Acacium Group
Care of the Dying Client Policy

Policy Reference | CLIN 41

Version | V2.1

Policy Name	Care of the Dying Client Policy
Purpose of Document	To ensure all Acacium Group workers are informed regarding national guidance when caring for a dying client
Target Audience	All Acacium Group workers
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Author	Kate Nicholson-Florence
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Risk and Resource Implications	Resource: Training
Associated Strategies and SOPs	See pages 14-15
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V1	Aug 2016	First draft.	KNF
V1	Sept 2016	Approved and published.	KNF/KMS
V1.1	Dec 2016	Implementation of new policy template.	KNF/SJ
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V1.1	Mar 2018	Updated front sheet to include new review frequency date.	KMS/MS
V1.1	May 2018	Updated CSSIW to CIW	LW
V1.2	Apr 2019	Implementation of new policy template	SJ
V1.3	Dec 2019	Update to brand information	KG
V1.4	Aug 2020	3 yearly review	Clinical Advisory Group
V1.5	Oct 2020	Update re Rebrand	CCR/CC
V1.6	Jan 2021	Update re Rebrand 2	CC
V1.7	Apr 2021	Added CHS brand	CC
V2	Sept 2023	Reviewed and updated	Clinical Advisory Group
V2.1	Jan 2024	Rebrand	Clinical Advisory Group

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1. Introduction

1.1 There were 667,479 deaths in the United Kingdom in 2021 Statista Published by D. Clark, May 12, 2023 The number is expected is dependent on any impacts Pandemics may have.

1.2 In Republic of Ireland 31,140 occurred in 2018. It is estimated that almost 50,000 children and young people aged 19 or under in the UK (40,000 of these in England) are living with a life-limiting condition and may need palliative care.7 Dec 2016 NICE.

1.3 "Without an evidence-based approach to the care of the dying client there is a danger of placing tradition and familiar policies before the needs of individuals and families" (NICE guidelines, December 2015).

1.4 End of life care is care that affects us all, at all ages, the living, the dying and the bereaved. It is not a response to a particular illness or condition. It is not the parochial concern of a particular group or section of society. (National Palliative and End of Life Care Partnership, 2015).

1.5 The ways in which client's die and how long this process takes varies widely. This is generally due to the underlying diseases, the client's personality / robustness and their social setting. Some clients can be self-caring until the end, others may die unexpectedly and rapidly, whilst others can have a slow decline needing lots of input and care for both themselves and their loved ones.

1.6 Each client and their families should expect good end of life care whatever the cause of their condition (NICE, 2013).

1.7 Acacium Group are a staffing and commissioned provider in both the community and acute settings and are aware that protocols differ geographically. Therefore, this Policy is for guidance only, and we ask workers to follow local protocols and procedures and details specified within the client's care plan.

2. Definitions

Definition	Explanation
End of Life (EOL) Care	**"**Care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die". (NCPC)
EOL Care Pathway	The multi-agency EOL care pathway is detailed below. Trust staff will contribute to the care pathway as part of a multiagency approach.
Gold Standards Framework (GSF)	The Gold Standards Framework is a national initiative to deliver a "gold standard of care" to all people with advanced disease, please see: (http://www.goldstandardsframework.org.uk/). The GSF helps all services to identify those at the end of their life and aims to provide a structured and coordinated response to their care.
Palliative care	"Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." (WHO)

Dignity and respect	The uniqueness and intrinsic value of individual service users / clients is acknowledged, and each person is treated with respect.
Good death	Although every individual may have a different idea about what would, for them, constitute a "good death",
Treatment Escalation Plan (TEP)	A guide to clinical care to improve and aid communication between medical staff, patients and families. Helps to facilitate 'difficult conversations' by broadening the issues covered.
Mental capacity	The ability to make a decision about a particular matter at the time the decision needs to be made.
Cheyne-Stoking	Is an abnormal pattern of breathing characterised by progressively deeper and sometimes faster breathing, followed by a gradual decrease that results in a temporary stop in breathing called an apnoea.
Last offices	The term "last offices" relates to the care given to a body after death. It is a process that demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements". (Dougherty and Lister, 2004).
LPA (Lasting Power of Attorney)	A representative previously appointed by the client to protect the future needs of the client in case of incapacity. There are 2 types of LPA, financial and health and welfare.
Independent Mental Capacity Advocate (IMCA)	Representative for those who lack capacity and have no family or support network to support decision making.
Clinically assisted hydration	Clinically assisted hydration can also be provided by intravenous or subcutaneous infusion of fluids through a 'drip'.
DNAR,	Do Not Attempt to Resuscitate orders apply only to cardiopulmonary resuscitation, it does not imply "non-treatment".
ReSPECT	A **ReSPECT form** is a very specific type of Advanced or Anticipatory care planning (ACP) that summarises the emergency care aspect of a wider ACP process. **ReSPECT** records that information so as to make it accessible rapidly to professionals who need to make immediate decisions about care and treatment in a crisis.
ACP	Advance Care Planning' (ACP) is the term used to describe the agreed care, future wishes, needs, preferences and priorities of care, for people nearing the end of their life. It enables better planning and provision of care, to help them live well and die well in the place and the manner of their choosing. Advanced Care Planning ensures that service users **receive medical care that is consistent with their values, goals and preferences.**

