

## Document Control

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|---|--------------------|----------------------------------|--|
| <b>Title</b>  |                    |                                  |  |
| <b>End of Life Care Policy for Adults and Paediatrics</b>   |                    |                                  |  |
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## 1. Contents

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## 2. Purpose

The purpose of this document is:

To ensure that all staff work with the 5 Priorities of Caring for the Dying Person.

- 1. Recognise.** The 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.
- 2. Communicate.** Sensitive communication takes place between staff and the dying person, and those identified as important to them
- 3. Involve.** 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.
- 4. Support.** The needs of the families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- 5. Plan and Do.** An individual plan of care , which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Completion of the of the Priorities of Care Integrated Record will ensure that the 5 Priorities are addressed

To ensure all clinical staff working within all multidisciplinary teams develops a person centred holistic plan of care to meet the end of life needs, (physical, psychological, spiritual, social and cultural) of patients and their families

For Children and Young People it may be necessary to include the family, parents and carers to develop a plan of care to meet the end of life needs.

To support staff confidence, communication and partnership working through provision of standards of practice and education.

To ensure that high quality and compassionate care is delivered and the privacy, dignity, wishes and needs of all patients at the end of life are respected

To enable patients to express their preferred place of dying and for this to be facilitated as far as is reasonably possible and safe

To ensure that the carers are supported, appropriately informed, enabled and empowered throughout the end of life and in the bereavement period of their relative or friend

To ensure there is robust review and targeted education where deficiencies of care are identified.

### 3. Definitions

**End of Life Care-** End of life (EOL) care has been defined as care that

*'helps all those with advanced progressive incurable illness to live, as well as possible, until they die. It enables the supportive and palliative care needs of both the patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support'* (Department of Health (2008) End of Life Care Strategy. DH: London)

Within the National EOL strategy, End of Life care is defined as that needed in the last year of life. For many long-term conditions this represents the end-stage of an illness. There are exceptions to this statement and that needs to be recognised. This may mean that the end-stage of illness may be protracted for longer than a year. (National Council for Palliative Care 2006, the End of Life Strategy 2008)

**'Family'** refers to carers, friends, relatives and anyone the patients regards as family.

**Advance Care Planning (ACP)** is the process of discussing and planning ahead in anticipation of some deterioration in the patient's condition and is important for ensuring patient focussed care is central to end of life care. The process of discussing this can be seen as part of the solution in that it enables 'catch up' and adaptation to the new reality and normalisation of life. Sensitive discussion of advance care planning can strengthen coping mechanisms and enable realistic planning. There is some evidence that it increases rather than decreases realistic hope.

**An Advance Decision to Refuse Treatment (ADRT)** is a statement made by a mentally competent person aged over 18 years, which defines in advance their refusal of medical treatment should they become mentally or physically incapable of making their wishes known. To be legally binding the ADRT should be appropriately signed and witnessed, should be applicable to the condition being considered and should include a statement indicating that the patient understands that their life may be at risk if treatment is refused.

**Advance Statements** may be made to express patient's wishes, feelings, beliefs and values about future care. Unlike the ADRT, an advance statement is not legally binding but must be taken into account if the person loses capacity as it can add to the clinical team's ability to make a 'best interest' decision about that person's care. Advance statements may be made either in writing or verbally (conversation recorded in patient's notes). If the patient is under 18 years of age they should be encouraged to participate in the discussion about their future wishes in liaison with their parents / legal guardian.

## Enduring Power of Attorney

Lasting power of attorney (LPA) replaced enduring power of attorney (EPA) on 1<sup>st</sup> October 2007. EPAs signed prior to that date are **still valid** and can be registered but the LPA is far more flexible and you have the option of taking out either a Property and Financial Affairs LPA or a Health and Welfare LPA, or both.

