

**Liverpool Care Pathway for the Dying Patient (LCP ICU)
Supporting care in the last hours or days of life in a Hospital
Intensive Care Unit**

**Information sheet to be given to the relative or carer following a
discussion regarding the plan of care.**

Your relative or friend is being cared for in the Intensive Care Unit (ICU). The doctors and nurses will have explained to you that there has been a change in your relative or friends condition. They believe that they have given the care required to achieve the best possible results but despite their best efforts and treatments the doctors and nurses believe that your relative or friend is now dying, and is in the last hours or days of life.

The LCP ICU is a document which supports the doctors and nurses to give the best quality of care in the last hours or days of life. All care will be reviewed regularly. All decisions will be reviewed regularly. If after a discussion with the doctors and nurses you do not agree with any decisions you may want a further discussion, a second opinion or discussion with the Specialist Palliative Care Team.

Communication

There are information leaflets available for you as it is sometimes difficult to remember everything at this sad and challenging time. If you plan to stay at the bedside with your relative or friend we will try and make you as comfortable as possible and if you wish to go home or leave the Intensive Care Unit for a period of time we will ask you for contact details as keeping you informed and updated is a priority.

Medication

Medicine that is not helpful at this time may be stopped and new medicines prescribed. Medicines for symptom control will only be given when needed, at the right time and just enough and no more than is needed to help the symptom. The type of medication and the way it is given will be explained to you.

Comfort

The doctors and nurses will not want to interrupt your time with your relative or friend. They will make sure that as far as possible any needs at this time are met. Please let them know if you feel those needs are not being met, for whatever reason.

You can support care in important ways such as spending time together, sharing memories and news of family and friends.

Organ and Tissue Donation

You may be approached by the Specialist Nurse in Organ Donation to discuss the option of organ and tissue donation. Your relative or friend may have had a wish to donate their organs/tissue, and this may be explored with you.



Information sheet to be given to the relative or carer continued:

Monitoring

We may reduce the amount of electronic monitoring and the number of tubes or drips. These decisions will be made in your relative or friend's best interest and may promote comfort and reduce intrusion.

The nurse looking after your relative or friend will leave you and your family to spend some private and uninterrupted time together at the bedside. However if you have any questions or concerns please ask us, we are here to help and support you during this time.

You may notice a change in your relative or friend's appearance. Their skin colour may change and become cooler and their breathing pattern may alter. These are natural and normal changes and if you have any questions, worries or concerns please speak to the nurse looking after your relative or friend.

Ventilation and Breathing

Your relative or friend may be on a breathing machine called a ventilator. The ventilator pushes oxygen in and out of the lungs making the chest rise and fall with each breath. If a ventilator is in use, the doctors and nurses will explain to you what to expect and any decision to change treatments that support your relative or friend's breathing will be discussed with you, before any changes are made.

Reduced need for food and drink

Your relative or friend may be receiving fluids by a drip or food via a tube. These will be continued if helpful and not harmful. Any decision to change these treatments will be discussed with you before any alterations are made.

Good mouth care is very important at this time. The nurses will explain to you how mouth care is given and may ask if you would like to help them give this care.

Caring well for your relative or friend is important to us. Please speak to the doctors or nurses if there are any questions that occur to you, no matter how insignificant you think they may be or how busy the staff may seem. This may all be very unfamiliar to you and we are here to explain, support and care.



We can be reached during daytimes at:.....

Night time at:.....

Other information or contact numbers (e.g. palliative care nurse / district nurse):

.....
.....
.....

This space can be used for you to list any questions you may want to ask the doctors and nurses:

.....
.....
.....



Name:..... NHS no:..... Date:.....

