Healthier Communities, Outstanding Care

LAST DAYS OF LIFE FOR ADULTS POLICY

POLICY

Reference	CPG-TW-LDOL		
Approving Body	General Palliative and End of Life Care Committee (GP&EOLC)		
Date Approved	30th October 2024		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	31st October 2024		
Version	V4.0		
Summary of Changes from Previous Version	• Shortened the introduction to the Policy • Updated the definitions/abbreviations • Included the Comfort and Memory MakingTrollies • Updated the Training and Implementation Section • Updated the reference list • Updated Appendix B		
Supersedes	Version 3.0, Issued 22nd October 2021		
Document Category	• Clinical		
Consultation Undertaken	• End of Life Care Team • GP&EoLC Committee • Specialist Palliative Care Team		
Date of Completion of Equality Impact Assessment	25th September 2024		
Date of Environmental Impact Assessment (if applicable)	N/A		
Legal and/or Accreditation Implications	To comply with statutory requirements and promote best practice in-line with NICE quality standards QS144,QS13 and guideline NG31		
Target Audience	All Trust Medical, Nursing and Allied Health Care Professionals and staff who care for people in the last days of life		
Review Date	31st October 2027		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Lead Nurse for End of Life Care, Elizabeth Sansom		
Lead Division/ Directorate	Clinical Support, Therapies and Outpatients		
Lead Specialty/ Service/ Department	Nursing/End of Life Care		
Position of Person able to provide Further Guidance/Information	Macmillan Lead Nurse for End of Life Care		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
What to expect in the final days of life (patient information leaflet)	May 2024
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

Caring with compassion for people at the end of their lives should be the aim of all healthcare staff. Excellent care for the dying is as important as at any other time of life.

Caring for people who are close to death demands compassion, kindness, and a skilled application of knowledge. The Leadership Alliance for the Care of Dying People published a document in June 2014 "Priorities for Care: Duties and Responsibilities for Health and Care Staff" which sets out Five Priorities for Care in the last few days and hours of life. It also sets out the Duties and Responsibilities of Health and Care Staff to ensure the Priorities are achieved when they are involved in the care of dying people. In addition, enabling people to have choices at the end of their life needs to become an integral component of advance care planning in any care setting, including Acute Trusts (The Choice in End of Life Care Programme Board, (2015) What's Important to Me - a Review of Choice in End of Life Care).

The Priorities are all equally important to achieving good care in the last few days and hours of life. Each supports the primary principle that individualised care must be provided according to the needs and wishes of the patient.

This policy has been developed to meet the priorities of care and requirements of national guidance and to ensure that staff deliver high quality, patient centred, individualised care.

2.0 POLICY STATEMENT

The purpose of this Policy is to:

- Promote the delivery of last days of life care following the five key priorities which are:
    1. Recognise dying
    2. Communication
    3. Involve
    4. Support
    5. Plan and do
- Support safe and accountable practice when providing symptom relief for patients in the last days/hours of life
- Clarify roles and responsibilities.

This policy applies to:

Staff group(s)

- All clinical staff who need to follow/ implement the last days of life individualised care plan e.g. doctors, nurses, specialist nurses, therapy staff.

Clinical area(s)

- This document will be used by all adult in-patient wards; assessment areas; emergency department; ACCU
- All hospital sites: King's Mill Hospital; Mansfield Community Hospital; Newark Hospital.

Patient group(s)

- This document applies to all in-patient adults.

Exclusions

- Paediatric patients under 18 years of age
- Pregnant women under the care of the maternity services.

