care pack and equipment	6am – 6pm	2451
	6pm – 6am	1109 via porters
Chaplaincy & chapel		01226 432725
PALS (Patient advice and liaison service)		01226 432430
Pall Call (Out of hours palliative care telephone advice service)		01226 244244

Hospice

Barnsley Hospice	01226 244244

Name:……..... NHS :……

Who is involved in my care?

Family and friends	
Name Relationship Address Contact no	Name Relationship Address Contact no

My community / care home team			
GP	Name	Contact no	
District nurse	Name	Contact no	01226 644575
Community Matron	Name	Contact no	01226 644575
Specialist Palliative care / Macmillan professional	Name	Contact no	01226 644575
Specialist nurse	Name	Contact no	
Out of hours nurses	Name Crisis Response Team	Contact no	01226 644575
Care manager	Name	Contact no	
Care agency	Name	Contact no	
Continuing Health Care	Name	Contact no	01226 433634
Other	Name	Contact no	

My hospital team			
Consultant	Name	Contact no	
Ward nurse	Name	Contact no	
End of life care team	Name	Contact no	01226 436238 01226 435489
Specialist Palliative Care nurse	Name	Contact no	01226 434921
Other	Name	Contact no	

Hospice team			
Consultant	Name	Contact no	01226 244244
Nurse	Name	Contact no	01226 244244
Other	Name	Contact no	01226 244244

Name:……..... NHS :…….

Signature sheet

All those using this care plan, please sign below

Name (Print)	Full Signature	Qualification	Date

Comments or concerns

You, and those important to you, are invited to write any comments or observations about your care or changes in your condition to ensure all your care needs are met

Date / time	Comments/concerns	Name of person and relationship

Name:……..... NHS ……

Assessment for last days of life care

Preferred Name	
How do I communicate and what support do I need?	
Making Decisions: I need to make my own decisions and choices, even if they seem unwise, unless there is a belief that I lack mental capacity to make certain decisions and then you will need to follow the principles and practice of the Mental Capacity Act to test my capacity, support me in making decisions I am able to make and make decisions in my best interests for those I am unable to make without help.	
What Matters to me at this time in my life and how can you best support me? What is important? Who is important? (e.g. personal preferences and wishes, things that make me happy, faith or beliefs, things that help me to feel calm, people who are important to me): Please check with me, or those looking after me, as I might have already told someone, and it might be written down	
Preferred place of care Where would you like to be cared for?	
Would you like any further spiritual support?	Does the person/family wish for additional support Yes ☐ No ☐ If yes, please indicate who has been contacted
Wishes regarding care after death	Specific Wishes _____ Burial _____ Cremation _____ Funeral Plan _____ Funeral Director _____
Who should we ask about your care if you are not able to make decisions for yourself? (ask the person)	Name: _____ Relationship _____ Contact details _____ When to contact Day_____ Night_____ Anytime_____
Does anyone hold a Lasting Power of Attorney for health and welfare? If Yes, a copy needs to be seen and kept in the medical notes.	Name: _____ Relationship: _____ Contact No: _____ Date copy seen :_____ Copy in notes : _____

Name:……..... NHS no …….

Known allergies	
Risks identified	
Multi-disciplinary team assessment (MDT) **Include** • current condition • reasons for deterioration • nutrition and hydration • current symptoms • personal care • environment preferences e.g. pictures, music, hospital dove symbol	
Medical management plan **Consider** • Hydration & nutrition • Treatment escalation • Observations • Blood test • Blood glucose monitoring • Medication review • Oxygen • Management of ICD (Contact Barnsley Hospice 01226 244244 to speak to Consultants for advice) • Resuscitation status	**Remember to review if the person's condition changes (deteriorates/improves) and reassess**
Pre-emptive medication prescribed	Pain Yes ☐ No ☐ Nausea/vomiting Yes ☐ No ☐ Agitation/fear Yes ☐ No ☐ Respiratory tract secretions Yes ☐ No ☐ Breathlessness Yes ☐ No ☐ Has pre-emptive medication and possible side effects been discussed with patient/other? Yes ☐ No ☐ ***If no, please document reasons in MDT evaluation section of My Care Plan***

Senior Doctor responsible for care

Name:…… Designation: ……

Signature:…… Date & Time: ……

Name:……..... NHS ……

What matters to those important to you • Wishes • Wants • Fears • Concerns	
How can we help those important to you?	
Communication	**MDT members involved in assessment and planning discussion** Name: …… Designation: …… Name: …… Designation: …… Name: …… Designation: …… **This has been discussed with the person and those important to them.** Discussed with the person Yes ☐ No ☐ If No, state why ……. **Discussed with those important to the person**. Yes ☐ No ☐ If No, state why …… If Yes, Name ……Relationship ……
Does the person consent to sharing this plan with other professionals?	Yes ☐ No ☐ Unable to consent ☐ Unable to consent, Best Interest decision taken to share in records ☐

Registered Nurse responsible for care and development of an agreed personalised care plan

Name:…… Designation: ……

Signature:……Date & Time: ……

My Care Plan

Name:……..... NHS :……

Please add or amend goals and actions according to individual needs.

