# Study Session:

# End Of Life Care in residential and nursing settings

Starting 09.30

**Please tell us where you are from**

**Join at slido.com**
**#3794092**

# Welcome

## Study Day: End of Life.

### Date: 19 May 2025

**This Session will begin shortly**


Hertfordshire

Centre of Excellence
Valid until 11/2025
skillsforcare

# Housekeeping

Please keep your mobiles on silent during the presentations


Exits

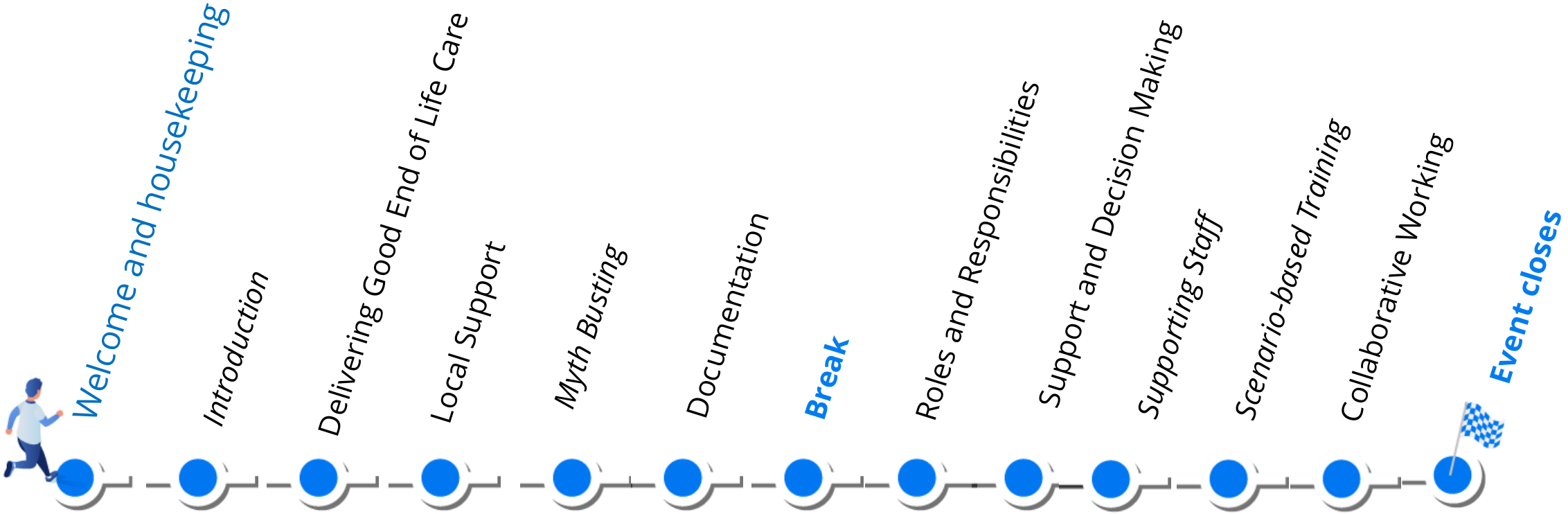

No planned fire drills

Comfort Break

# Jessica Bentley

## *Education, Quality and Integration Development Manager*

# Agenda

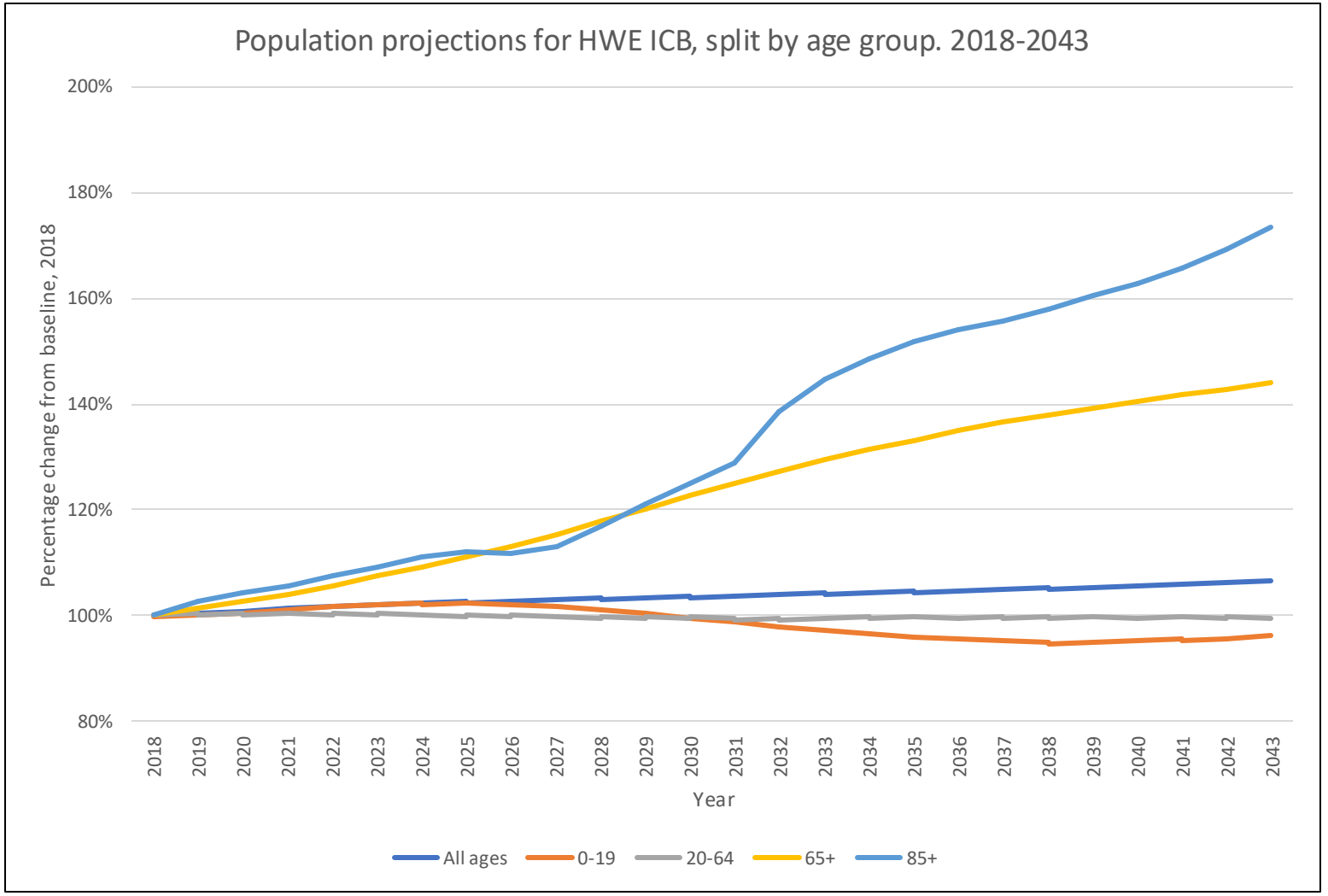



