Policies, Procedures, Guidelines and Protocols

Document Details	
Title	End of Life Care guidance for adults who are in the last months, days, weeks and hours of life and care after death.
Trust Ref No	2200-69809
Local Ref (optional)	
Main points the document covers	End of Life care in the last months, weeks, days and hours of life
Who is the document aimed at?	All staff in SCHT who provide end of life care. Agency, locum and Bank staff. In adult services.
Owner	Cath Molineux- Consultant Nurse. Lead for End of Life Care
Approval process	
Who has been consulted in the development of this policy?	See list of people Consulted within the document
Approved by (Committee/Director)	Clinical Policies group
Approval Date	10/8/2021
Initial Equality Impact Screening	Y
Full Equality Impact Assessment	N/A
Lead Director	Steve Gregory- Executive Director of Nursing and Operations
Category	Clinical
Sub Category	
Review date	10/8/2024 or before if any guidance changes or new guidance
Distribution	
Who the policy will be distributed to	All clinical teams and wards. To be available to agency, locum, bank clinical staff
Method	Datix, Heads of Services, Team meetings, Training sessions
Keywords	End of life care, palliative, months, weeks, day's hours, EOL, dying
Document Links	
Required by CQC (Care Quality Commission)	
Other	

Amendments History		
No	Date	Amendment
1	August 2021	New policy
2		
3		
4		
5		

Contents

1 Introduction

End of Life is when a person is in or is approaching the last 12 months of life. Early recognition of when a person is in or approaching their last 12 months of life leads to planning ahead and a proactive approach to end-of-life care. However, the difficulties in recognising when a person is in the last months, weeks, days of life are widely documented, as are the challenges of having these important conversations with patients and those close to them: this document will help guide clinicians through these challenges.

Please note, a person may be expected to die in the next 12 months but sometimes this can happen sooner than expected.

We have compiled some phrases captured from clinical teams when they recognise a person is approaching the last 12 months of life, along with the Supportive and Palliative Care Indicators tool (SPICT) and the Clinical Frailty score they can help with realising that a patient requires end of life care:

'Appetite has reduced, not taking fluids as well'
'Not making as much conversation as they used to'
'Staying in bed more, not very good on their feet'
'Turned their back to the wall, not engaging very much'
'Had enough, just wanted to go'
'Much more fatigued, sleeping much more'
'Can't go to sleep at night- agitated and anxious'
'Swallowing is more difficult'
' Walked home last admission- now can't get out of bed'

2 Purpose

to provide guidance and prompts to staff that provide end of life care (EOLc) to people in Shropshire Community Health NHS Trust either at home, in a care home or in a community hospital. It is a resource for all staff involved in end-of-life care including Bank and agency/locum staff. To support what should be in place once a person has been recognised in the last months, weeks, days, hours of life. It indicates how to access resources available and where to seek support and help. Early recognition enables planning ahead and exploring treatment and care options.

3 Definitions

End of Life Care (EOLc) *is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. Patients are approaching the end of their lives when they are likely to die within the next 12 months. This includes patients whose deaths are imminent (expected within a few hours and days) and those with:*
• *Advanced, progressive, incurable conditions*
• *General frailty and co-existing conditions that mean they are expected to die within 12 months.*
• *Existing conditions if they are at risk of dying from a sudden acute crisis in their condition*

• *Life threatening acute conditions caused by sudden catastrophic events'*
Source: General Medical Council (2010)
Clinical Frailty score (CFS) - Rockwood- a tool with visual aids and descriptors to guide clinicians in determining the degree of frailty.
ReSPECT- Recommended summary plan for emergency care and treatment. This creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.
DNaCPR- Do Not attempt Cardio-Pulmonary Resuscitation
Advance Directives/Decision (Living will) is a document that sets out a decision to refuse certain treatments.
Advanced care plan (ACP)-an advance statement that sets out future wishes, preferences about a person's future care.
Anticipatory care plan. This is a plan that recognises and anticipates significant changes in a patient and describes action(s) which could be taken to manage this anticipated problem in the best way
Non - medical prescriber (NMP)
PRN- not scheduled medication, given as required
SCHT- Shropshire Community Health Trust.
End of life advocate (EOLa) this is a team or ward member of staff who has oversite of a patients EOL care and is a point of contact for the patient and their family
SPICT tool- Supportive and Palliative Care Indicators tool. A decision-making aid to help to determine when a person may be in the last 12 months of life.
EPR- electronic patient record. RiO
FFA- Fact finding assessment. A form completed with information prior to a transfer to another care setting.
GP-General Practitioner
DS1500- a form completed by the GP to access benefits when a person is terminally ill. A factual form about a person's illnesses and treatment.