Personal need	Key actions for people involved in my care	Frequency of review
1. To ensure that aims of my treatment and care have been fully considered by all involved and are regularly reviewed.	a. Tell me and my family which Doctor and Nurse are responsible for my care. b. It is important that I and those important to me are given the choice and opportunity to be involved in any decision making and discussions concerning my care. c. Listen to me. d. Have a care plan which is discussed and agreed with me or my advocates and those caring for me. e. Discuss and explain this to those important to me, unless I have stated not to. f. Ensure this plan is reviewed daily and changed according to any change in my condition or needs. g. Ensure that I and those important to me, are aware of changes in my condition and care plan as appropriate h. Offer myself and those important to me an opportunity to write any comments or observations about my care or changes in my condition to ensure all my care needs are met. i. Provide us with appropriate written information when required and appropriate. j. Provide us with information about services involved in my care and their contact numbers k. Ensure information about my care plan is shared with relevant services (including out of hours services) if I have consented to this. l. Ensure that those important to me and I (if appropriate) know who to contact if further help and advice is needed at all times. m. Ensure those important to me understand what to do in the event of any changes in my condition n. Offer me the opportunity to access spiritual/religious support as I need o. p. q.	Daily

Name:……..... NHS :……

Personal need	Key actions for people involved in my care	Frequency of review
2. To ensure I am in the environment of my choice whenever possible	a. Offer me or my advocate(s) the opportunity to discuss my preferred place of care and wherever possible support my care in this place b. Consider my personal preferences within the environment e.g. fragrance, lighting, privacy, photographs, music or sound c. Help those important to me, to spend as much time with me as we wish d. Access equipment which I might need to help support my care e. f.	Daily
3. To be comfortable and for any symptoms I may have to be managed **Consider** • Pain • Agitation • Fear • Nausea and vomiting • Breathlessness • Respiratory tract secretions	a. Utilise appropriate assessment tools b. Monitor my condition for any signs of distress or discomfort c. Assess and treat any reversible causes of distress or discomfort e.g. urine retention, opioid toxicity, need for positional change d. Discuss with me or my advocates preferences for my treatment options e. Consider holistic treatment of my symptom needs e.g. using fan, positional changes, relaxation, listening f. Provide me and those important to me, with information and explanations about medications or treatments which may be used g. Ensure medications are prescribed for symptoms which may occur - see medication guidelines. h. Ensure a syringe driver is available and if used, medication is given as required; doses based on previous medication use – see guidelines. i. In hospital, hospice or care home ensure symptoms are reviewed at least four hourly j. At home review at least daily and ensure that I and/or those important to me, understand how to report any occurrence of symptoms so timely review can occur (i.e. provide contact numbers for all times) k. Ensure any medication required is administered in a timely manner, safely and appropriately l. Discontinue inappropriate interventions, for example, do not send stool samples m. n.	4 hourly or if at home at each visit

Name:……..... NHS :……

Personal need	Key actions for people involved in my care	Frequency of review
4. To receive hydration and nutrition to meet my needs	a. Support me to take fluid and food as long as I desire and am able to do so b. If I am unable to swallow an assessment will be made to maintain my comfort and hydration needs. The assessment will review the need for clinically assisted hydration or nutrition (e.g. having a drip)– any decision should if possible be taken in consultation with me and/or those important to me (see guidance) c. If I am receiving clinically assisted hydration or nutrition ensure I receive this as prescribed d. e. f.	Daily
5. To maintain all my personal care needs	a. Ensure all my personal care, including skin care, eye care, bladder and bowel function, changing of clothing, is provided in accordance with my wishes. b. Provide information and explanations to those important to me and if appropriate advise them about how to provide my personal care c. d. e.	4 hourly or if at home at each visit
6. To keep my mouth moist and clean	a. Assess my mouth care needs – see guidance b. Provide regular mouth care as I require – see guidance c. Provide information and explanations to those important to me and if appropriate advise them about how to provide mouth care d. e.	4 hourly or if at home at each visit
7. To maintain my comfort and prevent pressure damage of my skin	a. To assess potential pressure damage and provide me with pressure relieving aids as needed b. To change my position as required c. Monitor my skin for any signs of skin damage and treat appropriately d. e.	4 hourly or if at home at each visit

Name:……..... NHS :……

Personal need	Key actions for people involved in my care	Frequency of review
8. For those important to me to feel supported	a. Provide information and explanations to those important to me as they need b. Consider particular spiritual/ religious/cultural needs of those important to me c. Listen to any worries and concerns of those important to me and respond to these appropriately d. Provide them with written information as required and appropriate e. In hospital / hospice / care home explain facilities and support available f. At home ensure they have contact numbers and know how to get help and support day and night g. h.	Daily
9.		
10.		

Name:……..... NHS :……

Personal need	Key actions for people involved in my care	Frequency of review
11.		
12.		

Care plan discussed and agreed by: Yes ☐ No ☐ N/A ☐

Name:…… Relationship (if applicable) ……

Date …… Time ……

Name:…… Relationship (if applicable) ……

Date …… Time ……

Health Professional …… Designation …… Signature ……

Date …… Time ……..

Name:……..... NHS :……

Multi-disciplinary evaluation

Day 1

Daily Review by Senior Clinician

Signature:

Time and date	Goal number	Evaluation comments	Signature and designation

Name:……..... NHS :…….

Day 2

Daily Review by Senior Clinician

Signature:

Time and date	Goal number	Evaluation comments	Signature and designation

Name:……..... NHS :……

Day 3

Daily Review by Senior Clinician

Signature:

Time and date	Goal number	Evaluation comments	Signature and designation