Care in the Last Days of Life Document

Policy for Use

March 2017

1.0 Background

It has long been recognised that hospices deliver the highest quality of end of life care available within the UK, however, hospices are a finite resource and are not able to look after all people that are dying. In response to this, the Marie Curie Palliative Care Institute developed the Liverpool Care Pathway(LCP) in the late 1990's, aiming to be guidance document to guide care professionals through the principles of high quality end of life care. This became a popular and effective guide and was rolled out Nationally. However, following heavy criticism in 2012, a review was undertaken lead by Baroness Neuberger, which was published in the document More Care, Less Pathway: a review of the Liverpool Care Pathway.

The review highlighted key themes:

- Lack of senior involvement in decision making
- Poor recognition that a person is dying.
- Poor symptom management.
- Inappropriate withdrawal of hydration and medications.
- Lack of education/training.
- Misunderstanding of term pathway
- Lack of communication with patient/family and involving them in decisions

The main recommendation of the review was to phase out the LCP by July 2014. In place of the LCP each organisation caring for patients at end of life was advised to develop a care plan that could be personalised to meet each individual's needs whilst supporting the 5 Priorities of Care for the Dying person as set out in the Priorities of Care for the Dying Person (Leadership Alliance 2014) guidelines.

Lindsey Lodge Hospice is working collaboratively within the region. At strategic level, we are representative at the Northern Lincolnshire Multi-Agency End of Life Strategy Group. At operational level we form part of the North Lincolnshire Specialist Palliative Medicine Subgroup. It has been agreed at the Multi-Agency End of Life Strategy Group that the Trust designed Care in the Last Days of Life document be adopted throughout Northern Lincolnshire. Following a pilot of the document,

Lindsey Lodge Hospice has now adopted the first part of the document, whilst continuing our own personalised care plans for the day to day care. Any updates to the document will include senior clinical staff from the hospice, to ensure updated versions are representative of the hospice.

2.0 Process

For any patient who has been recognised as being in the last days of life, a consideration for using the Last Days of Life Care Plan should be made.

2.1 Who can make the decision to commence the Care in the Last Days of Life Care Plan?

Recognition that a patient is dying is clinical skill that requires experience and clinical judgement to exclude potentially reversible causes for the deterioration such as medication side effects (especially opioid medication), infection, acute neurological event (e.g seizure) and electrolyte imbalance.

The following members of staff should be able to recognise a dying patient and can commence the Last Days of Life Care Plan:

- Any member of the medical team. Those in junior/training posts should discuss this with a senior member of the team to ensure they agree that the patient is dying.

- An experienced nurse looking after the patient, in agreement with the nurse in charge to ensure they agree the patient is dying, provided all the following apply:
    - The patient is a ceiling of care level 1 or 2 (hospice care only)
    - The patient has been recognised as being in a deteriorating phase of illness
    - For those with ceiling of care level 2, reversible causes as listed above should be considered. If there is a potentially reversible cause, this should be discussed with a doctor as to whether it is appropriate to treat it. It may be necessary to run a set of clinical observations (blood pressure, pulse, temperature and oxygen saturations) and dip urine in the event of a sudden decline.

2.2 Document one (see appendix 1) should be completed by the clinical team (nursing and medical) as fully as possible, ensuring that patients (if still able to communicate) and relatives/significant others are communicated with to explain that death is approaching and any changes being made to the care delivered. Conversations should focus upon;

- Any medications being discontinued
- Anticipated symptoms, including respiratory secretions and changes in breathing pattern
- Anticipatory medications
- Nutrition and Hydration
- Preferred place of death (unless already discussed/identified earlier in the patient journey)
- Spiritual considerations
- Any other preferences expressed by patient
- How any relatives/significant others wish to be informed of any changes in condition

2.3 Care plans should be reviewed and new care plans introduced as appropriate

2.4 Relatives should be offered open visiting and be shown the other facilities available to them – such as the kitchen, relatives' rooms, meals.

2.5 A diary sheet should be offered to the relatives/significant others and kept in the patient's room. This should be reviewed daily by the care team.

2.6 Informal assessments of whether the patient is still in the last days of life should be made on a daily basis. The Care in the Last Days of Life document has a section for formal re-assessment every 3 days. In the event of improvement in clinical condition of the patient, it may be appropriate to discontinue the Care in the Last Days of Life document, ensuring the relevant discontinuation section is completed.

2.7 Document one has daily sheets for recording medical reviews, including signature box to confirm the diary sheet has been reviewed. All other MDT documentation is to be recorded on the standard evaluation sheets, and kept with document one.

2.8 Commencement or use of the Last Days of Life Document and the prescription of anticipatory medication should be recorded on the electronic patient record on SystmOne for the purposes of data collection.

3.0 Patient Movement

In the event that a patient changes location of care following commencing The Care in the Last Days of Life Document, the document(s) (one and or two) including any additional MDT evaluation sheets should follow the patient and should **not** be retained by the organisation that commences it. However, copies should be kept for further reference.

3.1 For patients who are transferred to Lindsey Lodge Hospice, staff will continue to complete document one with the addition of MDT evaluation sheets. Following discontinuation of the document or death of the patient, a photocopy of all the pages commenced outside the organisation will be kept within the hospice records and the originals will be sent back to the place of care that commenced the document.

3.2 For patients who are transferred from the hospice, a photocopy will be made of the completed pages to be retained in the hospice records. The original document will be sent with the patient.

4.0 After Death

4.1 Following the death of a patient within the hospice, verification should be completed by a member of staff with appropriate training and experience.

4.2 An after death checklist should be completed to ensure the necessary procedure, paperwork and standards have been undertaken in the usual way following the expected death of a patient.

5.0 Audit

5.1 The use of the Last Days of Life Document will be published within the suite of quarterly clinical data published by the hospice.

5.2 At yearly intervals the completion of Document one will be audited using the locality audit tool. See appendix 3. Results will provide evidence of our compliance with Priorities of Care for the Dying Person 2014 and with the NICE Quality Standard QS144: Care of dying adults in the last days of life 2017. Results will also be analysed to inform improvements in care.

REFERENCES: Lead Author Dr Lucy Adcock Ratified by QA committee 13th July 2017 Review period: 2 years				
ISSUE DATE July 2017				
TO BE REVIEWED	REVIEW COMPLETED	BY	APPROVED BY	CIRCULATION
July 2019				

Appendix 1

WQN 1123 = Care in the Last Days of Life

Appendix 2

WQK 011 = Patient and Family Diary.pdf

Appendix 3

Copy of Copy of End of Life Care data colle