

## TRUST-WIDE CLINICAL POLICY DOCUMENT

# END OF LIFE CARE

Policy Number:	SD47
Scope of this Document :	All Staff Trust-wide
Recommending Committee:	Physical Health Strategy Group
Approved By:	Executive Director of Nursing & Operations
Date Ratified:	February 2020
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Version Number:	2020 – Version 5
Lead Executive Director:	Executive Director of Nursing & Operations
Lead Author(s):	Modern Matron (Physical Health)

## TRUST-WIDE CLINICAL POLICY DOCUMENT

2020 – Version 5

Striving for perfect care  
and a just culture

# TRUST-WIDE CLINICAL POLICY DOCUMENT

## END OF LIFE CARE

### Further information about this document:

Document name	End of Life Care Policy (SD47)
Document summary	<b>This document clarifies the responsibility of Trust staff and establishes the principles and standards to ensure that consistent compassionate patient centred care is provided for patients who require end of life care in our services.</b>
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To be read in conjunction with	<b>SD29 Physical Health Policy</b> <b>ICO1 Infection Prevention and Control Policy</b> <b>SD07 Resuscitation Policy including Do Not Attempt Cardiopulmonary Resuscitation</b> <b>SA19 Management and Decontamination of Medical Devices Policy</b> <b>SD12 Handling of Medication Policy</b> <b>SD06 Consent to Examination and Treatment Policy</b> <b>SD 02 Death of a service User</b> <b>SD 19 Advanced Statements and Advanced Decisions</b> <b>SD 44 Nutrition Policy</b> <b>SD 30 Management of Dysphagia</b> <b>SOP 104 End of Life Adults – For all Staff Working in Liverpool and South Sefton Community Division</b>
<b>This document can be made available in a range of alternative formats including various languages, large print and braille etc</b>	
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**Version Control:**

Version History:		
Version 1	Circulated to: Trust-wide Divisions, Associate Medical Director for Physical Health Strategy Group	September 2016
Version 2	Policy Group - Review	December 2016
Version 3	Executive Committee - for Ratification	January 2017
Version 4	Policy Group – Review	November 2017
Version 5	Amendments and Review – End of Life Group	February 2020

## SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

### SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child /adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

### EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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## 1. PURPOSE AND RATIONALE

- 1.1 This policy establishes the trust wide minimum standards for the evidenced based guidelines for the holistic care of a patient who may be approaching the last few days of life in accordance to the 'One Chance to get it Right' document (LACDP2014).
- 1.2 The expected death of a patient in our care is an infrequent event for inpatient services and recurrent event for community services. Therefore staff may not be familiar with the standard of care required or the support services available in this situation. This policy aims to provide staff with the principles to ensure that consistent compassionate patient centred care is provided for patients who require end of life care in our services.
- 1.3 Dying is an uncertain process and it can be difficult to determine and predict when a person will die. Therefore, the care of a person who has been assessed to be at this stage of their life needs to receive consistent and responsive evidenced based patient centred care while they are in this transition period.

## 2. OUTCOME FOCUSED AIMS AND OBJECTIVES

- 2.1 When it is recognised that a person may be entering the last few months, weeks or days of their life the aims and objectives of this are as follows.
  - a) to ensure that a patient receives ongoing holistic assessments and regular reviews in order to identify any changes in their:
    - palliative care
    - physiological condition
    - treatment
    - physical health needs
    - risks
    - support
    - psychological needs
    - spiritual needs

to determine if the patient is nearing death, stabilising or recovering.
  - b) to ensure that the patient and/their family and/those who are important to them are involved in the patient's care provision as appropriate and are supported;
  - c) to ensure that the patient is consistently monitored throughout this stage of life and that a responsive care approach is tailored to the changing needs of the patient;
  - d) for staff to ensure that the patient's care provision is seamless across support services and that the patient is maintained in a state of comfort and dignity throughout this period.

## 3. SCOPE

- 3.1 This policy applies to all Trust-wide staff.

#### 4. DEFINITIONS (Glossary of Terms)

##### 4.1

Glossary of Terms	Definition
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
LACDP	Leadership Alliance for Care of Dying People
RC	Responsible Clinician
SALT	Speech And Language Therapist

#### 5. DUTIES – BOARD OF DIRECTORS

5.1 Health care providers are under obligation to provide safe care to their patients and appropriate training to their staff. This duty encompasses ensuring the care of patients whilst under the care of the organisation and the Trust has an obligation to comply with its statutory and regulatory observations.

