University Hospitals of Morecambe Bay NHS Foundation Trust

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Document Title: **Caring for the Dying Patient (CDP)**	**Version Number:** 2.4
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Scope: All UHMBT Staff	**Classification:** Organisational
Author / Title: Joy Wharton, Macmillan Lead Palliative Care Nurse	**Responsibility:** Palliative & End of Life Care
Replaces: Version 2.3, Caring for the Dying Patient, Corp/Guid/023	**Head of Department:** Dr Nick Sayer, Consultant Palliative Care
Validated By: Palliative Care Group Medicine DGAG	**Date:** 31/05/2016 15/07/2016
Ratified By: Procedural Document & Information Leaflet Group	**Date:** 17/08/2016
Review dates may alter if any significant changes are made	**Review Date:** 01/07/2019 (Extended – Form 065/2019)

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 1,2,3,4 Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** None Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Reference Check Completed by……Joanne Shawcross …..Date……10.5.16….

To be completed by Library and Knowledge Services Staff

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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

This Guideline sets out the approach to caring for dying people.

The approach on which this Guideline is based focuses on achieving the Five Priorities for care detailed in 'One Chance to get it right 2014'[1], these make the dying person themselves the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying person.

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

1. 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.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. 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.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. 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.

The Priorities are all equally important to achieving good care in the last few days and hours of life. Each supports the primary principle that individual care must be provided according to the needs and wishes of the person. Caring for people who are close to death demands compassion, kindness and a skilled application of knowledge.

In line with NICE CG31[4] this guideline covers the clinical care of adults (18 years and over) who are dying during the last 2 to 3 days of life. It aims to improve end of life care for people in their last days of life by communicating respectfully and involving them, and the people important to them, in decisions and by maintaining their comfort and dignity. The guideline covers how to manage common symptoms without causing unacceptable side effects and maintain hydration in the last days of life.

2. PURPOSE

To deliver the five Priorities for care of the Dying Person consistently for all patients in the last few days and hours of life.

3. SCOPE

Duties of all staff within UHMBT caring for dying patients are to follow this Guideline.

All health and care staff who care for dying patients must ensure that they are aware of and follow up to date guidance and local best practice- they must recognise that the evidence on which this is based will continue to evolve, so a commitment to lifelong learning is fundamental.

The End of Life Care Strategy[2] stipulates that: 'ensuring that health and social care staff at all levels have the necessary knowledge, skills and attitudes related to care for the dying will be critical to the success of improving end of life care. For this to happen, end of life care needs to be embedded in training curricula at all levels and for all staff groups. End of life care should be included in induction programmes, in continuing professional development and in appraisal systems.

4. GUIDELINE

Document the information supporting the team's opinion that the patient is dying in the patient record.

The 'Caring for the Dying Patient' (CDP) is a local adaptation of the Northern England Strategic Clinical Network document The Care for the Dying Patient Documentation[3].

UHMBT CDP Documents are available to print as attachments from this document.

Commence the CDP document and CDP e-care plan which comprises:
CDP 1 (see Appendix 1) - Title and Guidance page
CDP 2 (see Appendix 2) - Medical Assessment
CDP 3 (see Appendix 3) - Daily review stickers
CDP 4 (see Appendix 4) - Holistic Nursing assessment (incorporated into CDP e-care plan)
CDP 5 When someone is dying leaflet. The 'When Someone Is Dying' leaflet is available to print from the Northern England Strategic Clinical Network internet pages (see Section 7 for link).

Make a plan (CDP 2, CDP 4) in consultation with the patient if possible, and involving their relative/carer if appropriate consisting of the following:

- Identify any relevant decisions made in advance (e.g. Preferred Priorities for Care [PPC], Advance Decision to Refuse Treatment [ADRT], DNACPR etc.)
- Decide about any relevant monitoring/ investigations/ interventions
- Assess symptoms and agree options for symptom control
- Explore the patient and relative/carer's understanding and concerns about the situation. Provide written information if wished (CDP 5)
- Identify the patient's current wishes, beliefs, values and spiritual needs.
- Discuss and agree with the patient and their relative(s)/carer(s) the options regarding hydration and feeding. Patients should be offered food and drink if they can swallow.

Confirm and document the plan of care and the conversations that have taken place (CDP 2)

Ensure that any medication or equipment that may be required has been prescribed, is available and has been discussed with the patient and their relative/carer. (CDP 2)

Medication must be prescribed subcutaneously on an 'as required' basis for symptoms that commonly occur at end of life (pain, agitation, respiratory secretions, nausea/ vomiting and breathlessness) (CDP 2).

