Priorities for the Care of the Dying Person

Recognise

The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

Communication and Shared Decision-making

Open and honest communication between staff and the person who is dying and those identified as important to them is critically important to good care. Communication should be regular and proactive. Every effort should be made to maximise the opportunity of effective communication e.g. involvement of an interpreter or learning disability specialist nurse if appropriate. Information about a dying person's wishes may be sought from family, those identified as important to the individual, taking into account Lasting Power of Attorney or with reference to previously Advance Care Planning, DNACPR discussions or registration on the Organ Donor Register. All decisions must involve consideration of the potential benefits, burdens and risk of treatment (or non-treatment) for the individual person. Any decisions made on behalf of someone who lacks capacity must be done in their best interests, after considering what is known of their preferences.

Clinically Assisted Hydration

Support the dying person to drink if they wish to and are able to. Check for any difficulties, such as swallowing problems or risk of aspiration.Consider a therapeutic trial of clinically assisted hydration if the person has distressing symptoms or signs that could be associated with dehydration, such as thirst or delirium, and oral hydration is inadequate. Monitor at least every 12 hours for changes in the symptoms or signs of dehydration, and for any evidence of benefit or harm.

Pharmacological interventions

When it is recognised that a person may be entering the last days of life, review their current medicines and, after discussion and agreement with the dying person and those important to them (as appropriate), stop any previously prescribed medicines that are not providing symptomatic benefit or that may cause harm.Decide on the most effective route for administering medicines in the last days of life tailored to the dying person's condition, their ability to swallow safely and their preferences.Consider using a syringe pump to deliver medicines for continuous symptom control if more than 2 or 3 doses of any 'as required' medicines have been given within 24 hours.

Anticipatory Prescribing

Use an individualised approach to prescribing anticipatory medicines for people who are likely to need symptom control in the last days of life. Specify the indications for use and the dosage of any medicines prescribed.

Table 1: Practical Aspects of Care

Communicate	Document clearly communication with patient and individuals important to them. Consider need for interpreters, learning difficulty team etc.
Share	If appropriate, in addition, seek information from e.g. Lasting Power of Attorney, Nominated Representative, Advance Care Plan, Organ Donation Register to determine patient's wishes. If patient lacks capacity and any one to provide information, consider IMCA.
Support 1) Psychological 2) Spiritual 3) Social 4) Explore the option of dying @ home	Provide appropriate information and refer to chaplaincy if appropriate. Seek information about cultural/religious wishes, including after death. Rapid Discharge pathway link
Nutrition and Hydration	Consider risk and benefits of ongoing nutrition and hydration. Follow GMC guidance. Discuss with individuals important to patient.
Symptom management 1) Pain 2) Anxiety 3) Secretions 4) Nausea and Vomiting 5) Dyspnoea 6) Other symptoms	Daily review of patient or more often if symptoms change Use BSUH Observation of Symptoms of a Dying Person Chart. Anticipatory prescribing for symptom management. Stop any medications that are no longer required. See prescribing guidelines on Intranet for advice. Document rationale for treatment, dose and dose frequency. Specialist Palliative Care advice available (on line referral, bleep 8420 or ext 3021). Out of hours information available for RSCH from Martlet's Hospice 01273964164 or for PRH from St. Peter's and St. James' Hospice 01444471598.
Monitoring/observations	Document expected frequency of observations etc.
Lines	Document plan for lines. Document plan if IV access lost and ensure anticipatory prescribing appropriate if no IV route
ETT/Tracheostomy/Oxygen	Document plan regarding artificial airway. Document plan regarding oxygen therapy
Positioning	Document plan regarding positioning

1. INTRODUCTION

There is only one opportunity to get end of life care right for an individual and this requires recognition that the patient is dying, sensitive communication, involvement of the patient and those important to them, support of the patient and those important to them and appropriate planning and treatment for symptom management.

2. PROCESS

Recommendation (Action)	Justification (Rationale)
Early recognition that the patient is dying to allow communication of this to the patient (if appropriate), those important to them and care givers	Allows determination of any wishes the patient or those important to them might have around end of life care. Allows assessment of wishes including input from (if appropriate) Power of Attorney, Nominated representatives and assessment of Advance Care Plans and e.g. registration of organ donation register. Patients should be involved directly (if appropriate) or decisions made according Mental Capacity Act if patient does not have capacity. Allows staff to recognize that the patient is dying so avoiding treatments and procedures which may no longer be in the patient's best interests.
Individualised Care Plan which is clearly communicated to the patient (if appropriate) or those identified as important to them.	Management of the patient should take into account the patient's wishes if know or those of individuals identified as being important to the patient. Good communication is essential with appropriate discussion of the risks and benefits of all interventions. Poor communication was a key concern in reviews of the use of the Liverpool Care Pathway (now abandoned). Symptom management should be based on a daily assessment of the patient's symptoms and response to treatment. Anticipatory prescribing should be appropriate for the patient (e.g. opiate naïve, opiate tolerant etc). Nutrition and hydration are highly emotive issues and should be specifically addressed so a comprehensive and clear plan can be instituted. This should also be reviewed on a daily basis. Again an assessment of risk and benefit must be made for each individual patient and communicated with those identified as being important to the patient. There is GMC guidance to guide this.

3. REFERENCES

Priorities of care for the dying person: Duties and responsibilities of health and care staff published by Leadership Alliance 2014

4 ONLINE RESOURES

GMC 2010 guidance, Treatment and care towards the end of life: good practice in decision-making

Mental Capacity Act 2005 and the MCA Code of Practice (with accompanying guides for staff and members of the public)

NICE guidelines QS 13 End of Life care for Adults

NICE guidelines NG31 Care of dying adults in last days of life