Care For the Dying Patient - Guidance for Professionals

Top priority: timely, explicit and sensitive communication about dying with patients and their families

‘One Chance To Get It Right’ (LACDP; June 2014) is the new National guidance on care for patients in the last days of life. This guidance identifies priorities which are the responsibility of ALL professionals.

National, regional and local audit standards are based upon these priorities and include:

- Recording the reason(s) a patient may die, reversible factors considered and action taken;
- Recording discussion with patient about dying and patient’s wishes (if known) including any advance statement regarding preferred priorities of care and preferred place of death;
- Documentation of a management plan/aims and what has been explained to patient, including limits of intervention (recorded on STEP & DNACPR forms) and decisions about management of chronic conditions (e.g. diabetes), physiological observations and recording NEWS (usually discontinued in an expected death);
- Review of medication; stopping non-essentials, converting essentials to appropriate route (usually s-c), prescribing Rx for 5 common symptoms at end of life (see Pall Care Guidelines);
- Making, communicating and recording decisions about natural and artificial Hydration and Nutrition in accordance with GMC guidance (Treatment and care towards the end of life: paragraphs 112-127; GMC:2010);
- Documented discussion with those close to the dying person regarding plans above and considering their own needs and concerns.

Responsibility of Senior Medical Staff
(this applies to senior clinical nursing staff in areas with no full-time medical cover; the endorsement of senior medical professionals is expected as soon as practicably possible)

The documented care must meet the standards set out above. Regional/local tools with prompts to record this plan are available (see Resources); a comprehensive free text medical entry or use of other template is equally acceptable.

Consultants/GPs must countersign the plan if they do not write it themselves.

Daily reassessment should be completed by a doctor (acute hospital setting) or senior clinician (community setting/community hospital/care home) and filed chronologically in patient’s notes.

Responsibility of Nursing Staff

Nurses should complete a Core Care Plan for the Dying Patient (see Resources) to record the care plan provided and related communication. Care plans for related or additional needs should also continue or be completed. Evaluation sheets should be completed at every intervention.

Documentation must be kept close to the patient (as far as practicably possible) to ensure communication is maintained and access is available to all professionals, including Out Of Hours services, and patients/carers if appropriate.

Transfer of the dying patient between care settings demands a professional responsibility to ensure that all relevant documentation (copy of care plan, records of communication, DNACPR form, medication directives) accompany the patient. Direct verbal handover to GP, Out of Hours service and Community Nursing Team is essential.

Care after death documentation must be completed following Trust policy G140.

RESOURCES

Medical guidance: Intranet > Services A-Z > Palliative Care > End of Life Care > (various documents)

Nursing Care Plans: Intranet > Services A-Z > Nursing & Midwifery > Nursing Care Plans