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| **Date & Time** | **Gold Standards Framework Care Plan****Needs Based Coding Red** |
| * Patients have differing requirements at varying stages of their illness; the use of needs-based colour coding can be very helpful in prioritising need. This helps focus on giving the right care at the right time, within regular reviews to trigger actions at each stage
* Coding Red suggests patients may be in the final days of life requiring terminal care.
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| **Patient agreed goals/outcomes** |
| * To ensure high quality care in the last days of life, respecting and referring to the patient’s and relative/carer’s wishes.
* To ensure good clear comprehensive communication is given to the patient where appropriate and to the relative/ carer
* To ensure the changes in care are reviewed regularly by the multidisciplinary team.
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| **Actions, Intervention and Care Instructions** | **Signature & Date** |
| Recognition of dying phase. Review daily. |  |
| Establish patient preferred place of death |  |
| Consider rapid discharge to facilitate Preferred place of death |  |
| Consider deactivation of ICD. |  |
| Ensure effective communication with family and others important to the patient. Provide written information as appropriate. |  |
| Continual assessment, care planning and review to reflect 5 priorities of care and NICE guidance. Commence personalised care plan for care in the final days of life |  |
| Review ACP and Best Interest decisions to ensure care is provided in alignment with their wishes and preferences.  |  |
| Consider religious, spiritual, and cultural needs. |  |
| DNACPR in place. |  |
| Anticipatory medication in place. Access to syringe driver available if required. |  |
| Update GP/OOH’s/ EPaCCS if patient is being discharged and equipment is in place |  |
| Support families and others important to the patient – If PPD is ward-based care review accommodation, refreshments, etc |  |
| Patient’s personalised goals / interventions: |  |