

END OF LIFE CARE POLICY

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Ratified by:	Senior Management Team
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Relevant Staff Groups:	All Clinical staff working in Inpatient Services and Community Teams

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DOCUMENT CONTROL

Reference CL/Feb17/EoL	Version 5	Status Final	Author Consultant in Palliative Care Head of Division, East Somerset
Amendments	<ul style="list-style-type: none"> - reviewed to incorporate policies developed for Infection Prevention and Control of Deceased Patients, and Care of Patients in the Last Days of Life. Reviewed by key clinicians and shared at relevant Best Practice Groups. - cross referencing of the One Chance to get it right documentation and review by Palliative Care Consultants. - the addition of the Planning Ahead Document at Appendix L. - reviewed by End of Life Policy Working Group July 2016 - Updated Appendix B (Feb 2017) 		
Document objectives: To ensure that relevant staff within Somerset Partnership NHS Foundation Trust are competent in the skills necessary to provide good quality End of Life Care to patients, and are aware of the processes to be followed			
Intended recipients: All Clinical Staff working in Inpatient Services (including Medical Staff), Community Nursing Teams and Healthcare Assistants			
Committee/Group Consulted: End of Life Best Practice Group			
Monitoring arrangements and indicators: Please see relevant Section			
Training/resource implications: Please see relevant Section			
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Contact for review	Consultant in Palliative Care		
Lead Director	Medical Director		

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1. INTRODUCTION

- 1.1 In England, approximately half a million people die each year, about 1% of the population. The majority of deaths occur following a period of illness relating to conditions such as heart disease, stroke, liver disease, renal disease, cancer, chronic respiratory disease, neurological disease and dementia.
- 1.2 In Somerset, approximately 5000 people die each year. Of these deaths, around three quarters are expected, so we have the potential to improve the experience of care in the last year and months of life for around 3750 people in Somerset each year. This number is expected to rise by 17% from 2012 to 2030.
- 1.3 The first national End of Life Care Strategy for England (2008) set out a whole systems approach to the commissioning and delivery of end of life care. NHS England subsequently published Actions for End of life care: 2014-16: a step to developing a vision for end of life care beyond 2015. In September 2015, the Ambitions for Palliative and End of Life care: 2015-2020 was published. These documents give a national framework to guide local action. They rely on the 2011 'NICE quality standard for End of Life Care' to give further guidance on service operation.
- 1.4 National Voices have produced a narrative for 'person centred coordinated care' called Every Moment Counts. This sets out critical outcomes and success factors in end of life care, support and treatment. It is written from the perspective of the people who need that care, and their carers, families and those close to them.
- 1.5 This policy is written to reflect the NICE clinical guideline Care of dying adults in the last days of life published in December 2015. It is centred around the Five priorities of care, the recommendations produced by the Leadership Alliance for the care of dying people in June 2014. These priorities are reflected in the Trust's End of life personalised care plan (Appendix A).
- 1.6 Although every individual may have a different idea about what would, for them, constitute a 'good death', for many this would involve:
- Being treated as an individual, with dignity and respect;
 - Being without pain and other symptoms;
 - Being in familiar surroundings; and
 - Being in the company of close family and/or friends.
- 1.7 This policy has been written to support Trust staff to provide the best care to patients and those important to them at the end of their lives through proactive holistic assessment of the person nearing the end of their life. End of life care is everyone's business.

2. PURPOSE AND SCOPE

- 2.1 This policy is to enable all Trust staff to work in their multidisciplinary teams to provide high quality person centred care to people who are felt to be in their last year of life.
- 2.2 This policy covers the care of patients whose death is expected. It does not cover sudden unexpected deaths.
- 2.3 This policy aims to ensure that patients are treated with privacy and dignity both before and after their death. There is a separate care after death/ last offices policy (in development).
- 2.4 This policy aims to support patients' choice for their care at the end of their lives, in particular to support them in the location of their choosing.
- 2.5 This policy aims to ensure that family, carers and people important to the patient are supported and kept informed, enabled and empowered throughout a patient's illness.
- 2.6 This policy applies to all staff in both clinical and support roles who have contact with patients in their last year of life. This includes temporary, locum, bank, agency and contracted staff.