Liverpool Care Pathway for the Dying Patient (LCP ICU) Supporting care in the last hours or days of life in a Hospital ICU

Name of ICU Consultant: Name of Consultant from referring team: Ward:

As with all clinical guidelines and pathways the LCP ICU aims to support but does not replace clinical judgement

- ❑ This document has been designed to support patients who require ICU Level 3 care. Intensive Care Society (ICS) Definition of ICU level 3 care – Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least 2 organ systems. All complex patients requiring support for Multiple Organ Failure. *Intensive Care Society 2009.*
- ❑ The LCP ICU may be used to support patients who require Level 2 care if they are cared for in an environment where the management of the patient is coordinated by the ICU Team.
- ❑ The LCP ICU document guides and enables healthcare professionals to focus on care in the last hours or days of life of the level 3 ICU patient. This provides high quality care tailored to the patient’s individual needs, when their death is expected.
- ❑ Using the LCP ICU requires regular assessment and involves continuous reflection, challenge, critical senior decision-making and clinical skill, in the best interest of the patient. A robust continuous learning and teaching programme must underpin the use of the LCP ICU.
- ❑ The recognition and diagnosis of dying is always complex; irrespective of previous diagnosis or history. Uncertainty is an integral part of dying. There are occasions when a patient who is thought to be dying lives longer than expected and vice versa. Seek a second opinion or specialist palliative care support as needed.
- ❑ Changes in care at this complex, uncertain time are made in the best interest of the patient and relative or carer and needs to be reviewed regularly by the ICU Multi-disciplinary Team (MDT).
- ❑ Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented.
- ❑ If a goal on the LCP ICU is not achieved this should be coded as a variance. This is not a negative process but demonstrates the individual nature of the patient’s journey based on their particular needs, your clinical judgement and the needs of the relative or carer.
- ❑ The LCP ICU does not preclude the use of clinically assisted nutrition, hydration or antibiotics. All clinical decisions must be made in the patient’s best interest. A blanket policy of clinically assisted (artificial) nutrition or hydration, or of no clinically assisted (artificial) hydration, is ethically indefensible and in the case of patients lacking capacity prohibited under the Mental Capacity Act (2005).

The patient will be assessed regularly and a formal full ICU MDT review must be undertaken every 24 hours

For the purpose of this LCP ICU version 12 document - The term best interest includes medical, physical, emotional, social and spiritual and all other factors relevant to the patient’s welfare.

The responsibility for the use of the LCP ICU document as part of a Continuous Quality Improvement Programme sits within the governance of an organisation and must be underpinned by a robust education and training programme.

References: *Ellershaw J. & Wilkinson S. (2011) Care of the dying: a pathway to excellence. 2nd rev ed. Oxford: Oxford University Press. Ellershaw and Wilkinson Eds (2003) Care of the dying: A pathway to excellence. Oxford: Oxford University Press. National Institute for Clinical Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. London, NICE. MCPCIL (2009) National Care of the Dying Audit Hospitals Generic Report Round 2. www.mcpcil.org.uk. L. Chapman (2009) The LCP for the dying patient: what is its role in the ICU? European Journal of Palliative Care 16(3);116-119.*



Always remember that the Specialist Palliative Care Team are there for advice and support.

Name:..... NHS no:..... Date:..... Ward / Unit:.....

Algorithm – Decision making in: diagnosing dying & use of the LCP ICU Supporting care in the last hours or days of life in a hospital ICU Level 3

The ICU Team have identified that the patient may be dying despite optimal treatment

ICU Multidisciplinary team (MDT) assessment

- Is there a potentially reversible cause for the patient's condition?
- Could the patient be in the last hours or days of life?
- Is Specialist referral needed? e.g. Specialist Palliative Care or a second opinion

Patient is **NOT** diagnosed as dying (in the last hours or days of life)

Review the current plan of care

Discussion with the patient and relative or carer to explain the new or revised plan of care

Patient is diagnosed as dying (in the last hours or days of life). Patient, relative or carer communication is focused on recognition & understanding that the patient is dying

Discussion with the patient, relative or carer (IMCA as required) to explain the current plan of care & use of the LCP ICU

Contact on call Specialist Nurse in Organ Donation as soon as the diagnosis of dying is made by the ICU MDT

Determine Place of Care ICU / Other

The Liverpool Care Pathway for the Dying Patient (LCP ICU) is commenced including ongoing regular assessments

Preliminary discussions suggest that the patient is Brainstem dead

Follow local Brainstem death protocol and refer to Specialist Nurse in Organ Donation

A full ICU multidisciplinary team (MDT) reassessment & review of the current plan of care should be triggered when 1 or more of the following apply:

Improved conscious level, vital signs, functional ability, oral intake, mobility, ability to perform self-care

Concerns expressed regarding management plan from either patient, relative or carer or team member

It is **24 hours** since the last **full ICU Multidisciplinary Team (MDT)** assessment

and or



Name:..... NHS no:..... Date:.....