## Lasting powers of Attorney (LPAs)

were created under the Mental Capacity Act 2005, and came into effect on 1 October 2007. Their purpose is to meet the needs of those who can see a time ahead when they will not be able to look after their own personal and financial affairs. The LPA allows them to make appropriate arrangements for family members or trusted friends to be authorised to make decisions on their behalf. There are two types of LPA:

### Health and welfare (includes medical care)

### Property and financial affairs

## 4. Introduction

Caring for people at the end of life and providing support to families and friends at this time is of profound importance. There is only one chance to get it right for the individual patient and the impact of that death will live on in the memories of those close to them.

This policy details arrangements to assist staff in maintaining high standards of end of life care for patients and their relatives and friends. It has been developed to ensure that all staff working for/within the Northern Devon Healthcare Trust (NDHT) who are caring for patients who are believed to be in the last 12 months of their life deliver quality and compassionate end of life (EOL) care which respects the individual's choices, values and beliefs. This includes the support and care given to relatives, friends and carers. For those in the last days of life the '5 Priorities of Care' (National Leadership Alliance for Care of the Dying People, June 2014) will be met.

It will ensure that those patients who die in hospital have the best care possible and that those patients who wish to die at home, or elsewhere, are enabled to do so by supportive discharge arrangements and partnership working with other agencies whenever possible.

All staff working within the Northern Devon Healthcare Trust and visiting professionals have a responsibility to ensure that all patients have their end of life care needs met. This includes the needs of relatives and friends during and after the death of the patient.

The Care Quality Commission (CQC) sets out essential standards for people accessing health and social care services, with particular reference to those standards of care required at the end of life.

This policy sets out the care needed for patients in hospital who are at the end of their life. It defines the requirements, standards and actions necessary to deliver high quality end of life care across the organisation.

The NDHT recognises the need to support standards and a programme of education for all staff to deliver high quality compassionate care to service users and their carers that have an advanced life limiting illness.

This guidance is underpinned by the national End of Life Strategy which promotes the use of frameworks (including Gold standard Framework) in order to provide good end of life care for all patients and involves the following.

- Identification of people approaching the end of life;
- The opportunity to discuss personal needs and preferences;
- Co-ordination of care and support;
- Rapid specialist advice and clinical assessment
- Delivery of high quality care and support in the last days of life;
- Services that treat people with compassion, dignity and respect
- Appropriate support and advice for carers
- Care after death;

These principles are supplemented by guidance and recommendations from More Care, Less Pathway (A review of the Liverpool Care Pathway, 2013), One Chance to get it Right (National Leadership Alliance for care of dying people, 2014), NICE Guidelines for the Care of Dying Adults (2015) Care of dying adults in the last days of life NICE QS144 (2017) and NHS Chaplaincy Guidelines, Promoting Excellence in Pastoral, Spiritual and Religious Care (NHS England, 2015) and Ambitions for Palliative and End of Life Care (National Palliative and End of Life Care Partnership, 2015).

This policy is to be used in the care of all patients who are identified as being in the last 12 months of life, with specific application of the 5 priorities of care to those patients who are within the last few days of life. Those patients for whom death is unexpected should be managed under the resuscitation policy although the principles of this policy are applicable to their care in the “pre-arrest” period and after death.

A Mental Capacity Assessment leading to a “best interests” decision must be made by a suitably qualified and trained professional acting as part of the consultant team in respect of the resuscitation decision if a patient has lost capacity, or has never had the capacity. The aim of this decision making process is to act in the patient’s best interests if they are no longer able, or have never had the ability to discuss the details of their care and treatment. LPAs for health and welfare legally allow the holder of the LPA to speak on behalf of the patient to establish goals of care and treatment.

ADRTs allow the patient to give their legally binding view if they lose capacity. Best interests decisions by medical staff must take both of these views into consideration when formulating 'best interests' plans for care and treatment. The treating team must also speak to the patient's family to gather information about the patient's more informal wishes. It is best practice to include family in the process of 'best interests' decision making at the end of life if the patient themselves has lost capacity. This ensures that the patient's values and wishes are taken into consideration by the clinical team and also, importantly, gives the family information and maintains their involvement in planning care and treatment. Good communication with families at the end of life is likely to reduce family distress and is likely to improve their longer term adjustment.

