Hospice Care

(Hospice Isle of Man)

Clinical Policy 28

Clinical Care

Originator: Clinical Care Policy Working Group (Chair – Dr Ben Harris, Clinical Director). Adapted from Policy on Clinical Care, Isle of Man Hospice Care, 2002
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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, care, and cultural needs.

3.2 There will be effective communication with other agencies (professional and voluntary) providing 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.

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 guidelines not instructions.

3.6 The patient and his/her carers will have access to counselling, spiritual, and psychological care.

3.7 The 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 Therapeutic Interventions

4.1 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 any 'invasive' procedures such as those involving intravenous cannulation. However, there is evidence to support the use of these procedures at times and examples include the treatment of hypercalcaemia; blood transfusion; epidural infusions.

4.1.1 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.

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

4.2.1 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.

4.3 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 prior to and/or on admission to the In-patient Unit are made aware of the Hospice Resuscitation Policy for Adults [Clinical Policy 11(a)], and their wishes taken in to account.

4.4 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.

4.5 Treatments and medications are for the 'palliation of symptoms' and would not be expected to have curative potential.

4.6 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).

4.7 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.

4.8 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].

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

5. **Funeral Attendance**

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

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

5.3. 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.

5.4 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

Nursing and Midwifery Council Code of Conduct (2007) available at www.nm.stir.ac.uk/documents/the-**code**.pdf - accessed 22.9.09