3.0 DEFINITIONS/ ABBREVIATIONS

Trust or 'SFHFT'	Sherwood Forest Hospitals NHS Foundation Trust.
Staff	All employees of the Trust including those managed by a third party on behalf of the Trust.
'Syringe Pump'	A device used for administration of medication continuously by the subcutaneous route.
'Healthcare Professionals'/'Staff'	All employees of the Trust including those managed by a third party organisation on behalf of the Trust.
'Preferred place of care/ death' (PPC/D)	A preference stated by the patient.
Advance Decision to Refuse Treatment (ADRT)	A decision to refuse a specific type of treatment at some time in the future.
Guide to treatment of specific symptoms at end of life: anticipatory medication	A guideline for ensuring medication is available to manage symptoms as they arise and without delay.
Multi-Disciplinary Team (MDT)	The ward team which includes consultants, doctors, nursing staff, physiotherapists, occupational therapists, social workers and other specialist services e.g. Specialist Palliative Care.
Independent Mental Capacity Advocate (IMCA)	The Independent Mental Capacity Advocate (IMCA) is a role created by the Mental Capacity Act 2005. A local council or NHS body has a duty to involve an IMCA when a vulnerable person who lacks mental capacity needs to make a decision about serious medical treatment, or an accommodation move. This could be an older person with dementia or a learning disability. The IMCA will help support the older person to make the decision, will represent their views and should act in the person's best interests.
Integrated Discharge Advisory Team (IDAT) and Frailty Intervention Team	Integrated Discharge Advisory Team (IDAT) Frailty Intervention Team (FIT).
Butterfly Symbol	A picture of a butterfly to signify that the patient is in the last days of life (temporarily affixed to the door of a side room, attached to the bedside screens or affixed to the wall behind a bay bed space, whilst a dying patient is occupying that space). The purpose is to ensure that any staff caring for the patient, including non-clinical staff, are aware of the need for sensitivity, respect and a peaceful environment, before entering the side room or bed space of the patient. A butterfly sticker is also used to close the medical notes and direct clinicians to write in the Last Days of Life Individualised Care Plan.
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment.

4.0 ROLES AND RESPONSIBILITIES

Divisional General Managers, Service Line Managers, Matrons and Heads of Nursing
The responsibility for ensuring that the policy is followed within areas is with both Clinical Leads

and Heads of Nursing to:

- Ensure that staff are released to attend training
- Ensure that staff have access to the Last Days of Life supporting documentation.

Line Managers

- To ensure that staff access training and attend mandatory training.

All Healthcare Professionals

- Will attend training sessions and complete the reducing harms workbook, as required
- Take responsibility for providing excellent care in the last few days and hours of life through the following principles:
  - The possibility [that a patient may die within the next few days or hours] is **recognised** and communicated clearly, decisions are made and actions taken in accordance with the patient's needs and wishes, and these are regularly reviewed and decisions revised accordingly
  - Sensitive **communication** takes place between staff and the dying patient, and those important to them
  - The dying patient, and those important to them are **involved** in decisions about treatment and care to the extent that the dying patient wants
  - The needs of families and others important to the dying patient are actively explored, respected and met as far as possible to ensure **support**
  - An individual **plan** of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

5.0 APPROVAL

This policy has been discussed and any amendments agreed at the General Palliative and End of Life Care Committee on 30th October 2024.

6.0 DOCUMENT REQUIREMENTS

This Policy follows the five key Priorities set out by the Leadership Alliance for the Care of Dying People published in June 2014, which are:

1. Recognise dying
2. Communication
3. Involve
4. Support
5. Plan and do.

The Priorities for Care reinforce that the focus of care in the last few days and hours of life must be the patient who is dying. They are all equally important to achieving good care in the last days and hours of life. Each supports the primary principle that individual care must be provided according to the needs and wishes of the dying patient. To this end the Priorities are set out in sequential order.

