END OF LIFE CARE

VERSION No	3
REVIEWED BY	Manager (MP)
NUMBER OF PAGES	5

Policy Statement

This policy fully reflects the current guidance issued by NICE and the Leadership Alliance for the Care of Dying People 5 priorities of care which are:

i. ***Recognise***
ii. ***Communicate***
iii. ***Involve***
iv. ***Support***
v. ***Plan and Do***

The above guidance provides specific, concise quality statements, measures, and audience descriptors to provide the public, health- and social care professionals, commissioners, and service providers with definitions of high-quality care.

Procedure

As an organisation we seek to adhere to the following statements, and through assessment and planning provide effective and caring end of life care for our residents. We work closely with outside professionals such as cancer care nurses, Macmillan nurses, and the GP to ensure the best possible outcome for the individual.

The following list of statements is taken from the NICE guidelines and reflects the 5 Priorities of care:

Statement 1: People approaching the end of life are identified in a timely way.

Statement 2: People approaching the end of life, and their families and carers, are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.

Statement 3: People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

Statement 4: People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.

Statement 5: People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences and maximises independence and social participation for as long as possible.

Statement 6: People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

Statement 7: Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

Statement 8: People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

Statement 9: People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.

Statement 10: People approaching the end of life who may benefit from specialist palliative care are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

Statement 11: People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication.

Statement 12: The body of a person who has died is cared for in a culturally sensitive and dignified manner.

Statement 13: Families and carers of people who have died receive timely verification and certification of the death.

Statement 14: People closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

Statement 15: Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and for their families and carers.

Statement 16: Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in both number and in the mix of skills to provide high-quality care and support.

What the Quality Statement Means for Us

We ensure that systems are in place to identify people approaching the end of life in a timely way. We use these systems to identify people approaching the end of life in a timely way and at the right time to receive care and support to meet their needs and preferences.

End of life forms part of holistic care, and as such it should be respected and planned (ADL 12). As much information as possible is gained following admission during the initial assessment process to ensure that when the death of an individual occurs the relatives are aware of the individual's preferences, for instance the individual's choice of burial or cremation.

Training Statement

All staff involved in End of Life Care receive training and support both in house and from outside health professionals to enable them to meet the ever-changing needs of the individual resident.

Further Guidance

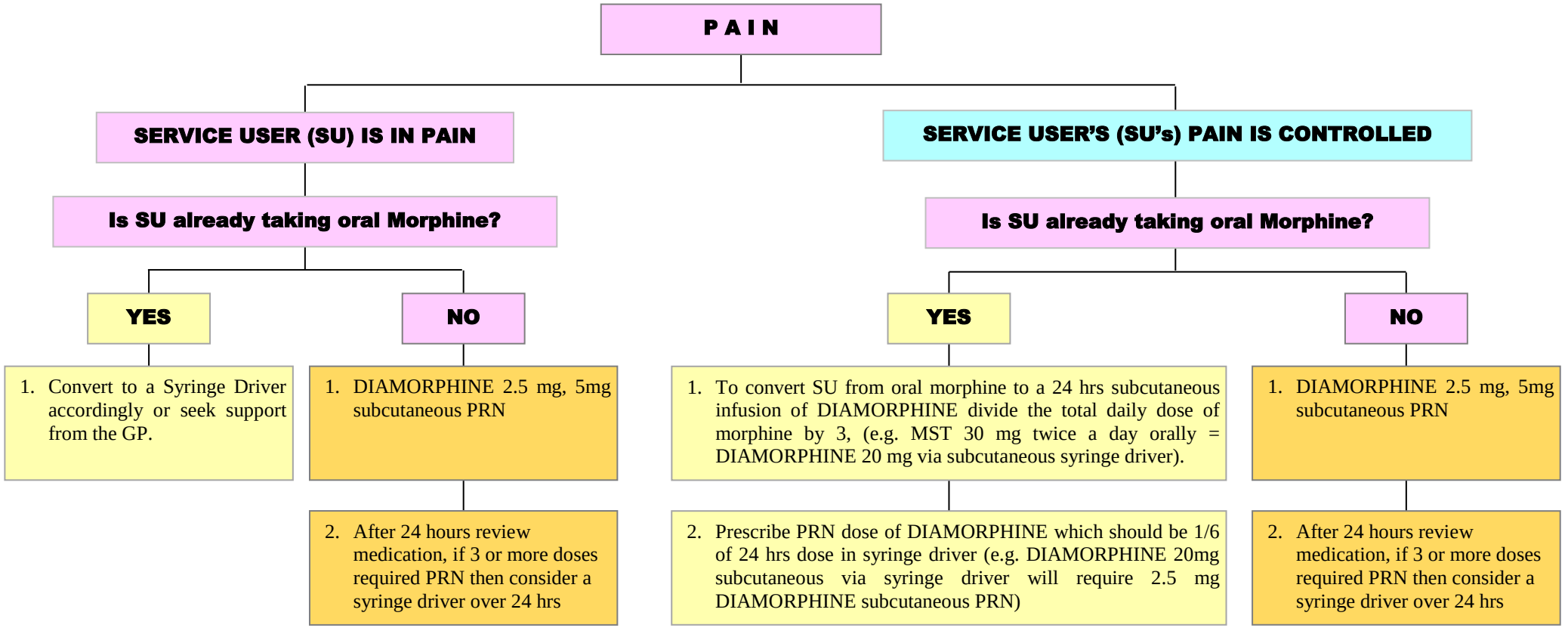
- Nice Guidelines NG31 published December 2015 Care of dying adults in the last days of life.
- End of life care for adult. Quality Standard (QS13) published Nov 2011 updated March 2017
- Skills for Care - Common Core principles and Competences for social care and health workers working with adults at the end of life http://www.skillsforcare.org.uk/Topics/End-of-Life-Care/End-of-life-care.aspx
- One Chance to get it Right – Leadership Alliance for the Care of Dying People. (5 Priorities of Care):https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

