A collaboration between Bridgewater Community Healthcare NHS Trust, NHS Warrington Clinical Commissioning Group, Warrington and Halton Hospitals NHS Foundation Trust and St. Rocco's Hospice.

First name
Surname
NHS number
Date of Birth
Plan of Care Commenced on:
Discontinuation Date:

Individual plan of care and support for patients at end-of-life (IPOC)

This document seeks to involve the patient, family and those involved in their care

Revision date: 31 August 2017

End-of-Life Care Plan

This document should only be used when all reversible causes for the patient's deterioration have been identified and appropriately managed. The patient has been identified as being in the final hours/days of life by the most senior members of the multi-disciplinary teams involved in caring for the patient. This decision has been communicated with the patient (if appropriate) and the patient's family/carer.

Principles of caring for people who are dying

1 The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

2 Sensitive communication takes place between staff and the person who is dying, and those identified as important to them.

3 The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4 The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5 An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Principles and essential elements of excellent end-of-life care (as outlined in the 'One Chance to Get it Right' document and per NICE Guidelines NG31 Care of Dying Adults in last days of life)

All health and social care staff at a level appropriate should:

- **Recognise** that death may be imminent and conduct an appropriate assessment that includes reversible causes of decline or to signpost to appropriate other professionals.
- **Involve** patients and those that are important to them in all discussions and decisions about their care and to work with them to develop care plans that take account of their wishes and preferences as far as they wish to.
- **Communicate** effectively and sensitively with patients and those that are important to them such that they have the information they need or wish for and have had the opportunity to express their wishes and preferences, thoughts or concerns.
- **Support** patients and those that are important to them psychologically, spiritually, practically and socially with compassion and understanding both before and after death.
- **Plan** individualised care that takes account of the wishes and preferences of the patient and those important to them and includes food and drink, symptom control, psychological, spiritual and social support, hygiene and privacy needs.
- **Do** all they can to ensure that excellent care is delivered according to the wishes and preferences to the dying person and those that are important to them. Work effectively as a member of a multidisciplinary team to provide symptom management according to the needs of the patients, support the patient to eat and drink as they wish and are able to do so, have their hygiene and dignity needs attended to and spiritual and psychological care given.

Assessment of capacity

Date of Assessment:

Diagnostic Test Is there an impairment of, or disturbance in the functioning of the person's mind or brain (temporary or permanent)	Yes. Give Details	No

If yes, does the impairment or disturbance affect the person's ability to make a specific decision?				Yes	No
Functional Test - Is the person able to:	1	Understand the information	relevant to the decision to be made		
	2	Retain the information?	Long enough to use info to make a decision		
	3	Use and Weigh the information	To arrive at a choice?		
	4	Communicate the decision Note: Assessor must assist communication with all practical steps	e.g. by talking, signing, use of your organisation Communication Tool		
Does the patient lack Capacity to make the Decision? (tick YES if any of the functional test boxes are ticked in 1-4 above)					
Can the decision be delayed because the person is likely to regain capacity in the near future?					
Would it be inappropriate to delay? Give details:					
Is there a DOLS in place for this patient? If Yes date & time started give details					
Is there a Lasting Power of Attorney in place for Health and welfare?					
Has the person made an advanced decision to refuse treatment?					
Has the person made an Advanced Statement or Request?					

If the person has been confirmed to lack Capacity and has no family, friends and only paid carer to support them, an Independent Mental Capacity Advocate (IMCA) must be contacted. This is a requirement in law.

Independent Mental Capacity Advocate (IMCA): Tel: 01744 451 531 Fax: 01744 759 937
Email: hkwsimca@together-uk.org

Consultation: Who has been involved in this decision *(names and signatures to be provided)*		
	Name	**Signature**
Doctor		
GP		
Nurse		
Social Worker		
Therapist/Dietician		
Family *(please state relationship)*		
Friends		
IMCA		
Other		

I have reasonable belief that I have:	Yes	No
considered all relevant circumstances listed in the document		
ensured that the decision recommendation is not based on assumptions		
considered that the decisions concerning the provision or withdrawal of life sustaining treatment have not been motivated by a desire to bring about a person's death		

Person completing the assessment:	
Signature	Print Name

(Affix patient *addressograph* label here or write)

