

## “One Chance to Get it Right “

**Title: Palliative & End of Life Care “One Chance to Get it Right “**

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**Links to :**

Ambitions for Palliative & End of Life Care. A National Framework for local action 2015-2020.

National Palliative & End of Life Care Partnership (2015)

NICE guidance for Care of the Dying Adult in the Last Days of Life (2015).

One Chance to Get it Right (Leadership Alliance 2014)

One Chance to Get it Right : One Year On Report (2015).

More Care Less Pathway (2013)

National End of Life Strategy fourth edition (2012)

End of Life suite of Resources (2014)

Verification of Expected Death (2014).

Syringe Pump Policy (2014)

Breaking Bad News (2015)

Just in Case Bags (JICB) Anticipatory Prescribing (2015)

Treatment Escalation Plan (TEP) (2014)

Standards for Bereavement Support (2015)

Bereavement Pack (2015)

Advanced Decision to Refuse Treatment (ADRT) 2014

Preferred Priorities for Care (PPoC) 2014

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## EXECUTIVE SUMMARY

This guidance presented by Torbay & South Devon NHS Foundation Trust has been developed in response to the Ambitions for Palliative & End of Life Care which is a National framework for local action 2015-2020, The “One Chance to Get it Right” document (2014), and NICE Guidance for Care of the Dying Adult in the Last Days of Life (Dec 2015).

### **NICE guidance Care of the Dying Adult in the Last Days of Life (2015)**

<http://www.nice.org.uk/guidance/ng31>

### **Ambitions for Palliative & End of Life Care 2015-2020**

<http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>

The “One Chance to get it Right” document in 2014; sets out the approach to caring for dying people that health and care organisations and staff caring for dying people should adopt in the future. The approach should be applied irrespective of the place in which someone is dying i.e. at home, in a care home, in hospital, in a hospice and during transfers between different settings.

### **One Chance to Get it Right (2014)**

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/323188/One\\_chance\\_to\\_get\\_it\\_right.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf)

### **One Chance to Get it Right: One Year On Report (2015)**

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/450391/One\\_chance\\_-\\_one\\_year\\_on\\_acc.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/450391/One_chance_-_one_year_on_acc.pdf)

The approach has been developed by the Leadership Alliance for the care of Dying People a coalition of 21 national organisations concerned to ensure high quality, consistent care for people in the last few days and hours of life. The alliance was established following an independent review of the Liverpool care Pathway for the Dying Patient (LCP), which reported in July 2013.

### **More Care Less Pathway (2013)**

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212450/Liverpool\\_Care\\_Pathway.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf)

The LCP was an approach to care developed during the 1990s, based on the care of the dying within the hospice setting, with the aim of transferring best practice to other settings. The review panel found evidence of both good and poor care delivered through use of the LCP and concluded that in some cases, the LCP had come to be regarded as a generic protocol and used as a tick box exercise. Care should be individualised and reflect the needs and preferences of the dying person and those who are important to them. The review panel recommended that use of the LCP should be phased out by July 2014.

**The ambitions for Palliative & End of Life Care framework for local action 2015-2020****Each person is seen as an individual**

1

*I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.*

**Each person gets fair access to care**

2

*I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.*

**Maximising comfort and wellbeing**

3

*My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.*

**Care is coordinated**

4

*I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.*

**All staff are prepared to care**

5

*Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.*

**Each community is prepared to help**

6

*I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.*

The “One Chance to Get it Right” document sets out the approach that should be taken in future in caring for all dying people in England, irrespective of whether organisations were previously using the LCP. The approach focuses on achieving five Priorities for care. These make the dying person themselves the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying person.

The way in which the Priorities for care are achieved will vary, to reflect the needs and preferences of the dying person and the setting in which they are being cared for. This approach is not, in itself, new. Where good care for dying people has been and continues to be given, it is typified by looking at what that care is like from the perspective of the dying person and the people who are important to them and developing and delivering an individualised plan of care to achieve the essentials of good care. Many health and care organisations and staff are already doing this and in some cases, as the review panel found, used the LCP to help them do so. However in other places, the LCP was associated with standardised treatment and care, carried out irrespective of whether that was right for the particular person in the particular circumstances. In some cases, the delivery of standardised treatment and care caused unnecessary distress and harm to dying people and those who were important to them. The risk of this continuing to happen is not tenable. Hence, the new approach will replace the LCP.

The approach focuses on achieving five ‘Priorities for Care’, (below) which should be applied irrespective of the place in which someone is dying: hospital, hospice, own or other home and during transfers between different settings.

### **Five Priorities for Care of the Dying Person**

<http://www.nhs.uk/media/2483136/pfcdp-leaflet2.pdf>

1: **RECOGNISE:** This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly.

2: **COMMUNICATE:** Sensitive communication takes place between staff and the dying person, and those identified as important.

3: **INVOLVE:** The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4: **SUPPORT:** The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5: **PLAN & DO:** An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

### **Nothing less will do.**

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## 1: Background

1.1 Good palliative/end of life care (box 1) is an essential component in the care of people in Torbay & South Devon (World Health Organisation WHO 2011). There is also an increasing need for such care.

### Box: 1: Definitions

**Palliative care** is defined 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”. (World Health Organisation (WHO 2011)).

**End of life (EOL)** care refers to the care during the last part of life, from the point that it is clear that the person is in a progressive state of decline. (Watson et al 2009).