3. Roles & Responsibilities

3.1 The overall organisational roles and responsibilities are set out in the Policy for Drafting, Approval and Review of Policies and Standard Operating Procedures (SOPs).

3.2 Acacium Group acknowledges that the delivery of good general care is the responsibility of all its workers. The following table outlines the responsibilities of the key people involved in effective general care.

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurse	The Clinical Director is responsible for ensuring that policies, SOPs, protocols, training, and competencies, are in place to support Acacium Group workers in the delivery of safe and effective care. His / her role is also to ensure that high standards of care are delivered and maintained. The Clinical Director also has a duty to ensure that any improvements to practice are made as a result of findings in audit, and the relevant policy, protocol and / or SOP is revised accordingly.
Line Managers / appropriate others	Line Managers / appropriate others: • demonstrate leadership • are informed about, and take responsibility for, the actions of their workers • ensure that all workers follow policies and procedures • lead on working with partners and agencies locally, in order to provide timely and seamless care • ensure that care is routinely planned and reassessed with the appropriate use of resources • maintain confidentiality • ensure their workers access training, supervision, and support, relevant to their roles and responsibilities • ensure their workers are clear about their professional roles and responsibilities • ensure their workers make comprehensive and accurate healthcare records • ensure their workers operate effectively with professionals from other relevant organisations facilitate and / or undertake regular audit of practices.
Individual workers	Individual workers: • provide a consistently high standard of care • promote service user / client safety, dignity, privacy, independence, choice, equality and individuality • plan care routinely and use resources wisely • be aware of, and comply with, Acacium Group policies procedures and guidance • promote confidentiality, sharing information with partners on a need-to-know basis • take part in training, including attending updates, so that they maintain their skills and are familiar with procedures • are registered; non-registered should access regular supervision and support in line with local procedures • should maintain accurate, comprehensive and legible records, which are stored securely in line with local guidance

	support the undertaking of audits and implement revisions to policies, protocols, and procedures.
CAG	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

4. Recognising when a Client is Dying

NICE Quality Statement 1: People approaching the end of life are identified in a timely way

4.1 If it is thought that a client is dying, gather and document information on:

- The client's physiological, psychological, social and spiritual needs
- Current clinical signs and symptoms
- Medical history and the clinical context, including underlying diagnosis
- The person's goals and wishes
- The views of those important to the person about future care.

4.2 Assess for changes in signs and symptoms or any changes that may include:

- signs such as agitation using the appropriate agitation and pain scale, Cheyne-Stokes breathing, deterioration in level of consciousness, mottled skin, noisy respiratory secretions and progressive weight loss
- symptoms such as increasing fatigue and loss of appetite
- functional observations such as changes in communication, deteriorating mobility or performance status, or social withdrawal

4.3 Use the knowledge gained from assessments and other information gathered from the MDT, the client and those important to them to help determine whether the person is nearing death or deteriorating. Within the community, actions required, and the escalation process are detailed within the Care Plan and other documentation.

4.4 Monitor for further changes in the client and report the changes appropriately.

5. Communication

NICE Quality Statement 2: People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.

5.1 End of life can be a very distressing time for all concerned. Therefore, effective communication with all parties is essential when caring for the end of life client. which includes both the client and their family / people important to them. This also applies to care staff who have built relationships with the client and their families, staff should be offered support and time out to discuss.

5.2 Some healthcare professionals can find it uncomfortable discussing end of life issues. As such, they do not always have the skills and confidence to give difficult news or talk about the dying process. Therefore, it is important that healthcare professionals caring for clients who are dying are adequately trained.

