**Creating a Coordinate My Care Emergency Treatment Plan**

**for Adult Patients Likely to be in the Last Year of Life**

Coordinate My Care (CMC) is the live electronic palliative care coordination system (EPaCCS) used across London for the documentation of Advance Care Plans. CMC has replaced the use of PEACE and Thinking Ahead although previously created documents may still apply if a CMC record has not been created subsequently. This guidance should be read in conjunction with the CMC Standard Operating Procedure (SOP).

**Who is this guidance for?**

* Registered health care professionals (primarily doctors and Clinical Nurse Specialists) creating or updating the Emergency Treatment Plan (ETP).

**What is the Emergency Treatment Plan?**

* Crisis guidance for registered healthcare professionals who may not be familiar with the patient.
* Particularly useful for Care Home Staff and Urgent Care Services e.g. 111 and Ambulance Services.
* Specific, individualised clinical advice and not simply guide the viewer to seek advice elsewhere.
* **NOT** aimed at other carers or family members, although they should be involved in preparation of this section and aware of its content.
* **NOT** intended to document the patient’s wishes and priorities in relation to non-medical aspects of personal care which should be documented in the **Preferences** section under **Patient Wishes**. e.g. dietary requirements, favourite music etc.

**Which patients require an Emergency Treatment Plan?**

* All patients leaving hospital in the last weeks or short months of their lives (i.e. GSF Amber or Red) should have a CMC record including an ETP.
* May also be appropriate for patients with a longer prognosis if complex needs.
* Suggested management will lean more towards palliative management in the community rather than active management in hospital; however we are likely to care for many other patients with a CMC record who may have a longer prognosis and in which case a more active approach to management may be appropriate.
* The ETP should always reflect the individual patient’s circumstances and wishes.

**Preparing to create/update the Emergency Treatment Plan.**

* Relevant problems/symptoms and clinically appropriate management should always be guided by the responsible Consultant (or most senior member of the team available on their behalf, ideally ST3 or above) or the Specialist Palliative Care Team prior to discussing with the patient/advocate.

**Agreeing the Emergency Treatment Plan with the patient & family**

* Include the patient’s family or other main carer in discussions about the ETP (with the patient’s consent).
* Offer patient (or advocate) information about potential options which are likely to benefit them, allowing them to accept or decline these options.
* Together agree a plan which is medically appropriate and acceptable to the patient (or advocate).

**Documenting and Sharing the Emergency Treatment Plan**

* Complete and finalise the ETP only after agreeing content with patient/advocate and/or family.
* Offer patient/advocate and/or their family access to CMC (via myCMC or proxy access) and a printed copy of the CMC record.
* Offer patient’s main carer **Providing Comfort and Care at the End of Life** leaflet (found on the intranet and available in print). This leaflet addresses the more personal wishes and needs as well as the generic needs of patients in the last days or weeks of life. It is aimed to guide and reassure both trained and informal carers and families. A similar advisory poster is available in local care homes, published by North East London Foundation Trust (NELFT) and entitled End of Life and Comfort and Care.

**Guidance on content of the Emergency Treatment Plan**

* This guidance is intended to encourage rigorous thought and discussion of appropriate management for each problem/symptom.
* As above, relevant problems/symptoms and clinically appropriate management should always be guided by the responsible Consultant prior to discussing with the patient/advocate.
* For patients in the **last days of life**, all sections indicated with an asterisk**\*** must be completed.
* For patients with a longer prognosis it is not essential to complete all sections if not relevant to your patient but if a particular problem is already present, definitely anticipated or particularly likely to occur state this clearly.
* Guidance should be concise to be of utmost benefit to clinicians in an emergency situation.

**Prescribing**

* Please see the Palliative Care pages of the BHRUT intranet for additional information on appropriate medications (Prescribing Guidance and Authorisation).
* N.B. A Medicines Authorisation and Administration Record (MAAR chart) is required for injectable medications by all community healthcare professionals including Ambulance Services.