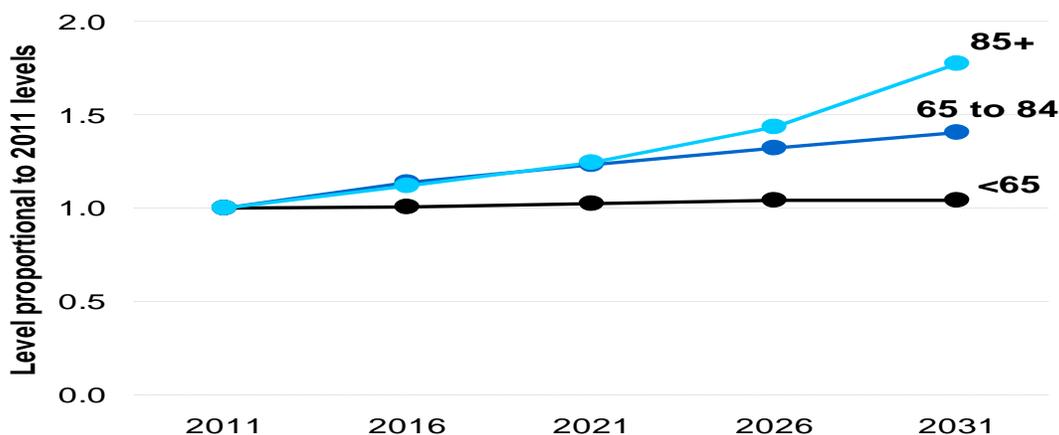
## 2: Ageing Population

Older people are the fastest growing sector of our population with reports estimating a 151% global increase in numbers between 2005 and 2030 (National Institute on Aging 2007). An increase of 142% in the UK is forecast by the year 2033 (National End of Life Intelligence Network 2010). The number of those over 75 years will rise by 70% (Gurcharan & Abdulla 2012). Generally people will be dying at older ages. Indeed, deaths among the very elderly, those aged 85+, will account for almost 45% of the deaths in 2030. (Gomes & Higginson 2008). The shift in degenerative conditions of older people is accompanied by changes in the patterns of death to a more gradual deterioration as the boundaries between being ill and dying have been obscured and prolonged. (Jakobsson 2006).

### 3: Population of Devon

Currently the population in Devon is over 755,000, and this is predicted to rise to 811,000 in the next five to ten years. We have a greater proportion of people in the older age groups and a lower proportion of younger age groups when compared with the national picture. The older population will grow by more than a third by 2021. In planning end of life care we need to consider 17% of our population are lone pensioners, with 12% of the county's 72,000 carers aged over 65 years. We know that by 2021 just over 26% of the total population will be aged 65 and over and, those over 80 years will rise by 8%.

**Figure: shows population projections by age group until 2031.**



### 4: Torbay & South Devon NHS Foundation Trust

4.1 Torbay and South Devon NHS foundation Trust is an integrated health and adult social care organisation. We provide acute hospital and community health services in Torbay and South Devon and in Torbay we provide adult social care services. We provide services to around 375,000 people in the community.

4.2 Our aim is to provide you with the **right care**, in the **right place**, at the **right time**. We are constantly developing new ways to make services more accessible for the local population, and introducing new opportunities for persons to take more control over the care and support they receive to help all to live life the way they want to.

## **5: Purpose of this document –**

5.1 The purpose of this Torbay & South Devon guidance is to support patients, carers and professionals working together to make individual plans for care at the end of life. It describes and provides links for the Torbay & South Devon Toolkit for End of Life Care; a suite of documents that empower professionals to support individuals as they make choices and develop plans at different stages of their end of life journey. The Toolkit should dovetail with disease-specific long term conditions guidance: All guidance should continue in parallel with the end of life care tools.

5.2 There are a number of key areas which compose the 'building blocks' of good end of life care. This document covers in more detail the range of services and resources that have been introduced, or are under development to be implemented within the strategic implementation plan.

### **Key Areas**

- 
- To raise the profile of end of life care in professionals and the wider society and change the attitudes to death and dying
- Strategic commissioning to provide an integrated approach to planning across agencies
- To identify/recognise earlier those people approaching the end of life
- Care planning to assess the needs and wishes of the person and agree a care plan for the future – Advance Care Planning, Advance Decisions to Refuse Treatment, Preferred Priorities of Care
- Co-ordination of care
- Rapid Access to Care and Support 24 hours a day, 7 days a week
- Delivery of high quality services in all locations
- Increase the access and choices to care closer to home
- Use of an individualised care plan in the last days of life
- To involve and support carers
- Education, training and continued professional development of all health and social care professionals, and volunteers working in this care domain
- Measurement and research to monitor the care given and develop further services
- Rapid Access to Continuing Healthcare

## 6: Introduction

6.1 The Palliative & End of Life Care team in Torbay & South Devon NHS Foundation Trust have collectively developed this local guidance, which describes how we may support our patients and their families when someone is believed to be in the last year of life in Torbay & South Devon. All health and care staff that care for dying people must ensure that they are aware of, and follow, guidance and local best practice. They will recognise that the evidence on which this is based will continue to evolve, and this guidance will be reviewed at regular intervals.

6.2 Irrespective of diagnosis, a person may be described as 'approaching the end of life' when they are believed to be likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

- Incurable, progressive, eventually fatal illness; including organ failure, cancer, and neurodegenerative problems.
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

6.3 Palliative care can be provided by a range of health and social care staff and may be done alongside active treatment. Advance care planning, symptom control, rehabilitation to maximise social participation, and emotional and spiritual support are all important in helping the individual to live well until they die.

6.4 Understanding and delivering patient choice is central to excellent care at the end of life. Ability to achieve patient choice may be used to measure quality of service. In relation to place of death, national statistics demonstrate a disparity between patients' preferred place of death and their actual place of death. Although when asked, over 50% of patients state they would prefer to die at home, only around 20% achieve this aim (Gomes & Higginson 2008).

