1. TAB ONE GSF Prognosis

#### Consent Status Requires patient or their representative to give their consent for information in this template to be uploaded to the Summary Care Record.

Details of person giving consent and rationale if NOT patient:

Palliative care plan review taken place in the last 4 weeks Date…………………….

|  |  |
| --- | --- |
| Stable | **🞏** |
| Liable to exacerbations | **🞏** |
| Ongoing Symptom control issues | **🞏** |
| Deteriorating | **🞏** |

**Current trend of patient’s condition**

|  |  |
| --- | --- |
| BLUE – Year plus prognosis likely | **🞏** |
| GREEN – deterioration seen over months | **🞏** |
| YELLOW – deterioration seen weekly | **🞏** |
| RED days – daily deterioration | **🞏** |

**GSF Stage – Possible Prognosis**

#### Functional Status

**Australian** **Modified Karnofsky Performance Status Scale:** …………………..% score

100% - Normal, no complaints, no evidence of disease

90% - Able to carry out normal activity, minor signs or symptoms of disease

80% - Normal activity with effort, some signs or symptoms of disease

70% - Cares for self, but unable to carry out normal activity or to do active work

60% - Able to care for most needs, but requires occasional assistance

50% - Considerable assistance and frequent medical care needed

40% - In bed more than 50% of the time

30% - Almost completely bedfast

20% - Totally bedfast and requiring extensive nursing care by professionals and/or family

10% - Comatose or barely arousable, unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly

1. TAB TWO GFS Meeting - Plan

#### GSF Stage – Blue Prognosis likely >12months

[ ]  Discussion/information around Advance care Planning ……………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………….

[ ]  Known to Social Services ………………………………………………………………………………………………………………….

[ ]  Information around finance provided (e.g. CAB, MacMillan )…………………………………………………………..

………………………………………………………………………………………………………………………………………………………………………

[ ]  Need for patient to consider a Will discussed (particularly if co-habiting) or leaflet provided

……………………………………………………………………………………………………………………………………………………………………….

#### GSF Stage – GREEN Monthly deterioration or Symptom Control Issues

[ ]  DS1500 disability living allowance completed. Date…………………………..

[ ]  Referred to Community Care team for identified care needs or introduction of service

[ ]  Information about local hospice services provided. (e.g. day centre )

[ ]  “Rescue Medications” considered (e.g. antibiotics, steroids, anti-emetics, diuretics)………………………

………………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………...

#### GSF Stage – YELLOW Weekly change or Potential Sudden Event

[ ]  NHS Continuing Healthcare Fastrac funding applied for. Date of application …………………………………..

☐ Preferred place of death already recorded?

[ ]  Anticipatory medications - FP10 and community administration PRN charts issued. Drugs and charts

in patient’s home…………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………….

[ ]  Hospital bed, mattress and continence equipment considered. Anything needed or on offer?

………………………………………………………………………………………………………………………………………………………………………

#### GSF Stage – RED Daily Deterioration. Dying

[ ]  Frequent Community Nursing Input.

[ ]  Package of Care in place sufficient to support needs………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………………

[ ]  Known to the Hospice at Home / End of Life nursing team

[ ]  Verification of Death form completed where appropriate.

#### Resuscitation Status and Documentation

[ ]  DNACPR form discussed and in place

1. TAB THREE Future Planning

#### Considerations for Care before Death

**Patient, Family or Next of Kin wishes & preferences for care** – detail below.

**Preferred Place of Death** e.g. discussions so far, 2nd choice if 1st not possible…

|  |  |
| --- | --- |
| Cardiac pacemaker only | **🞏** |
| Active cardioverter defibrillator | **🞏** |
| Cardioverter defibrillator deactivated | **🞏** |

**Pacemaker & Status of Internal Cardiac**

#### Considerations for Care After Death

**Wishes and Requirements following death.** Preparation of the body. Other religious, cultural, family or patient requirements/wishes. Is the patient to be buried or cremated.

[ ]  **DOLS in place**. Will require referral to coroner if DOLS granted.

[ ]  **Referral to Coroner Required.** Detail reasons.

**Wishes to be a tissue donor.** This may include details of research requests for rare condition. Include contact details if available.

#### Support Available - Provide names and telephone numbers of any teams available Out of Hours

1. TAB FOUR Avoiding Unplanned Admissions

**Who does the patient live with?**

**Home access information, risks, Pets & other**. Record details relevant in an emergency situation.

**Emergency Contact Details 1**. Name & Tel./s plus address if known.

……………………………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………..

**Next of Kin.** Name & Tel./s plus address if known.

……………………………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………..

**🞏 Power of Attorney in place.** Name & Tel./s plus address if known.

……………………………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………..

#### Treatment Escalation Planning. Record problem/s and suggested management of each. Where necessary include whether patient, family or clinicians agree to each management plan.

**Anticipated problems related to EoL condition, if present.**

**Anticipated problems due to other conditions, if present.**

**Treatment Escalation Plan** (details of any discussions about admission etc. if not entered above)

**🞏** **Has Advance Decision to Refuse Treatment**. Give location of document and brief details of content.

……………………………………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………….

**Patient CPR Status.**Give details if patient, family or others not all in agreement with status.

Also give location of DNACPR document if completed.

1. TAB FOUR AUA

Observations to be considered with Avoiding Unplanned Admissions

**🞏** **Diabetic on insulin** – usual BM range and suggested response if abnormal

**🞏** **Type 2 respiratory failure**

**🞏** **Is patient at risk of CO2 retention?** Please see information below and record details.

|  |
| --- |
| **CO2 Retention Risk Factors (BTS guidelines 2012):**Patients may be at risk of CO2 retention and therefore respiratory depression with higher oxygen concentrations if;* They have a past history of CO2 retention
* They have chronic chest disease, such as COPD, musculoskeletal disease or chronic neuromuscular conditions.
* They have all 3 of the following risk factors;
	+ long term smoker
	+ >50 years old
	+ unexplained exertional dyspnoea
 |

**🞏** **Has home O2** – please specify reason and normal/acceptable O2 sats range

**Heart rate and rhythm** – please document useful information (e.g. AF, on betablockade, normal rate, etc.)

**Any longstanding abnormal signs / examination findings**  e.g. hemiparesis or glass eye, etc.