

Primary Care Services

End of Life Policy

Version 1.0

Document Control Document Control

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B. Document Details

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Introduction:

The WHO describes palliative care as 'the active, holistic care of patients with advanced, progressive illness'.¹

GPs are in an ideal position to provide and coordinate this care for a number of reasons:

- They have long-established relationships with their patients which are so important at this critical time in a patient's life
- They are used to dealing with co-morbidity and uncertainty
- They are trained to treat patients holistically which is central to the palliative care approach.

GPs have to be able to provide high quality, equitable care, and to work together effectively with specialist teams if they are to provide the best primary palliative care for all who require it.

There is an increasing imperative to be able to recognise the needs of all patients nearing the end of their lives, not just those with cancer, and to be able to extend some of the developments in care provided for cancer patients to those with other illnesses, which constitute 75% of all deaths.

Proactive end of life care

In order to provide optimal care for any patient nearing the end of their life, i.e. not just in the terminal or dying phase, but in their last year, we need to be able to do three things:

1. Identify where a patient is on their illness trajectory – do they have years, months, weeks or days to live? This then allows proactive management, calmer planning and less 'fire-fighting' crisis management
2. Assess their needs, and those of their family/carers, in the light of their advance care plan
3. Plan (using a management plan) and then provide their care according to the patient's preferences and varying needs, at different times.

Palliative care is important to GPs and is an intrinsic and special part of the job. So, despite its demands, many practitioners prioritise care of the dying and have made comments such as "it reminds us of why we came into medicine in the first place", and "it brings us back to what matters, real patient care".

This Policy is for all staff across ELFT, both clinical and non-clinical.

Responsibility:

- Each surgery has a clearly identified lead clinician responsible for End of Life Care.
- All patients identified with a new cancer diagnosis or an EoL prognosis should have a nominated GP, preferably someone who knows the patient well, who will make contact with the patient in a timely fashion
- Details such as next of kin/ Power of Attorney can be ascertained at this time.
- Each practice should have an administrator responsible for EoL care. This entails arranging, coordinating and minuting the MDT (GSF) meeting as well as managing a specific palliative care/EoL task box.
- Any staff member who has concerns about a patient receiving palliative/EoL care can raise these via a task to the Palliative/EoL inbox to facilitate discussion regarding the patient at the next MDT meeting
- MDT meetings with appropriate clinicians i.e. lead GP, specialist palliative care nurse, district nurse etc should be held regularly but not less than 6 weekly.
- More urgent considerations should be directed to the relevant GP or the specialist community palliative care hub.
- All clinicians are responsible for ensuring that they have the relevant training and any learning needs are identified and met.
- ELFT will endeavour to support and provide training to clinicians as required or be able to signpost them to the most relevant training resource.

Policy:

All people approaching the end of their life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions put in place in the form of a care plan.

In some cases, people may want to make an advance decision to refuse treatment in case they lack capacity to make such a decision in the future.

Others may want to set out more general wishes and preferences about how they are cared for and where they would wish to die. These should all be incorporated into the care plan.

The care plan should be subject to review by the multidisciplinary team, the patient and carers as and when a person's condition, or wishes, change.

Palliative care plans are confidential and will only be used by professionals involved in the patient's care. Where consent is given by the patient, the care plan will also be available to other professionals who have a legitimate reason to access it.

The Leadership Alliance for the Care of Dying People (LACDP) has set out the following five priorities for palliative care:

- The possibility that a person may die within the next few days or hours should be recognised and communicated clearly. Decisions should then be made and actions taken in accordance with the person's needs and wishes. These should be regularly reviewed and decisions revised accordingly.
- Sensitive communication should take place between healthcare professionals and the dying person, and those identified as important to them.
- The dying person, and those identified as important to them, should be involved in decisions about treatment and care to the extent that the dying person wants.
- The needs of families and others identified as important to the dying person should be actively explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, should be agreed, coordinated and delivered with compassion.

Involving Family Members and Carers

The family and carers of people approaching the end of their life have a vital role in the provision of care. They need to be closely involved in decision making, with the recognition that they also have their own needs.