6.5 The choices that patients make are likely to depend on which stage they are at in their end of life journey. Thus a patient with months to live is likely to have different priorities to a patient believed to be in the final hours of life.

6.6 Excellent communication with patients and families will allow professionals to understand individual preferences and to work together to develop plans for end of life care. Delivering genuine choice presents real challenges.

6.7 Teamwork is crucial. By matching need with resource, services can be more effectively and efficiently delivered. If well planned care is provided in the community, fewer patients may need admission to specialist services such as hospitals or hospices.

6.8 Torbay & Southern Devon aspires to the following underlying principles for dignity at the End of Life, recognising that individual's choices are fluid and may change during their journey or, during changes in their personal circumstances and capacity

#### **6.9 Promoting Choice over**

- Where people wish to die
- Who is with them when they die
- Involvement in decisions about their care and treatment

#### **6.10 Ensuring Access to**

- Expert information on their choices for end –of – life care
- High quality palliative care that is tailored to individual needs in whatever care setting
- Support for peoples families and carers

#### **6.11 Promoting Individual's Control over**

- Supporting people's wishes and preferences.
- How their symptoms and pain are relieved
- Planning the end of their life in advance if they so wish

### **7: Prognosis of less than 1 year**

7:1 A patient may wish to discuss end of life issues at any time. Professionals must be concerned about priorities for end of life care when a patient is believed to be in the last year of life.

7:2 Identifying the point when a people may have a life expectancy of one year is complex, especially for those with a non-cancer diagnosis. For patients with a cancer diagnosis, there is often a clear point at which the person moves from curative to palliative care. For those with a non-cancer diagnosis it is not unusual for there to be periods of deterioration which respond well to specific interventions.

7:3 Prognostic indicators have been suggested to support clinicians making this decision.

#### **Gold Standard Framework (Prognostic Indicators)**

<http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>

7:4 In order that patients and carers can be fully involved in planning individual priorities for care, it is vital to consider whether it is appropriate to talk about prognosis at this stage.

7:5 **'Breaking Bad News Guidelines'** have been produced to support this.

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Breaking%20Bad%20News.pdf>

**Any professional having sensitive discussions about prognosis should have received appropriate communication skills training. For more information re training see South Devon healthcare (Horizon Centre). Telephone- 01803 655555**

**Breaking bad news Guidelines (hospital)** click on link and follow speciality protocol & guidelines and Palliative Care.

<http://nww.sdhs.nhs.uk/link.php?page=dept/Clinaud/CEDept.html>

7:6 At this time, a key worker should be identified. This is 'a named professional who is 'best placed' to ensure the person receives co-ordinated, holistic and timely end of life care'. In primary care the key worker is likely to be an experienced member of the community nursing, long term conditions or social service team; whilst in secondary care; clinical nurse specialists often fulfil this responsibility. All care should be provided in conjunction with the wider multidisciplinary team and the persons Doctor/ GP.

7:7 The key worker should complete a holistic assessment and physical examination of the patient to identify any unmet needs. This will determine whether other actions are required, such onward referral to disease-specific management teams or Specialist Palliative Care.

7:8 Additionally, there should be a rigorous assessment of carer needs. 'Carer fatigue' is a major contributory factor in hospital crisis admissions. The risk of fatigue is higher if there is a lack of appropriate and timely support and equipment provision. Assessment should consider the full range of respite care – at home or in a bedded facility – and provision of assistive equipment.

**7.9 Torbay & South Devon NHS Foundation Trust offer support for carers** in the form of four week courses which are run in the locations of Torquay and Newton Abbot.

The course can help carers to –

- : Cope with the uncertainty of the future.
- : Develop ways of coping with the effects of illness.
- : Getting the help and support needed.

**For further information please contact the Palliative & End of Life Team**

**Telephone – 01803 547113**

## **8: Coordination of care**

8.1 The One Chance to Get it Right (2014) and The End of Life Care Strategy (2012) recognises the importance of coordinated care. Coordination of services must exist within teams and across organisational boundaries.

### **End of Life Care Strategy fourth edition (2012)**

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf)

8.2 Methods for more effective communication between primary and secondary care (The Electronic Palliative Care Coordination System, EPaCCS) is available in Torbay & Southern Devon.

### **The Electronic Palliative Care Coordination System, (EPaCCS)**

<http://www.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/end-of-life-care/coordination-of-care.aspx>

## **9: Gold Standard Framework (GSF)**

9:1 In managing patients believed to be in the last year of life, the primary healthcare team may consider adopting the 'Gold Standards Framework for Community Palliative Care'.

<http://www.goldstandardsframework.org.uk/content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>

9:2 This evidence-based framework aims to improve palliative care provided by the whole primary care team through optimising continuity of care, teamwork, advance planning (including out of hours), symptom control and patient, carer and staff support.

9:3 **The GSF focusses on seven key principles;**

- **Communication**
- **Co-ordination of the person's care**
- **Control of symptoms**
- **Continuity of care**
- **Continued learning**
- **Carer support**
- **Care of the dying**

9:4 In accordance with the General Medical Services contract Quality Outcomes Framework section 'Palliative Care', details of patients believed to be in the last year of life should be added to a practice register and their care reviewed regularly. The Quality Outcomes Framework measures are a minimum and additional end of life quality standards and outcome measures are being developed locally to support further service improvement and monitoring.

## **10: Safeguarding and the Mental Capacity Act**

10.1 Torbay & South Devon NHS Foundation Trust are committed to making improvements in services for people requiring palliative care across Devon. The Mental Capacity Act and Safeguarding Adult agenda are relevant to End of Life Care.