5.3 Key principles in managing difficult conversations:

- Be able to work through your own reaction to the news before preparing yourself to share this with someone else.
- Good, clear, sensitive communication can and does make all the difference to how a family receives and responds to the information.
- You need to make the time and space to share the information by allowing enough uninterrupted time.
- Know your facts and anticipate what the issues might be.
- Be adequately prepared in relation to the clinical situation and the family situation, for example think about what roles different people play in the family and how they process information.
- Always be prepared to ask for help if you need further support.

5.4 Establishing communication needs is essential, according to NICE guidelines (2015). When establishing communication needs, health professionals needs to take into account:

- if the client would like a person important to them to be present when making decisions about their care
- the client's current level of understanding that they may be nearing death
- the client's cognitive status and if they have any specific speech, language or other communication needs
- how much information the client would like to have about their prognosis
- any cultural, religious, social or spiritual needs, or preferences, the client may have.

5.5 Mental capacity: For some clients who are entering the last days of life, mental capacity to understand and engage may be limited. Their changes in mental capacity can be temporary or fluctuating. It could be caused by delirium associated with infection, dehydration or organ failure. It is important to ensure that mental capacity is assessed on a regular basis, and that health professionals are aware of any pre-decided decisions on treatment options prior to the change in the client's mental capacity.

5.6 Providing information: NICE guidelines document the importance of providing the dying client and those important to them with:

- accurate information about their prognosis (unless they do not wish to be informed) explaining any uncertainty and how this will be managed, but avoiding false optimism
- an opportunity to talk about any fears or anxieties, and to ask questions about their care in the last days of life
- information about how to contact members of their care team
- opportunities for further discussion with a member of their care team.

5.7 Documentation: It is important that all discussions and interactions / interventions are documented in line with the Acacium Group Medical Records Management Policy.

6. Shared Decision Making

6.1 NICE guidance suggests that healthcare professionals caring for adults at the end of life need to take into consideration the client's current mental capacity to engage and actively participate in shared decision-making on their end of life care.

6.2 Effective shared-decision making can help to ensure that clients receive the right care in the last days of their life.

6.3 The shared decision-making process should always take into account:

- whether the dying client has an advance statement or an advance decision to refuse the treatment in place, or has provided details of any legal lasting power of attorney for health and welfare
- the client's current goals and wishes
- whether the dying client has any cultural, religious, social or spiritual preferences.

6.4 It is important for the dying client to be involved (if they wish) in the planning of their individualised care. NICE guidance suggests that the individualised care plan should include the dying client's:

- personal goals and wishes
- preferred care setting
- current and anticipated care needs including (preferences for symptom management, needs for care after death)
- resource needs.

6.5 Ensure that all discussions around shared decision making are documented in the client's care notes.

7. Maintaining Hydration

7.1 It is important to support the dying client if they wish to drink. Observe the client drinking to identify any concerns such as swallowing problems or an increased risk of aspiration.

7.2 Offer frequent mouth care (see SOP GEN 14), it is important to ensure that the dying client's mouth and lips remain moist to prevent unnecessary uncomfortableness.

7.3 Some clients will have clinically assisted hydration (clinically assisted hydration can be provided by alternative methods for example, intravenous or subcutaneous infusion of fluids) which may relieve distressing symptoms or signs related to dehydration (please refer to the client's care plan and MAR chart).

8. Pharmacological Interventions

8.1 Providing non-pharmacological interventions such as re-positioning, using fans, reassurance and massage is just as important as using pharmacological interventions.

8.2 Pharmacological interventions prescribed for the dying client will be individualised to that client and local area. Please ensure that you read the client's individualised care plan and Medicine Administration Record (MAR) chart to provide safe, effective and evidenced based care.

8.3 Symptom management medication must be tailored to the dying client's condition, their ability to swallow safely and their preferences.

8.4 NICE guidance state that when considering medicines for symptom control of the dying client the medical practitioner should take into account:

- the likely cause of the symptom
- the dying client's preferences alongside the benefits, harms and undesirable side effects of the medicine

- any individual or cultural views that might affect their choice
- any other medicines being taken to manage symptoms
- any risks of the medicine that could affect prescribing decisions. For example, prescribing cyclizine to manage nausea and vomiting may exacerbate heart failure.

8.5 Ensure that you document all medication administered to the client on the MAR chart.

8.6 Managing pain: It is important to remember that not all clients will experience pain. If pain is identified, then it should be managed promptly and effectively. Treatment should be given to any reversible causes of pain such as urinary retention.

