

## **YCN Palliative Care (End of Life) Pathway**

### **End of Life Pathway**

The end of life pathway is expected to begin 6 to 12 months prior to death and finish 6 to 12 months after death

The accurate recognition of patients nearing the end of life i.e. 6-12 months can be difficult. However early identification can trigger better assessment, planning and provision of care related to the patient and family's needs. The Gold Standards Framework has produced guidance to aid professionals in the identification of adult patients with advanced disease in the last months/year of life, who are in need of supportive and palliative care.

It suggests 3 trigger methods:

1. The surprise question, "Would you be surprised if this patient were to die in the next 6- 12 months?" - an intuitive question integrating co-morbidity, social and other factors.
2. Choice/ Need - The patient with advanced disease makes a choice for comfort care only, not 'curative' treatment, or is in special need of supportive / palliative care.
3. Clinical indicators - Specific indicators of advanced disease for each of the three main end of life patient groups- cancer, organ failure, elderly frail/ dementia

(see Prognostic Indicator Guidance vs.2.25 - © Gold Standards Framework Programme England 2005 or visit [www.goldstandardsframework.nhs.uk/](http://www.goldstandardsframework.nhs.uk/))

### **Pathway elements**

The elements identified as important for patient experience have been taken from those used in the supportive pathway. These are as follows

#### **Holistic Assessment (a)**

The Holistic assessment also includes Supportive Care Planning & Appropriate Care Delivery. The following domains are covered in the national Holistic Needs assessment Guide, which has been agreed to be adopted for use by the YCN; -

1. Background information and assessment information/preferences
2. Physical well-being
3. Social and occupational well-being: including managing at home and in the community, Work and finance, family and close relationships, social and recreational.
4. Psychological well-being
5. Spiritual well-being

Also included in the holistic assessment is: -

- a. the development of a care plan to meet the needs identified in the assessment
- b. the delivery of care required as part of the care plan
- c. appropriate referral to other services to enable the delivery of the care required as part of the care plan

Further work is ongoing by the Rehabilitation group to support the Holistic assessment and referral to Allied Health Professionals for rehabilitation

#### **Single Contact with the assigned Key Worker (◆)**

The Single point of contact for patients entering the palliative/end of life pathway will be assigned when patients are assessed for their needs and identified dependent on the patients needs. Patients should already have a key worker in place and it may be appropriate for that person to continue in that role. The key worker role may need to change during the pathway dependent on patient needs and care setting.

### **Key Discussion Point (©)**

These are the points in the pathway where significant information/discussions take place e.g. recognition of last 12 months of life, last days/weeks of life. The discussions will include for example advance care planning, DNAR decisions, post mortems, organ donation.

Patients will be supported during the key discussions to be as much involved in the decision making process as they wish.

### **Patient Information (i)**

Patients and carers will be offered the minimum information identified on the information pathway (which incorporates generic information). They will be assessed for any additional needs and offered appropriate information. They will be provided with support to understand and cope with the information provided. The information will be sufficient to enable the patient to play as active a role in their own care and decision making processes as they have decided is appropriate for them.

### **Abbreviations used on the Pathway**

CAF – common assessment framework

IT – information technology

GSF – gold standards framework

ACP – advance care planning

PPC – preferred priorities of care

LCP – Liverpool care pathway for dying patient

DNAR – do not attempt resuscitation

OOH – out of hours

**YCN Palliative Care (End of Life) Pathway – November 2008**

**a** - Holistic Assessment  
**□** - Single Contact with the assigned Key Worker  
**©** - Key Discussion Point  
**i** - Patient/carer information

