

Considerations for the care of a person who it is thought may die within the next few days or hours

This is based on the five priorities for the care of the dying person, developed by the Leadership Alliance for the Care of Dying People in the document, 'One chance to get it right – Improving peoples experience of care in the last few days and hours of life' (LACDP, 2014). The aim is to support decision making, planning and delivery of compassionate high quality, individualised care for people who it is thought may die within the next few days or hours.

The principles of the 2005 Mental Capacity Act should be applied throughout. Discussions and information should be tailored to the person's preferences.

All decisions must be a team approach involving the person, and their family*/ those identified as important to the person.

Any indications of improvement or change in the person's condition must be noted and appropriate actions taken. If the person is no longer thought to be dying, the plan of care must be reviewed.

As a minimum, care planning (and the supporting documentation) will be aligned to the five priorities for the care of the dying person (LACDP, 2014). These are:

Priority 1 – This possibility [that a person may die in 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.

- Have reversible causes been considered and acted upon if appropriate?
- Why is the person considered to be dying?
- What relevant diagnoses and specific clinical factors are relevant to the decision?
- Who has been involved in the decision? (Should include the most senior clinician available).
- Has the senior responsible clinician and registered nurse responsible for their care been identified and communicated to the person and their family?
- If the person has capacity, discuss current preferences to the extent that the person wants
- If the person lacks capacity is it appropriate to elicit the views of those close to the person and use these as part of the best interest decision?

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

- Use open, honest & understandable language. This regular proactive communication should be sensitive and respectful both in tone and pace (methods of enhancing communication should be considered e.g. use of interpreter). This communication should include:
 - What is happening, why you think the person is dying, wishes and

preferences for care, likely prognosis and clinical uncertainties and how you will try to address those concerns

- If the dying person chooses not to discuss this, their wishes should be respected but further opportunities to discuss offered
- The person and the family are involved in decisions about treatment and care, if the dying person consents
- Any differences in opinion should be openly discussed and actively addressed e.g. seeking a second opinion

Priority 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.

- If the person has capacity discuss current preferences to the extent that the person wants
- Check whether the person has an advance care plan:
 - advance statement of wishes and preferences
 - advance decision to refuse treatment
 - a Lasting Power of Attorney for health and welfare decisions
 - If no advance care plan, discussions must include resuscitation decisions and should include wishes and preferences, preferred place of care and death, wishes for care after death as appropriate
- If the person lacks capacity it is appropriate to elicit the views of the family and use these as part of the best interest decision
- Consult an Independent Mental Capacity Advocate (IMCA) if the person lacks capacity and has no friends, family or carers

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

- The needs and concerns of the family must be acknowledged and actively assessed, explored, respected and met as far as possible
- Family contact details should be clearly established
- Ensure that contact details are provided for those services involved in the persons care
- If additional support is required there will be signposting to appropriate supportive services for the family

Priority 5 – 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.

- An individual plan of care must give priority to communication, comfort and dignity and include: physical, psychological, social, emotional, cultural, religious needs and spiritual support, food and drink and symptom control:
 - Anticipatory medication prescribed for the five key symptoms (pain, breathlessness, agitation, respiratory secretions, nausea & vomiting) that may develop during the last days of life
 - Assessment of the spiritual needs of the person and their family
 - Assessment of the person's physical needs and symptoms
 - Review of care interventions during the last days of life e.g. mouth care,

- pressure area care, continence, personal care
- Review of the person's needs with regards to eating and drinking, ensuring food and drink continues to be offered to those who can swallow without serious risk of choking or aspiration
- Review of current medications and treatments
- Assess equipment requirements and source
- If the person has complex needs refer to Specialist Palliative Care Team
- Ensure regular review of the person's care plan is undertaken
- Ensure documentation e.g. resuscitation decisions, special patient note is completed and communicated appropriately
- Ensure there is on-going re-evaluation of the focus of care depending on the person's individual needs and circumstances
- Signed authorisation by a doctor for nurse verification of death where permitted by organisational policy
- Care after death is in accordance with the person's and family's wishes and preferences.

Appendix 1 – Symptom Management Guidelines (N.B. These have been reviewed by Northamptonshire Prescribing Advisory Group who have requested these are reviewed by Kettering and Northampton General Hospital pharmacy committees before full agreement. Once agreed, these will be attached to this document).

Notes

*For the purposes of this document 'family' means any individual identified as important to the person.

It is imperative that all who view these guidelines must work within their own organisational guidelines at all times.

With thanks to staff from the following organisations who formed the Task Group to devise the guidelines:

- Northamptonshire Healthcare Foundation Trust
- Northampton General Hospital NHS Trust
- Kettering General NHS Foundation Trust
- Corby Clinical Commissioning Group
- Nene Clinical Commissioning Group
- St Andrew's Healthcare
- Primecare
- East Midlands Ambulance Service
- Healthwatch

The team acknowledge Dr Rosie Bronnert, Palliative Medicine Consultant, End of Life Care Lead, UHL who was kind enough to allow us to use the Leicestershire guidelines as a basis for this document.

References

Mental Capacity Act. (2005) London: Crown Copyright.

<http://www.legislation.gov.uk/ukpga/2005/9/contents> [Accessed 09-07-2014]

The Leadership Alliance for the Care of Dying People (2014) : One Chance to Get it Right, Improving people's experience of care in the last few days and hours of life.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=kii9U7P5Dcq47Abz_IHgAQ&ved=0CBQQFjAA&usg=AFQjCNEgcg_jzLOtAfp0LsYyKNvDQ0J2uw [Accessed 09-07-2014]

Royal College of Physicians (2014) : National care of the dying audit for hospitals.

https://www.rcplondon.ac.uk/sites/default/files/ncdah_national_report.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=GSm9U_XJBuul7Abi9IGICg&ved=0CBQQFjAA&usg=AFQjCNEI4obDviTqlcUUvfAIRjmAGGIVYg [Accessed 09-07-2014]

Further Information

For information on symptom control guidance;

- i. PANG (<http://book.pallcare.info/index.php>)
- ii. e-ELCA (<http://www.e-lfh.org.uk/programmes/end-of-life-care/>)
- iii. Clinical Knowledge Summaries (<http://cks.nice.org.uk/>)
- iv. palliative drugs.com, which requires membership (<http://www.palliativedrugs.com/index.html>)

This can be provided in large print, in Braille, on audio tape, on disc and in any other languages or formats. Please phone the Patient Advice and Liaison Service on 0800 9178504 or email pals@nhft.nhs.uk for alternative copies.

Developed and published by the Northamptonshire end of life collaborative July 2014

Review date: September 2015