Electronic palliative care co-ordination system (EPaCCS), formally known as the 'Adastra Register' is a register hosted by Devon Doctors which enables the recording and sharing of people's care preferences and key details about their care at the end of life across providers. A leaflet entitled "Out-of-hours treatment for patients with palliative care needs" is available from Devon Doctors to explain this system and its advantages to patients and families. When the patient has consented to sharing information, a clinician may log onto the EPaCCS system (<https://nww.devondoctors.nhs.uk/eol/>) and upload it themselves. Passwords and training for the EPaCCS register can be obtained from Devon Doctors. Staff can also ring 01392 823157 to speak to a member of the Devon Doctors end of life team to ask for information to be added to the register.

This policy will also work alongside the implementation of Johns Campaign throughout the Trust. Johns Campaign [www.johnscampaign.org.uk](http://www.johnscampaign.org.uk) is a simple campaign that aims for the right to stay with people with dementia in hospital. The campaign will involve working with families and carers as 'partners in care' to deliver the best possible open visiting and access to the person in hospital at the end of their lives. This policy also recognises that parents, carers and family of children and young people may also have open access and be able to stay. This has led NDHT to develop and enhance facilities for people who are in the final days of their life in hospital. The SNUG quality improvement project developed by Lundy ward, has been adopted by the organisation and will be rolled out across the trust in 2019. This means that patients and families that may require additional resources at a challenging time in their life journey may be able to access a SNUG wherever they are dependent on availability. The principles behind the SNUG are to give patients and their carers/families a more private, welcoming and dignified space when it is most needed, such as when patients are at the end of life or when patients with dementia or a learning disability are admitted.

## 5. Responsibilities

### 5.1. The role of the Medical Director and the Chief Nurse:

The medical director and chief nurse have joint overall responsibility for ensuring processes are in place to provide patients with appropriate end of life care and for ensuring that this policy is reviewed and that there are appropriate quality assurance mechanisms in place in relation to the guidance in this policy. They will provide clinical and cultural leadership which recognises that the care of a dying person is a priority and a responsibility of all healthcare staff. They will also ensure delivery of appropriate end of life education programmes.

### 5.2. The role of the End of Life Steering Group

The End of Life Steering Group is responsible for the review of this policy. It has a leadership role for end of life care, providing good integrated working within and across the health community, supporting clinical teams within specialties and promoting end of life care across the organisation. The group will oversee the delivery of the trust end of life training programme.

### 5.3. The role of the Senior Responsible Clinician:

The senior responsible clinician will have supportive discussions with patients and or parents or carers, of patients who are identified as being in the last year of life, so that the patient's wishes can be taken into account. Discussions will be recorded in the clinical record and on the treatment escalation plan. It is also best practice to record patients' wishes on the EPaCCs system with the patients consent. They are responsible for identifying patients within the last few days of life and planning, reviewing, co-ordinating, communicating and delivering an individualised plan of care in conjunction with the multi-disciplinary team.

### 5.4. The role of the registrant responsible for the patients care:

The role of the registrant caring for a patient at the end of their life has the responsibility for ensuring the completion and co-ordination of the individualised care plan.

### 5.5. The role of all staff:

Any member of staff who has concerns over any aspect of a patients care at end of life should escalate it immediately to a more senior member of the multidisciplinary team and report as an incident, using the Trust incident management system.

## 5.6. The role of Managers:

Managers will ensure that all staff involved in end of life care have received the appropriate training to support them in their practice. They will make available the relevant documentation and patient information. They will assess the education and training needs of their staff to support their provision of such care, and arrange appropriate access to such education and training.

## 5.7. The role of Health Care Professionals:

Any professional with direct responsibility for a patient or for an aspect of the patient's care and treatment must respect the five priorities of care of the dying patients as defined 'One Chance to get it Right' document. They must ensure that they maintain the skills and competencies appropriate to their role to manage the assessment, communication and symptom management of patients at End of Life. They must raise any need for additional training with their line manager and review their experience and competencies within their appraisal review. All staff must operate within the legal framework provided by the Mental Capacity Act 2005 and their relevant code of practice.

