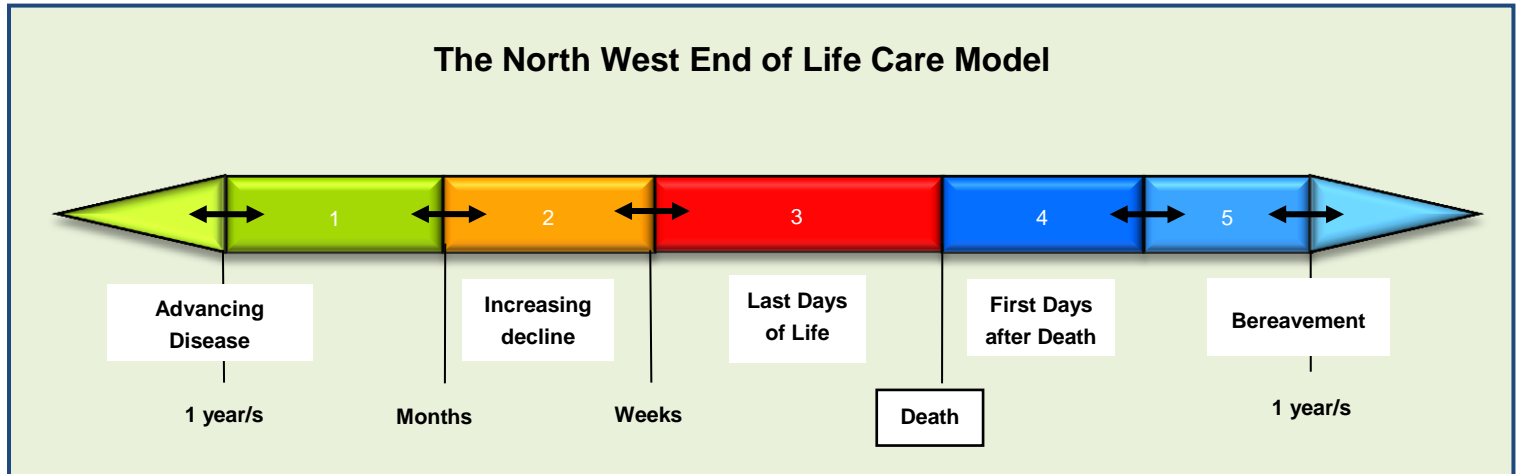


# The North West End of Life Care Model

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	INCREASING DECLINE Months/Weeks	LAST DAYS OF LIFE Days	CARE AFTER DEATH 1 year/s
<ul style="list-style-type: none"> <li>✚ Patient identified as deteriorating despite optimal therapeutic management of underlying medical condition(s)</li> <li>✚ Clear, sensitive communication with patient and those identified as important to them</li> <li>✚ Person and agreed others are involved in decisions about treatment and care as they want</li> <li>✚ Needs of those identified as important are explored, respected and met as far as possible</li> <li>✚ Patient included on Supportive Care Record /GP Gold Standards Framework register and their care reviewed regularly</li> <li>✚ Request consent to share information and create EPaCCS record</li> <li>✚ Holistic needs assessment : physical, psychological, spiritual &amp; social</li> <li>✚ Keyworker identified</li> <li>✚ Identify when there is an opportunity to offer an Advance Care Planning discussion . PPC/ADRT/LPA Making a will</li> <li>✚ DNACPR discussion if appropriate</li> <li>✚ Benefits review of patient and carer including: grants/prescription exemption</li> <li>✚ Provide information on Blue Badge (disabled parking) scheme</li> <li>✚ Agree on-going monitoring and support to avert crisis</li> <li>✚ Referral to other services e.g. Specialist Palliative Care</li> <li>✚ OOH/NWAS updated including Advance Care Plan/DNACPR</li> <li>✚ ICD discussion if applicable</li> </ul>	<ul style="list-style-type: none"> <li>✚ Medical review</li> <li>✚ All reversible causes of deterioration explored</li> <li>✚ Clear, sensitive communication with patient and those identified as important to them</li> <li>✚ Person and agreed others are involved in decisions about treatment and care as they want</li> <li>✚ Needs of those identified as important are explored, respected and met as far as possible</li> <li>✚ Prioritised as appropriate at Gold Standards Framework meeting</li> <li>✚ On-going District Nurse support</li> <li>✚ Agree on-going monitoring and support to avert crisis</li> <li>✚ Holistic needs assessment</li> <li>✚ Ongoing communication with Keyworker</li> <li>✚ Review or offer advance care plan discussion, share information with patients consent</li> <li>✚ Consider Continuing Health Care funding/DS1500</li> <li>✚ Equipment assessment</li> <li>✚ Anticipatory medication prescribed and available</li> <li>✚ DNACPR considered and discussed, outcome documented, information shared appropriately including ambulance service</li> <li>✚ Out of Hours/NWAS updated including DNACPR status and Advance Care Plan</li> <li>✚ Referral to other services e.g. Specialist Palliative Care</li> <li>✚ Update EPaCCS Record as and when necessary</li> <li>✚ ICD discussion and deactivation</li> </ul>	<ul style="list-style-type: none"> <li>✚ Medical review</li> <li>✚ All reversible causes of deterioration explored</li> <li>✚ Multidisciplinary Team agree patient is in the last days of life</li> <li>✚ Clear, sensitive communication with patient and those identified as important to them</li> <li>✚ Dying person and agreed others are involved in decisions about treatment and care as they want</li> <li>✚ Agree on-going monitoring and support to avert crisis</li> <li>✚ Advance Care Planning discussion offered or reviewed</li> <li>✚ On-going District Nurse support</li> <li>✚ ICD discussion and deactivation if not previously initiated</li> <li>✚ Decisions made are regularly reviewed and revised accordingly</li> <li>✚ 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</li> <li>✚ Anticipatory medication prescribed and available to prevent a crisis</li> <li>✚ Needs of those identified as important are explored, respected and met as far as possible</li> <li>✚ OOH/NWAS updated</li> <li>✚ Update EPaCCS Record as and when necessary</li> <li>✚ Review package of care if necessary</li> <li>✚ Referral to other services e.g. Specialist Palliative Care</li> </ul>	<ul style="list-style-type: none"> <li>✚ Nurse verification of death where indicated</li> <li>✚ Certification of death</li> <li>✚ Clear sensitive communication</li> <li>✚ Relatives supported</li> <li>✚ Department for Work &amp; Pensions 011 Booklet; What to do after a death or similar</li> <li>✚ Post death Significant event analysis</li> <li>✚ Update Supportive Care Record/ Gold Standards Framework Register/EPaCCS with date and place of death</li> <li>✚ Inform all relevant agencies ; social care, ambulance service, OOH, Specialist Palliative Care Team, , Allied Health Professionals equipment store</li> <li>✚ Funeral attendance if applicable and to include carer permission if appropriate</li> <li>✚ Follow up bereavement assessment to those identified as important</li> <li>✚ Referral of those identified as important to bereavement counselling services as required</li> <li>✚ Staff supported</li> </ul>

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