First name	Place of Care/Ward
Surname	
NHS number	GP/Consultant
Hospital number	
Date of Birth	

Responsible Doctor Name and Contact Details (e.g. Consultant/GP)
District Nurse/Clinical Nurse Specialist
Care Home Nurse name and contact details

Date of commencement	Time

Signatures of professionals involved in the identification of dying

As their Clinician/s, I/we actively engage with supporting the patient with this Care Plan	
Print Doctor's name	Signature
Print Nurse's name	Signature

About the Patient

Diagnosis	Date of Diagnosis
Other relevant conditions	

Does the patient have a pacemaker? (please circle answers)	**Yes**	**No**
Does the patient have an implantable cardioverter defibrillator device (ICD) in situ?	**Yes**	**No**
If 'Yes', has the device been deactivated?	**Yes**	**No**

Patient's next-of-kin & main contact details

Main Contact - Name & Contact No:
Next of Kin - Name & Contact No:

Further advice and support is available from these Specialist Palliative Care Teams

Community team	**01925 570 781**
Hospice	**01925 575 780**
Hospital team	**01925 662 915**

Care plan for caring for the dying patient

This guidance is intended as an aide-memoire to the principles of best practice when caring for a dying patient.

Remember to document your decision making regarding why this person is thought to be dying, include items such as primary diagnosis or any co-morbidities there may be.

This should be an MDT decision and reversible causes excluded.

Communication

Communication is an essential component for caring for the dying patient, and must be open and honest.

- Include the patient as far as possible, if patient lacks capacity ensure this is assessed and documented using the appropriate Trust/organisational documentation
- Provide the family/carer/Lasting Power of Attorney with the right information for them as requested
- Document whether there have been any discussions regarding advance statements
- Document whether there are any spiritual, religious or cultural needs for the patient or family/carer and offer support as appropriate
- Document who was there for conversation and decision making
- Ensure the patient and their family/carer/Lasting Power of Attorney are involved about the current plan of care and that this is documented in the Notes

Nursing and Medical Interventions

Medication

- Using prescribing guidelines (Appendix 1) ensure appropriate medication is prescribed for all 5 potential symptoms (pain, agitation, respiratory tract secretions, nausea and vomiting, dyspnoea)
- Ensure there is access to a continuous subcutaneous infusion (CSCI) if needed

Interventions

- What intervention(s) occur now – is it appropriate to continue with them? i.e. blood glucose, TPR, bowel intervention
- Document decision
- Is there a valid DNACPR order documented and where is it kept?
- Does the patient have an ICD? If so contact Liverpool Heart & Chest Hospital NHS Trust on 0151 228 1616

Nutrition

- Ensure patient is supported to take food by mouth for as long as possible.
- How is the patient receiving nutrition? (e.g. PEG, NG, NJ, Oral)
- Is this adequate/appropriate?
- Is the patient's swallow compromised?
- Document discussion and decision, who was present?

Hydration

- Ensure patient is supported to take liquid by mouth for as long as possible.
- How is the patient currently hydrated? (e.g. PEG, NG, NJ, S/C, orally)
- Is this adequate/appropriate?
- Is the patient's swallow compromised?
- Document discussion and decision, who was present?

Skin Care

- Document current Waterlow/maelor score
- What interventions are needed to maintain skin integrity?
- What equipment is available/required?

Oral Hygiene

Ensure the family/carers are aware of the importance of mouth care, and reiterate that the symptoms of dry mouth, cracked lips do not necessarily mean the patient is thirsty, and this may be more related to the patient mouth breathing.

(Affix patient *addressograph* label here or write)

First name	Place of Care/Ward
Surname	
NHS number	GP/Consultant
Hospital number	
Date of Birth	

It has been recognised that..... may die in the next hours or days by the person (where possible), those who are important to them (where possible) and the professionals caring for them. Reversible causes of decline have been considered (by the doctors and nurses caring for the person together) and excluded where appropriate or taken account of in the plan of care, e.g. it may be appropriate to continue to treat with antibiotics.

Decision making around end-of-life care

1. How, and with whom, has this decision to support end of life care been made? Please detail all *professionals* involved in making this decision:

.....

.....

.....

.....

