# End of Life Care Policy

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| **Policy Lead** | Richard Drakeford |
| **Registered Manager** | Robin Page |
| **Nominated Individual** | Richard Drakeford |
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| **Signature** | RICHARD DRAKEFORD |

# Contents

## 1.0 Introduction

This policy will ensure people with palliative and end-of-life care needs receive safe, personalised, lawful and compassionate transport and care that upholds their dignity, preferences and legal rights; and that our service meets CQC Fundamental Standards and UK law.

Re-Pat Ltd has an obligation to be aware of DNACPR's and service user wishes. All appropriate Re-Pat Ltd staff should make themselves aware of the correct processes to follow when caring for a service user who is approaching the end of their life and has an advanced care plan.

This policy does not include service users who do not have a documented refusal of resuscitation in the form of a DNAR, Living will, advance directive or decision.

This procedure only includes service users whose Advance Decision to Refuse Treatment or Lasting Power of Attorney legal documents refers to the decision not to resuscitate if their heart stops. All other refusal of treatment or treatment choices under these legal documents do not fall under the scope of this policy. Failure to comply with the requirements of this procedure may result in investigation and subsequently may result in formal action in line with Re-Pat Ltd.'s disciplinary procedures.

## 2.0 Policy Statement

Re-Pat Ltd will ensure that all procedures and supporting documentation reflect current legislative requirements and guidance in relation to EoLC management and that any additional statutory or best practice requirements and recommendations are implemented appropriately.

All people are presumed to be "For CPR" unless:

- A valid DNACPR decision has been made and documented; or
- A valid and applicable Advance Decision to Refuse Treatment (ADRT) prohibits CPR; or
- A personal welfare attorney (PWA), appointed by the service user to make life-sustaining treatment decisions when they lack the capacity to do so themselves, or has refused consent to CPR.

For the purposes of this policy Re-Pat Ltd has made distinctions between service users with Do not Resuscitate decisions into the following categories:

- People with a valid DNACPR order
- End of Life Service users – Transfer home - who are dying, from a care facility to home.
- End of Life Service users – Transfer to care facility - who are dying, to a care facility.
- End of Life Service users – Ongoing care - who are symptomatic and may require ongoing care and support.

Re-Pat Ltd will seek to increase awareness amongst staff on all matters relating to advanced care plans/service users who are reaching the end of their lives with documented advanced decisions.

## 3.0 Scope

This procedure applies to all staff that may come into contact with end-of-life service users.

## 4.0 Roles and Responsibilities

**Registered Manager**

- Has overall responsibility for ensuring that systems for the safe, compassionate and humane care for service users being treated under an advanced care plan and those with a valid DNACPR are followed by Re-Pat Ltd.
- Has responsibility and accountability for monitoring and ensuring the provision of the appropriate resources required to implement this procedure.
- Is responsible for the development, implementation and co-ordination of the consistent, quality, efficient and clinical based approach to the advanced care plan and DNACPR process across the business.

**All Staff**

- Are responsible for understanding and complying with the requirements of this procedure, its associated work instructions, forms and clinical instructions in line with their clinical grade and trained scope of practice.
- All personnel involved in the care of end-of-life service users must exercise sound ethical and clinical judgement to act in accordance with the person's wishes, insofar as these can be ascertained.
- All staff are responsible for ensuring they are competent in the latest DNAR, ADRT and ROLE procedures as part of their continued professional development and Re-Pat Ltd issued clinical memos.

## 5.0 Definitions

**Advance Care Planning (ACP) –** Is a process of discussion between an individual and their care providers irrespective of discipline. This can cover one or more of:

- Advance statement
- Lasting Powers of Attorney
- Advance decision to refuse treatment
- Do not resuscitate order.

**Advance Decision to Refuse Treatment (ADRT) –** The Mental Capacity Act (2005) provides the statutory framework to enable adults with capacity to document clear instructions about refusal of specific medical procedures should they lack capacity in the future. An advance decision to refuse treatment:

- Can be made by someone over the age of 18 who has mental capacity.
- Is a decision relating to refusal of specific treatment and may be in specific circumstances.
- Can be written or verbal.
- If an advance decision includes refusal of life sustaining treatment, it must be in writing, signed and witnessed and include the statement 'even if life is at risk'.
- Will only come into effect if the individual loses capacity.
- Only comes into effect if the treatment and circumstances are those specifically identified in the advance decision.
- Is legally binding if valid and applicable to the circumstances.