10.2 The Mental Capacity Act provides the legal framework for decision- making when a person may lack capacity to make these decisions. Wherever possible the person should be enabled to reach appropriate decisions by themselves. Where this is not possible, the Act offers guidance to ensure that those empowered to make decisions on behalf of someone else – including family members, carers, health and social care professionals and attorneys, always act in the best interests of those who lack mental capacity.

10.3 The Mental Capacity Act provides the mechanism for people to complete Advance Care Plans (a clear instruction refusing some or all medical procedures) and Advance Statements (an indication of the person's wishes).

10.4 The aim is to ensure that people who may be vulnerable to abuse or harm are protected by services which ensure that peoples' human rights are respected. In this context abuse includes acts of commission or omission, neglect, assault, sexual violence, financial abuse and discriminatory abuse. The abuse may be perpetrated by strangers, partners, friends, family members, people who use the services or people who provide the services.

10.5 Under the terms of the Mental Capacity Act 2005 formalised outcomes of advance care planning might include one or more of the following:

- i) Advance statements to inform subsequent best interest's decisions;
- ii) Advance decisions to refuse treatment which are legally binding if valid and applicable to the circumstances at hand;
- iii) Appointment of Lasting Powers of Attorney ('health and welfare' and/or 'property and affairs').

### **Mental Capacity Act (2005)**

<https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>

## 11. Advanced Care Planning

11.1 Advance care planning (ACP) is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and, if they wish, set on record: choices about their care and treatment and/or an advance decision to refuse a treatment (ADRT) in specific circumstances; so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide once their illness progresses.

11.2 It is recommended that an individual Advance Care Plan for End of Life be considered at the point when a person is believed to be in the last year of life. For those people who have capacity and who wish to participate, advance care planning is an integral part of the individualised care planning process. Not everyone will wish to make such records: if this is the case, professionals should share this with others involved.

11.3 Less formally, a person may wish to name someone whom they wish to be consulted if they lose capacity. An Advance Care Plan could be drawn up by the patient with any nominated health or social care worker. Patients may need help from a variety of appropriately trained professionals (possibly including those able to give specialist psychological support) to fully explore their options and determine their wishes.

11.4 Relevant documents e.g. 'Planning for your Future Care', and further information about Preferred Priorities of Care, and Advance Decisions to Refuse Treatment may be found in the Torbay & Southern Devon End of Life Toolkit.

### Planning for your future care

[http://www.devon.gov.uk/d\\_0903\\_004\\_139223\\_v4\\_-\\_a4\\_low\\_res2.pdf](http://www.devon.gov.uk/d_0903_004_139223_v4_-_a4_low_res2.pdf)

### Planning for your future care leaflet

<http://www.torbaycaretrust.nhs.uk/yourlife/endoflife/Documents/PlanYourFutureCareLeaflet.pdf>

### Advanced Decision to Refuse Treatment (ADRT)

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Pall%20Care%20-%20Advance%20Decision%20to%20Refuse%20Treatment.doc](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Pall%20Care%20-%20Advance%20Decision%20to%20Refuse%20Treatment.doc)

**Advanced Decision to Refuse Treatment (ADRT) Hospital. Please follow link to protocols & guidelines and Palliative Care.**

<http://nww.sdhs.nhs.uk/link.php?page=dept/Clinaud/CEDept.html>

### Preferred Priorities of Care (PPoC)

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Pall%20Care%20-%20Advanced%20Care%20Planning%20\(ACP\)%20-%20Preferred%20Priorities%20for%20Care.doc](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Pall%20Care%20-%20Advanced%20Care%20Planning%20(ACP)%20-%20Preferred%20Priorities%20for%20Care.doc)

**Advanced Care Planning materials are available from:**

**The Palliative & End of Life Team: Telephone – 01803 547113**

11.5 These are sensitive subjects, and staff working alongside patients require training. Torbay & Southern Devon Health & Care **provide weekly education sessions** at various geographical locations throughout the Trust footprint. The sessions incorporate all aspects of Advanced Care Planning, TEP, and JICB and include verification of expected death. Places can be booked via the Horizon Centre. Telephone- 01803 655555

11.6 By addressing these subjects and recording choices, it is more likely that patients will achieve their wishes. Recording such details also allows services to audit outcomes of care and analyse any reasons for deviation from original decisions.

**12: Do Not Attempt Cardiopulmonary Resuscitation**

Do Not Attempt Cardiopulmonary Resuscitation is a medical decision regarding whether cardiopulmonary resuscitation would be appropriate for a patient with a life limiting illness should be documented. According to best practice guidelines set out by the General Medical Council (GMC) such decisions must be made in conversation with patients and carers and reasoning carefully explained and recorded. It is important to be clear that cardiopulmonary resuscitation is a very specific treatment and a decision not to attempt CPR does not preclude treatment of acute medical problems such as infection or hypercalcaemia.

**Treatment Escalation Plan (TEP)**

12:1 The whole of Devon use the same Treatment Escalation Plan (TEP). Current version 10.

[http://www.devontep.co.uk/wp-content/uploads/2012/03/V10\\_TEP\\_FINAL\\_INFO\\_ONLY.pdf](http://www.devontep.co.uk/wp-content/uploads/2012/03/V10_TEP_FINAL_INFO_ONLY.pdf)

12:2 The Treatment Escalation Plan (TEP) is a clinical guidance document for health care professionals. It is not a legal document. Common sense and professional judgement should be applied to who should have one and how it is implemented.

12:3 All forms should be filled out as fully as possible by a doctor. The information must reflect the individual needs of each patient. Patient demographics, doctor's details (including GMC number) and Mental Capacity status must be recorded.