2. With whom have appropriate conversations taken place?

Patient (if appropriate) If not appropriate, state why	Date/time:

Details of conversation:

.....

.....

.....

Relative If not, state reason	Date/time:

Details of conversation:

.....

.....

.....

Carers If not, state reason	Date/time:

Details of conversation:

.....

.....

.....

'Communication booklet' given? Yes / No

'What happens when someone is dying' leaflet given? Yes / No

Second opinion if requested

If family has concerns with the decision, have you requested a second opinion? Yes / No

If 'Yes', name Doctor you have referred to: .....

Outcome and signature of Doctor: .....

(Affix patient *addressograph* label here or write)

First name	Place of Care/Ward
Surname	
NHS number	GP/Consultant
Hospital number	
Date of Birth	

3. Where is the patient's preferred place of death? (please circle)

Home	Hospice	Hospital	Care Home	Other (please state)

4. Is there a DNACPR form in place? Y / N if no, state reason

5. Have all 5 anticipatory medications been prescribed (as per Appendix 1)?
Y / N if no, state reason

6. Has the patient been referred to Specialist Palliative Care Team, dependant on location/need:
a. Referral to Warrington Hospital Specialist Palliative Care Team **Y / N**
b. Community referral to Macmillan Team **Y / N**

Has any significant issue with regard to end of life care been raised by the patient or family? If so, document below:

.....

.....

.....

.....

.....

.....

7. Have Spiritual, Religious or Cultural needs been assessed? Y / N

.....

.....

.....

.....

.....

Review of this plan should take place daily by the most Senior Health Care Professional involved in the patient's care.

Initial assessment – to be used in conjunction with the aide-memoire

This patient is thought to be dying, please ensure that the rationale for this decision is documented below. Include primary diagnosis and any co-morbidities and ensure subsequent communication has occurred with the family/carer and patient (if they are able to take an active role in communication).

Nursing and Medical Interventions – if interventions are discontinued i.e. observations, blood tests, Blood Sugar checking, medication(s); please provide rationale why

Date	Time		Signature and Initials

Medication Review

Date .....

Medication rationalised?	**Yes / No**	
Does the patient need insulin?	**Yes / No / Not Applicable**	If yes, what dose?
Dexamethasone S/C to be continued?	**Yes / No / Not Applicable**	If yes, what dose?
Is the patient on any Anticoagulation (e.g. S/C or PO) - has this been reviewed?	**Yes / No / Not Applicable**	

For Nutrition/Hydration go to next page

Nutrition/Hydration – remember to document how the patient is currently receiving nutrition/hydration and ensure this is supported to continue for as long as is safe to do so

Date	Time		Signature and Initials

Is the person receiving food and fluid through another route e.g. PEG? **Yes / No**
if yes, please explain decision around nutrition/hydration:

.....

.....

.....

Skin care

Date	Time		Signature and Initials

Oral hygiene

Date	Time		Signature and Initials

On-going care provision, monitoring of symptoms and psycho-social support

Review

On-going medical support should continue during this period of time. However, seek medical advice/support if:

- The patient shows signs of improvement
- Any concerns are expressed by relative or carer

Remember daily to check and maintain clinical records

- Monitor for symptoms (pain, agitation, respiratory tract secretions, nausea, vomiting, dyspnoea)
- Continence – bladder: has the patient passed urine, is catheter equipment available as needed, what continence aids are available, do any orders for continence equipment need to be made?
- Continence – bowel: when did the patient last have their bowels open, do any orders for continence equipment need to be made?
- Nutrition and Hydration – Has this been reviewed?
- Oral hygiene – what provision is available? Is the family/carer able to maintain adequate oral hygiene needs?
- Personal Hygiene – how are current needs met, is this adequate?
- Skin Integrity – is skin intact; is current pressure relieving regime appropriate?
- Environment – is current environment appropriate to maintain respect and dignity for the patient and their family, is privacy available?
- Psychological support – Ensure patient and family feel supported and are given the opportunity to discuss fears/concerns as needed

Care after Death

- Ensure last offices (care after death) are performed
- Ensure death has been confirmed appropriately (either verified by Nurse or confirmed by Doctor)
- Provide support/information for family/carer
- Provide booklet *'What to do after death in England and Wales'*
- Ensure patient's death is communicated appropriately across organisations including electronically
- Consider religious and cultural needs

This is to act as an aide-memoire, in the absence of appropriate clinical guidance. It is aimed to help clinicians maintain quality high standard clinical care.

