Principles of care and support for the dying patient- Primary Care

NHS England

Clinical Review

Agree deterioration in patient's condition suggests the patient 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 consultant with experience in patient's condition &/or palliative care team?
3. Is there an Advance care plan or Advance Decision to Refuse Treatment?

MULTIDISCIPLINARY TEAM ASSESSMENT AGREES

Patient is potentially imminently dying and no likely reversible causes identified

Communicate

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

- Recognition of dying or potential for dying and the rationale for this
- The patient's understanding and wishes for treatment and care
- Proposed plan of care including discussion about
  - Advance Care Plans/DNACPR 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 consult with the IMCA service.

Document

The GP and/or lead clinician must ENSURE that the care plan and all conversations are clearly documented in the patient's clinical notes

Re-evaluate

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

Patient is assessed as no longer dying

Explore patient's understanding and wishes for treatment and care

Treatment trial and timescale for review

DAILY REVIEW OF PATIENT – COMMUNICATE AND DOCUMENT CARE PLAN

For advice and support contact the Palliative Care Team

Monday to Fridays
East Palliative Care Team - 01625 663177
Central Palliative Care Team- 01606 544155

For advice out of hours, contact the 24 hr advice line:
East Cheshire Hospice: 01625 666999
St Luke's Cheshire Hospice: 01606 551246

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 patient / 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 patient (where possible) and family
- Discuss and document DNA-CPR order

Care

MAINTAIN EXCELLENT BASIC CARE - Frequent assessment, action and review

- Regular mouth care. Turning for comfort as appropriate observing skin integrity
- Encourage and support oral food / hydration as patient is able
- Check bladder and bowel function
- Consider essential equipment for safe handling and to maintain patient comfort
- 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 patient 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