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has overall responsibility for procedural documents and delegate's responsibility as appropriate.
- 3.2 **Director of Nursing and Patient Safety** will oversee implementation of the End of Life Care Policy.
- 3.3 **End of Life Best Practice Group** will, alongside both the Community Hospitals Best Practice Group and the District Nursing Best Practice Group to provide assurance that the End of Life Policy is fully implemented.
- 3.4 **Community Hospital Sisters/In-Patient Ward Managers and District Nursing Team leaders** are responsible for ensuring that staff are aware of the policy and that any staff training needs are identified and addressed.
- 3.5 **All In-Patient Ward/Ward Staff/Community nurses** are responsible for adhering to the policy which provides a framework for best practice. When a patient is felt to be at the end of their life, the nursing team have a responsibility to review and update the personalised care plan and communicate sensitively with both the patient and important others alongside the medical practitioner and multidisciplinary team to agree treatment and care delivery during this time.
- 3.6 **The Multi-disciplinary Team** members have a responsibility to identify patients who appear to be nearing the end of their life and to work in collaboration with Primary Care in developing a plan of care to meet the needs of those patients and their carers.

- 3.7 All patients identified as nearing the end of life will be placed on the end of life register, with the patient's consent. This will enable more effective communication of patient preferences, including preferred place of death, across organisations. It is the responsibility of all health care professionals to ensure that this information is updated in a timely manner.

The information held on the Electronic Palliative Care Coordination System includes:

- care co-ordinator/lead professional details;
- diagnosis and complications;
- advance care planning document status;
- consent to share information;
- just in case box status;
- special requests;
- resuscitation status;
- date of death/discharge;
- recording of variances which would assist future service planning.

4. EXPLANATIONS OF TERMS USED

- 4.1 End of life care: The 2008 End of life care strategy defined this as “care in the last year of life”. Where expected time scales are shorter; likely hours to days then this is stated within the policy.
- 4.2 Palliative care: The WHO defines palliative care as: an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
- 4.3 GP – General practitioner
- 4.4 EPaCCS – Electronic Palliative Care Coordination System
- 4.5 GSF – Gold Standards Framework
- 4.6 CPR – cardiopulmonary resuscitation
- 4.7 DNA CPR – Do Not Attempt Cardiopulmonary resuscitation

5. IDENTIFICATION OF PATIENTS WHO MAY BE IN THEIR LAST YEAR OF LIFE

- 5.1 Community hospitals: Patients may be admitted for end of life care, or they may be identified as likely to die in the next 12 months while they are there.
- 5.2 Mental health units: patients may be identified as likely to die during an inpatient stay, or that they are likely to be in the last year of life following their discharge from an inpatient unit.

- 5.3 Patients can be identified as likely to be in the past 12 months of life by any health care professional who is involved in their care.
- 5.4 One process to support this identification is using the Gold Standards Framework (GSF) prognostic indicator guidance. These patients are recorded in the GP practice and discussed at the practice end of life meetings.
- 5.5 All health care professionals involved in patients care must ensure that information about patients is shared between all professionals involved.

6. ADVANCE CARE PLANS

- 6.1 An advance care plan is the result of a discussion between the patient (and those close to them if patient wishes) and health care professional that addresses a patient's wishes for their future care. It is a key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. The Somerset Planning Ahead document is a patient held record of their advance care plan. It is key that these plans are communicated to GPs and to out of hours, by using special patient notes to update the EPaCCS database.
- 6.2 The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs and preferences and deliver care to meet these needs.
- 6.3 The option of tissue donation can be sensitively explored as part of an advance care plan discussion.

7. ESCALATION OF TREATMENT

- 7.1 It is imperative that the patient is asked whether they would like to be involved in discussing their treatments, including those about CPR. If they want to be involved in these discussions then health care professional are obliged to do so.
- 7.2 A sensitive explanation about escalation of treatment is likely to involve decisions about hospital admission, artificial nutrition and hydration, ventilation and CPR. If the senior clinician involved in a patients care does not feel that that attempting to restart a patient's heart after they have died is a valid treatment option then professionals are not obliged to offer it. A decision not to start CPR does not equate to no active treatment, it just means that chest compressions will not be performed once a patient has died. A DNACPR decision allows death to happen naturally and without the indignity of chest compressions.
- 7.3 If the patient has an internal cardiac defibrillator (ICD) and it is no longer required to defibrillate, then a sensitive discussion explaining the need to deactivate the defibrillator part of the ICD is required. Further guidance on this is available in the [Verification of Expected Death of Adult Patients by Registered Nurses Policy](#), section 7 Implantable Cardioverter Defibrillators.

