End of Life Policy

Introduction

Quality Statement associated with this policy:

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes will commit to the following quality statement for End of Life Care.

Elizabeth Finn Homes aims to provide all residents with a symptom free, dignified death, supporting the resident, relatives and friends.

End of life and palliative care is support for people who are in the last months or years of their life.

Scope

This policy fully reflects the current guidance issued by NICE and the Leadership Alliance for the Care of Dying People 5 priorities of care which are:

- Recognise - 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, these are reviewed regularly and decisions revised accordingly.

- Communicate - Clear and sensitive communication needs to take place between staff and the person who is dying and those identified as important to them. This includes identifying the extent of the person’s need for information and allowing them to decline discussions regarding the possibility that they may be dying.

- 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 wishes.

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

- Plan & Do - An individual plan of care is agreed, coordinated and delivered with compassion. (Including: food and drink, symptom control, psychological, social and spiritual support).

This policy uses the following definition of people approaching the end of life from the General Medical Council's guidance on treatment and care towards the end of life (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life): People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions

- General frailty and coexisting 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.
- This policy and procedure are provided for the regulated activity of accommodation for people with personal care and nursing.

Equality Statement

Elizabeth Finn Homes is committed to equal rights and the promotion of choice, person centred care and independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Key Points

This document contains the required standards for end-of-life care and links to the advanced directives.

Death and dying practices aligned to faiths and religions are included.

- Staff will be trained in end of life care including communication, maintaining comfort & wellbeing, and raising concerns.
- The organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan, including wishes after death, and to ensure effective multidisciplinary team communication and service delivery.
- We will continuously review health and care needs, and update care plans (increasing in frequency the nearer end of life).
- The End of Life Champion supports staff and residents with information and support for end of life planning.
- Staff will be rostered in line with commissioned contract and resident needs.
- Advanced care planning is important to ensure that the residents wishes are recorded and met at the end of life when they may not be able to communicate their needs.
- The organisation will follow processes to take into account the views of carers and other people important to the person if the person approaching the end of their life lacks capacity to make decisions in line with the Mental Capacity Act 2005.

Policy Statement

The guidance provides specific, concise quality statements, measures, and audience descriptors to provide social care professionals and service providers with definitions of high-quality of end-of-life care. This policy should be read in conjunction with the Equality & Diversity Policy and the Dignity & Respect Policy.

The organisation undertakes regular reviews of residents and their changing needs, which supports identifying people with health concerns and escalating them to their GPs and other healthcare professionals.

Working in a multidisciplinary team with the GP and other healthcare professionals, the organisation will identify residents changing needs including health concerns. Health concerns will include identification of terminal illnesses, and by continuously monitoring resident changing needs and escalating these to healthcare professionals, staff will help identify residents approaching end of life in a timely way.

By working with the resident, their family and healthcare professionals we will develop end of life holistic care plans to meet the needs of the individual.

As much information as possible is gained following admission to the service during the initial assessment process to ensure that, when the death of an individual occurs, the relatives are aware of the individual's end of life preferences, any advanced planning they wish is in place and what their after-death requirements are.

The Policy

At Elizabeth Finn Homes, we seek to adhere to the following statements and, through assessment and planning, provide effective and caring end of life care for our residents. We work closely with healthcare professionals such as Cancer Care nurses, Macmillan nurses and GPs to ensure the best possible outcome for the individual.

The following list of statements is taken from the NICE guidelines and reflects the 5 priorities of care:

Statement 1. People approaching the end of life are identified in a timely way.

The organisation will achieve this through:

- Completion of My Wishes for the Future Care Plan.
- Escalation of concerns - staff are trained to identify and raise concerns about resident changing health and social care needs to healthcare professionals e.g. GP.
- Identifying changing needs - as needs change risk assessments, care assessments and care and health plans are updated e.g. Advanced Care Planning.
- Monthly care plan reviews – including residents risk assessments, care and health needs, medication plans, falls risk and any other documentation related to the direct care of the resident.

Statement 2. People approaching the end of life, and their families and carers, are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.

The organisation will achieve this through:

- Registered Manager – the Registered Manager will identify training, support and best practice for provision of end of life care. This will include working with the End of Life Champion to identify care pathways which meet best practice guidance including:
    - End of life care for adults: service delivery (NG142)
    - Care of dying adults in the last days of life (NG31) and covers care of adults in their last 2 or 3 days of life
- End of Life Champion – the organisation employs an end of life champion who supports staff and residents with information and support for end of life planning.
- Third sector information and signposting – the end of life champion works with the Registered Manager to develop relationships, information cache, and referral routes to third sector organisations who provide specialist information and support e.g. Alzheimer's Society.
- Staff will be trained in end of life care including:
    - Leadership Alliance for the Care of Dying People 5 priorities of care, which are:
        - Recognise
        - Communicate
        - Involve
        - Support
        - Plan & Do
    - Common Core Principles and competences for social care and health workers working with adults at the end of life (skill for care)
        - Communication skills
        - Assessment and care planning
        - Symptom management, maintaining comfort and wellbeing
        - Advance care planning
    - Equality and Diversity
    - Dignity and Respect
    - Communicating and sharing information between services
    - Providing individualised care
    - Maintaining hydration
    - Raising concerns and responding quickly e.g. managing pain