Follow local prescribing guidelines (see Section 6):

i. Just in case drugs
ii. Palliative care prescribing guidelines
iii. Prescribing of opioids guidance

Patients requiring regular medication should have a syringe driver prescribed with the lowest doses needed to manage their symptoms. The purpose of the syringe driver and medication should be fully explained, as well as any common side-effects e.g. drowsiness.(CDP 2) Follow guidelines on use of T34 Syringe Driver to deliver continuous subcutaneous medication for symptom control (see Section 6).

This plan should be recorded on the initial Medical (CDP 2), CDP e-care plan and Nursing assessment documents (CDP 4).

All Medical staff should continue to use the clinical history sheets to document ongoing patient care following the initial assessment. Nurses should record in the e-care plans follow structured writing guidance.

The senior responsible clinician should make key decisions, unless it is an emergency. They should regularly review (DAILY) whether the patient is still expected to die.

Regular assessment of patients
Patients need to be assessed regularly to have their treatment and care needs re-evaluated and addressed. There needs to be regular communication with patients and their families. A 24 hour Communication Record for patient/carer is available if required [5].

At least daily medical assessment using (CDP 3) to guide comprehensive assessment. Daily assessment by the senior responsible clinician.

Daily Patient Assessment Checklist (Medical) (CDP 3)

- Has there been a significant deterioration or improvement in the patient's condition?
- Any changes in symptoms: Pain? Nausea/vomiting? Upper respiratory secretions? Breathlessness? Agitation/distress?
- Do any drug doses or routes need adjusting?
- Review hydration and nutrition
- Any questions or concerns from patient or family?
- Is the patient in their Preferred Place of Care?
- Do you need discuss/refer this patient with a more senior colleague or Specialist Palliative care?
- Does the current management plan need to change?

Nursing evaluation and documentation:
At least 4 hourly nursing assessment.
Use validated tool to assess pain in patients who cannot verbalise (for example Abbey Pain Scale)
Record assessments and evaluations in e-care plans

Consider referral to Bereavement Specialist Nurse/ Macmillan Nurse/Chaplain as required.

Follow Standard operating procedure for Verification of expected death by nurses, and

Care after Death, including last offices and legal documentation (see Section 6).

5. ATTACHMENTS	
Number	**Title**
1	CDP 1 – Guidance Page
2	CDP 2 – Medical Assessment
3	CDP 3 – Daily Review stickers
4	CDP 4 – Holistic Nursing Assessment
5	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Guid/081 (Attachment)	Palliative care just in case administration sheet http://uhmb/cs/tpdl/Attachments/CORP-GUID-081/
Corp/SOP/005	Use of T34 Syringe Drivers to administer subcutaneous symptom management in palliative care UHMB http://uhmb/cs/tpdl/Documents/CORP-SOP-005.docx
Corp/SOP/025	Ensuring adherence to NICE clinical guideline 140 : opioids in palliative care and NPSA 2008/RRR05 : reducing dosing errors with opioid medicines (SOP) UHMB http://uhmb/cs/tpdl/Documents/CORP-SOP-025.docx
Corp/Proc/048	Standard operating procedure for care after death, including last offices and legal documentation UHMB http://uhmb/cs/tpdl/Documents/CORP-PROC-048.docx
Corp/SOP/023	Nurse Verification of Expected Death http://uhmb/cs/tpdl/Documents/CORP-GUID-088.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Number	References
1	DoH (2014) One Chance to get it right: Improving people's experience of care in the last few days and hours of life. [Online] Available at: https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations (accessed 6.10.15)
2	DoH (2008) End of Life Care Strategy: promoting high quality care for adults at the end of their life. [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf (accessed 6.10.15)
3	Northern England Strategic Clinical Network, End of Life Care. Available from: http://www.nescn.nhs.uk/common-themes/end-of-life-care/ (accessed 6.10.15)
3	Northern England Strategic Clinical Network (2015) End of Life Care – When someone is dying leaflet: Information for Relatives, Friends and Carers. [Online] Available at: http://www.nescn.nhs.uk/wp-content/uploads/2014/05/When-someone-is-dying-leaflet.pdf (accessed 6.10.15
4	NICE CG31 Care of dying adults in the last days of life [Online] Available at https://www.nice.org.uk/guidance/ng31(accessed 19.5.16)
5	Northern England Strategic Clinical Network (2015) Additional Supportive Rewsources Care for the Dying Patient 24 Hour communication Record_Patient/carer http://www.nescn.nhs.uk/wp-content/uploads/2014/05/24-hr-communication-record_patientcarer.pdf
Bibliography	
	Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Palliative and End of Life Care Education and Training Group (2015) Recommended Core Education Standards for Care and Support for the Dying Person in the Last Days and Hours of Life. [Online] Available at: http://www.gmlscscn.nhs.uk/attachments/article/109/RecommendedCoreEducationStandardsforCareandSupportfortheDyingPerson.pdf (accessed 13.10.15)

