The Greenwich Care Home Illness Plan (GCHIP)

Patient name and DoB		
Relative name address and contact number		
Named/primary nurse		
GP		

In the event of worsening in the condition of this patient, the recommendations below should be observed.

Contingency Plans

Intensive medicine

We *do/ do not recommend* that cardiopulmonary resuscitation, ventilation or intensive care medicine is appropriate[1] GP to initial and dateف

We *do/ do not recommend* that Cancer chemotherapy or other treatments with severe side effects are appropriate (*but could discuss further if the need arose*)[2]
GP to initial and dateف

We *do/ do not recommend* that Complex surgical procedures are appropriate (*but could discuss further if the need arose*)[3] GP to initial and dateف

Use of Acute hospitals[4]

We *do/ do not recommend* that hospital admission may be appropriate for injuries such as fractures[5] GP to initial and dateف

We *do/ do not recommend* that hospital admission may be appropriate for illness such as chest infections[6] GP to initial and date
ف

If dehydration occurs and is causing the patient to suffer then we *do/ do not recommend* that hospital admission may be appropriate to treat this.[7] GP to initial and dateف

Terminal care

When dying is imminent and the patient is distressed *we would expect* that medication will be given to alleviate the distress that may occur during death[8]
GP to initial and dateف

Further recommendations

THE GCHIP IS A LIVE AND CHANGING DOCUMENT AND CAN BE REASSESED AT ANY TIME IN DISCUSSION WITH FAMILY/ADVOCATES ETC

THE DOCUMENT IS INTENDED TO BE A BROAD EXPRESSION OF WISHES AND EXPECTATIONS. IF A DECISIONS APPEAR TO BE CAUSING SUFFERING OR AVOIDABLE HARM, THEN ITS AUTHORITY SHOULD BE QUESTIONED.

Declaration by key relative/ advocate

I understand the above and think that it reasonable

…….. Date……..

ڤThe patient has made an advance directive and this has been included in the discussions
The patient has not made an advance directive

ڤThe patient has made a Lasting Power of Attorney and appointed ……..
to make health care decisions on his her behalf [9]

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The following people should be contacted as and when the is a significant deterioration in the patient clinical condition

Appointee of Lasting Power of attorney …….

Next of kin/ advocate …….

Pastor / faith representative[10] …….

Others …….

Further requests
These might include people who would want to be with the patient when they are dying etc.

This form is to be kept in the front of the nursing home notes and a copy should be sent with the paitent in the event of any trips to hospital etc

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Explanatory notes for relatives

The GCHIP should be filled in soon after arrival in the nursing home and should involve the family members, staff at the home and GP as well as other relevant professionals. It aims to recognize why the patient is here, and aims to allow the reality of multiple medical and other problems to be recognized. Many residents are approaching the last months or years of their lives and so it is even more important that this nursing home becomes their home.

In such circumstances it is the case that, for many, acute hospital medicine can be more distressing and less effective than might be hoped for. This document aims therefore to promote discussion of what may happen in future as a result of illness or deterioration in the persons health. One concern may be that in such circumstances, going to hospital as a result of a deterioration may merely mean a change of location, along with intensive medicine and distress, but without any real change in outcome.

So please look carefully at this document and the explanatory notes at the end. If you have concerns you must discuss them through with the nursing staff. As time passes, the decisions made now may change as a result of changes in the illness of the patient. So please remember that this can be re-discussed and changed at any time.

We often find that relatives are distressed and some feel that they are responsible for deciding if someone lives or dies. This is, of course, untrue; such decisions very rarely make the difference between life and death, but they can make a big difference to a persons experience and suffering. As a result, the main page of this document is a series of recommendations about the sort of care the person may receive. With each recommendation there is an attached explanatory footnote to explain a little why such a decision may be made.

IF YOU DISAGREE WITH ANY OF THE RECOMMENDATIONS AND FEEL THAT THEY ARE NOT REASONABLE, WE ABSOLUTELY WANT YOU TO DISCUSS THIS THROUGH AGAIN WITH STAFF.

Below are some notes to explain why some of the decisions suggested might be made.

1 Cardiopulmonary resuscitation has a very low success rate when undertaken in nursing homes (less that 1 in 100 survive). It is almost always associated with worsened confusion and also distress. Ribs are frequently broken and if the patient survives they will spend their time on an intensive care unit on a ventilator etc. if they did survive, this might be very distressing for them.

2 Treatments for some cancers involve very toxic chemicals which cause severe nausea, distress and pain. Examples are some forms of treatment for leukaemia or breast cancer. In people with memory problems and other frailties such treatments may hasten death but may also be very distressing as the patient will not be able to understand what the treatment is for etc.

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3 Complex surgical procedures carry considerable risk and are painful and difficult. There may therefore be patients in whom simpler interventions are better to give , even though those simpler procedures are not curative but are aimed at relieving symptoms.

4 Acute hospital care. It is worth noting that towards the end of life, acute hospitals may not be curative and indeed, the outcome both in terms of quality and also survival may be better when patients remain at home with their familiar carers rather than going into hospital. There may therefore be situations when it is felt the patient should go to hospital, and other times when this is not the case. There might also be times when, as a result of sudden change or severe distress, hospital is the only option. But, very often, acute hospital admissions are not associated with saving life and significant gains for sick patients from settings such as nursing homes.

5 Acute injuries Just occasionally, when someone is actually dying, it might be reasonable to leave someone at home with a broken hip. But the best treatment for this is, almost always, hospital admission.

6 Acute illnesses Often enough, antibiotics can be administered at the home and outcomes can be quite good. But there may be some risks associated with this;- the decision here relates to the extent to which the comfort of staying at home and better care resulting from familiarity with staff etc, conflicts with the possibility that death might be avoided by hospital admission. It must be remembered that as a result of hospital acquired infection and other factors, hospital can sometimes be a dangerous place. Similarly, patients may do not better if they go to hospital with a heart attack or stroke than if they stay in the nursing home.

7 Dehydration When dehydration occurs and the person cannot eat or drink solutions to this include fluids given into the veins or under the skin. Fluid given into veins is rarely possible in nursing homes. Fluids into the skin is occasionally possible. When patients are dying imminently (in the next 2-3 days) it may be better to give pain relief. It is absolutely clear however that patients should not suffer as a result of dehydration.

8 Terminal care Death can be distressing and it is normal practice to give strong pain killers when death is associated with severe distress. These medicines may shorten life, but are important because of the need to spare dying people pain and distress.

9 Advanced directives and Lasting Powers of attorney Where such an appointment has been made this person MUST be included in this process and has authority to consent to or refuse to treatments.

10 Faith and spiritual needs Many people would wish to see someone from their religious background when they are dying. For example a vicar, priest, Imman. Others may have special prayers or rituals they wish to happen when they are dying (such as the use of water from a holy place etc). Be sure to notify these wishes if you can.

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