‘Doing it my way’

GUIDELINES FOR IMPLEMENTING RELEVANT DOCUMENTATION IN END OF LIFE CARE

A life without limits for the people we support

ST ANNE'S COMMUNITY SERVICES

St Anne's Community Services is a Registered Charity, Number 502224, registered Provider (Social Housing, number H3158)

The following flowchart is designed to provide help and guidance to care staff members when implementing specific documentation to monitor an individual's health. Naturally, it should be adapted to allow for personal circumstances wherever necessary.

For guidance on how to complete the documentation, please refer to the examples we have provided for our notional character, Patricia Oxfield.

PRIOR TO MOVING IN:

- Medical History – document to be completed once - *Appendix 1*.
- Mental Capacity Assessment form – to be completed annually, or when required – *Appendix 2*.
- Client Positive Risk Assessment 3
- Mental Health Risk Assessment 4

AS SOON AS POSSIBLE AFTER MOVING IN:

- Weight chart (to gain a baseline) - monthly, or more often in the event of rapid weight loss or gain – *Appendix 5*.
- Waterlow (to gain a baseline) - monthly, or more often if health starts to deteriorate - Appendix 6.
- Bowel chart – daily – *Appendix 7.*
- Daily records – daily – *Appendix 8*.
- Moving In document – to be completed once – *Appendix 9*.
- POLE leaflet distributed to families – to be given to families before completing the Advance Care Plan – *Appendix 10*.
- My Advance Care Plan – once reviewed, then annually during PCP meeting – *Appendix 11*.
- Services that an individual comes into contact with – document to be completed once and amended as and when necessary – *Appendix 12*.
- Person-Centred Planning Meeting – annually – *Appendix 13*.
- PCP Action Plan – annually – *Appendix 14*.
- National Early Warning Score (to gain a baseline) – Monthly or more often if needed - *Appendix 15*.

OPTIMUM HEALTH:

- Health Care Guidelines – reviewed monthly and changed if necessary – *Appendix 16*.
- Menstruation Chart (if applicable) – as and when necessary – *Appendix 17*.
- Health Care Diary – after appointments, discussions or telephone calls with other healthcare professionals – *Appendix 18*.
- PRN guidelines (if necessary) – reviewed monthly or more often if required – *Appendix 19.*

DEPENDENT UPON PERSONAL REQUIREMENTS:

- Fluid Balance chart – completed daily – *Appendix 25*.
- Health Action Plan -completed once and reviewed as and when required – *Appendix 26*.
- Nursing Care Intervention Plans – completed as and when required, if in receipt of nursing Care – *Appendix 27*.
- Assessment of nutritional status – *Appendix 28*.

CARING AT THE END OF LIFE:

- 'Justin case' or Anticipatory Medication – depends upon personal needs but could be as frequent as hourly. GP and District Nursing Team will provide guidance at this stage – *Appendix 24*.

PROGRESSION OF DISEASE WHICH NO LONGER RESPONDS TO TREATMENT:

- Hospital tracking form (if applicable) – if hospital admission takes place, to be filled in daily until the individual returns home – *Appendix 22*
- Weight chart (to ensure changing needs are met) – monthly or more often if necessary to monitor weight gain or loss.
- Waterlow chart (to ensure changing needs are met) – monthly or more often if necessary to monitor deterioration of tissue.
- DNA CPR – *Appendix 23*.

LIFE THREATENING CONDITIONS THAT RESPOND TO TREATMENT:

- PRN Guidelines (if applicable) – reviewed monthly or more frequently if necessary.
- National Early Warning Score (to monitor observations and enable fast response) – monthly or more often if necessary.

CONGENITAL ABNORMALITIES THAT WILL AFFECT LIFE EXPECTANCY:

- Record of seizure chart (if applicable) – filled in after seizure - *Appendix 20*.
- Complete OK Health Check – annually in PCP meeting – *Appendix 21*.
  Note: There may be a fee to use this health check and you may wish to design your own.

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