DO NOT WRITE IN THIS BINDING MARGIN

YOUR LOGO HERE	**CARE PLAN** **FOR THE DYING PERSON** **VICTORIA**	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

CARE PLAN

FOR THE DYING PERSON

VICTORIA

YOUR LOGO HERE

CARE PLAN

FOR THE DYING PERSON
VICTORIA

UR no: _____
Surname: _____
Given name(s): _____
DOB: _____
Please fill in if no UR label available

Health professional guidance

RECOGNISING DYING

The possibility that a person may die within the next few days or hours is recognised and communicated clearly; all decisions made and actions taken are in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

Each multidisciplinary team (MDT)* assessment should always consider:

1. Is there a potentially reversible cause for the person's condition? E.g. exclude opioid toxicity, renal failure, hypercalcaemia, infection.
2. Is a specialist referral required? Seek a second opinion or specialist palliative care support as needed.

COMMUNICATE, INVOLVE AND SUPPORT

Sensitive communication takes place between staff, the dying person and those identified as important to them.

Staff must check if there is an existing advance care directive and if so, ensure it is reviewed.

Shared decisions are made about treatment and care to the extent the dying person wants or is able to participate. The possibility that the person may be dying is discussed. This communication must be conducted in a way that maximises dignity and privacy.

The needs of relative/friend(s)/support person/medical decision maker are explored, respected and met as far as possible. Staff must check understanding of the information being communicated and document this.

CREATE AN INDIVIDUALISED PLAN WITH ONGOING MEDICAL REVIEW

A care plan tailored to the individual needs of the dying person and those identified as important to them is developed and continually reviewed.

The agreed plan of care is co-ordinated and delivered with dignity, care and compassion. It is inclusive of, but not limited to, needs related to food and drink, symptom management and emotional, spiritual, religious and cultural support.

REVIEW

This care plan should be a continuum. The dying person's condition, needs and wishes should be reviewed at least daily by the senior treating doctor* and a registered nurse (Div 1).

A full MDT reassessment and review should be triggered when:

1. There is a significantly improved conscious level, functional ability, mobility, ability to perform self-care and/or
2. There are concerns expressed regarding the plan of care from the dying person, relative, friend, support person, medical treatment decision maker or treating team member.

This care plan will be discontinued in the event that the person's condition improves and a new goal of care must be developed and initiated.

International Collaborative for Best Care for the Dying Person

Safer Care Victoria

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The aim of the **Care Plan for the Dying Person – Victoria** is to guide and enable health professionals to focus on individualised care during the last days and hours of life. It facilitates the delivery of high-quality care tailored to the individual needs of the dying person and those identified as important to them, when death is expected.

As with all care plans, the information in this document aims to support but does not replace clinical judgement.

GUIDING PRINCIPLES

- Recognising clinical deterioration and probable death is fundamental to quality care provision.
- Comprehensive and clear communication must occur especially when it is thought that a person is imminently dying.
- Everyone – the healthcare team, the dying person and those identified as important to them – must understand and accept the person is thought to be imminently dying prior to any discussions related to commencing the Care Plan for the Dying Person – Victoria.
- The Care Plan for the Dying Person – Victoria should not be commenced if there is not full acceptance by the MDT or relative/friend(s) that death is imminent.
- All clinical decisions must be made in the dying person's best interest and be inclusive of medical, physical, emotional, religious, spiritual and cultural factors.
- The care plan does not preclude the use of clinically assisted nutrition, hydration or antibiotics.
- Continuing care decisions should always be made in consultation with the senior treating doctor*, the MDT* the person who is dying (when possible and appropriate) and those identified as important to them.
- Uncertainty is an integral part of dying and there are occasions when a person who is thought to be dying lives longer, or dies sooner than expected. Daily review of care needs and wishes must be undertaken and a second opinion or specialist palliative care support sought as needed.

Responsibility for the use of the **Care Plan for the Dying Person – Victoria** as part of a continuous quality improvement program sits within the governance of an organisation and must be underpinned by an education and training program.

The care plan should be implemented in conjunction with the **Care Plan for the Dying Person – Victoria, Health professional user guide**.

This is a legal document and should be used in conjunction with other relevant clinical documentation as per individual health service policies and procedures.

***DEFINITIONS** (for the purposes of this document)

Senior treating doctor
The most senior doctor responsible and familiar with clinical care decisions related to this dying person.

Multidisciplinary team (MDT)
At a minimum a MDT consists of a senior treating doctor and a registered nurse (Div 1) who is responsible for the care of this dying person.

