

Study Session:

End Of Life Care in Homecare settings

Starting 1.30pm

Please tell us where
you are from

Join at [slido.com](https://www.slido.com)
#4794093



Welcome

Study Day: End of Life.

Date: 19 May 2025

This Session will begin shortly





Housekeeping



Please keep your mobiles on silent during the presentations



Exits



No planned fire drills



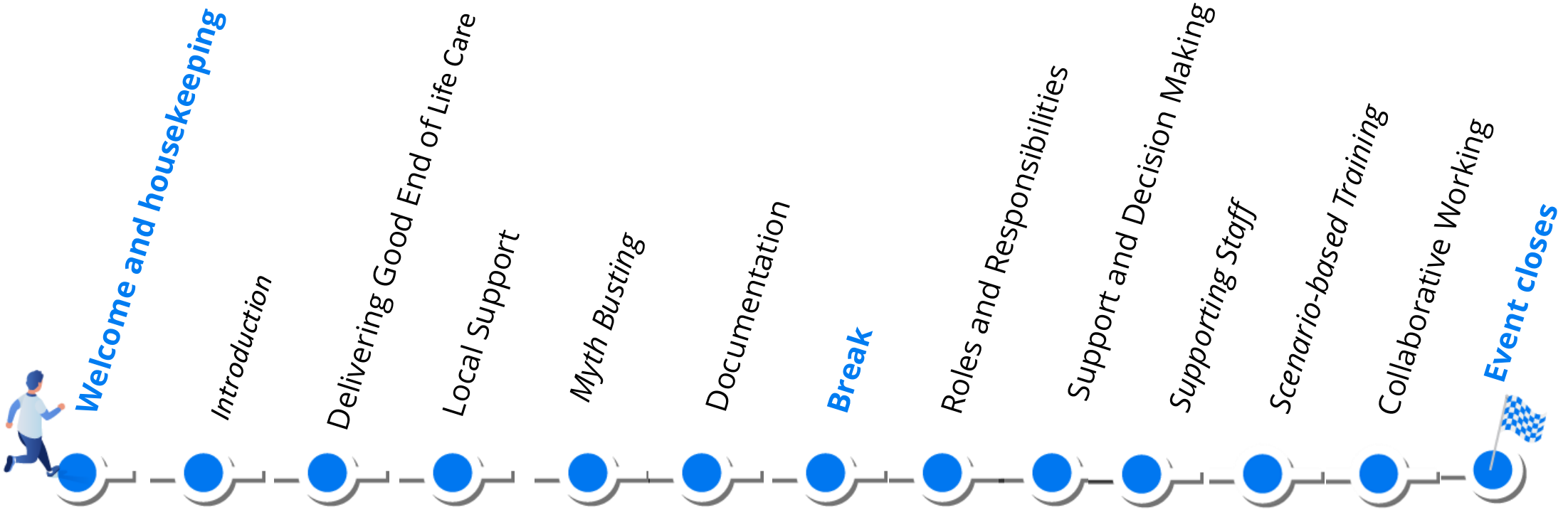
Comfort Break

Jessica Bentley

*Education, Quality and Integration
Development Manager*



Agenda



Use your table pack to capture notes and actions for the session



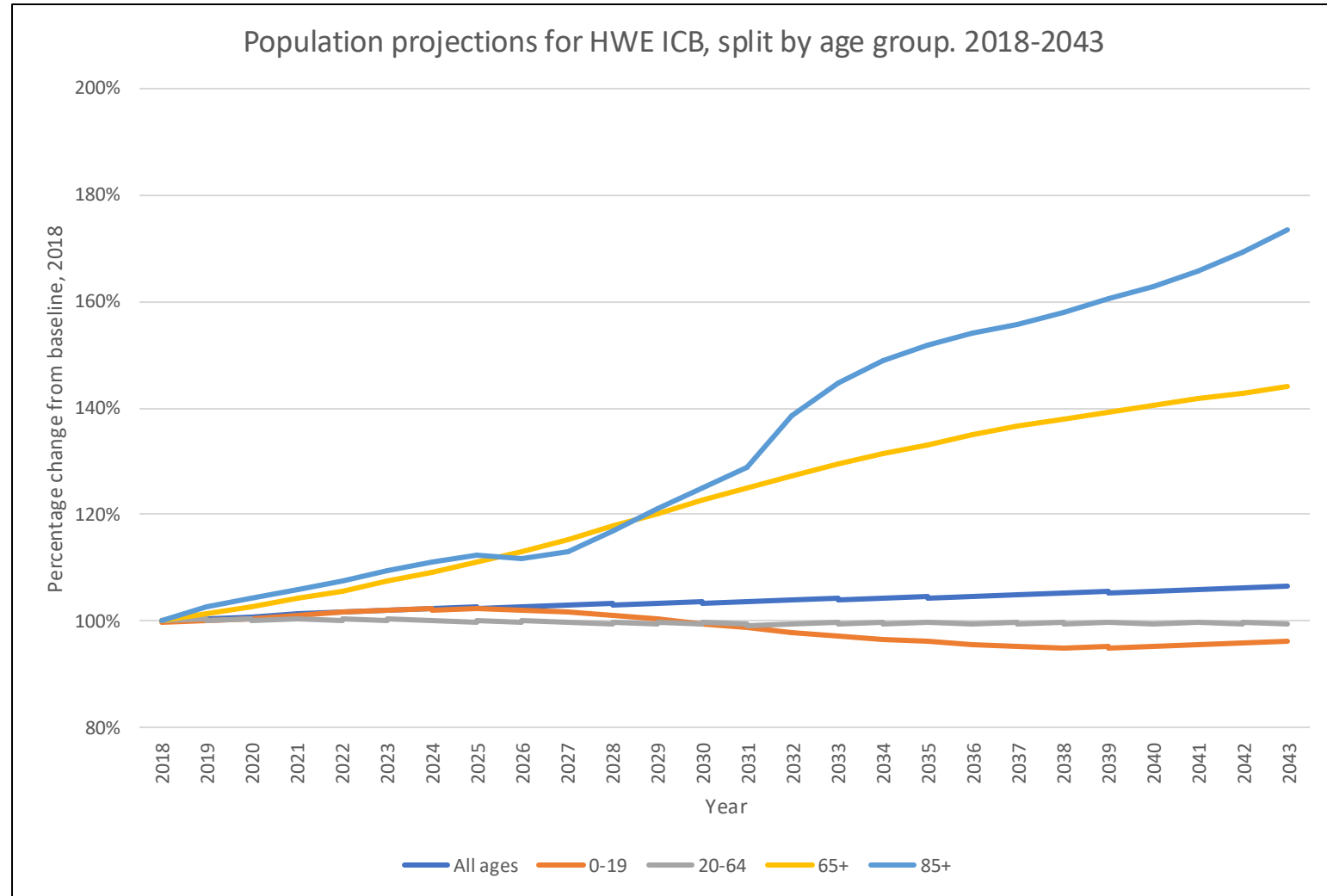
Compassionate and Effective
End of Life Care and Planning