**Use your table pack to capture notes and actions for the session**


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 changed 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

The Hospice of st francis

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

Rennie Grove Hospice Care
Peace Hospice Care
Rennie Grove Peace

Leonie Lowrie - 07736976744
Clinical Advice Line - 01923 606030
Leonie.lowrie@renniegrovepeace.org
Learning&development@renniegrovepeace.org

Isabel Hospice
Together we care

Wendy Freeman - 07843218316
Clinical Advice Line - 01707382575
Wendy.freeman@isabelhospice.org.uk
education@isabelhospice.org.uk

# 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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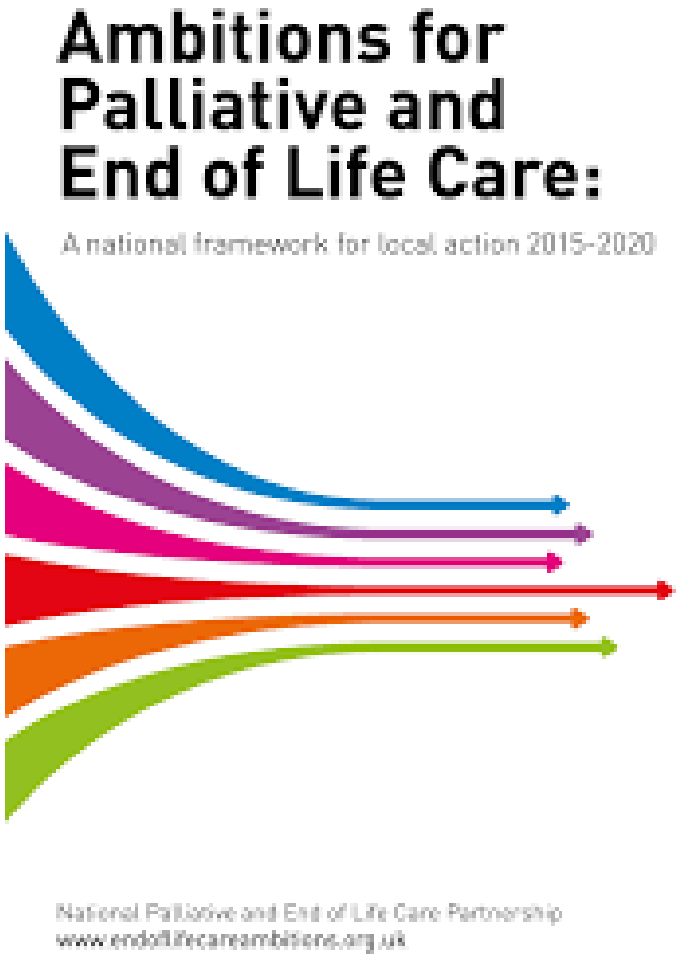
slido.com
#3794092