**Advance Statement –** Is a summary term embracing a range of written and / or recorded oral expressions, by which people can, write down or tell people about their wishes or preferences in relation to future treatment and care, or explain their feelings, beliefs and values that govern how they make decisions. They are not legally binding but should be used when determining a person's best interests in the event they lose capacity to make those decisions.

**Cardiopulmonary Resuscitation (CPR) –** Is an emergency procedure which may include chest compressions and ventilations in an attempt to maintain cerebral and myocardial perfusion, which follows recommended current Resuscitation Council (UK) guidelines.

**Cardiac Arrest –** Is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness and apnoea or agonal gasping respiration. In simple terms, cardiac arrest is the point of death.

**Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) –** Refers to a decision not to make efforts to restart breathing and / or the heart in cases of respiratory / cardiac arrest. It does not refer to any other interventions, treatment and/or care such as fluid replacement, feeding, antibiotics etc.

**DNAR –** A DNAR form (also called a DNR or DNACPR order) is a document issued and signed by a doctor, which states not to attempt cardiopulmonary resuscitation (CPR).

**End of Life Care (EoLC) –** This is the common name for care in the last stages of life.

**Lasting Power of Attorney (LPA) –** The Mental Capacity Act (2005) allows people aged 18 years or over, who have capacity, to make a LPA by appointing a Personal Welfare Attorney (PWA) who can make decisions regarding health and wellbeing on their behalf once capacity is lost.

Note: Not all PWAs have authority to make life-sustaining treatment decisions. All LPA documentation should be checked and, if in doubt, contact should be made with the Office of the Public Guardian to clarify the validity of the LPA. LPA provides for a 'proxy' decision maker to provide or withhold consent once a person has lost capacity.

**The Mental Capacity Act 2005 (MCA) –** This act was fully implemented on 1 October 2007. The aim of the act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.

**Mental Capacity –** An individual aged 16 or over is presumed to have the mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals will lack capacity if they are suffering from an impairment of, or disturbance in, the functioning of the mind or brain and are unable to demonstrate that they can do any of the following:

- Understand information relevant to the decision provided to them in the most appropriate way for the individual; or
- Retain that information for long enough to make a decision; or
- Use or weigh that information as part of the process of making the decision; or
- Communicate the decision, whether by talking or sign language or by any other means.

**National Institute for Health and Clinical Excellence (NICE)** – The independent body that guides the NHS on promoting good health and treating illness.

**Palliative Sedation –** This is very heavy sedation, meaning that the service users are unconscious until death.

**Respiratory Arrest –** Is the cessation of normal respiration due to failure of the lungs to contract effectively.

**ROLE –** Recognition of Life Extinct.

## 6.0 Duty Of Candour

Re-Pat Ltd acknowledges it responsibilities and duties under the provisions detailed within Regulation 20 of the 'CQC Fundamental Care Standards' relating to a duty of candour.

Re-Pat Ltd is committed to ensuring that it is open and honest with service users and other relevant persons (people acting lawfully on the behalf of service users) when things go wrong with care and treatment, and that they provide them with reasonable support, truthful information and a written apology where necessary.

## 7.0 Legislation & Guidance

**Legislation**

Under the Mental Capacity Act (2005), health and social care staff are expected to understand how the act works in practice and the implications for each service user for whom a DNACPR decision has been made.

The following sections of the Human Rights Act (1998) are relevant to this policy:

- The individual's right to life (article 2).
- To be free from inhuman or degrading treatment (article 3).
- Respect for privacy and family life (article 8).
- Freedom of expression, which includes the right to hold opinions and receive information (article 10).
- To be free from discriminatory practices in respect to those rights (article 14).

### 7.1 EoLC Frameworks

**Gold Standards Framework (GSF)**

This aims to ensure that symptoms are well controlled and that service users are enabled to die in their preferred place of care. Through advance care planning it aims to foster security and support thus ensuring fewer crises leading to hospital admission. Communication is paramount in supporting carers and giving staff the confidence to provide good quality EoLC.