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
CDP	Care for the Dying Patient document, a set of documents used by staff to guide, structure and record treatment decisions, communications and care given to patients who are expected to die in days/hours
PPC	Preferred Priorities of Care, a statement of the patient's wishes for their care made in advance, eg it might include where they would prefer to be cared for
ADRT	Advance Decision to Refuse Treatment, a legally binding written decision made in advance of which treatments the patient would wish to refuse if they were no longer able to express their consent.
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
T34 Syringe driver	A small battery driven device which continuously delivers symptom control medication under the patient's skin.

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**
Dr Nick Sayer	Clinical Lead Palliative Care	
Dr Amy Gadoud	Consultant Palliative Care	
Joy Wharton	Macmillan Lead Palliative Care Nurse	
Jennifer Culley	Macmillan CNS Palliative Care	
Gerard Kenyon	Macmillan CNS Palliative Care	
Elaine Hemingway	Macmillan CNS Palliative Care	
Carole Palmer	Bereavement Specialist Nurse	
Lindsay Pinch	Bereavement Specialist Nurse	
Dianne Smith	Dementia Matron	

10. DISTRIBUTION PLAN	
Dissemination lead:	Joy Wharton
Previous document already being used?	Yes
If yes, in what format and where?	Policy CORP/GUID/023 and on Palliative pages intranet
Proposed action to retrieve out-of-date copies of the document:	Update electronic copies
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News (August 2016) – New documents uploaded to the Document Library

11. TRAINING Is training required to be given due to the introduction of this policy? Yes		
Action by	**Action required**	**Implementation Date**
Specialist palliative Care Team	One-to-one support and information from the Specialist palliative Care Team to Ward Teams	Ongoing
SPC Team	Rolling programme of training to junior doctors and provide guidance when a patient is to commence a CDP if required.	Ongoing
Cross-boundary Alliance (Hospices, Community and hospital SPC teams)	Full day training session in line with SCN Competencies (4) Delivered at local hospices by SPC teams for RGNs, sessions also for CSWs	Rolling program

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
2	17/8/2016	Page 3 Summary Page 4 Guideline Page 5 Guideline	Reference to Nice CG31added Reference to CDP4 located within e-care plans added Reference to nurse recording in the CDP e-care plan added A 24 hour Communication Record for patient/carer is available if required (reference 5) Recommendation to use validated pain scale in patients who cannot verbalise (Abbey Pian Scale) Nurses to record assessments and evaluations in e-care plans	01/08/2018
2.1	03/10/2017	Page 3	BSF page added	01/08/2018
2.2	11/04/2018	Page 1	Review Date extended – form 050/2018	01/09/2018
2.3	16/05/2018	Page 1	Review Date extended – form 064/2018	01/12/2018
2.4	08/05/2019	Page 1	Review Date extended – form 065/2019	01/07/2019

Appendix 1 – CDP 1 - Guidance Page

Guidance- Caring for the Dying Patient

NHS
Northern England Strategic Clinical Networks

Initial assessment of the dying patient

1. Document the information supporting the team's opinion that the patient is dying.
2. Make a plan, in consultation with the patient if possible, and involving their relative/carer if appropriate:
    a. Identify any relevant decisions made in advance (e.g. ADRT, DNACPR etc.)
    b. Decide about any relevant monitoring/ investigations/ interventions.
    c. Assess symptoms and agree options for symptom control
    d. Explore the patient and relative/carer's understanding and concerns about the situation
    e. Identify the patient's current wishes, beliefs, values and spiritual needs.
    f. Discuss and agree with the patient and their relative(s)/carer(s) the options regarding hydration and feeding. Patients should be offered food and drink if they can swallow.
2. Confirm and document the plan of care and the conversations that have taken place.
3. Ensure that any medication or equipment that may be required has been prescribed, is available and has been discussed with the patient and their relative/carer.
4. Medication must be prescribed subcutaneously on an 'as required' basis for symptoms that commonly occur at end of life (pain, agitation, respiratory secretions, nausea/ vomiting and breathlessness).
5. Patients requiring regular medication should have a syringe driver prescribed with the lowest doses needed to manage their symptoms. The purpose of the syringe driver and medication should be fully explained, as well as any common side-effects e.g. drowsiness.

