End of Life Care Good Practice Guide

LAST YEAR OF LIFE
Year/s

- Patient identified as deteriorating despite effective management of underlying medical condition(s)
- Clear, sensitive communication with patient and those identified as important to them
- Person and agreed others are involved in decisions about treatment and care as they want
- Needs of those identified as important are explored, respected and met as far as possible
- Patient included on Supportive Care Record /GP Gold Standards Framework register and their care reviewed regularly
- Request consent to share information and create EPACCS record
- Holistic needs assessment
- Keyworker identified
- Identify when there is an opportunity to offer an Advance Care Planning discussion and/or refer on. ADRT/PPC/MCA/ DNACPR/making a will
- Benefits review of patient and carer including Grants/prescription exemption
- Provide information on Blue Badge (disabled parking) scheme
- Agree on-going monitoring and support to avert crisis
- Referral to other services e.g. Specialist Palliative Care
- OOH/NWAS updated including Advance Care Plan/DNACPR
- ICD discussion if applicable

INCREASING DECLINE
Months/Weeks

- Medical review
- All reversible causes of deterioration explored
- Clear, sensitive communication with patient and those identified as important to them
- Person and agreed others are involved in decisions about treatment and care as they want
- Needs of those identified as important are explored, respected and met as far as possible
- Prioritised as appropriate at Gold Standards Framework meeting
- On-going District Nurse support
- Agree on-going monitoring and support to avert crisis
- Holistic needs assessment
- Ongoing communication with Keyworker
- Review or offer advance care plan, share information with patients consent
- Consider Continuing Health Care funding/DS1500
- Equipment assessment
- Anticipatory medication prescribed and available
- DNACPR considered, outcome documented, information shared appropriately including ambulance service
- Out of Hours/NWAS updated including DNACPR status and Advance Care Plan
- Referral to other services e.g. Specialist Palliative Care
- Update EPaCCS Record as and when necessary
- ICD discussion and deactivation

LAST DAYS OF LIFE
Days

- Medical review
- All reversible causes of deterioration explored
- Multidisciplinary Team agree patient is in the last days of life
- Clear, sensitive communication with patient and those identified as important to them
- Dying person and agreed others are involved in decisions about treatment and care as they want
- Agree on-going monitoring and support to avert crisis
- Advance Care Planning discussion offered or reviewed
- On-going District Nurse support
- ICD discussion and deactivation if not previously initiated
- Decisions made are regularly reviewed and revised accordingly
- Individual plan of care for the dying person including holistic assessment, review of hydration and nutrition, symptom control etc. is agreed, coordinated and delivered with compassion
- Anticipatory medication prescribed and available to prevent a crisis
- Needs of those identified as important are explored, respected and met as far as possible
- OOH/NWAS updated
- Update EPaCCS Record as and when necessary
- Review package of care if necessary
- Referral to other services e.g. Specialist palliative care

CARE AFTER DEATH
1 year/s

- Nurse verification of death where indicated
- Certification of death
- Clear sensitive communication
- Relatives supported
- Department for Work & Pensions 011 Booklet; What to do after a death or similar
- Post death Significant event analysis
- Update Supportive Care Record/ Gold Standards Framework Register/EPaCCS with date and place of death
- Inform all relevant agencies ; social care, Allied Health Professional, ambulance service, OOH, Specialist Palliative Care Team, equipment store
- Funeral attendance if able and to include carer permission if appropriate or applicable
- Follow up bereavement assessment to those identified as important
- Referral of those identified as important to bereavement counselling services as required
- Staff supported

ADRT - Advance Decision to Refuse Treatment
DNACPR - Do Not Attempt Cardio Pulmonary Resuscitation
EPaCCS - Electronic Palliative Care Coordinating System
GP - General Practitioner
ICD - Implantable Cardioverter Defibrillator
NWAS – North West Ambulance Service
OOH – Out of Hours
PPC - Preferred Priorities of Care

Jan 2015