**Preferred Priorities of Care (PPC)**

The PPC is a document that individuals hold themselves and take with them if they receive care in different places. It has space for the individual's thoughts about their care and the choices they would like to make, including saying where, if possible, they would want to be when they die.

Information about choices and who might be involved in their care can also be recorded, so any care staff can read about what matters to the individual, thereby ensuring continuity of care.

This is especially useful for ambulance service personnel when deciding the best course of action to take when called to see a service user with a terminal illness.

### 7.2 Priorities of Care for the Dying Person

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours:

- This possibility is recognised and communicated clearly, decisions made, and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the dying person, and those identified as important to them.
- The dying person, 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, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

### 7.3 Guidelines

The NICE guidelines - Quality standard for EoLC for adults (2011) provides a comprehensive picture of what high quality EoLC should look like. Delivered collectively, this should contribute to improving the effectiveness, safety and experience of care for adults approaching the end of life and the experience of their families and carers.

This is described through the 16 quality statements. The standards relevant to this policy include:

- 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.
- The body of a person who has died is cared for in a culturally sensitive and dignified manner.
- People closely affected by a death are communicated with in a sensitive way and are offered immediate and on-going bereavement, emotional and spiritual support appropriate to their needs and preferences.
- People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.
- People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.
- Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.
- Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.

### 7.4 Resuscitation Council UK

Recommended standards for recording decisions about cardiopulmonary resuscitation (CPR) 2015. Through the wording and implementation of their resuscitation policy, all healthcare organisations should therefore ensure:

- Effective recording of decisions about CPR in a form that is recognised and accepted by all those involved in the care of the service user.
- Effective communication with and explanation of decisions about CPR to the service user, or clear documentation of reasons why that was impossible or inappropriate.
- Effective communication with and explanation of decisions about CPR to the service user's family, friends, other carers or other representatives, or clear documentation of reasons why that was impossible or inappropriate.
- Effective communication of decisions about CPR among all healthcare workers and organisations involved with the care of the service user.
- To facilitate this (and to facilitate clinical audit) it is recommended that decisions about CPR are recorded on a standard form that is used, recognised and accepted across geographical and organisational boundaries. It is recommended that:
- Paper forms on which CPR decisions are recorded should travel with the service user whenever possible.
- When a person is at home and has a current CPR decision (a DNACPR decision), they understand and accept they should have with them a CPR decision form recording that situation.
- If healthcare organisations require copies of CPR decision forms for audit or record purposes it is recommended that each form is available in duplicate or triplicate with non-carbon copies that are a different colour and that have different printed wording to reflect their purpose. Only the original (top) copy can then be identified as a CPR decision record for clinical use, avoiding the potential danger of a copy being used to guide clinical decisions when the original may have been cancelled.
- If CPR decision forms are completed and / or stored electronically:
    - They should contain all the required elements defined in this quality standard; they should be accessible immediately by all the organisations and individuals who may be involved in the person's care.
    - There should be robust arrangements in place to ensure that they remain current and appropriate.

## 7.5 Overview (End Of Life & Palliative Care)

A working definition of EoLC has been developed by the National Council for Palliative Care: EoLC helps all those with advanced, progressive, incurable conditions to live as well as possible until they die.

It enables the supportive and palliative care needs of both service user and family to be identified and met through the last phase of life and into bereavement. It includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

Palliative care may be defined as: the active holistic care of service users with advanced progressive illness, along with the total care of service users at a time when their disease is no longer responsive to curative treatment and when life expectancy is relatively limited. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount.

The goal of palliative care is achievement of the best quality of life for service users and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.

The needs of such service users include the basic and underlying needs of any service user. However, there are added considerations and actions that must be adopted to ensure that the best possible care is given.

According to the National Council for Palliative Care, palliative care aims to:

- Affirm life and regard dying as a normal process.
- Provide relief from pain and other distressing symptoms.
- Integrate the psychological and spiritual aspects of service user care.
- Offer a support system to help service users live as actively as possible until death.
- Offer a support system to help the family cope during the service user's illness and in their own bereavement.

### 7.6 Do Not Attempt Resuscitation

Re-Pat Ltd acknowledge the involvement of specialist palliative care teams in the decision-making process of a service user's care when placed on an end-of-life care and palliative care plan. These decisions also include the initiation of cardio-pulmonary resuscitation.