ICU MDT Decision / Diagnosing Dying				
Outcome of ICU MDT decision and discussion	Healthcare professional documenting the ICU MDT decision			
	Following a full ICU MDT assessment and a decision to use the LCP ICU:			
	Date LCP ICU commenced:.....			
	Time LCP ICU commenced:.....			
Consultant's Name (ICU):.....				
Discussion with referring team if applicable Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Name:.....				
ICU Consultant's Signature:.....				
Place of care:				
ICU <input type="checkbox"/>	Other hospital ward <input type="checkbox"/>	Home <input type="checkbox"/>	Hospice <input type="checkbox"/>	
	Contact Critical Care Outreach Team Yes <input type="checkbox"/> No <input type="checkbox"/> If no state why.....	Contact Hospital Specialist Palliative Care Team Yes <input type="checkbox"/> No <input type="checkbox"/>	DNAR order in place Yes <input type="checkbox"/> No <input type="checkbox"/>	Prescribe s/c medication Yes <input type="checkbox"/> No <input type="checkbox"/>
	Contact Hospital Specialist Palliative Care Team Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Contact Hospital Specialist Palliative Care Team Yes <input type="checkbox"/> No <input type="checkbox"/>			

All personnel completing the LCP ICU please sign below
You should also have read and understood the guidance on the previous pages

Name (print)	Full signature	Initials	Professional title	Date

Record all ICU MDT reassessments (including full formal ICU MDT assessment every 24 hours)

Reassessment date:..... Reassessment time:.....
 Reassessment date:..... Reassessment time:.....
 Reassessment date:..... Reassessment time:.....
 Reassessment date:..... Reassessment time:.....

If the LCP ICU is discontinued please record here:

Date LCP ICU discontinued..... Time LCP ICU discontinued.....

Reasons LCP ICU discontinued:.....

Decision to discontinue the LCP ICU shared with patient Yes No

Decision to discontinue the LCP ICU shared with relative or carer Yes No



Name:..... NHS no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Diagnosis & Baseline Information	DIAGNOSIS: Co-morbidity: Yes <input type="checkbox"/> No <input type="checkbox"/> please state:.....		Ethnicity:.....			
	DOB:..... Age:..... NHS no:.....		Female <input type="checkbox"/> Male <input type="checkbox"/>			
	At the time of the assessment is the patient:					
	In pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Able to swallow	Yes <input type="checkbox"/> No <input type="checkbox"/>	Confused	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Agitated	Yes <input type="checkbox"/> No <input type="checkbox"/>	Continent (bladder)	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>(record below which is applicable)</i>	
	Nauseated	Yes <input type="checkbox"/> No <input type="checkbox"/>	Catheterised	Yes <input type="checkbox"/> No <input type="checkbox"/>	Conscious	<input type="checkbox"/>
	Vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Continent (bowels)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Semi-conscious	<input type="checkbox"/>
	Dyspnoeic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipated	Yes <input type="checkbox"/> No <input type="checkbox"/>	Unconscious	<input type="checkbox"/>
	Restless	Yes <input type="checkbox"/> No <input type="checkbox"/>	Aware	Yes <input type="checkbox"/> No <input type="checkbox"/>	Intubated	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Distressed	Yes <input type="checkbox"/> No <input type="checkbox"/>			Respiratory Support	
UTI problems	Yes <input type="checkbox"/> No <input type="checkbox"/>			Ventilated	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Experiencing respiratory tract secretions			Yes <input type="checkbox"/> No <input type="checkbox"/>	CPAP	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Experiencing other symptoms (e.g. oedema, itch)			Yes <input type="checkbox"/> No <input type="checkbox"/>	N.I.V	Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Face Mask	Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Other		

