Last days of Life on Critical Care

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GUIDELINE REVIEW HISTORY

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1. Introduction

Airedale NHS Foundation Trust fully recognises that the obligation to implement guidance should not override any individual clinician to practice in a particular way if that variation can be fully justified in accordance with Bolam Principles. Such variation in clinical practice might be both reasonable and justified at an individual patient level in line with best professional judgement. In this context, clinical guidelines do not have the force of law. However, the Trust will expect clear documentation of the reasons for such a decision and for this variation. In addition, any decision by an individual patient to refuse treatment in line with best practice must be respected, escalated to the consultant and fully documented in the appropriate records of care/treatment.

This guideline aims to encourage clarity and standardisation of care for patients in the critical care unit where a decision has been made that further treatment is futile. It outlines key steps and documentation in the care of such patients in the last hours of life, including decision making around withdrawal of life sustaining treatment.

2. Management

Recognition of the last hours of life

This usually occurs when an intensive care specialist makes an assessment that continuing treatment would be futile. Patients in this situation are nearly always sedated in a critical care unit which means we cannot discuss this with the patient and decide what to do. The futility decision **must** be communicated to the family and any decision made to withhold or withdraw life sustaining treatment must be made in partnership with relatives. If there are no relatives then input from an IMCA may be sought (refer to the Mental capacity Act Policy) which states 'If an NHS body is proposing "serious medical treatment" or a move into long term care and the patient has no appropriate person to consult about their best interests, the NHS body **has a statutory duty** to consult an independent consultee.

IMCA's are available between 9am and 5pm Monday to Friday and are contactable via the MCA advisors on ext. 2046 or bleep 3222 or alternatively any member of the Trust MCA Advisory team

Where a decision cannot wait for IMCA involvement it is considered to be an emergency and treated as such'

The 'parent team' i.e the admitting specialist should also be consulted and involved in the diagnosis of futility as should the rest of the multidisciplinary team (nursing staff and allied health professionals).

Once a decision has been made involving the MDT and the family then this guideline gives a record that can be used in the patient's notes for documenting end of life decisions and the practicalities of withdrawal of life support.

Care decisions for the last days of life the critical care unit must be recorded in the document found in Appendix 1 and filed in the clinical record. This document can

only be used in the critical care unit. Should a patient be discharged whilst the document is active then they should be transferred to the Personalised last days of life care plan.

3. Implementation & audit

This guideline will be shared with the intensive care unit staff and the anaesthetic staff as well as palliative care staff. Paper copies of the record will be printed off and stored in the critical care unit to be used in the medical record alongside the critical care daily review and admission forms.

It will be possible to track its use and thereby audit documentation completion as well as gather staff views on how the form works in practice.

4. Development

The patient record for care decisions in the last days of life for use in critical care units should evolve as it is used. This is version 1 and was based on documents from the Wales critical care network and from the Wye Valley NHS Trust. Several guidelines and care pathways were considered by a group of critical care nurse, palliative care and intensive care medical staff in a small working group. These two guidelines were considered to be the simplest and most practical.

4.1. Consultation

This document has been shared with Intensive care unit staff, Anaesthetic medical staff and palliative care medical and nursing staff. It was also shared with the West Yorkshire Critical care network.

4.2. Peer review

Once the document is in use and an audit has been collected it will be peer reviewed with the assistance of the West Yorkshire Critical Care Network.

5. Glossary of terms

Bolam principles

The case Bolam v Friern Hospital Management Committee (1957) 1 WLR 583 established that if a doctor acts in accordance with a responsible body of medical opinion, he or she will not be negligent. This means that we think this guideline is in accordance with a responsible body of medical opinion.

IMCA

Independent mental capacity advocate. The Mental Capacity Act (MCA) 2005 came into force in 2007 and introduced the statutory role of the Independent Mental Capacity Advocate (IMCA) to support people who lack capacity to make certain decisions

MCA

Mental Capacity Act 2005

MDT

Multidisciplinary team – in critical care this will include nurses, allied health professionals and doctors.

6. References

7. Appendices

Appendix A Care decisions for the last days of life in the critical care unit