MDT delegate
Doctor or registered nurse (Div 1) with delegated responsibility from a senior treating doctor to make decisions related to commencing this dying person on the **Care Plan for the Dying Person – Victoria.**

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1. Recognising dying (must be completed by a doctor)

1.1 Commencement

Must be completed by a senior treating doctor and co-signed by a registered nurse (Div 1)

The MDT has assessed the person as imminently dying and they support the commencement of the **Care Plan for the Dying Person – Victoria.** ☐ Yes ☐ No (If 'No', do not commence)

A resuscitation plan is documented:	☐ Yes	☐ No	Further action:	Initial:
Will the dying person have CODE BLUE/MET calls in response to deterioration?	☐ Yes	☐ No	State reason for call:	Initial:

MDT authorisation

Senior treating doctor (Print name)	Signature:	Date: / /20 Time: : hours	
Registered nurse (Print name)	Signature:	Date: / /20 Time: : hours	

Verbal authorisation

If the senior treating doctor is not immediately available, the nominated MDT delegates can sign authority to commence the **Care Plan for the Dying Person – Victoria.**

SENIOR TREATING DOCTOR SIGNATURE MUST BE OBTAINED WITHIN 24 HOURS OF COMMENCEMENT

Name of the senior treating doctor verbal authorisation was obtained from:

MDT delegate (Print name)	Signature:	Date: / /20 Time: : hours	
MDT delegate (Print name)	Signature:	Date: / /20 Time: : hours	

1.2 Legal and relevant decision assisting information

Does the person have capacity to make medical decisions at this time?	☐ Yes	☐ No	Further action:	Initial:
Is there an instructional and/or a values directive in a patient's record/ MyHealthRecord/ or available elsewhere?	☐ Yes	☐ No	Further action:	Initial:
Is there a medical treatment decision maker identified for if/when this person does not have capacity?	☐ Yes Name:	☐ No		Initial:

Registered organ/tissue/ corneal donor?	☐ Yes	☐ No	☐ Follow up	Further action:	Initial:
Will this be a reportable Coronial death? (Refer to health service policy/procedures)	☐ Yes	☐ No	☐ Follow up	Further action:	Initial:
Other e.g. autopsy, donating to medical science	☐ Yes	☐ No	☐ Follow up	Further action:	Initial:

Record more detailed responses/instructions in Section 4.2 or 4.3

YOUR LOGO HERE	**CARE PLAN** **FOR THE DYING PERSON** **VICTORIA**	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

1.3 Communication – Information exchange		
Is an interpreter required? Language(s):	☐ Yes	☐ No
Is the dying person able to take a full and active role in communication?	☐ Yes	☐ No
Does the dying person understand that they are now dying?	☐ Yes	☐ No
Are the relative/friend(s) able to take a full and active role in communication?	☐ Yes	☐ No
Are the relative/friend(s) aware that their relative / friend is now dying?	☐ Yes	☐ No
Are the relative/friend(s) aware that the Coroner is likely to be involved?	☐ Yes	☐ No
Have relevant staff been informed that this person is imminently dying?	☐ Yes	☐ No

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

2. Medical review of care needs (must be completed by a doctor)

2.1 Initial assessment

☐ Conscious	☐ Semi-conscious	☐ Unconscious
☐ Able to swallow	☐ Experiencing delirium	

2.2 Medication management

Medications must be prescribed and available in anticipation of symptoms which may develop. Anticipatory prescribing is recommended in end-of-life care

Medication prescribed for:		**The person is currently:**		
Pain	☐ Yes	In pain	☐ Yes	☐ No
Agitation	☐ Yes	Agitated	☐ Yes	☐ No
Nausea and vomiting	☐ Yes	Nauseous and/or vomiting	☐ Yes	☐ No
Dyspnoea	☐ Yes	Dyspnoeic	☐ Yes	☐ No
Respiratory tract secretions	☐ Yes	Experiencing secretions	☐ Yes	☐ No

2.3 Current interventions

Have current interventions been assessed and non-essentials discontinued?