# 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?




- 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 import 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 couldnt 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**

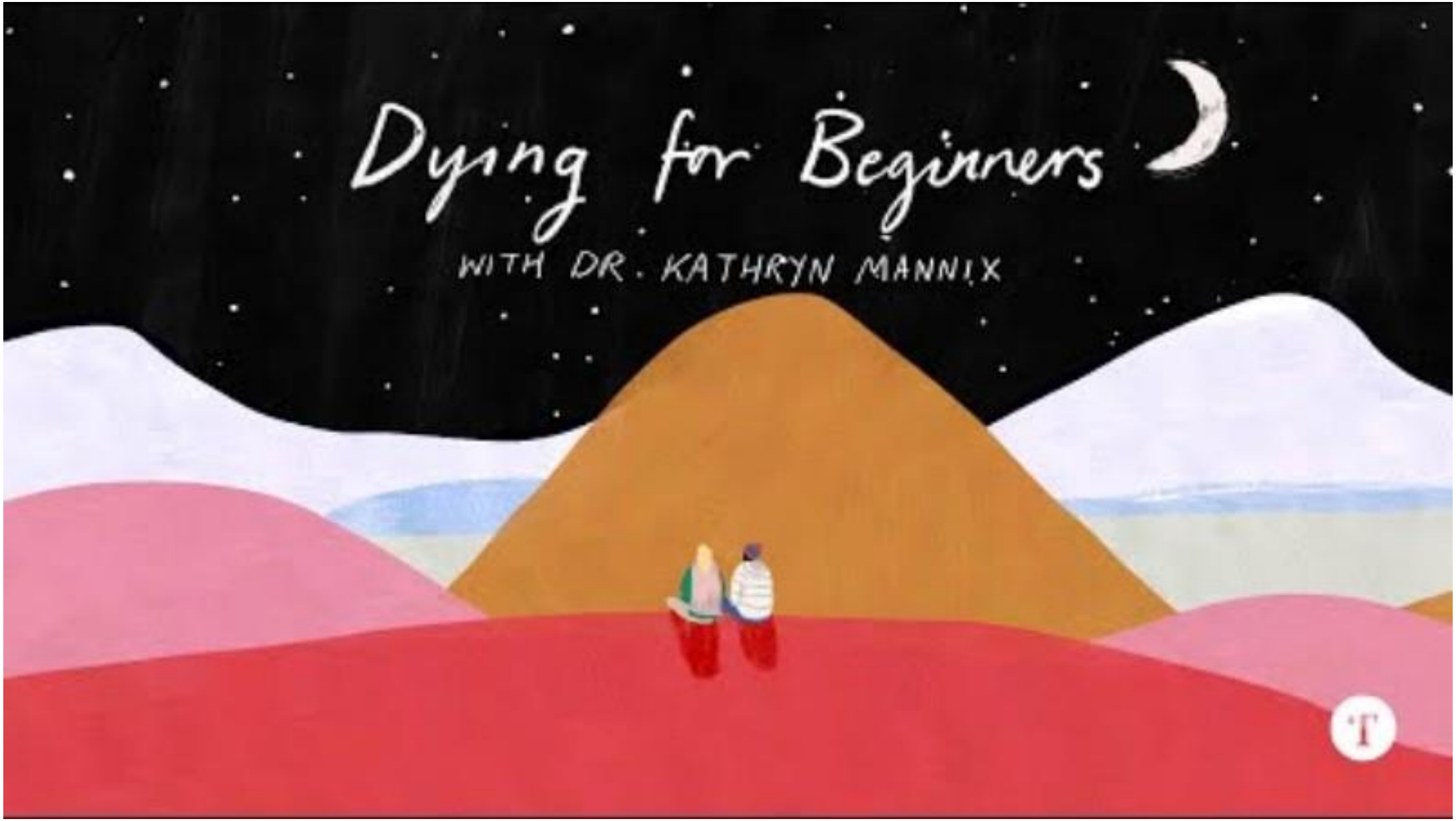
Things in order
Funeral plans
Letters
PPC/PPD
Symptom control
Complete bucket list
Right support around them

**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

# ReSPECT Recommended Summary Plan for Emergency Care and Treatment

| | |
|---|---|
| Full name | |
| Date of birth | |
| Address | |
| NHS/CHI/Health and care number | |

## 1. This plan belongs to:

| | |
|---|---|
| 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 |

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ReSPECT

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**

Document the full capacity assessment in the clinical record.