is

“everyone’s
business”

Demographic Profile

- The total population of HWE ICB is expected to increase by 6% overall between 2018 and 2043.
- There are marked differences in expected changes in population across age bands.
- There will be limited growth (or reductions) in children and working age adults.
- There will be a 44% increase in over 65-year-olds between 2018 and 2043
- And a 73% increase in over 85-year-olds (associated with the increased birth rate following World War 2) between 2018 and 2043.



Hertfordshire and
West Essex Integrated
Care System



NEGATIVE IMPACTS

Individual wishes not followed and loss of dignity

Dying in non preferred place such as hospital

Staff not confident to manage care and support

Lack of accountability for conversations and planning

Unsure where to get support and default to 999 due to lack of response

Inconsistent family involvement – stress, confusion and frustration

Aims

Support care providers to ensure they are delivering compassionate and effective end-of-life care. Supporting staff ensures they can handle the emotional and practical challenges of end-of-life care.

Ensuring comfort, honouring the patient's wishes, providing emotional support, and knowing the right actions to take are crucial for the best care.

what

can

we do

?



Ice Breaker



Share your experience of supporting end of life care and what you hope to get out of today



Welcome



Dee Cooke - 01442869550
Clinical Advice - 01923 335356
Dee.Cooke@stfrancis.org.uk
education@stfrancis.org.uk

Leonie Lowrie - 07736976744
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Wendy.freeman@isabelhospice.org.uk
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Delivery- Good End of Life Care



Setting the scene

- 1% of the population will die each year
- 500,000 deaths in England each year
- 75% of these deaths are expected
- 30% of the hospital population are likely to be in their last year of life
- We only get “one chance to get it right”
- “How people die remains in the memory of those left behind”

What makes a good death?

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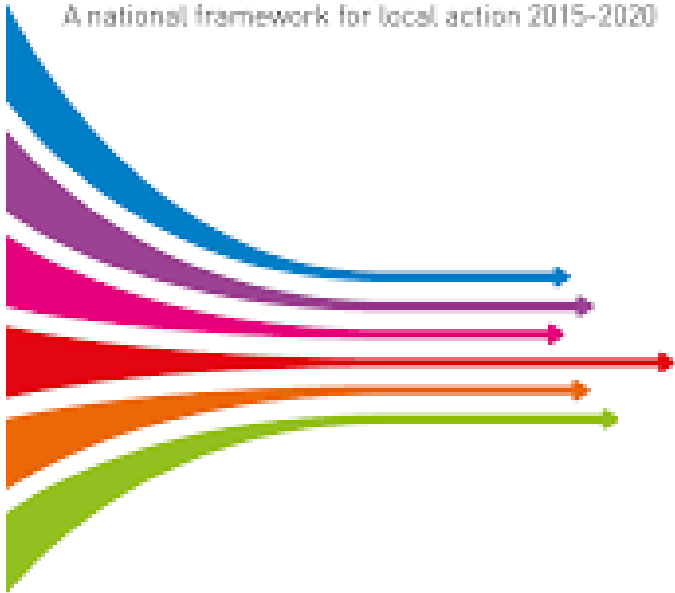


Considerations for Practice 1

- Can you/your staff recognise subtle signs of deterioration?
- Can you/they recognise signs of dying?
- When is an expected death unexpected?
- As a care provider do you act quickly enough? – including collaboration and asking for help
- Does each service user have a set of normal baseline recorded observations?
- Are you/your staff aware of the trajectories and the fine balance of deterioration?

Ambitions for Palliative and End of Life Care:

A national framework for local action 2015-2020



National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

Each person is seen as an individual

Each person gets fair access to care

Maximising comfort and wellbeing

Care is coordinated

All staff are prepared to care

Each community is prepared to help

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.

|

Support

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



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.