This plan should be recorded on the initial Medical and Nursing assessment documents. Ensure anticipatory medications are prescribed and available. All staff should continue to use the clinical history sheets to document ongoing patient care following the initial assessment.

The senior responsible clinician should make key decisions, unless it is an emergency. They should regularly review whether the patient is still expected to die.

Regular assessment of patients

Patients need to be assessed regularly to have their treatment and care needs re-evaluated and addressed. There needs to be regular communication with patients and their families.

- At least daily medical assessment
- At least 4 hourly nursing assessment
- Daily assessment by the senior responsible clinician

Daily Patient Assessment Checklist

- Has there been a significant deterioration or improvement in the patient's condition?
- Any changes in symptoms: Pain? Nausea/vomiting? Upper respiratory secretions? Breathlessness? Agitation/distress?
- Do any drug doses or routes need adjusting?
- Review hydration and nutrition
- Any questions or concerns from patient or family?
- Is the patient in their Preferred Place of Care?
- Do you need discuss this patient with a more senior colleague or Specialist Palliative care?
- Does the current management plan need to change?

Pilot July 2015 V2

Appendix 2 – CDP 2 - Medical Assessment

Patient's Name:..... D.O.B.:..... NHS/hospital no.:.....

Medical Assessment - Recognition that the patient is dying

The decision relating to the patient's prognosis must be endorsed by the most senior clinician responsible for the patient's care (Consultant/GP)

Date ..... **Time** ..... **Place (e.g. Home/Hospital/Hospice)**.....

Responsible consultant/GP: ..... **GP Practice**:.....

If the current clinical impression is that the patient is ill enough that they may die in the next hours or days, and any reversible causes have been considered, please document the key information which supports this decision:

.....

.....

.....

.....

Does the patient have a valid DNACPR document? Yes ☐ No ☐

If not, please state reason: .....

Who has this been discussed with? Patient / relative / carer .....

Patient Preferences

Does the patient currently have capacity to make decisions regarding current and future treatment plans? Yes ☐ No ☐

(If the patient currently lacks capacity, decisions should be made using a best interest process, taking into account the patient's expressed preferences. Further information about all these issues is available in the *Deciding right* resources section on the Northern England Strategic Clinical Network website www.nescn.nhs.uk)

Are there any of the below documents in place?		Location
Advance Decision to Refuse Treatment (ADRT)	☐	
Advance Statement	☐	
Emergency Health Care Plan (EHCP)	☐	

Is there a Lasting Power of Attorney (LPA) for Health & Welfare?

Yes ☐ No ☐ Name: .....

Are there any additional expressed wishes or decisions? e.g. organ / tissue donation .....

.....

Patient's current preferred place of death:.....

(If not expected to achieve this, please state reason: .....)

Patient's Name:..... D.O.B.:..... NHS/hospital no.:.....

Medical Assessment - Developing a Plan of Care

In certain circumstances it may be appropriate to continue certain medications/interventions:

Current Interventions	Currently not being taken or given	Discontinued	Continued / commenced	Comments
Routine blood tests	☐	☐	☐	
Antibiotics	☐	☐	☐	
Blood glucose monitoring	☐	☐	☐	
Recording of routine vital signs	☐	☐	☐	
Oxygen therapy	☐	☐	☐	
Other	☐	☐	☐	

Does the patient have an Implantable Cardioverter Defibrillator (ICD) or other device in place? Yes ☐ No ☐

Document any actions required: .....

.....

.....

.....

Review of regular medications

Review all medication and decide whether it is necessary or is beneficial for symptom control. Consider alternative routes if patient is unable to swallow. Yes ☐

Remember to prescribe anticipatory medication for the following (refer to NECN Palliative and End of Life Care Guidelines):

- ☐ Pain
- ☐ Nausea and vomiting
- ☐ Agitation/distress/delirium
- ☐ Breathlessness
- ☐ Respiratory secretions

Please consider the impact of pre-existing, new or worsening **renal dysfunction** when prescribing regular and as-required medication

Does the patient have any long term condition? e.g. diabetes, seizures Yes ☐ No ☐

If yes, please document plan for managing this:

.....

.....

.....

Patient's Name:..... D.O.B.:..... NHS/hospital no.:.....

Medical Assessment - Nutrition and Hydration

If the patient expresses a wish to eat or drink, staff should offer assistance when required. **Even if there are concerns that a patient's swallow is impaired or unsafe, he/she may still elect to eat and drink.** If the patient has mental capacity and understands the risk of aspiration, oral food and fluids must **NOT** be withheld from a patient who wishes to eat and drink.