4 Duties

4.1 **Chief Executive** has overall responsibility to accountability for strategic and operational management in the Community Trust. Ensuring effective and appropriate procedures, processed are in place for end-of-life care.

4.1.1 **Director of Nursing and Operations-**responsibility for safe and effective service delivery in all aspects of end-of-life care.

4.2 **Deputy Director of Operations, Deputy Director of Nursing and Quality, Deputy Director for Allied Health Professionals, Divisional Service Managers, Clinical Service managers**- to ensure all service leads, Heads of service have seen the guidance

and are aware of the contents and to cascade to all services in Shropshire Community Health Trust

4.2.1 **Health care staff- Team Leaders/Ward Managers**- to ensure all staff who provide end of life care in a community setting (including Agency, Bank and Locum staff) have ready access to the guidance.

5 End of Life Care guidance for adults who are in the last months, days, weeks and hours of life

This section gives guidance of what should be in place as the person is approaching last months, weeks, days/hours of life. This is for guidance only and should work hand in hand with clinical decision-making. There are documents/polices/procedures already available and in place in SCHT to support this guidance and will be referenced throughout these are:

Fact finding assessment
Shropshire End of Life Plan
Severn Hospice
Shropdoc palliative care helpline
Rockwood clinical frailty score
Resuscitation council
Advance care plan/ Advance care planning framework
Continuing Health Care- Fast tracks
STOPP/START guidance
NG5 Medicines optimization
EOL Care in Diabetes Care. Clinical recommendations 2018. Diabetes UK
West Midlands Palliative Care Physicians guidelines for the use of drugs in symptom control
Community equipment stores
Adult Safeguarding website
Medicines management policies
Waterlow
SSKIN
Pressure Ulcer prevention and treatment policy
Care After Death policy
Access to these resources is referenced throughout the guidance.

5.1 Procedure

This section gives guidance of what should be in place as the person is approaching the last months, weeks, days/hours of life. Tools to aid decision-making are detailed further in the section below however these decisions need to be discussed with other health professionals involved in that patients care and a clear picture of their clinical history and disease progression.

The End-of-Life Advocate (EOLa) is a person in the team/ward who is a key point of contact for staff, family and patient and also has oversight of the care that is delivered and care and interventions that are planned

Referral to Community teams- referral information needs to be recorded on the RIO End of Life form (under Adult Global forms) within the electronic patient clinical record, not all information may be available at this time, but this can be added as and when an

assessment and further assessments are undertaken. On referral into the team complete a triage checklist.

Referral to Community hospitals- either from GP/Community or acute trust.

- Information needs to be obtained from the initial transfer information sheet, the Fact-finding assessment (FFA) and the clinical verbal handover if the person is EOL.
- The receiving clinician must ask if there is a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document in place (see next section for details) and this needs to be documented in the clinical records, electronic and paper. If not and the person is eol a ReSPECT needs to be completed prior to transfer
- Is the Community hospital the preferred place of care/death?
- Is the patient already on the Shropshire end of life plan - if the Shropshire EOL plan has been started in the acute trust/home this must accompany the patient.

Where to seek help/advise:

In hours- Severn Hospice provides 24-hour 7 day a week telephone access and advice

Severn Hospice-Shrewsbury site - 01743 236565

Severn Hospice-Telford site - 01952 221350

Contact the persons GP

Speak to senior nurse/clinician in the team or on the ward.