5.2 The Trust Board has overall responsibility for ensuring that all staff are appropriately trained and competent to effectively fulfil their role within the organisation and maintain the safety of patients.

##### 5.3 **Lead Executive Director**

The Lead Executive Director for this policy (Executive Director of Nursing & Operations) has strategic responsibility for ensuring that the standards with this policy are monitored and reported to the board accordingly.

##### 5.4 **Policy Lead**

The Policy Lead (Modern Matron – Physical Health) will oversee the implementation and promotion of the policy across the Trust. They will be responsible for monitoring and reviewing the policy as necessary.

##### 5.5 **The Medical Director**

Will support and oversee the implementation and promotion of this policy, especially to medical staff and supporting the monitoring and review of the policy.

##### 5.6 **Divisional Senior Management Teams**

Accountable to the Director(s) with responsibility for Clinical Divisions for ensuring delivery of high standards of care and adherence to this policy within their clinical division.

##### 5.7 **Service Leads, Modern Matrons and Ward Managers**

Service Leads, Modern Matrons and Ward Managers are responsible for ensuring that high standards of care are maintained within their areas of responsibility and to adhere to the standards set out in this policy. They also have responsibility to identify training needs of staff and to liaise with appropriate personnel to meet those needs.

## 5.8 All Healthcare Practitioners

All staff working with service users in inpatient services and community areas have a responsibility to work in accordance with the standards set out in this policy.

## 6. PROCESS

### 5 Priorities of Care, One Chance to get it Right (LACDP 2014)

#### Priority 1

**The possibility that a person may die within the coming days and hours is recognized and communicated clearly, decisions made about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.**

- 6.1 When it has been recognised that a person may be entering the last few days of life, their condition must be consistently monitored and assessed as to whether the condition is potentially reversible.
- 6.2 If it is decided that the person is entering their last days of life, the Consultant/GP and/or Multi Disciplinary Team (Clinical Nurse Specialist or District Nurse) must communicate the prognosis in a clear and sensitive way to the patient, their family or people who are important to them. During this meeting the doctor may need to provide time for any queries that arise and sensitively establish where the patient would like to be during this part of their life.
- 6.3 Once the patient, their family or people who are important to them decide on the patients preferred place of death a holistic care plan needs to be devised to support patient choice.
- 6.4 If the patient is detained under the Mental Health Act the Doctor (Responsible Clinician) must consider whether it is appropriate to continue with the detention or decide if the order could be revoked.
- 6.5 When devising a plan of care the team must establish if the patient has:
  - a) the mental capacity to make an informed choice about her/his future care including last days of life;
  - b) if it is thought that the patient EITHER does not OR may not have the capacity to make such an informed choice, a Mental Capacity Act compliant capacity assessment must be completed;
  - c) where it is established that a patient does NOT have the mental capacity to make such a decision a Best Interests checklist assessment must be completed. This will include checking for:
    - an advance decision to refuse treatment (note: ordinarily such decisions may be verbal or written. However, if the decision is to refuse life-saving treatment it must be written, witnessed, signed by the patient and include a statement acknowledging that to refuse the treatment may result in her/his death),
    - a Health and Welfare Lasting Power of Attorney (LPA) authorised to make treatment decisions on behalf of the patient,



- a Court Appointed Deputy decision authorised to make treatment decisions on behalf of the patient,
- any specific Court of Protection treatment decision.

6.6 In most case decisions taken by the above are legally binding. **If in doubt contact the Trust's Legal Team 0151 473 2799 or the On Call Service via Switchboard.**

### **Priority 2**

**Sensitive communications take place between staff and the dying person and those identified as important to them.**

6.7 The team must maintain regular, respectful, sensitive, open and honest communications with the dying person, their family or those identified as being important to them. Careful consideration must be given to the timing of sensitive communications and any quick decisions regarding the patient's safety and comfort.

### **Priority 3**

**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.**

6.8 Sensitive communications must be undertaken to establish if the dying person, their family or those who are important to them wish to be involved in the decisions regarding the treatment and the way it is delivered.

6.9 The multidisciplinary team must enable the patient, their family or those important to them, to be involved in the decisions and plans for the future treatment and care of the patient. The care plan must be made in accordance with the needs and wishes of the patient, their family or those who are important to them. This plan needs to be consistently reviewed and revised accordingly.

