Palliative Care Policy

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Introduction

Hope Citadel recognises providing palliative care is a privilege which when done well brings huge benefit to the patient, family and to the GP themselves. Palliative care by its nature is complex and requires many skills. Hope Citadel Healthcare will do all it can to ensure GPs and other healthcare professions deliver palliative care with technical skill, open and honest communication and compassion. This guidance is intended to be used alongside RCGP guidance and also local NHS guidance.

Starting the palliative care process

Any patient who is expected to die within one year, from whatever cause, will be placed on to the GSF held within the practice and will be discussed at a regular MDT or quality meeting. This judgement can be made by GPs within the practice or following advice from specialists within secondary care. Wherever possible patients on the GSF will be signposted to additional community support such as Macmillan nurses or District Nurses. As part of the GSF, patients will be seen regularly either within the practice or at home and clinically reviewed to ensure they are experiencing the best quality of life and are symptom free. Part of this clinical review will be to consider where appropriate the DNAR status form, this should always include where possible communication with the family and the patient.

Filling in a DS1500 form should be considered. This is a form completed by a GP, Consultant, hospital doctor or specialist nurse, which enables someone who is terminally ill to claim Universal Credit.

It is appropriate to complete the form if the patient's death can "reasonably be expected within 6 months." This does not mean it is more likely than not, simply that death within 6 months would not be unexpected.

Recognising the importance of communication

Communication is hugely important in providing palliative care. There are often many professionals and services involved in the care of the patient. GPs are encouraged to discuss management with colleagues in secondary care and community services.

Communication will be facilitated by:

- Discussing patients on the GSF at the internal practice quality meeting which is attended by district nurses and the Macmillan nursing team
- Seeking support of local hospice services at an early stage - including, where provided, referral to day hospice.
- Identifying which consultant(s) are responsible for the care of the patient and ensuring the patients are given the opportunity for regular review by consultants.
- Identifying who are the significant relatives within the patient's life and deliberately building relationships with them.
- Discussing with the patient and the family what their concerns and wishes are for end of life.
- Considering the possibility of giving the patient a copy of a clinical summary which can be kept with them in case of acute admission to aid communication with secondary care staff regarding diagnosis, medications, allergies and DNAR status.
- Understanding that palliative care involves a whole person approach and seeking support, where appropriate, from religious or cultural leaders.

Although the Liverpool Care Pathway (LCP) is no longer in use, in the absence of a replacement, the clinical team are to ensure they are familiar with the delivery of its component parts. In particular, how to facilitate administration of 'end of life' palliative medication in the community. Local pathways are currently being piloted and are to be adopted by GPs when appropriate. GPs are also expected to provide documentation into household DN notes and complete medication schedules for use with drivers as well as supply FP10's to help obtain the necessary supplies for that household/patient.

Any patients who are on 'end of life' medication or where there is a high clinical suspicion that they will require out of hours visits or advice, must have their details passed onto the OOH provider before surgery closes for the day. This should be a clinical summary as well as any suggested plan should the patient deteriorate. This is especially key on a Friday or before a holiday period.

It is also important to fill out and share a 'Statement of intent' with the OOH. This is essential for all patients who are nearing the end of their illness and especially if the named GP may be unavailable over a weekend.

Choices in palliative care

In recent years there has been an improvement in services which facilitate patients dying in their own homes. Current practice suggests that where possible patients should pass away in their chosen location. On-going discussion with the patient and the family ensures that choices are maintained, and dignity is kept. It is recognized that the burden on families at this time is significant and that support is needed. Patients may need to be moved from their home if symptom control is not achievable within that environment. Locally we are served by some excellent hospices which offer an alternative choice to home or hospital. Wherever the patient dies it the responsibility of the GP to ensure that dignity is maintained, compassion is given, and the best possible clinical care is offered. Culture, religion and belief are significant and cultural and religious practices surrounding death are to be encouraged and accommodated.

After Death

GPs when able should ensure a death certificate and any other paperwork are completed as soon as possible after death. GPs must abide by GMC recommendations regarding contacting the coroner. It is important that if a case is referred to the coroner that this is explained to the family at the earliest opportunity. There has recently been new guidance on deaths in cases of 'Deprivation of Liberty' - in all such scenarios the Coroner's office must be contacted.