Hospice Care

(Hospice Isle of Man)

Clinical Policy 28

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Reader Information	
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Policy Description	This policy is to guide healthcare practitioners in the general principles of care provided by Hospice Care.
Ratified	Clinical Governance Committee
Cross Reference	Safe Handling of Medicines [Clinical Policy 12] and Implementation and Authorisation of Patient Group Directions [Clinical Policy 13]. Advance Care Planning [Clinical Policy 69]
Superseded Documents	Clinical Policy 28 version 2

1. Purpose

1.1 To guide healthcare practitioners in the general principles of care provided by Hospice Care.

2. Policy

2.1 This policy applies to all clinical staff employed by Hospice Care.

3. Principles of Care

3.1 The multidisciplinary clinical team will ascertain and respond to the patient's and carer's wishes regarding privacy, dignity and cultural needs.

3.2 There will be communication with other agencies (professional and voluntary) with the aim of providing optimal continuity of care and support for patients and carers.

3.3 All patients will have their symptoms managed to a degree that is acceptable to them and achievable by the multidisciplinary team (MDT) within current palliative care knowledge.

3.4 In the best interests of the patient and their carers, relationships between Hospice staff and those that they come into contact with through their professional role must remain on a professional basis at all times. This is in accordance with the professional boundaries stipulated by the relevant professional bodies i.e. *NMC Code of Professional Conduct.*

3.5 The patient and his/her carers will have the information they seek relating to the diagnosis, prognosis and progress of the illness and care options available to enable them to make informed choices. They should be encouraged to become involved in "Advance Care Planning" (CF Clinical Policy 69).

3.5.1 **NB** Conversations between the Hospice MDT and the patient's carers must only relate to general information re the services available, until the patient gives consent for their personal information to be shared.

3.5.2 No discussions will take place between the Hospice MDT and relatives/carers if a patient is unwilling for such discussions to take place.

3.5.3 The views of relatives/carers are important and every effort will be made to establish these. It is important to note however, that views expressed by relatives/carers must not override those of the patient, and are given to staff as guidance not instructions.

3.6 The patient and his/her carers will have access to complementary therapies, spiritual and psychosocial care.

3.7 Carers will have access to bereavement counselling, information and support services, including external agencies.

3.8 Specialist knowledge and training will be gained through courses, work experience and seminars, and disseminated to other professionals wherever possible.

4. Registration Standards - Since September 2013 Hospice Isle of Man has been assessed against the Hospice Standards provided by the Isle of Man Government Registration and Inspection Unit. *"There are two key factors in the provision and the regulation of palliative care services. First, the need to respond to issues with a sense of urgency as time is limited for the service recipient nearing the end of their life. Second, the often complex and diverse .needs of both the service recipient and their carers need to be met by access to a multi-professional specialist palliative care team with a range of skills to assist with physical, psychological, social and religious and cultural needs. The standards reflect this."*

The Standards include 15 areas that Hospice Isle of Man has to achieve success in. The Quality Accounts produced each year demonstrate the information provided to the Registration and Inspection Unit to fulfil these Standards.

Standard 1	Service recipients and prospective service recipients, their families and carers, are clear about the arrangements for palliative care.
Standard 2	Service recipients are cared for by people who have the relevant expertise.
Standard 3	The needs of service recipients and carers are appropriately assessed.
Standard 4	Service recipients receive appropriate palliative care
Standard 5	Service recipient care is based upon accurate records
Standard 6	The risk of service recipients, staff and visitors acquiring a health care-associated infection is minimised.
Standard 7	Service recipients' rights are observed around the issue of resuscitation
Standard 8	Responsibility for obtaining, prescribing, storing, use, handling, recording and disposal of medicines is clear
Standard 9	Medicines, dressings and gases are handled in a safe and secure manner
Standard 10	Appropriately and qualified health care professionals administer all medicines and drugs to service recipients
Standard 11	Service recipients are assessed, consulted and advised before they are enabled to self-administer medicines
Standard 12	Medical gases are stored and supplied appropriately
Standard 13	The special needs of children are addressed
Standard 14	Children are cared for by appropriately qualified and trained staff
Standard 15	Children's special needs are addressed by the facilities provided

5. Therapeutic Interventions

5.1 As professionals delivering palliative care we are rightly concerned about both the benefits and the risks of any procedure to be carried out on a patient. We would not want to cause further distress to a patient and their family/carers in the vague hope of doing some good. As a result of this we are wary of undertaking 'invasive' procedures unless there are compelling reasons. However, there is evidence to support the use of such procedures at times and examples include the treatment of hypercalcaemia; blood transfusion and epidural infusions.

5.1.1 In general it is not considered appropriate for interventions to occur at Hospice the delivery of which would be more suitable for acute medical, acute surgical or others places of specialised care.

5.2 The Hospice Care In-House Management Team produced formal guidelines on Therapeutic Interventions in September 1995. These state:

5.2.1 In palliative care we do not strive to officiously keep patients alive, but there are occasions when it is appropriate for the patient to have distressing physical symptoms alleviated and this may include invasive therapies. These will only take place after discussion with the patient. Where a patient decides against such treatments, this decision will be respected.

5.3 In the event of a patient experiencing a sudden unexpected collapse, active support will be given to ensure that the patient is comfortable and free from distress. Active resuscitative care – that is treatment to reverse the causes of sudden unexpected collapse – is seldom appropriate. However, there will be some patients for whom it is appropriate. All patients/carers prior to and/or on admission to the In-patient Unit are made aware of the Hospice Resuscitation Policy (CF Clinical Policy 11), and their wishes taken in to account.

5.4 It is the policy that all treatments offered to patients under the care of Hospice Care will at all times be appropriate for the individual patient as determined by the multi-professional clinical team led by the Clinical Director.

5.5 Measures to relieve pain and discomfort should be provided without concern for addiction. Moreover, even if the analgesia/sedation required has the potential to shorten life it should still be given if it is necessary to make the patient comfortable in the time they have left. The principle of 'double-effect' supports and protects a practitioner who acts in this way (Huxtable 2004).

5.6 After a patient has been admitted to the In-Patient Unit the MDT assesses the patient's symptoms and other needs as appropriate. Together with the patient and his/her carer the team formulates a plan of care, which is documented in the patient's case notes. The team monitors and reviews the plan of care as often as is required to

optimise symptom management and other aspects of clinical management.

5.7 The prescribing and dispensing of medicines will be in accordance with the Safe Handling of Medicines [Clinical Policy 12] and Implementation and Authorisation of Patient Group Directions [Clinical Policy 13].

5.8 Hospice Care employs a number of non-medical prescribers, who act in accordance with the Isle of Man Non-Medical Prescribers' Policy.

6. Funeral Attendance

6.1 If possible, a minimum of one member of staff will be present at a funeral to represent Hospice

6.2 Staff who attend a funeral service should leave after the service and not attend the wake, unless express permission is obtained from their line manager. If attending a wake, staff are not permitted to consume alcohol as they are still representing Hospice.

6.3. Any staff member who wishes to attend a funeral but is already scheduled to work may do so after clarification and with permission of their line manager.

6.4 A staff member who attends a funeral on their day off may not claim the time back from hospice.

References

Huxtable, R. (2004) Get out of jail free? The doctrine of double effect in English law. *Palliative Medicine*. 18: 62-68

Hospice Minimum Standards Registration & Inspection Unit September 2013 Department of Social Care

Nursing and Midwifery Council Code of Conduct (2015) available at **http://www.nmc.org.uk/standards/code/**