CLINICAL GUIDELINE FOR END OF LIFE CARE PLAN

1. Aim/Purpose of this Guideline

To give guidance to all healthcare professionals working on RCHT adult wards on the correct process for completing the end of life care plan. End of life care involves providing support to allow patients to die with dignity, keeping them as comfortable as possible until the end and assisting families to manage this often distressing experience. The aim of the end of life care plan is to identify and meet the care and support needs of the patient and their family. This includes management of pain and other symptoms and the provision of psychological, social, spiritual and practical support.

2. The Guidance

2.1. Priorities for Care Document Guidance Notes

Commencing this document should be an MDT decision. Any member of the MDT can raise the possibility that the patient may be approaching end of life. End of life, in the context of commencing this document for the patient, refers to an expectation that the patient has a few hours/days to live. If the patient makes an unexpected recovery e.g. it is thought they may survive beyond the period of a few weeks, this document can be discontinued. Any document is only as good as the information provided/completed. MDT members should work together in a supportive manner, to ensure the document is as fully completed as possible.

2.2. RECOGNISE (Medical Actions)

2.3. No.1

Write the name of the consultant involved and what time and date they were contacted in the daily communication record. A record of the discussion by the MDT that deemed the patient as approaching end of life, including names of people involved in the discussion, should also be entered on the daily communication record.

2.4. No.6

"no longer of therapeutic benefit" means medications that are not being used for symptom control and/or medications not being used to treat a potentially reversible condition. It is essential to note that “end of life” does not mandate cessation of active treatment if there is still a chance (however small) that the patient may recover from a reversible condition. A patient may be considered likely to die, but may recover despite this. Examples are sepsis and hypercalcaemia. Any decision must be based on assessment of the individual.
2.5. Preferred Place of Care

If the preferred place of care is not realistic, this needs to be discussed with the patient and/or family in an open and honest but sensitive manner, in order to agree the place of care. It may be appropriate for medical staff to lead the discussion.

If the preferred place of care is home and care at home is appropriate, the following flow chart will assist in arranging discharge.

**Flow Chart:**

1. **MDT agreement following patients/relatives request**
2. **Does the person need a package of care?**
   - **Yes**
     - Fast track to onward care team
     - Contact OT to assess needs
   - **No**
     - Contact OT if the person requires assessment/equipment
3. **Identity and refer to community staff**
   - GP to be telephoned by ward doctor
   - Nursing staff to phone DN and/or community matron
   - Community Palliative Care referral to be sent
4. **Arrange TTOs and e-Discharge letter including medication list**
5. **Documentation to complete**
   - **Doctors**
     - **Up to date TEP** (send with patient)
     - **Pre-notified death form and / or Special Patient Notes** (whichever is most appropriate)
     - **Syringe driver and injectable drugs prescription**
       - 7 days of syringe driver meds, 10 vials of PRN injectable drugs (send with patient)
       - NB Anticipatory prescribing can be documented on this prescription, even if syringe driver is currently not prescribed
     - **Community Prescription Sheet**
       - Required if DN needs to administer any medications e.g. pain relieving patch, insulin (send with patient)
     - **Hoof form** for oxygen if required
   - **Nurses**
     - **Record sheet for Issuing Medical Devices (MD11 form)**. Required by DN if discharging with syringe driver (send with patient).
6. **Documents to fax / email**
   - Pre-notified death form / Special Patient Notes to Cornwall Health and GP
   - Up to date TEP to GP and Cornwall Health (fax no. for Cornwall Health 01872 224046)
7. **Arrange Transport** (inform them end of life discharge)
8. **Send medication and documentation with patient.**
2.6. Advice and Guidance for Health Professionals to Support Care of the Patient in the Last Few Days of Life

Use this advice and guidance to inform the individual management plan for the patient.

2.6.1. Difficulty Swallowing

Oral intake should be reviewed and it should be considered whether a SALT assessment is required. Medication may require a different route of administration e.g. transdermal, subcutaneous injection, continuous subcutaneous infusion.

2.6.2. Observations / Blood Tests

Usually would stop e-obs (and thereby NEWS score). If they will not alter the management plan, they may be unhelpful, in terms of causing distress to the patient or taking emphasis away from patient comfort. This needs to be decided by the medical team on an individual basis.

2.6.3. Hydration / Intravenous / Subcutaneous Fluids

Patients should be allowed and encouraged to take oral fluids as they wish and are able. Support the patient with regular mouth care. For many patients IV/SC fluids are an unnecessary burden and may carry specific risks in particular patient groups e.g. patients in anuric renal failure. Assess the patient for distressing symptoms or signs that could be associated with dehydration, such as thirst or delirium. Consider a therapeutic trial of clinically assisted hydration if appropriate. Decisions should be discussed and decided on an individual patient basis.

2.6.4. Nutrition / PEG / RIG / NG Feeding

The patient should be encouraged to eat if they wish and are able to. It is normal for the patient in the last days of life to experience loss of appetite and a decreased interest in food or drink. Some patients may have already commenced artificial nutrition and the question whether to withdraw / stop may arise. This can be a cause of great unease and distress for the patient and/or their family/carer. The risks and benefits of discontinuing or reducing the feed should be discussed with the patient and/or their family/carer and outcome documented. Decisions by the medical team must be on an individual basis.

