WE WORK TOGETHER

Development of Macmillan GP post in South Wales: progress to date in Cwm Taf

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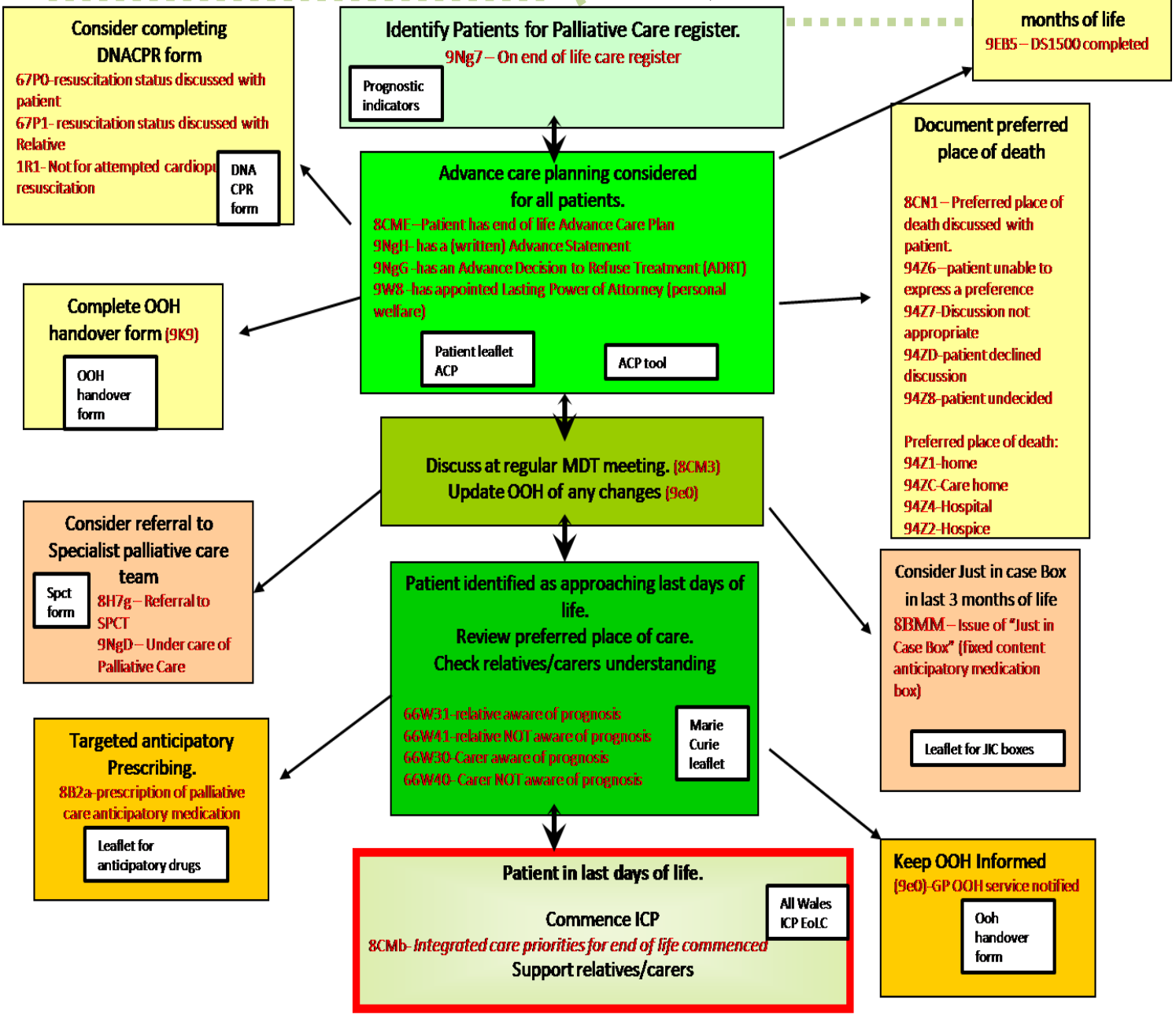
Macmillan GP Facilitators (RL, NL) took up post in September 2012. Support from the LHB, the GP Clinical Directors and the Specialist Palliative Care Team has allowed us to introduce the following service developments:

