GUIDELINES FOR THE CARE OF TERMINALLY ILL PATIENTS
(PALLIATIVE CARE)

AIMS
A To encapsulate within the guidelines what is already accepted policy within the practice for the care of the terminally ill (from malignant or non-malignant conditions).

B To provide the best possible quality of care for terminally ill patients, facilitating a peaceful, dignified death with the optimum use of all available resources.

C To provide advice, facts and information to patients and their families, allowing them to make choices and informed decisions on the type of care and treatment they will receive.

D To provide practical and emotional support for carers and families - the degree of effective support and help given can make the difference between coping and not coping.

E To provide a management plan which is flexible and tailored to the needs of each individual.

GUIDELINES
1 All terminally ill patients will be cared for by a named doctor within the practice, who will discuss the diagnosis fully and honestly with the patient.

2 All terminally ill patients will be referred, at an early stage in their terminal illness, to the District Nurses.

3 Referral to the Macmillan Unit nurses should be considered and encouraged for all patients at an early stage in their terminal illness.
4 A list of “priority patients” will be kept at Reception with a list of the doctor responsible for their care – this will avoid unnecessary questions being asked if a visit etc., is requested (to be co-ordinated on a monthly basis by Dr M Keeling).

5 All terminally ill patients will be cared for by a multi-disciplinary team which will set up a good network of communication to ensure a well co-ordinated approach. All patients on the priority list will be discussed at the regular “Palliative Care Meetings”.

6 Any significant event occurring to a terminally ill patient during “out of hours” work should be communicated to the responsible doctor.

7 The District Nursing team should be notified of all terminally ill patients who are admitted to hospital and of all deaths.

8 During periods away from the practice, the patients’ responsible doctor will make arrangements for a partner/registrar to care for their patient in their absence.

9 The District Nursing team will be responsible for providing information about:

- finance & benefits (including DS1500)
- available services
- counseling
- respite care
- day care
- sitters
- local voluntary groups
- relevant organizations

10 The District Nurses will mobilize other members of the PHCT, e.g. social services or PAMS as appropriate and agreed with the patient.

11 Regular nursing and medical intervention will be discussed by the Dr and DN so that this is spread appropriately through the week.
12 A holistic approach to the patient's needs will be provided offering help with physical, psychological and spiritual needs. The wishes of the patient regarding where they wish to die will be discussed openly with them. If the patient is to be cared for at home the practice will use the LIVERPOOL CARE PATHWAY in the final stages of Palliative Care including the prescribing of anticipatory drugs.

13 The team will provide care for the patient and also consider and meet the needs of the carer(s) (the next of kin’s name, address and telephone number to be recorded in the patient’s notes).

14 Close links will be developed between the practice and the consultants in Palliative Medicine.

15 When the patient dies the carer/spouse will be visited soon afterwards (24-48 hrs) and offered a further bereavement consultation following the patient’s funeral. (The death will be recorded in the patient. Spouses and 1st degree relatives' computer notes).

16 Any relevant hospital specialists will be informed of the patient’s death.

17 If appropriate the patient’s death should be used as a means of offering preventative care to relatives in the ensuing months.

18 Lessons learnt (positive and/or negative) will be discussed as SIGNIFICANT EVENTS.