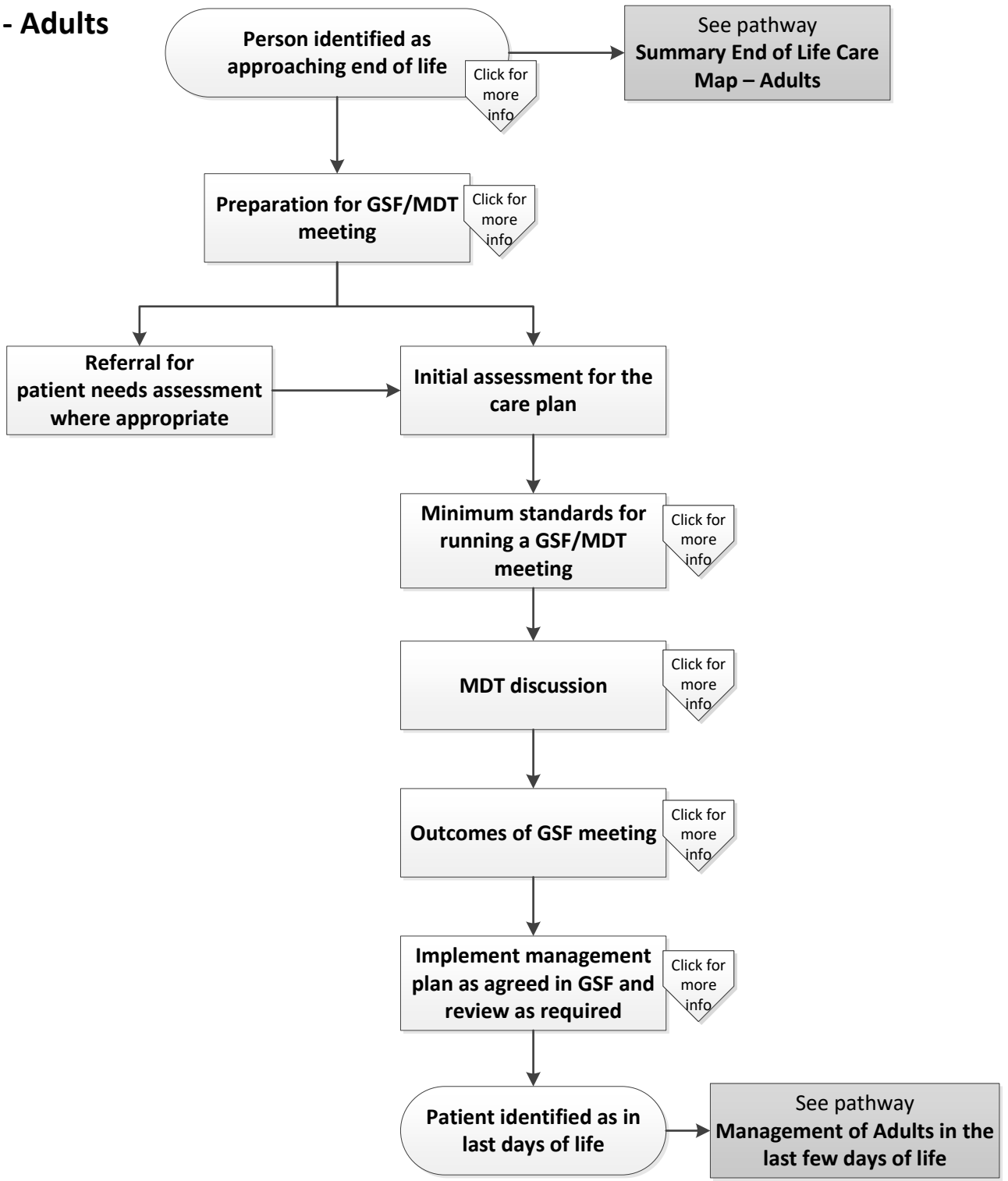
GSF End of Life MDT - Adults



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Preparation for GSF/MDT meeting

- Each practice should identify a GSF co-ordinator from within their Practice Admin Team
- This person should liaise with relevant staff prior to GSF meeting to identify active patients for discussion at the meeting. Priority patients will be:
- All those who are in the last few days of life (red)
- All patients whose conditions / symptoms have changed
- All people who have recently been identified
- GSF meeting should be set up and coordinated by the GSF coordinator including setting the agenda and taking minutes.
- The GSF coordinator will identify the most appropriate people to be included in the meeting
- Patients identified for discussion at the meeting to be added to the GSF meeting register
- GP to discuss record sharing with the patients and ask for consent to share the electronic record. Enable the share if consent is given and record consent on the EPaCCs (End of Life template)
- Ensure access to SystmOne / EMIS EPaCCs (End of Life template)
- Share record if consent is given
- The GSF Coordinator may find it useful to give the key worker prior notice that they will be required to report current status of particular patients.

