Care of dying adults in the last days of life

PLEASE REFER TO THE NICE GUIDELINES FOR CARE OF DYING ADULTS IN THE LAST DAYS OF LIFE AVAILABLE ON PALLIATIVE CARE HOMPAGE ON INTRANET

St George's Healthcare NHS
NHS Trust

Recognising Dying

Deterioration in patient's condition suggests the patient is actively dying i.e. has the potential to die in hours or short days
REVIEW & CONSIDER WHETHER ESCALATION/ACTIVE TREATMENT APPROPRIATE

1. Gather & document information on the patient's medical history, current clinical signs and symptoms & clinical context including underlying diagnosis.
2. Exclude reversible cause's e.g. opioid toxicity, over sedation, renal failure, infection, hypercalcaemia.
3. Is specialist opinion needed from consultant with experience in patient's condition?
4. Is there an advance care plan and/or advance decision to refuse treatment?

UNDERTAKE MULTIDISCIPLINARY TEAM ASSESSMENT

where possible this assessment should be done during working hours by the MDT caring for the patient under the guidance of the senior clinician responsible. Where it is unavoidable, urgent, and clearly in the patient's best interests such decisions should be made by a clearly identified senior responsible clinician accountable for their care during the 'out of hours' period.

Communicate

COMMUNICATION

Where the senior responsible clinician has identified that a patient under their care is actively dying or has the potential to be dying soon, they must discuss & agree the plan of care with the patient/patient's family to clarify and explain:

1. The recognition of dying or the potential for dying
2. The rationale for this, and
3. Respond to the patient/family's questions/concerns

Document reason(s) if family contact genuinely impossible (e.g. no family)
Consider the patient's current mental capacity to communicate & actively participate in the plan of care

Shared Decision Making

DOCUMENT AN INDIVIDUALISED END OF LIFE CARE PLAN

In agreement with the patient (where possible and the patient wishes) and family, the senior responsible clinician must ensure that an individualised end of life care plan and all conversations are documented clearly in the patient's medical records.
Refer patient to the palliative care team (see below)
Ensure DNACPR form is completed
The care plan should consider the patients hydration needs
The care plan should review and consider what pharmacological interventions are required
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The St. George's Hospital Palliative Care Team is available for face to face visiting 9am-5pm 7 days per week, via bleep 6508. Outside of these hours telephone advice is available via the on call SpR at Trinity Hospice on 0207 787 1000

On-going Care

REVIEW & RE-EVALUATION OF CARE & CLINICAL DECISIONS

AT MINIMUM 4 HOURLY REVIEW AND GIVING OF NURSING CARE – PLEASE USE **NURSING DAILY EVALUATION LAST HOURS & DAYS OF LIFE** AVAILABLE ON THE PALLIATIVE CARE HOMEPAGE ON THE INTRANET

AT MINIMUM DAILY REVIEW & RE-EVALUATION BY THE RESPONSIBLE MEDICAL TEAM.

If unsure that the care plan is appropriate or the patient / family raise concerns, all staff must ask the senior responsible clinician