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, and these are regularly reviewed and decisions revised accordingly. Always consider reversible causes e.g. infection, dehydration, Hypercalcemia

Communicate

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

How can we facilitate a good death if we don't ask? – The individual.....

What matters to you to help you live well but also what would you want to die well?

If you could direct your healthcare for the future what would it look like?

Have you ever thought about what would happen if you couldn't tell us your wishes?

For me to be able to deliver the best care for you I need to know what you would and wouldn't want?

How can we facilitate a good death if we don't ask? - Ourselves.....

Have you considered the 'surprise question'?

What do we have in place to support the people in our care and their families?.

Who can we call early on to support us?

What training do my staff need to be able to do the best care at end of life?

Are we prepared for that "*rainy day thinking*" and manage it well instead of managing a crisis

Who else do we need to support and engage with

Living well with a life limiting illness

What is important to me re: spiritual/cultural beliefs.

How I would like to be presented to my visitors, what is important?

What gives me hope.....

What music I like....

What TV programme I like.....

How do I like to lie in bed when I sleep

How I like to be addressed.

What time do I like to go to bed or get up.

How would I like to be cared for

Dying well

Who would you like contacted in your final hours

Who would you like/not like with you

Any religious needs, such as seeing a priest or a prayer offered.

Cultural considerations at End of Life

Any personal requests such as music, flowers, pets on the bed.

Light left on and curtains open.

Someone sitting holding their hand.

Mouthcare with their favourite tipple.

A poem/prayer or story read

Favourite music playing

Fairy lights around the bed.

Advance Care Planning (rainy day thinking) Having the conversation



What people want

Things in order
Funeral plans
Letters
PPC/PPD
Symptom control
Complete bucket list
Right support around them

What people don't want

Resuscitation
Artificial hydration/
nutrition
IV antibiotics
Blood products
Hospital admissions

Who they want to speak on their behalf

Lasting power of attorney - health and finance

Dying for Beginners

WITH DR. KATHRYN MANNIX





Considerations for practice 2

- Have you an understanding of different cultures/faiths/spiritual needs for the service users wishes at end of life?
- Do you provide Namaste care Training?
- Do you have an End of life trolley with all items for facilitation of a good death experience for all?
- How do you communicate to the Team and people you support that someone has died?
- Do you use any signage for a door to respect privacy/Dignity and a peaceful environment?

Myth Busting

TRUE or FALSE

As a table come to a consensus

- DNACPR is legally binding.
- ReSPECT forms can be used for everyone.
- A pump delivering morphine means you are in the final hours of your life.
- Palliative Care means you are imminently dying.
- Does somebody at very end of life need to go into a Hospice or hospital.
- Your next of Kin can make decisions about your health when you are no longer able to.
- An ambulance crew can accept a photocopy of a ReSPECT form





Key End of Life care Documents

1. This plan belongs to:

Full name	
Date of birth	
Address	
NHS/CHI/Health and care number	
Preferred name	
Date completed	

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 Yes No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me Quality of life and comfort matters most to me

What I most value: What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	Balance extending life with comfort and valued outcomes	Prioritise comfort
clinician signature	clinician signature	clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended Adult or child	For modified CPR Child only, as detailed above	CPR attempts NOT recommended Adult or child
clinician signature	clinician signature	clinician signature

Version 3.0 © Resuscitation Council UK

5. Capacity for involvement in making this plan

Does the person have capacity to participate in making recommendations on this plan? Yes No

If no, in what way does this person lack capacity?

Document the full capacity assessment in the clinical record. If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

A This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.

B This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.

C This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):

1 They have sufficient maturity and understanding to participate in making this plan

2 They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.

3 Those holding parental responsibility have been fully involved in discussing and making this plan.

D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time

Senior responsible clinician:

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: <input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional
<input type="checkbox"/>			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: Name: DoB: ID number:

Version 3.0 © Resuscitation Council UK. Form used under a Creative Commons Attribution Non-Commercial-ShareAlike license. See http://respectprocess.org.uk for more information.

ReSPECT Forms/ DNACPR Forms

ReSPECT

- Not legally binding- but if completed would have to have a good reason not to follow their guidance
- ReSPECT forms should be completed now instead of a DNACPR form – but at present sit alongside the DNACPR forms in Hertfordshire



Legal Considerations...

- **Advance Decision to Refuse Treatment (ADRT) are generally legally binding**
- **Lasting power of attorney also legally binding**

Note:

- Need to see documentation
- Check validity
- Also- other documents might not be legally binding- but if they have been written with the patient or with the patient's best interest at heart, they should be taken into account and not disregarded
- If there is disagreement amongst families/ staff- should be addressed ahead of a crisis



Assisted dying

- Is not currently legal in this country
BUT
- If people talk about it- we should equip staff to explore hopes and fears without becoming defensive or steering away from the issue
- Staff should know who they can approach for support and what should be flagged up as a safeguarding concern





Coffee

Some Interesting Facts: Coffee break thought provokers

Frail elderly have a 1.8% chance of survival from a CPR attempt

We need to reduce unplanned admissions to hospital from care homes by 25%

One week in bed or on a stretcher = 10% loss of strength and independence.