For service users who are not on an End-of-Life Plan, or who have not had a do not resuscitate decision.

The British Medical Association, Royal College of Nursing and Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:

Where competent service users express a desire not to be resuscitated.
Where cardiopulmonary arrest is the end result of a disease process where appropriate treatment options have been exhausted.

Where resuscitation would be followed by a duration or quality of life that would be unacceptable to the service user.

Any agreed DNA-CPR request must be communicated to relevant healthcare professionals which includes the ambulance service.

DNAR decisions will have been made following, where appropriate, discussion and consultation with the service user and in most cases with consideration of the views of the service users' family / next of kin.

This process will have taken place following full consideration of the service user's condition and based on set standards. It is the responsible clinician's duty to ensure these standards are adhered to.

DNAR decisions may have also been initiated by the service user themselves and in line with best practice and End Of life frameworks advance care planning by the service user is common practice in the current environment.

Re-Pat Ltd support best practice and service user choice and will ensure an understanding of service user wishes and documentation in line with this Do not Resuscitate and End of life Plan policy.

### 7.7 Advance Care Planning

Advance care planning (ACP) is a process of discussion between an individual and their care providers irrespective of discipline.

The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and / or ability to communicate wishes to others.

**Advance Statement -** Re-Pat Ltd acknowledges that this is not a legal binding statement and will where clinically appropriate support the wishes of the service user when staff / contractors of services may be placed in the position where decisions about care and treatment must be made in line with their trained scope of practice.

**Lasting Powers of Attorney -** Re-Pat Ltd acknowledges that if a service user is deemed to no longer have the capacity to make decisions, the decision to initiate CPR will be decided by the nominated attorney. The documentation must be signed and stamped on every page and must be a LPA for health and welfare only.

Re-Pat Ltd and contractors of services must ensure the 'proxy' decision maker is present if the decision not to initiate CPR is undertaken (see section 7 for definitions):

**Advance Decision to Refuse Treatment (ADRT) -** Re-Pat Ltd acknowledges that the ADRT must specifically state that the service user does not want to receive lifesaving treatment in the form of CPR if their heart were to stop and it must be signed and dated to that effect.
An ADRT may be present which clearly refers to artificial resuscitation in the event of a worsening chest infection in a service user with COPD. This would not however, preclude treatment if the service user chokes on a food bolus.

**Do not Resuscitate Order (DNAR) -** The DNAR order if valid, is relevant regardless of the reason for the death. It should not be confused with an Advanced Decision to Refuse Treatment, which is specific to the context to which it refers.

A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include but are not restricted to choking, a displaced tracheal tube or a blocked tracheotomy tube.

Re-Pat Ltd staff and contractors of services must take note that a DNACPR decision does not include immediately remediable life-threatening clinical emergencies such as choking or anaphylaxis. Appropriate emergency interventions including CPR should be attempted.

## 7.8 Types Of DNACPR Orders

Many areas of the country now have a unified document that remains in the care of the individual. Currently unified DNACPR forms are used in the Northeast, YAS, EMAS, East of England, South East Coast, South Central areas.

Smaller areas where they apply are Coventry and Warwickshire, South Warwickshire, Bristol, South Gloucester, North Somerset regions. This system is under review in most areas, and it anticipated that unified forms will ultimately cover England and Wales.

There are a number of valid forms used by the different trusts around England and Wales. Some examples of different documents in circulation are:

- Traditional red or black bordered DNAR form.
- Treatment Escalation Plan (TEP) form.
- Trust headed letter style document.

Service users who have an "indefinite" DNA-CPR order in place will usually hold their own paperwork as it becomes their own property.

### 7.9 Location Of DNACPR Documentation

Re-Pat Ltd acknowledges the importance of being able to access DNACPR documentation. At Re-Pat Ltd any information around DNACPR will be found on 'RDrive' an encrypted cloud based digital platform accessed by administrator and given to a crew when needed

### 7.10 Validity Of Advance Care Plan Documents

All DNACPR forms require a signature of authority and the date the DNACPR order was made. The DNACPR Order must contain the following information:

- The service user's full name, date of birth and address should be written clearly.
- The date of recording the decision should be entered.
- This decision will be regarded as "INDEFINITE" unless it is clearly cancelled or a definite review date is specified.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and "CANCELLED" written clearly between them, signed and dated by the healthcare professional cancelling the decision.