For many people, this will have been the first time they have cared for someone who is dying.

They will require information about the likely progress of the person's condition and information about services that are available.

They may well also need practical and emotional support, both during the person's life and after the point of death. Carers already have the right to have their own needs assessed and reviewed and to receive carer's care.

Regarding patients in residential, care or nursing home settings, concerns from staff should be responded to and met within an appropriate time frame.

Final Days of Life:

There is a template for "End of Life and Palliative Care" on SystemOne/EMIS. Anticipatory medications should be prescribed on the clinical system using Arden's Templates where appropriate.

Drug administration charts should be issued for the community staff to administer these drugs when appropriate

Relevant teams should be informed such as Out of Hours and potentially the ambulance service with clear guidance as to the management plan that has been put in place for the patient.

It may also be prudent to inform the district nurses, if they have not been previously involved, so that they can anticipate the demand for anticipatory meds, syringe drivers etc that the patient may require if their final days.

Visiting Patient's in the Terminal Phase of their Illness:

In recent months, due to Covid-19, GP visiting has been infrequent.

With EoL/palliative patients, it is inappropriate in most cases for their final contacts with a GP to be via video consultation.

A visit from a GP generally gives comfort to the patient and provides support for the family members or carers.

A GP is best placed to make assessment of the patient's condition and to respond to the need for amendments to medication or provision of additional medications for symptom control

There should be a system in place for all practices that means there is GP cover for the patient if their usual GP is unavailable.

It is beholden upon the usual GP to put these measures in place.

Obviously, there may be situations where this is the only means available and is necessary to avoid the need for referral to the Coroner when the patient passes away.

Whilst we are still in a pandemic situation, all visits need to be carried out using full PPE and with strict adherence to infection control guidelines

After the Death of a Patient:

All clinicians need to be aware of the pathways that need to be followed after the patient passes away especially in light of changes due to Covid-19.

This allows correct information to be given to the next of kin in a timely fashion.

It is considered good practice for a bereavement/welfare call to be made to the patient's next of kin after the patient passes away.

Support should be offered and the necessary information regarding the patient's wishes following death can be confirmed i.e. which undertaker is being used, are they for cremation or burial?

Audit and Review

A register of all patients in need of palliative care/support, irrespective of age, is maintained.

The Practice End of Life Care Lead has regular

Any information that needs to be cascaded to the Primary Care Team should be brought to the practice clinical governance meetings.

Aims of the meeting include:

- To improve the flow of information between teams in relation to these patients and in particular to out-of-hours providers
- To ensure that each patient on the register has a personal management plan, and that decisions associated with this are taken and acted upon by the most appropriate person.
- To ensure the needs of carers are engaged with and addressed wherever possible.

- To ensure the management plan displays a preference for the patient's chosen place of care.

All patients on the register will have, as a minimum;

- Red/Amber/Green patients will have a preferred place of death recorded
- Red/Amber patients will be offered/prescribed anticipatory medications
- Red/Amber patients will have a DNACPR in place or have had a discussion about DNACPR.

An up to date list of patients is accessible to all staff on the shared drive as well as minutes of meetings.

Patients identified as being palliative/EoL should be identified to all staff as priority patients.

Concerns Regarding Care of a Dying Patient:

If it is deemed that there were issues or problems during the patient's last illness, these should be raised and discussed at an appropriate meeting i.e. GP meeting, MDT with palliative care team or Significant Event and recorded on Datix.

If the issue is deemed to be more widespread than the individual practice then, again, this should be addressed at an appropriate level meeting.

In the interests of learning and improvement in patient care, the outcome of any analysis following a patient's death should be disseminated to the relevant staff members or to the wider clinical community.

Resources:

www.goldstandardsframework.nhs.uk

www.endoflifecare.nhs.uk

www.nice.org.uk

www.gmc-uk.org/guidance/ethical_guidance/end_of_life_guidance.asp

www.cqc.org.uk

www.dyingmatters.org/gp