SESLHD POLICY COVER SHEET

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KEY TERMS	End of life care, terminal care plan, palliative care
SUMMARY	To provide clinical guidance and a framework to ensure the best care for patients during the last 72 hours of life in the acute hospital environment.

Feedback about this document can be sent to seslhd-executiveservices@health.nsw.gov.au

1. POLICY STATEMENT

This policy outlines the requirements for all South Eastern Sydney Local Health District Medical, Nursing and Allied Health staff when providing end of life care to a patient when death is expected.

2. AIMS

The aim of the Terminal Care / End of Life Care Plan (TC/EOLCP) is to direct staff to provide comfort and maintain the person's dignity, as well as provide information and support for families. The TC/EOLCP is holistic: it alerts clinical staff not only to physical problems, but also to the emotional, social and spiritual needs of dying patients and those close to them. It also aims to ensure that unnecessary and possibly harmful tests and treatments are at least reconsidered, if not stopped.

The TC/EOLCP is for use in the last 72 hours of life. As dying can be difficult to diagnose, any patient placed on the TC/EOLCP must have reassessment of this plan every 72 hours. Indications of the terminal phase (i.e. recognition of the dying patient):

- Essentially bed bound
- Profoundly weak
- Difficulty swallowing medications
- Only able to take sips of fluid
- Decreasing / fluctuating levels of consciousness.

The following may also be present:

- Noisy, moist breathing
- Peripheral shutdown
- Decreased urine output
- Change in the breathing pattern.

Once placed on a TC/EOLCP, this document will replace the need for the clinical bedside handover sheet and will become the patient's nursing care plan.

It also aims to assist nursing staff in assessing physical signs and symptoms at the end of life and provides documentation of the next of kin / person to be contacted.

It is expected that any cause for concern about comfort of the patient, or about distress for family and carers, which cannot be addressed by applying the parameters of the TC/EOLCP, **MUST** be reported to the Specialist Palliative Care team. In turn all complex symptomatology, and psycho-social distress, should be co-managed between the direct Specialist Team and Palliative Care.

3. TARGET AUDIENCE

All medical, nursing and allied health staff who are caring for a dying patient.

4. RESPONSIBILITIES

4.1 All SESLHD staff providing care to the patient on a TC/EOLCP will act in accordance with this policy:

- Medical Staff
- Nursing Staff
- Allied Health Staff.

4.2 General Managers and Line Managers will:

Ensure facilities have systems in place guaranteeing all relevant staff are aware of this policy and are educated regarding the correct processes. Clinical Business Rules may be developed at a facility level if Terminal Care / End of Life Care Plans are localised at each site.

4.3 District Managers / Service Managers will:

Provide support to staff in the implementation of this policy as required.

4.4 Medical Staff will complete and sign the initial patient assessment (Part 1 and 2)

- The aim of part 2 is to ensure that the patient plan of care is clearly outlined and documented. For example, PACE criteria assessed and altered. PACE calls may still be clinically appropriate to maintain patient comfort and safety (e.g. patient falls or clinical emergencies such as seizures).
- Ensure the 'Not for Cardiopulmonary Resuscitation' (No CPR) from has been completed.
- Clinical decisions are at the discretion of the patient's primary consultant.
- The TC/EOLCP has been designed to be used in the last 72 hours of life. Every patient on the TC/EOLCP is required to be reviewed by medical staff every 24 hours and documented in the patients' medical record.
- Patients who go beyond the 72 hour timeframe **MUST** be reviewed by a Medical officer to reassess ongoing care requirements. This review must be documented in the medical record, as well as on the TC/EOLCP, by a registrar or above. Where multiple medical teams are involved the review should be documented by the primary medical team. This review should consider input from all specialties as well as nursing and allied health.
- If a patient is not reviewed at 72 hours by medical staff then nursing staff must escalate this to the Nurse Unit Manager (NUM) whose responsibility it is to make sure a review by medical staff does occur. The ongoing care requirements are to be discussed and decisions made ensuring input from the multidisciplinary team, family and if applicable legal guardians.

4.5 Nursing Staff will: Complete the physical assessment (Part 1)

- Nursing staff are responsible for the completion of the TC/EOLCP each shift. The TC/EOLCP is part of the clinical bedside handover process and therefore must be signed each shift
- Each domain is marked either "A" for achieved or "NA" for not achieved
- If a domain is marked as not achieved, documentation in the patient health care record must be made and details of what interventions were attended to try to achieve the domain

- Psychological Signs and Symptoms table (Appendix A) provides resources for staff to assist in the provision of patient care in the terminal phase of illness.