8.7 Managing breathlessness: It is important to identify and treat reversible causes of breathlessness (examples of why dying clients experience breathlessness include pulmonary oedema or pleural effusions). Oxygen is not routinely used to manage breathlessness as a first line. Re-positioning and reassurance can alleviate some symptoms.

8.8 Managing nausea and vomiting: According to NICE guidance, clients who are dying can experience nausea and vomiting for multiple reasons. These include:

- certain medicines that can cause or contribute to nausea and vomiting
- recent chemotherapy or radiotherapy
- psychological causes
- biochemical causes e.g. hypercalcemia
- raised intercranial pressure
- gastrointestinal motility disorder
- ileus or bowel obstruction.

8.8.1 Nausea and vomiting can be treated by both pharmacological and non-pharmacological agents. Ensure the route is documented in the client's individualised care plan and or MAR chart.

8.9 Managing anxiety, delirium and agitation: Clients who are dying can experience anxiety, delirium and agitation due to a number of reasons including isolation, unrelieved symptoms, or bodily needs such as pain or full bladder. All pharmacological interventions to manage this must be carefully considered by a medical practitioner as it may be certain medications contributing to this (i.e. steroids causing restlessness and agitation)

9. Spiritual and Religious Considerations

NICE Quality Statement 6: People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

9.1 It is thought that death and dying arouses great curiosity. Many world religions teach that there is some kind of continuity or survival after death. Acacium Group workers must be prepared to acknowledge and respect a client's individual beliefs and values, even if they do not understand or agree with them. In many faiths, life is a preparation for death and the life to come. Many religions have rituals and ceremonies that are observed at the time of death or immediately afterwards. (More information can be found in the Acacium Group Death and Last Offices Policy and associated SOPs).

9.2 Some clients will not be religious but will still have strong spirituality and faith. It is important to support the client with these beliefs, even if the worker does not have the same beliefs.

9.3 “Spirituality is the dynamic dimension of human life that relates to the way persons (individual or community) experience, express and / or seek meaning purpose and transcendence, and the way they connect to the moment, self, to others, to nature, to the significant and / or sacred” (European Association for Palliative Care (EAPC) task force on spiritual care in palliative care).

9.4 Good practice points:

- always remember to be guided by the client and family and to ask if you are not sure
- never assume because a client or family have declared they are of a certain faith that you know the practices that they will follow
- if a client or family are outside of their home or country they may wish to be guided by their local community, or embassy, as to cultural and religious practices at time of death.

9.5 Multi-faith: The Multi-Faith Group for Healthcare Chaplaincy have produced guidelines that cover many different faiths with regard to different issues of relevance in healthcare, inclusive of death and dying. https://www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf

10. Last Offices

NICE Quality Statement 12: The body of a person who has died is cared for in a culturally sensitive and dignified manner.

10.1 The physical management of a person who has died can be a distressing and challenging experience for the family, and the care workers. Before undertaking last offices, there are several other events that must take place, including confirmation of the death.

10.2 Performing last offices is the final demonstration of respectful, sensitive care that a worker can offer a service user / client and their family. It enables families to be aware that care and respect continues after death, some family members may wish to be involved in the process It allows both worker and family members the opportunity for closure in the relationship, which can be helpful in the bereavement process. Families may wish to spend time with their loved one after death prior to last offices being performed. In this situation, the body should be repositioned and the environment tidied, in order to allow this time to be dignified and peaceful.

10.3 Religious and cultural needs: If the opportunity presents itself, it is good practice to sensitively discuss and document the service user's / client's wishes prior to death.

10.4 Infection control: Standard precautions should be used with all clients. Leakage of bodily fluids creates an infection control risk. Therefore, steps should be taken to avoid this. There are some situations which require extra caution when preparing a body for the mortuary, and a body bag may need to be used in some instances, for example:

- a known intravenous drug user
- severe secondary infection
- gangrenous limbs / infected amputation sites
- large pressure ulcer
- clostridium difficile, if leakage present.

11. Care of the Dying Child

11.1 Caring for a child before death can be challenging, involving participation in complex decision making and symptom management. Guidance published by (Together for Short Lives 2012) can be found at: www.togetherforshortlives.org.uk.

11.2 Effective, skilled and sensitive communication is essential in all aspects of children's palliative care. It is described by many as pivotal within a team approach to care whereby good communication and

information can empower families with the knowledge to make informed decisions about care. Working with children also requires the ability to communicate not only with the child but also siblings, friends and peers in an age appropriate manner.

11.3 Effective symptom management for children is pivotal in ensuring comfort and maximising their quality of life. Symptom management in children is a multi-professional approach ensuring that child centered care is delivered in partnership with the child and family.