QP pathway to reduce end of life hospital admissions

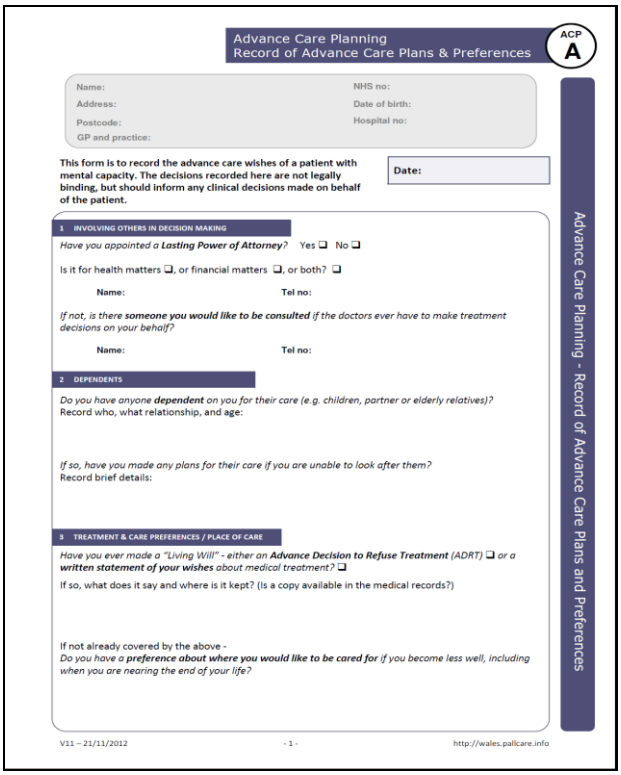
→ An optional Quality and Productivity (QP) pathway.

→ Aimed as a guide for GPs.
→ Standardised GP read codes used.
→ Relevant forms and guides embedded in the document. (Soon to be converted to internet links to ensure the up to date version is available.)



Advance Care Planning Pilot (ACP)

→ ACP tool for patients with capacity written by IB.
→ Pilot: 5 nursing homes, new admissions over 5 months .
→ Form completed by nursing staff.
→ Forms in residents notes, and a copy in GP records.
→ OOH informed that ACP in place.



Advance Care Planning
Record of Advance Care Plans & Preferences

ACP A

Name: NHS no:
Address: Date of birth:
Postcode: Hospital no:
GP and practice:

This form is to record the advance care wishes of a patient with mental capacity. The decisions recorded here are not legally binding, but should inform any clinical decisions made on behalf of the patient.

Date:

1 INVOLVING OTHERS IN DECISION MAKING

Have you appointed a ***Lasting Power of Attorney****?* Yes ❑ No ❑

Is it for health matters ❑, or financial matters ❑, or both? ❑

Name: Tel no:

If not, is there ***someone you would like to be consulted*** *if the doctors ever have to make treatment decisions on your behalf?*

Name: Tel no:

2 DEPENDENTS

Do you have anyone ***dependent*** *on you for their care (e.g. children, partner or elderly relatives)?*
Record who, what relationship, and age:

If so, have you made any plans for their care if you are unable to look after them?
Record brief details:

3 TREATMENT & CARE PREFERENCES / PLACE OF CARE

Have you ever made a "Living Will" - either an ***Advance Decision to Refuse Treatment*** *(ADRT) ❑ or a* ***written statement of your wishes*** *about medical treatment?* ❑

If so, what does it say and where is it kept? (Is a copy available in the medical records?)

If not already covered by the above -
Do you have a ***preference about where you would like to be cared for*** *if you become less well, including when you are nearing the end of your life?*

Advance Care Planning - Record of Advance Care Plans and Preferences

V11 – 21/11/2012 - 1 - http://wales.pallcare.info

Improving Palliative Care in the Out of Hours period

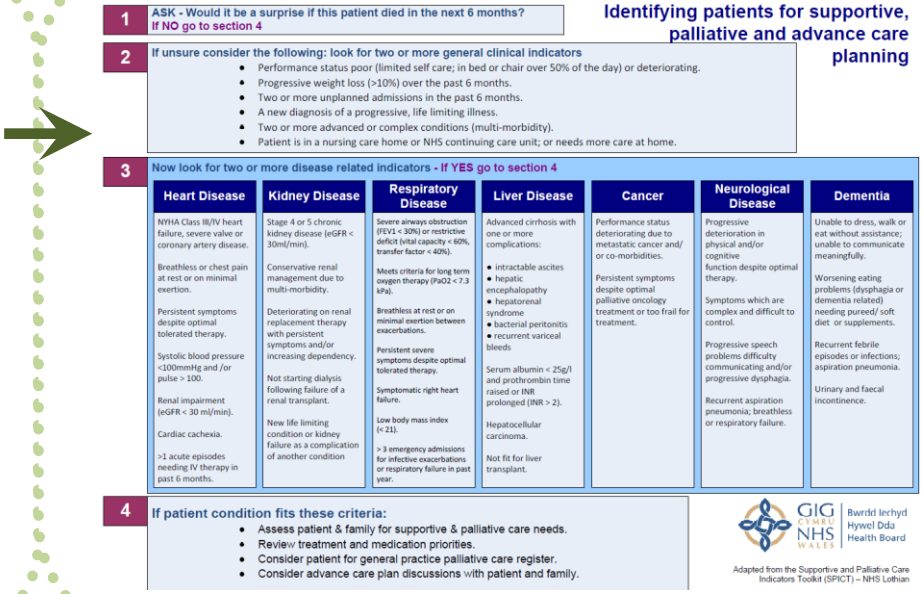
→ Electronic special notes communication form developed, with a secure email address.
→ Information pack for the mobile car with relevant forms and information for GPs (e.g. DNACPR, ICP.)
→Pilot for Just in Case boxes (JIC)