## 5.8. The role of the community nurse:

The Community Nurse is the 'key worker' and holds the clinical responsibility for an individual's nursing needs in the community, where needed the community nurse can call upon the expertise of colleagues, for example the Hospice team for clinical advice and support about symptom management. The community nurse will then consider that advice and make a decision about the patient's future care plan and act accordingly.

# 6. Planning and delivering end of life care

End of life care planning must be a multi-agency process which fully involves the patient and/or relatives and friends at all stages. Patients may access hospital services at various stages of their illness and receive care, treatment and support from a range of services. The co-ordination and communication of this may be aided by the use of the primary care end of life meetings. Teams should use the principles of care and support for the dying patient.

## 6.1. Holistic Care

All patients thought to be in the last year of life should have a holistic needs assessment at each key point of their care. Assessment of physical, psychological, social and spiritual needs should be undertaken and documented. For those with complex needs requiring referral to the specialist palliative care team at North Devon Hospice or NDHCT specialist palliative care team refer to BOB. Referral to the spiritual care team should be undertaken as appropriate. Staff caring for children with complex needs may contact the Children's Hospice South West for support and advice. Patients with learning disabilities should be referred to the hospital learning disabilities team.

## 6.2 Advance Care Planning

One of the key barriers to delivering good end of life care is a failure to have open discussions. Agreement is needed on when discussions should occur, and who should initiate them. Clinicians involved with patients who require end of life care should plan with the team as to who is the most appropriate to have an end of life discussion with the patient, at what points and in which environment.

Where the patient does not have the mental capacity to participate in these discussions, families should be involved. For patients without relatives and friends the Independent Mental Capacity Advocate (IMCA) service should be used.

Discussions about advance care planning must be:

- a. Recorded in the patient's notes.
- b. Inclusive of Treatment Escalation Plans (TEP). (Resuscitation Policy)
- c. Communicated to the GP.
- d. Included in the Discharge summary.
- e. Recorded on the Electronic Palliative Care Co-ordination (EPaCCs) register where appropriate.

Advance care planning may include the patient recording an Advance Decision to Refuse Treatment. It should always include TEP. Where end of life discussions include the use of the last days of life care plan the medical and nursing sections should be kept in the patient's medical records.

An early assessment of an individual's needs and an understanding of their wishes planning can ensure that relatives and friends understand what the patient's preferences for care are at a time when they cannot be communicated.

The booklet 'Planning for your Future Care' (<https://www.newdevonccg.nhs.uk/information-for-patients/planning-for-your-future-care-101641>) can be used for this. It can be filled out gradually over time, in discussion with family and friends. It is to be kept by the patient in a safe place. Apart from the Advance Decision to Refuse Treatment (ADRT), it does not need input from a health professional.

This booklet is a patient held record in which any preferences about future care should be recorded. It should be taken account of in any healthcare setting when decisions about care are being made. It should be reviewed and discussed with the patient at appropriate times e.g. change of care setting.

## 6.2. Treatment Escalation Plan Adult or Paediatric

A Treatment Escalation Plan (TEP) should be in place for all patients identified as being in the last year of life. The TEP identifies appropriate treatment options for the patient, and those which may be inappropriate. This should be discussed with the patient early in their hospital admission or in an appropriate outpatient setting. Ideally they would be discussed prior to admission, as some patients may deteriorate in hospital and therefore not have capacity to make specific decisions about future life sustaining treatments.

Sensitive discussion, where required, is usually between an appropriate doctor or a specialist nurse who has undergone extra training and the patient. With patient agreement, families should also ideally be involved in discussions. Both the discussion and the decisions need to be clearly documented. It may be judged that a patient would be too distressed by these discussions for them to be initiated. Similarly, if patients indicate that they do not wish to discuss these issues then this too should be respected. This should be documented.