People Aged over 80yrs is set to double in next 30-40yrs people living longer but living with 2 or more chronic conditions. (ageing.better.org.uk)

400,000 people living in care home settings in the UK. This equates to approx. 3 times the equivalent of UK Hospital beds (Skills for care 2023)

Many EOLC admissions from care homes into hospital can be prevented by the 999/111 service calling Hospice Advice Lines for support pre escalation.



Roles and Responsibilities



Who would be having these conversations in your team?

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CQC Standards....

Can you evidence that your EOLC care is:

Safe- that service users are protected from abuse and avoidable harm.

Effective- that the care, treatment and support you offer achieves good outcomes, helps maintain quality of life (and quality of death) and is based on the best available evidence.

Caring- that staff involve and treat service users with compassion, kindness, dignity and respect.

Responsive- That your services are organised so that they meet the needs of your service users

Well-led-that the organisation make sure it's providing high-quality care that's based around individual needs, encourages learning and innovation, and promotes an open and fair culture.

Safe	Effective	Caring	Responsive	Well-led
Capacity assessments	Individualised Care	Personalised care	Aware of individualised needs	Person- centred care
Risk management of food and drink	Responsive to changing needs	Dignity- avoid inappropriate resuscitation attempts	Aware of local support to help provide good care	Good leadership in a crisis
Clear process about administration of medicine	Staff have appropriate training	Flexible arrangements for families of those who are dying	Individualised advance care plans completed	Staff support and well being
Appropriate treatment plans	Good communication skills so families are on board and aware of deterioration	Identifying deterioration early and signposting	ReSPECT forms to guide decision making	Open to reflective practice and debriefs
	Plans in place for hospital avoidance at end of life		Knowledge of whom to call for early support	Palliative care for all that are eligible

Ethical Decision Making Tool

Actions	Responsibilities
1. Articulate the ethical problem(s) and identify the relevant facts	Be ethically sensitive and communicate clearly
2. Identify stakeholder's interests, needs and values	Be respectful and inclusive
3. Weigh the merits and demerits of available courses of action	Be informed and fair
4. Select the action which can best be supported by ethical principles	Be impartial and transparent
5. Review	Check: Have I been sensitive, clear, respectful, informed, fair, impartial and transparent?

Campbell and McCarthy (2016)

Good Example

1. This plan belongs to:

Date of birth: 05/05/1940
 Address: THE OLD NURSING HOME, 12 RUNAWAY ROAD, WELWYN GARDEN CITY, HERTS
 NHS/CHI/Health and care number: 246321RWHX

Preferred name: PAULA PATIENT
 Date completed: 13/5/24

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:
 PAULA IS 85 YRS OLD & HAS LIVED IN HER CARE HOME FOR 5 YRS NOW. DURING THIS TIME HER HEALTH HAS DETERIORATED WITH FREQUENT HOSPITAL ADMISSIONS. SHE SUFFERS WITH DEMENTIA / FRAILTY / HEART FAILURE & KIDNEY FAILURE

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):
 HAS ADVANCE CARE PLAN IN PLACE WITH WISHES + PREFERENCES IN THE HOME

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 Yes No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me Quality of life and comfort matters most to me

What I most value:
 PAULA VALUES HER QUALITY OF LIFE AS IT WAS BEFORE ALL HER HOSPITAL ADMISSIONS. SHE ENJOYS SINGING / ACTIVITIES / FOOD.

What I most fear / wish to avoid:
 PAULA FEARS MORE HOSPITAL ADMISSIONS & DYING IN PAIN. WANTS TO AVOID STAFF WHO DO NOT KNOW HER REQUIREMENTS

4. Clinical recommendations for emergency care and treatment

Prioritise extending life clinician signature	Balance extending life with comfort and valued outcomes clinician signature	Prioritise comfort clinician signature: DR FOSTER
--	--	--

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:
 PAULA RECOGNISES SHE MAY HAVE TO ATTEND HOSPITAL FOR UNWITNESSED FALLS, SEPSIS & FRACTURES SUSPECTED. SHE WOULD LIKE ALL OTHER TREATMENTS MANAGED IN CARE HOME IF POSSIBLE WITH HOSPITAL AT HOME SERVICES. ALL DISCUSSIONS AROUND ESCALATION INTO HOSPITAL NEED TO BE WITH CARE HOME STAFF WHO KNOW HER WELL OR HER FAMILY.

CPR attempts recommended Adult or child clinician signature	For modified CPR Child only, as detailed above clinician signature	CPR attempts NOT recommended Adult or child clinician signature: DR FOSTER
---	---	---

www.respectprocess.org.uk

1. This plan belongs to:

Preferred name **PAULA PATIENT**

Date completed

Date of birth **05/05/1940** **PAULA PATIENT**

Address **THE OLD NURSING HOME
12 RUNAWAY ROAD
WELWYN GARDEN CITY Herts**

NHS/CHI/Health and care number

246321 RWHX

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

FRAILTY

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8

Yes No

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me

Quality of life and comfort matters most to me

What I most value:

What I most fear / wish to avoid:

Not so Good Example

4. Clinical recommendations for emergency care and treatment

Prioritise extending life

Balance extending life with comfort and valued outcomes

Prioritise comfort

clinician signature

clinician signature

clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended
Adult or child

For modified CPR
Child only, as detailed above

CPR attempts **NOT** recommended
Adult or child

clinician signature

clinician signature

clinician signature
DR FOSTER

www.respectprocess.org.uk

Learning Disability Resources

www.hertfordshire.gov.uk

Search Learning Disabilities.

