Overarching Principles
Supporting the people in Pennine Lancashire to live well before dying with peace and dignity in the place of their choice

End of Life Care
“End of Life Care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patients and family to be identified and met throughout the last phases of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.”
National Council for Palliative Care (NCPC)

It should include:
- A person centered approach to care – including the person and those closest to them in all aspect of their care including the decision making process around treatment and care as they want
- Open, honest and sensitive communication with patient and those important to them
- Care which is coordinated and delivered with kindness and compassion
- All discussions and decisions to follow the principals of the Mental Capacity Act (MCA 2005)

The ‘Elements of Dedicated Palliative Care’ model applies throughout the stages of the ‘North West End of Life Care’ Model

Adapted from ‘The North West End of Life Care Model – End of Life Care Good Practice Guide’, Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network, May 2015
Patient identified as deteriorating despite effective management of underlying medical condition

Start clear, honest, open and sensitive communication with patient and those important to them. This could include recognition of advanced disease, treatment, care options and their choices

Suggest inclusion on Gold Standards Framework register

Pro-actively assess and identify needs, develop care plan and refer accordingly

Ensure Medical review
All reversible causes of deterioration explored
Clear, honest, open and sensitive communication with patient and those important to them about recognition of increasing decline, treatment and care options
Assess and identify needs

Ensure Medical review
All reversible causes of deterioration explored
Multi-disciplinary team agree that patient is in the last days of life
Provide care according to the 5 Priorities of Care for People in the Last Days of Life
Assess and identify needs of patients and those important to them
Agree on-going reviews
Offer relevant literature as appropriate

Verification of death by Nurse or Doctor
Certification of death with liaison with coroner if needed
Clear sensitive communication
Relatives supported
Department for Work & Pension 011 Booklet: What to do after a death or similar provided
Post death significant event analysis
Inform all relevant agencies
First two points above plus:
- Key worker identified
- Holistic needs assessment of patient and development of care plan for identified needs
- Include patient on Gold Standards Framework register and review their care regularly
- Carer's assessment – needs of those identified as important are explored, respected and met as far as possible
- Agree on-going monitoring and support to avert crises
- Identify when there is an opportunity to offer Advance Care Plan discussions/Preferred Priorities of Care/Do not attempt cardiopulmonary resuscitation/Deactivation of Implanted Cardioverter Defibrillator etc
- Referral to other services as indicated by identified needs such as Allied Health Professional, Speech & Language Therapy, Social Services, Specialist Palliative Care
- Request consent to share information and create Electronic Palliative Care Coordination System record
- Update Out of Hours/ North West Ambulance Service

As above plus:
- On-going communication with key worker
- Regular assessments and care plan adjusted according to changing needs
- Regular discussion at Gold Standard Framework meetings
- Pro-active carer’s assessment
- Regular District Nurse support and more frequent reviews
- Advance Care Plan discussions offered and reviewed
- Do not attempt cardiopulmonary resuscitation and Implanted Cardioverter Defibrillator deactivation considered and outcome documented
- Referral to other services as indicated by identified need
- Consider anticipatory medication for the dying patient
- Consider Continuing Health Care funding, DS 1500
- Update information on Electronic Palliative Care Coordination System, record
- Update Out of Hours/ North West Ambulance Service

As above plus:
- On-going support from key worker
- Daily reviews by District Nurses or ward nurses
- Care planned and delivered according to the 5 Priorities of Care for People in the Last Days of Life
- Anticipatory medication prescribed and available
- Carer’s assessment
- Advance Care Planning discussions offered and reviewed
- Rapid discharge for the dying patient if preferred place of death is at home (discharge within 24 hours)
- Review package of care and equipment and offer additional support
- Update Electronic Palliative Care Coordination System and Out of Hours/ North West Ambulance Service
- Do not attempt cardiopulmonary resuscitation, Implanted Cardioverter Defibrillator discussion and deactivation if not previously initiated
- Referral to other services as indicated by identified need

As above plus:
- Liaison between services to agree who will provide bereavement follow up contact
- Follow up bereavement contact 2-4 weeks after bereavement and sign post to bereavement counselling services as needed
- Staff supported
- Offer dedicated access to bereavement support services
- Refer to Dedicated Bereavement Service if needed

Pennine Lancashire Palliative and End of Life Care Model

The North West End of Life Care Model

1 YEAR / S

1

Advancing Disease

1 YEAR / S

2

Increasing Decline

MONTHS

3

Last Days of Life

WEEKS

4

First Days after Death

DEATH

5

Bereavement

Core Palliative Care Services

District Nurses
GPs
Community Hospitals
Nursing Homes
Some disease specific Community Nurse Specialists (depending on specialty)
Allied Health Professionals
Hospice at Home
Hospice Day Therapy including Complementary Therapy and Physiotherapy
Integrated Care Services
Spiritual Support Services
Bereavement Support Services
Referral as per identified needs and if complexity of needs cannot be met by core palliative care services
Work collaboratively with universal and core services
Assessment and development of management plan and regular re-assessments as needed
Advice and support of patients, those important to patient and health care professionals
Offer Advance Care Plan etc.
Discharge patient when needs have been met
Provide teaching and education for core and universal palliative care services
Referral as per identified needs
Work collaborative with key worker and core services to meet identified needs and to support the addressing of above points
Provide care and interventions

As previous column

As previous column

Support core services with above

It is important to recognise that response time is critical to the success of this model. It is intended that expected response times will be reviewed separately.