Appropriately qualified and trained healthcare professionals have a legal duty to discuss resuscitation with any patient with mental capacity to participate in discussions, unless the doctor thinks this will cause the patient physical or psychological harm. If it is not possible to have this discussion with the patient, where it is both practicable and appropriate, they must discuss the patient's situation and the decision with those close to the patient (subject to any confidentiality restrictions expressed if, and when, the patient had capacity. The decision as to whether resuscitation should be attempted remains with the senior responsible doctor. Neither the patient nor the family can demand or require cardiopulmonary resuscitation if it is deemed clinically inappropriate (Decisions relating to cardiopulmonary resuscitation, 2016).

If the discussion has been with the patient, it should be established whether the patient wishes this discussed with family and, if so all reasonable efforts should be made to try and achieve this. Evidence of this discussion will be recorded by the professional completing the TEP. Such decisions should be made by senior doctors, or following consultation with them. All discussions relating to TEP should be carried out according to the Trust Resuscitation Policy

The TEP should be reviewed as the patient's condition changes, particularly if there is a return of mental capacity. If there is a change in decision, the original decision must be clearly scored through, signed and dated. It should then be filed to the rear of the notes. A new TEP form showing the current decision must be completed and placed in the front of the patient record. All decisions need to be recorded, dated and justified in the medical and nursing notes, clearly communicated to all clinical teams and discussed with the patient/family.

The TEP form is intended to be patient-held and community-wide in Devon. A TEP form introduced during one hospital admission must be reviewed at any subsequent admission to hospital by the medical team responsible for the patient's new episode of care. It should accompany the patient on discharge. To avoid unnecessary distress it is important that the patient, and preferably their family/ carers, have been involved in the TEP discussions prior to discharge. A photocopy of the form should be filed as above in the patient's clinical record. Whilst it is intended that this is patient-held, it is appreciated this may not be suitable for all circumstances and alternative arrangements may be necessary e.g. family/ carer held, with GP or care home.

### 6.3. Co-ordination of Care

Once a holistic assessment has been carried out, it is important that this is shared appropriately in order to co-ordinate care for the patient, relatives and friends, and carers. Trust staff will need to work closely with the healthcare community and social services.

The patient's details should also be recorded on the Electronic Palliative Care Co-ordination (EPaCCs) register, with consent. The information provided on the EPaCCs register can also be used to ensure that care is individualised to each patient. Those patients with complex palliative care needs (complex physical or psychological symptoms, complex social or spiritual needs) should be referred to the hospital palliative care team for assessment and advice. Patients in the community should be referred to North Devon Hospice or the Children's Palliative Care Team. Patients' spiritual needs should be assessed and may need referral to other agencies. Religious / multi faith Information is available on the Trust Intranet to assist staff in religious care.

For planning discharge from hospital, there needs to be a comprehensive coordinated discharge plan led by an identified person. This will include assessment of patient and family requirements regarding Preferred Place of Care (PPC) and link in with health and social care professionals to support the patient's end of life wishes. This includes obtaining rapid access to Continuing Health Care funding (Fast Track discharge).

Fast track discharge should be initiated for any patient who is rapidly deteriorating and likely to be entering the terminal stage of their illness expected to die and expresses a wish not to die in hospital. These patients should be assessed by the clinical team including hospital specialist palliative care team (where already involved with the patient). The fast track assessment enables the patient's end of life needs to be clearly identified and a care plan initiated for prompt discharge from hospital provided adequate package of care is available.

There is a rapid discharge process for patients discharged who are thought to be in the last two to three days of life which includes close liaison, communication and cooperation from community teams.

For patients who are discharged using ambulance transport the crews should be informed that the patient is receiving end of life care. The TEP form should be sent with the patient. Any resuscitation decision made with the patient and recorded on the TEP will apply both in transits in the ambulance and at the community setting, until reviewed by the GP.