7.4 Trust Policy must be followed once a DNACPR decision has been made [Trust Resuscitation Policy](#).

8. CARE OF THE DYING PATIENT (IN THE LAST DAYS TO HOURS OF LIFE)

8.1 Following the publication of 'One Chance to Get it Right' by the Leadership Alliance for the Care of Dying People, Somerset Partnership commits to uphold the five priorities for the care of the dying person. An individualised plan of care is written for every patient. The Trust has developed an individualised plan of care for the last days of life, written in conjunction with the patient and those close to them. This focusses on the five priorities of care; Recognise, communicate, involve, support, plan and do. Sensitive, timely and compassionate communication is key to enabling the wishes of the dying person and those important to them to be met. The five priorities are set in bold type, with guidance on how to support them below:

- **The possibility of end of life is recognised and communicated clearly, decisions made and actions taken in accordance with the persons needs and wishes, and these are regularly reviewed and decisions revised accordingly;**

When a person's condition deteriorates and it is thought that they may die soon, an assessment as to whether the condition is potentially reversible is made by the most senior clinician available.

Signs and symptoms that a person is in the last days of life include: Cheyne Stokes breathing, decreased consciousness, mottled skin, noisy respiratory secretions and progressive weight loss. This may be on the background of a global change in functional status such as deteriorating mobility, changes in communication and reduced functional status.

Use the information gained from assessments and information from the multi-professional team, the person, and those important to them to help determine whether the person is nearing death, deteriorating, stable or improving.

Where a potentially reversible condition is identified, a plan is made to address this, in line with the patient's wishes. If the patient is unable to participate in this discussion then information about their previously expressed wishes can be sought from the current treatment escalation plan or clinical management plan.

If the person is detained under the mental health act, the responsible clinician must consider whether to continue with the detention.

If the person is subject to an authorisation under the Deprivation of Liberty Safeguards (DoLS), then a senior team member should

discuss the situation with the DoLS team within the supervisory body (usually Somerset County Council) to decide whether the authorisation should continue or be ended.

If the doctor's judgement, and that of the multidisciplinary team is that the patient is dying, this should be sensitively explained to the person, in a manner appropriate to the circumstances of the person and their family and those important to them. This may include explanation of uncertainty of timing of death, and how death may be expected to occur. The person and those important to them must be given the opportunity to ask questions, and this offer should be available at any time.

- **Sensitive communication takes place between staff and the dying person, and those identified as important to them;**

Sensitive and honest communication with the dying person and those important to them must ascertain the extent to which they wish to be involved in being informed about changes in their condition.

Open and honest communication within the multidisciplinary team and all involved in caring for the patient and between these teams and the person and those close to them is key to delivering high quality care. Refer to the Trust [Handover policy for inpatient wards](#).

Staff must endeavour to update and communicate with the person and those important to them frequently. They must provide an opportunity to talk about any fears or anxieties. They must listen to and act on any concerns expressed.

It is good practice to sensitively check understanding of any information provided.

- **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;**

It is good practice for individuals to be involved in discussions and decisions about their health, including their end of life care.

Sensitive and honest communication with the dying person and those important to them must ascertain the extent to which they wish to be involved in decisions about their treatment. This includes being clear as to whether they are being informed about, consulted about or making decisions.

All shared decision making processes should take into account

- Whether the person has an advance statement, and advance decision to refuse treatment or has appointed any legal Lasting Power of Attorney for health and welfare
- The person's current goals and wishes
- Whether the dying person has any cultural, religious, social or spiritual preferences

The person dying and those important to them will be informed of who the senior doctor in charge of their care is and who the senior nurse is in an inpatient setting. Patients at home will be informed of the GP in charge of their care and the district nursing team. Contact numbers for both in and out of hours will be provided.

Decisions relating to treatment escalation should be made proactively by the team caring for the dying patient rather than by the out of hours team, where this is possible.

If the person who is dying lacks capacity to make decisions, they should still be involved in decisions as far as possible. For further information see Trust guidance on capacity ([Consent and Capacity to Consent to Examination and/or Treatment Policy](#))

A DNACPR decision should be sensitively communicated and explained to the person, if this is in line with their information wishes.

