Avon and Wiltshire Mental Health Partnership NHS Trust

End of Life Care Policy

Board library reference	Document author	Assured by	Review cycle
P011	Lead Nurse	Quality and Standards Committee	3 Years

Contents

1. Introduction

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) has welcomed the publication of the Leadership Alliance for the Care of Dying People (LACDP) report One Chance to get it Right (2014) which was established following an independent review of the Liverpool Care Pathway for the Dying Patient.

AWP will ensure that where the end of an individual's life is expected the care will involve assessing and responding to the holistic and changing needs of dying individual and their families.

The expected death of a patient in our care is not a regular event and therefore staff may not be fully conversant with how to deal with this event or be aware of the support services available. This policy will provide the structure to ensure consistent and quality care is provided for those patients in the last few days and hours of life.

2. Purpose

In line with the One Chance to get it Right document the purpose of this policy is to ensure that care given to patients in the last days and hours of life

- Is compassionate
- Is based and tailored to the needs, wishes and preferences of the dying person and, as appropriate, their family and those identified as important to them.
- Includes regular and effective communication between the dying person and their family and health care staff, and between health care staff themselves
- Includes assessment of the person's condition whenever that condition changes and timely and appropriate responses to those changes
- Is led by a senior responsible Doctor and a lead responsible nurse, who can access support from specialist palliative care services when needed
- Is delivered by doctors, nurses, carers and others who have a high professional standards and the skills, knowledge and experience needed to care for dying people and their families.
- reflects the 5 priorities of care

3. Scope

This policy specifically relates to the priorities of care for a dying person and therefore applies to all AWP health care staff involved in the delivery of this care.

4. Definitions

Patients are 'approaching the end of life' when they are likely to die within the next 12 months. this includes patients whose death is imminent (expected within a few hours or days) and those with:

(a) advanced, progressive, incurable conditions

(b)general frailty and co-existing conditions that mean they are expected

to die within 12 months

(c) existing conditions if they are at risk of dying from a sudden acute crisis

in their condition

(d)life-threatening acute conditions caused by sudden catastrophic events.

(One chance to get it Right 2014)

5. Priorities of care

5.1 Priority 1

The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.

When a person's condition deteriorates unexpectedly and it is thought that they may die soon (within the next few hours or days) an assessment as to whether the condition is potentially reversible must be undertaken by a competent ward Doctor. Medical guidance can be found here

If the persons condition is deemed reversible all efforts should be taken to attempt this provided it is in the persons wishes or best interests if capacity is lacking.

If the individual is detained under the Mental Health Act the RC must consider whether it is appropriate to continue with the detention.

If the Doctors judgement is that the person is dying this must be clearly and sensitively explained to the person in a way that is appropriate to their circumstances and their family and others identified as important to them. This may include explaining when and how death might be expected to occur and the basis for that judgement, acknowledging and accepting any uncertainty about the prognosis, and giving the dying person the opportunity to ask questions.

The plan of care must be discussed and agreed with the person where possible and involve those identified as important to them. It should reflect the person's wishes, views and preferences and changes are made in response to changes in the person's needs and preferences.

As it is a judgments as to whether a person is dying the multi-disciplinary team must acknowledge the uncertainty relating to this judgement and associated uncertainties must be accepted and communicated as part of the discussions on prognosis and care planning.

5.2 Priority 2

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

High quality care will be informed by open and honest communication between the multi-disciplinary team, the dying person and those identified as important to them.

Staff must seek to engage in regular and pro-active communication with the dying person and those identified as important to them to listen as well as provide information.

Communication must be respectful and maintain privacy and sensitivity.

Staff must check the other person's understanding of the information that is being communicated.

5.3 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.

The NHS Constitution pledges the right for all individuals to be involved in discussions and decisions about their health and care which includes end of life care. “Where appropriate this right includes your family and carers.”

Sensitive and honest communication with the dying person and those identified as important to them must be undertaken to assess to what extent they wish to be involved in the decisions about the treatment and the way it is delivered.

In order to alleviate confusion it is important to make clear to dying people and those who are important to them whether they are being informed about, consulted about, involved in or taking particular decisions about treatment and care.

The dying person and those identified as important to them must be informed of who the Senior Doctor responsible for the treatment and care is and the nurse leading the care.

Where the dying person lacks capacity, best interest action is undertaken and attempts should be made to for the dying person to continue to be involved as far as possible.

Decisions relating to life prolonging treatments made out of hours are less likely to involve people whom the dying person has indicated they would like to be involved in such decision making. Therefore the care team must decide which decisions need to be made on the spot to ensure the person’s comfort and safety, and which can and must wait for a review of the person’s condition by the senior doctor or the delegated on call clinician.