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

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: ☐ | | | optional |
| ☐ | | | optional |
| ☐ | | | optional |
| ☐ | | | optional |
| ☐ | | | 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:**

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# ReSPECT Forms/ DNACPR Forms

- 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%

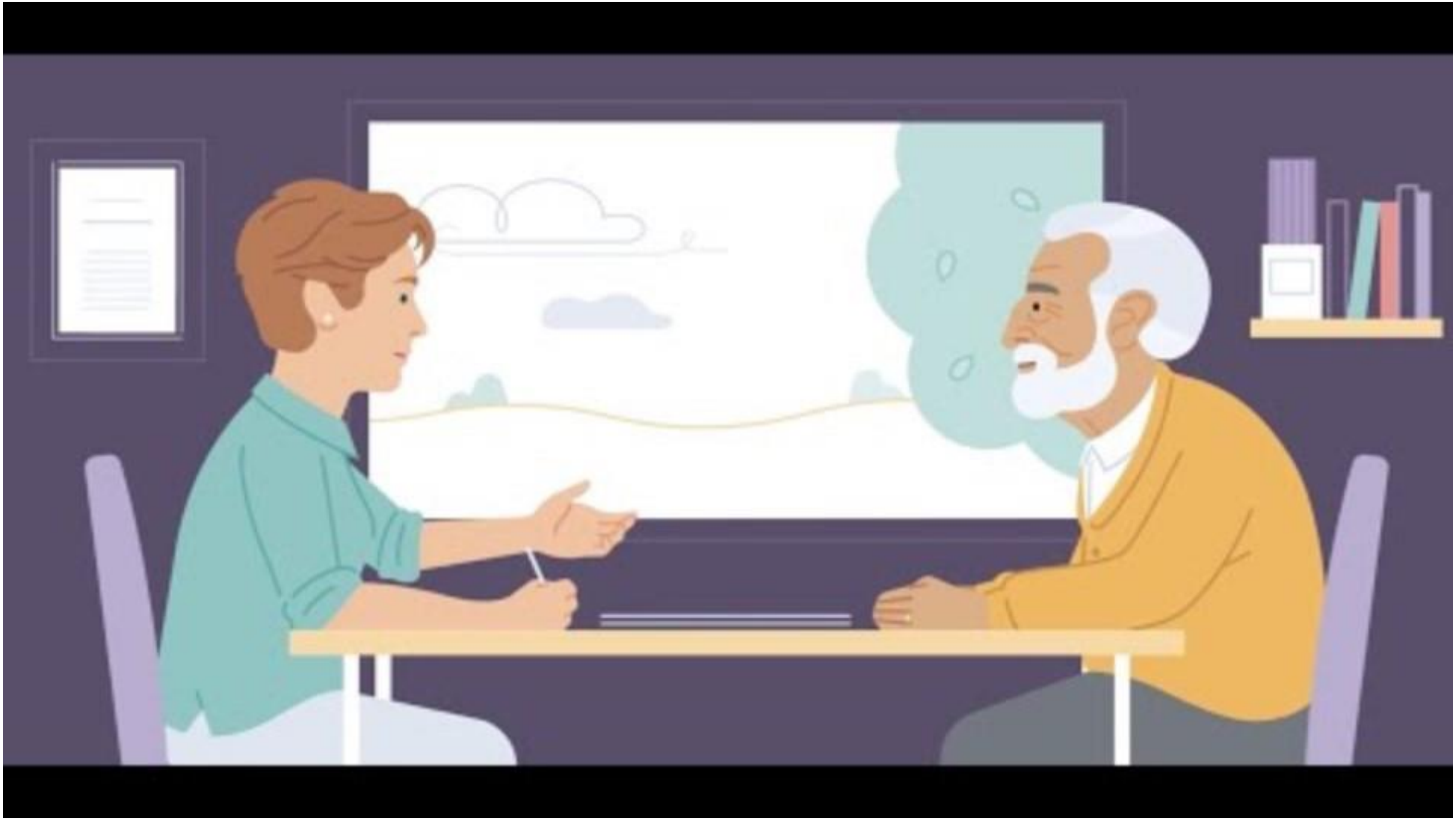
One week in bed or on a stretcher =10% loss of strength and independence.