6.10 The dying person and those who are important to them must be informed of the Doctor/GP who has overall responsibility for the patient's treatment and care.

6.11 Where the dying person lacks capacity, the staff must continue to attempt to involve the patient at all levels of care when Best Interests action is undertaken.

6.12 The resuscitation status of a dying person should be established and agreed in line with the Trust's Resuscitation Policy incorporating Do Not Attempt Cardiopulmonary Resuscitation.

6.13 A holistic patient centred plan of care must include nutrition and hydration, symptom control, physiological, pharmacological, psychological, cultural, social and spiritual support to be agreed, coordinated and delivered with compassion.

6.14 The team must ensure that they work in partnership with external providers to deliver timely seamless holistic care for the patient and meet their physical, spiritual, emotional, social and psychological needs in order to maximize the patient's comfort and symptom control during this period.

### **Priority 4**

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

6.15 The team must be receptive and respectful to the needs of the family and others identified as important to the dying person.

- 6.16 Carers needs should always be assessed.
- 6.17 It may not be possible to meet the needs of the family but staff can provide opportunities for open communications and respectful support.
- 6.18 Staff must recognise this is an emotive and challenging time for the family, offer appropriate support throughout this time of the patient's life.
- 6.19 Ensure where possible that the family and carers have privacy for reflection and any expressed emotion, in a quiet space or room.
- 6.20 Allow the family access to stay with the patient should they wish to and say their final goodbyes when the time comes.

### **Priority 5**

**An individual plan of care, which includes food and drink, symptoms and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.**

- 6.20 The dying person's preferences, expectations, needs and wishes must be assessed and used to formulate a holistic, compassionate patient centred plan of care. This must be done in collaboration with the patient, their family and those who are important to them together with the palliative care team the nurses, medics and any support teams that are involved. The team may include the: Palliative Care Team, District Nurses, Chaplaincy, Physiotherapists, Pharmacists, Dietitians, Legal Team and GP's, etc. This will ensure that all the essential teams, supplies, key tools and measures are anticipated and in place for the delivery of optimal care at this time of the patient's life.
- 6.21 In the last days of a patient's life, the patient centred care plan must ensure that the patient's comfort takes precedence over nursing/clinical procedures to ensure a dignified end to life. In addition to the person's physical, emotional, psychological, cultural, social, spiritual, and religious needs the care plan must include:
  - **Symptom Control:**  
 There needs to be ongoing holistic assessment by the medical, pharmacological and nursing teams during the patient's decline to ensure that the patient consistently receives an effective and responsive care approach that is tailored to the patient's changing needs and the plan of care adjusted accordingly.  
 The patient may need to be referred to specialist palliative care teams for effective complex symptom control and family/carer support.  
 If an inpatient the patient will need to be referred to the district nurses for any administration of medication that requires a syringe driver in conjunction with pharmacy.  
 The patient may need to be referred to the Dietetics team.  
 The clinical staff may need to arrange for the delivery of any anticipatory medication prescribed for keeping the patient comfortable in the last days of life.  
  
[www.nice.org.uk](http://www.nice.org.uk)  
 (Care of dying adults in the last days of life NG 16<sup>th</sup> December 2015)  
 (Care of dying adults in the last days of life Quality Standard 144 2<sup>nd</sup> March 2017)
  - **Nutrition and Hydration Intake**  
 The aim of nutrition care must be patient centred which includes to monitor, reassess and encourage the nutrition and hydration needs of the patient ensuring the patient's comfort throughout the last days of life and maximise their quality of life.

The care plan should specify how the person will be supported to eat and drink for as long as it is safe to do so or for as long as the patient wishes to continue. On inpatient wards, nurses may monitor the nutritional and fluid status of the patient using diet and fluid charts and report any issues throughout this period of the patient's life. The nurses can refer to the Dietetics or SLT Team for support as required. Refer to Oral feeding difficulties and dilemmas 'A guide to practical care, particularly towards the end of life' (The Royal College of Physicians 2010).