Communication	Goal 1.1: The patient is able to take a full and active part in communication.	Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/>
	Barriers that have the potential to prevent communication have been assessed	
	First Language..... Other issues identified.....	
	Consider need for an interpreter (contact no):	
	Other barriers to communication.....	
	Consider: Hearing, vision, speech, learning disabilities, dementia (use of assessment tools) neurological conditions and confusion	
	The relative or carer may know how specific signs indicate distress if the patient is unable to articulate their own concerns	
	Does the patient have:-	
	An advance care plan?	
	An advance decision to refuse treatment (ADRT)?	
Does the patient have the capacity to make their own decisions on their own treatment at this moment in time?		
consider the support of an IMCA – please document below:		
Name:..... Contact details:.....		
Comment:.....		
Goal 1.2: The relative or carer is able to take a full and active part in communication	Achieved <input type="checkbox"/> Variance <input type="checkbox"/>	
First Language..... Other Issues identified.....		
Consider need for an interpreter (contact no):..... Other barriers to communication:.....		
Goal 1.3: The patient is aware that they are dying	Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/>	
Goal 1.4: The relative or carer is aware that the patient is dying	Achieved <input type="checkbox"/> Variance <input type="checkbox"/>	
Goal 1.5: The opportunity for organ/tissue donation is considered by the ICU MDT and the Specialist Nurse in organ donation has been contacted	Achieved <input type="checkbox"/> Variance <input type="checkbox"/>	
Organ donation supportive information letter given Yes <input type="checkbox"/> No <input type="checkbox"/>		
Tissue donation leaflet given Yes <input type="checkbox"/> No <input type="checkbox"/>		
Goal 1.6: The Clinical team have up to date contact information for the relative or carer as documented below	Achieved <input type="checkbox"/> Variance <input type="checkbox"/>	
1st contact name:.....		
Relationship to the patient:..... Tel no:..... Mobile:.....		
When to contact: At any time <input type="checkbox"/> Not at night-time <input type="checkbox"/> Staying with patient overnight <input type="checkbox"/>		
2nd contact:.....		
Relationship to the patient:..... Tel no:..... Mobile:.....		
When to contact: At any time <input type="checkbox"/> Not at night-time <input type="checkbox"/> Staying with patient overnight <input type="checkbox"/>		
Next of Kin (NoK) - this may be different from above		
Name:.....		
Contact details:.....		
Lasting Power of Attorney (LPA) (if applicable)		
Name:.....		
Contact details:.....		



Name:..... NHS no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Facilities	<p>Goal 2: The relative or carer has had a full explanation of the facilities available to them and an ICU facilities leaflet has been given Achieved <input type="checkbox"/> Variance <input type="checkbox"/></p> <p>Facilities may include: car parking, toilet, bathroom facilities, beverages, payphone, accomodation</p>
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Spirituality	<p>Goal 3.1: The patient is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith , beliefs, values, organ donation Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/></p> <p>Patient may be anxious for self/others. Consider specific cultural needs. Consider music, art, poetry, reading, photographs, something that has been important to the belief system or the well-being of the patient</p> <p>Did the patient take the opportunity to discuss the above Yes <input type="checkbox"/> No <input type="checkbox"/> Unconscious <input type="checkbox"/></p> <p>Religious tradition identified, please specify:</p> <p>Support of the chaplaincy team offered Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no give reason:.....</p> <p>In-house support Tel/bleep no: Name: Date/time:</p> <p>External support Tel/bleep no: Name: Date/time:</p> <p>Needs now:.....</p> <p>.....</p> <p>Needs at death:.....</p> <p>.....</p> <p>Needs after death:.....</p> <p>.....</p>
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	<p>Goal 3.2: The relative or carer is given the opportunity to discuss what is important to them at this time e.g. their wishes, feelings, faith, beliefs, values Achieved <input type="checkbox"/> Variance <input type="checkbox"/></p> <p>Comments.....</p> <p>.....</p>
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Medication	<p>Goal 4.1: The patient has medication prescribed on a prn basis for the following 5 symptoms which may develop in the last hours or days of life Achieved <input type="checkbox"/> Variance <input type="checkbox"/></p> <p>Pain <input type="checkbox"/></p> <p>Agitation <input type="checkbox"/></p> <p>Respiratory tract secretions <input type="checkbox"/></p> <p>Nausea / Vomiting <input type="checkbox"/></p> <p>Dyspnoea <input type="checkbox"/></p> <p>The patient is only receiving medication that the ICU MDT agree is beneficial at this time</p> <p>Anticipatory prescribing in this manner will ensure that there is no delay in responding to a symptom if it occurs</p> <p>Medicines for symptom control will only be given when needed, at the right time and just enough and no more than is needed to help the symptom</p>
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	<p>Goal 4.2: The patient has equipment to support a continuous infusion of medication where required Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Already in place <input type="checkbox"/> Not required <input type="checkbox"/></p> <p>If a continuous infusion is to be used explain the rationale to the patient, relative or carer. Not all patients who are dying will require a continuous infusion</p>
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Name:..... NHS no:..... Date:.....