Statement 3. People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

The organisation will achieve this through:

Holistic needs assessment – the organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan. This will include resident needs and requirements including:

- Spiritual and religious
- Cultural and ethnic background
- Health
- Social care
- Family involvement and support

Advanced care planning, including:

- The individual's concerns and wishes
- Their important values or personal goals for care
- Their understanding about their illness and prognosis
- Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.
- Wishes after death

The organisation will develop processes to take into account the views of carers and other people important to the person if the person approaching the end of their life lacks capacity to make decisions in line with the Mental Capacity Act 2005

Statement 4. People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.

The organisation will achieve this through:

- Holistic needs assessment and care planning.
- Advanced care planning.
- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs
    - Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

Statement 5. People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences and maximises independence and social participation for as long as possible.

The organisation will achieve this through:

- Holistic needs assessment – the organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan. This will include resident needs and requirements including:
    - Spiritual and religious
    - Cultural and ethnic background
    - Health
    - Social care
    - Family involvement and support
    - Advanced care planning, including:
        - The individual's concerns and wishes
        - Their important values or personal goals for care
        - Their understanding about their illness and prognosis
        - Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.
    - Wishes after death
- End of Life Champion providing signposting to third sector information.
- Staff will be trained in end of life care.
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

Statement 6. People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

The organisation will achieve this through:

- Holistic needs assessment – the organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan. This will include resident needs and requirements including:
    - Spiritual, cultural and religious
    - Health
    - Social care
    - Family involvement and support
    - Advanced care planning, including:
        - The individual's concerns and wishes
        - Their important values or personal goals for care
        - Their understanding about their illness and prognosis
        - Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.
    - Wishes after death
- End of Life Champion providing signposting to third sector information and religious groups to support the residents spiritual needs.

Statement 7. Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

The organisation will achieve this through understanding and responding to family and carer needs including:

- The development of relationships with families and carers to build rapport and gain insight into their needs, stressors and wishes.
- Support from the End of Life Champion to signpost family and carers to support, including health and local authority services.
- The provision of third sector information and signposting for families and carers.

- Staff will be trained in end of life to ensure they are able to have informed conversations with families and carers.
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life). This will include support for family and carers.
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

Statement 8. People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

The organisation will achieve this through:

- Holistic needs assessment and care planning.
- Advanced care planning.
- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs
    - Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

Statement 9. People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.

The organisation will achieve this through:

- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
- Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses.
- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

Statement 10. People approaching the end of life who may benefit from specialist palliative care are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

The organisation will achieve this through:

- Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses.
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).

- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

Statement 11. This statement has been removed and replaced by Care of dying adults in the last days of life Quality standard (QS144)

QS144: Statement 1

Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering.

The organisation will achieve this through:

- Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses.
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs
- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.

QS144: Statement 2

Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan.

The organisation will achieve this through:

- Holistic End of Life Care Plan – the organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan. This will include resident needs and requirements including:
    - Spiritual, cultural and religious
    - Family involvement and support
    - Advanced care planning, including:
        - The individual's concerns and wishes
        - Their important values or personal goals for the last days
    - Wishes after death
- End of Life Champion providing signposting to third sector information and religious groups to support the residents' and families spiritual needs.

QS144: Statement 3

Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.

QS144: Statement 4

Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options.

The organisation will achieve this through:

- Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses.
- Advanced care planning, including:
    - The individual's concerns and wishes
    - Their important values or personal goals for the last days
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs

Statement 12. The body of a person who has died is cared for in a culturally sensitive and dignified manner.

The organisation will achieve this through:

- Holistic needs assessment – the organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan. This will include resident needs and requirements including:
    - Spiritual and religious
    - Cultural and ethnic background
    - Health
    - Social care
    - Family involvement and support
    - Advanced care planning, including:
        - The individual's concerns and wishes
        - Their important values or personal goals for care
        - Their understanding about their illness and prognosis
        - Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.
- Wishes after death - the end of life plan will include details of the resident's requirements after death.

Statement 13. Families and carers of people who have died receive timely verification and certification of the death.

The organisation will achieve this through:

- Staff will follow the Death of a resident (Verification & Certification) Policy, including:
    - District Nurse will verify death if in attendance.
    - If no trained person in attendance:
        - Contact GP who will follow locally agreed Verification of Death Pathway e.g. GP or District Nurse visit to verify death or
        - GP may ask the care worker to assist them in verifying death remotely using the Guidance for Remote Verification of Expected Death (VoED) Out of Hospital protocol from the British Medical Association (BMA)
        - Care worker can decline if they do not feel confident or are not comfortable.

- If care worker is willing to support the GP, the GP will follow the protocol and then verify death.
- GP will be responsible for
  - Updating medical records
  - Notifying the resident's GP if they are not from their practice e.g. out of hours service
  - Death certification process
  - Informing coroner
  - Offering family bereavement support as per the BMA protocol.