	Not required	**Discontinued**	**Continued**	**Commenced**
Essential medications via appropriate route	☐	☐	☐	☐
Continuous subcutaneous infusion (CSCI) (Refer to health service policy/ procedures)	☐	☐	☐	☐
Intravenous antibiotics	☐	☐	☐	☐
Clinically assisted hydration ☐ PEG/PEJ ☐ NG/NJ ☐ IV ☐ SC	☐	☐	☐	☐
Clinically assisted nutrition ☐ PEG/PEJ ☐ NG/NJ ☐ TPN	☐	☐	☐	☐
Oxygen therapy	☐	☐	☐	☐
Anticoagulation therapy	☐	☐	☐	☐
Routine blood tests	☐	☐	☐	☐
Blood glucose monitoring	☐	☐	☐	☐
Recording of vital signs	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Implantable Cardioverter Defibrillator (ICD) is deactivated	☐ Yes	☐ Further action	☐ Not appropriate

Record more detailed responses/instructions in Section 4.2 or 4.3

YOUR LOGO HERE	**CARE PLAN** **FOR THE DYING PERSON** **VICTORIA**	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

2.4 Referral to specialist palliative care service

Does the dying person require a specialist palliative care referral?	☐ Yes	☐ No
	☐ Palliative care team already involved	

Describe reason for referral:

Doctor completing medical review

Print name:	Signature:
Date: / /20	Time: : hours

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

3. Planning individualised care (to be completed by any member of the MDT)

3.1 Brochures

Those identified as important to the dying person have had a full explanation of the facilities and services available to them including relevant information brochures	☐ Yes	☐ No

☐ **Care Plan for the Dying Person – Victoria** 'Family member/friend information brochure'	☐ Other specific brochures List:	☐ Facility orientation brochure

3.2 Contact information

1st contact person

Name:	Relationship:	
Have contact numbers been checked and updated?	☐ Yes	☐ No
Interpreter required?	☐ Yes	☐ No

When to contact:

☐ Anytime ☐ Not at night ☐ Deterioration ☐ Death only

Other relevant information:

2nd contact person

Name:	Relationship:	
Have contact numbers been checked and updated?	☐ Yes	☐ No
Interpreter required?	☐ Yes	☐ No

When to contact:

☐ Anytime ☐ Not at night ☐ Deterioration ☐ Death only

Other relevant information:

3.3 Funeral arrangements (please check clinical record first for this information)

Funeral arrangements discussed	☐ Yes	☐ No	☐ Not appropriate
Name of funeral director (if known)			

3.4 Person-centred communication

Is the dying person able to fully participate in this discussion?	☐ Yes	☐ No – please go to Section 3.6 and refer to instructional/values directive.

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3.5 Communication with the dying person (If appropriate, ask the dying person the following questions)

Does the dying person understand that they are now dying?	☐ Yes	☐ No
Do you have any emotional, spiritual, religious/cultural needs or wishes we need to be aware of now, at the time of and/or after death?	☐ Yes	☐ No
If yes, what are they?		
What is important to you now?		
What would bring comfort at this time? E.g. music, own pillow/bed linen, etc.		
In the absence of relative/friend(s), who else do you want us to share this information with? Name: *Record in Section 3.2*		
Is there anything else you would like to tell us, ask us or we can support you with?	☐ Yes	☐ No
If yes, please describe:		

3.6 Communication with relative/friend(s)

Ask the relative/friend(s) the following questions

What is important to you now?		
What is important at the time of death?		
What is important for your relative/friend at the time of and/or after death?		
Is there anything else you would like to tell us, ask us or we can support you with?	☐ Yes	☐ No
If yes, please describe:		

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3.7 Bereavement risk

Potential risk is identified	☐ Yes	☐ No
Referral made to:		

High risk factors: limited social support, emotional distress, family conflict, cumulative losses, sudden or unexpected deterioration

3.8 Allied health/support services required

	Person		**Relative**		**Contacted (date/initial)**	**Additional information**
Social work	☐ Yes	☐ No	☐ Yes	☐ No		
Spiritual/religious advisor/pastoral care	☐ Yes	☐ No	☐ Yes	☐ No		
Cultural advisor/ healer/elder	☐ Yes	☐ No	☐ Yes	☐ No		
Aboriginal hospital liaison officer	☐ Yes	☐ No	☐ Yes	☐ No		

Record more detailed responses / instructions in Section 4.2 or 4.3

Further comments

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4. Delivery of care (to be completed by any member of the MDT)

4.1 Initial assessment

This care plan should be reviewed at least daily by the MDT

Minimum documentation is four hourly however certain psychosocial issues may only need assessment once per shift

Care plan day:	Date: / /20

SYMPTOM MANAGEMENT

A = Assessment and no action required R/C = Routine care	F/A = Further action required N/A = Not applicable

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Free of pain												
Free of agitation/ restlessness												
Free of nausea/ vomiting												
Free of dyspnoea/ breathlessness												
Free of respiratory tract secretions												
Free of urinary problems												
Free of bowel problems												
Subcutaneous cannula care												
Subcutaneous infusion check												

PERSONAL COMFORT CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Receives food and fluids to support needs												
Is comfortably positioned												
Skin care needs are met												
Personal hygiene needs are met												
Mouth is clean and moist												
Eyes are clean and moist												
Environment supports needs												