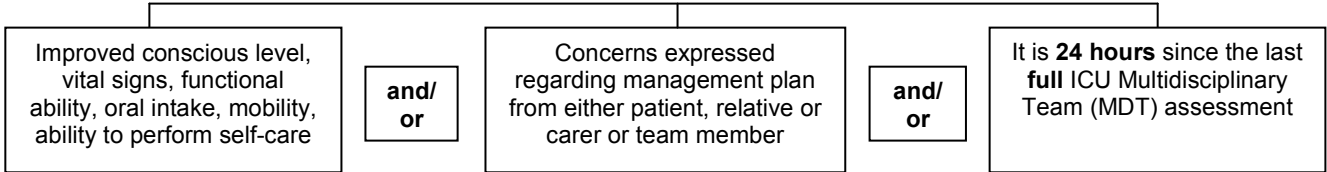
Variance analysis sheet for Initial assessment		
What variance occurred & why? (what was the issue?)	Action taken (what did you do?)	Outcome (did this solve the issue?)
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....



Name:..... NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP ICU DAY 1 (First 12 Hours)

Undertake an ICU MDT assessment & review of the current management plan if:



Consider the support of the specialist palliative care team and/or second opinion as required. Document all reassessment dates and times on page 4

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

Record an A or a V not a signature	HOURLY													
Goal a: The patient does not have pain Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use a pain assessment tool if appropriate. Consider prn analgesia for incident pain														
Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity														
Goal c: The patient does not have respiratory tract secretions Consider positional change. Discuss symptoms & plan of care with patient, relative or carer Medication to be given as soon as symptom occurs														
Goal d: The patient does not have nausea Verbalised by patient if conscious														
Goal e: The patient is not vomiting														
Goal f: The patient receives respiratory support according to their individual needs Monitor for signs of respiratory distress/breathlessness. Amend the mode of basic or advanced respiratory support given as appropriate. Explain the plan of care to the patient, relative or carer														
Goal g: The patient does not have urinary problems														
Goal h: The patient does not have bowel problems Monitor – constipation / diarrhoea. Monitor skin integrity Bowels last opened:.....														
Goal i: The patient does not have other symptoms Record symptom here..... <i>If no other symptoms present please record N/A</i>														
Goal j: The patient's comfort & safety regarding the administration of medication is maintained If IV/ CSCI in place – monitoring sheet in progress S/C butterfly in place if needed for prn medication location:..... The patient is only receiving medication that is beneficial at this time. <i>If no medication required please record N/A</i>														



Name:..... NHS no:..... Date:.....

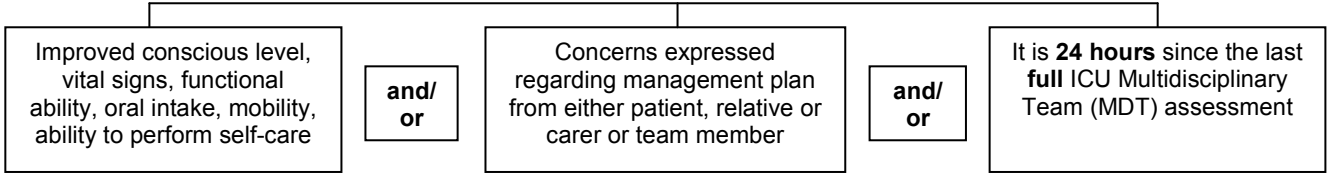
Section 2 Ongoing assessment of the plan of care – LCP ICU DAY 1 (First 12 Hours) continued											
Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)											
HOURLY											
Goal k: The patient receives fluids to support their individual needs The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration and/or distress. Consider the continuation of clinically assisted (artificial) hydration if in the patient's best interest. If in place monitor & review rate/volume. Explain the plan of care with the patient, relative or carer											
Goal l: The patient's mouth is moist and clean See mouth care policy. Relative or carer involved in care giving as appropriate. Mouth care tray at the bedside.											
Goal m: The patient's skin integrity is maintained Assessment, cleansing, positioning, use of special aids (mattress / bed). The frequency of repositioning should be determined by skin inspection and the patient's individual needs. <i>Waterlow/Braden score:.....</i>											
Goal n: The patient's personal hygiene needs are met Skin care, wash, eye care, change of clothing according to individual needs. Relative or carer involved in care giving as appropriate											
Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence/music, light/dark, pictures/photographs, nurse call bell accessible											
Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – Consider support of chaplaincy team											
Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents/carers. Allow the opportunity to reminisce. Offer/provide a drink											
Signature of person making assessment											
Signature of the registered nurse per shift	Night	Early		Late		Night					