4.6 The Multidisciplinary Team will complete the Psychosocial Assessment

- The initial psychological assessment can be completed by any member of the multidisciplinary team.
- The psychological assessment incorporates the religious and cultural needs of the dying patient and their family.
- The psychosocial assessment also encourages an open and frank dialogue between the patients, carers and the health care team.

Where there is any disagreement between staff either medical or nursing regarding the use or content of a TC/EOLCP, this must be immediately addressed by the consultant medical officer with all relevant staff and teams.

5. DOCUMENTATION

- SESLHD Terminal Care Plan SES060.146
- NSW Health Resuscitation Plan – Adult SMR020.056
- NSW Health – Standard Adult General Observation Chart

6. REFERENCES

- NSW Ministry of Health Policy - PD2014_030 Using Resuscitation Plans in End of Life Decisions
- Therapeutic Guidelines: Palliative Care, Version 4, 2016 Therapeutic Guidelines Limited, Australia.
- NSW Ministry of Health (2011). Recognition and management of patients who are clinically deteriorating PD2011_077
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- Clark, K., Byfieldt, N., Green, M., Saul, P., Lack, J. and Philips, J. (2014). Dying in two acute hospitals: would usual care meet Australian national clinical standards?. *Aust. Health Review*.
- Virdun, C., Luckett, T., Davidson, P. and Phillips, J. (2015). Dying in the hospital setting: A systematic review of quantitative studies identifying the elements of end-of-life care that patients and their families rank as being most important. *Palliative Medicine*.

7. REVISION & APPROVAL HISTORY

Date	Revision No.	Author and Approval
March 2016	DRAFT	SESLHD Palliative Care Working Party
April 2016	DRAFT	Draft for Comment
May 2016	DRAFT	Further two week Draft for Comment period
June 2016	1	Endorsed by Executive Sponsor
July 2016	1	Approved by Clinical and Quality Council
July 2018	2	Major review approved by Executive Sponsor
August 2018	2	Processed by Executive Services prior to out of session submission to SESLHD Clinical and Quality Council – major review
August 2018	2	Endorsed by Clinical and Quality Council

Appendix A
Psychological Signs and Symptoms

Prior to completing the psychological assessment, if you do not feel you are the appropriate person to address the issues below, please discuss with the senior nurse on duty. The term 'family' incorporates any person significant to the patient.

Understanding the Prognosis

Expected Outcome:

Patient and their family understand the prognosis and the implications of the situation

Action:

Staff member is able to answer the patient's and/or family's questions regarding the patient's management in the terminal phase, or refers to the appropriate health care worker.
Ensure ongoing communication with the family regarding the patient's condition.
The family is involved in decision making.

Staff resource:

Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers - Communication Guidelines
To better support health professionals to have end of life conversations, the NSW Ministry of Health has developed the *Supporting Health professionals in Advance care Planning and End-of-life (SHAPE) Conversations* education framework. The framework was developed through an expert panel and broad consultation. It involves two complimentary elements:
• *SHAPE End of Life Conversations* eLearning, available to NSW Health staff via HETI Online
• Advanced skills workshops, which are targeted to health professionals who have end of life conversations with patients and their carers and families.
The package will be available through HETI in 2016.

Spiritual Support and Cultural Considerations

Expected Outcome:

The patient's spiritual and cultural needs are met.

Action:

Provide the opportunity for expression of beliefs, fears, hopes and worship.

Refer the patient to the appropriate pastoral care worker.

Staff resource:

Care of the Spirit

Care Search

Environment

Expected Outcome:

The patient's environment is private, and free from distraction and noise. An environment is provided where the patient's and the family's needs are met and dignity is maintained.

Action:

Encourage the family in caring activities for the patient as appropriate - individualised to the patient's wishes and culture. Discuss with the patient and family what environmental needs are required (e.g. single room if available, type of lighting, room temperature, favourite music, familiar scent, etc.).

If available, provide family access and ensure comfort (i.e. provide a place to sleep/rest).

Bereavement

Expected Outcome:

Bereavement support is provided to the family.

Action:

Refer to a social worker or bereavement counsellor / service as needed.

Staff resource:

Bereavement and Grief