Related Policies

Advance Care Planning
Assessment of Need and Eligibility
Basic Life Support
Consent
Death of a Resident
Dignity and Respect
DNACPR
Notifications
Nutritional and Hydration Needs
Person Centred Planning
Prevention of Pressure Ulcers

ADL 12	END OF LIFE CARE (EoLC)

PHYSICAL COMFORT GUIDELINES



FURTHER GUIDANCE:

- **To convert from other strong opioids contact GP**
- **If symptoms persist contact the GP and/or Palliative Care Team**
- **Morphine 5, 10 mg subcutaneous PRN may be utilised as an alternative**
- **Anticipatory prescribing in this manner will ensure that in the last days and hours of life there is no delay responding to a symptom if it occurs**

ADL 12

END OF LIFE CARE (EoLC)

PHYSICAL COMFORT GUIDELINES

TERMINAL RESTLESSNESS & AGITATION

PRESENT

1. MIDAZOLAM 2.5 mg, 5mg subcutaneous PRN
2. Review the required medication after 24 hrs, if 3 or more PRN doses have been required then consider a syringe driver over 24 hrs
3. Continue to give PRN dosage accordingly

ABSENT

1. MIDAZOLAM 2.5 mg, 5mg subcutaneous PRN
2. If 3 or more doses required PRN, consider use of a syringe driver over 24 hrs.

FURTHER GUIDANCE:

- **If symptoms persist contact the GP and/or Palliative Care Team**
- **Anticipatory prescribing in this manner will ensure that in the last days and hours of life there is no delay responding to a symptom if it occurs**

RESPIRATORY TRACT SECRETIONS

PRESENT

1. HYOSCINE HYDROBROMIDE 0.4 mg subcutaneous bolus injections. Consider syringe driver 1.2 mg over 24 hrs.
2. Continue to give PRN dosage accordingly
3. Increase total 24 hrs dose to 2.4 mg after 24 hrs if symptoms persist.

ABSENT

1. HYOSCINE HYDROBROMIDE 0.4 mg subcutaneous PRN
2. If 2 or more doses of PRN HYOSCINE HYDROBROMIDE required then consider a syringe driver subcutaneous over 24 hrs.

FURTHER GUIDANCE:

- **If symptoms persist contact the GP and/or Palliative Care Team**
- **Glycopyrronium 0.4 mg subcutaneous PRN may be used as an alternative**
- **Anticipatory prescribing in this manner will ensure that in the last days and hours of life there is no delay responding to a symptom if it occurs**

ADL 12 — END OF LIFE CARE (EoLC)

PHYSICAL COMFORT GUIDELINES

NAUSEA & VOMITING

PRESENT

1. CYCLIZINE 50 mg subcutaneous bolus injection.
2. Review dosage after 24 hrs. If 2 or more PRN doses given, then consider use of a syringe driver.
3. CYCLIZINE 150 mg subcutaneous via syringe driver over 24 hrs.

ABSENT

1. CYCLIZINE 50 mg subcutaneous 8 hourly PRN.

FURTHER GUIDANCE:

- ***ALWAYS USE WATER*** **for injection when making up Cyclizine.**
- **If symptoms persist contact the GP and/or Palliative Care Team**
- **Cyclizine *IS NOT RECOMMENDED* for people *WITH HEART FAILURE. Alternative antiemetics* may be prescribed e.g.:**
  - ***Haloperidol*** **subcutaneous 2.5 – 5 mg PRN (5 – 10 mg via subcutaneous syringe driver over 24 hrs)**
  - ***Levomepromazine*** **subcutaneous 6.25 mg PRN (6.25 – 12.5 mg via subcutaneous syringe driver over 24 hrs)**
- **Anticipatory prescribing in this manner will ensure that in the last days and hours of life there is no delay responding to a symptom if it occurs**

DYSPNOEA

PRESENT

Is SU already taking oral Morphine for breathlessness?

YES

1. Convert to DIAMORPHINE and give 4 hourly or via syringe driver (for further advice and support liaise with GP

NO

1. DIAMORPHINE 2.5 mg, 5mg subcutaneous PRN
2. After 24 hours review medication, if 3 or more doses required PRN then consider a syringe driver over 24 hrs

ABSENT

1. DIAMORPHINE 2.5 mg subcutaneous PRN

FURTHER GUIDANCE:

- **If the SU is breathless and anxious consider *MIDAZOLAM* stat 2.5 mg subcutaneous PRN**
- **If symptoms persist contact the GP and/or Palliative Care Team**
- **Anticipatory prescribing in this manner will ensure that in the last days and hours of life there is no delay responding to a symptom if it occurs**