6.1 Recognise

- Initiating a decision regarding recognising the patient is nearing the end of life must be part

of an MDT discussion, which could be at the board round, ward round, MDT meeting or routine assessment. The conclusion of this discussion must be documented in the medical notes. The patient whose condition has deteriorated unexpectedly must be assessed as nearing the end of their life and expected to die in the next few days/hours

- Establish that the deterioration does not have a reversible cause, and/or further treatment is not desirable

- If potentially reversible, prompt action must be taken to attempt this, provided in accordance with the patient's wishes (or best interests, if the patient lacks mental capacity)

- A management plan will be established and agreed following a consultant/senior clinician led MDT discussion

- The goals of treatment and care, including the patient's preferred place of care and death, must be established and agreed with the patient, unless they have indicated that they do not wish to discuss this, then documented within the Last Days of Life Individualised Care Plan. Initiate the use of the 'butterfly symbol' – this needs discussion with the patient, if they are able, and those important to the patient, to ensure that they understand the purpose of the symbol.

6.2 Communicate

- An open and honest discussion with the patient about dying will take place in a sensitive and timely manner. This discussion must include an explanation of what is happening, why it is thought the patient is dying, their wishes and preferences, likely prognosis and any clinical uncertainty. The discussion must be documented within the Last Days of Life Individualised Care Plan *(Where this discussion has not been held, the reasons must be clearly documented).*

- If the dying patient chooses not to discuss this, their wishes should be respected but further opportunities to discuss should be offered.

- If the patient wishes, the same open and honest discussion about the patient dying should also take place with those important to them and documented. *(Where this discussion has not been held, the reasons must be documented within the Last Days of Life Individualised Care Plan).* This is often most helpful as a joint discussion.

- The patient will be fully informed about the management plan, if able. If the patient is not able to understand (e.g. due to lack of mental capacity or unconsciousness) this should be clearly documented within the Last Days of Life Individualised Care Plan.

- The relative/carer will be fully informed about the management plan if consent is given by the patient.

- The person to contact from this point on and in the event of death is clearly established and with whom the patient wishes their information to be shared. This must be clearly documented on page 1 of the Last Days of Life Individualised Care Plan.

- The GP must be notified when the patient has died.

6.3 Involve

- If the patient has capacity to discuss their current preferences discussions must be offered to establish whether the patient has an Advance Care Plan:
    - Advance statement of wishes and preferences (including organ donation)
    - Advance Decision to Refuse Treatment
    - Lasting Power of Attorney (LPA) for health and welfare decisions
    - ReSPECT document.

- If there is no Advance Care Plan in place, the opportunity must be offered for the patient and those important to them to discuss their wishes, concerns and preferences to the extent that the patient wants. This may include the patient's wish for direct release to the undertaker after death.

- If the patient lacks capacity it is appropriate to elicit the views of those important to the patient and incorporate these into the overall Last Days of Life Individualised Care Plan.

- The Independent Mental Capacity Advocate (IMCA) is a role created by the Mental Capacity Act 2005. A local council or NHS body has a duty to involve an IMCA when a vulnerable person who lacks mental capacity needs to make a decision about serious medical treatment, or an accommodation move. This could be a patient with dementia or a learning disability. The IMCA will help support the patient to make the decision, will represent their views and should act in the patient's best interests. An IMCA must be consulted if the dying patient lacks capacity and has no person's important to them to ensure decisions have been made in their best interest.

- Discussions with the patient and/or those important to the patient need to be had with regards to DNACPR decisions, as appropriate.

- A senior responsible clinician and registered nurse responsible for their care must be identified and communicated to the patient and those important to them.

6.4 Support

- The needs and concerns of those important to the patient must be acknowledged and actively assessed, explored, respected and met as far as possible (including any spiritual, religious or cultural needs).

- A referral to the Specialist Palliative Care Team should be considered, if there are any complex pain or symptom management issues. The referral should be made via ICE (Non-urgent) or Call for Care **01623 781899 option 2.**

- Consideration will be made to arrange care in the patient's preferred place of care and refer to the Integrated Discharge Advisory Team (IDAT/FIT Team) for Rapid Discharge Home to Die or Fast Track Discharge. It is the responsibility of the medical team to ensure that the

Fast Track Continuing Healthcare Tool is completed.