Where the dying person is assessed as lacking in capacity the multi-disciplinary team must comply with the legal requirements in relation to representation or advocacy and Best Interest decisions. Mental Capacity Act including Deprivation of Liberty Standards Policy

The Resuscitation status of the dying person should be agreed and recorded in line with the AWP Resuscitation Policy and AWP Policy for Making Decisions in Relation to Do Not Attempt Resuscitation Orders on Inpatient Facilities

5.4 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.

Families and those identified as important to the dying person are likely to have needs during such a time of distress and therefore these must not be overlooked. It is not always possible to meet the needs of all family members however staff must ensure opportunities are available for sensitive and open conversation in quiet surroundings to provide updates on care provided and to offer support.

If a lack of capacity is assessed in the dying person the decision-making process should be explained to those people who are supporting the person and they should be involved as much as possible.

Access to the AWP chaplaincy service should be considered - chaplaincy service.

5.5 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.

In the event of sudden death, care planning is unachievable.

Where dying has been judged as likely the person’s needs and wishes must be assessed to formulate a plan of care in collaboration with the dying person, and, if they wish, their family or those important to them. This process must include the senior Doctor and identified nurse responsible for the care.

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

- symptom control (e.g. relief of pain and other discomforts)

  all medications, including anticipatory medicines, must be targeted at specific symptoms, have a clinical rationale for the starting dose, be regularly reviewed, and adjusted as needed for effect.

  Methods of medication delivery and possible side effects.

  Referrals to specialist palliative care teams must be undertaken if adequate pain relief is not being achieved.

- Food and fluid intake

  The care plan must specify how the person will be supported to eat and drink as long as they wish to do so and how nursing staff will assess and monitor nutritional and fluid status.

  If there is concern that there may be serious risks associated with food and drink consumption specialist advice must be sought e.g. choking assessment and alternative methods of hydration considered. Decisions about clinically assisted hydration and nutrition must be in line with the general Medical Council 2010 guidance GMC Treatment and Care Towards the End of Life.

  If the dying person makes an informed choice to eat or drink, even if they are deemed to be at risk of aspiration, this must be respected.

- Consideration of comfort and dignity.

  Assessment of the dying persons comfort and dignity must be documented in the care plan and include the use of relevant assessment tools, the frequency of reviews and how personal and mouth care are delivered.

  Specialist equipment used for comfort and dignity must be sought if deemed necessary e.g. specialist mattresses and bedrails (AWP Using Bedrails Safely and Effectively Policy).

- Specialist advice from palliative care teams.

  If it is established that the person lacks capacity to make decisions then any decisions made must be in the person's best interests. Guidance for assessing mental capacity can be found here.

  If the dying person has an Advance Decision, guidance can be sought here.

- Spiritual and religious care

  The dying persons religious/spiritual needs must be assessed and access to the chaplaincy service must be considered.

  Staff, must seek to establish from the dying person, their family and those important to them, details of any relevant cultural or religious-specific requirements, including what constitutes respectful treatment of the body after death. Further guidance is available here and from the chaplaincy service . Guidance for Humanists can be found at Humanism.org.uk.

6. Care required at the time of death

6.1 When death has been assessed as likely

When death has occurred the medical practitioner responsible for that persons care (or delegated authority) must be informed. In the instance of the death of a detained person the CQC must also be informed by the agreed senior Doctor or manager involved in the management of the death.

Verification of the death must be completed by a Doctor before the body is transferred. The professional verifying the death is responsible for confirming the identity of the deceased person (where known) using the terminology of 'identified to me as'. In addition to recording the details

of the death on the electronic patient record the completion of the death registration form must also be completed.

The Registered Nurse or Doctor present at the death must record the time, who was present, the nature of the death, and details of any relevant devices in situ on the electronic health care record.

During the process of verifying death the practitioner must ascertain whether the person had a known or suspected infection and whether this is notifiable (refer to AWP Management of Communicable Diseases Policy and AWP Management of Infection Policy

6.2 The privacy and dignity of the deceased person is maintained

The privacy of the body must be maintained and no unauthorised persons must be granted access to the body.

After death has been certified, the nurse in charge is responsible for ensuring that the spiritual and cultural wishes of the deceased person and their families are maintained whilst ensuring procedural obligations are met.

Medical devices should be respectfully removed by competent practitioners and clear documentation must highlight any medical devices that are unable to be removed such as pacemakers.

The Health and Safety of everyone who comes into contact with the body must be protected. Guidance for Infection control management can be sought from AWP Management of Infection Policy Any preparation of the body that is immediately required is to be undertaken prior to the transfer to funeral director's premises.

Staff must provide support for the family or carers present.

Local delivery Units will have local procedures relating to the removal of the deceased patient and contacting funeral directors. The movement of bodies and their transfer to undertakers must be fully documented.in the electronic patient record.

Further guidance can be sought here.