However, a DNACPR order has no natural expiry date and may be in place over a prolonged period of time.

The advance decision must:

- Be clear and unambiguous.
- Have been made when the service user was over the age of 18 and fully informed about the consequences of refusal of treatment, including the fact that it may hasten death.
- Not have been made under the influence of other people.
- Be written down and be signed and witnessed if it relates to refusing lifesaving treatment.

An advance decision cannot be used to:

- Refuse treatment at a time when you still have capacity to give or refuse consent.
- Refuse basic care essential to keep the service user comfortable, such as washing or bathing.
- Refuse the offer of food or drink by mouth (but it can be used to refuse feeding by tube, for example).
- Refuse the use of measures solely designed to maintain comfort – for example, painkillers (which relieve pain but do not treat the condition).
- Demand specific treatment.
- Refuse treatment for a mental disorder in the event that you are detained under the Mental Health Act 1983.
- Ask for anything that is against the law, such as euthanasia or assisting you in taking your own life.

If a service user has both a valid ADRT and a valid LPA in place then the most recent document is the one that must be followed and takes precedence.

If the validity of a DNACPR, ADRT or LPA is in doubt by a staff member advice must be sought via the Clinical management team. In emergency situations where there is no time to appropriately verify the document and justification is evident for the doubt in validity of the documents CPR should be initiated. A full account of the incident must also be completed in line with Re-Pat Ltd policies and procedures.

### 7.11 Absence Of DNACPR Order Or ADRT Specifying DNACPR

Where staff are advised that a DNACPR order or ADRT is in place but is not provided at the location, they should enquire in a confidential environment about whether the order is in place and is still valid.

Where it cannot be ascertained that a valid DNACPR or ADRT is in place then the staff should advise that CPR will be attempted in the event of cardio-pulmonary arrest.
If a valid DNACPR Order or ADRT is not in place or cannot be found the Re-Pat Ltd staff and contractors of services must initiate CPR in line with their clinical scope of practice.

### 7.12 Notification Of DNACPR

Staff members should generally be made aware of a DNACPR order by the management team, who will have been informed of the order on registration.

### 7.13 Next Of Kin

Staff members may also need to be aware of whether the next of kin have been informed that there is an existing DNACPR order on a relative, especially if the next of kin is intending to attend with the relative. Staff members should enquire in a confidential environment to ensure there is an understanding of the DNACPR order.

If a service user has a DNACPR in place and does not wish their relatives to be made aware of it, their decision must be respected. In the event of the person dying and the need to withhold CPR occurs, the existence of the DNACPR should be explained to the relatives or carers. To inform the relatives or carers of its existence prior to death would go against the service user's human rights.

### 7.14 Confidentiality

At no time should the existence of a DNACPR order be questioned in an open environment. CQC regulations clearly state that the care, dignity and respect of the individual and service user confidentiality should be adhered to at all times.

### 7.15 Service users With DNACPR And No EOLP

The service user must be cared for in line with their treatment plan and Re-Pat Ltd policies and procedures.

### 7.16 Developing an End-of Life Care Plan

Re-Pat Ltd recognises that service users who are suffering from terminal illness and who are in the last stages of that illness need total care, including emotional care and frequent attention.

We achieve this by drawing up an end-of-life care plan in partnership with the service user, the family and relevant health professionals.

Any changes to the person's medication regime as a result of any changes to her/his condition, which have been authorised by the medical practitioner are fully recorded and acted upon.

The care plan includes descriptions of how to:

- reduce or control pain and discomfort
- reduce or control signs of restlessness, anxiety or agitation
- manage or control respiratory secretions
- manage or control any nausea/vomiting
- maintain mouth care
- manage or control elimination of urine or faeces
- relieve pressure, reduce or manage pressure points and sores

The care plan will then be stored on Birdie for staff to access it. The care plan contains details of any new procedures or interventions to be made in the light of the person's changing condition and of any current procedures or interventions that have been modified.