- Wellbeing of those important to the dying patient must be considered. Staff must ensure that there is sufficient support available. This includes:
  - Offering beverages
  - Offering overnight facilities to enable them to remain close to the patient
  - Utilising items from the Trust's Comfort and Memory Making Trollies to offer a bespoke experience, tailored to individual need
  - Offering car parking concessions to those important to the patient.

- The spiritual wellbeing of the dying patient and those important to them must be acknowledged. The Faith Centre is available to all faiths and provides facilities for prayer.

- Families and those important to the dying patient may require additional support if the death has been unexpected (e.g. understand how this impacts on the postmortem, coroners' and death certification procedures).

- The patient must be treated with respect and dignity whilst Care After Death procedures are being undertaken.

- The spiritual, religious and cultural needs of the deceased patient must be respected and carried out according to their wishes.

- Universal precautions and infection risks must be adhered to in accordance with local policy.

- The patient's property and valuables must be managed in accordance with the Safeguarding and Custody of Patients Property Policy. After death the patient's property and valuables may be given to the relative or labeled and stored for safe keeping for family/those important to the patient to collect at an appropriate time.

- A *"Sincerest Sympathies*" booklet is to be given to those important to the patient. This will provide information regarding how and when to contact the Bereavement Centre – and will explain the death certification process and the Coroner's involvement if necessary. Patient's property where appropriate must be given to those important to the patient; no property should be sent to the Mortuary/Bereavement Centre. Any items of jewelry, etc. that remain on the deceased patient must be clearly documented in the Last Days of Life Individualised Care Plan. If items of jewelry are removed from the deceased and given to those important to the patient this also needs to be clearly documented. If appropriate, those important to the patient should be informed of the Medical Examiners process.

6.5 Plan and Do

- An individualised plan of care, which includes food and drink, symptom control and psychological, social, and spiritual support must be agreed, coordinated and delivered with compassion.

- Symptom management will be considered and anticipatory medications targeted at specific symptoms will be prescribed (see Appendix B).

Nutrition and hydration will be considered. Diet and oral fluids are provided as tolerated and wished for. It is likely appropriate to stop intravenous fluids at this stage. If the patient is unable to swallow, decisions about clinically assisted hydration and nutrition must be in line with GMC guidance (see references) and relevant clinical guidelines.

- Implantable Cardiac Defibrillator (ICD) – Identify any ICD, if not already deactivated, instigate the process for deactivation (see Deactivating Implantable Cardiac Defibrillators (ICD/CRS-D) at End of Life Guidelines for Adults (aged 18+)).

- Ensure section 4 (resuscitation status) of the ReSPECT form has been reviewed/completed.

- Ensure the drug card/EPMA (Electronic Prescribing and Medicines Administration) has been reviewed, and non-essential medications are stopped (for example antibiotics and medications for most chronic conditions).

- All inappropriate routine measurements of observations and routine blood tests will be discontinued.

6.6 Daily Action Review (At board round/daily MDT discussion)

A daily action review must be undertaken by a senior clinician or senior nurse and incorporate the following:

- Assess as an MDT daily if the patient is still in the last days of life
- Record outcomes/changes to the management plan within the Last Days of Life Individualised Care Plan
- Communicate daily with the patient and/or those important to the patient regarding current management plan and on-going changes in condition and treatment
- Review anticipatory medications and if any adjustments are needed escalate to the medical team to review
- Consideration must be made when reviewing changes to the patient's preferred place of care when circumstances change. This may require support from the IDAT/FIT Team to provide a rapid discharge home to die if this is requested.

6.7 Supporting Documentation

The Last Days of Life Individualised Care Plan has been developed to enable good practice and facilitate the implementation of an individualised care plan for the last days of life.

Hard copy useable versions of the documentation should be ordered via Clinical Illustration.