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| **Anticipated Problem or Symptom** | **First Line Management**  Consider including immediate non-pharmacological management. |
| **Crisis Management\*** | Known to Saint Francis Hospice / Redbridge Community Team. Please call XXX if any concerns.  Document carefully whether or not hospital treatment should be considered in the event of specific serious incidents which could affect any patient e.g. fractured neck of femur, stroke, cardiac event, gastrointestinal (GI) bleed or head injury.  Might hospital treatment be required to promote comfort? Would hospital treatment be appropriate/desirable with the aim of prolonging life? Have you prescribed any medications which could be useful in the event of a crisis?  Include potential palliative care emergencies or other complications specific to your patient’s condition (e.g. GI obstruction, ascites, spinal cord compression or superior vena cava obstruction) with clear guidance on appropriate management and goals of treatment.  Suspected infection is a common problem.  Provide guidance on features of infection that may be observed e.g. fever and delirium.  Consider in what circumstances treatment would be appropriate and what the goals of treatment would be. Are there any circumstances in which admission to hospital for intravenous antibiotics may be appropriate? Usually assessment by a community doctor e.g. GP would be appropriate to assist with diagnosis and management planning taking into account your guidance.  If antibiotics are not appropriate or possible to administer in the preferred place of care it may be more appropriate to control fever (fan therapy, cold compresses and Ibuprofen/Paracetamol). You may wish to advise of the anticipatory medication you have prescribed. |
| **Bleeding** | Does the patient have any potential sources of bleeding? If bleeding occurred (either minor or major) how might this be managed?  If a catastrophic haemorrhage is possible/expected then you may wish to highlight that the most effective intervention is staying present and providing reassurance. Also recommend dark blankets to camouflage the blood.  NB If you are prescribing a larger than usual dose of Midazolam specifically for potential catastrophic bleeding ensure you also complete the specific section of the pan London Medicines Authorisation and Administration Record (MAAR chart). |
| **Breathlessness\*** | Breathlessness is a common symptom and should usually be discussed. Depending on the specific circumstances and prognosis of the patient you should consider whether there may be any reversible causes requiring medical assessment and/or treatment, and specify any medications you have prescribed with the aim of reducing breathlessness.  Excessive respiratory secretions and irregular (Cheyne-Stoke) breathing are frequent symptoms in the last hours of life. Both should be specifically mentioned with appropriate management (including reassurance of family) when prognosis is poor.  You may also want to give advice on patient positioning, particularly for patients in care homes. |
| **Delirium - in the context of a dementia diagnosis** | For patients with Dementia consider how you would advise delirium is managed.  Consider how this might be reversed and medication you have prescribed which may be of use. Consider whether or not investigation/treatment of a potential cause is appropriate. E.g. Urinary Tract Infection. |
| **Seizures** | Include this section if seizures are a significant possibility or previous problem. Consider providing a brief seizure history in addition to advice on first aid, medication and further management (including dose of anticonvulsant +/- steroids) in the event of a seizure.  If your patient takes a regular anticonvulsant give advice on alternative management in the event that your patient is unable to swallow oral medication. |
| **Medication related problems** | Consider providing advice on alternative routes of any medications which should be continued if oral medication is no longer appropriate.  Examples of medications which could require specific advice due to risk of complications or difficulty administering are:   * hypoglycaemic medications * steroids * opioids * insulin |
| **Mental Health Emergencies** | Consider whether your patient has any pre-existing mental health issues and any resultant difficulties which may arise. If needed seek specialist advice in order to complete this section.  Include Community Mental Health Team details either here or in the ‘Contacts’ section. |
| **Nausea and Vomiting\*** | Consider potential causes of nausea and vomiting and advise accordingly.  State any medications you have prescribed which may be of use, and whether or not investigation/treatment of a potential cause is appropriate. |
| **Pain\*** | Guidance here will vary depending on whether pain is a pre-existing complaint or a future possibility.  Consider advising on common reversible causes of pain such as urinary retention, constipation or pressure areas.  State any medications you have prescribed which may be of use, and whether or not investigation/treatment of a potential cause is appropriate. If you anticipate additional medications may be required in the future, specify them here.  If your patient is being discharged to a care home you should also advise on non-pharmacological methods of reducing pain and anxiety i.e. soft lighting, music, scents, touch, massage, heat, repositioning, checking for common reversible causes. |
| **Terminal Restlessness\*** | Terminal restlessness with no clear cause is a common symptom at the end of life; however you should consider and document potential causes of discomfort which could lead to restlessness and should be ruled out e.g. urinary retention, constipation, pressure areas. Emotional or spiritual distress may also be a factor in which case reassurance etc. may be of benefit.  State any medications you have prescribed which may be of use. |
| **Worsening Liver Function** | If patient is at risk of worsening liver dysfunction, document the likely cause, symptoms/signs and appropriate management. |
| **Worsening Renal Function** | If patient is at risk of worsening renal dysfunction, document the likely cause, symptoms/signs and appropriate management. |
| **Worsening Mobility and Falls\*** | Deteriorating mobility is inevitable as the end of life approaches in the context of steadily increasing frailty, and this should be clearly stated. However you should consider whether a sudden change in mobility would require investigation e.g. is spinal cord compression or intracerebral pathology likely to be an issue.  In the event of falls resulting in head or limb injury consider whether there are any circumstances in which you patient may benefit from assessment/treatment in hospital or whether management of symptoms in their usual place of care would me more suitable. |
| **Worsening oral intake of food and fluids\*** | Gradual reduction in appetite and oral intake (often associated with difficulty swallowing) is to be anticipated in the last days of life and this should be clearly stated. In this circumstance encourage carers to offer food and fluids while awake and able to tolerate.  Artificial nutrition/hydration is not usually indicated with this natural decline in oral intake at the end of life but consider whether there are any specific circumstances for your patient in which artificial nutrition/hydration should be considered and if so, by what route. E.g. Are they likely to develop disease specific dysphagia or GI tract obstruction?  Consider giving advice on mouth care and monitoring for signs of oral candida. |
| **Other** | Many patients will have other issues that require guidance. You may add as many ‘Other’ anticipated problems or symptoms as you need within this section.  As above consider describing how these issues may present and suggest appropriate assessment and treatment.  Examples of the kind of “other” issues that may be *relevant* include:   * New onset delirium * Suspected infection * Blocked urinary catheter * Constipation * Ascites * Itch * Tracheostomy management * Management of pre-existing artificial nutrition/hydration |