People Aged over 80yrs is set to double in next 30-4oys 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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#3794092

# 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.

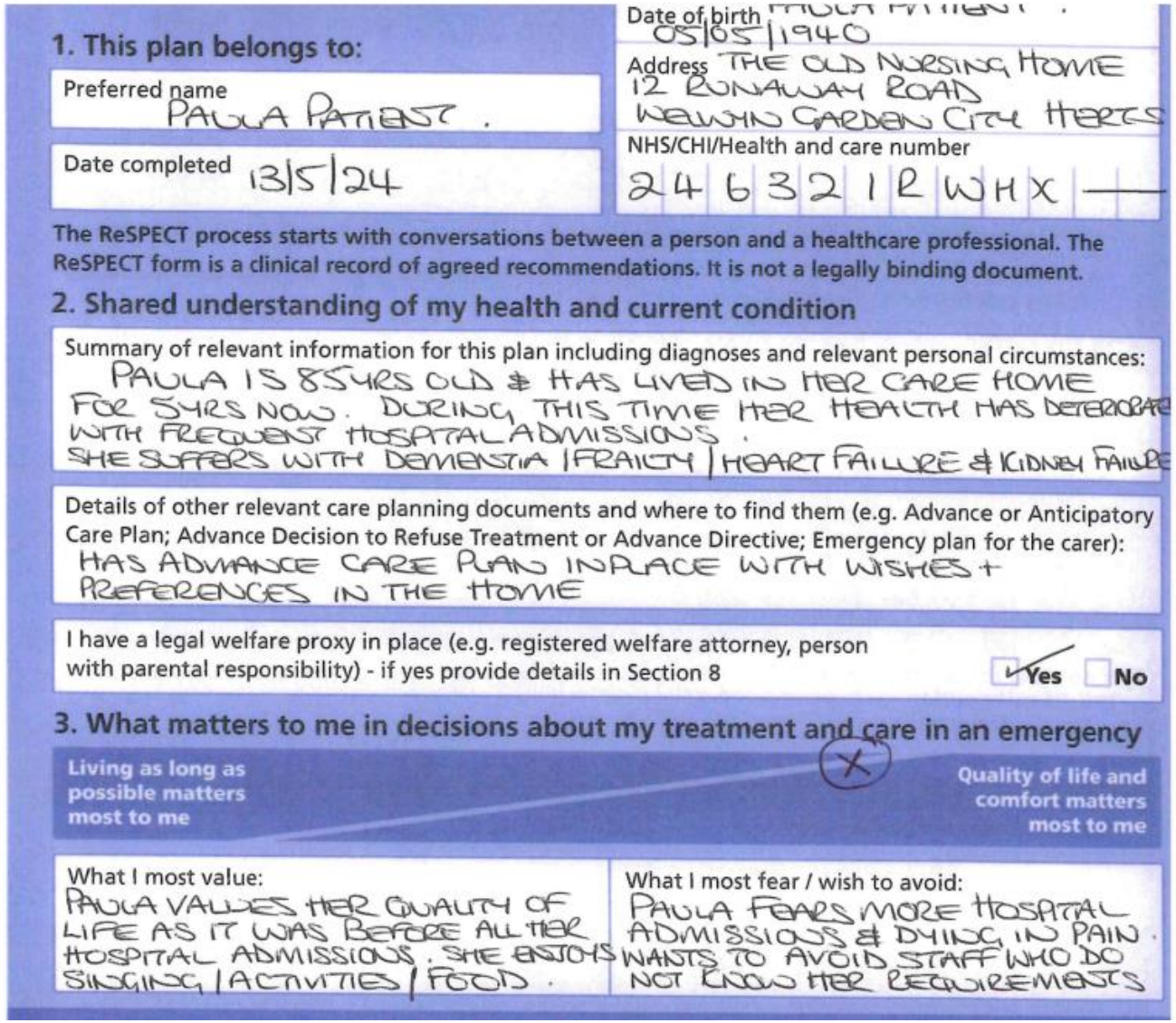
| Safe | Effective | Caring | Responsive | Well-led |
|---|---|---|---|---|
| Capacity assessments | Individualised Care | Personalised care | Aware of individualised needs | Person- centred care |
| Risk management of food and drink | Responsive to changing needs | Dignity- avoid inappropriate resuscitation 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:**

Preferred name: PAULA PATIENT.