12:4 It is not mandatory to complete all of the treatment options section. Use this section when it reflects your treatment plan.

12:5 Complete the rationale box – detailed and relevant information significantly improves decision making.

12:6 Documentation of the patient and relative discussions will ensure effective communication. This is of particular importance if the patient lacks capacity. For patients

lacking capacity, a Best Interests decision and the reasoning behind it should be recorded in the clinical notes.

### **Best Interest Decisions flow chart**

[http://www.devontep.co.uk/wp-content/uploads/2012/03/Guidance\\_for\\_TEPv10\\_and\\_Flowchart\\_for\\_printing1.pdf](http://www.devontep.co.uk/wp-content/uploads/2012/03/Guidance_for_TEPv10_and_Flowchart_for_printing1.pdf)

12:7 The Treatment Escalation Plan (TEP) form should be completed in collaboration with the patient and family where possible. However a blanket policy enforcing discussions with all patients is morally and ethically indefensible. The form should be reviewed when the clinical condition changes or where a patient moves from one location to another.

12:8 The Treatment Escalation Plan (TEP) is only effective if everyone knows it exists – please update the Electronic Palliative Care Coordination System (EPaCCS) register.

12:9 The original Treatment Escalation Plan (TEP) travels with the patient wherever they go.

### **Devon TEP Website**

<http://www.devontep.co.uk/>

### **Torbay & South Devon Community TEP Policy**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Treatment%20Escalation%20Plan%20Policy.pdf>

**Torbay & South Devon Hospital TEP Policy.** Please follow link to Trust wide Guidance & Resuscitation

<http://nww.sdhs.nhs.uk/link.php?page=dept/Clinaud/CEDept.html>

## **13. Prognosis of less than six months**

13.1 At this stage the person (regardless of diagnosis) may apply for attendance allowance or disability allowance under special rules using a DS1500 form, available from GP or Palliative Care Nurse Specialist. This will ensure applications are processed on a fast-track method. There should also be further assessment of the continuing care needs of the person, with application for support according to eligibility criteria.

### **Fast Track/Special Rules**

<https://www.citizensadvice.org.uk/benefits/sick-or-disabled-people-and-carers/personal-independence-payment/who-can-get-personal-independence-payment-pip/personal-independence-payment-pip-special-rules-if-you-are-terminally-ill/>

## **14. Prognosis of ‘a few weeks’**

14.1 This stage is characterised by a deterioration suggesting the patient is entering the final weeks of their life. Such a change should trigger a review of advance care plans. Check patients and carers understand as much as they wish to about what is happening; now time appears to be short. Any desired changes to an individual’s priorities for care, particularly any changes to preferences around place of care or death, should be clearly documented. Professionals should renew efforts to deliver high quality care; anticipating physical care needs, maintaining good symptom control, giving consideration to psychosocial issues and supporting carers. A further assessment of the physical care needs of the person should take place.

14.2 The framework for NHS Continuing Healthcare funding includes a fast track process which can be used by a senior clinician for people with a rapidly deteriorating condition. This is appropriate for patients who have reached the ‘weeks prognosis’ stage to allow any needs to be met urgently (for example, to be at home to die). If a patient requires care, apply for support.

### **T&SDFT Fast Track Pathway Tool**

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/CHC%20Fast%20Track%20Tool%20\(Revised%20Nov%202012\).doc](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/CHC%20Fast%20Track%20Tool%20(Revised%20Nov%202012).doc)

14.3 A prescription of anticipatory medication (‘Just in Case Bag’) should be considered at this stage, after discussion with the patient and carer. This ensures there is an emergency supply of ‘as required’ subcutaneous medication in the patient’s home, in advance of any deterioration in the patient’s ability to take medication orally. If needed, such medication will help control any distressing symptoms of pain, restlessness and agitation, nausea and vomiting, and respiratory tract secretions which may occur.

### **T&SDFT Standard Operating Procedure (SOP) for the anticipatory supply of palliative care medication**

[http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Just%20In%20Case%20Bags%20\(JICB\)%20-%20SOP.pdf](http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Just%20In%20Case%20Bags%20(JICB)%20-%20SOP.pdf)

### **Just in Case Bags supplies are available from the Palliative & End of Life Team**

**Telephone – 01803 547113**

14.4 Symptom management guidelines are available as part of the T&SD End of Life Resources/ Toolkit.

### **Supporting End of Life & Resources/ Toolkit**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Supporting%20end%20of%20life%20care.pdf>

## **Revised Approach for Caring for Patients at End of Life**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life-%20Revised%20approved%20for%20care%20of%20the%20dying%20patient.pdf>

## **Guidelines for good care of dying patients**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Guidelines%20for%20Good%20Care%20of%20Dying%20Patient.pdf>

## **Pain in the last days of life**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Pain%20in%20the%20last%20days%20of%20life.pdf>

## **Respiratory symptoms in the last days of life**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Respiratory%20Tract%20Secretions%20in%20the%20last%20days%20of%20life.pdf>

## **Restlessness & Agitation in the last days of life**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Restlessness%20and%20Agitation%20in%20the%20last%20days%20of%20life.pdf>

## **Shortness of Breath in the last days of life**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Shortness%20of%20Breath%20in%20the%20last%20days%20of%20life.pdf>

## **Nausea & Vomiting in the Last days of life**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Vomiting%20and%20Nausea%20in%20the%20last%20days%20of%20life.pdf>

## **Standards for good end of life care in the hospital setting**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20life%20-%20Standards%20for%20Good%20End%20of%20Life%20Care%20in%20a%20Hospital%20Setting.pdf>

14.5 The carer's needs should be reviewed to ensure that the appropriate type and level of support is in place to enable them to cope, especially if the patient has chosen to die at home. Information should be provided on how to access advice and support if a crisis arises. Sharing information (including DNACPR documentation) with Out of Hours Care and the ambulance service is essential at this time.