The dying person should be asked about any future wishes to become a tissue donor, and whether they had expressed wishes to donate to medical research, for example the brain bank.

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

It is important to ask families and those important to the dying person about their needs at such a difficult time.

This includes asking about their own social, personal, spiritual and practical support.

- **An individual plan of care which includes food and drink, symptom control and psychological, social and spiritual support is agreed co-ordinated and delivered with compassion, dignity and respect.**

Where dying is felt to be likely in the next few hours to days, a person's needs and wishes must be assessed and incorporated into an individual plan of care. This process should involve the senior doctor and senior nurse involved in the patients care. It should include the dying person's

- Personal goals and wishes
- Preferred care setting
- Current and anticipated care needs to include preferences for symptom management and individual requirements for care after death
- Resource needs

In addition to the physical, emotional, spiritual and religious needs, the care plan must include:

All medications should be reviewed and rationalised according to the needs of the patient.

Anticipatory medication should be prescribed on the MAR chart to treat the five symptoms that can be present at the end of life (pain, breathlessness, nausea, agitation and respiratory secretions). The Wessex handbook provides clinical guidance for this (see embedded document:



Wessex Palliative
Care Handbook.pdf

Management of delirium should be in accordance to NICE CG 103: Delirium: prevention, diagnosis and management.

Advice for symptom control at the end of life is available from the St Margaret's hospice 24 hour advice line (0845 0708910), Dorothy House Hospice (01225 722999) or Weston Hospice (01934 423912) and on the hospices websites.

Staff should always consider whether non pharmacological options to treat symptoms are appropriate prior to deciding to administer medication.

For patients who have not previously been given medications for symptom management, start with the lowest effective dose and titrate as clinically indicated. Consider a syringe pump to deliver medications for continuous symptom control if more than 2 or 3 doses of any "as required" medication have been given within 24 hours.

The dying person should be reviewed daily to ensure that their symptoms are reviewed and medication adjusted accordingly. Seek specialist palliative care advice if the dying persons symptoms are not controlled or they experience undesirable side effects.

Food and fluid intake: The dying person should be supported to eat and drink for as long as they are able to do so. Check for any difficulties such as swallowing problems or risk of aspiration. Discuss the benefits and risks of continuing to drink, with the dying person and those involved in the dying person's care. If a dying person makes an informed decision to eat and drink, even if they are at risk of choking or aspirating, this decision should be respected.

Decisions about clinically assisted hydration and nutrition must be in line with [GMC Guidance](#). Clinically assisted hydration may relieve distressing symptoms of thirst related to dehydration but it may cause other problems including fluid overload. It is uncertain if giving clinically assisted hydration will prolong life or extend the dying process. It is also uncertain whether not giving clinically assisted hydration will hasten death.

Further guidance is also available in the Trust's subcutaneous fluid policy [Subcutaneous \(Hypodermoclysis\) Administration Policy](#)

Consideration of comfort and dignity: assessment of the persons comfort and dignity must be undertaken at regular intervals and include detail of how both personal care and mouth care will be delivered. For further guidance please see the Trust's intentional rounding Standard Operating Procedure.

Further information on Spiritual, Religious and Cultural contacts can be found in the [Verification of Expected Death Policy](#).

9. TRAINING REQUIREMENTS

- 9.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis) (where mandatory training is indicated). Where no mandatory training is indicated please specify how training will be provided for this policy (eg local induction, recommended training, etc). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.
- 9.2 All registered Nurses will be required to comply with the NMC Code: Professional standards of practice and behaviour for nurses and midwives 2015.
- 9.3 All staff caring for patients should develop and maintain basic professional competence in caring for patients nearing the end of their life and those at the end of their life or should have a good understanding of the physiological processes and the practical and emotional challenges in the final stages of a patients care.
- 9.4 Appropriate staff should attend a programme of training relating to end of life care, which includes advance care planning, verification of death and syringe driver training, in agreement with their line manager.