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA		UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

PSYCHOSOCIAL CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Emotional, spiritual, religious, cultural needs/rituals are met												
Procedures/care plan explained												
Information regarding changes provided												
Relative/friend(s) supported												
Record all F/A in Section 4.2: Further care action report												
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial
Print name of person doing assessment												
N:												
AM:												
PM:												
N: RESPONSIBLE REGISTERED NURSE: (If different from above)												
N:												
AM:												
PM:												

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA		UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

4. Delivery of care (to be completed by any member of the MDT)

4.1 Ongoing assessment

This care plan should be reviewed at least daily by the MDT

Minimum documentation is four hourly however certain psychosocial issues may only need assessment once per shift

MDT review. Is the person imminently dying?		☐ Yes	☐..No
If 'No', has the MDT agreed that this care plan should be discontinued?		☐ Yes	☐..No
Care plan discontinued:	Date: / /20	Time: : hours	
Please complete 'Section 6 - Care plan discontinued' and attach to the **front** page of this care plan and file			
Care plan day:		Date: / /20	

SYMPTOM MANAGEMENT

A = Assessment and no action required

F/A = Further action required

R/C = Routine care

N/A = Not applicable

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Free of pain												
Free of agitation/ restlessness												
Free of nausea/ vomiting												
Free of dyspnoea/ breathlessness												
Free of respiratory tract secretions												
Free of urinary problems												
Free of bowel problems												
Subcutaneous cannula care												
Subcutaneous infusion check												

PERSONAL COMFORT CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Receives food and fluids to support needs												
Is comfortably positioned												
Skin care needs are met												
Personal hygiene needs are met												
Mouth is clean and moist												
Eyes are clean and moist												
Environment supports needs												

PSYCHOSOCIAL CARE												
	0200	**0400**	**0600**	**0800**	**1000**	**1200**	**1400**	**1600**	**1800**	**2000**	**2200**	**2400**
Emotional, spiritual, religious, cultural needs/rituals are met												
Procedures/care plan explained												
Information regarding changes provided												
Relative/ friend(s) supported												
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial
Print name of person doing assessment												
N:												
AM:												
PM:												
N: RESPONSIBLE REGISTERED NURSE: (If different from above)												
N:												
AM:												
PM:												

YOUR LOGO HERE	**CARE PLAN** **FOR THE DYING PERSON** **VICTORIA**		UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

4. Delivery of care (to be completed by any member of the MDT)

4.1 Ongoing assessment

This care plan should be reviewed at least daily by the MDT

Minimum documentation is four hourly however certain psychosocial issues may only need assessment once per shift

MDT review. Is the person imminently dying?		☐ Yes	☐..No
If 'No', has the MDT agreed that this care plan should be discontinued?		☐ Yes	☐..No
Care plan discontinued:	Date: / /20	Time: : hours	
Please complete 'Section 6 - Care plan discontinued' and attach to the **front** page of this care plan and file			
Care plan day:	Date: / /20		

SYMPTOM MANAGEMENT

A = Assessment and no action required

F/A = Further action required

R/C = Routine care

N/A = Not applicable

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Free of pain												
Free of agitation/ restlessness												
Free of nausea/ vomiting												
Free of dyspnoea/ breathlessness												
Free of respiratory tract secretions												
Free of urinary problems												
Free of bowel problems												
Subcutaneous cannula care												
Subcutaneous infusion check												

PERSONAL COMFORT CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Receives food and fluids to support needs												
Is comfortably positioned												
Skin care needs are met												
Personal hygiene needs are met												
Mouth is clean and moist												
Eyes are clean and moist												
Environment supports needs												

PSYCHOSOCIAL CARE												
	0200	**0400**	**0600**	**0800**	**1000**	**1200**	**1400**	**1600**	**1800**	**2000**	**2200**	**2400**
Emotional, spiritual, religious, cultural needs/rituals are met												
Procedures/care plan explained												
Information regarding changes provided												
Relative/ friend(s) supported												
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial
Print name of person doing assessment												
N:												
AM:												
PM:												
N: RESPONSIBLE REGISTERED NURSE: (If different from above)												
N:												
AM:												
PM:												

YOUR LOGO HERE

CARE PLAN

FOR THE DYING PERSON
VICTORIA

UR no: _____
Surname: _____
Given name(s): _____
DOB: _____
Please fill in if no UR label available

4. Delivery of care

4.2 Further care action report

Date	Time	Issue/item	Action	Outcome of action			
				Was the action effective?		Time	Initial
				Yes	No		