11.4 Predicting death in children is not easy, it can be an intensely emotional waiting game for a child to reach the point of death.

11.5 After death, parents may need guidance on what they are able to do. For example, they may seek permission to cuddle their child. It is important to work alongside the family and to go at their pace.

12. Notification to CQC, RQIA, CIW and SCI

12.1 If Acacium Group are the commissioned provider of care to a dying client and the client dies, Acacium Group are required to complete a notification to the relevant regulator.

12.2 CQC: When a client dies in England, as part of 'Outcome 18 Notification of death of a person who uses the services', the death must be notified to the CQC. The notification must include the following, if applicable:

- A unique identifier or code for the person
- The date when they started using the service
- The date and time of their death
- The time the person was found
- Whether the death was expected
- Whether the person was being restrained at the time of their death or within the seven days before their death
- Whether there are concerns about the use of controlled or other drugs relating to the death
- Whether there are concerns about the use of medical devices relating to the death
- Relevant dates and circumstances, using unique identifiers and codes where relevant
- Personal details about the person (date of birth, gender, ethnicity, disabilities, religion, sexual orientation).

12.3 Care Inspectorate: When a client dies unexpectedly in Scotland, immediate reporting is required. This includes reporting if:

- The person normally used a 24-hour service but was not present in that service at the time of death
- A death occurs, or was identified, when a support service, including day care and care at home, was being provided.

12.4 RQIA: There is no requirement for domiciliary care agencies or nursing agencies to report deaths, whether expected or unexpected, according to the RQIA reporting requirements.

12.5 CIW: When a client dies in Wales the CIW require us to complete a REG 26 Form, details should include:

- Time of death
- Date of death
- Cause of death (if known)

- Place of death.

13. Training

13.1 Acacium Group will enable their workers to participate in training in effective general care and communication. This will be backed up in local induction programmes. The training will be proportionate and relevant, to the roles and responsibilities of each worker.

13.2 The delivery of training is the responsibility of the Line Managers / appropriate others. It is the responsibility of the central training team to organise and publicise educational sessions, and to keep records of attendance.

14. Implementation Plan

14.1 For consultation, ratification and dissemination of this Policy see the Policy for Drafting, Approval and Review of Policies and SOPs.

14.2 This Policy will be implemented through:

- Communication of the Policy to all relevant workers
- Communication of the Policy to all stakeholders
- Raising awareness and understanding of the Policy and related processes throughout the organisation through committee meetings, Acacium Group workers' meetings, Acacium Group Pages on the intranet, the website and general communication
- Through Acacium Group induction programmes and related training.

14.3 This Policy will be implemented as part of the review of governance mechanisms and policies in Acacium Group during 2011. The Clinical Director will ensure the dissemination of this Policy across the organisation.

14.4 **Audit and monitoring**

14.4.1 The Clinical Director will monitor compliance with this Policy. See also the Policy Author's responsibilities in Table 2 in the Acacium Group Policy for Drafting, Approval and Review of Policies and SOPs.

14.4.2 Processes for monitoring the effectiveness of this Policy include:

- Audits of specific areas of practice
- Evidence of learning across the organisation
- Appraisal and Personal Development Plans (PDPs).

14.4.3 The audit will:

- Identify areas of operation that are covered by this Policy
- Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance
- Highlight where non-conformance to procedures has occurred and suggest a tightening of controls, and adjustment to related procedures
- Report the results to the Governance Committee via the Clinical Director.

14.4.4 Specific elements for audit and monitoring are the:

- Investigation of incidents in a manner appropriate to their severity
- Standard of documentation
- Completion of relevant action plans
- Aggregation of incidents and claims
- Frequency and appropriateness of logging incidents
- Management of incidents according to timescales
- Evidence of structured learning across Acacium Group.

14.5 This Policy replaces all other Acacium Group care of the dying client policies.

15. Associated Policies / SOPs

Policies
CLIN 03 Medicines Management Policy
CLIN 06 Consent Policy
CLIN 27 Death of a Client and Last Offices Policy
CLIN 40 Do Not Attempt Resuscitation
CLIN 40-1 Do Not Attempt Resuscitation (ROI)
CLIN 43 Deprivation of Liberties / MCA Policy
CORP10 Policy on Policies Policy