All patients thought to be at the end of life should be referred to community nursing services, with details of the needs discussed and communicated to the community team. This should also be communicated to the GP via the discharge letter from the clinical team or via a telephone call if the patient is thought to be in the last days of life. The Community Nurse is the 'key worker' and holds the clinical responsibility for an individual's nursing needs in the community, where needed the community nurse can call upon the expertise of colleagues, for example the Hospice team for clinical advice and support about symptom management. The community nurse will then consider that advice and make a decision about the patient's future care plan and act accordingly.

When a patient is discharged from the hospital and dies within 5 days of discharge the hospital team who cared for them may, in some situations, be asked to complete the death certificate.

#### **6.4. Deactivation of implantable cardioverter defibrillators (ICD)**

Patients with an implantable cardioverter defibrillator (ICD) may develop terminal illness due to worsening of their underlying heart disease or other chronic non-cardiac disease. Patients at the end of life are more likely to develop conditions such as hypoxia, sepsis, pain, heart failure or electrolyte disturbances, predisposing them to arrhythmias and thus increasing the risk of shock therapy. Shocks can be physically painful and psychologically stressful, without prolonging a life of acceptable quality, a result of which is inconsistent with comfort care goals.

Furthermore, near the end of life, patients may either not wish to undergo cardiopulmonary resuscitation (CPR) or CPR may not be medically appropriate, therefore ICD tachycardia therapy deactivation should be considered when the patient's clinical status worsens and death is near.

Towards the end of life, discussions about deactivating ICD tachycardia therapy should take place as early as appropriate to enable proactive care management to avoid unnecessary distress. Although deactivation is not a complicated process, it may only be possible at certain times, because of the specific programmer required and technician support, therefore early planning is required. Criteria for deactivating a defibrillator should be discussed with a patient and/or their family. Ideally, discussions should take place while the patient is still able to be involved in the decision making process, including the ability to sign a consent form for ICD deactivation.

If the patient does not have the capacity to participate in the discussion the decision should be guided by an ADRT or lasting power of attorney if present. If these documents are not completed, a best interests decision should be made by the clinical team with the involvement of the family/IMCA. The deactivation of the defibrillator should be performed in accordance with the NDHT policy Deactivation of Implantable Cardioverter Defibrillators (ICD) towards the end of life (2015).

If urgent deactivation of an ICD is required outside of standard working hours, then this can be done by placing a large magnet over the ICD. Such magnets can be obtained in an emergency from the cardiorespiratory department, Victoria ward, GP out of hours service or the emergency department.

#### **6.5. Care in the last days of life**

If the possibility that a person may die within a few days/hours is recognised, and it is felt that there are no reversible factors, a senior clinician in consultation with the multidisciplinary team should document this condition and care should be guided by the Priorities of care Integrated Record, a personalised care plan for the last days of Life (Appendix 1). It is important that where possible a full discussion is had with the patient and family. It should be explained that the patient is thought to be dying and the reasons for this. Discussions including the likely course of their condition and around sensitive issues such as nutrition and hydration, resuscitation, symptom management, and the need for psychological, spiritual and social support should be held. Such discussions must be recorded and families should be given the patient information leaflet regarding caring for someone in the last days of life and other relative information they may find useful. In particular it should be discussed how the family may contribute to the patients care should they wish. Discussions regarding the patient's treatment escalation should also be held and recorded. The trust has introduced a scheme whereby a butterfly symbol is used to make staff aware that a patient is entering the end of life.

Using the Priorities of Care Integrated Record a personalised care plan for each patient should be drawn up and shared with the multidisciplinary team. The communication and comfort rounding sheets and the symptom observation chart should be available at the bedside of an inpatient to facilitate patient and relative involvement in their care. The patient should be reviewed at least daily by a senior doctor and/or senior nurse to assess for potential signs of recovery and to review the overall care plan. This review should be performed earlier if a significant change in the patient's condition is noted or the patient is experiencing distressing symptoms which require review. If the patient or family are not in agreement with the recommended plan of care a second opinion should be offered.

