Principles of care and support for the dying Care Home resident

Clinical Review

Agree deterioration in resident's condition suggests the resident has the potential to die in hours/days or is imminently dying.

1. Exclude reversible causes e.g. opioid toxicity, renal failure, infection, hypercalcaemia.
2. Is specialist opinion needed from a doctor with experience in resident's condition &/or palliative care team?
3. Is there an Advance care plan or Advance Decision to Refuse Treatment?

MULTIDISCIPLINARY TEAM ASSESSMENT AGREES

Resident is potentially imminently dying and no likely reversible causes identified

Communicate

Where the senior responsible clinician (G.P.) has identified that a resident under their care is dying or has the potential to die, they must discuss and agree a care plan with the resident/resident's family/carer clarifying;

- Recognition of dying or potential for dying and the rationale for this
- The resident's understanding and wishes for treatment and care
- Proposed plan of care including discussion about
  - Ceiling of care/CPR status
  - Risks and benefits of nutrition and hydration
  - Discontinuation of routine observations
  - Symptom control and medications prescribed for pain, nausea and vomiting, dyspnoea, agitation and chest secretions – including the need to commence a syringe pump if required
- Respond to family/carer questions/concerns

For those who lack capacity and have no-one else to support them (other than paid staff), please consider consulting with the IMCA service.

Document

The senior clinician must ENSURE that the care plan and all conversations are clearly documented in the resident's clinical notes

Re-evaluate

Resident is imminently dying and no reversible causes identified or resident opts for comfort care
ACTIONS - care for resident – see key areas to be addressed on reverse/below
For advice and support contact the Palliative Care Team

Resident is assessed as no longer dying

Explore resident's understanding and wishes for treatment and care

Treatment trial and timescale for review
- Define ceiling of care

DAILY REVIEW OF RESIDENT – COMMUNICATE AND DOCUMENT CARE PLAN

For advice and support contact the Palliative Care Team

Macmillan Community Palliative Care team (Central locality) on 01606 544155 or East Cheshire (Macclesfield) Palliative Care team 01625 663177

For advice outside these times, contact 24 hr advice line at St. Luke's Hospice on #6530 or 01606 551246 or East Cheshire Hospice on 01625666999

Please also see www.cheshire-epaige.nhs.uk a web-based resource to support health & social care professionals delivering care in the last year of life.

Daily Review

Communicate Document

COMMUNICATE with resident / family to clarify aims of care and update family on a regular basis and following any change in management.

DOCUMENT significant conversations in the notes and ensure contact numbers for key family members.

- Opportunity to discuss and document wishes for tissue donation.

Rationalise

RATIONALISE INTERVENTIONS AND MEDICATIONS – focus on comfort and support

- Discuss and document DNA-CPR order
- Justify interventions based on a balance of benefits and burdens including observations, blood tests, artificial hydration, nutrition and antibiotics
- Communicate decisions with resident (where possible) and family

Care

MAINTAIN EXCELLENT BASIC CARE - Frequent assessment, action and review

- Regular mouth care. Turning for comfort as appropriate
- Encourage and support oral food / hydration as resident is able
- Check bladder and bowel function
- Ensure dignity and compassion in all care

Symptoms

ASSESS SYMPTOMS REGULARLY - Frequent assessment, action and review

- Prescribe medications as required for anticipated symptoms e.g. pain, nausea, agitation, respiratory secretions
- Medications via a subcutaneous syringe pump if symptomatic or no longer tolerating oral medication
- Advice available from the Palliative Care Team, see also Palliative Care Prescribing guidelines on intranet

Family

IDENTIFY SUPPORT NEEDS OF FAMILY

- Ensure contact numbers updated for key family members
- Explain facilities available e.g. parking permits, folding beds for relatives
- Consider side room
- Early referral to bereavement services if appropriate

Spiritual Care

IDENTIFY SPIRITUAL NEEDS - For both resident and family

- Document specific actions required
- Refer to Chaplaincy or faith leader as appropriate

After care

CARE AFTER DEATH

- Timely verification & certification of death
- Family bereavement booklet
- Inform GP and other involved clinicians
- Referral to bereavement services if appropriate