10. EQUALITY IMPACT ASSESSMENT

10.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

11. MONITORING COMPLIANCE AND EFFECTIVENESS

11.1 Monitoring arrangements for compliance and effectiveness

11.1.1 Overall monitoring will be by the End of Life Best Practice Group, by review of incidents.

11.1.2 The Trust's End of Life Best Practice Group will monitor procedural document compliance and effectiveness.

11.2 Methodology to be used for monitoring

11.2.1 See Clinical Audit Standards in attached Appendix C.

11.2.2 Concerns/Complaints monitoring.

11.2.3 Incident reporting via DATIX.

11.2.4 Included in the 3 year Trust audit plan.

11.3 Frequency of monitoring

11.3.1 Annual reporting.

11.4 Process for reviewing results and ensuring improvement in performance occur

11.4.1 Audit results will be presented to the Trust End of Life Best Practice Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

12. COUNTER FRAUD

12.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

13. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

13.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 15: Premises and equipment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed
- Regulation 20: Duty of candour
- Regulation 20A: Requirement as to display of performance assessments.

13.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

- Regulation 16: Notification of death of service user
- Regulation 17: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
- Regulation 18: Notification of other incidents

13.3 Detailed guidance on meeting the requirements can be found at:

[CQC Guidance for providers on meeting the regulations](#)

14. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

14.1 References

- Leadership Alliance for the Care of Dying People (2014): One chance to get it right: Improving peoples experiences of care in the last few days and hours of life: www.gov.uk/government/publications/one-chance-to-get-it-right
- Actions for end of life care: 2014-2016
- NICE quality standard for End of life care 2011
- Ambitions for palliative and end of life care 2015
- Department of Health (2003): Building on the Best, Choice, Responsiveness and Equity
- End of life care strategy: high quality care for all Department of Health July 2008

- Care of dying adults in the last days of life NICE CG 31 Published 16 December 2015
- Every Moment Counts: a narrative for person-centered coordinated care for people near the end of life. National Council for Palliative Care and National Voices
- Prognostic Indicator Guidance (PIG) 4th Edition Oct 2011 © The Gold Standards Framework Centre In End of Life Care CIC, Thomas.K et al
- www.nhsbt.nhs.uk/tissuedonation
- <https://www.resus.org.uk/dnacpr/tracey-v-cuh-and-secretary-of-state-for-health/>
- Somerset wide end of life care strategy
- Just in case box policy
- GMC: guidance on clinically assisted nutrition and hydration in end of life care
- Department of Health (2006): End of Life Care Programme, Progress Report
- Department of Health (2006): Our Health, Our Care, Our Say, A new direction for community services
- DCA (2007): Mental Capacity Act 2005 - Code of Practice
- Department of Health (2008): End of life care strategy promoting high quality care for all adults at the end of life
- Prognostic indicator guidance (PIG) 4th Edition 2011. The gold standards framework centre in end of life care. K Thomas

- www.nhsbt.nhs.uk/tissuedonation
- www.resus.org.uk/dnacpr/tracey-v-cuh-and-secretary-of-state-for-health
- National Institute for Clinical Excellence (2004): Improving supportive and palliative care for adults with cancer www.nice.org.uk
- Ross, Fisher et al (2000): In Introductory Guide to End of Life Care in Care Homes, Department of health 2006
- NHS National End of Life Care Programme. Route to success: nursing to end of life care
- NHS National End of Life Care Programme, Guidance for staff responsible for care after death (last offices)
- NMC Code: Standards of Conduct, Performance and Ethics www.nmc-uk.org/documents/standards/the-code
- 'Statutory notification, Regulation 17, Care Quality Commission (Registration) Regulations 2009: Death of a person using the service who is detained or liable to be detained under the Mental Health Act 1983'
- http://intranet.sompar.nhs.uk/a_z_directory/chaplaincy/end_of_life_care_multi-faith.aspx

14.2 Cross Reference to Other Procedural Documents

- Chaplaincy and Spiritual Care Policy
- Clinical Supervision Policy
- Consent and Capacity to Consent to Examination and Treatment Policy
- Medicines - Controlled Drugs Policy
- Do Not Attempt Resuscitation (DNAR) Policy
- Handover policy for inpatient wards
- Waste Healthcare (Clinical) Waste Policy
- Just in Case Box Protocol – Standard Operating Procedure
- Learning Development and Mandatory Training Policy
- Medicines Policy
- Inpatient Property Management Policy
- Privacy, Dignity and Respect Policy
- Resuscitation Policy
- Risk Management Policy
- Risk Management Strategy
- Safeguarding Adults at Risk Policy
- Serious Incidents Requiring Investigation (SIRI) Policy
- Equality and Diversity Policy