YOUR LOGO HERE

CARE PLAN
FOR THE DYING PERSON
VICTORIA

UR no: ____________________
Surname: __________________
Given name(s): ______________
DOB: _____________________
Please fill in if no UR label available

4. Delivery of care

4.3 Integrated progress notes

IMPORTANT: Record any of the following: MDT reviews, changes in condition, appropriateness of the care plan (by MDT daily), significant events/conversations/visits or other

Time	Date	Notes	Designation

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5. Care after death (this section MUST be completed)

5.1 Verification of death

A doctor and/or registered nurse(s) can verify death. (*Refer to health service policy/procedures)*

Where a doctor is unavailable immediately to sign a Medical Certificate of Cause of Death (death certificate) or to document that a person has died, other health professionals (registered nurses and midwives) can **verify the fact of death.**

There is a minimum guideline for the clinical assessment necessary to establish that death has occurred.

Please refer to the **'Care Plan for the Dying Person – Victoria, Health professional user guide'** for further guidance.

Verification of death by:

Doctor/registered nurse	Signature
Registered nurse	Signature
Location of the clinical assessment	
Date of death: / /20	Time of death: : hours

☐	No palpable carotid pulse **and**
☐	No heart sounds heard for 2 minutes **and**
☐	No breath sounds heard for 2 minutes **and**
☐	Fixed (non-responsive to light) and dilated pupils **and**
☐	No response to centralised stimulus (e.g. trapezius muscle squeeze, supraorbital pressure, mandibular pressure or the common sternal rub) **and**
☐	No motor (withdrawal) response or facial grimace in response to painful stimulus (e.g. pinching inner aspect of the elbow)
☐	**Optional** ECG strip shows no rhythm

5.2 Notifying relative/friend(s)

Person(s) present at time of death	

If relative/friend(s) not present, have they been notified?		☐ Yes	☐ No
Name of person informed		Relationship	
The relative/friend(s) have been provided with information regarding the next steps, including bereavement information.		☐ Yes	☐ No

5.3 Care of the deceased

Care of the deceased has been undertaken according to the dying person's/relative/friend(s) wishes and health service policy/procedures	☐ Yes	☐ No

5.4 Communication by health service

Other documentation has been completed according to health service policy/procedures

• Death certificate or eMedical Disposition Form	☐ Yes	☐ No
• Discharge letter	☐ Yes	☐ No
• Other:	☐ Yes	☐ No

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The death is communicated according to health service policy/procedures.		
• Healthcare team/GP	☐ Yes	☐ No
• Health service IT system	☐ Yes	☐ No

If a 'No' is recorded, a further action **must** be recorded in Section 4.2: Further care action report

5.5 Coroner

Is this a reportable Coronial death? If 'yes', refer to health service policy/procedures	☐ Yes	☐ No

5.6 ONLY complete this section in the context of possible organ donation

Brain death may have occurred. The formal determination of brain death is usually in the context of organ donation and requires specific requirements and preconditions to its clinical determination.

☐ **Person declared brain dead**

Date of death: / /20	Time of death: : hours

Please attach a copy of the ANZICS documentation 'Determination of Brain Death'.

Consider any staff support needs following this death. Refer to health service policy/ procedures.

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

6. Care plan discontinued

6.1 Multidisciplinary team (MDT) decision making

Complete when the MDT has made the decision the person is no longer imminently dying and attach to the **front** page of this care plan and file.

Senior treating doctor Print name:	Signature:
Date: / /20	Time: : hours

☐ Verbal authorisation

☐ **Senior treating doctor** Print name: Pager/contact number:	Signature:
☐ **Registered nurse** Print name:	Signature:

Date: / /20	Time: : hours	Ward

Has the resuscitation plan been reviewed and updated?

☐ Yes, reviewed and updated ☐ Yes, reviewed and unchanged ☐ No

Has the CODE BLUE/MET call criteria been reviewed and updated (if needed)?	☐ Yes	☐ No

Other MDT decision makers (where applicable)

Name:		Designation:	
Name:		Designation:	

6.2 Reason(s) why the Care Plan for the Dying Person – Victoria was discontinued

6.3 Outline discussion with person/relative/friend(s)

Person involved in discussion and aware of discontinuation of **Care Plan for the Dying Person – Victoria**: ☐ Yes ☐ No

☐ Verbal

☐ Name:		Relationship:	
☐ Name:		Relationship:	

6.4 Referral to specialist palliative care service

Does the person require specialist palliative care referral?	☐ Yes	☐ No
Already referred, name of service:		
Describe reason for referral:		
Contact made by:		
Designation:		Date: / /20