Date completed: 13/5/24

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

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 85YRS OLD & HAS LIVED IN HER CARE HOME FOR 5YRS 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 INPLACE WITH WISHES + PREFERENCES IN THE HOME

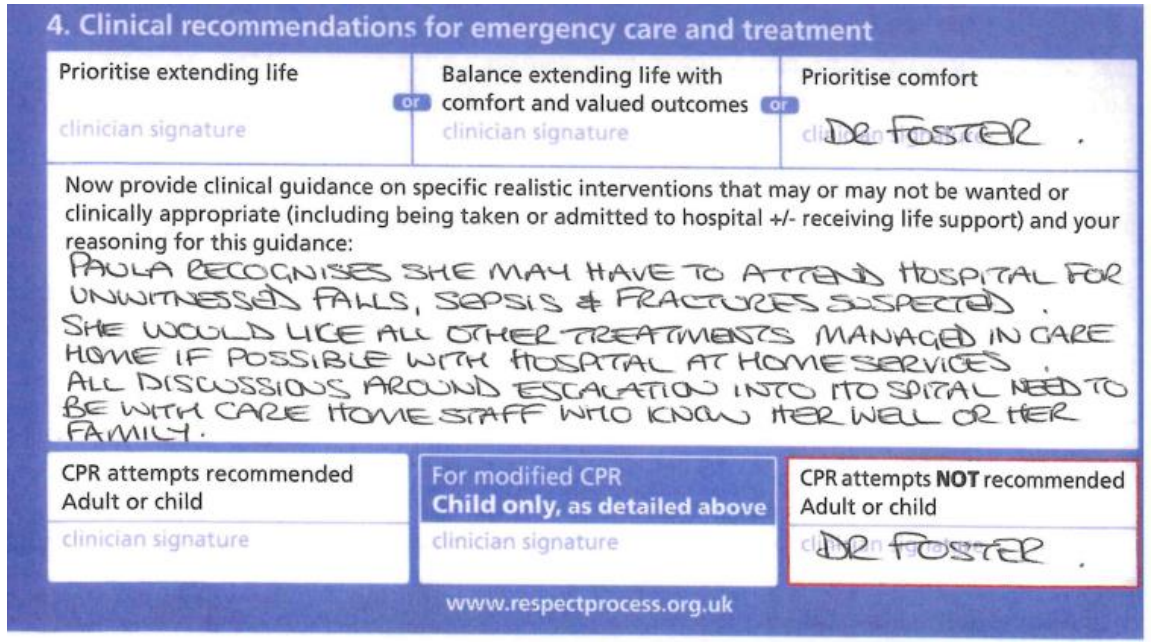
I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☑ Yes ☐ No

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

Living as long as possible matters most to me — (X) — 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 | or | Balance extending life with comfort and valued outcomes | or | Prioritise comfort |
|---|---|---|---|---|
| clinician signature | | 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 | For modified CPR **Child only, as detailed above** | CPR attempts **NOT** recommended Adult or child |
|---|---|---|
| clinician signature | clinician signature | DR FOSTER. |

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# Not so Good Example

## 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:

## 4. Clinical recommendations for emergency care and treatment

| Prioritise extending life | or | Balance extending life with comfort and valued outcomes | or | 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:

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|---|---|---|
| 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]

| | |
|---|---|
| **S**<br>Describe Situation | ➢ Who holds POA and their contact details…NOK contact details…. |
| **B**<br>Provide Background | ➢ The client has lived with us since (date of admission)<br>➢ They have been admitted to hospital ** times in the last 6 months<br>➢ In the last month the client has been admitted to hospital with**** /seen by the GP with****<br>➢ They are also known to suffer from (outline all known medical problems in clients records with particular note of underlying hear problem, diabetes, respiratory problems, renal problems dementia)<br>➢ The clients' medication list includes…….<br>➢ In cases where the client does have a DNACPR/ACP/Respect please outline what this plan states |
| **A**<br>Provide client assessment | Summarize the facts and give your best assessment on what is happening:-<br>➢ I think the current problem is *** OR I don't know what the problem is but the client is deteriorating<br>➢ The normal NEWS score when the client's well is *** the current NEWS score is ***<br>➢ The most recent weight is ***kg (weight on admission ***kg)<br>➢ The client is currently able/not able to eat & drink<br>➢ The client is currently able/not able to walk and the normal mobility is……. |
| **R**<br>Make Recommendation | ➢ What actions are you asking for? (What do you want to happen next )<br>2 recommended outcomes are possible:<br>➢ Convey the person to hospital for further assessment. This decision will be based upon the premorbid functional/cognitive statu 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).<br>➢ Stabilise the person in the care home either with an agreed action plan and clear criteria indicating when a further referral is nee OR Palliate the person in the care home which may require an updated RESPECT form to be sent, End of Life medications prescr (available locally) and a drug administration form sent to allow the community team to deliver medication. |
| **D**<br>Make decision | ➢ What have has been agreed?<br>➢ 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."