Out of hours and weekends:

Severn Hospice provides 24-hour 7 day a week telephone access and advice as above

Palliative Care Helpline- hosted by Shropdoc - 01743 454912 (available for health professionals and patients and their families

Locality manager/Director on call via Shropdoc

5.1.1 In or approaching the last 12 months of life

Symptoms that lead to restrictions in daily activities are common at EOL with a notable increase beginning in the last 5 months prior to death.

At this point consider the following:

Recognising End of Life

Tools to aid decision-making to help recognise when a person may be in the last 12months of life:

- Clinical Frailty score- Rockwood www.nice.org.uk >clinical frailty scale. Add the Frailty score to RIO. This is under Adult Global- Clinical Frailty Score- Rockwood.
- SPICT tool- Supportive and Palliative Care Indicators tool. www.spict.org.uk

If a Clinical Frailty score is of 7 and above (moderate to severe frailty) you must start discussions about ReSPECT and advance care planning and care/treatment options. A senior clinician/GP can support this.

ReSPECT (Recommended summary plan for emergency care and treatment)

www.resus.org.uk/respect

- Consider Do Not attempt Cardiopulmonary Resuscitation (DNaCPR) decisions and any other advance directives during these discussions. A senior clinician/GP will support this to be undertaken if required.
- Upload ReSPECT form onto Rio electronic patient records and add any DNaCPR decision in the alerts and add ReSPECT document in place alert

- What are the key summary points in the ReSPECT form, is a review needed if anything has changed? The form can be reviewed and signed and dated in the review section of the ReSPECT document. A more detailed account of the review needs to be recorded in the RIO electronic patient records.
- Please see Appendix 1 for further guidance

Advance care planning (ACP)-

- Does the person already have an advance care plan in place? if so, be aware of their wishes and preferences and document them. Further guidance can be found from the advance care planning toolkit www.severnhospice.org.uk/advance-care-planning

- If not, is the time right now to start having these discussions? Where is the ACP? Has it been shared with the persons consent?

Anticipatory care planning-

- This is a plan that has been put in place to support some of the clinical/care priorities discussed with the patient and a senior clinician.
- To access guidance www.severnhospice.org.uk/advance-care-planning
- Not all patients will have or need one of these. If they do, please be aware of the contents as this will influence/inform future care and treatment options. This is a document held by the patient alongside the ReSPECT form and Advance care plan.

Other areas to give consideration at this point are:

- Holistic assessment on referral even though input may not be needed immediately.
- Support and collaboration from specialists in place who may be able to offer advice to discuss care/treatment options, E.g., Parkinson's Disease Nurse, Multiple Sclerosis Nurse, Hospice Outreach team
- Support for carers (informal/unpaid) if required, e.g., Admiral Nursing service, social worker, Macmillan for financial, benefits advice, discussions around Lasting power of attorney
- Referral to GP practice community care co-ordinator (links to voluntary sector) for advice and support networks
- Consider other referrals which may provide support as condition deteriorates and they still have some control over, eye tests, hearing tests, dental if lost weight and not eating well and dentures not fitting, continence team.
- Consideration of DS1500- for claiming benefits under special rules. This involves a factual statement with regards to the person's terminal illness so they can claim benefits. This can be completed if the person's death is expected within 6 months. The patient's GP will do this if requested.
- Involve Health visitor and/or social worker if the person has children.
- Pressure ulcer prevention advice to be introduced at this stage.
- Referral to wheelchair services or consider this for a future need as the person condition deteriorates and to enable the person to get out as much as possible. Alongside this disabled badge for the car.
- Health promotion advice to try to emphasise the importance of keeping as healthy as possible to help prevent complications in the future, hydration, nutrition, mobility.

5.2 The last months of life

There may be some noticeable change in the person, such as increased lethargy and not being able to carry out activities of daily living as well as they used to. Increase/change in the symptoms of their underlying condition and medication changes are not helping to improve these. The disease has a relentless progression and is less reversible. Treatment benefits are waning.