- **Mouth Care**  
There will come a time when food and drink is no longer needed. The team must ensure that the patient receives excellent mouth care to ensure the patient's comfort through this transition time. (Please refer to supporting SOP Use of oral swabs with foam heads for mouth care of unconscious patient)
- **Comfort and Dignity**  
There must be an ongoing assessment and review regarding the patient's personal comfort throughout the person's decline. Assessments must be made to establish if the patient would benefit from specialised equipment which if required must be sourced in advance.
- **Spiritual and Religious Care**  
The Religious and spiritual needs of the dying patient must be assessed and access to the Chaplaincy service enabled for the patient as required.
- **End of Life Care Plan Record** can be assessed on EMIS or booklet form.

6.22 Ensure that documentation and key information is kept up to date and clearly communicated in a timely manner.

6.23 Good end of life care does not end at death, please refer to Policy No. SD02 Death of a Service User for care after death has occurred.

## **7. CONSULTATION**

7.1 The following staff were consulted in the development of this policy:

- a) Medical staff;
- b) Nursing staff;
- c) Divisional Directors, Service Leads and Modern Matrons.

## **8. TRAINING AND SUPPORT**

8.1 Training will be delivered to staff in line with this policy and through consultation with specialist clinicians within the divisions.

- 8.2 Training will be delivered according to the outcomes focused aim and objectives within this policy.
- 8.3 All training will be quality assured and evaluated to evidence continual improvement as part of the educational governance process within the Learning and Development Plan and policy.

## **9. MONITORING**

- 9.1 The standards in this policy will be monitored at the Trust's End of Life Care Group.
- 9.2 The application of this policy will also be subject to monitoring by the Trust's End of Life Care Group through consideration of themes arising from the analysis and mortality reviews of Datix reports generated on the death of a patient.

10. EQUALITY AND HUMAN RIGHTS ANALYSIS

# Equality and Human Rights Analysis

<b>Title:</b> End of Life Care
<b>Area covered:</b> Inpatient Areas

<p><b>What are the intended outcomes of this work?</b></p> <p><b>This is a review of the policy that has been slightly amended to include an appendix (End of Life Guidance for Nurses).</b></p> <p>In line with the 'One Chance to get it Right' document. This policy establishes the trust wide minimum standards for the evidenced based guidelines for the holistic care of a patient who may be approaching the last few days of life in accordance to the One Chance to get it Right document (2014).</p>
<p><b>Who will be affected?</b></p> <p>Patients who require end of life care in our inpatient services.</p>

<b>Evidence</b>	
<b>What evidence have you considered?</b>	The policy.
<b>Disability (including learning disability)</b>	No issues identified on discussion.
<b>Sex</b>	No issues identified on discussion.
<b>Race</b>	No issues identified on discussion.
<b>Age</b>	No issues identified on discussion.
<b>Gender reassignment (including transgender)</b>	No issues identified on discussion.
<b>Sexual orientation</b>	No issues identified on discussion.
<b>Religion or belief</b>	Spiritual and Religious Care. The religious and spiritual needs of the dying patient must be assessed and access to the Chaplaincy service enabled for the patient as required.
<b>Pregnancy and maternity</b>	No issues identified on discussion
<b>Carers</b>	To ensure that the patient and / their family and/ those who are important to them are involved in the patient's care provision as appropriate.
<b>Other identified groups</b>	No issues identified on discussion.
<b>Cross Cutting</b>	Where the dying person lacks capacity, the staff must continue to attempt to involve the patient at all levels of care when Best Interests action is undertaken.

<b>Human Rights</b>	<b>Is there an impact? How this right could be protected?</b>
<b>Right to life (Article 2)</b>	<p><b>Human Rights based approach supported.</b></p> <p>In line with the 'One Chance to get it Right' document. This policy establishes the trust wide minimum standards for the evidenced based guidelines for the holistic care of a patient who may be approaching the last few days of life in accordance to the 'One Chance to get it Right' document.</p> <p>The following added under End of life guidance for nurses.</p> <ol style="list-style-type: none"> <li>1. Following assessment and agreement the decision that patient is dying must be a MDT decision between a GP (for out of hours a GP working for the out of hours service) and the District Nurse (either by telephone or face to face).</li> </ol> <p>This ensures assurances about when a patient is dying there will need to multi team agreement. This will also ensure that those making the decision are part of a team and as such the responsibility is not focused upon one person.</p>
<b>Right of freedom from inhuman and degrading treatment (Article 3)</b>	<p><b>Human Right based approach supported.</b></p> <p>Where it has been recognised that a person may be entering the last few days of life, their condition must be consistently monitored and assessed as to whether the condition is potentially reversible.</p> <p>If it is decided that the person is entering their last days of life, the Doctor must communicate the prognosis in a clear and sensitive way to the patient, their family or people who are important to them. During this meeting the doctor may need to provide time for any queries that arise and sensitively establish where the patient would like to be during this part of their life.</p> <p>Dignity</p> <p>The guidance ensures that a patient's dignity is promoted at all stages in the end of life care.</p>
<b>Right to liberty (Article 5)</b>	<p><b>Human Rights Based Approach Supported</b></p> <p>If the patient is detained under the Mental Health Act or Deprivation Of Liberty Safeguard (DoLS). The doctor (RC) must consider whether it is appropriate to continue with the detention or decide if the order could be revoked - Seek advice from the legal team.</p>