It is important that a patient's symptoms are actively managed in accordance with their wishes using the minimum (but adequate) dose of medication required to provide good symptomatic control. Non-pharmacological interventions to relieve symptoms should be considered, for example spiritual support. As distressing symptoms may be anticipated at the end of life, appropriate as required (PRN) medication should be prescribed. Prescribing guidelines for relief of common symptoms experienced at end of life are available on the Trust intranet under End of Life Care. If symptoms fail to be rapidly controlled this should be escalated to a senior clinician for review and if necessary further escalated to the specialist palliative care team at NDDH or North Devon Hospice. In the case of a child contact the senior clinician or the Children's Palliative Care Team

There is access to specialist palliative care advice, through the specialist palliative care hospital team bleep 401 Monday – Friday 8.30-16.30, and out of hours (or if the hospital specialist palliative care team are not available) by contacting the North Devon Hospice see Supportive and Palliative Care page on BOB for contact details. There is an on call palliative care doctor available at the hospice at all times. For support and advice in the case of children and young people the Children's Hospice South West can be contacted on 01271 321999

For some patients in the last days of life 'Fast Track' discharge can enable their preferred place of death. The clinical team together with the Pathfinder discharge team should assess the patient's condition on a daily basis to ensure that discharge/travel from hospital is still in the patient's best interest.

## 6.6. Care after death

**The Bereavement Support team** are the central point of contact following a death in NDDH. Their role is to offer support and guidance to the families of patients who die in NDDH or very soon after discharge. They are also responsible for locating the most appropriate doctor to complete the documentation needed – this is the Medical Certificate of Cause of Death and also a Cremation Form if requested by the family.

After an inpatient's death the Trust's Last Offices - Standard Operating Procedure should be used to ensure continuation of high quality care and provide appropriate support and information to relatives and friends. All beliefs of the patient or family must be respected in this process.

The ward doctor should ensure that death certificates and cremation certificates are completed in good time, liaising with the Coroner's Office as appropriate.

The family should be offered an appointment to speak to a member of the medical team if they have unanswered questions regarding their relative's care in the future.

## **7. Monitoring Compliance with and the Effectiveness of the Policy**

### **7.1. Standards/ Key Performance Indicators**

- Key performance indicators comprise:
  - Increased number of patients on the end of life register
  - Reduction in complaints relating to end of life
  - Increase in documentation of preferred place of death
  - Increased number of patients on the integrated priorities of care record

### **7.2. Process for Implementation and Monitoring Compliance and Effectiveness**

- Audit on a quarterly basis using the nationally recognised tool
- Audit of the bereavement service via a bereaved relatives survey
- TEP Audits quarterly or when an amendment to the TEP form is issued
- Results of audits taken to the End of Life Steering Group initially and fed back to directorate teams to address any shortfalls.
- Audit will be undertaken by the end of life lead with the support of the clinical audit and effectiveness team.

## 8. Equality Impact Assessment

Table 1: Equality impact Assessment

| Group  | Positive Impact | Negative Impact | No Impact | Comment |
|--|-----------------|-----------------|-----------|---------|
| Age  | X               |                 |           |         |
| Disability   |                 |                 | X         |         |
| Gender   |                 |                 | X         |         |
| Gender Reassignment  |                 |                 | X         |         |
| Human Rights (rights to privacy, dignity, liberty and non-degrading treatment) | X               |                 |           |         |
| Marriage and civil partnership   |                 |                 | X         |         |
| Pregnancy  |                 |                 | X         |         |
| Maternity and Breastfeeding  |                 |                 | X         |         |
| Race (ethnic origin)   |                 |                 | X         |         |
| Religion (or belief)   |                 |                 | X         |         |
| Sexual Orientation   |                 |                 | X         |         |

## 9. Associated Documentation

- [End of Life Care Strategy](#)
- [Patients at Risk of Deterioration policy](#)
- [Resuscitation Policy](#)
- [Consent Policy](#)
- [Specialist Palliative Care Symptom Guidelines](#)
- [Standard Operating Procedure](#)
- [Spiritual Care Bundle](#)
- [End of Life Care Bundle](#)