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Banda Label Patient Identification

**Management plan for care of patients at end of life in Hospital**

Patients Named Senior Clinician..................................................................

Patients Named Senior Nurse.....................................................................

|  |  |  |
| --- | --- | --- |
| 1. **Diagnosis of dying**
 | **Y/N** | **Comments / action taken**  |
| Is my patient approaching end of life? |  |  |
| Is my patient’s diagnosis and prognosis clearly documented in their medical notes?* Are staff aware at handover for each shift?
* Have meaningful conversations taken place and been documented?
 |  |  |
|  |
|  |
| Is my patient aware of their diagnosis / prognosis (taking into account mental capacity)?  |  |  |
| Are my patient’s NOK / carers aware? * Have meaningful conversations taken place and been documented?
 |  |  |
| **Preparation for death and bereavement** |  |  |
| 1. Is a **DNAR** order in place?
 |  |  |
| Is the **MEWS trigger** appropriate? |  |  |
| 1. Is my patient worried, anxious or frightened?
 |  |  |
| Does my patient want a spiritual advisor? |  |  |
| Are any religious rituals required? |  |  |
| Does my patient have any verbal or written requests? * Advance Care Plan (patient preferences for care, e.g. My Life Booklet)
* Advanced Directive to Refuse Treatment (legally binding)
* Writing a will
* People to call in
* Saying goodbyes
 |  |  |
| 1. **Patient Comfort: Nutrition**
 |  |  |
| Is my patient **nauseous**? |  |  |
| Is my patient **vomiting**? |  |  |
| Does my patient have a **dry, sore mouth or candida**? |  |  |
| Is my patient **hungry or thirsty**? |  |  |
| Can my patient **eat and drink**? |  |  |
| 1. **Patient Comfort: Elimination**
 |  |  |
| Is my patient’s **bowel functioning** naturally for them? |  |  |
| Is my patient **passing urine** comfortably? |  |  |
| 1. **Patient Comfort: Physical symptoms**
 |  |  |
| Is my patient **in pain**? |  |  |
| Is my patient **short of breath**? |  |  |
| Is my patient **coughing**? |  |  |
| Is my patient on the **correct bed/ mattress**? |  |  |
| Is my patient **agitated/confused**? |  |  |
| Is my patient **oedematous**? (useful source of subcutaneous fluid) |  |  |
| Are any **other physical symptoms** distressing my patient? |  |  |
| 1. **Care for NOK/ carers**
 |  |  |
| * Are NOK / carers comfortable
* Refreshments
* Food
* Toilet facilities
* Overnight accommodation / arrangements
* Contact numbers and chain for messages
 |  |  |
| * Have NOK/carers been offered open visiting?
 |  |  |
| * Have NOK/carers been informed of reduced parking fees?
 |  |  |
| * Have NOK/carers been provided with discounted meal vouchers / comfort care pack?
 |  |  |
| * Are the NOK/carers prepared for the death?
 |  |  |
| * Have NOK / carers been given a Bereavement Information booklet?

A bereavement follow up service will be offered to relatives by bereavement office staff |  |  |
| 1. **Informing people of the death**
 |  |  |
| Have the NOK/carers been informed that my patient has died? |  |  |
| Have professionals been informed of my patient’s death?* In hospital
* In community
 |  |  |
| 1. **Staff support**
 |  |  |
| Is my team comfortable with the care delivered? |  |  |
| Is any member of my team unduly distressed? |  |  |
| Do I, or my team, need to debrief? |  |  |

There are Specialist Palliative Care teams in all 3 Trust hospitals that can be contacted for advice and clinical support

:

Good Hope Tel 49900

Solihull Tel 44127

Heartlands Tel 42442

Completed by...........................................................(print name)

Signature...........................................................................Date..............

Review Date (1).....................................

Review Date (2)...................................

Review Date (3).......................................