Re-Pat Ltd makes every effort to ensure that the service user's wishes in respect of their religious or cultural practices are fully respected. In most instances we are aware of these as they will have been recorded previously in their service user plan of care or as an advanced directive.

Where the person's wishes remain unclear and they have lost the mental capacity to clarify and communicate these, Re-Pat Ltd makes every effort to ascertain them from relatives, friends and professional who know the person. This then enables the arrangements made to be as close as possible to what the person would probably have wished, in accordance with the "best interests" principle of the Mental Capacity Act 2005.

### 7.17 Service user Who Dies, Who Has A DNACPR Order, But Was Not Expected to Die

In the unlikely event of a service user going into cardiac arrest whilst in the care of staff members, 999 should be called immediately by the staff in the presence of the service user.
If the service user does not have a DNACPR order or the existence cannot be validated, then CPR must be initiated.

Maintaining the dignity of the service user who has passed away is paramount.

The following must be documented by the staff if the service user has passed away.

- The service user details.
- That the DNA CPR order was seen and CPR not initiated.
- Details of any interaction with the service user prior to cardiac arrest (e.g. how the service user appeared, interacted and communicated prior to arrest).
- If there was any noted deterioration during the service user treatment (such as coughing, vomiting, chest pain, or no clinical concern noted).
- Details of basic vital signs in observation section (e.g. Level of consciousness –U, Breathing – 0 or absent, Pulse 0 or absent).
- Details of the care provided (e.g. Service user found unresponsive, breathing and pulse checked and found to be absent, 999 called, blanket placed on service user for dignity, service user handed over.

Management at Re-Pat Ltd will then report this to the CQC.

## 8.0 End of Life Care- Re-Pat Ltd

### 8.1 Booking and Pre-Transport Assessment

At time of booking staff at Re-Pat Ltd must confirm:

- Service user is receiving palliative or end-of-life care
- Current clinical status, mobility, and comfort needs
- DNACPR and ReSPECT forms are completed and available
- Family or clinical escort (if required)

Re-Pat Ltd staff will use end of life care Transport Checklist (Appendix A) to guide pre-journey planning.

The organisation will prioritise and confirm the need for same-day or urgent transport when returning home to die (fast-track discharge).

### 8.2 Care and Communication Principles

When communicating with service users and their relatives, Re-Pat Ltd staff will ensure that service users are always treated with respect and dignity.

Staff will:

- Use calm, respectful tone. Avoid rushed or clinical jargon.
- Allow service users time to express needs or fears.
- Maintain dignity by offering blankets, covering body appropriately, and ensuring privacy.
- Inform family members of estimated arrival times and allow them to travel where possible.

To ensure that service users are comfortable throughout their journey, staff will ensure that vehicle environment is comfortable and fully equipped. Staff will;

- Ensure stretchers are cushioned and reclined appropriately.
- Maintain interior warmth and cleanliness.
- Ensure presence of:
    - Blankets and pillows
    - Oxygen (if required)
    - Waste disposal for soiled materials
- Securely transport any medication or devices

### 8.3 Emergency Procedures

**If service user deteriorates or dies en route:**

- Stop the vehicle in a safe place.
- Do not initiate CPR if valid DNACPR or advance directive is present.

- Contact clinical lead, GP, or 111/999 as per local protocol.
- Inform control centre and receiving team.
- Treat service user and family with utmost respect.

Please read in conjunction with medical emergency/deteriorating service user policy

### 8.4 Documentation and Confidentiality

Re-Pat Ltd staff must follow processes for document and record keeping in both the documentation policy and GDPR policy.

At handover, Re-Pat Ltd staff must ensure that the following has been recorded:

- Pickup and drop-off times
- Service user observations and comfort interventions
- Any incidents or concerns

Any paper documentation used during transportation must be uploaded onto electronic recording system to avoid any duplication of records.

## 9.0 Staff Welfare

Re-Pat Ltd acknowledges that care of an end-of-life service user, especially when the service user passes away, can be difficult and emotive.

Re-Pat Ltd also acknowledges its role in the welfare of the service user, family and friends present and that of our staff who have been interacting with all involved.

Where appropriate, welfare checks shall be completed by members of the management team and where indicated referrals can be made to occupational health in line with HR policies and procedures.

