Principles of care and support for the dying patient

NHS England
Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network & Senate

Clinical Review

Deterioration in patient's condition suggests the patient has the potential to die in hours/days or is imminently dying

1. Exclude reversible causes e.g. opioid toxicity, renal failure, infection, hypercalcaemia
2. Is specialist opinion needed from consultant with experience in patient's condition &/or palliative care team?
3. Is there an Advance Care Plan or Advance Decision to Refuse Treatment?

MULTIDISCIPLINARY TEAM ASSESSMENT AGREES

Patient is potentially imminently dying and no likely reversible causes identified

Discuss and Agree Care Plan

Where the senior responsible clinician (ST3 or above) has identified that a patient under their care is dying or has the potential to die, if appropriate they should discuss and agree a care plan with the patient and/or the family and others identified as important to them clarifying;

- Recognition of dying or potential for dying and the rationale for this
- The patient's understanding and wishes for treatment and care
- Proposed plan of care including discussion about
  - Ceiling of care/CPR status
  - Risks and benefits of nutrition and hydration
  - Discontinuation of routine observations
  - Symptom control and medications prescribed for pain, nausea and vomiting, dyspnoea, agitation and chest secretions – including the need to commence a syringe pump if required
  - Spiritual needs
- Respond to family/carer questions/concerns

Communicate

The senior clinician must ENSURE that the care plan and all conversations are clearly communicated to the patient, patient's family/carer and all staff involved in the patient's care.

Document

The senior clinician must ENSURE that the care plan and all conversations are clearly documented in the patient's clinical notes.

Care

Care for the Patient and Support for the Family Using the Key Actions Below/Overleaf

Re-evaluate daily

No improvement in patient's condition
Patient is assessed to still be imminently dying and no reversible causes identified or patient opts for comfort care
For advice and support contact the Palliative Care Team

Patient's condition has improved
Patient is assessed as no longer dying

- Explore patient's understanding and wishes for treatment and care
- Treatment trial and timescale for review if appropriate
- Re-define ceiling of care if appropriate

For advice and support contact the Palliative Care Team

Hospital Palliative Care Team xxxx daily Extension xxxx	Community Palliative Care Team xxxx daily Telephone – xxxxx

For Palliative Care Advice outside these times, contact 24 hour advice line xxxx

Key Actions

Communicate Document

COMMUNICATE with patient / family to clarify aims of care and update family on a regular basis and following any change in management.

DOCUMENT significant conversations in the notes and ensure contact numbers for key family members.

- Opportunity to discuss and document wishes for tissue donation.

Rationalise

RATIONALISE INTERVENTIONS AND MEDICATIONS – focus on comfort and support

- Discuss and document DNA-CPR order
- Justify interventions based on a balance of benefits and burdens including observations, blood tests, artificial hydration, nutrition and antibiotics
- Communicate decisions with patient (where possible) and family

Care

MAINTAIN EXCELLENT BASIC CARE - Frequent assessment, action and review

- Regular mouth care and assessment of hygiene needs. Turning for comfort as appropriate
- Encourage and support oral food / hydration as patient is able
- Check bladder and bowel function – consider catheterisation

Symptoms

ASSESS SYMPTOMS REGULARLY - Frequent assessment, action and review

- Prescribe medications as required for anticipated symptoms e.g. pain, nausea, vomiting, breathlessness, agitation, respiratory secretions
- Consider delivery of medications via a subcutaneous syringe pump if symptomatic or no longer tolerating oral medication
- Advice available from the Palliative Care Team, see also Palliative Care Prescribing guidelines

Family

IDENTIFY SUPPORT NEEDS OF FAMILY

- Ensure contact numbers updated for key family members
- Explain facilities available e.g. parking permits, folding beds for relatives
- Consider side room

Spiritual Care

IDENTIFY SPIRITUAL NEEDS - For both patient and family

- Document specific actions required
- Refer to Chaplaincy or faith leader as appropriate

After care

CARE AFTER DEATH

- Timely verification & certification of death
- Consider family/carer involvement in “care after death” procedures eg washing and dressing deceased person
- Provide practical & written information including Bereavement booklet
- Inform GP and other involved clinicians
- Referral to Bereavement services if appropriate