Name:..... NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP ICU DAY.....

Undertake an ICU MDT assessment & review of the current management plan if:



Consider the support of the specialist palliative care team and/or second opinion as required. Document all reassessment dates and times on page 4

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

Record an A or a V not a signature	0400	0800	1200	1600	2000	2400
Goal a: The patient does not have pain Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use a pain assessment tool if appropriate. Consider prn analgesia for incident pain						
Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity						
Goal c: The patient does not have respiratory tract secretions Consider positional change. Discuss symptoms & plan of care with patient, relative or carer Medication to be given as soon as symptom occurs						
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Name:..... NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP ICU DAY..... continued

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

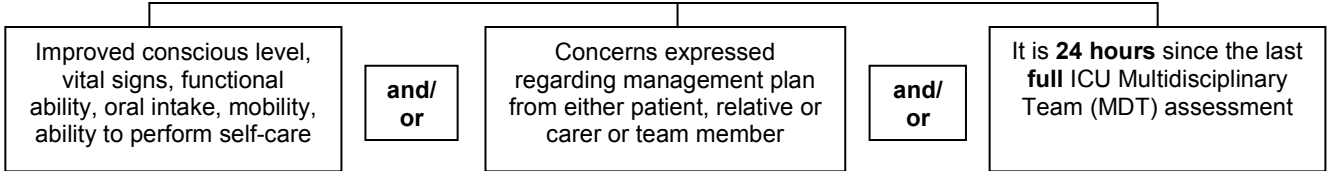
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<p>Goal n: The patient's personal hygiene needs are met Skin care, wash, eye care, change of clothing according to individual needs. Relative or carer involved in care giving as appropriate</p>						
<p>Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence/music, light/dark, pictures/photographs, nurse call bell accessible</p>						
<p>Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – Consider support of chaplaincy team</p>						
<p>Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents/carers. Allow the opportunity to reminisce. Offer/provide a drink</p>						
Signature of person making assessment						
Signature of the registered nurse per shift	Night	Early		Late		Night



Name:..... NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP ICU DAY.....

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Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity						
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Goal f: The patient receives respiratory support according to their individual needs Monitor for signs of respiratory distress/breathlessness. Amend the mode of basic or advanced respiratory support given as appropriate. Explain the plan of care to the patient, relative or carer						
Goal g: The patient does not have urinary problems						
Goal h: The patient does not have bowel problems Monitor – constipation / diarrhoea. Monitor skin integrity Bowels last opened:.....						
Goal i: The patient does not have other symptoms Record symptom here..... <i>If no other symptoms present please record N/A</i>						
Goal j: The patient's comfort & safety regarding the administration of medication is maintained If IV/ CSCI in place – monitoring sheet in progress S/C butterfly in place if needed for prn medication location:..... The patient is only receiving medication that is beneficial at this time. <i>If no medication required please record N/A</i>						



Name:..... NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP ICU DAY..... continued						
Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)						
	0400	0800	1200	1600	2000	2400
Goal k: The patient receives fluids to support their individual needs The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration and/or distress. Consider the continuation of clinically assisted (artificial) hydration if in the patient's best interest. If in place monitor & review rate/volume. Explain the plan of care with the patient, relative or carer						
Goal l: The patient's mouth is moist and clean See mouth care policy. Relative or carer involved in care giving as appropriate. Mouth care tray at the bedside.						
Goal m: The patient's skin integrity is maintained Assessment, cleansing, positioning, use of special aids (mattress / bed). The frequency of repositioning should be determined by skin inspection and the patient's individual needs. <i>Waterlow/Braden score:.....</i>						
Goal n: The patient's personal hygiene needs are met Skin care, wash, eye care, change of clothing according to individual needs. Relative or carer involved in care giving as appropriate						
Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence/music, light/dark, pictures/photographs, nurse call bell accessible						
Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – Consider support of chaplaincy team						
Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents/carers. Allow the opportunity to reminisce. Offer/provide a drink						
Signature of person making assessment						
Signature of the registered nurse per shift	Night	Early		Late		Night



Name:..... NHS no:..... Date:.....