When the clinical incident is reviewed by the clinical management team further information or welfare requests will be initiated and discussed in liaison with the operational team and the staff member themselves in line with HR policies and procedures.

## 10.0 Training & Education

Training will be delivered to ensure competency in areas of DNAR and End of life procedures. This will be delivered face to face with a registered trainer and will be renewed annually.

All service user facing staff will be responsible for ensuring they are competent and up to date with regard to DNAR procedures.
All admin team members will also receive End of Life and DNACPR awareness training relevant to their role provided by Re-Pat Ltd.

## 11.0 Monitoring

All incidents, complaints or feedback regarding EoL service users and DNACPR will be reported via the Re-Pat Ltd incident reporting mechanisms.
Where appropriate procedures and education materials shall be reviewed and issued in line with actions determined from any incident reported.

## 12.0 Relevant Policies and Procedures

Person Centred Care Planning
Information Governance
Advanced Care Planning
Duty of Candour

## 13.0 Legislation and Guidance

Overview | End of life care for adults: service delivery | Guidance | NICE
National guidelines for end of life care | Marie Curie
End of life care - NHS

## Appendix 1 – End of life care transport checklist

**Patient Name:** _____
**NHS Number:** _____
**Date of Transport:** _____ **Time Requested:** _____

**Patient Status**

| | Yes | No | Notes |
|---|---|---|---|
| Is the patient confirmed as receiving end-of-life or palliative care? | ☐ | ☐ | |
| Is this a fast-track or urgent discharge? | ☐ | ☐ | |
| Has a clinical referrer (e.g. nurse/doctor) confirmed that transport is appropriate? | ☐ | ☐ | |
| Is the patient medically stable for transport? | ☐ | ☐ | If no, escalate to clinical team. |

**Documentation**

| | Yes | No | Notes |
|---|---|---|---|
| DNACPR form is completed and will travel with the patient | ☐ | ☐ | Confirm validity and visibility |
| Advance care/treatment escalation plan available (e.g. ReSPECT form) | ☐ | ☐ | |

| | Yes | No | Notes |
|---|---|---|---|
| Medication and/or syringe driver accompanies patient | ☐ | ☐ | Ensure safe packaging and securement |
| Receiving location has been confirmed (e.g. hospice/home) | ☐ | ☐ | Confirm with contact name/number |

**Patient Needs**

| | Yes | No | Notes |
|---|---|---|---|
| Does the patient require a stretcher? | ☐ | ☐ | |
| Is oxygen required during transport? | ☐ | ☐ | Check flow rate and supply |
| Will a clinical escort or carer accompany the patient? | ☐ | ☐ | Name/contact: _____ |
| Are there mobility, hoisting, or infection control needs? | ☐ | ☐ | Specify: _____ |
| Does the patient require special handling (e.g. pressure care)? | ☐ | ☐ | Blankets/cushions arranged |

**Communication**

| | Yes | No | Notes |
|---|---|---|---|
| Has the family/carer been informed of estimated transport time? | ☐ | ☐ | |
| Has the receiving facility confirmed readiness? | ☐ | ☐ | Contact name: _____ |
| Do staff understand how to respond to deterioration en route? | ☐ | ☐ | Follow EoLC Protocol |
| Is there an agreed escalation pathway if the patient deteriorates or dies during transport? | ☐ | ☐ | |

**Vehicle & Staff Preparedness**

| Checklist Item | Complete | Notes |
|---|---|---|
| Appropriate vehicle allocated (clean, warm, stretcher-equipped if needed) | ☐ | |
| Blankets, pillows, and hygiene items available | ☐ | |
| Oxygen cylinder functional (if needed) | ☐ | |
| Staff are aware the journey is end-of-life care | ☐ | |
| Driver and escort (if present) trained in EoLC awareness | ☐ | |
| Emergency contact numbers for clinical support available | ☐ | |

**Final Confirmation**

| | Complete | Notes |
|---|---|---|
| All documentation secured and accompanies patient | ☐ | |

| | Complete Notes |
|---|---|
| Dispatch and crew briefed on patient needs and plan | ☐ |
| Time of pickup confirmed with family/care provider | ☐ |
| Patient dignity and privacy will be maintained throughout | ☐ |

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**Completed By:** _____
**Date/Time:** _____
**Signature:** _____