## 15. Prognosis of days or hours

15.1 In accordance with the approach set out by the national LACDP in ‘One chance to get it right’ when it is thought that a person may die within the next few days or hours the 5 ‘Priorities for Care’, should be applied irrespective of the place in which someone is dying :

### Priorities for Care of the Dying Person

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#### Duties and Responsibilities of Health and Care Staff

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Published June 2014 by the Leadership Alliance for the Care of Dying People

<b>RECOGNISE</b>	The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly.  Always consider reversible causes, e.g. infection, dehydration, hypercalcaemia, etc.
<b>COMMUNICATE</b>	Sensitive communication takes place between staff and the dying person, and those identified as important to them.
<b>INVOLVE</b>	The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
<b>SUPPORT</b>	The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
<b>PLAN &amp; DO</b>	An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

Local palliative care contact:

If unsure, or the dying person or those important to them raise concerns, a senior clinician must review the person and the goals and plan of care. The titles above are intended as memory prompts and attention should be paid to the whole description for each section. Expanded explanations are included overleaf.

15.2 It is recommended that the recognition of dying is identified by the most senior responsible doctor whenever possible in discussion with a multidisciplinary team who know the patient well. Recognising Dying is a record of medical opinion on a specific day and requires documentation of an explanation to the patient and/or carer that the patient is believed to be in the final days or hours of life. Recognising Dying is equally appropriate in the event of acute illness leading to death, even if the patient has not previously been diagnosed as being in the last part of life. Patients and carers may wish to discuss what to expect at this time. If the senior responsible doctor does not feel competent to have this discussion it is imperative they seek a colleague (e.g. a member of the Specialist Palliative Care Team) for support.

15.3 Patients (where appropriate) and carers should be offered written information.

### **Coping with Dying Leaflet**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/End%20of%20Life%20-%20Coping%20with%20Dying%20Leaflet.pdf>

15.4 Recognising Dying deliberately records opinion at a specific point in time, because patients may change and the process of dying can be unpredictable, particularly for those with a non-malignant diagnosis. Recognising Dying empowers the team to focus on priorities for care in the final hours of life. It may also be used to facilitate audit of quality of care in the last hours of life. Recognising Dying is the ultimate trigger to review any Advance Care Plan or priorities for care at this final and most crucial period. Professionals should document an individual plan for the patient's care using existing notes or T&SDHCT Palliative & End of Life Care Plan taking into account any expressed preferences.

### **T&SDFT Community Palliative & End of Life Care Plan**

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Palliative%20Care%20for%20the%20Dying%20Patient%20August%202014.pdf](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Palliative%20Care%20for%20the%20Dying%20Patient%20August%202014.pdf)

**T&SDFT Hospital Palliative & End of Life Care Plan.** Follow link click on protocols & guidance and Palliative Care.

<http://nww.sdhs.nhs.uk/link.php?page=dept/Clinaud/CEDept.html>

15.5 It is acknowledged that patients who are actively dying should not receive care that is fundamentally different to care given at any other stage of life. However, at this vital time, utmost attention to detail is warranted. Regular (for residential/in-patient settings, 4 hourly; for patients at home at least daily) review of the patient and carers should be documented. This period of care is consistent with 'care of the dying' as defined in the GSF; the focus is on proactive management. Any choices previously or currently expressed by the patient and family should be respected and as far as possible delivered.

15.6 Patients should be supported to eat and drink as they feel able. Whenever appropriate, decisions about clinically assisted nutrition or hydration should be carefully discussed with patients (where possible) and carers.

15.7 Assessment of current medication, the discontinuation of non-essential drugs and the anticipatory prescribing of as required sub-cutaneous medication for treatment of adverse symptoms are integral components of care at this stage. Guidance can be found attached to the Palliative & End of Life Care Plan. A syringe pump may be required at this stage if the person is unable to tolerate oral medications.

## Syringe Pump Policy

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Syringe%20Pump%20Device%20administration%20of%20medication.pdf>

## Syringe Pump Documentation

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Appendix%201syringepumpprescriptionformFINAL23.10.13.pdf](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Appendix%201syringepumpprescriptionformFINAL23.10.13.pdf)

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Appendix%202%20PMAR%20community%20subcutaneous%20route%20FINAL%20June%202012.docx](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Appendix%202%20PMAR%20community%20subcutaneous%20route%20FINAL%20June%202012.docx)

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Appendix%203%20PMAR%20community%20bolus%20record%20FINAL%20June%202012.docx](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Appendix%203%20PMAR%20community%20bolus%20record%20FINAL%20June%202012.docx)

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Appendix%205%20Community%20Medication%20Stock%20Record%20FINAL%20June%202012.docx](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Appendix%205%20Community%20Medication%20Stock%20Record%20FINAL%20June%202012.docx)

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Appendix%207%20Safe%20Transfer%20of%20Care%20Guidelines%20FINAL%20June%202012.docx](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Appendix%207%20Safe%20Transfer%20of%20Care%20Guidelines%20FINAL%20June%202012.docx)

## Syringe pump patient leaflet

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/Appendix%208%20McKinley%20T34%20Syringe%20Pump%20Patient%20Leaflet.pub](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/Appendix%208%20McKinley%20T34%20Syringe%20Pump%20Patient%20Leaflet.pub)

15.8 It is crucial that providers of Out of Hours Care and the ambulance service are notified of the patient's status as this time using the relevant notification forms.

15.9 If a patient in hospital is believed to be in the last hours of life and they wish to die at home, Rapid Discharge may be considered.