Consider all the above section and:

- If ReSPECT and/or DNaCPR discussion and document not in place yet, instigate these discussions or raise with senior clinician/GP to support this process. Include DNaCPR decision.

- Advance care plan- documenting wishes and preferences, preferred place of care/death should be in place at this point. Some patients may not want this and this needs to be considered and recorded in the RIO electronic patient records, progress notes. However, ensure the patient is aware that the ACP will help protect them from ineffective/inappropriate/ unwanted treatment.

- Review any existing advance care plan/advance directives to explore wishes and preferences and consider if anything has changed.

- Assessment/discussions/review with regards to equipment and care needs and what may need to be put into place as the person's condition deteriorates i.e., bed downstairs, personal care, carer support.

- Pressure ulcer and prevention information and advice. Assess Waterlow calculation and ensure appropriate pressure relieving equipment is in place

- Continuing Health Care Fast track to be considered if person in last 2-3 months of life this is available from www.gov.uk/government/publications/nhs-continuing-healthcare-fast-track-pathway-tool. This when completed then needs to be sent to the continuing health care team currently there are two different routes for fast-track referrals, these are:

    - Shropshirechcsafehaven@nhs.net is the email route for all Shropshire GP registered patients. For any telephone enquiries 01743277531
    - Complex.care1@nhs.net & Adults.Brokerage@telford.gov.uk for all Telford and Wrekin (T&W) GP registered patients. For telephone enquiries 01952580349 Brokerage are sourcing the care for T&W and this has been the case since April last year.

- Give patient, carer/partner/family contact numbers for Out Of hours support
    - Palliative Care helpline 01743 454912

- Complete Anticipatory Care Plan/Integrated advance care plan - if required

- Medication review by GP/Advanced Clinical Practitioner/Non- medical prescriber (NMP) and/or pharmacist. Consider de-prescribing of some medication especially for

those who are moderate to severely frail. The STOPP/START medication review/decision making tool is the one recommended by NICE (NG5 Medicines optimisation) and NHS England, which is available in the Toolkit for General Practice in supporting older people with frailty (March 2017) www.nhsengland.nhs.uk

- For Diabetes care at the end of life please refer to End of Life Diabetes Care. Clinical recommendations. (2018) Diabetes UK. This is accessed via the Trusts intranet, staff zone under policies.

- Hospice at Home referral if required- referral forms available from the Severn Hospice website www.severnhospice.org.uk. Access the Healthcare professionals tab and then click on making a referral.

- Give patient/family/carer the information packs all wards and teams have a supply of these, which contains leaflets on:
  - Community Dying Well fund
  - Grieving- how it might feel
  - Information about signs and symptoms at end of life
  - Thinking ahead- advance care planning
  - What to do after death

- A referral may be required to Speech and Language team (SALT) if swallow is becoming a cause for concern. Provide advice on taste for pleasure. Guidance for this can be accessed in the Mouth Care Policy in the policies section of the SCHT website.

- Review of support visits and carer support, these may need to increase as their condition changes

- Open discussions as appropriate regards spirituality and making memories, treasuring moments, the importance of photos/videos/voice recordings

- Benefits of complimentary therapies, massage, deep breathing techniques

- Just in case medications and authorisation in place if required.

5.2.1 The last weeks of life

Recovery is less likely; the risk of death is increasing. Consider all the above and:

- Ensure patient, carer/partner/family has contact numbers for Out Of hours support- Shropdoc and Palliative Care helpline 01743 454912

- GP to flag patient as EOL/Palliative with Shropdoc

Non- palliative medication

Medication review at this point with GP/ACP/NMP and/or Pharmacist to consider stopping any non- palliative medication which is no longer beneficial. Discuss this with the patient and the relatives/family/partner and document the decisions made

Anticipatory medication

Request Just in case medications and an authorisation from GP/NMP/Shropdoc, which needs to be kept with the medication in the patient's house.

Community hospitals- just in case medications to be prescribed on the drug chart.