<p><b>Right to a fair trial (Article 6)</b></p>	<p>Human Right Based Approach Supported</p> <p>When devising a plan of care the team must establish if the patient has:-</p> <ol style="list-style-type: none"> <li>1. The mental capacity to make an informed choice about her/his end of life pathway.</li> <li>2. If it is thought that the patient Either does not OR may not have the capacity to make such an informed choice, a Mental Capacity Act compliant capacity assessment must be completed.</li> </ol> <p>Where it is established that the patient does NOT have the mental capacity to make such a decision, a Best Interests checklist assessment must be completed. This will include checking for: An advanced decision to refuse treatment (note: Ordinarily such decisions may be verbal or written. However, if the decision is to refuse life-saving treatment it must be written, witnessed, signed by the patient and include a statement acknowledging that to refuse the treatment may result in her/his death).</p> <p>A Health and Welfare Lasting Power of Attorney (LPA) authorised to make treatment decisions on behalf of the patient – A Court Appointed Deputy decision authorised to make treatment decisions on behalf of the patient – Any specific Court of Protection treatment decision. In most cases decisions taken by the above are legally binding. If in doubt contact the Trust's Legal Team.</p>
<p><b>Right to private and family life (Article 8)</b></p>	<p>Human Rights Based Approach Supported</p> <p>If the patient, their family or the people who are important to them decide that they would like to die in an inpatient setting then a holistic care plan will be devised. If not, then the team needs to make the necessary arrangements on behalf of the patient to assist transfer to the site where the patient has chosen to spend this part of their life.</p>
<p><b>Right of freedom of religion or belief (Article 9)</b></p>	<p>Not Engaged</p>
<p><b>Right to freedom of expression</b>  <b>Note: this does not include insulting language such as racism (Article 10)</b></p>	<p>Not Engaged</p>
<p><b>Right freedom from discrimination (Article 14)</b></p>	<p>Not Engaged</p>

## Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.*

The following staff were consulted in the development of this policy:

Medical staff

Nursing staff

Divisional Directors, Service Leads and Modern Matrons.

## Summary of Analysis

### Eliminate discrimination, harassment and victimisation

This policy is about end of life care for inpatients. Processes in place to reduce the impact/ possibility of discrimination.

The process for the patients who require end of life care takes into account a wide range of issues:

- Dignity
- Capacity to make decisions
- Wishes of the family
- Principles of the Mental Health/Capacity Acts
- Human Rights
- Religious and spiritual needs.

### Advance equality of opportunity

N/A

### Promote good relations between groups

N/A

## What is the overall impact?

Impact should be positive.

## Addressing the impact on equalities

N/A

## Action planning for improvement

N/A

## For the record

**Name of persons who carried out this assessment:**

**Joanna Morgan Physical Health Nurse**

**George Sullivan Equality and Human Rights Advisor**

**Reviewed by above**

**Date assessment completed:**

19th August 2016.

Reviewed 11 August 2017



**Name of responsible Director: Executive Director of Nursing**  
Ray Walker

**Date assessment was signed:**

August 2016

# Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
<b>Monitoring</b>	<p>The standards in this policy will be monitored at the Trust's End of Life Care Group.</p> <p>The application of this policy will also be subject to monitoring by the Trust's Mortality Review Group through consideration of themes arising from the analysis and mortality reviews of Datix reports generated on the death of a patient.</p>		
<b>Engagement</b>	<p>Policy to be placed on the Trust website along with this equality and human rights analysis.</p>		
<b>Increasing accessibility</b>	<p>This document can be made available in a range of alternative formats including various languages, large print and braille, etc.</p>		