Section 3 Care after death

Verification of death

Time of the patient's death recorded by the healthcare professional in the organisation:.....
 Date of patient's death:/...../..... Time of patient's death.....
 Verified by doctor Verified by senior nurse (trained to verify a death) Date / time verified:.....
 Cause of death.....

Details of healthcare professional who verified death

Name:..... (please print) Signature:..... Bleep No:.....
 Comments:.....

Persons present at time of death:.....
 Relative or carer present at time of death: Yes No If not present, have the relative or carer been notified Yes No
 Name of person informed:..... Relationship to the patient:.....
 Contact number:.....
 Is the coroner likely to be involved: Yes No
 Consultant:..... Doctor:..... Bleep No:..... Tel No:.....

Patient Care Dignity	Goal 10: last offices are undertaken according to policy and procedure Achieved <input type="checkbox"/> Variance <input type="checkbox"/> The patient is treated with respect and dignity whilst last offices are undertaken Universal precautions & local policy and procedures including infection risk adhered to Spiritual, religious, cultural rituals / needs met Organisational policy followed for the management of ICDs, where appropriate Organisational policy followed for the management & storage of patient's valuables and belongings
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Relative or Carer Information	Goal 11: The relative or carer can express an understanding of what they will need to do next and are given relevant written information Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Conversation with relative or carer explaining the next steps Grieving leaflet given Yes <input type="checkbox"/> No <input type="checkbox"/> DWP1027 (England & Wales) or equivalent is given Yes <input type="checkbox"/> No <input type="checkbox"/> Information given regarding how and when to contact the bereavement office / general office / funeral director to make an appointment – regarding the death certificate and patient's valuables and belongings where appropriate Wishes regarding tissue/organ donation discussed Discuss as appropriate: viewing the body / the need for a post mortem / the need for removal of cardiac devices / the need for a discussion with the coroner Information given to families on child bereavement services where appropriate – national & local agencies
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Organisation Information	Goal 12.1 : The primary health care team / GP is notified of the patient's death Achieved <input type="checkbox"/> Variance <input type="checkbox"/> The primary health care team / GP may have known this patient very well and other relatives or carers may be registered with the same GP telephone or fax the GP practice
	Goal 12.2 : The patient's death is communicated to appropriate services across the organisation Achieved <input type="checkbox"/> Variance <input type="checkbox"/> e.g. Bereavement office / general office / palliative care team / district nursing team / community matron (where appropriate) are informed of the death The patient's death is entered on the organisation's IT system

Healthcare professional signature:.....
Date:..... Time:.....

Please record any variance on the variance sheet overleaf

Section 3 Care after death ICU MDT progress notes - record any significant issues not reflected above

Date	



Name:..... NHS no:..... Date:.....

Variance analysis sheet for section 2 and 3 of the LCP ICU		
What variance occurred & why? (what was the issue?)	Action taken (what did you do?)	Outcome (did this solve the issue?)
<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>
<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>
<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>
<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>
<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>	<p>Signature:.....</p> <p>Date / Time:.....</p>



Name:..... NHS no:..... Date:.....

Variance analysis sheet for section 2 and 3 of the LCP ICU		
What variance occurred & why? (what was the issue?)	Action taken (what did you do?)	Outcome (did this solve the issue?)
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....
Signature:..... Date / Time:.....	Signature:..... Date / Time:.....	Signature:..... Date / Time:.....

LCP ICU SUPPORTING INFORMATION

Each organisation must develop medication guidance in accordance with local medicines management / palliative care guidelines / policy & procedure and reference them accordingly.

It is helpful to have the guidance attached to each LCP ICU.