6.7.1 Combined Medical and Nursing Last Days of Life Individualised Care Plan

The Last Days of Life Individualised Care Plan should be commenced as part of the individualised care planning process. This includes placing a butterfly sticker (which comes with the Care Plan) into the Medical section of the patient's notes, to alert colleagues that the Last Days of Life Individualised Care Plan has commenced.

The Last Days of Life Individualised Care Plan contains pages to record 7 days of care. In instances where additional pages are required, a Continuation Sheet is available from

Clinical Illustration. This must be inserted at the back of the Last Days of Life Individualised Care Plan, to ensure that a complete record of care is provided for the patient.

This process also includes the following:

For Medical Colleagues (complete the pink sections of the Last Days of Life Individualised Care Plan):

- Recognising dying and documenting of clinical decisions, including how the decision has been made and that this was MDT/consultant led. Any reversible causes should be considered (Priority 1 – 'Recognise' section of the Last Days of Life Individualised Care Plan)
- Initial discussions with the patient and those important to them regarding recognising dying and the initial management plan being documented
- Record the patient's wishes, preferences or any advance care plans, ADRT or LPA
- Preferred Place of Care (PPC)/death has been documented
- Symptom management, including rationale for prescribing anticipatory medication and communication to the patient/those important to them
- **A daily medical review should take place** (including weekends and bank holidays), this could be from a resident doctor, consultant or advanced clinical practitioner, and will include the assessment of any changes in condition and recognition that the patient is still deemed to be in the last days of life; a review of the anticipatory medications and adjustments made; a review of the PPC may be appropriate at this stage. Any discussions that have taken place with the dying patient or those important to them should be clearly documented
- When the patient dies, the verification of adult death and cause of death should be clearly documented, within the Last Days of Life Individualised Care Plan.

For Nursing Colleagues (complete the lilac sections of the Last Days of Life Individualised Care Plan):

The Last Days of Life Individualised Care Plan includes the following:

- Confirming a management plan has been established
- Completion of the following sections:
  - Priority 2 – Communication
  - Priority 3 – Involve
  - Priority 4 – Support
  - Priority 5 – Plan and Do.

Baseline Assessment

The baseline assessment consists of several areas to be considered when establishing the level of a patient's individual needs. This enables the nurse to tailor the Last Days of Life Individualised Care Plan (under Priority 5 – Plan and Do). For example this will include the following:

- Mouth care
- Fluids and nutrition
- Personal hygiene
- Skin integrity
- Bladder management
- Bowel management
- Symptom Management.

On-going Nursing Assessment
The on-going nursing assessment follows the action rationale process of delivering care. The on-going assessment of identified problems and evaluation of interventions will be undertaken in relation to the patient's needs. This may be required as frequently as 2 hourly but no longer than 4 hourly intervals.

The on-going assessments will record if the patients' needs are being achieved; any changes in condition must be documented within the Last Days of Life Individualised Care Plan. At the end of a period of care delivery there will also include a summary of the patient's status throughout that day or night.

Record of Communication Sheet
Any conversations or concerns shared by the patient and those important to them must be recorded within the Last Days of Life Individualised Care Plan.

Care After Death
Ensure a copy of the 'Sincerest Sympathies' booklet is given to those important to the patient, prior to leaving the Ward. (Copies of the leaflet are available from the Bereavement Centre).

The 'care of the person after death' section considers information about the patient's death, personal care of the deceased, relatives information needs such as Bereavement Services, and organisation information. **This section must be completed in a timely manner.**

6.8 Butterfly Symbol

The purpose of the butterfly symbol is to alert all staff that a patient is entering the last days/hours of life. This will prompt staff to approach the patient and those important to them in a sensitive and thoughtful manner. An explanation of the symbol should be given to those important to the patient.

If the patient/those important to the patient agree, the symbol may be temporarily affixed to the door of a side room, attached to the bedside screens or affixed to the wall behind a bay bed space, whilst a dying patient is occupying that space. This also applies to the cubicles and ward areas within the Emergency Department and Emergency Assessment Unit.