- Medicines - Subcutaneous fluids administration policy
- Syringe Driver Policy and Standard Operating Procedures in the usage of McKinley T34
- Untoward Event Reporting Policy
- Use of Advance Decisions/Statement of Treatment Preferences Policy
- Verification of Expected Death of Adult Patients by Registered Nurses Policy
- Visiting Inpatient Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

15. APPENDICES

15.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A Trust individualised end of life care plan

Appendix B Deactivation of ICD

Appendix C Clinical Audit Standards

Trust Individualised End of Life Care Plan – Still being piloted



Affix Patient Label here:

Date Commenced:

INDIVIDUAL END OF LIFE CARE PLAN AND COMMUNICATION TOOL

To be completed on all patients who are deemed to be in their last days of life. Each section should be completed

RECOGNISE- Assessment

- Consider potentially reversible causes if sudden deterioration.
- A doctor must assess and confirm patient is likely to die within few hours or days
- Nursing staff involvement in decision making to have taken place.

Document assessment and decision below, including names of other staff involved:

Signature:..... Name:..... Date:.....

COMMUNICATE: -Assessment

- Ensure open and honest conversation takes place sensitively between The health care professional, patient and/or family using clear, understandable and plain language
- Listen to the views of the patient (if possible) and those important to them.
- Check the patient's understanding (an IMCA should be involved if the patient lacks capacity and has no family/carer)
- Ensure decisions about DNAR/TEP are discussed with the patient and/or family
- Contact the GP to keep them informed of the decisions which have been made (as necessary)
- Find out if the patient is on the organ donor register or wishes further information about donating tissue. Tissue Service – Tel: 0800 432 0559

Document discussion below:

Signature:..... Name:..... Date:.....

INVOLVE:- Assessment

- Involve the patient (and /or family) to the extent to which they wish to be involved
 - Day to day decisions (e.g. food and drink)
 - Clinical treatment decisions
 - Decisions about their preferred place of care
- Find out who is important to them
- Inform them who is responsible for both nursing and medical care (add contact details)

Document discussion below:

Signature:..... Name:..... Date:.....

SUPPORT:- Assessment

- Offer last days of life leaflet and ensure practical issues have been discussed for example- **community hospital**; Visiting, parking. **Within the home**; packages of care. Equipment etc.
- Ensure contact numbers are correct and agreed
- Listen and acknowledge the needs of the Patient and family/carer, (including spiritual care. Consider chaplaincy support)

Document discussion below:

Signature:..... Name:..... Date:.....

PLAN AND DO:- Care planning

[Responsibility of All Staff]

- Ensure anticipatory drugs are prescribed according to symptom control guidance
- Consider what interventions can be stopped and which should be continued (e.g. observations and blood tests)
- Ensure DNAR/TEP discussed with patient and/or family and completed
- Review the need for food/fluid and develop an individualised plan for the patient (artificial hydration may not be needed at this stage but good mouth care is essential)
- If present, ensure ICD deactivated.
- Update EPACCs as required
- Review existing Care plans, discontinue those no longer appropriate

Date of review

Document discussion below:

Signature:..... Name:.....Date:.....

Complete EOL sticker in medical notes (**community hospitals only**) and ensure all documentation is completed in this individual end of life care plan and communication tool record .

If writing in communication tool, please ensure you complete the signature confirmation record.

Daily medical review must continue. (**Community hospitals only**)

If the condition of the patient changes, reconsider interventions required and maintain communication with patient and family.

Help and advice can be obtained from:
St Margaret's Hospice 24hr Advice Line 08450708910

Affix Patient Label here:

**INDIVIDUAL END OF LIFE CARE PLAN
AND COMMUNICATION TOOL**

Cont Sheet.....

Please remember to **SIGN** and **DATE** every entry

RECOGNISE	COMMUNICATE	INVOLVE	SUPPORT	PLAN AND DO
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Daily record of interventions

Affix Patient Label here:

**INDIVIDUAL END OF LIFE CARE PLAN
AND COMMUNICATION TOOL**

Cont Sheet.....

Please remember to **SIGN** and **DATE** every entry

RECOGNISE	COMMUNICATE	INVOLVE	SUPPORT	PLAN AND DO
Daily record of interventions				

Affix Patient Label here:

**INDIVIDUAL END OF LIFE CARE PLAN
AND COMMUNICATION TOOL**

Cont Sheet.....