It is good practice for all 'as required' Just in Case medications to be prescribed for the following:

- Morphine/Diamorphine for pain/breathlessness
- Midazolam for agitation/restlessness
- Levopromazine for nausea and vomiting
- Hyoscine Butylbromide for excessive respiratory secretions.
- Water for diluent

Please note: Morphine is currently the first line treatment for pain/breathlessness due to Diamorphine shortage.

Ensure the authorisation is signed and dated and the prescriber has entered their GMC/PIN number and when the review date is. Make sure the writing and doses are clear. Ensure the maximum dose in 24hours section is completed and the frequency of the dosing.

Ensure the 'as required'(PRN) doses prescribed are equipotent to the overall 24hr dose (1/6 of 24hr dose) e.g., 30mgs diamorphine over 24hrs in a syringe driver -patient should be prescribed 5mgs diamorphine PRN as a breakthrough dose.

For further advice and support:

- Prescribing Guidelines attached to the Shropshire EOL plan- available in Clinical document library in Share point this is accessed through the SharePoint Home page icon on Desktop on the Trusts computers.
- West Midlands Palliative Care Physicians. Guidelines for use of drugs in symptom control. www.wmcares.org.uk. These are available online or to download.
- Severn Hospice-Shrewsbury 01743 236565
- Severn Hospice-Telford 01952 221350
- Hospice website- information hub for health professionals www.severnhospice.org.uk

Equipment

Ensure any equipment is in place and assess whether any further equipment may be required. Community equipment contact details are Shropcom.communityequipmentservices@nhs.net phone number 01952 603838

Pressure Ulcer prevention- Assess the patient's pressure ulcer risk using the RIO Waterlow form. Provide written and verbal give information leaflets/guidance on pressure ulcer prevention as mobility is reducing and the increased risks associated with that. If concordance issues are identified record your discussions using the 'ADDER' format and refer to the Self- neglect framework. Support the patient in their decision making. The Self-neglect framework is available for guidance via the Trust's Adults Safeguarding web page under useful links.

Where to seek help/advise:

In hours- Severn Hospice provides 24hour 7day a week telephone access and advice
Severn Hospice-Shrewsbury site- 01743 236565
Severn Hospice-Telford site-01952 221350
Contact the persons GP
Speak to senior nurse/clinician in the team or on the ward.

Out of hours and weekends:
Severn Hospice provides 24hour 7 day a week telephone access and advice as above
Palliative Care Helpline- hosted by Shropdoc- 01743 454912 (available for health professionals and patients and their families
Locality manager/Director on call via Shropdoc

The last days and hours of life

Consider all the above, check completed and:

The person is now actively dying, and the body is shutting down, this can be represented by some of the signs of dying:

- Fatigue/low energy levels
- Person sleeping for longer periods progressing to that they may be asleep for most of the time.
- Reduced need for diet and fluids- the effort to eat or drink becomes too much.
- Changes in breathing – longer pauses between breaths
- Changes in skin temperature and colour.

Using the SPICT tool, indicators such as ‘eating and drinking less’ have become ‘not eating at all’ and ‘drinking very little or not at all’

Diabetes and End of Life care- please refer to End of Life Diabetes care- clinical care recommendations (2018) 3rd Edition. Diabetes UK, which can be accessed via the trust website on the staff zone under the policies section www.staffzone.shropcom.nhs.uk

This gives guidance on Diabetes and medication when a person is end of life.

Syringe Driver

- A syringe Driver may be required to manage symptoms if PRN doses are becoming frequent and symptoms are not under control and the person is unable to take medication or anything orally. However, if the patient has not required any medication prior to the dying phase and does not have any evidence of symptoms and is comfortable they should also be pre-emptively prescribed ‘as required’ (PRN) but may not ever require syringe driver medication.

- A GP/ Advanced Clinical Practitioner/NMP will be required to review the person to determine the starting doses to be started in the syringe driver based on their current PRN doses and symptoms.
- A syringe driver authorisation needs to be completed and kept in the person’s home with the medication. (These are available in the Clinical documents library in SCHT SharePoint)

- A prescription will be required for the syringe driver doses, ensuring anticipatory planning to ensure that there is a good supply over any weekend/Bank Holiday period.

