Barnsley End of Life Care Guidance - What to do in the Community

Prognosis: Years	Prognosis: Months Unstable / Advanced	Prognosis: Weeks Deteriorating / Exacerbation
 Complete holistic assessment Consider completion of EPaCCS (electronic palliative care coordination system on SystmOne or EMIS if appropriate) Offer Advance Care Planning (ACP) discussions Maintain regular reviews Ensure patient/family/carer understand who to contact should condition change Key: Red For Dr Blue For either Dr /Nurse / AHP or whoever is most appropriately placed Black For neighbourhood teams 	 Holistic assessment and care / treatment plan established Consider completion of EPaCCS (electronic palliative care coordination system on Systmone or EMIS) and discussion at palliative care MDT Offer opportunity to complete ACP including escalation planning, DNACPR, if appropriate Review and rationalise current medication Identify appropriate key worker Consider welfare benefits, if less than 6/12 prognosis, consider DS1500 Consider Blue Badge Consider social care needs and offer referral for care assessment if appropriate Ensure patient/family/carer understand who to contact should condition change 	 Dr review of treatment plans and discuss with patient and/or family. Exclude reversible causes Complete holistic assessment and develop plan of care Check patient/family/carer understanding of condition and acknowledgement that likely prognosis is short Consider pre-emptive medication/ drug administration card Refer to DN for assessment and care Review ACP discussions including preferences and wishes about care and place of care, DNACPR, escalation and treatment planning Update EPaCCS Complete CHC Fast Track Review social care needs – consider Supportive Care at Home referral Ensure patient/family/carer have urgent contact numbers Regular reviews – minimum weekly

Key Community Teams Contact Right Care SPA on 01226 644575

- Neighbourhood Teams: including District Nursing to provide support and care referral in last weeks and days of life is usually required
- Community Matron: consider referral for those who need support with long term condition management
- Consider referral to Community Macmillan Specialist Palliative Care: if patient has advanced life limiting illness and complex palliative care needs requiring additional specialist support. Needs can be emotional, physical, social, complex symptom management. Includes medical consultant, physio, OT dietitian, specialist nursing and social worker (advice line or to discuss referral Contact 9am – 4.45 pm)
- Breathe Team: Specialist respiratory support / home oxygen referral via SPA
- Out of Hours Crisis Response Team: Contact via SPA number or if SPA closed contact number will be provided
- Out of Hours Palliative Care Advice: Pall Call advice line via Barnsley Hospice contact 01226 244244
- Supportive Care at Home: provides individualised packages of care for carer support and respite, consider referral in last weeks and days of life 01226 645281

Barnsley Hospice Contact 01226 244244

Consider referral to Hospice services when a patient has advanced life-limiting illness and complex palliative care needs requiring specialist input for needs that may be psychosocial, spiritual or physical and are often a combination of all of these. Hospice services are for these patients and their families and carers.

Services include:

- Inpatient unit stay for assessment and management of holistic needs and may include care in the last days of life for some patients.
- Outpatient medical review, counselling and bereavement support, lymphoedema management, complementary therapy, and day therapy support.
- Outpatient services have both virtual and face to face elements and include provision for individuals and groups.

Days to Live Last Days of Life Care

review to exclude reversible cause tablish medical management plan (use Care Plan if appropriate)

- gent referral to DN if not known nsitive discussion with patient and/or nily/carer
- eview and rationalise medication, ensure e-emptive medication and drug charts mpleted.
- view and update EPaCCS and calation planning including DNACPR d preferred place of death,
- sure CHC funding is in place
- mplete My Care Plan if appropriate to sure holistic, coordinated personalised re plan including symptom control, dration and nutrition and needs of family onsider Supportive Care at Home referral nimum daily review in place
- sure family/carers have urgent contact Imbers

Barnsley End of Life Care - Our Vision 2021-2023



For everyone at the end of their lives, and those important to them, to receive high quality care which respects their personal preferences and choices, and is supported by a workforce which is consistent, honest, skilled and confident.



Our mission

- Your end of life care is provided in the last year(s) of life and includes months, weeks, days, hours and bereavement care.
- Your care is equitable irrespective of diagnosis
- Your care is personalised with your own individual plan of care, led by your choices and preferences
- All care planning and delivery always considers the needs of those important to you



What we will ensure

- coordinated, high quality services.
- deliver care to the standards we expect.
- We recognise end of life care needs.
- Once recognised, we offer open and honest conversations.
- making.
- to you.

Useful Links and Numbers

• Gold Standard Framework: Aims to clarify the triggers that help identify those patients who are in the last year of life.		
Once identified then patients can receive proactive support. <u>www.goldstandardsframework.org.uk</u>	Adult Social Services	01226 773300
 SPICT Tools: Prognostic indicator guidance to identify when a person is approaching the last year of life. <u>www.spict.org.uk</u> EPaCCS (Electronic Palliative Care Coordination System) available on SystmOne and EMIS – provide links to medication 	Barnsley Right Care SPA	01226 644575
advice, referrals EPaCCS Electronic Palliative Care Coordination System Local guideline or pathway (barnsleyccg.nhs.uk)*	Barnsley Hospice	01226 244244
• My Care Plan: Personalised care plan developed to support and guide last days of life care in all settings across Barnsley.	Barnsley Hospital	01226 730000
 A paper document that stays with the patient 	Community Equipment Store	01226 645400
 Commenced following multi-disciplinary agreement and communication with the patient and / or their family / carers. 	Continuing Health Care	01226 433634
 Used when a person is thought to be approaching last few days to hours or life. (Access link via live EPaCCS template)** 	iHeart (Out of Hours GP)	01226 242419
Barnsley Palliative Care Formulary: Guide for palliative care symptom management.	Pall Call	01226 244244
 Palliative Care Formulary Local guideline or pathway (barnsleyccg.nhs.uk) * Last Days of Life Symptom Management Guidance: Guidance to symptom management in the last days of life including 	Supportive Care at Home	01226 645281
 prescribing pre-emptive medication, syringe drivers. <u>Pre-emptive Drugs Local guideline or pathway (barnsleyccg.nhs.uk)</u>* List of Palliative Care Pharmacy Stockists: List of pharmacies who stock additional palliative care medication to ensure 	Welfare Rights Barnsley	07809 103254 or 07741 168743
available as required. Pre-emptive Drugs Local guideline or pathway (barnsleyccg.nhs.uk)*		

*Accessed via Barnsley BEST (https://best.barnsleyccg.nhs.uk)

****LINKS to CHC forms, medication prescribing advice, MY Care Plan, DNACPR forms and leaflets are available on the EPaCCS template**

In partnership with:

- South West Yorkshire Partnership NHS Foundation Trust
- Barnsley Primary Care Network

• We have a shared approach across all partners in Barnsley to support seamless and

• Have a workforce with the required skills and competency, with sufficient capacity to

• You, and those most important to you, are at the centre of your plans and decision

• All service developments will be informed by feedback from you and those important