Last Days of Life
Health Care Professional Information

As with all clinical guidelines and pathways LDL aims to support but does not replace clinical judgement

- The LDL document guides and enables health care professionals to focus on care in the last hours or days of life. This guides the delivery of high quality care tailored to the patient's individual needs in the last days and hours of life, when their death is expected.
- Using the LDL in any care setting requires regular assessment that includes reflection, review and critical decision-making in the best interest of the patient by a team of health care professionals. All health care professionals must be cognisant of their scope of practice when using the LDL, including undertaking assessments, completing documentation and prescribing/administering medications, and making psychological spiritual interventions.
- A robust continuous education and teaching programme must underpin the use of the LDL.
- The recognition and diagnosis of dying is always complex irrespective of previous diagnosis or history. Uncertainty is an integral part of dying, and there are occasions when a patient who is thought to be dying lives longer, or dies sooner, than expected. Seek a second opinion or specialist palliative care support as needed.
- Changes in care are made in the best interest of the patient and relative or carer. This needs to be reviewed regularly and discussed within the Multidisciplinary Team (MDT).
- Good, comprehensive, clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented.
- If a goal on the LDL is not achieved this must be coded as a **VARIANCE**. Documenting a variance is a useful way of recording the decisions made for each patient based on their individual needs, your clinical judgement and the needs of the relative or carer.
- The LDL does not preclude the use of clinically assisted nutrition, hydration or antibiotics. All clinical decisions must be made in the patient's best interest. A blanket policy of clinically assisted (artificial) nutrition or hydration, or of no clinically assisted nutrition or hydration, is ethically indefensible and in the case of patients lacking capacity is prohibited under the Mental Health (Compulsory Assessment and Treatment) Act (1992).
- In LDL Version 12, the term 'best interest' includes medical, physical, emotional, social, spiritual/religious and cultural factors relevant to the patient's welfare.
- The responsibility for the use of the LDL Version 12 document as part of a continuous quality improvement programme in New Zealand sits within the governance of the registered organisation.

The patient will be assessed regularly and a formal MDT review must be undertaken every 3 days.

REFERENCES:

Ellershaw, J.E; Wilkinson, S. (2003). *Care of the dying: A pathway to excellence.* Oxford University Press. Oxford.
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Minister of Health. (2001). *New Zealand Palliative Care Strategy*. Author: Wellington.
National Institute for Clinical Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. London, NICE MCPCIL (2009) National Care of the Dying Audit Hospitals Generic Report Round 2. www.mcpcil.org.uk