Palliative Care Update

GSF

It has come to my attention that there is patchy attendance at GSF/supportive care meetings from community nursing and specialist palliative care or these meetings are being cancelled at short notice due to lack of support from community teams. If you are not getting regular input from WCFT at GSF meetings or if meetings are not happening please let me know at XXXXXXXXXX.

DNACPR

In November WUTH went live with electronic DNACPR. You will have had patients discharged with these in place from WUTH. The content of the form is the same but looks different as it is not currently printed on the usual lilac paper. These forms are being accepted by NWAS. There are no requirements for them to be re-written after discharge. If you are having issues with them please let me know so I can feed back to Mike Ellard.

Record of Care for the Last Days of Life (ROC)

Please note: If you are reviewing a patient in a care home virtually and they are dying, please consider the use of the Record of care for the Last Days of life to promote best practice. In normal circumstances the GP would sign this at the point of starting the record, however, if you are reviewing the patient remotely it has been agreed with EOL Practitioners & care homes that rather than the GP visiting the home for the sole purpose of signing the form this can be actioned verbally.

The contact details for the community palliative care service have changed and the ROC has been updated and is attached please disseminate this within your practices.

XXXXXXX - can you embed the updated document which is attached please

Rapid Discharges from WUTH

Sometimes patients are discharged home from WUTH to die at home if this is their PPC. As part of the discharge process the GP should be informed by phone that the patient is being discharged that day. I have been made aware of occasions when this has not happened. I have discussed this with the palliative care team within WUTH who will ensure this happens. If this is not happening please let me know or complete a datix so it can be investigated.

Palliative & EOL Care Governance Group

This group meets every 2 months to examine incidents, complaints and risks across the palliative care service in Wirral. In this way, we can ensure that lessons are learned across our system and we can act collectively to make any necessary changes to how services are delivered.

If you come across any incidents occurring practice please complete a datix so that these can be investigated robustly and reviewed at the governance group.

Advance Care Planning

The covid pandemic highlighted the importance of advance care planning for patients at the end of life. If you are having these discussions with your patients please make use of the following documents.

Advance care planning Framework

The Cheshire & Merseyside Palliative & End of Life Care Network (PEOLCN) commissioned the Marie Curie Palliative Care Institute Liverpool (MCPCIL) to develop a framework that will support health and social care staff, through enhanced skills, confidence and resources to incorporate Advance Care Planning conversations in to everyday practice. This framework, which has been developed in collaboration with colleagues across the network, gives clear recommendations on how to make advance care planning a reality.

Advance Care Planning Framework

The following resources are useful when making & recording Advance Care Plans.

Planning for your future care - a guide for patients

This is a useful booklet explaining advance care plans to patients and comes in several language options.

Planning for your future care - patient information

Planning for your future care leaflet

https://www.nwcscnsenate.nhs.uk/files/8814/4066/2313/Advance_Statement.pdf?PDFPATHWAY=PDF