- Obtaining anticipatory medications- the prescription will be in the patient's name, so the relatives will need to collect these from a pharmacy. Only in very exceptional circumstances can the community nurse collect these. See Medicines management policy part 2: Controlled Drugs (Policy no 10469) available via the Trusts website, staff zone www.staffzone.shropcom.nhs.uk under the policies section.

- For Community hospitals these medications will be written up on the designated part of the drug chart. Always check the dose and amount to be delivered over 24 hours

- Liquid doses should be prescribed in millilitres (mls) and micrograms.

For further advise and support:

- Prescribing Guidelines attached to the Shropshire EOL plan- available in Clinical document library in SharePoint
- West Midlands Palliative Care Physicians. Guidelines for use of drugs in symptom control. www.wmcares.org.uk. These are available online or to download.
- Severn Hospice-Shrewsbury 01743 236565
- Severn Hospice-Telford 01952 221350
- Hospice website- information hub for health professionals www.severnhospice.org.uk
- Diabetes in end-of-life care- Clinical recommendations. 2018 Diabetes UK. Accessed through SCHT website- intranet staff zone under policies.

Shropshire EOL plan

- To be started if the person has been diagnosed as dying and is in the last days of life (Shropshire EOL plan available with prescribing guidelines from the Clinical document library in Share point) The team or ward should have some printed copies available. These need to be printed along with the prescribing guidance.
- A decision should be made in discussion with the person's GP and any other key people involved in the care if the patient is at home that the person is entering the dying phase and there is no reversible cause for the change.

- In Community hospitals this will be a ward team decision including medical input and/or Advanced Clinical Practitioner

- The decision to start the end-of-life plan should be referenced in the main patient records and onto the electronic patient records (RiO).

- This is a paper document and all staff involved in the persons care need to contribute to this, all other documentation will at this point will cease with the exception of medication administration sheets/drug charts.

- The patient if able should be part of the discussions that they are nearing the end of their life. If the patient is unable to be part of the discussions, those important to

them need to be notified that the EOL plan has been started and the reasons for this.

- Give information sheet for patients/families/carers that is attached to the Shropshire End of life plan

Mouthcare – This should be a regular part of all care as the need for diet and fluid reduces. Please refer to SCHT's Mouthcare Policy in the staff zone of the Trust website.

Taste for pleasure is the approach for patients who are in the dying phase, allowing small sips of their preferred drink and tastes of the food they like. Assess the oral mucosa for any signs of oral thrush, coating of tongue. Please refer to the Mouthcare Policy via the Trusts website in the staff zone under the policies section. www.staffzone.shropcom.nhs.uk

Pressure Ulcer Prevention and management

- Ensure person is assessed at least every day (or more in a community hospital); sign the Waterlow and SSKIN tools.
- Ensure the findings are recorded and escalated as per guidance.
- Provide a SSKIN form for carers/family to complete
- Pressure Ulcer prevention and treatment Policy- available in the policies section in the staff zone of SCHT's Intranet.
- Ensure care staff and family members have the information leaflet and how to raise any concerns about any changes and who to contact.

Consider bladder/bowel function, urine retention may be a cause of agitation

5.2.2 Care after death

- Care After Death Policy- available in the polices section in the Intranet staff zone
- Verification of Death Policy available in the policies section in the Intranet staff zone. All Registered Nurses should be trained to verify a death.
- Personal and team clinical supervision and debrief
- Bereavement support and visit and collection of the syringe driver if this has been in place
- Trust Condolence card.

6 Consultation

Dr Karen Stringer- Associate Medical Director (Strategy). Shropshire Community Health Trust

Susan Watkins- Chief Pharmacist. Shropshire Community Health Trust

Angela Cook- Head of Nursing. Shropshire Community Health Trust.

Deana James- Community Practice Teacher. Shropshire Community Health Trust

Donna Jones- Clinical Services Manager (lead for Interdisciplinary teams). Shropshire Community Health Trust.

Liz Hagon- Adult Allied Health Professional (AHP) Professional Lead/Electronic Patient Record (EPR) Clinical Project Manager. Shropshire Community Health Trust.

