BRADFORD, AIREDALE, WHARFEDALE AND CRAVEN STANDARDS FOR THE CARE OF PEOPLE IN THE LAST DAYS AND HOURS OF LIFE

Bradford, Airedale, Wharfdale and Craven Palliative Care Managed Clinical Network

These standards have been produced by the Bradford and Airedale Palliative Care Managed Clinical Network (MCN) and agreed for use across Bradford, Airedale, Wharfedale and Craven. They take into account NICE quality standards, and recommendations from the National leadership alliance for care of the dying adult and its Priorities for care. (ref 1&2)

DOMAIN	STANDARD	ENABLERS
Standard 1 Communication and Patient Centred Care*	Communication with the patient is delivered in an honest and open manner and ensures that they are involved in decisions about their care and treatment if they wish. This should include discussions about nutrition and hydration, preferred place of death and DNACPR. Relatives/important others and advocates of the dying patient will be involved in discussions about the patient's plan of care and will be given the opportunity to discuss their own concerns. This will be supported by written information.	**Communication Skills Training to appropriate level.** **Information leaflet for patients/carers Last Days of Life.**
Standard 2 Multi Disciplinary Care	All care decisions will be made by a multi disciplinary team. Decisions will be reviewed if a patient's condition changes, if a patient transfers care setting or, at least every 3 days. Each patient should have a named senior responsible doctor and a named lead responsible nurse.	**Priorities for Care – Duties and Responsibilities of Health and Care Staff - Leadership Alliance for the Care of Dying People June 2014**
Standard 3 Pain & Symptom Management	Patients being cared for at the end of life will be assessed as agreed in their personalised care plan for any symptoms including pain. Any symptoms present will be dealt with in a timely fashion. Specific guidelines relating to symptom management at the end of life will be made available to all clinical staff. Anticipatory medications for the 5 main symptoms of pain, agitation, dyspnoea, nausea and vomiting and respiratory tract secretions will be prescribed, taking into account any medication currently taken and prescribed via an appropriate route. Patients receiving care at the end of life will be assessed for problems relating to bowels or bladder as agreed in their personalised care plan. Any equipment used to administer symptom relief such as a syringe driver will be explained fully to patient and carer. The equipment should be obtained in a timely manner. The multi-disciplinary team will refer to the Specialist Palliative Care Team where appropriate. (For example if there are any uncontrolled symptoms or psychological needs that the normal caring team require support with).	**MCN Symptom Control in the Last Days of Life.** **Policy and Procedure for use and access to syringe drivers.** **Access and clear referral pathway to Specialist Palliative Care advice.**
Standard 4 Nutrition and Hydration	Patients being cared for in the last hours or days of life will be supported to eat and drink for as long as they are able to. Patients being cared for in the last hours or days of life and with 'unsafe swallow' will be given the opportunity to eat and drink at risk when the risks have been explained to them or their carer and they understand this. Patients being cared for in the last hours or days of life will have an assessment of their need for clinically assisted artificial hydration and nutrition. This will incorporate the stated or documented wishes and preferences of the patient and/or carer. The patient's mouth will be assessed regularly as agreed in their personalised care plan and mouth care will be given as tolerated.	**MCN Symptom Control in the Last Days of Life.**

Standard 5 **Pressure Area**	All patients receiving care at the end of life will be assessed and when appropriate cared for on a pressure relieving mattress in order to minimise the risk of skin breakdown and as a comfort aid. Changing of position should be for comfort measures and take into account individual preferences.	**Relevant Tissue Viability Policy .**
Standard 6 **Privacy and Dignity/Spiritual Care**	Wherever possible, patients being cared for in the last days of life who are not in their own home will be offered a single room. All patients and their relatives/carers will have their spiritual needs assessed and a referral will be made to faith/ chaplaincy or other spiritual support services as appropriate. All patients will have their personal values and beliefs documented and all efforts will be made to meet these.	**Referral procedure to chaplaincy**
Standard 7 **Carer Support**	When a person is not in their own home services and facilities available to relatives and carers should be explained and offered (for example, visiting hours, car parking, contact numbers). Where appropriate supporting written information should be provided. An assessment of the carers own needs in relation to the dying patient will be made and responded to appropriately.	**Facilities leaflet** **Completed contact sheet** **Patient and Carer information leaflet about last days of life**
Standard 8 **Documentation**	All patients receiving care in the last days of life will have a documented medical plan and appropriate nursing care plans implemented including DNACPR decision.	**Personalised Care Plan in the Last Days of Life.** **DNACPR Policy & Procedure.**
Standard 9 **Transfer of Care**	Where a patient is being transferred to achieve their preferred place of death, professionals will ensure effective communication to enable seamless care.	**Systmone record updated.** **Fast track discharge process using organisational agreed documentation eg Rapid discharge pathway** **Discharge letter**
Standard 10 **Care After Death**	Carers/family member will be given time to spend with their loved one and supported in an appropriate and compassionate manner. The patient's wishes and preferences regarding how their body and possessions are handled after death should be documented and respected. This should include respect for the patient's values, religion and beliefs. Verification of death should be made in a timely fashion. The patient will be treated with dignity and respect whilst last offices are undertaken & all local policies and procedures should be followed. Verbal and written information should be given to the carer/family member and explained.	**Personalised Care Plan. Guidance for Care in Last Days of Life.** **Care after Death Policy and Procedures**. **Verification of death policy and procedure** **Bereavement information leaflet**

MONITORING
These standards should be monitored on an annual basis using: Care of the dying audit Bereaved Relatives Survey *Preferred Place of Death Audit

References:

1. NICE Quality Standards for End of Life Care For Adults updated Oct 2013 – Quality Statement 11
2. One Chance to get it right – Improving peoples experience of care in the last few days and hours of life – Leadership Alliance for Care of dying people – June 2014