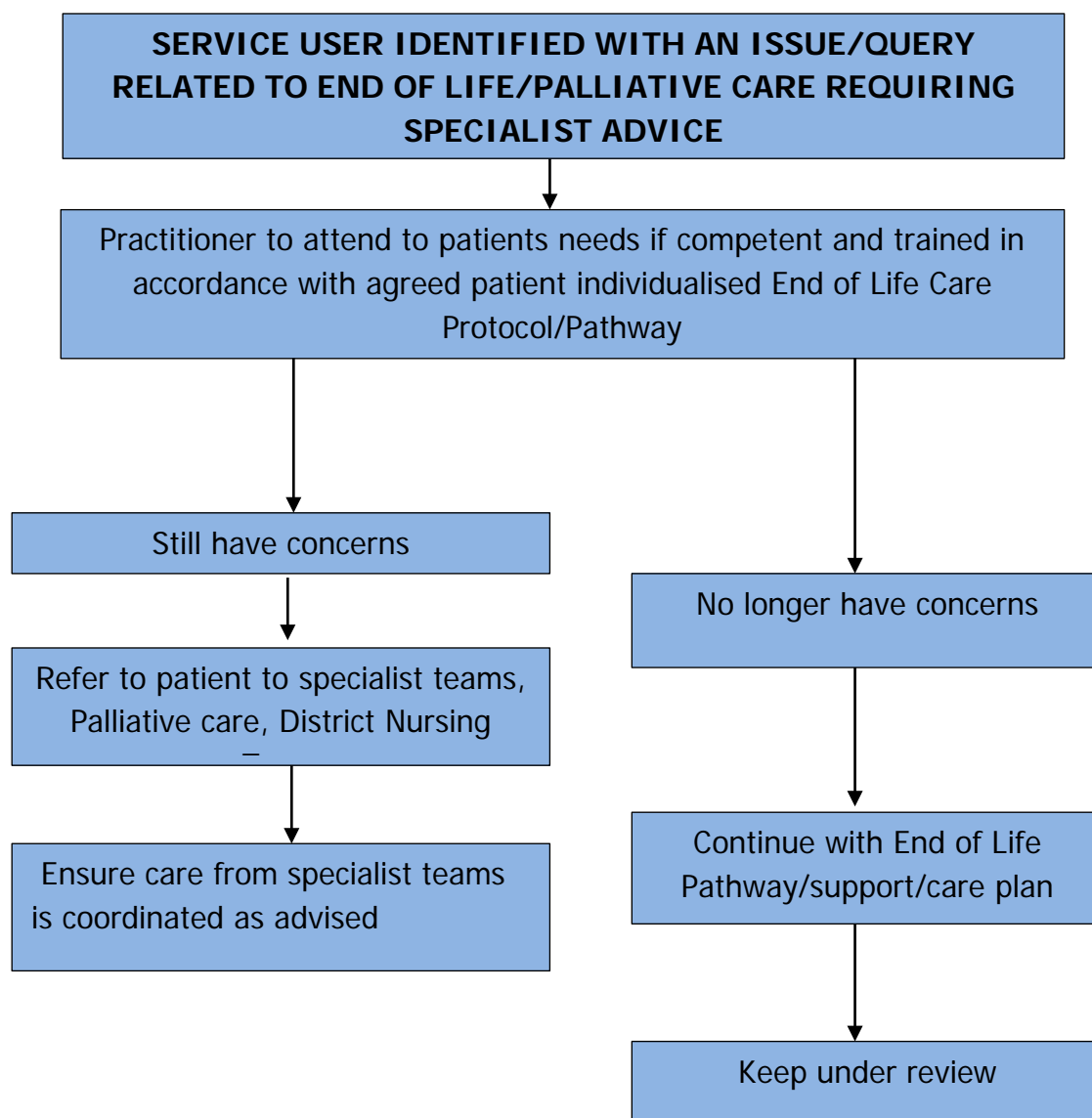
## 11. SUPPORTING DOCUMENTS

1. Avon and Wiltshire NHS Trust (2015) End of Life Care Policy, Version 3.0
2. Human Right Act 1988
3. Leadership Alliance for the Care of Dying People (2014): One chance to get it right
4. Mental Capacity Act (MCA) 2005 (amendments 2007)
5. National Institute for Health and Care Excellence (2015) NG31 Care of Dying in the last days of life NICE
6. National Palliative and End of Life Care Partnership, Ambitions for Palliative and End of Life Care : A national framework for local action 2015-2020
7. NICE (2015) Guidelines Care of dying adults in the last days of life (2015)
8. NICE (2019) End of Life Care for Adults: Service delivery. (2019)
9. Oral Feeding difficulties and dilemmas 'A guide to practical care, particularly towards the end of life' (The Royal College of Physicians 2010)
10. Royal College of Physicians (2018) Talking about Death: How to begin honest conversations about what lies ahead
11. Somerset Partnership NHS Foundation Trust End of Life Care
12. The Mental Health Act (1983)