6.9 Patient/Carer Information

Information Leaflets are available for those important to the patient, as follows:

- What to Expect in the Final Days of Life
- Sincerest Sympathies.

Resources are available to promote comfort and for memory-making from the Comfort and Memory making trollies/box. The trollies are for use Trust wide and are hosted at:

- Emergency Assessment Unit – Kings Mill Hospital (Trolley)
- Short stay unit – Kings Mill Hospital (Trolley)
- Sconce Ward – Newark (Trolley)

- Oakham Ward – Mansfield Community Hospital (Box).

The code to unlock the trollies is: 4571

Items can be taken from the trollies to create a bespoke experience for individual patients and those important to them.

Additional faith/spiritual resources are available from the Faith Centre, extension number 3047.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc) and by who)
A review of all incidents involving Last days of Life	Divisional Leads	Incidents will be notified via the Trust's Datix incident reporting procedure and assessed to ensure that appropriate actions are taken to reduce the identified risks	As and when they occur	SFHFT General Palliative & End of Life Care Committee
Where several incidents occur, these will be investigated to identify the root cause	Policy Lead	Incidents will be notified via the Trust's Datix incident reporting procedure and assessed to ensure that appropriate actions are taken to reduce the identified risks	As and when they occur	SFHFT General Palliative & End of Life Care Committee
Last Days of Life Individualised Care Plan review	End of Life Care Team	Audit	Annually	SFHFT General Palliative & End of Life Care Committee
Last Days of Life Ward Metrics	End of Life Care Team	Audit	After 24 hours of patient being on the care plan	Nursing, Midwifery and Allied Health Professionals Committee
The individual practitioners will be expected to audit their own clinical practice	The individual practitioners and line managers	Appraisal	Annually	The individual practitioner's appraisal

8.0 TRAINING AND IMPLEMENTATION

Staff who are involved in care of the dying patient should take every opportunity to access the relevant training and education for end of life care to support their practice.

The End-of-Life Care Team will support good practice and implementation of this Policy by the delivery of training and education, relevant to end of life care, including face to face training based in both classrooms and clinical environments and e-Learning. Training will be underpinned by best available evidence and expert opinion, mapped to regional and national guidance for end of life care.

The End of Life Care Team will facilitate quarterly study days for The End of Life Care Champions Network. Delegates will be expected to share and cascade the learning from these study days throughout their teams, to ensure distribution of knowledge throughout the Trust.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A.

- This document is not subject to an Environmental Impact Assessment.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Ambitions for Palliative and End of Life Care (2021-2026) (Reviewed May 2021) - ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk) [online] (accessed 18/10/2024)

- General Medical Council (2010): *Treatment and care towards the end of life: good practice in decision-making*. *Guidance for Doctors.* GMC/EOL/0510 - Treatment_and_care_towards_the_end_of_life___English_1015.pdf_48902105.pdf (gmc-uk.org) [Online] (accessed 25/09/2024)

- Leadership Alliance for the Care of Dying People (June 2014): *One chance to get it right Improving people's experience of care in the last few days and hours of life*. Publications Gateway Reference 01509 - One Chance to get it right (publishing.service.gov.uk) [Online] (accessed 25/09/2024)

- Mental Capacity Act (2005) http://www.legislation.gov.uk/ukpga/2005/9/contents [Online] (accessed 25/09/2024)

- NHS England (2023) Specialist palliative and end of life care services - Adult service specification [Online]. Available at : B1674-specialist-palliative-and-end-of-life-care-services-adult-service-specification.pdf (england.nhs.uk) (accessed 18/10/24)

- NICE Care of dying adults in last days of life (2015) – NICE Guideline NG31- Overview | Care of dying adults in the last days of life | Guidance | NICE [Online] (accessed 25/09/2024)