For patients who do not have mental capacity, decisions regarding: whether to allow eating/drinking should be made using the best interests process (further information is available in *Deciding right* via www.nescn.nhs.uk)

Are there any concerns that the patient's swallow is impaired / unsafe? Yes ☐ No ☐

Nutrition

Please document decisions regarding oral, enteral or parenteral nutrition: .....

.....

.....

Hydration

Please document decisions regarding oral or parenteral hydration: .....

.....

.....

Plan of Care and Communication

Document the plan of care and discussion that has taken place with the patient and relative / carers, including any specific concerns or issues.

This should include the discussion regarding the changing of medication (including use of syringe drivers if needed), plan of care for provision of fluids and nutrition, and any treatments which are discontinued or should continue.

If conversations about the treatment plan have already been documented in main notes or electronic patient record, please provide a brief summary here, and state the date(s) and time(s) that are documented in the patient record for reference:

Summary of key issues and plan of care:.....

.....

.....

.....

.....

.....

Patient's Name:..... D.O.B.:..... NHS/hospital no.:.....

Medical Assessment continued

.....

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.....

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.....

.....

Communication with patient / relative / carer .....

.....

.....

.....

.....

Please state who was present during discussion

Patient Yes ☐ No ☐

Staff member(s):.....

Relative/Carer(s):.....

Other:.....

Can this patient's death be verified by a registered nurse? Yes ☐ No ☐

If no, please state the reason and plan for care after death:

.....

Does this patient's death need to be referred to the coroner? Yes ☐ No ☐

If yes, please state reason: .....

Signature: ..... Date: ..... Time: .....

Print name: ..... Designation: ..... GMC No: .....

If appropriate, discussed plan with senior clinician:

(Name: ..... Time: ..... date: .....)

Appendix 3 – CDP 3 – Daily Review stickers

Daily Medical Review CDP

- Improvement/deterioration in condition?
- Symptom management-medication review?
- Nutrition and hydration?
- Patient/family questions or concerns?
- Specialist advice needed?
- Continue current plan?

Daily Medical Review CDP

- Improvement/deterioration in condition?
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Appendix 4 – CDP 4 – Holistic Nursing Assessment

Patient Name: _____	DoB: _____	NHS/Hospital N°: _____

Initial Holistic Nursing Assessment: Caring for the Dying Patient
Please complete with the patient and relative / carer if appropriate

If the patient is unable to contribute to their care assessment, complete on their behalf. Circle any identified problems and add any additional comments, continue evaluation in the patient record.

Physical problems	**Support for people important to the patient**
Do you have any problems with your comfort? Pain / discomfort / breathlessness Mouth – sore / dry / painful Chest secretions Sputum / cough / swallowing difficulties Eating / drinking Feeling sick / being sick Constipation / diarrhoea Urinary problems Catheter care Sweats – hot / cold Skin – sores / wound / dry / itch / weeping Oedema (swelling) Personal care – washing / hair care Sleep Mobility Other: _____	*Do you feel the needs of you and your family/carers are being met?* Eating / drinking facilities Quiet environment Comfortable surroundings Worries / fears Written information Update on plan of care Support for relative / carer / friend Support for children Financial concerns Parking facilities Other: _____
Emotional wellbeing	**Spiritual / religious needs**
Do any of these words describe how you feel? Distressed Upset / sad Lack of peace / calm Agitated / restless Frightened / worried Angry / frustrated Other: _____	*Are the things important to you being considered?* Faith Support from faith leader Prayers / rights / rituals Culture Values Music Things that help you cope Other: _____

Assessment completed by:
Name (print): _____ Designation: _____ Signature: _____

Completed and discussed with: *(please circle)* Patient/relative/carer Name: _____

Date completed: _____ Time: _____

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Appendix 5 - EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	• Age		
	• Disability		
	• Race		
	• Sex		
	• Religious belief – including no belief		
	• Sexual Orientation		
	• Gender reassignment		
	• Marriage and civil partnership		
	• Pregnancy and maternity		
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination are there any exceptions - valid, legal and/or justifiable?**		
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
4a	**If so can the impact be avoided?**		
4b	**What alternative are there to achieving the policy/guidance without the impact?**		
4c	**Can we reduce the impact by taking different action?**		

For advice in respect of answering the above questions, and / or if you have identified a potential discriminatory impact of this procedural document, please contact the relevant person (see below), together with any suggestions as to the action required to avoid/reduce this impact.

For Service related procedural documents: Lynne Wyre, Deputy Chief Nurse & Lead for Service Inclusion and Diversity

For Workforce related procedural documents: Karmini McCann, Workforce Business Partner & Lead for Workforce Inclusion and Diversity.