End of Life Care Planning Policy and Procedure

Inmind Reference:	CLN12
Category:	Clinical Policy
Version Number:	V1.0
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Lead Officer:	Director of Nursing
Equality Impact Assessment completed:	Yes

Applicable Legislation/Regulations:

- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice

Codes of Practice:

Purpose:

To provide a framework to guide best practice, care and support of the Service User who has been identified as nearing the end of their life.

Version Control Table		
Date Ratified	**Version Number**	**Status**
		Live

Date	Key Revision

Please check to ensure this is the most current electronic copy of this document as it is updated and published in electronic format only (hard copies may become out of date).

Equality Impact Assessment for this policy

Protected Characteristic (domain)	Area of conflict	Resolution
Age	Nil	N/A
Disability	Nil	N/A
Gender Reassignment	Nil	N/A
Pregnancy & Maternity	Nil	N/A
Race	Nil	N/A
Religion or Belief	Nil	N/A
Sex	Nil	N/A
Sexual Orientation	Nil	N/A
Marriage and Civil Partnership	Nil	N/A

All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Registered Manager and the service will actively respond to the enquiry.

Key Question	Key Line of Enquiry (KLOE)
SAFE	S3: How does the service make sure that there are sufficient numbers of suitable staff to support people to stay safe and meet their needs?
EFFECTIVE	E1: Are people's needs and choices assessed, and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?
CARING	C3: How are people's privacy, dignity and independence respected and promoted?
RESPONSIVE	R1: How do people receive personalised care that is responsive to their needs?
WELL-LED	W1: Is there a clear vision and credible strategy to deliver high-quality care and support, and promote a positive culture that is person-centered, open, inclusive and empowering, which achieves good outcomes for people?

1. Aim

1.1 To meet the legal requirements of the regulated activities that Inmind Nursing Home is registered to provide:

- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice

2. Scope

2.1 The following roles may be affected by this policy:

- Registered Manager
- Nurse
- Care staff

2.2 The following people may be affected by this policy:

- End of Life Service Users

2.3 The following stakeholders may be affected by this policy:

- Family
- Advocates
- External health professionals

3. Objectives

3.1 To provide an opportunity to understand the wishes, needs and preferences around end of life care of the Service User and to assure the Service User that they will have access to end of life care when needed.

3.2 To give guidance and stimulate considerations, when supporting a Service User to think about the end of their life.

3.3 To enable staff to work in a multidisciplinary team to provide high-quality person-centred care to people who are felt to be in their last year of life and to ensure that family and people important to the Service User are supported and kept informed, enabled and empowered throughout a Service User's illness.

4. Policy

4.1 Inmind Nursing Home will model the Government commitments to end the variation in end of life care across the health system. These commitments include:

- Having honest discussions between care professionals and dying people
- Dying people making informed choices about their care
- Personalised Care Plans for all
- The discussion of personalised Care Plans with care professionals
- The involvement of family and carers in dying people's care
- Having a main contact so that dying people know who to contact at any time of day

4.2 This Policy is dovetailed with the National End of Life Care Programme, elements of which are consistent

with the best practice identified within the review and in particular, the individualised assessment and person-centred Care Plans.

The Organisation will carry out advanced care planning where it is assessed that the Service User is nearing the end of their life or as the Service User discloses.

The Service User will be comfortable and as pain-free as possible.

Spiritual and emotional support will be available for all Service Users to choose if they should so wish.

4.3 Where it applies, end of life care will be in accordance with the Deprivation of Liberty Safeguards Policy and Procedure, the Mental Capacity Act 2005 Policy and Procedure as well as care planning policies and procedures.

5. Procedure

5.1 When to Initiate End of Life Care Planning

Service Users will respond differently to being able to discuss end of life wishes.

For Service Users who openly disclose their views, information can be gathered when offered, from the point of service commencement and ongoing.

Staff should have access to a recognised prognostic indicator to assist with identifying the right time to initiate a conversation. Staff should ask themselves 'Would you be surprised if the Service User died within the next 6-12 months?' If it would be a surprise that they were to live longer than 6-12 months, they are a high priority for talking and planning.

The presence of any of the following should trigger concern when associated with advanced age and/or disease:

- Limited self-care and interest in life: in bed or a chair for more than 50% of their time
- Breathless at rest or on minimal exertion (MRC scale 4/5)
- Progressive weight loss (>10% over last six months)
- History of recurring or persistent infections and/or pressure ulcers

Staff should have access to literature and signposts to recommended sources to support the Service User when considering end of life care planning.

Staff will adhere to the Mental Capacity Act 2005 and Best Interest Decision Making in accordance with the Mental Capacity Code of Practice for those Service Users who are unable to participate in end of life discussions.

