One trust in England piloted a new tool to help ensure nurses consider the Priorities of Care for the Dying Person when caring for patients who are in the last days of life.

**Personalised care plans in the last days of life**

**In this article...**
- Priorities of care for people in the last days or hours of life
- Prompts to remember the five priorities
- Results of an audit of a pilot personalised care plan

**5 key points**
1. One Chance to Get It Right and Priorities of Care of the Dying Person set out an approach to caring for dying people
2. Individualised care plans should be made in discussion with the dying person, loved ones and the multidisciplinary team
3. The dying person and loved ones must be the focus of care
4. Individualised care plans must prioritise comfort and dignity, and support dying persons to eat and drink as long as they wish to
5. The person's physical, emotional, cultural and religious needs must be studied to create a care plan

Although widely used to inform care of patients in the last days of life, the Liverpool Care Pathway was withdrawn after criticism of its application for some patients (Ford, 2013). The Leadership Alliance for the Care of Dying People, when planning care. This article discusses the results of an acute hospital audit comparing the quality of care planning for patients in the last days of life using the trust care record documentation with the use of a personalised care plan for patients.

**Trust Care Record**

The LACDP did not recommend a single set of support materials, preferring to allow organisations to choose their own approach to personalised care planning for patients in the last days of life. Derby Teaching Hospitals Foundation Trust did not replace the LCP with an individualised care plan for patients in the last days of life; instead, care planning for patients in the last days of life was integrated into the Trust Care Record (TCR).

A form was developed to enable medical staff to document:
- When a patient was recognised as dying;
- The reasons behind this recognition;
- A summary of the discussion held with the patient, those important to the patient and other professionals involved in the patient’s care.

The TCR is a care planning document that enables nursing staff to assess, plan and deliver care, treatment and support. It aims to ensure care is person-centred and considers all aspects of patients’ individual circumstances, and immediate and longer-term needs. It addresses the following potential problems:
- Maintaining a safe environment;
- Infection prevention and control;
- Discharge planning;
- Risk of developing a deep vein thrombosis;
- Observations;
- Care of a patient undergoing a planned/unplanned procedure; communication;
- Hygiene;
- Nutrition and hydration;

**Keywords:** End of life/Palliative care/ Care plan/Dying patient

*This article has been double-blind peer reviewed.*
**Innovation**

» Sleep, rest and comfort;
» Pain; mobility and pressure ulcer prevention;
» Elimination;
» Care of patients requiring oxygen therapy;
» Care of patients with diabetes;
» Administration of medicines;
» Specialist care.

An end-of-life care facilitator worked alongside the hospital palliative care team, supported by the palliative medicine research sister. They undertook an end-of-life care benchmarking exercise across the trust in October-December 2014 to measure the impact on care planning of the LCP’s withdrawal and the care being delivered trust-wide using the TCR.

The results identified that, without the ‘prompts’ of the LCP, staff had difficulty developing care plans for patients at the end of life. While each potential problem in the TCR has several prompts, these were not fully used. The specialist care section also enables nurses to add problems specific to individual patients, again benchmarking found no evidence that the TCR was being used in this way.

The benchmarking exercise highlighted several key themes:

» Care plans mainly focused on the physical aspects of care, such as hygiene, tissue viability and mouth care;
» Reference to symptom management was made primarily when a patient presented with an actual problem, rather than anticipating that a symptom might occur;
» The only symptoms mentioned were pain and agitation. No reference was made to the other potential common symptoms in the last days/hours of life. Where there was evidence in the medical records of prescribing for the symptoms of nausea, dyspnoea, agitation and retained respiratory secretions, there was little documented evidence of the effectiveness of symptom control in the nursing care plan being evaluated.

» There was also no documented evidence of emotional, psychological, spiritual care or support for patients or their families.

The Care Quality Commission inspected the trust in December 2014, with end-of-life care being one of the core services under scrutiny. Results identified that, after the change in approach to caring for dying people, individualised care planning using the current nursing documentation was not always consistent. Based on these findings, the end-of-life team developed a document based on the Priorities of Care for the Dying Person.

**Developing a new care plan**

**Aims and objectives**

We aimed to develop a document – the Personalised Care Plan for the Last Days of Life (PCP) – aligned with the Priorities of Care for the Dying Person to facilitate consistent personalised care planning for patients in the last days of life.

**Standards**

The PCP is divided into five sections, one on each of the Priorities of Care. For each priority, there are prompts to consider when planning care for a patient in the last days of life. For example, for Priority 1, ‘recognise’, there is a prompt to ensure the care plan includes the importance of ensuring that individual patients and those important to them are involved in all discussions about care, and whether patients are in their preferred place of death.

**Methodology**

The PCP was piloted on three medical wards (cardiology, elderly medicine and oncology), which were chosen as they frequently care for patients in the last days/hours of life. The pilot would be undertaken over three months or when the sample size reached 30.

Medical staff were required to complete the Trust Recognising Dying form;

“The pilot care plan helped nurses reassess the needs of patients approaching end of life and facilitated discussion between staff, patients and families”

if this was not done, it had to be clearly documented in the patient’s medical notes that the patient was recognised to be in the last days or hours of life and this had been discussed with both the patient and those important to the patient. This was the prompt for nursing staff to initiate the care plan.

