The Impact of the LCP on care at the end of life – Case Note Analysis

Unique Identifier:

1. Demographic information

a) Date of birth	b) Gender
c) Religion	d) Ethnicity
e) Date of admission	f) Date of transfer to ICU (ICU only)
g) Diagnosis on admission	

2. Death

a) Date of death	b) Time of death	
c) Date of Verification	d) Time of verification	e) Verified by (staff)
f) Cause(s) of death i. ii. iii.		
g) Was this patient referred to the coroner? (Details: postmortem, etc.)		

3. Advanced directives

a) Last documented preferred place of care (location, date and time)

b) Last documented preferred place of death (location, date and time)

c) How was this information recorded (i.e. formal document, etc.)?

d) Last documented DNAR statement (Date, status)

e) Details of any other form of advanced directive used (e.g. Living Will)

4. Identifying the dying phase (last hours or days of life)

a) Date and time patient was identified as being in the dying phase

b) Which members of staff were involved in this discussion? (Profession and grade)
c) Which relatives/informal carers were involved in this discussion? (Relationship to patient)
d) If the relative/informal carers were not present for this discussion, when were they informed? (Date, time and method of communication)

e) How has the commencement of the dying phase been identified (i.e. LCP commenced, MDT meeting, discussion with family, etc.)

5. The dying phase (between identification of dying phase and time of death)

a) Narrative of conversation(s) with the relatives/carers regarding the patient's condition and plans for their care (e.g. who was present, topics discussed, outcome)

b) Is there documented evidence that visitors were given the opportunity to remain in the environment overnight? (e.g. what facilities were offered, did relatives stay overnight)

c) Narrative relating to the patient's cultural, spiritual and/or religious needs (e.g. how were these needs identified and addressed? With whom were they discussed?)

d) Narrative relation to the assessment / (dis)continuation of current medications, including artificial hydration and/or nutrition (e.g. saline, nasogastric tube [ng], Ryall's tube, etc.)

e) Narrative relating to the prescription of prn medication (as identified on the drugs chart)

f) Narrative relating to use / discontinuation of a syringe driver (csci) [NH only]

6. The last 24 hours of life (record frequency, assessment, staff involved, care undertaken, etc.)

NB: All medication has been recorded on copy of the drugs chart, and appended

a) Narrative relating to the following: pain, agitation, RTS, nausea, vomiting, dysnoea

b) Narrative relating to assessment and care of the patient's hygiene needs

c) Narrative relating to assessment of the patient's mouth and eye care needs

d) Narrative relating to assessment and care of the patient's repositioning

7. After death

a) Who was present at the time of death? (i.e. relationship to patient)

b) Narrative indicating that the procedures for laying out were followed according to policy
c) Narrative relating to how the patient's cultural, spiritual and/or religious beliefs were respected at time of death and after (i.e. what was to done to ensure this?)
d) Was the medical equipment was removed at the time of death? (PEG, ICD, syringe driver, bags of fluid, machinery, etc.)

e) Narrative relating to relative/carer being given information on what to do next (e.g. written or verbal information, bereavement services, etc.)
f) Narrative indicating that the Primary Health Care Team was informed (date, time, method)

g) Narrative of any other pertinent care after death

Tick here to confirm that a copy of the drugs chart is attached to this CNA document ❒

8. Continuation (record question # being continued)