South Devon NHS Healthcare
NHS Foundation Trust

STANDARDS FOR GOOD END OF LIFE CARE IN THE HOSPITAL SETTING

Decision making and documentation

1.) Content and outcomes of discussions with individuals and their family or carers should be clearly documented in the patient's clinical notes, including conversations about prognosis, treatment goals and care plans at each point in time and any particular concerns that the person or their family or carers have expressed.
2.) The existence of an Advance Decision to Refuse Treatment, Advance Care Plan or a Lasting Power of Attorney for health and welfare should be ascertained and recorded in the clinical notes.
3.) The decision that a patient may be approaching end of life should be made by a named senior clinician (where possible someone that has been caring for the patient) in consultation with the wider clinical team and documented in the clinical notes.
4.) Discussion(s) should be held with the patient (if possible) and family or carers around preferred place of care at end of life and documented in the clinical notes.
5.) Patients and carers should be informed of their named Consultant/Senior responsible clinician.
6.) Patients and carers should know the name of the registered nurse responsible for leading their nursing care for each shift.
7.) Completion of a Treatment Escalation Form to summarise appropriate ceiling of care should be considered.
8.) The patient's GP should be informed of the situation by the medical team caring for the dying person.

Prescribing

9.) All medications should be reviewed by the medical team and any unnecessary medications discontinued.
10.) Subcutaneous crisis medications should be prescribed in anticipation of common symptoms that may arise.
11.) All medications used in the care of the dying patient, including sedative medication, must be targeted at specific symptoms, used in the smallest dose that works for the shortest time necessary, and their use regularly reviewed and adjusted.
12.) Where a syringe pump is being commenced, the rationale for this and the reasons for including each medication should be recorded in the clinical notes and explained to the patient (where possible), family or carers.

Please contact your EOL lead for advice, support and guidance on this document

Review of current treatment

13.) Consideration should be given as to whether routine observations such as pulse and blood pressure should be continued or not and decision recorded in the clinical notes with rationale for decision (e.g. will not change clinical management).
14.) Nursing assessment of symptoms should be recorded 1-4 hourly (to include pain, nausea and vomiting, agitation, respiratory secretions, shortness of breath, mouth care) along with any actions taken.
15.) The dying person should be supported to eat and drink as long as he/she is able and wishes to do so.
16.) The dying person should be assessed as a minimum on a daily basis by an appropriately trained doctor.
17.) All unnecessary interventions which will not influence current clinical management, such as blood tests or X-rays, should be stopped.
18.) Deactivation of any Implantable Cardioverter Defibrillators (ICD's) should be considered.

Exploration of wishes and needs

19.) Patient's wishes regarding tissue or organ donation should be looked in to and recorded in the clinical notes.
20.) Consideration should be given to the patient and family or carer's spiritual/religious needs.
21.) Consideration should be given to the patient, family or carer's emotional/psychological needs.