CareQuality Commission

hcpa

# 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** | health assured |
| **Wellbeing Centre** | Expert blogs, articles, healthy habits and tips for a healthier lifestyle.<br><br>A wealth of fitness videos including Yoga, Cardio, Strength and Pilates.<br><br>Nutritional tips, education, and thousands of recipes from HelloFresh to help employees eat healthier.<br>Mindfulness videos including how to handle stress and anxiety and tools to aid sleep.<br>Exercise (& Classes), nutrition, mental health & wellbeing support<br>**Move, Munch, Money, Mind**<br>Financial education from money experts along with tools to help your employees handle their money matters. | The Wellbeing Centre |

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

Join at

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# Scenarios

## Best  Practice Workshop

# Consider the scenarios

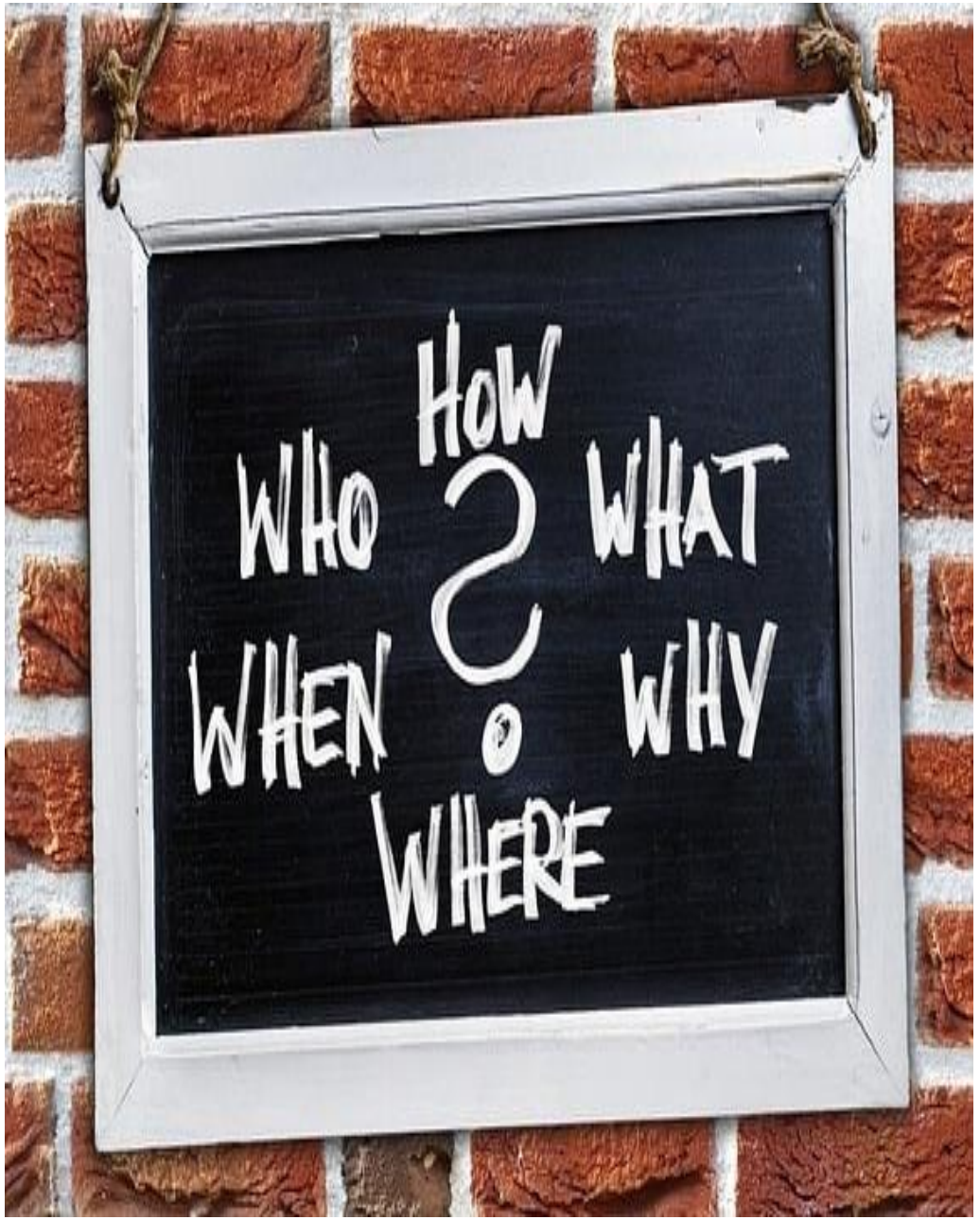
What could be done differently

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.