SOP
SOP GEN 13 Eye Care
SOP GEN 14 Mouth Care
SOP GEN 16 Death and Last Offices
SOP GEN 17 Last Offices: Requirements for People of Different Religious Faiths
SOP GEN 20 Pressure Area Care
SOP MEDS 01 Controlled Drugs
SOP MEDS 02 Oral Administration
SOP MEDS 04 Subcutaneous Administration
SOP MEDS 06 IM Administration
SOP MEDS 07 IV Administration
SOP MEDS 08 Administration Via A Central Line

16. References

- Together for Short Lives, 2015. *A core care pathway for children with life-threatening and life-limiting conditions*. Third Edition. TFSL.
- Together for Short Lives, 2012. "A guide to end of life care". TFSL.
- National Institute for Health and Care Excellence, December 2015. *Caring for dying adults in the last days of life*. NICE.
- National Institute for Health and Care Excellence, 2017. End of life care for adults. NICE.
- The Children Act 2004. London: Stationery Office.
- The Human Rights Act 1998. London: Stationery Office.
- The Care Act 2014.
- Mental Capacity Act 2005 (England, Scotland and Wales) HMSO.
- Faith at end of life; A resource for professionals, providers and commissioners working in communities Public Health England 2016
- Dying-and-Death-in-Ireland-what-do-we-routinely-measure-how-can-we-improve-2021.pdf (hospicefoundation.ie)

- Advance-Healthcare-Directive.pdf (endoflifeireland.ie)

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DRA DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1.1 This Policy is supported by legislation and national guidance as set out in the table below

National policies, guidance and legislation supporting general care

Act, policy, guidance	Explanation
Caring for dying adults in the last days of life (NICE, 2015)	An evidence-based approach to the care of dying people.
End of life care for adults (NICE, 2017)	A quality standard covering all settings and services in which care is provided by health and social care staff to all adults approaching the end of life.
Actions for end of life care: 2014 – 16 (NHS England)	Sets out NHS England's commitments to end of life care for adults and children.
Ambitions for palliative and end of life care (NHS England, 2015)	A national framework to ensure that clients who are receiving end of life care are able to access the best service possible.
End of life care for infants, children and young people with life-limiting conditions: planning and management (NICE, Dec 2016)	The guidelines cover the planning and management of end of life and palliative care for infants, children, and young people (0-17yrs), with life limiting conditions.
Mental Capacity Act 2005 (MCA) (England and Wales)	The Mental Capacity Act was a law passed to offer protection to vulnerable people aged sixteen and above who require medical treatment or care but who, for one reason or another, may not have the ability to retain and use the information given in order to make a decision about the choices they are offered. It places a duty on health professionals to assess capacity, where this in doubt and ensure provisions are made to support those with making the right decisions where this is needed. The MCA also ensures that advance decisions are fully complied with.
Mental Health Act 2007 (MHA)	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment and guardianship.
Deprivation of Liberty Safeguards: Code of Practice 2008	The Code of Practice contains guidance on the deprivation of liberty safeguards. It is particularly intended to provide guidance for professionals involved in administering and delivering safeguards. The DoLS code is also intended to provide information for people who are, or could become, subject to the deprivation of liberty safeguards, and for their families, friends and carers, as well as for anyone who believes that someone is being deprived of their liberty unlawfully.
Children Act 1989	This sets out the details regarding who has parental responsibility for a child.

Children Act 2004	The Children Act 2004 requires providers to protect from harm, safeguard and promote the welfare of children. A breach in this consent policy would be against those principles. The Act builds on the Children Act 1989.
Human Rights Act (1998) (HRA)	All UK national legislation is underpinned by the Human Rights Act 1998, which came into full effect in 2000. The Human Rights Act has implications for providers of healthcare. See Appendix B Human rights are about ensuring that clients and workers are safe in healthcare settings, have their privacy and confidentiality safeguarded, and are treated with fairness, dignity and respect.
Delivering high quality end of life care for people with a learning disability NHS England	This guidance has been developed by NHS England in association with the Palliative Care for People with Learning Disabilities (PCPLD) Network 2. The guide aims to support commissioners, providers and clinicians to reduce inequalities in palliative and end of life for people with a learning disability, focusing on 'The Ambitions for Palliative and End of Life Care' 1. These six ambitions provide a framework for national and local health and care system leaders to take action to improve palliative and end of life care. Developed by 27 organisations across the palliative and end of life care system, these ambitions set out what high quality palliative and end of life care looks like.

1. **Equality and diversity**

   Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

2. It is often challenging to be certain that a client is dying. There is often uncertainty about how long a client has to live and the signs that suggest that a client is dying are complex, and subtle. NICE have produced guidelines for the health professional to consider when caring for a dying client.