- Nice Quality standard (QS144) Care of dying adults in the last days of life (2017) [Online]. Available at: Quality statements | Care of dying adults in the last days of life | Quality standards | NICE (accessed 18/10/2024)

- NICE Quality Standard (QS13) End of Life Care for Adults (November 2011, updated September 2021) - Update information | End of life care for adults | Quality standards | NICE [Online] (accessed 25/09/2024)

- Nottinghamshire End of Life Toolkit [Online}. Available at: nottinghamshireeolcare.uk (accessed 18/10/24)

- Nottinghamshire Guidance for End of Life (2022): end_of_life_care_guidance.pdf (nottsapc.nhs.uk) (accessed 18/10/2024)

- Our Commitment to End of life care; 'What's important to me publication' Department of Health (2016) - Our commitment to you for end of life care: the government response to the review of choice in end of life care (publishing.service.gov.uk) [Online] (accessed 25/09/2024)

- Palliative Network Guidelines (2016) - Palliative Care Guidelines Plus (pallcare.info) [Online] (accessed 25/09/2024)

- Royal College of Physicians (2021). End of Life Care in the acute setting [Online]. Available at: acute-care-resource-end-of-life-care-in-the-acute-care-setting.pdf (rcp.ac.uk). Accessed on: 18/10/24.

- Sherwood Forest Hospitals Foundation Trust Strategy (2024-2029)

- Talking about dying: How to begin honest conversations about what lies ahead. Royal College of Physicians (2018) - Talking about dying: How to begin honest [Online] (accessed 25/09/2024)
- Conversations about what lies ahead | RCP London [Online] (accessed 25/09/2024).

Related SFHFT Documents:

- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy
- T34 Syringe Pump Procedures for Adult Patients (accessed via Marsden Manual)
- Discharge Policy
- Care After Death Policy – including procedure for the direct release of a deceased patient
- Safeguarding and Custody of Patients Property Policy
- Verification of an Expected Adult Death by Registered Nurses Policy
- Trust Car Parking Policy.

11.0 KEYWORDS

die; dying; death; End of Life; Palliative Care; and; Priorities of Care, Last Days of Life

12.0 APPENDICES

Appendix A – Equality Impact Assessment
Appendix B – Guide to treatment of specific symptoms in the last days/hours of life

APPENDIX A - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: LAST DAYS OF LIFE FOR ADULTS POLICY			
New or existing service/policy/procedure: Existing			
Date of Assessment: 25th September 2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	Not applicable	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion	None	Not applicable	None
Disability	None	Not applicable	None
Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None
Socio-Economic Factors (i.e. living in a	None	Not applicable	None

poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- **N/A**

What data or information did you use in support of this EqIA?

- **N/A**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **No**

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact *(Delete as appropriate)*

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Reviewed by Jennifer Hatfield, EoLC Clinical Nurse Specialist

Signature:

Date:
25th September 2024

Sherwood Forest Hospitals
NHS Foundation Trust

Appendix B: Guide to treatment of specific symptoms in the last days/hours of life

1. Pain

If the patient is opioid naïve, prescribe 2.5–5 mg Morphine SC PRN (1-hourly). If 2 or more doses are required in 24 hours start Morphine by continuous subcutaneous infusion (CSCI - 'syringe driver') over 24 hours according to the number of PRN doses required. If the oral route is available, 2.5 -5 mg Oramorph STAT and PRN is an alternative.

If the patient is already on oral Morphine, calculate the subcutaneous equivalent daily dose (total daily oral dose divided by 2), and prescribe one sixth of this as the PRN dose. **NB** The dose calculation is different for other opioids (see www.book.pallcare.info for dose conversions).

Review the CSCI dose daily and consider increasing this to include any additional PRN doses given.

Dosing example: Total daily dose Morphine PO is 30 mg (modified release plus PRN). Subcutaneously, the equivalent is 15 mg. The PRN dose is one sixth of this (2.5 mg).

