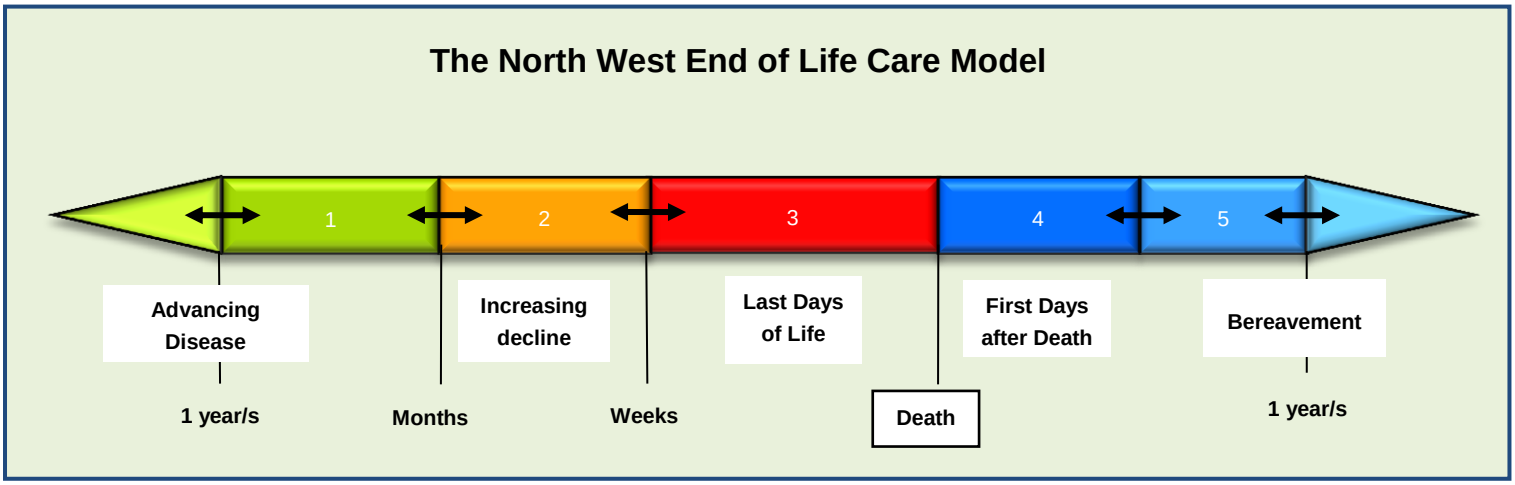
Cheshire and Merseyside Strategic Clinical Networks

Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks

The North West End of Life Care Model

Supporting the people of the North West to live well before dying with peace and dignity in the place of their choice



End of life care

- Is about the individual and those important to them
- Is about meeting the supportive and palliative care needs for all those with an advanced progressive incurable illness or frailty, to live as well as possible until they die'.
- Support may be needed in the last years, months or days of life.

It should include:

- A person centered approach to care – involving the person, and those closest to them in **all** aspects of their care including the decision making process around treatment and care
- Open, honest and sensitive communication with the patient and those important to them
- Care which is coordinated and delivered with kindness and compassion
- The needs of those identified as important to the person to be actively explored, respected and met as far as possible
- All discussions to follow guidance set within the Mental Capacity Act (MCA 2005)

Key recommended Training for health and care staff:

Communication skills
Holistic assessment to include: physical, psychological, spiritual and social care
Symptom control
Advance care planning
Caring for carers
Priorities for care of the dying person
Bereavement support
Mental Capacity Act

The model supports the assessment and planning process for patients from the diagnosis of a life limiting illness or those who may be frail. The model comprises 5 phases and the Good Practice Guide (overleaf) identifies key elements of practice within each phase to prompt the assessment process as relevant to each setting.

End of Life Care Good Practice Guide

LAST YEAR OF LIFE
Year/s

- Patient identified as deteriorating despite optimal therapeutic 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 : physical, psychological, spiritual & social
- Keyworker identified
- Identify when there is an opportunity to offer an Advance Care Planning discussion . PPC/ADRT/LPA Making a will
- DNACPR discussion if appropriate
- 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 discussion, share information with patients consent
- Consider Continuing Health Care funding/DS1500
- Equipment assessment
- Anticipatory medication prescribed and available
- DNACPR considered and discussed, 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 carel, ambulance service, OOH, Specialist Palliative Care Team, , Allied Health Professionals equipment store
- Funeral attendance if applicable and to include carer permission if appropriate
- 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

May 2015