Standard operating procedure (SOP) · HSP-SOP-003 · Version 1.0 · Approved by the ASF Expert Committee

Supports: 10.6

At a glance

- When a patient is dying, a written dying care plan is in place (HSP-FRM-005).
- Comfort measures and pain control are given as the plan sets.
- The family present is supported to stay and to take part in care.
- The plan is reviewed at each change in condition.
- Stop and get help straight away if: a dying patient has no written plan, or pain and comfort are not reviewed when the condition changes.

1. Purpose

To give dying patients a dignified, planned and comfortable death (10.6).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of the facility
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions

Term	Meaning
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background

The last days of life need a clear plan, comfort measures and a dignified environment. Without a plan, care becomes improvised and the patient suffers.

5. Responsibilities

Role	Responsibility	Competence
Lead palliative clinician	Owns the dying care plan	Clinician
Nurse	Delivers the comfort plan and records it	Nurse

6. Materials and equipment

Item	Requirement	Condition
Records and forms named in this document	Current version	Checked before use

7. Safety

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Step 1. Plan.

- Write the dying care plan on HSP-FRM-005 as soon as the patient is recognised as dying.

Key point: Planned early.

Step 2. Comfort.

- Give comfort measures and pain control as the plan sets, and record each dose.

Key point: Comfort first.

Step 3. Review.

- Review the plan at each change in condition, and support the family present.

Key point: Reviewed at change.

10. Decision points

- No decision points in this procedure.

11. Special situations

Situation	Action
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

12. Escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Dying patients with a written care plan	100%	Monthly	Lead palliative clinician	Escalate to medical director

14. Records

Record	Kept in	Retention
Record named in this document	Patient record or the area file	the period set by the facility’s records policy years

15. Training

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

16. Related documents

ID	Title	Use
HSP-FRM-005	Dying care plan record	Record
CLN-FRM-003	Individual care plan (existing, reused)	Record

17. Evidence

Reference	Note
E-009	Based on the WHO Palliative Care fact sheet and the Lancet Commission on the Global Access to Palliative Care and Pain Relief (2017).
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

E-learning for this document

- **Care & Treatment: Clinical Standards for Accreditation** (H-04)
- **Patient Identification, Informed Consent and Patient Rights** (T-07)

References

- Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)
- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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