If additional support or advice is needed then please remember to contact Specialist Palliative Care as detailed on page 5.

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day One: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day One: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day Two: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day Two: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day Three: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day Three: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day Four: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day Four: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day Five: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day Five: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day Six: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day Six: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Ongoing daily assessment and communication

If answer to questions is 'Yes', please note what action was taken and the outcome on the free text adjacent.

Day Seven: ___ / ___ / ___

Has the patient experienced any...	Time	Time	Time	Time	Time	Time
Pain?						
Nausea/ vomiting?						
Agitation?						
Respiratory tract secretions?						
Dyspnoea?						
Other Symptoms (see page 11) e.g. bowel/ bladder care, environment, psychological support						
Health Care Professional's (HCP) initials and signature						

Has the patient's nutrition and hydration been assessed?						
HCP initials and signature						

Day Seven: ___ / ___ / ___

Time	Care delivery and subsequent management	Action taken	Signature and initials

Communication – use this space to include any conversations and who was present for these		
Time	Conversation content	Signature and initials

Nutrition and hydration reviewed:		
Time		Signature and initials

Care after death

- The body of the person who has died is cared for in a culturally sensitive and dignified manner.
- The person's loved ones should be allowed to express their grief and to participate in 'last offices' if they so wish.
- Verification of death should be carried out in a timely manner.
- The medical certificate of cause of death should be completed in a timely manner.

Patient's first name	
Middle name(s)	
Surname	
Date of death	
Time of death	
Place of death	
Persons present at the time of death	
Name two nurses who attended the patient in their dying phase	
Care after death performed by whom and when?	
Was the Family Bereavement booklet given to the person's loved ones?	Y / N
Name and role of clinician verifying death	
Date of verification of death	
Time of verification of death	
Death verification process/documentation	
To be completed by the Medical Officer	
Medical Certificate of Cause of Death:	
I. (a)	
I. (b)	
I. (c)	
II.	
Will the death need to be reported to the coroner? e.g. DOL's	Y / N
Content of discussion with coroner?	
Has the patient's GP been informed of the death?	Y / N
Have other involved clinicians been informed of the death?	Y / N

GUIDANCE ON PRESCRIBING DRUGS TO BE GIVEN SUBCUTANEOUSLY VIA SYRINGE PUMP OR AS REQUIRED

PRESCRIBING OPIOIDS - It is the responsibility of the prescriber to ensure that guidelines are followed when prescribing opioids. Advice should be sought if prescribing outside of these guidelines or when the limits of own expertise is reached (Ref: NPSA Alert/2008/RRR05)

OPIOIDS FOR PAIN RELIEF

DIAMORPHINE may be used subcutaneously, see conversion boxes below.

OPIOID NAIVE PATIENT IN PAIN - Prescribe **DIAMORPHINE** 5 - 10 mg/24 hours via continuous subcutaneous infusion (CSCI) and an as required dose of 2.5-5mg sc hourly PRN.

OXYCODONE - If a patient is established on oral **OXYCODONE** convert to the subcutaneous route as below.

TRANSDERMAL OPIOID PATCHES. **e.g. FENTANYL, BUPRENORPHINE (TRANSTEC®/BUTRANS®)** - in dying phase patch should remain in situ and be replaced regularly according to the prescribing guidance for individual patches. If patient has pain, seek advice from Specialist Palliative Care Team. **DO NOT COMMENCE PATCHES IN THE DYING PHASE.**

CONVERSIONS OF OPIOIDS FROM ORAL TO SUBCUTANEOUS SYRINGE PUMP

SC DIAMORPHINE	SC OXYCODONE	OTHER SC OPIOIDS	AS REQUIRED DOSES
Subcutaneous dose is 1/3rd of total oral daily dose e.g. **MORPHINE MR** 30mg bd = 60mg orally/24 hours. Prescribe OPIOID as SC PRN 20mg over 24 hours via syringe pump	**Subcutaneous dose is ½ (half) of total oral daily dose** e.g. **OXYCODONE MR** 30mg bd = 60mg orally/24 hours. Prescribe OPIOID as SC PRN 30mg over 24 hours via syringe pump	**MORPHINE - subcutaneous dose is (½) half the total oral daily dose** **ALFENTANIL – seek advice from list below** **HYDROMORPHONE – seek advice from list below**	Prescribe 1/6th of the 24 hour dose of **OPIOD as SC PRN** SC PRN maximum of 6 doses in 24 hours