Emily Peer- Associate Medical Director. Shropshire Community Health Trust.

George English- Professional Lead for Community Nursing. . Shropshire Community Health Trust.

Lynda Randle- Team Leader. Telford. Shropshire Community Health Trust.

Laura Lane- Lead Advanced Clinical Practitioner. Whitchurch Community Hospital. Shropshire Community Health Trust.

Sarah Venn- Team Leader. Care Home MDT.. Shropshire Community Health Trust.

Menna Wigley- Community Matron. Shropshire Community Health Trust.

Tracey Fisher- Community Practice Teacher. Shropshire Community Health Trust.

End of Life Operational Group members. Shropshire Community Health Trust.

Clinical Policies Group Members - SCHT

7 Dissemination and Implementation

7.1 **Dissemination-**To be sent to all Service leads and clinical staff in Shropshire Community Heath Trust

7.2 Implementation

The guidance will be referenced to in all parts of the End-of-Life care training programme.

The end-of-life care competency workbook will link theory to practice and competencies assessed and achieved

8 Monitoring Compliance

Monitoring NACEL audit (National Audit for care at the end of life) - an annual audit

SCHT audits- ReSPECT and Shropshire EOL plan audits- annual

Community Hospital Bereavement survey.

EOL training and development data and evaluation- annual report.

EOL Datix incidents/themes and actions/learning arising from this

EOL strategy implementation and programme plan

Compliments and complaints

Learning from Deaths Group and data/reviews

9 References

End of Life Care In Diabetes Care. Clinical recommendation. 3rd Edition 2018. Diabetes UK

SPICT- Supportive and Palliative care indicators tool. April 2019. University Of Edinburgh. Nhs Scotland.

West Midlands Palliative Physicians. Guidelines for use of drugs in symptom control. 2021

10 Associated Documents

The Shropshire End of Life Plan and prescribing guidelines-. Shropshire Community Health Trust.

ReSPECT document/ Standard Operating procedure-. Shropshire Community Health Trust.

Rockwood Clinical frailty score

SPICT tool

Advance care planning framework

Continuing Health care fast track tool

End of Life care in Diabetes care. Clinical recommendation. 2018 Diabetes UK-. Shropshire Community Health Trust.

West Midlands Palliative Care Physicians. Guidelines for use of drugs in symptom control

Medicines management policy part 2. Controlled Drugs-. Shropshire Community Health Trust.

Mouth Care Policy-. Shropshire Community Health Trust.

Pressure ulcer and treatment policy-Shropshire Community Health Trust.

Care After Death Policy-Shropshire Community Health Trust.

Verification of Death Policy -Shropshire Community Health Trust.

Appendices:

Appendix 1 Dying Well at a glance

Dying Well: Months; weeks; Days

End of life and palliative care: what is important and when?

Months: about 12

Stop: discuss, consider, plan, record, share.

Check **Summary Care Record additional information** to establish Diagnosis and check Prognosis. Check which system records are accessible including eg SCRai

Make A Start on the **ReSPECT process**, complete, add code to RiO. Share a copy with GP and request coding in EMIS. Original always stays with patient.

Alert colleagues to patients who may be in last 12 months of life and identify an end of life advocate (EOLA)

Stop unnecessary medications: Use **STOPP Tool** to support

Use **SPICT Tool** to support early identification of dying

Weeks: a few (about 4)

Get Ready: review, discuss, plan, record, share.

Update the **ReSPECT process**

Stop unnecessary medications: Use **STOPP Tool** to support

Confirm Community Teams and GP are involved with patients who may be in last weeks of life

Check **equipment** in place, eg beds to aid carer support

Ensure **Just in Case** medications with patient

Days: some (about 7)

GO: review, discuss, consider, plan, record, share.

Ensure patient, family and carers are aware

Initiate **Shropshire EOL Plan**

Set up **syringe driver** if/when appropriate

Death:

Verify Death

Consider bereavement support needs of family and carers

Consider debrief and bereavement support needs of clinicians