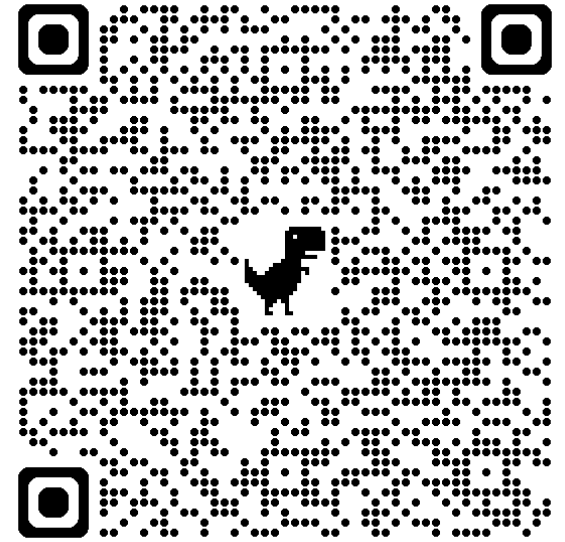
Look for resources.

Go to factsheets on this page search for ReSPECT

then chose ReSPECT forms completed

<https://www.hertfordshire.gov.uk/media-library/documents/adult-social-services/factsheets/easy-read/health/planning/planning-for-end-of-life-respect-plans-completed-examples.pdf>

HCPA are currently updating these resources in the HCPA Resource Library for ease of access





Considerations for Practice 3

- Where are you capturing peoples wishes?
 - Are you sharing this with other professionals?
 - Can you start the respect document?
 - What are your managerial responsibilities for auditing end of life care?
 - How do you record Power of Attorney? how and when to contact a service users 'family' in decision making
-



Support and Decision Making



Who do you call?

Join at
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Hertfordshire Care Provider Support Service Directory

HCPA Provider Hub

HCPA Members Zone

Download our Care Home Directory poster which displays key contact information for services [East & North](#) [South & West](#)



Below you can search our Support Services Directory by viewing all services, filtering by criteria, or searching for a keyword.

[View all services](#) ↓

[Filter By](#)



Search services

Search

[Support Service Directory - HCPA](#)

<p>S Describe Situation</p>	<ul style="list-style-type: none"> ➤ Who holds POA and their contact details...NOK contact details....
<p>B Provide Background</p>	<ul style="list-style-type: none"> ➤ The client has lived with us since (date of admission) ➤ They have been admitted to hospital ** times in the last 6 months ➤ In the last month the client has been admitted to hospital with**** /seen by the GP with**** ➤ They are also known to suffer from (outline all known medical problems in clients records with particular note of underlying heart problem, diabetes, respiratory problems, renal problems dementia) ➤ The clients' medication list includes..... ➤ In cases where the client does have a DNACPR/ACP/Respect please outline what this plan states
<p>A Provide client assessment</p>	<p>Summarize the facts and give your best assessment on what is happening:-</p> <ul style="list-style-type: none"> ➤ I think the current problem is *** OR I don't know what the problem is but the client is deteriorating ➤ The normal NEWS score when the client's well is *** the current NEWS score is *** ➤ The most recent weight is ***kg (weight on admission ***kg) ➤ The client is currently able/not able to eat & drink ➤ The client is currently able/not able to walk and the normal mobility is.....
<p>R Make Recommendation</p>	<ul style="list-style-type: none"> ➤ What actions are you asking for? (What do you want to happen next) 2 recommended outcomes are possible: ➤ Convey the person to hospital for further assessment. This decision will be based upon the premorbid functional/cognitive status, co-morbidities and the likelihood that hospital care will improve outcome (client will be a candidate for treatment which can't be delivered in the care home e.g. oxygen/intravenous treatment). ➤ Stabilise the person in the care home either with an agreed action plan and clear criteria indicating when a further referral is needed OR Palliate the person in the care home which may require an updated RESPECT form to be sent, End of Life medications prescribed (available locally) and a drug administration form sent to allow the community team to deliver medication.
<p>D Make decision</p>	<ul style="list-style-type: none"> ➤ What have has been agreed? ➤ Clearly document the agreed plan in the patients records

Supporting Staff



Retaining and Supporting Staff

“Staff wellbeing and satisfaction are affected by working conditions, including stress and anxiety.

Over the last two years, care staff have generally been more than twice as likely to record ‘anxiety/stress/depression’ as the cause of their sickness absence than any other reason.

Many adult social care services describe difficulties attracting new staff to roles to fill vacancies, citing low pay, high pressure, and staff burnout as key causes.”

So how can you support staff?

- Ensure staff receive **education and training** related to death and dying. Increased awareness about what to expect and how to communicate may reduce concerns and fears about caring for people who are dying
- Provide **resources** that are up to date and accessible
- Create a **culture of self-care** and resilience – staff meetings, reflection, work life balance
- **Lead by example.** Staff need to be able to talk openly about their feelings and emotions. Managers can support staff to do this in one-to-one meetings as well as group settings. This acknowledges the importance of staff to the care and confirms how important and valuable their contributions are to good care.
- Warming Up – Cooling Down



The question is not how to survive, but how to thrive with passion, compassion, humour and style.” ~Maya Angelou

After the death of a person you support

- Good practice lies in acknowledging staff may be affected by a death and need time to reflect on, and deal with feelings of bereavement.
- Recognise the loss of each person when they die – e.g. by placing flowers or a photograph of the person in an appropriate place at your service; by contributing to a ‘memory book’ dedicated to the person. Not only for staff but the people you support.
- Support the attendance of staff/people you support at the funeral/memorial service (subject to permission from the family).
- Ensure that there are procedures in place to inform off duty staff that a person they have been caring for has died.