Using the Priorities of Care as the audit standard, an audit pro-forma was developed. The aim was to identify whether there was documented evidence that the principles outlined in the Priorities of Care for the Dying Person had been considered and applied to the care plan.

At the same time, the AMBER Care Bundle facilitator, who is responsible for implementing the AMBER Care Bundle – a tool used to identify uncertain recovery, used the proforma to audit care plans on three wards where mortality data identified similar death rates to the pilot wards.

In total, 15 patients were identified during the audit period as being in the last days/hours of life and their care was planned using the TCR.

Staff on all six wards involved in the pilot had not received training specific to individualised care planning for patients in the last days of life. A number of consultants were responsible for the care of the patients on those six wards, depending on specialty. It is acknowledged that the data sample sizes were not equal; this was due to fewer deaths on the wards using the TCR.

**Results**

For each priority we asked: is there documented evidence in the end-of-life care plan that these principles have been discussed and documented in the PCP?

**Priority 1: recognise**

Recognise: The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly

**Priority 2: communicate**

Communicate: Sensitive communication takes place between staff and the person who is dying and those important to them

**Priority 3: involve**

Involves: The dying person, and those identified as important to them, are involved in decisions about treatment and care

**Priority 4: support**

Support: The people important to the dying person are listened to and their needs are respected

**Priority 5: plan and do**

Plan and do: Care is tailored to the individual and delivered with compassion – with an individual care plan in place

**Source:** Leadership Alliance for Care of the Dying People (2014)

---

**Box 1. Five Priorities of CARE the Dying Person**

1. **Recognise** The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly.

2. **Communicate** Sensitive communication takes place between staff and the person who is dying and those important to them.

3. **Involve** The dying person, and those identified as important to them, are involved in decisions about treatment and care.

4. **Support** The people important to the dying person are listened to and their needs are respected.

5. **Plan and do** Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

Source: Leadership Alliance for Care of the Dying People (2014)
Innovation

these are regularly reviewed and decision revised accordingly.

Ninety-two per cent of the PCPs showed evidence that the principles of this priority were discussed and documented, compared with 36% of end-of-life care plans using the TCR (Fig 1).

**Priority 2: communicate**

Communicate: Sensitive communication takes place between staff and the dying person and those identified as important to them. Of the PCPs, 91% showed evidence that the principles of this priority were discussed and documented compared with 14% of TCRs.

**Priority 3: involve**

Involve: The dying person, family and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

In total, 32% of the PCPs showed evidence that the principles of this priority were discussed and documented, compared with 9% of TCRs. The results show an improvement using the PCP, although the figures remain low compared with the results from other priorities. This may reflect the need for communications skills training for staff caring for patients in the last days of life.

**Priority 4: support**

Support: The needs of the families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Of the PCPs, 76% showed evidence that the principles of this priority were discussed and documented, compared with 10% of TCRs.

**Priority 5: plan and do**

Plan and do: An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support is agreed, coordinated and delivered with compassion. Of the PCPs, 83% showed evidence that the principles of this priority were discussed and documented, compared with 18% of TCRs.

**Key findings**

A total of 48 patients died on the three pilot wards during the audit period. Of these deaths, 30 (63%) were known to have been supported by the pilot care plan. While the team were aware of the 30 patients when undertaking the real-time audit (Monday to Friday), additional data may have been missed if any died ‘out of hours’ or at the weekend.

The main reasons for patients not being supported by the pilot care plan were rapid deterioration, with the patient dying very quickly, and late recognition that the patient was dying, resulting in delayed completion of documentation by the medical team.

A focus group comprising a ward sister from each area was held for each pilot ward to discuss their experience of using the pilot care plan; the ward sisters brought with them comments from their staff. The nurses felt the pilot care plan helped them reassess the needs of patients who were recognised as approaching the last days of life. They also felt it helped multidisciplinary team communication. All members of the focus group agreed that the pilot care plan helped to facilitate discussion between staff, patients and families.

The feedback from the focus group was positive and all three wards were keen to continue using the care plan to support patients in the last days or hours of life.

**Conclusion**

The pilot of the PCP showed the tool was successful in facilitating individualised care planning for patients in the last days of life, resulting in an increased use of the Priorities of Care for the Dying Person. The prompts for each priority facilitated nurses’ consideration of a wider range of actual and potential problems that patients in the last days of life and those important to them may experience.

Although the results show the care plan has facilitated the planning and provision of more personalised care, this varies between priorities. This reflects that some aspects of care planning are more difficult than others, such as involving family in decisions around care.

The results show that, when planning care using the TCR, the Priorities of Care for the Dying Person are not always considered. In contrast, when care is planned using the PCP, the Priorities for the Care of the Dying Person and those important to them are evident. In response to the results, the trust is now implementing the document for all dying patients; this will be supported by a programme of training. NT

![Fig 1. Audit results comparing use of PCP with TCR when planning care](image-url)

**References**

Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right: Improving People’s Experience of Care in the Last Few Days and Hours of Life. bit.ly/LACDPOneChance


Further reading: NT team

- Getting the priorities right in end-of-life care
- bit.ly/NTeolPriorities
- Using volunteers to support end-of-life care
- bit.ly/NTeolVolunteers

www.nursingtimes.net / Online issue 9 / Nursing Times 07.09.16 9