Please remember to **SIGN** and **DATE** every entry

RECOGNISE	COMMUNICATE	INVOLVE	SUPPORT	PLAN AND DO
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Daily record of interventions

Affix Patient Label here:

**INDIVIDUAL END OF LIFE CARE PLAN
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Cont Sheet.....

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RECOGNISE	COMMUNICATE	INVOLVE	SUPPORT	PLAN AND DO
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Daily record of interventions

Acknowledgement: Yeovil District Hospital NHS Foundation Trust

PATHWAY FOR THE DEACTIVATION OF INTERNAL CARDIOVERTER DEFIBRILLATORS (ICDs)

**DISCUSS DEACTIVATION WITH PATIENT/CARERS AT THE FOLLOWING POINTS OF CARE.
ADVICE AVAILABLE FROM ARRHYTHMIA SPECIALIST NURSES at MPH –
01823 343595, BHFarrhythmianurses@tst.nhs.uk**

- Prior to implantation
- Patient experiencing repeated inappropriate activations from ICD
- No longer clinically appropriate or a patient wishes to deactivate
- When a 'DNACPR' decision has been made or a decision to limit treatment options that would allow a natural death, this should be recorded on the TEP chart.
- Patient on EPaCCS (electronic palliative care co-ordination system) or palliative care end of life register.
- Development of a life limiting condition and prognosis less than 12 months If conditions are met for an advance decisions document

DECISION TO DEACTIVATE AGREED WITH PATIENT, FAMILY OR THOSE IMPORTANT TO THE PATIENT

IN HOURS Monday-Friday 9-5

From outside MPH call 01823 342953 to speak to physiologist and provide:

- Patient's name and DOB
- Place of patient care and telephone number
- Why deactivation is required
- Urgency
- Contact details of clinician (Tel/bleep/mobile)
- Any known details of device including manufacturer (if known)

Physiologist to contact a Consultant Cardiologist, preferably Dr Dayer or if available. Record permission for physiologist to deactivate in clinical notes. If YDH patient-contact Senior Nurse Cardiology or Arrhythmia Nurse to arrange deactivation and inform physiologist at MPH.

Physiologist contacts place of care and organises the visit as soon as possible but within 48 working hours. At visit physiologist assesses patient and may discuss further with Consultant Cardiologist at MPH. Deactivate device.

OUT OF HOURS

IF DEATH IS EXPECTED BEFORE NEXT IN HOURS PERIOD:
17.00 to 09.00 Monday to Friday, 24 hours
Saturday, Sunday and Bank Holidays

If the Doctor responsible for care feels deactivation is appropriate and urgent, discussion with patient and/or family should take place. If further advice required: please contact the duty cardiologist or St Margaret's Hospice advice line. All such conversations must be recorded in clinical notes and the Doctor is responsible for communication with relevant local nursing and care teams.

Magnet applied as per 'How to use a magnet Guide' and magnet application chart completed. Magnets located: OOH, Hospices, Emergency Response Vehicle, YDH A&E, and Community Hospitals. Physiologists at MPH or YDH appropriately must be contacted urgently on the next working day to arrange ICD programmed deactivation.

Pathway developed by the ICD and End of Life Working Group. Review January 2019

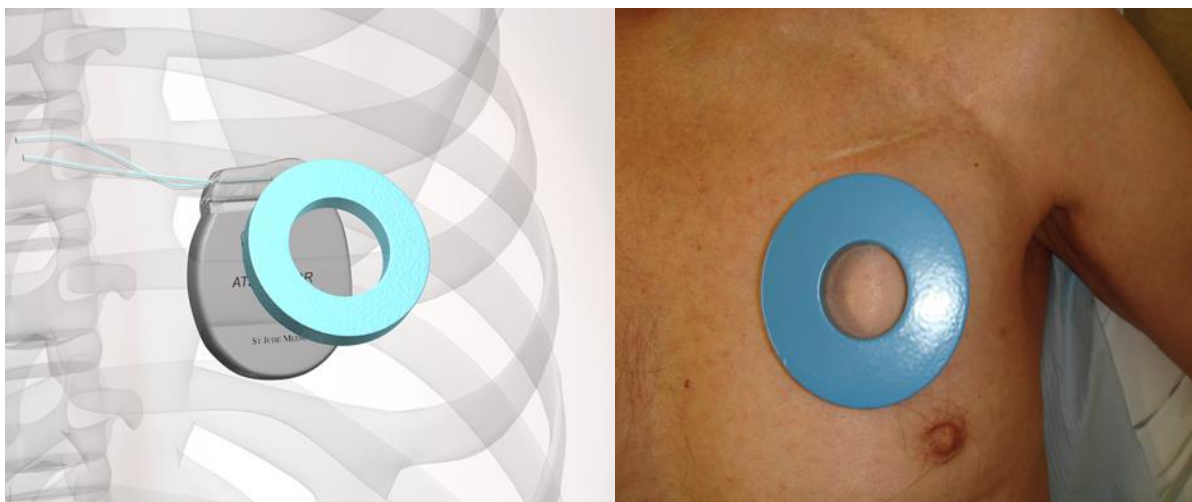
How to use a Magnet.