6.3 Belongings and affects

Any personal effects and belongings of the patient must remain safe on the unit until directed by persons entitled to administer the estate. A receipt should be obtained to indemnify the Unit against all possible claims.

Where a person dies intestate (referring to a situation where a person dies without leaving a valid will) and is not survived by entitled kin, his estate (if solvent) belongs to the Crown. If the estate consists solely of a cash balance of less than £250, it need not be referred to the Treasury Solicitor. D.O.H. HSG (92) 8.

(Treasury Solicitor (BU), Queens Anne's' Chambers. 28 Broadway, London. SW14H 9JS (0710 210311/5/6/7).

6.4 Sudden or unexpected death

This policy does not provide guidance for care in the situation of unexpected or sudden death. However if a sudden or unexpected death is suspected emergency actions must be initiated to sustain life or to ascertain if death has occurred. For further guidance please see AWP Resuscitation Policy

7. Roles and responsibilities

7.1 The Director of Nursing and Quality

The Director of Nursing and Quality is nominated by the board as the Executive Lead with the responsibility for the development and implementation of this policy.

7.2 Responsible Clinicians and Doctors

When end of life is suspected Doctors will undertake an assessment to determine whether symptoms are reversible or confirm that death is likely.

Doctors will communicate the outcome of the assessment to the service user and those most important them and the Multidisciplinary team

The Responsible Clinician for the service user must identify themselves to the service user and those important to them.

The Responsible Clinician will consider Mental Health Act Restrictions and whether there is a continued need for detention.

Doctors will undertake Mental Capacity assessments and record the outcome clearly in the electronic patient record.

Doctors will consider the resuscitation status of the service user under the direction of the Resuscitation Policy and the AWP Policy for Making Decisions in Relation to Do Not Attempt Resuscitation Orders on Inpatient Facilities ,

In conjunction with Nursing team the Doctor will lead on the development of a Multi-Disciplinary Care plan which recognises the needs and wishes of the service user, those important to them and considers the 5 priorities of care

The Doctor will offer sensitive, regular and effective communication with the service user and those important to them

Should death occur the Doctor will complete verification of the death

7.3 Team managers

Managers will bring this policy to the attention of all their staff and ensure that the contents are adhered to.

Managers will nominate an End of Life Care Lead from the registered staff group who will undertake training to develop skills in managing End of Life Care.

Managers will complete a manager's report for all planned End of Life Care deaths.

7.4 Nursing staff

The nursing team will offer sensitive, regular and effective communication with the service user and those important to them

Registered Nurses will ensure the agreed care plan is recorded on the electronic patient record and will include consideration of the service users' needs and wishes in relation to

- symptom control (e.g. relief of pain and other discomforts)
- Food and fluid intake
- comfort and dignity.
- Specialist advice from palliative care teams.
- Spiritual and religious care

The nursing team will deliver care in accordance with the agreed care plan

The nursing team, as part of the wider multi-disciplinary team, will review and update the care plan according to the needs, wishes and symptoms of the service user and those important to them.

Nursing staff must ensure the privacy and dignity of the deceased person is maintained. This will include

- Safe removal of any medical devices
- Allowing only authorised persons access to the body
- Consideration of the persons spiritual and cultural wishes
- Consideration of any Infection Control requirements

Nursing staff will offer support to any friends or family present

Nursing staff will ensure personal effects remain safe on the ward until directed by persons entitled to administer the estate

7.5 Collective responsibilities, e.g., all managers and all clinical staff

All staff involved in End of Life Care has a duty to adhere to the contents of this policy and ensure the 5 priorities of care are delivered, recorded and reflected upon through supervision.

Ensure the completion of an incident form for all in-patient planned End of Life Care deaths.

8. Training

The Trust's overarching policy for training is the Learning and Development Policy and this should be read in conjunction with this policy.

Each Older Adult ward will support the training of a nominated Registered Nurse to undertake training in Improving End of Life Care.

9. Monitoring or audit

The Trust reports on the efficacy of its incident reporting and management arrangements through bi-annual reports to the Quality and Standards Committee.

10. References

Leadership Alliance for the Care of Dying People (2014), One chance to get it right

NHS National End of Life Care Programme, 2011, Guidance for staff responsible for care after death

Actions for End of Life Care: 2014-16, NHS England,

Version History

Version	Date	Revision description	Editor	Status
1.0	Nov 2005	Draft for approval	EB/TP	Approved
2.0	25 Mar 2009	Approved by Board	RA/EB	Approved
3.0	1 September 2015	Approved by Quality and Standards Committee. Title of policy amended from Bereavement Policy.	SP	Approved
3.1	6 September 2018	Extended to 30 September and marked as under review	JW	Approved
3.2	15 October 2018	Extended to 31 December	JW	Approved
3.3	3 September 2019	Extended until end March 2020	Julie Kerry Nursing Director	Approved