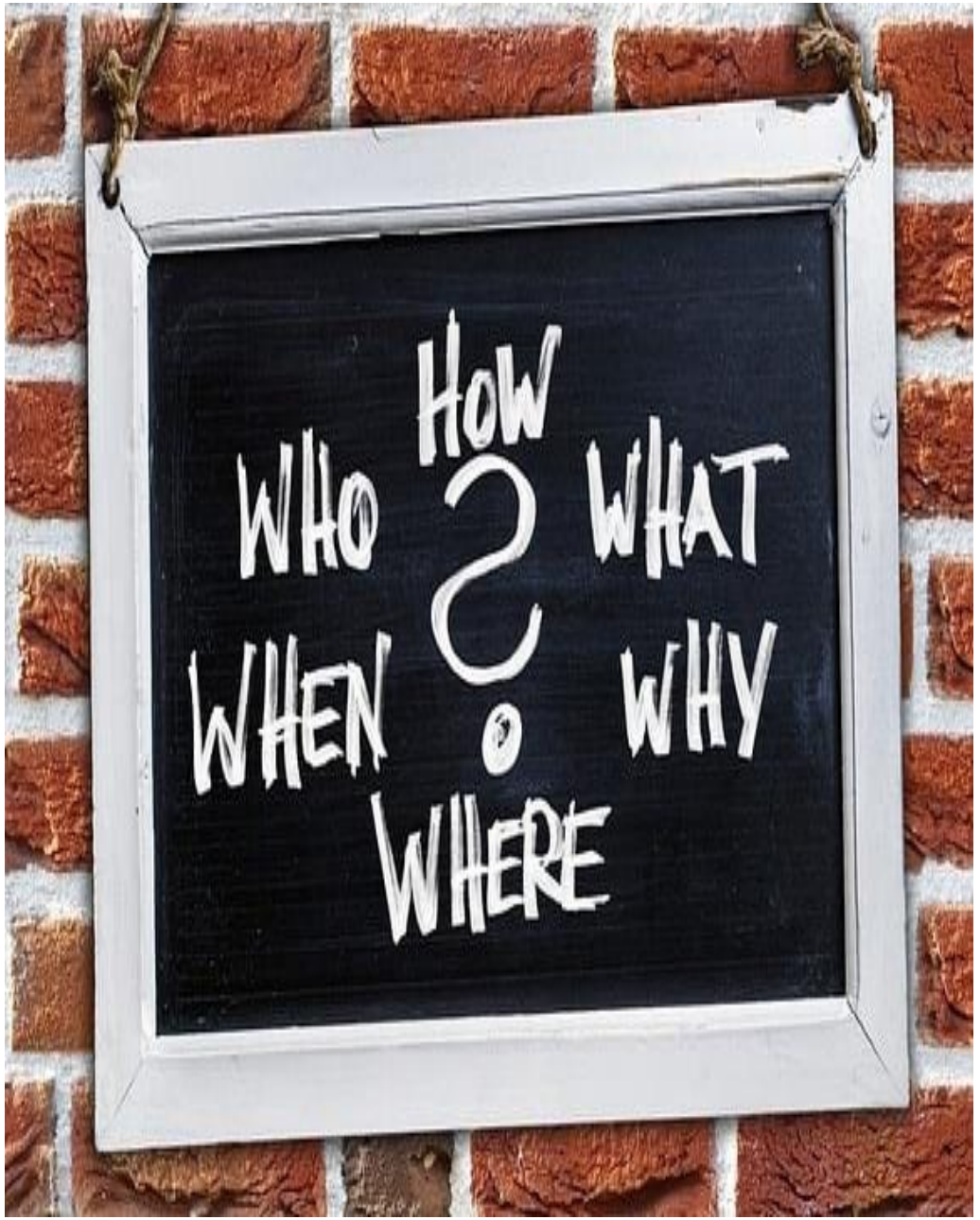

# Susan - Feedback

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 Garys 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

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**.
On weekends and bank holidays, call **03000 200 656**, option 1, then option 1.
Out of hours advice line, please call **01923 335 356**.

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-deathsmarriages-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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- 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.the10 minuteleader.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?

Join at

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# Newsletters

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Ensure you and your leadership team are signed up to receive HCPA's newsletters.

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