If patient is on an alternative opioid such as Oxycodone or Fentanyl, or is sensitive to Morphine, see www.book.pallcare.info. Dose conversion: Morphine 10mg oral = Morphine 5mg SC. Morphine 5mg SC = Fentanyl 100 micrograms SC.

Fentanyl is a strong opioid which can be used as an alternative to Morphine and Oxycodone (seek Specialist Palliative Care advice if needed). It is VERY POTENT and short acting, about 1 hour. Its main place in therapy is in patients with renal and hepatic impairment, as dose adjustment is not normally required. Consider use if eGFR is less than 30 ml/min or has factors of severe hepatic impairment (PT >130% of normal, platelets <150 x 10^9/L, bilirubin >100 micromol/L, severe cirrhosis (Child-Pugh C), ascites, hepatic encephalopathy, hyponatraemia, concurrent moderate renal impairment).

Starting dose: If a patient is currently not taking opioids a suitable starting dose of Fentanyl is 12.5 – 25 micrograms SC PRN, 1-hourly. If any PRN doses of Fentanyl are required, commence a CSCI over 24 hours of Fentanyl with a dose based on the PRN use or Fentanyl 100 micrograms/24-hours as a starting dose (if the total PRN doses are less than this). **Contact the Specialist Palliative Care team if advice needed via Call for Care (01623 781899).**

The opioid dose converter on the PANG guideline site www.book.pallcare.info is helpful to check conversion doses. At higher doses use conversions cautiously and monitor closely to avoid toxicity.

3. Dyspnoea

Consider causes of dyspnoea and treat appropriately (eg hypoxia, pulmonary oedema, respiratory tract secretions, bronchospasm).

Non-drug management – e.g. explanation, reassurance, repositioning, fan, relaxation, breathing techniques.

If non-pharmacological treatments are ineffective, try Morphine 2.5 mg SC PRN. If there is concurrent anxiety combine with Midazolam 2.5mg SC PRN.
If more than 2 doses in last 24 hours, combine subcutaneous doses into a CSCI over 24 hours, and continue PRN prescription.

NB: PRN Morphine dose should be one sixth of total daily dose.

3. Nausea and Vomiting

If the oral route is no longer viable, continue and convert any effective PO anti-emetic medication to the parenteral route. If conversion advice is required please contact Medicines Advice Centre on ext.3163

If no prescription exists, prescribe Levomepromazine 6.25 mg SC PRN (hourly)

If more than 2 PRN doses in 24 hours, add to CSCI: Levomepromazine 12.5 mg / 24 hours and continue PRN prescription.

If more than 2 PRN doses in the subsequent 24 hours, increase CSCI prescription to Levomepromazine 25 mg / 24 hours.

If you are requiring more than Levomepromazine 25 mg / 24 hours to control nausea and vomiting, please discuss with Specialist Palliative Care (C4C 01623 781299) and request review.

4. Respiratory Tract Secretions

Explain to the patient's relatives that noisy breathing is due to the inability of the patient to clear secretions, and that they are not choking.

Try repositioning the patient upright, on their side, .

Prescribe Hyoscine Butylbromide 20 mg SC (hourly) and administer if non-pharmacological methods ineffective. If any doses are used commence a CSCI of Hyoscine Butylbromide 40 – 60 mg / 24h.

Continue to give PRN doses as required.
If symptoms persist beyond 24 hours, increase the dose to 120 mg / 24 hours.

6. Agitation and Delirium

Consider treatable causes – for example increased pain, urinary retention, and faecal impaction.

Prescribe Midazolam 2.5 – 5 mg SC PRN (hourly). Consider adding Levomepromazine 6.25 – 12.5 mg SC PRN (hourly) as second line.

If more than 2 PRN doses in 24 hours add respective doses to CSCI.

Written in line with Nottinghamshire Guidance for End of Life (2022):
end_of_life_care_guidance.pdf (nottsapc.nhs.uk)
(eolcare.uk)