## Rapid Discharge Pathway

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/EOL%20RAPID%20DISCHARGE%20PATHWAY%20EOL.FINAL.docx](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/EOL%20RAPID%20DISCHARGE%20PATHWAY%20EOL.FINAL.docx)

15.10 In the event of the patient dying (whatever the setting) certification of death should be carried out as soon as possible. In some settings (nursing homes and community hospitals, OOH nursing) nursing staff are trained to undertake what is referred to as 'verification of death'. This expedites transfer of the patient's body and the process of events after death. T&SDHCT have a policy in place to guide nurses in the process of verification of expected death

## **Verification of Expected Death by a Registered Nurse.**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Verification%20of%20Expected%20Death%20by%20a%20Registered%20Nurse%20in%20a%20Community%20Setting.pdf>

## **16. Care after Death/Bereavement Support**

16.1 Following a death all relevant services should be informed, including the provider of Out of Hours Care, GP and the ambulance service. Bereavement Care, should consider the provision of support for all those who are bereaved following a death. At this time, nurses/AHP's/carers may have the advantage of established rapport with relatives. Continuity of care at this stage is particularly beneficial, and may allow most accurate risk assessment for complicated grief. Onward referral to specialist services may be appropriate. Whilst spiritual support is central for patients and carers at any stage, it may have particular emphasis at this stage.

## **17. T&SD Community & Community Hospital Bereavement Standards**

17.1 In T&SD there are standards for bereavement support to ensure that the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

### **The Community Bereavement Standards**

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Bereavement%20Policy.pdf>

**All relatives//carers/ or persons who are important to individuals who die whilst under the care of Torbay & Southern Devon Health & Care Trust are offered/provided with :**

**A bereavement telephone call to offer condolences /and /or a bereavement face to face visit** (please note this is only appropriate to community teams and not community hospitals,)

**A bereavement pack containing :**

**Booklet : Help for you following your bereavement :**

**Sources of support information following bereavement**

**Relative/Carer experience questionnaire :**

**Envelope/folder :** containing above information "we are here for you"

All packs will contain a stamp addressed envelope for return to Bay House

Bereavement Packs available from the Palliative & End of Life Team : Tel : 01803 547113

## **Bereavement Packs**

[http://icare/forms/community\\_nursing/Trial%20Community%20Nursing%20Forms/bereavment\\_booklet.pdf](http://icare/forms/community_nursing/Trial%20Community%20Nursing%20Forms/bereavment_booklet.pdf)

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Bereavement%20Information%20Sheet.pdf>

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Bereavement%20-%20We%20are%20there%20for%20you%20leaflet.pdf>

<http://www.torbaycaretrust.nhs.uk/publications/TSDHC/Bereavement%20Survey.pdf>

**The relative/ carer experience questionnaire will be evaluated yearly and feedback provided to teams.**

**Acute Hospital Bereavement Support.** Please click on link below.

[http://nww.sdhct.nhs.uk/corporate/nursing\\_and\\_governance/patient\\_services/bereavement/Pages/default.aspx](http://nww.sdhct.nhs.uk/corporate/nursing_and_governance/patient_services/bereavement/Pages/default.aspx)

## **18. Continued Learning: opportunities for professionals after a patient has died**

18.1 There is a well-recognised need for continued learning as professionals undertake care of dying patients. Circumstances that should prompt further discussion among teams include unexpected deaths of patients, deaths of patients that do not occur in the preferred place of care and feedback from any audit process. Use of the GSF 'After Death Analysis Tool' is recommended. Additional services to meet individual needs Additional services may be needed at any stage of end of life

## **19 Additional services to meet individual needs**

19.1 Additional services may be needed at any stage of end of life care, according to the individual patient or carer's requirements and circumstances. Such services include specialist condition-specific care, specialist psychological support, respite care, self-help and support groups, equipment loan services, spiritual care and specialist palliative care. Many people will access psychological, emotional and spiritual help through their own informal support networks, but the need for access to specific services should be discussed as part of the regular review process.

19.2 Specialist Palliative Care Referral for specialist palliative care involvement should be considered at any stage where there are complex physical and/or psychosocial needs. Patients may be referred to, and/or advice sought from specialist palliative care teams for:

- Complex pain and symptom management

- Psychological support for patients and families who are experiencing difficulty in accepting and coming to terms with the disease process
- Discharge planning (for those in hospitals) where specialist support is considered a requirement to help promote the quality of life for the patient and family
- Terminal care where specialist advice is required to enhance the comfort of the patient and family
- Staff support

**In T&SDFT Community Specialist Palliative Care is provided by Rowcroft Hospice.** For further information click on link below or contact your community nurses for details of the Palliative Care Nurse Specialist allocated to your area.

If an inpatient in Torbay Hospital Specialist Palliative Care will be provided by the Hospital Specialist Palliative Care Team.

### **Rowcroft Hospice**

<http://www.rowcrofthospice.org.uk/>

**Marie Curie also provide specialist support** (for contact for T&SDFT see appendix 1)

<https://www.mariecurie.org.uk/help/nursing-services/get-marie-curie-nurse>

## **20. Standards of End of Life Care/Audit**

20.1 It is important that we monitor the standards of Palliative & End of Life Care provision in Torbay & South Devon NHS Foundation Trust. An audit tool has been developed to measure the quality of end of life care provision in T&SD and to identify if the quality of our care meets the requirements of the five priorities for care for the dying person. The audit will be completed in both the community/ community hospital and acute hospital on a yearly basis.