2.6.5. Blood Glucose Monitoring for Patients on Insulin

During the last days of life, poorly managed blood glucose can adversely affect a patient's end of life experience. Oral hypoglycaemic agents are usually stopped. For patients taking insulin, monitoring may need to be continued on a daily basis at teatime, and long acting insulin prescribed if needed. Type 1 diabetics should never have their insulin stopped, but daily dose should be reduced to one third of normal dose. For advice, please contact the diabetes CNS (Clinical Nurse Specialist) via hospital switchboard.

2.6.6. Review Medications

Discontinue all medication no longer contributing to symptom control. Exceptions may include e.g. diuretics prescribed for pulmonary oedema, steroids for raised intracranial pressure symptom prevention. Prescribe anticipatory medication following the guidance.
If the patient requires a continuous subcutaneous infusion (CSCI) the prescription should be completed on the Continuous Subcutaneous Infusion Prescription Chart and recorded on EPMA as “Syringe Driver see chart”.

2.6.7. Oxygen Therapy

Administer oxygen only if this is contributing to patient comfort. Aim for the lowest flow rate required via nasal specs for patient comfort, rather than monitoring O2 saturation, and review patient daily.

2.6.8. Patients on Non Invasive Ventilation (NIV)

Discuss plan for weaning off and discontinuing NIV with the patient and family/carer. If felt to be contributing to symptom control and tolerated well by patient, continue (this may require specialist discussion)

2.6.9. Implantable Cardioverter Defibrillator (ICD)

The benefits of an ICD may be outweighed by the burden of repeated shocks from the device. Discuss the rationale for possible deactivation with the senior medical team, prior to discussing with the patient and their family/carer. Document discussions. Contact the Cardiology department for guidance regarding deactivation.

2.6.10. RCHT Palliative Care Guidelines

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>The audit will take into account record keeping by health professionals working on RCHT adult wards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>End of Life Care Training Facilitator.</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit tool document developed for ward use</td>
</tr>
</tbody>
</table>
| Frequency               | • 40 care plans of patients that are approaching end of life on RCHT adult wards will be audited monthly.  
                              • A report will be completed quarterly.  
                              • The report will be shared quarterly. |
| Reporting arrangements  | • End of Life Care Group  
                              • During the process of the audit if deficiencies are identified, this will be highlighted at the next End of Life Care Group and an action plan agreed. |
| Acting on recommendations and Lead(s) | • Action leads will be identified and a time frame for the action to be completed.  
                                • The action plan will be monitored by the End of Life Training Facilitator. |
| Change in practice and lessons to be shared | • Required changes to practice will be identified and actioned within a time frame agreed on the action plan.  
                              • A lead member of the group will be identified to take each change forward where appropriate.  
                              • End of Life Care Newsletter. |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality, Diversity & Human Rights Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>CLINICAL GUIDELINE FOR END OF LIFE CARE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>10/11/16</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>10/11/16</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>10/11/18</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Allison May  
End of Life Care Training Facilitator  
Palliative Care Team |
| Contact details: | 07810 815 806 |
| Brief summary of contents | To give guidance to all healthcare professionals working on RCHT adult wards on the correct process for end of life care planning and processes. |
| Suggested Keywords: | End of life, care plan, EOLC |
| Target Audience | RCHT  
PCH  
CFT  
KCCG |
| Executive Director responsible for Policy: | Christine Perry |
| Date revised: | |
| This document replaces (exact title of previous version): | New Document |
| Approval route (names of committees)/consultation: | End of Life Care Group |
| Divisional Manager confirming approval processes | Karen Jarvill |
| Name and Post Title of additional signatories | Not required |
| Signature of Executive Director giving approval | |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet  
✓ Intranet Only |
| Document Library Folder/Sub Folder | Palliative |
| Links to key external standards | Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020 |
Related Documents:  End of Life Care Strategy

Training Need Identified?  Yes. Ward based training. Learning and development department informed.

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
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All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Clinical guidelines to support the completion of individual end of life care plans</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>New</td>
</tr>
<tr>
<td>Name of individual completing assessment: Allison May</td>
<td>Telephone: 07810 815 806</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   - Who is the strategy / policy / proposal / service function aimed at?
   - To give guidance to all healthcare professionals working on RCHT adult wards regarding completion of the end of life care plan.

2. **Policy Objectives**
   - To ensure all staff communicate and document effectively when caring for patients who are approaching end of life and to promote excellence in care of the dying patient.

3. **Policy – intended Outcomes**
   - Good communication, good standards of documentation and improved patient experience.

4. **How will you measure the outcome?**
   - Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?**
   - RCHT adult patients approaching end of life.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?
   - Yes

   b) If yes, have these *groups been consulted?
   - Yes

   C). Please list any groups who have been consulted about this procedure.
   - Palliative care team, ward managers and their teams, Palliative Care Consultants, Medical Consultants.

7. **The Impact**
   Please complete the following table.

<table>
<thead>
<tr>
<th>Are there concerns that the policy <strong>could</strong> have differential impact on:</th>
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</thead>
<tbody>
<tr>
<td>Equality Strands:</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No x |

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director | Date of completion and submission

Names and signatures of members carrying out the Screening Assessment
1. Allison May
2. 

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed _____ A.J. May ____________

Date _____ 10/11/16 ____________