After the death of a person you support

- Staff may have developed effective ways to deal with loss and grief that can be shared (formally and informally) with their colleagues. Staff can support each other by:
 - Recognising and acknowledging the loss and grief that a colleague may be experiencing.
 - Encouraging colleagues to share their concerns and feelings following the death of a person you support.

Care Professional Rewards



EAP Helpline – Employee Assist Programme

24/7/365 Confidential telephone helpline, Legal information services, Manager consultancy and support, Debt and financial information, Monthly well-being newsletter, Telephone advice relating to critical incidents, Online Health and Wellbeing Portal



Wellbeing Centre

Expert blogs, articles, healthy habits and tips for a healthier lifestyle.

A wealth of fitness videos including Yoga, Cardio, Strength and Pilates.

Nutritional tips, education, and thousands of recipes from HelloFresh to help employees eat healthier.

Mindfulness videos including how to handle stress and anxiety and tools to aid sleep.

Exercise (& Classes), nutrition, mental health & wellbeing support

Move, Munch, Money, Mind

Financial education from money experts along with tools to help your employees handle their money matters.



What do you have in place to support your staff and yourself?

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Scenarios

Best Practice Workshop

Consider the scenarios



What could be done differently



What went well?



How could you improve current practice, learning lessons from others...?

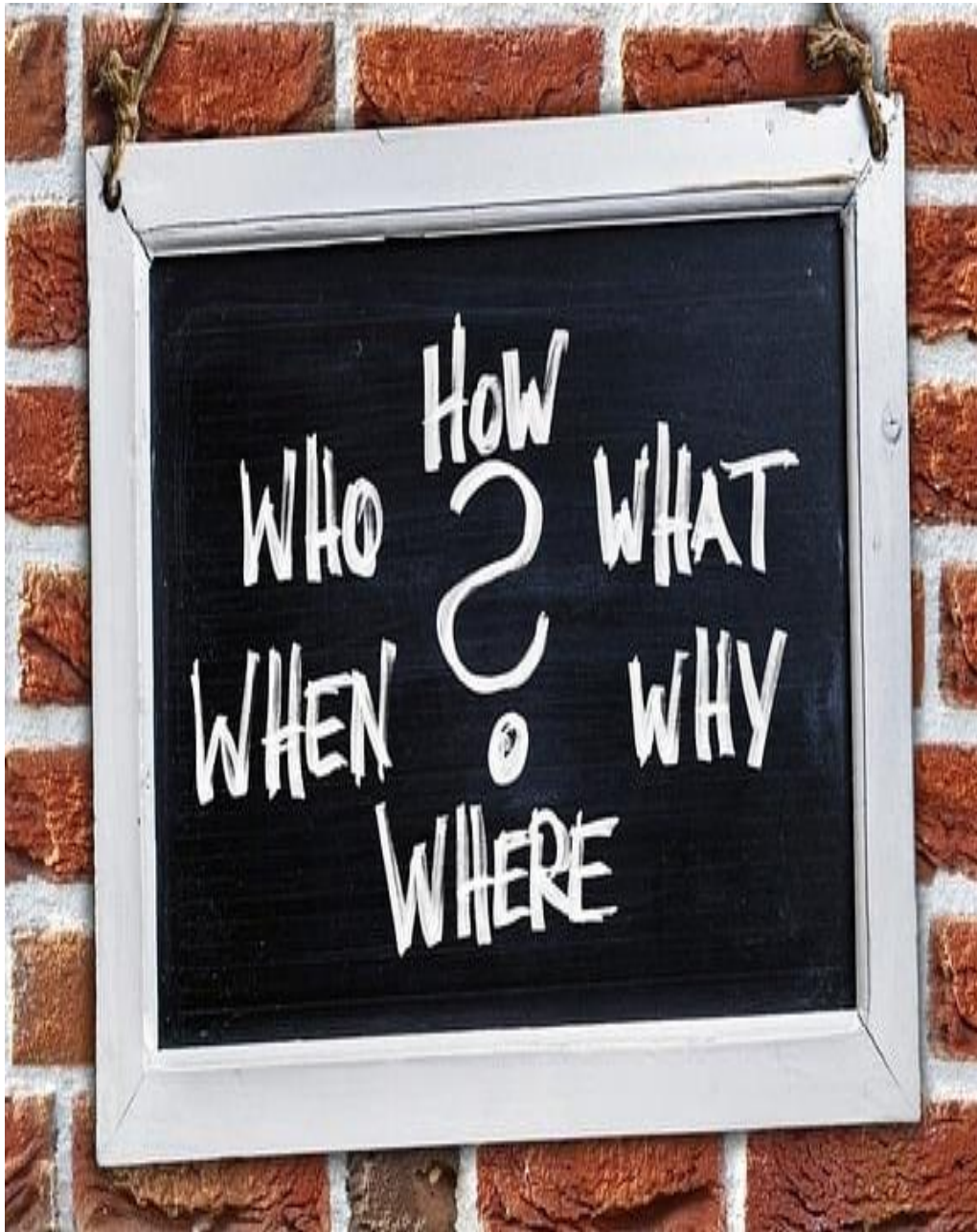


Susan

- Susan 72, has advanced metastatic breast cancer she has stopped all active treatment. She lives at home alone, and has a ReSPECT document in place. The DNACPR section is completed and she is not for CPR, this has been discussed with her and her family, the GP has signed the form and all are in agreement.
- Susan is being visited at home by carers four times a day for personal care and has been deteriorating gradually over the last week.
- Carer visits Susan and finds her unresponsive.
- Carer calls 999 for emergency assistance.
- Paramedics arrive but refuse to accept the photocopied ReSPECT document.
- Paramedics begin CPR, despite the ReSPECT
- The Carer remains calm and explains the legal and medical importance of the ReSPECT document.
- The paramedics still refuse to accept the document, the carer remains respectful and contacts her supervisor for clarification, who advises the paramedics talk to Ambulance control, the situation is escalated, and the paramedics Stop CPR.

Susan - Feedback

How could you improve current practice, learning lessons from others...?

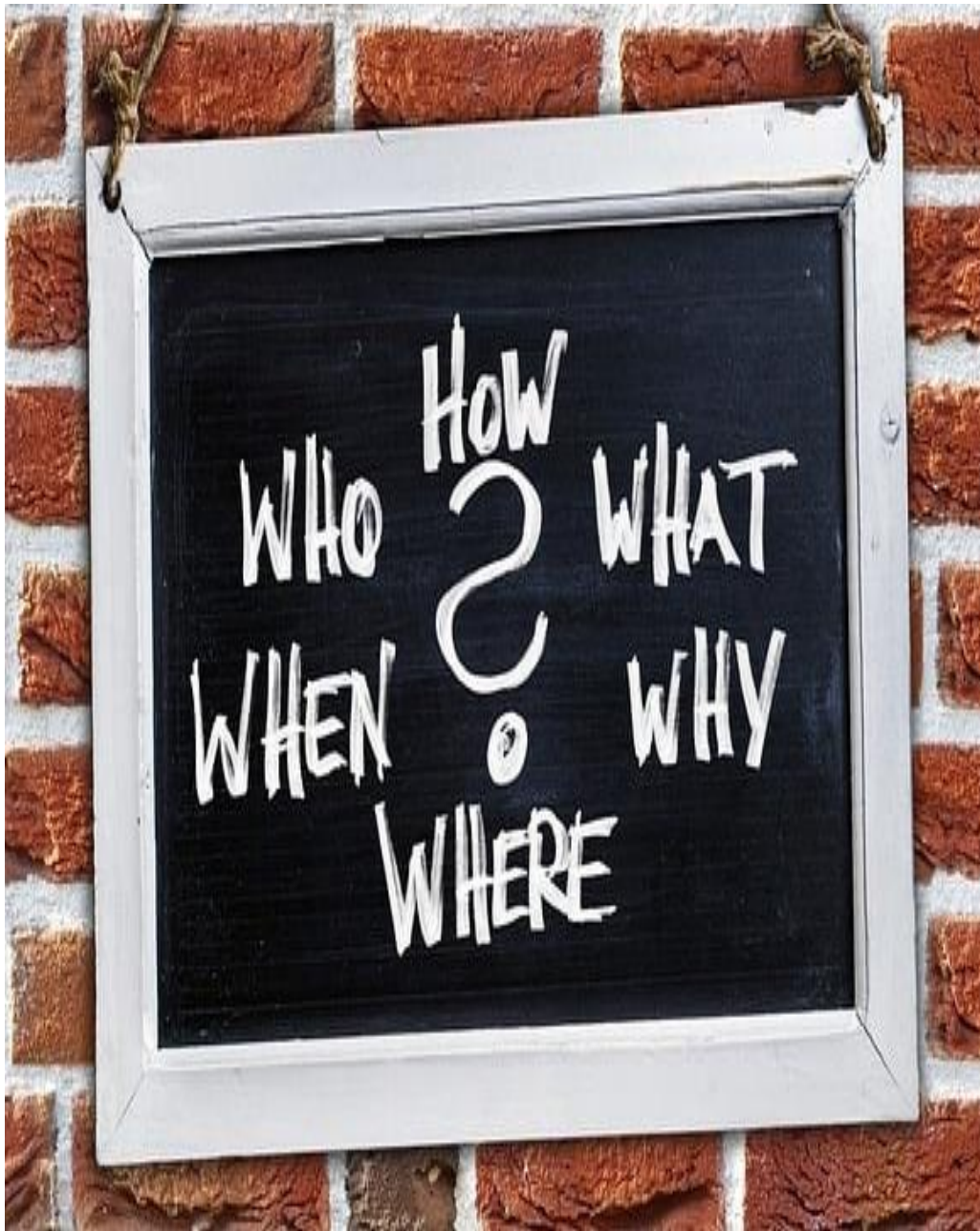


- Who do we call and why?
- Do we have a process for an unexpected but expected death
- Are our staff empowered to advocate
- Where do we keep important documentation for each person you support?