Statement 14. People closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

The organisation will achieve this through:

- Signposting family and carers to their GP who will offer family bereavement support.
- In addition:
  - The End of Life Champion will signpost family and carers to additional support which may be available from health and local authority services.
  - As well as third sector information and referral to organisations who provide specialist information and support e.g. Alzheimer's Society.

Statement 15. Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and for their families and carers.

The organisation will achieve this through:

- Staff will be trained in end of life care including:
  - Leadership Alliance for the Care of Dying People 5 priorities of care which are:
    - Recognise
    - Communicate
    - Involve
    - Support
    - Plan & Do
  - Common Core Principles and competences for social care and health workers working with adults at the end of life (skill for care)
    - Communication skills
    - Assessment and care planning
    - Symptom management, maintaining comfort and wellbeing
    - Advance care planning
  - Equality and Diversity
  - Dignity and Respect
  - Communicating and sharing information between services
  - Providing individualised care
  - Maintaining hydration
  - Raising concerns and responding quickly e.g. managing pain

Statement 16. Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in both number and in the mix of skills to provide high-quality care and support.

The organisation will achieve this through:

- Working with resident, family, health professionals and third sector organisations involved in their care and support to ensure effective multidisciplinary team communication and service delivery.
- Continuous review of health and care needs, and updates to care plans (increasing in frequency the nearer end of life).
    - Urgent contacts, and escalation of changing needs/concerns, for GP and Specialist Cancer Nurses e.g. Macmillan Nurses
- Staff rostered in line with commissioned contract and resident needs, including:
    - Sleeping and/or waking nights
    - 24 hour care
    - Training and skills mix
    - Care and medication planning e.g. Controlled Drugs
- Holistic needs assessment – the organisation will work with the resident, family members, healthcare professionals and relevant agencies to develop the holistic End of Life Plan. This will include resident needs and requirements including:
    - Spiritual and religious
    - Cultural and ethnic background
    - Health
    - Social care
    - Family involvement and support
    - Advanced Care planning, including:
        - The individual's concerns and wishes
        - Their important values or personal goals for care
        - Their understanding about their illness and prognosis
        - Their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.
    - Wishes after death
- End of Life Champion – the organisation employs an end of life champion who supports staff and residents with information and support for end of life planning.
- Staff will be trained in end of life care including:
    - Leadership Alliance for the Care of Dying People 5 priorities of care which are:
        - Recognise
        - Communicate
        - Involve
        - Support
        - Plan & Do
    - Common Core Principles and competences for social care and health workers working with adults at the end of life (skill for care)
        - Communication skills
        - Assessment and care planning
        - Symptom management, maintaining comfort and wellbeing
        - Advance care planning
    - Equality and Diversity
    - Dignity and Respect
    - Communicating and sharing information between services
    - Providing individualised care
    - Maintaining hydration
    - Raising concerns and responding quickly e.g. managing pain

Notification

Elizabeth Finn Homes will notify the Care Quality Commission (CQC) by email within 24 hours of the death of a resident in the care of the organisation, in line with the Care Quality Commission (Registration) Regulations 2009, Regulation 16.

Death of a resident

It is important that staff are aware of how, and when, to communicate with family in order to minimise distress and adhere to any cultural beliefs or preferences that the resident, their family, or power of attorney have expressed as part of their care and support plan. Resident preferences will have been discussed and recorded within the End of Life Plan and these must be adhered to after their death, including:

- Staff must remember that confidentiality is still in place.
- The organisation will co-operate with partner agencies to ensure lawful requirements are met and will assist when directed by a lead agency.
- Sensitive and professional communication is in place, which promotes dignity and respect of the resident and their family.

Review following the death of a resident.

After a resident has died after having been cared for under an end of life plan of care, the End of Life Champion will review the practice and procedure followed with those involved (staff team, other professionals and relatives).

The purpose of the review is to:

- Assess the quality of communication between the staff and partner agencies.
- Ensure best/evidence-based practice was followed.
- Identify any areas of improvement and learning.
- Identify support for staff, including grief counselling.

A short, anonymised report will be written to identify any areas of improvement, actions to be taken and identify best practice to be shared with team members.

Reflection Following The Death Of A Resident

All homes are encouraged to reflect on each death. This provides staff with an opportunity for closure but also assists to facilitate learning from each situation.

References

See Equality & Diversity Policy

NICE Guidelines (NG31) published December 2017 Care of dying adults in the last days of life

NICE guidelines (NG142) October 2019 End of life care for adult's service delivery

NICE. End of life care for adult. Quality Standard (QS13) updated March 2017

Care of dying adults in the last days of life Quality standard (QS144)

Skills for Care - Common Core principles and Competences for social care and health workers working with adults at the end of life

One Chance to get it Right – Leadership Alliance for the Care of Dying People. (5 Priorities of Care)

NICE COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community

NEWS2 and deterioration in COVID-19

Guidance for Remote Verification of Expected Death (VoED) Out of Hospital protocol from the British Medical Association (BMA)

Coronavirus (COVID-19): verifying death in times of emergency

Review date	Next Review Date
February 2024	February 2027