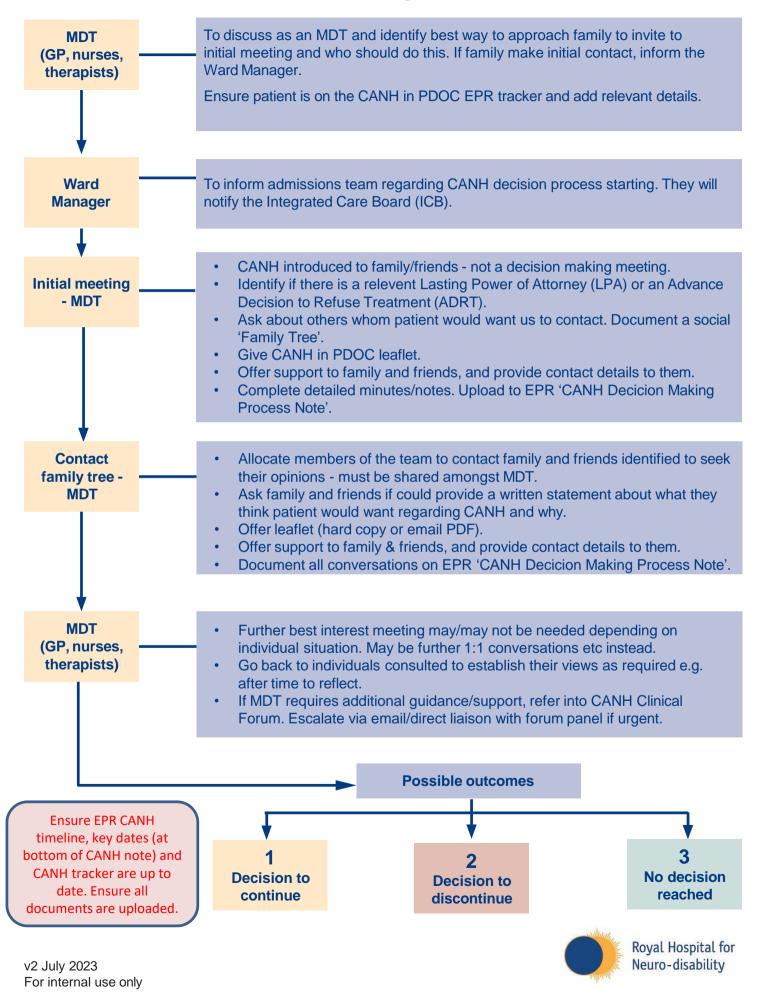
For CURRENT PATIENTS in Continuing Care



For CURRENT PATIENTS in Continuing Care

Outcome 1: Decision to continue

Where all agree that it is in the person's best interests to continue CANH:



Key points to communicate with family. Nursing team to take lead on communicating with family, unless clearly delegated to another team member.



1. Nursing team to ensure all consulted are aware of the decision and review date. This can be delegated to key family member or friend to disseminate if appropriate.



2. Most appropriate MDT member (negotiate this as a team) to complete Continue CANH Decision form (on Clinical Form Index or EPR). It requires a very clear review date and to be signed by the decision maker (GP/LPA holder).



3. Ward manager to notify admissions team who will send notification of the continue decision and the review date to the ICB.





Decision to be reviewed as per review date. This should be at least annually, as part of the patient's annual review. This is also an oportunity to review TEP and other decisions. Ensure clearly documented.

Ensure EPR CANH timeline, key dates (at bottom of CANH note) and CANH tracker are up to date. Ensure all documents are uploaded.



For CURRENT PATIENTS in Continuing Care

Outcome 2: Decision to discontinue

Where all agree that it is in the person's best interests to discontinue CANH:



Key points to communicate with/update family. Nursing team to take lead on communicating with family, unless clearly delegated to another team member.

Families should be contacted at least every two weeks, even if no news, during process leading up to discontinuation.

- The MDT to ensure all consulted individuals are aware of the decison to discontinue and what happens next.
 - Offer family/friends support

2. **GP** to formally notify Neuro-Palliative Lead

 Most appropriate MDT member to complete discontinue CANH form.
 Needs to be signed by decision maker (in MCA/DoLS system - best interest form).

 Neuro-Palliative Lead will inform Medical Director and seek second opinion as per RHN policy.

The **Neuro-Palliative Lead** to notify **Admissions team** who will contact ICB regarding decision to discontinue and funding for second opinion.

 Therapy team to compile PDOC assessment summary form with history of assesssment findings (in clinical form index).

If last MDT review/PDOC assessment was >6 months ago, then therapy team to complete 3x WHIMs or CRSRs.

PDOC Specialist Consultant to complete RCP Form 2f.

6. **GP** to refer to **Trinity Hospice/Palliative**Care Consultant re:
draft terminal care plan.

 Neuro-Palliative Lead to liaise with MDT regarding second opinion date.

MDT to be available for second opinion visit as requested by second opinion Doctor.

Nurse to link in with family regarding of date and time of second opinion visit so family can be available to consult.

 Await second opinion report. Neuro- Palliative Lead to submit report to Medical Director.

If second opinion agrees with discontinue decision then discontinuation process proceeds.

 Ward manager and Matron to initiate/ continue support for ward team around decision/End Of Life care.

Arrange meeting with family about what to expect re: discontinuation and next steps.

Offer Trinity support to family.

- Case presented by Medical Director to RHN
 Executive Management team to check process has been followed correctly.
- 11. Case presented by **Medical Director** to RHN Ethics Committee to check process has been followed correctly.
- 12. **Medical Director** to inform Consultant/GP in writing. **Consultant/ GP** to inform family and provide decision in writing. **Nursing team** to lead on negotiating and agreeing date for discontinuation with family and the rest of MDT, and inform **Admissions Team** to notify ICB.
- 13. Discontinuation starts. Support for family and staff ongoing.



Royal Hospital for Neuro-disability

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For CURRENT PATIENTS in Continuing Care

Outcome 3: No decision reached

Where the issues are finely balanced or there is disagreement about what is in the person's best interests:



Key points to communicate with/update family. Nursing team to take lead on communicating with family, unless clearly delegated to another team member.

Families should be contacted at least every four weeks, even if no news.

2. CANH Clinical 3. If mediation to reach a settled view Forum to advise 1. MDT to escalate the case is not successful or possible then regarding additional to CANH Clinical Forum MDT to escalate to Neurosupport or mediation. if not already done so. **Palliative Lead and Medical** All parties to be kept Director. informed. 4. **GP** to compile medical summary, 5. Therapy team to compile PDOC assesment summary form with history stating diagnosis, current status and of assessments. trajectory. If last MDT review/PDOC assessment Link in with **PDOC Specialist** was >6 months ago, then therapy team to Consultant who will complete RCP form complete 3x WHIMs or CRS-Rs. 6. Most appropriate MDT member to 7. MDT to inform family/ friends consulted that complete Best interest summary form decision is going to court of protection (allocate (from MCA/DoLS system), stating unable to reach settled view and are as appropriate). Offer support to family/friends. continuing CANH at present pending best interest decision from court. **Medical Directors or Neuro-**10. ICB referral to COP to 8. Medical Director to take Palliative Lead to notify be followed up as case to EMT regarding Admissions Team to contact ICB outlined in RHN court bound. regarding referral to Court of Protection CANH in PDOC SOP. (COP). **GP** and **MDT** to support with completion of letter/ supporting documentation.

Ensure EPR CANH timeline, key dates (bottom of CANH note) and CANH tracker are up to date. Ensure all documents are uploaded.