Gary

- Gary is 85, his home is Blue Banks residential and nursing home he has been deteriorating in health for the last six weeks, and is now nursed in bed, he sleeps most of the time but sometimes wakes for visitors or small sips of water. He has a ReSPECT document and DNACPR.
- Today Gary's son has arrived bringing some of Gary's cousins and children, when they arrive Gary is comfortable in bed, breathing deeply with a small sigh each breath, Gary's son is concerned when he arrives that Gary does not respond to him
- Gary's son calls 999 and requests an urgent ambulance
- Shortly after calling 999 Gary's heart stops, the family ask staff to commence CPR and drag Gary to the floor, the situation is confusing and stressful for all involved as staff are aware of the DNACPR.
- Gary dies in his room when the paramedics decide to stop CPR



Gary - Feedback

How could you improve current practice, learning lessons from others...?

- Are families 'brought along' with decisions
- How do we communicate to families?
- Do we have significant conversations?

Collaborative Working

**Whose here to help you?
Educational offers?**

Who can support you?



Clinical Advice - 01923 335356

education@stfrancis.org.uk



Rennie Grove Peace

Clinical Advice Line - 01923 606030

Learning&development@renniegrovepeace.org



Clinical Advice Line – 01707 382525

education@isabelhospice.org.uk



Specialist Palliative Care Service can be contacted on [020 8102 6236](tel:02081026236).

On weekends and bank holidays, call [03000 200 656](tel:03000200656), option 1, then option 1.

Out of hours advice line, please call [01923 335 356](tel:01923335356).



Palliative care advice line is open 24 hours a day on 01462 416794.



North Hertfordshire: 01462 679540

East Hertfordshire: 01707 382575

West Hertfordshire: 0203 826 2377

Hertfordshire Care Provider Support Service Directory

[HCPA Provider Hub](#)

[HCPA Members Zone](#)

Download our Care Home Directory poster which displays key contact information for services [East & North](#) [South & West](#)



Below you can search our Support Services Directory by viewing all services, filtering by criteria, or searching for a keyword.

[View all services](#) ↓

[Filter By](#)



Search services

Search

[Support Service Directory - HCPA](#)

THE HCPA CARE PROVIDER HUB PROVIDING PEACE OF MIND.....



ASK us anything! We are your support service, here to answer your questions on all topics Adult Social Care related.

- Govt guidance, laws, standards and expectation
- Covid: PPE, vaccinations and infection control
- Liaison with Hertfordshire County Council
- Funding, contracting and commissioning
- Staff wellbeing and recognition
- HR, Staffing and recruitment
- Training and education
- Business continuity
- Data protection
- Monitoring
- Equipment
- Insurance

Your hub, your support service.....

01707 708108 / assistance@hcpa.co.uk (Mon to Fri - 9am to 5pm). www.hcpa.info/hub

HCPA: 'Sharing best practice in care through partnership'



Further Support Resources

- The Anne Robson Trust is a pre-bereavement charity offering company and support to anyone who is facing the end of life or the death of a loved one.. Free National Helpline: 0808 801 0688
Website: annerobsontrust.org.uk
- Cruse Bereavement Support Helpline: 0808 808 1677 Website: Cruse.org.uk Samaritans Helpline: 116 123 Website: <https://www.samaritans.org/how-we-can-help/contactsamaritan/talk-us-phone/>
- Hertfordshire County Council – Bereavement Services Website: <https://www.hertfordshire.gov.uk/services/births-deaths-marriages-and-citizenship/deaths/bereavement-services.aspx>
- Herts Partnership Foundation Trust
<https://www.hpft.nhs.uk/contact-us/Freephone> 0800 6444 101 or NHS 111 and select option 2 for mental health services

Continued

- goodlifedeathgrief.org.uk hopeagain.org.uk
- childhoodbereavementnetwork.org.uk
- Tracey versus Adenbrooks (2014) Accessed 27/09/2022
<https://www.judiciary.uk/wp-content/uploads/2014/06/tracey-approved.pdf>
- Advance decisions to refuse treatment A guide for health and social care professionals. Accessed 27/09/2022
<https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf>
https://www.westhertshospitals.nhs.uk/patientinformation/documents/palliativecare/41-2120-V3_End_of_Life_Care_PIL.pdf

Patient Information leaflet - West Herts Joint guidance from the BMA, Resuscitation Council (UK) and Royal College of Nursing (RCN) on decisions about CPR – including decisions not to attempt CPR (2016). <https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation>

References and Resources

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<https://www.northdevonhealth.nhs.uk/wp-content/uploads/2018/11/Mental-Capacity-and-Best-Interests-Assessment-v2-PRINT.pdf>

<https://www.resus.org.uk/respect/respect-healthcare-professionals>

Gov.uk (2021) make register or cancel lasting power of attorney accessed on 16/08/2022 <https://www.gov.uk/power-of-attorney>

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- Ellis, P (2018) Leadership, Management and Team Working in Nursing, Transforming Nursing Practice Series. Sage. London.
- Gopee, N & Galloway, J (2017) Leadership and management in Healthcare. Sage. London.
- E-lfH Communicating with empathy module, consists of six sessions that have been developed to promote sensitive and effective communication in end of life care.
- <https://www.the10minuteleader.com/nlp-communication-model/>
- Stuart et al (2017) The Dual Nature of Hope at the end of life. BMJ <https://blogs.bmj.com/bmj/2017/04/13/the-dual-nature-of-hope-at-the-end-of-life/>
- [Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences](#)
- [Dying for Beginners](#)

Next Steps

- Take your table packs away and review with your team
- Set actions to change the way you do things
- Offer training/information sessions for staff
- Review policies and procedures
- Connect with your local hospice
- Start the conversations



What are your key takeaway actions from today?

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