PALLIATIVE CARE HANDOVER FORM TO GP OUT OF HOURS SERVICE

Name of Patient:		Date of Birth:	
Address			
Postcode		Tel No:	
GP Surgery		Tel No:	
Why is patient having palliative care?	Cancer		Non Cancer
What is diagnosis?			
Is patient aware of diagnosis	Yes		No
Preferred place of care?			
If the patient dies of the illness stated on this form is it the intention of the patient's GP (or other GPs at the practice) to sign the medical certificate of cause of death?	**Yes**		**No**
DNACPR (Do Not Resuscitate) status:			
Current Medication:			
Emergency drugs left in patient's home?			
Drug sensitivities			
Other relevant medical history: Any other information:			
Is patient known to specialist palliative care team?	Yes		No
Name of District Nurse involved?			
Name of Carer:			
Is carer aware of diagnosis?	Yes		No
Plans for care in OOH period (e.g. Try to keep patient at home)			
Special wishes/requests of patient/carer?			
Is there a Just in Case box in the home?			

Prognostic indicator chart with communication form for secondary care

→ We have introduced this guide to primary and secondary care. Its aim is to encourage earlier identification of patients (especially non cancer) for the GP Palliative Care Register.
→ We have introduced a communication form for secondary care to help GPs identify patients suitable for their register.



Identifying patients for supportive, palliative and advance care planning

1 ASK - Would it be a surprise if this patient died in the next 6 months?
If NO go to section 4

2 If unsure consider the following: look for two or more general clinical indicators

- Performance status poor (limited self care; in bed or chair over 50% of the day) or deteriorating.
- Progressive weight loss (>10%) over the past 6 months.
- Two or more unplanned admissions in the past 6 months.
- A new diagnosis of a progressive, life limiting illness.
- Two or more advanced or complex conditions (multi-morbidity).
- Patient is in a nursing care home or NHS continuing care unit; or needs more care at home.

3 Now look for two or more disease related indicators - If YES go to section 4

Heart Disease	Kidney Disease	Respiratory Disease	Liver Disease	Cancer	Neurological Disease	Dementia
NYHA Class III/IV heart failure, severe valve or coronary artery disease. Breathless or chest pain at rest or on minimal exertion. Persistent symptoms despite optimal tolerated therapy. Systolic blood pressure <100mmHg and /or pulse >100. Renal impairment (eGFR < 30 ml/min). Cardiac cachexia. >1 acute episodes needing IV therapy in past 6 months.	Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min). Conservative renal management due to multi-morbidity. Deteriorating on renal replacement therapy with persistent symptoms and/or increasing dependency. Not starting dialysis following failure of a renal transplant. New life limiting condition or kidney failure as a complication of another condition	Severe airways obstruction (FEV1 < 30%) or restrictive deficit (vital capacity < 60%, transfer factor < 40%). Meets criteria for long term oxygen therapy (PaO2 < 7.3 kPa). Breathless at rest or on minimal exertion between exacerbations. Persistent severe symptoms despite optimal tolerated therapy. Symptomatic right heart failure. Low body mass index (< 21). > 3 emergency admissions for infective exacerbations or respiratory failure in past year.	Advanced cirrhosis with one or more complications: • intractable ascites • hepatic encephalopathy • hepatorenal syndrome • bacterial peritonitis • recurrent variceal bleeds Serum albumin < 25g/l and prothrombin time raised or INR prolonged (INR > 2). Hepatocellular carcinoma. Not fit for liver transplant.	Performance status deteriorating due to metastatic cancer and/ or co-morbidities. Persistent symptoms despite optimal palliative oncology treatment or too frail for treatment.	Progressive deterioration in physical and/or cognitive function despite optimal therapy. Symptoms which are complex and difficult to control. Progressive speech problems difficulty communicating and/or progressive dysphagia. Recurrent aspiration pneumonia; breathless or respiratory failure.	Unable to dress, walk or eat without assistance; unable to communicate meaningfully. Worsening eating problems (dysphagia or dementia related) needing pureed/ soft diet or supplements. Recurrent febrile episodes or infections; aspiration pneumonia. Urinary and faecal incontinence.

4 If patient condition fits these criteria:

- Assess patient & family for supportive & palliative care needs.
- Review treatment and medication priorities.
- Consider patient for general practice palliative care register.
- Consider advance care plan discussions with patient and family.

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Adapted from the Supportive and Palliative Care Indicators Toolkit (SPICT) – NHS Lothian