“Individual care plans are the key to good end-of-life care”

At last the NHS has published guidance on how we should care for the dying, replacing the Liverpool Care Pathway. For more than a year there has been uncertainty, and even fear, in the minds of health workers and the public. A year is too long for such a vacuum: 1% of the UK population dies each year. Nurses and doctors have largely stopped using the LCP and we have seen a return to the bad old days when dying was recognised late and prescribing was inadequate.

The 2013 report into the LCP was entitled More Care, Less Pathway – a choice of words that reflected the unhelpful headlines and simplistic opinions that surrounded concern about the LCP. Nurses and doctors began to encounter patients who were dying, and relatives who were frightened that staff would harm or even kill their loved one. It has been a confusing and distressing year for everyone.

Twenty-one organisations – the Leadership Alliance for the Care of Dying People – have worked to respond to the 44 recommendations in More Care, Less Pathway. Their response, One Chance to Get it Right, avoids anything that looks like a protocol, checklist or a care pathway despite the fact that such things have been central to many clinical improvements. Instead, One Chance to Get it Right recommends five priorities for care of the dying. When it is thought a person may die in the next few days or hours:

- This possibility is recognised and communicated clearly, with decisions made and actions taken in accordance with the person’s needs and wishes.
- These are regularly reviewed and decisions revised accordingly;
- Sensitive communication takes place between staff, the person who is dying and those important to them;
- The person who is dying and those identified as important to them are involved in decisions about treatment and care to the extent that the dying person wants;
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible;
- An individual plan of care that includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

The key difference is the focus on individual plans rather than plans that are applied to all people who are dying. The challenge in hospitals, patients’ homes, care homes and hospices will be to organise care so these principles of care are translated into practical steps that make our work organised and patient focused. There will be no national tool to help us do that; we must develop our own processes locally. There will, however, be a national inspection of end-of-life care through the Care Quality Commission.

We will start afresh by reading One Chance to Get it Right. Caring for the dying is part of the central privilege of our work. We want to get it right. And we will. NT

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SPOTLIGHT

Nurture sources of comfort at the end of life

Fear of death is understandable and it is not illogical to assume that when people approaching death dream, those dreams may have a nightmarish quality or focus on religious themes. The study reported on page 22, however, found this is not so. Hospice patients were asked to describe their dreams or visions over six months; they reported vivid, comforting dreams of deceased loved ones that often persisted after they awoke. Often dreams became increasingly prevalent as death approached. The study also found patients would not normally have talked about their experiences for fear of the response from relatives and health professionals. Further research is needed, but the implications are clear: if dreams and visions comfort people who are dying they should feel able to discuss them. Any source of comfort – real or imagined – should be nurtured.

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