Recognising Dying: Pocket guide

Recognising that a patient may be dying neither hastens nor postpones death.

Recognising someone is dying requires knowledge about the patient and considerable clinical skill. Professionals, patients or carers may recognise that someone is dying. It may help to think through the prompts listed on back of the Recognising Dying document. Professionals caring for a patient who are not doctors, who believe a patient may be in their last days of life, must discuss this with the responsible doctor, who will complete the Recognising Dying form if appropriate.

As with all clinical guidance the Recognising Dying document aims to support but does not replace clinical judgement. It must be completed by doctors but requires that dying is recognised by the multidisciplinary team (MDT) looking after a patient. As a minimum the MDT is usually a doctor and a nurse but may include other healthcare professionals/other personnel as appropriate.

The Recognising Dying document does not replace any documentation; it is intended to form part of the medical record and to be used with other key documents such as a RightCare® plan, medication records and core nursing plans. At the time of recognising dying, consider: are all other relevant documents completed i.e. DNACPR, Nurse verification of expected adult death, RightCare® plan.

Ensure anticipatory medications for symptom control prescribed and available.

Information leaflets for patients and families are available following a discussion about dying (see www.dchs.nhs.uk/end-of-life-care).

When a patient is dying it is crucial to document regular assessments of the condition of the patient and their carers. The frequency of assessments depends on individual needs, and where possible should be agreed with the patient; but it is recommended that where 24 hour trained nursing care is available, a nursing assessment is documented 4 hourly. If a patient is in their own home or a residential placement and care is directed by the GP and District Nursing service the patient must be formally assessed each time a professional/care provider visits. Professionals should continue to write in their standard social care, nursing or medical record/care plan during the hours when a patient is believed to be dying.

Detailed guidance regarding assessment, planning care and the management of symptoms for a dying patient is available as part of the ‘End of Life Toolkit’: see www.dchs.nhs.uk/end-of-life-care.
Recognising Dying

Deterioration in the patient’s condition suggests that the patient could be dying

Multidisciplinary team (MDT) assessment

- Is there a potentially reversible cause for the patient’s condition e.g. opioid toxicity, renal failure, hypercalcaemia, infection
- What are the patient’s wishes about treatment of potentially reversible causes?
- Could the patient be in the last hours or days of life?
- Is specialist referral needed? e.g. specialist palliative care or a second opinion

Refer to guidance notes on reverse of Recognising Dying document for more information

Assessment

Patient is NOT thought to be dying (in the last hours or days of life)

Review the current plan of care

Discuss with the patient and carer their wishes and needs and agree a new or revised plan of care

Consider whether current documentation/plans sufficient and appropriate.
eg: does this patient have an Advance Care Plan?
Is a RightCare© plan in place?
Is DNA-CPR appropriate?

Patient is thought to be dying (in the last hours or days of life)

Recognising Dying completed by most senior responsible doctor

Talk to the patient (where possible) and carer. Explain the patient is believed to be dying

Discussion with the patient or carer (IMCA as required) to develop an individualised plan of care for the last days of life

Ensure DNA-CPR completed

Clinical Decision

Communication

Management

Reassessment

A full multidisciplinary team (MDT) reassessment & review of the current plan of care should be triggered when either of the following apply:

- Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care
- Concerns expressed regarding management plan from patient, relative/carer or health/social care professional

Remember the Specialist Palliative Care Team is available for advice and support, especially if symptom control and/or communication is difficult

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