5.2 Care Setting

It should be the preference of the Service User and their loved ones where they would like to receive end of life care and this should form part of the Advance Care Plan. Decisions about preferred locations for end of life care will be respected and all measures taken to try and accommodate the Service User's wishes by use of a multidisciplinary approach in complex cases.

5.3 Step by Step End of Life Care

There are generally considered to be six steps in providing effective end of life care which staff must be familiar with and competent in:

- Step 1 Discussions as the end of life approaches
- Step 2 Individualised Assessment, care planning and review
- Step 3 Co-ordination of care
- Step 4 Delivery of high-quality services in different settings
- Step 5 Care in the last days of life
- Step 6 Care after death

5.4 Step 1 Discussions as the End of Life Approaches

A planned approach to advance care planning can be effective, and the approach staff should take is to:

- Raise the topic and giving information
- Facilitate a structured discussion
- Bring prior wishes to bear on actual decisions
- Complete the Care Plan
- Periodically review and update the Care Plan (as per care planning policies and procedures)

Discussions about end of life care require revisiting and regular review as Service Users can change their minds, particularly when they are faced with new fears, concerns and/or symptoms on a daily basis.

Care Plan reviews will be completed in accordance with local policies and procedures - refer to the Service User Care Planning Policy and Procedure.

5.5 Step 2 Individualised Assessment and Care Planning

The steps for individualised assessment and care planning, as structured within the care planning system are:

- Assess
- Document
- Develop
- Discuss
- Choose
- Plan
- Record
- Review

Template care planning is incompatible with any effective care delivery and should be avoided. Staff responsible for care planning must be trained to implement fully personalised and individual assessments and Care Plans.

Care Plan Content

Staff should consider the following areas when formulating an advance care plan:

- Assessment and communication
- Management plan
- Preferences and choices
- Family and significant others
- Symptom control
- Ongoing assessment

5.6 Step 3 Coordination of Care

The Home will ensure that all the staff involved in the coordination of care are

appropriately trained to achieve a quality outcome for the Service User.

To this end staff should:

- Be alerted by a Healthcare professional if an End of Life Care Plan has been created for a Service User
- Request a copy of the End of Life Care Plan and assessment
- Review the Care Plan ensuring that the detail reflects the healthcare professional's plan to ensure a cohesive service is provided
- Ensure an appropriate person on behalf of The Home attends all multidisciplinary review meetings

5.7 Ensure practical and emotional support is offered to the Service User's family and Carers whilst supporting Service Users with end of life care.

5.8 Step 4 Service Delivery

Service Users and their families may need access to a complex combination of services across several different settings. They should be able to expect the same high level of care regardless of the care setting.

It is the responsibility of the senior Carer to ensure that

effective co-ordination takes place. Essential practical day

to day procedural matters include:

- The Service User has access to a medical specialist in palliative care
- Pain management measurement is ongoing
- The Service User has comfort needs attending to; chair, bed etc.
- The Service User has diversional therapy e.g. music, radio etc.
- The Service User has a key worker, carer or nurse, with whom they can spend some one-to-one quality time each day
- The Service User's environment is clean, odour free and comfortable
- The Service User will have a Carer to sit with them if they are alone at the end of their life or if they request it
- The Service User's family are treated with empathy and offered support and refreshments according to their needs
- Families will be informed about any changes in the condition of the Service User
- Families will be informed of the death of a Service User at a time to minimise distress, e.g. in the morning after a death in the night, unless otherwise requested by the family
- Families will be given an appropriate length of time to remove belongings from the Service User's room
- Other Service Users will be informed of the death by a senior member of staff

5.9 Step 5 Last Days of Life

When an individual enters the dying phase, it is vital that staff can recognise that this person is dying, so they can deliver the care that is needed. How someone dies remains a lasting memory for the individual's relatives, friends and the care staff involved.

Individualised planning, individualised assessment, further planning, recording and review, and information giving are essential components of delivering care and support during the last days of life.

Effective documentation, such as detailed care planning and review are essential supports for effective delivery. Some form of care planning may be carried out by each of the healthcare professionals responsible for elements of the total package of care. It is the responsibility of staff to ensure that effective co-ordination takes place, particularly during the final days. It is also important that staff ensure that Care Plans are individualised.

5.10 Step 6 Care After Death

Good end of life care doesn't stop at the point of death. When someone dies staff need to follow good practice, which includes being responsive to family wishes. The support and care provided to families will help them cope with their loss.