Any magnet will affect the functioning of an ICD (Implantable Cardioverter Defibrillator).

When a clinical decision has been made with the agreement of the Cardiologist to deactivate the shock therapy of an ICD, a magnet can be used temporarily to deactivate the device in urgent 'out of hours' situations.

The Cardiology Dept. should be contacted ASAP during normal working hours to formally deactivate the device.

- Place magnet directly over ICD – chest hair may need to be shaved off first
- Securely tape magnet over ICD – use Mefix or a foam adhesive dressing
- Leave magnet in place over ICD
- **REMOVE the magnet for 2 seconds every 7.5 hours** (also check for pressure damage and trauma when removed) if the magnet has been in place for 8 hours the device is reactivated and the therapies turned back on.
- Ensure Cardiology Dept. is contacted (working hours Monday-Friday 8.30-5)



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Nb – the magnet will NOT affect the brady /CRT pacing function of the ICD.

After use the magnet can be cleaned and re-used or order a replacement from the BHF Arrhythmia Nurses: 01823 343595

END OF LIFE CLINICAL AUDIT STANDARDS

APPENDIX C

27/04/2016

Service area(s) to which standards apply:

	MH Inpatient (CAMHS)		Community CAMHS	X	CH Specialist Services
X	MH Inpatient (Adult)		C & YP Integrated Therapy		MH Specialist Services
X	MH Inpatient (Older)		School Nursing	X	MH Community Adult
	MH Rehab & Recovery		Health Visitors	X	MH Community Older
X	Community Hospital		CH Rehab		Learning Disabilities
	MIU		Musculo-Skeletal	X	District Nurses

END OF LIFE CLINICAL AUDIT STANDARDS

Standard		Policy/ document Reference	Compliance (%)	Exceptions	Definitions
1	All staff undergo mandatory training in end of life care (recommendation from RCP National care of the Dying Audit)	End of life policy paragraph 9	100%	None	
2	All patients identified as nearing the end of life will be placed on the End of Life Care Register	End of life policy paragraph 3.7	100%	<ul style="list-style-type: none"> • Unexpected deaths • Patient choice not to be added 	Information held on the Electronic Palliative Care Coordination System (EPaCCS) includes: <ul style="list-style-type: none"> • Preferred place of death • Diagnosis/complications • Advanced Care Planning document status • Consent to share information • Just in Case box status • Special requests • Resuscitation Status • Date of death/discharge • Keyworker
3	All patients who are identified as likely to be in the last year of life are offered the opportunity to discuss their wishes for care and treatment should they deteriorate	End of life policy paragraph 6.1	100%		
4	All patients who are identified as likely to be in the last year of life are offered the opportunity to have an Advanced Care Plan	End of life policy paragraph 6.1	100%		

END OF LIFE CLINICAL AUDIT STANDARDS

Standard	Policy/ document Reference	Compliance (%)	Exceptions	Definitions
<p>5 All patients who are identified as likely to be in the last days to hours of life should have an individualised plan of care, which includes the five priorities of care.</p>	<p>End of life policy paragraph 8.1</p>	<p>100%</p>	<p>None</p>	<p>The five priorities of care are:</p> <ul style="list-style-type: none"> • The possibility of end of life is recognised and communicated clearly, decisions made and actions taken in accordance with the persons needs and wishes, and these are regularly reviewed and decisions revised accordingly • Sensitive communication takes place between staff and the dying person, and those identified as important to them • 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 • The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible • An individual plan of care which includes food and drink, symptom control and psychological, social and spiritual support is agreed co-ordinated and delivered with compassion, dignity and respect