**The 10 Cs For Care of Patients Who May Be Dying**

Any patient who is seriously ill has a risk of death. When planning care for such patients it is always important to consider not only the possibility of improvement but also the possibility of stasis and even of continued deterioration with subsequent death. There is thus the need to have:

* Plan A – active treatment aimed at recovery
* Plan B – active treatment aimed at a good and dignified death

**C 1 Consider dying as a possibility**

* Possibility / probability / uncertainty
* What primary disease(s) does the person have?
* Trajectory – how are they / how were they / speed of change?
* Would you be surprised…?
* Consider CDM lists, Care Home residents, Housebound
* SPICT

**C 2 Competence (your own!)**

* Do you have enough knowledge, skills and experience?
* Do you need help?

**C 3 Compassion**

* Are you demonstrating compassion at this critical time?
* Are you giving care the way you would like to be cared for?
  + Be polite and courteous
  + Make it personal
  + Show interest
  + Little touches – unbidden acts of human kindness(!)
  + Give your time (even if you have very little!)

**C 4 Capacity**

* Does the patient have capacity?
* If not do they have a legally appointed representative e.g. PoA, Guardian?

**C 5 Communication – without this all below will probably fail**

* Who needs to know?
  + Patient / family / loved ones
  + All health and social care professionals who are, or may become, involved e.g. District Nurses, GPs, OOH Services, Acute, Specialists, Social workers, Social Carers, GP reception staff…
* What needs to be known?
  + Patient / family / loved ones views
    - What is important to them
    - What they want
    - What they don't want
    - Who they want involved
  + Professional views
    - Possibility / probability of death / need for Plan A & Plan B
    - Prognostic uncertainty
    - What we know or suspect
    - What we are concerned might happen
    - What the plans are
* How can this be improved?
  + Gathering
    - My Thinking Ahead & making Plans (MTA&MP)
  + Sharing
    - Key Information Summary (KIS)

**C 6 Current needs (or Comfort measures)**

* Consider the patients current needs
  + Physical
    - Symptom relief
    - Bowel / bladder care
    - Oral care
  + Psychological
  + Personal
    - Social
    - Spiritual – the inner self

**C 7 Ceilings of treatments / interventions**

* What are the ceilings of treatment / intervention? E.g.
  + Transplant
  + Transfer HDU / CCU
  + Ventilation
  + Dialysis
  + Surgery
  + Chemotherapy (including trial) / Radiotherapy
  + Implantable cardiac devices (defibrillators)
  + CPR
  + Nutritional support
  + Hydration – including S/C fluids
  + Blood tests – arterial / venous / capillary
  + Admission to Acute Hospital
  + I/V antibiotics
  + Oral antibiotics
  + Routine positional change

**C 8 Care Planning**

Consider

* Probable – what is likely to happen
* Possible – what might happen
* Prescribing
  + Rationalise medications –
    - What is essential
    - What is not needed
    - What to do with those in between
  + What might be needed?
    - Anticipatory prescribing / Just in Case
  + Need for S/C route? (Almost always needed)
* Processes
  + RNVoED
  + DNACPR – dealt with along with other ‘ceilings of treatment’
  + Individualised End of Life Care Plan (coming attraction!)

**C 9 Care in the Last Stages of Life**

**When dying is inevitable**

* Plan B – active treatment aimed at a good and dignified death is the only option
* Plan A – active treatment aimed at recovery is no longer viable
* This may only become apparent very close to end of life particularly in patients with non-malignant disease

**Care Planning in the Last Stage of Life – C 8**

* Essential that this is preceded by Care Planning earlier in trajectory
* Review ceilings of treatment / intervention – C 7
  + Including hydration
* Review probable / possible events
* Review current needs / comfort measures – C 6
  + Physical
    - Bowel and bladder function
    - Mouth care
    - Unpleasant medical/nursing interventions
  + Psychological
  + Personal
    - Social
    - Spiritual
* Review medication
  + What is still needed?
  + What is not needed?
  + What might be needed? (Just in Case anticipatory prescribing)
  + S/C route?
* Review processes
  + KIS update
  + Verification of Expected Death (VoED)
  + DNACPR (this should have been dealt with earlier)
* Plan for death

**Communication – C 5**

* Essential that all are aware and understand that death is inevitable and that now only ‘Plan B’
* Essential that all are aware of diminishing and eventually absent prognostic uncertainty

**Compassion – C 3**

* Demonstrate compassionate care at this critical time

**C 10 Continuing Care**

**Care after death of patient**

The episode of care does not end with the death of the patient.

For recently bereaved people knowing that support is available is hugely important.

Some factors can make matters more complicated e.g. if the patient died in hospital or was a patient of a different practice.

* Bereavement support
  + Ensure all practice staff know of death (top tips for staff card)
  + Consider noting details of deceased in key relative’s records
    - Date of death / relationship / cause of death
  + Consider contacting bereaved relative
    - Letter / Telephone
    - Surgery appointment
    - Visit
  + Consider informing GP practice of key relative(s) of deceased if not with your own practice
  + Consider possible need for additional bereavement support