OTHER SYMPTOMS - DOSES SUBCUTANEOUSLY OVER 24 HOURS

NAUSEA & VOMITING	1st Line **CYCLIZINE** 150mg (avoid in end stage heart failure) (MAX 150mg/24 hrs including PRN) + **HALOPERIDOL** 1.5-5mg if vomiting persists 2nd Line **LEVOMEPROMAZINE** 6.25- 25mg.
AGITATION	**MIDAZOLAM** 10-30mg.
BRONCHIAL SECRETIONS	**GLYCOPYRRONIUM** 1200-2400 micrograms
DYSPNOEA	**DIAMORPHINE** 5-l0mg + **MIDAZOLAM** 5-l0mg

MEDICATION WHICH SHOULD BE PRESCRIBED AS REQUIRED IN ANTICIPATION OF COMMON SYMPTOMS

NAUSEA & VOMITING	1st Line - **CYCLIZINE** 50mg sc 8 hourly PRN unless already in syringe pump (avoid in end stage heart failure)(MAX 150mg/24hrs) 2nd Line - **LEVOMEPROMAZINE** 6.25mg sc 8 hourly PRN or HALOPERIDOL 0.5 - 1 mg sc PRN (seek advice if more than 1mg is needed)
BRONCHIAL SECRETIONS	**GLYCOPYRRONIUM** 200 micrograms sc PRN (MAX 2400 micrograms sc/ 24 hours) including PRN)
***AGITATION**	**MIDAZOLAM** 2.5mg-5mg sc PRN for any indication
***DYSPNOEA**	**MIDAZOLAM** 2.5mg-5mg sc 4 HRLY PRN + **DIAMORPHINE** 2.5-5mg sc 4HRLY PRN

*MAXIMUM cumulative dose in 24 hours is 30mg irrespective of indication

FOR FURTHER ADVICE CONTACT SPECIALIST PALLIATIVE CARE: **Community team - 01925 570781** **Hospice - 01925 575780** **Hospital team - 01925 662915**

Appendix 2
Glossary of Terms in use within the document

CSCI	Continuous Subcutaneous Infusion
In a continuous subcutaneous infusion, a needle is inserted under the skin, rather than into a vein, and connected to an infusion pump which allows fluid to slowly enter the injection site, usually over a period of 24 hours. This method is frequently used in end of life care to deliver a combination of medications.	

DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
If someone's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). A DNACPR order should not affect other aspects of care and treatment, for example treatment of life threatening anaphylaxis, choking, infection, nutrition or hydration. All other care and treatment should be provided at all times.	

NG	Naso-gastric
An NG tube is passed through the nose and down through the nasopharynx and oesophagus into the stomach. It is a flexible tube made of rubber or plastic. It can be used to remove the contents of the stomach, including air, to decompress the stomach, or to remove small solid objects and fluid, such as poison, from the stomach. An NG tube can also be used to put substances into the stomach, and so it may be used to place nutrients directly into the stomach when a patient cannot take food or drink by mouth.	

NJ	Naso-jejunal
A tube similar to a naso-gastric tube but which ends in the jejunum	

PEG	Percutaneous Endoscopic Gastrostomy
A surgical procedure for placing a feeding tube without having to perform an open laparotomy (operation on the abdomen). The aim of PEG is to feed those who cannot swallow.	

S/C	Subcutaneous
Under the skin. For example, a subcutaneous injection is an injection in which a needle is inserted just under the skin.	

ACP	Advance Care Planning
ACP is a process of discussion between an individual and their care providers.	

ADRT	Advance Decision to Refuse Treatment
An advance decision enables the patient, whilst still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity.	

Advance Statement
An advance statement is a written statement that sets down patient preferences, wishes, beliefs and values regarding the patient's future care.

PO	Per Oral
By mouth	