20.2 Further measurement of the quality of care provided to dying patients and their carers will come from a national survey programme of people who have been bereaved (VOICES ), the analysis of complaints to the NHS relating to end of life care, and organisational self-assessment of structures and processes which demonstrate adherence to the 'Priorities for Care'.

20.3 The Care Quality Commission (CQC) and their chief inspectors will incorporate, as a key area, inspection of end of life care provided by all services. This new approach has started with the acute sector: all inspections of acute hospitals now include an inspection of end of life care services as one of eight core service areas which the inspection team routinely consider. Inspections look at palliative and end of life care across the hospital/community and are not limited to specialist services.

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20.4 In inspecting services which deliver end of life care in any setting, CQC will review whether people receive care in line with the 'Priorities for Care'. CQC inspections will include whether care is delivered by qualified, competent staff, who are supported in their development and in their roles. Inspection teams will gather views from people who use services and their families, carers and advocates; observe care; interview key members of the senior management team and staff at all levels; and may visit certain services out of hours and unannounced. They will consider the role health and care staff play in care in the last few days and hours of life as well as care provided after death, including the support provided to bereaved families and carers.

### References:

NICE Guidance (2015) for Care of the Dying Adult in the Last Days of Life.

Ambitions for Palliative & End of Life Care. A National Framework for local action 2015-2020  
National Palliative & End of Life Care Partnership  
[www.endoflifecareambitions.org.uk](http://www.endoflifecareambitions.org.uk).

One Chance to Get it Right (2014)  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/323188/One\\_chance\\_to\\_get\\_it\\_right.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf)

More Care Less Pathway (2013)  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/212450/Liverpool\\_Care\\_Pathway.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf)

Gomes B, Higginson I. (2008) Where people die (1974 – 2030): past trends, future projections and implications for care. *Palliative Med* 2008; 22:33

The National End of Life Care Strategy (2012) fourth edition Department of Health.  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136486/End-of-Life-Care-Strategy-Fourth-Annual-report-web-version-v2.pdf)

Gold Standard Framework (GSF) prognostic <http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>

National End of Life Care Intelligence Network (2012) Profiles for Torbay (2012)  
website: [www.endoflifecare-intelligence.org.uk/profiles.aspx](http://www.endoflifecare-intelligence.org.uk/profiles.aspx)

Gurcharan S R & Abdulla A (2012) Treatment of Older People. *The AvMA Medical and Legal Journal* volume 18 number 5.

World Health Organization (2013) available from [www.worldday.org](http://www.worldday.org)

Watson M L C, Hoy A & Wells J (2009) *Oxford Handbook of Palliative Care*. Oxford University Press, Oxford UK.

**Amendment History**

Issue	Status	Date	Reason for Change	Authorised
1	Current	Dec 2015	New document	16/12/15

**Monitoring tool**

Standards:

Item	%	Exceptions

# Marie Curie Nursing Service in Devon

## What we offer

- Free nursing care and support for terminally ill adults in Devon who are in their last days to months of life.
- Our Marie Curie Nurses and Healthcare Assistants are experienced in caring for people with any terminal diagnosis in their own home or in residential care homes.
- Depending on your patients' needs, we can provide day or night-time visits, on any day of the week.

## How to refer patients to our service

Before referring a patient to us, please check our referral criteria overleaf.

To make a referral, contact Marie Curie's Devon Coordination Office.

Phone: **08450 738 696**

8am – 6pm, Monday to Friday

10am – 3pm, weekends and bank holidays

When you contact our service out of hours, we will transfer your call to Marie Curie's national referral centre.

## What we need from you

When making a referral, we will ask you for detailed information about the patient's condition and needs.

Involvement and assessment from the patient's district nurses are essential to help us coordinate our nursing care. This means we will discuss any referrals made by another professional with the relevant district nurses.

The district nurse, community nursing team member or named referrer is responsible for making a full assessment of the risks of caring for the patient at home. This document, together with a district nursing care plan, must be made available in the patient's home before Marie Curie can provide any nursing care.

## How our service works

Service coordinators based at Marie Curie's Devon Coordination Office in Tiverton work together with Marie Curie Senior Nurses and Registered Nurses to manage all referrals to our service in Devon efficiently.

We allocate our nursing care on a day-to-day basis to ensure patients with the greatest needs are given the priority for our services.



### Referral criteria

- The patient is aged 18 or over, with any terminal diagnosis and has end of life care needs.
- The patient wants to be, and can be, safely cared for at home, with agreement from their GP.

### Priority for care

We want to be able to respond effectively to your requests for Marie Curie nursing care. Before making a referral, please refer to the categories below each time you make an assessment of your patient's needs.

#### Urgent – patients with a rapidly deteriorating condition

- Prognosis of hours to days, with same day/next day response needed
- Uncontrolled symptoms requiring nursing intervention
- Carer unable to cope with changing/unpredictable demands in patient's care
- Breakdown in care will lead to an in-patient admission
- Rapid discharge from an in-patient setting

*Urgent referrals can retain this category for up to five days.*

#### Patients and families with changing needs

- Prognosis of days to weeks
- Patient's needs are changing, requiring a high level of nursing care
- Patient has symptoms that are unstable
- High levels of patient/carer anxiety
- Needs of the family/carer are unstable with a risk of increasing further
- Patient is not in their preferred place of care

#### Patients and families with stable needs

- Prognosis of weeks to months
- Patient is deteriorating slowly, requiring a low level of nursing care
- Patient is asymptomatic or their symptoms are well controlled
- Low levels of patient/family anxiety

Marie Curie Cancer Care gives people with all terminal illnesses the choice to die at home. Our nurses provide them and their families with free hands-on care and emotional support, in their own homes, right until the end.

[mariecurie.org.uk](http://mariecurie.org.uk)