**Appendix 1**

**End of Life Patient Referral Signposting Pathway**

**Patient referral signposting / pathway – End of Life**



**Please remember to complete Patient Documentation.**

**If you are worried about a patient's immediate safety you should call 999**

<b>Standard Operating Procedures (SOP) for:</b>			
<b>Use of oral swabs with foam heads for mouth care of the unconscious patient.</b>			
<b>Replaces:</b>	<b>Version 1</b>		
<b>SOP Number:</b>	<b>1</b>	<b>Version Number:</b>	<b>2</b>
<b>Effective Date:</b>	<b>October 2019</b>	<b>Review Date:</b>	<b>October 2020</b>

<b>Date Impact Assessment Undertaken</b>	<b>N/A</b>
<b>Author:</b>	<b>Specialist Palliative Care Team</b>
<b>In Conjunction with:</b>	

<b>Authorisation:</b>	
<b>Name / Position</b>	
<b>Signature</b>	
<b>Date</b>	

<b>Purpose and Objective:</b>
To ensure the safe use of foam oral swabs for unconscious patients requiring assistance with mouth care

### **Background:**

Unconscious patients in the last few days of life are unable to take fluids or maintain their own oral hygiene. When this point is reached it becomes the nurse's responsibility to undertake oral hygiene and also to potentially delegate this to members of the patient's family. Mouth care can easily be carried out by the family, giving them greater involvement and empowering them in the care of their dying relative.

A dry mouth is a common symptom for people who are dying and it can be distressing for both the patient and the family. Dry mouth at the end of life can be due to multiple causes including lack of oral intake, dehydration, medications, oxygen therapy, mouth breathing and head and neck cancers.

Following a Medicines and Healthcare products Regulatory Agency (MHRA) alert in 2012 the use of foam oral swabs was stopped in the trust. This alert was issued following a patient's death due to a foam head of an oral swab detaching whilst mouth care was being undertaken.

However in line with current National Institute for Health and Care Excellence (NICE) guidance about oral care for palliative patients these devices remain in use for the unconscious patient. Their safe use, however, must be ensured and this SOP outlines safety requirements below.

Sponge sticks are not recommended by NICE for the conscious patient. A water spray, dropper or ice chips are recommended for the patient who is still conscious.

Other oral swabs available, such as Lemon and Glycerin are known to dehydrate the mucosa leading to an increased dry mouth. Therefore the use of oral swabs with foam heads remains our primary choice in providing effective mouth care for the unconscious patient at end of life (NICE 2018).

### **Procedure:**

Carry out mouth care as often as necessary to maintain a moist, clean mouth:

- Ensure that oral hygiene is offered at each visit using oral sponge with foam head.
- Ensure that family are aware that this should be done on an hourly basis in the nurses' absence (NICE 2018).

### **To ensure safe use of the oral swabs:**

- Follow the manufacturer's instructions for use (if available).
- Check that the foam head is firmly attached to the stick before use.
- Do not leave the swabs soaking in liquid prior to use as this may affect the strength of the foam head attachment. Only moisten the foam swabs immediately before use.
- Discard oral swabs after single use.

Ensure that this information has been disseminated and understood by both formal and informal carers.

### **Responsibilities:**

The SOP applies to all registered nurses working with Mersey care NHS Trust.

It is the responsibility of the District Nursing Team Leader to ensure that all staff are aware of the SOP.

It is the responsibility of the assessing nurse to ensure that the correct procedure for the use of oral hygiene sponges is used and that the appropriate advice is being given to family members.

Ensure any incidents are reported via Datix.

Oral Swabs with a foam head are to be ordered by each team via Oracle.

### **References:**

<https://www.gov.uk/drug-device-alerts/medical-device-alert-oral-swabs-with-a-foam-head-heads-may-detach-during-use>

<https://cks.nice.org.uk/palliative-care-oral>