

Caring for a Dying Patient - Guidance

For all staff at GHNHSFT, upholding the National Six Ambitions for End of Life Care is a minimum requirement.

1. Each person is seen as an individual
2. Ensure fair access to care
3. Maximise comfort and well-being
4. Care is co-ordinated
5. All staff are prepared to care
6. All communities are prepared to care

Joint Working with Patients and Those Close to them

We want to understand from individuals how they wish us to try and support them.

Sometimes, recognising decline is something that patients and those close to them are more able to do than healthcare professionals who may not be as familiar with that person. We encourage patients or those close to them to highlight to any member of the healthcare team any decline if they feel that this is happening.

We encourage patients and those close to them to highlight previously stated care preferences or advance decisions to decline treatment, where they exist.

Patients and those close to them can always ask questions and clarify anything that they are not sure about. They should also be aware that the option of asking for a second opinion is open to them and we realise that this is something which may feel important to them.

We encourage patients and those close to them to be as involved in their care as is felt to be appropriate/agreed by everyone. Documentation by patients/those close to them on the Shared care plan can sometimes form a part of that and the document is designed to allow this.

Overleaf are the specific responsibilities that we highlight to staff working at GHNHSFT around caring for patients who are thought to be dying.

Make yourself aware of local initiatives [EOLC Web page link when set up.](#)

ROLE SPECIFIC RESPONSIBILITIES

Staff are expected to ensure that they have completed and remain up-to-date, with appropriate organisational training around End of Life Care according to their role.

The documented care must meet the standards set out above. The local tools can be used (i.e. Shared Care record) or care documented within the medical notes provided all areas are addressed.

Responsibility of the Multi-Disciplinary Care Team Supporting a Patient in Inpatient or Out-Patient Settings

- 1. Timely, frank but sensitive communication about dying with patients and their families is vital.**
- 2. Careful and thorough documentation of discussions should include the reasons a person is felt to be dying.**
 - The persons expressed wishes around dying if known including any advance statement regarding preferred priorities of care and preferred place of death;
 - Agreed management plan/aims and what has been explained to patient, including limits of intervention, DNACPR forms, adjustment of chronic disease management such as diabetes, ensuring appropriate observations and review of all medications with selective de-prescribing.
 - Discussions around artificial hydration and nutrition.
 - Spiritual needs of the individual.
 - Needs of those important to the individual.
 - Prescribe medications in anticipation of the 5 common symptoms at end of life
<http://www.gloshospitals.nhs.uk/en/Wards-and-Departments/Departments/Palliative-Medicine/Palliative-Care-Guidelines/>
- 3. Documentation must be kept close to the patient.**
 - As far as practicably possible (not always feasible in a hospital setting due to multiple visitors) to ensure communication is maintained and access is available to all professionals, including Out Of Hours services, and patients/carers if appropriate/agreed.
- 4. Transfer of the dying patient between care settings**
 - This demands a professional responsibility to ensure that all relevant documentation (copy of care plan, records of communication, DNACPR form, medication directives) accompany the patient. The Shared care plan should travel with the patient but a copy be kept within the medical record of the transferring team. Direct verbal handover to GP, Out of Hours service and Community Nursing Team is essential-see 'think 333' document
[http://www.gloshospitals.nhs.uk/SharePoint75/Palliative%20Care%20Web%20Documents/End%20of%20life%20discharge%20planning3meds%20update%20levo%20\(2\).pdf](http://www.gloshospitals.nhs.uk/SharePoint75/Palliative%20Care%20Web%20Documents/End%20of%20life%20discharge%20planning3meds%20update%20levo%20(2).pdf) .
- 5. Care after death care and documentation**
 - Consider involvement of families/carers in care after death, this will be a very individual decision but they may wish to be involved, have specific wishes e.g. clothes
 - This must be completed following Trust/organisation policy.

ROLE SPECIFIC RESPONSIBILITIES

The documented care must meet the standards set out above. The local tools can be used (i.e. Shared Care plan) or care documented within the medical notes provided all areas are addressed.

Responsibility of Senior Medical Staff

(some aspects apply to senior clinical nursing staff in areas with no full-time medical cover; the endorsement of senior medical professionals is expected as soon as practicably possible)

Senior clinicians must be involved in the MDT discussion around a diagnosis of dying and focus of care.

Consultants/GPs must countersign documentation of this even if they do not write it themselves.

Senior clinicians should review the patients regularly on ward rounds to confirm that the care remains appropriate and the clinical picture has not changed.

The cause of death as stated on the death certificate should be decided by the Consultant/GP in charge of the patients care although they may designate completion of the paperwork to junior medical staff.

Responsibility of Ward Medical Staff

Daily review should be completed by a doctor (acute hospital setting) or attending clinician (community setting/community hospital/care home) and filed chronologically in patient's notes or shared care record if this is being used. This is a minimum requirement.

Responsibility of Nursing Staff

Nurses should complete an initial care plan assessment-this is found within the shared care record but can be free text provided all areas are addressed.

Care plans for related or additional needs should also continue or be completed.

Symptom observations chart should be completed 4 hrly. Symptom observations chart should be completed 4 hrly or with every visit if a patient is in their own home – HCA's can have a role in completing some sections as agreed appropriate.

Keep up-to-date with last offices policy.

Responsibility of other Healthcare Staff

Allied health professionals, chaplaincy, healthcare assistants can all contribute to the care of patients in their dying phase. Providing individualised care and support to those close to the patient is vital – the little things can really make a difference.

Spiritual needs should be considered; chaplaincy can support patients and those close to them whether they have religion or not.

Documentation of any input in the Shared care plan or ongoing medical/nursing record is important. Keep up-to-date with last offices policy.