Care after death includes:

- Honouring the spiritual or cultural wishes of the Service User and their family/carers, while ensuring legal obligations aremet
- Preparing the Service User for transfer to the mortuary or the funeral director's premises
- Offering family present the opportunity to participate in the process and supporting them to do so
- Ensuring that the privacy and dignity of the Service User is maintained
- Ensuring that the health and safety of everyone who comes into contact with the Service User is protected
- Honouring people's wishes for organ and tissue donation
- Returning the Service User's personal possessions to their families

An effective end of life support plan will also contain four elements of care which should be present throughout the six steps listed above:

- Support for carers
- Information for Service Users and carers
- Spiritual care
- Social care

5.11 Training and Education

Extensive, comprehensive and detailed training in the issues involved in end of life care is essential for all staff within a service providing end of life care.

Staff should be competent in the following areas in order to deliver effective end of life care planning:

- Communication skills
- Care planning and assessment
- Stages of end of life
- Supporting Service Users and families

- Accessing support services and timely referral

Delivery methods will be via formal training, mentorship support, supervisions and group discussion.

6. Definitions

6.1 Palliative Care

- The World Health Organisation (WHO) defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

6.2 End of Life Care

- End of life care is for people who are considered to be in the last year of life, but this timeframe can be difficult to predict. Its aims are to help people live as well as possible and to die with dignity. It also refers to treatment during this time and can include additional support, such as help with legal matters. End of life care continues for as long as it is needed.

6.3 Advance Care Plan

- Advance care planning is making decisions about the care people would want to receive if they become unable to speak for themselves. These are the decisions to make, regardless of what they choose for their care, and the decisions are based on their personal values, preferences, and discussions with their loved ones.

6.4 Healthcare Professional

- A healthcare professional is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic way to people, families or communities

Key Facts - Professionals

Professionals providing this service should be aware of the following:

- In England, some 1,300 people die every day
- Good end of life care is based on the understanding that death is inevitable, and a natural part of life
- Shared decision-making between staff and Service Users and their families is possible when all have an awareness that the Service User is approaching death as well as an awareness of the Service User's wishes

- Advance care planning aims to encourage people to consider, discuss, and document their future wishes for care well in advance
- The most effective end of life care is provided when there is skilful communication with Service Users and families about realistic goals of care, and attention to understanding the Service Users' and families' concerns

Key Facts - People Affected by The Service

People affected by this service should be aware of the following:

- Letting the family know about the Service User's wishes could help them if they ever have to make decisions about their care. Knowing that they are acting in accordance with their wishes can remove some of the stress from a very difficult situation
- Even though Service Users may not be approaching the end of life, they may still want to think about their wishes for their own end of life care
- Staff are on hand to support the Service User to talk about their views and wishes
- Staff supporting the Service User will have the knowledge, skills, and ability to provide resources and specialist support when needed.

Further Reading

As well as the information in the 'Underpinning Knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

Dying Matters: http://www.dyingmatters.org/page/resources-

understanding-death-and-dying RCGP:

http://www.rcgp.org.uk/endoflifecare

COMPASSION IN DYING: https://compassionindying.org.uk/wp-content/uploads/2014/11/IN09-Advance-Care-Planning- and-Advance-Care-Plans.pdf

Training

End of Life Care (Free e-learning)

- Lessons Learned - Interactive e-learning from Macmillan Cancer Support. You will need to register to use the site

– there is no charge

- Current Learning in Palliative Care (CLIP) - A collection of 15-minute, online tutorials, developed by Help the Hospices0
- With Respect - Training materials for home care and residential care hosted by the Dignity in Care Network and SCIE, two collections of dignity-specific training

resources designed for health and social care; downloadable print-based, rather than online learning

- End of life care for all (e-ELCA) - Skills for Care has worked in partnership with e-Learning for Health to provide free access to e-ELCA, End of Life Care for All, for adult social care employers registered with the National Minimum Data Set for Social Care (NMDS-SC)

Formally Recognised Training

Staff should access their local hospice in the first instance for training.

Gold Standards Framework: http://www.goldstandardsframework.org.uk/

Six steps training is hosted by local hospices - further information can be found at: http://www.skillsforcare.org.uk/Document-library/Skills/End-of-life-care/NationalendoflifequalificationsandSixStepsprogramme.pdf

Outstanding Practice

To be outstanding in this policy area you could provide evidence that:

- Staff are trained, competent and knowledgeable in end of life care and this is evidenced in daily practice through communication and documentation
- All Service Users are offered an opportunity to have an advanced care plan in place
- A learning culture is embedded in the service where staff follow best practice, promote national end of life initiatives and have a host of resources available for staff, Service Users and their loved ones when needed
- The Home undertakes thematic audits to ensure practice is benchmarked against the best, recommended practice and that it is reviewed and changed to meet need and provide high-quality current care
- The wide understanding of the policy is enabled by proactive use of the QCS App