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Minimum standards for running a GSF/MDT meeting

- Each locality should ensure that all practices have a designated time for GSF meetings
- Meetings should take place every 4-6 weeks
- Each locality should ensure that GSF meetings have a Co-ordinator to provide administrative support including the entry of data to the patients record and schedule review dates
- Information should be readily available for sharing
- Data should be entered into the patients EPaCCs (EoL Template) on Ardens/EMIS and the information made available at the time of the GSF meeting
- Meeting attendance minimum: GP, Specialist Palliative Care Nurse (or deputy), Community Nurse or AHP, GSF Co-ordinator
- Other: Other Allied Health Professional, Social Care, Hospices (e.g. Hospice at Home), Mental Health, Specialist Nurse

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MDT discussion

GSF Discussions Points should include:

(1) Identify patients who have not already had an Initial Assessment and refer as appropriate
(2) Identify most appropriate healthcare professional to carry out ACP
(3) Clinicians are responsible for ensuring ACP is carried out as agreed

Review /Update Advance Care Plan

(4) Priority ACP areas to be recorded in a standardised template and regularly reviewed include:

- Preferred Place of Care
- Preferred Place of Death
- Escalation plan for when the patient's condition deteriorates (for example: do not readmit to hospital)
- Consider the following:
  - Just in case guidance
  - Just in case medication including syringe driver
- Consider DNACPR
- Carers needs
- Crisis Management
- DS1500 assessment (benefits)

(5) Ensure ACP is shared with healthcare professionals generally - obtain consent from patient
(6) Ensure GP and GSF Co-ordinator is aware an ACP is now in place
(7) All deaths since the last meeting including death of patients who were not on the register and sudden or expected deaths – consider bereavement care needs
(8) Discuss any significant events, never events or complaints

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Outcomes of GSF meeting

At the end of each meeting patients should usually have in place:

- A named Key worker
- An End of Life Advanced Care Plan (EoL ACP) which is recorded in the GP clinical system (preferably using the Ardens EoL template)
- Ensure sharing of the record is enabled
- DNACPR should have been discussed and documented – this must be a face to face discussion with patient and family
- Actions from the meeting documented and communicated to all appropriate services – consider out of hours and hospice
- 'Thinking Ahead' sticker could be considered and put in place if appropriate
- Ensure patient held document is up to date
- Relevant contact numbers. These can be printed from the EoL template

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Implement management plan as agreed in GSF and review as required

- Named care co-ordinator to ensure clinical and social management plan is enacted with reviews as required
- GSF co-ordinator to ensure patients have regular GSF reviews if required
- GSF co-ordinator to liaise with clinicians if patient requires an earlier review date

Communicate with relatives, carers and patients

Establish the communication needs and expectations of people who may be entering their last days of life, taking into account:
- if they would like a person important to them to be present when making decisions about their care
- their current level of understanding that they may be nearing death
- their cognitive status and if they have any specific speech, language or other communication needs
- how much information they would like to have about their prognosis
- any cultural, religious, social or spiritual needs or preferences
- Identify the most appropriate available multi professional team member to explain the dying person's prognosis.

Base this decision on the professional's:
- competence and confidence
- rapport with the person

Discuss the dying person's prognosis with them (unless they do not with to be informed) as soon as it is recognised that they may be entering the last days of life and include those important to them in the discussion if the dying person wishes.
Provide the dying person, and those important to them, with:
*accurate information about their prognosis (unless they do not wish to be informed), explaining any uncertainty and how this will be managed, but avoiding false optimism
*an opportunity to talk about any fears and anxieties, and to ask questions about their care in the last days of life
*information about how to contact members of their care team
*opportunities for further discussion with a member of their care team.

Explore with the dying person and those important to them:
*Whether the dying person has an advance statement or has stated preferences about their care in the last few days of life (including any anticipatory prescribing decisions or an advance decision to refuse treatment or details of any legal lasting power of attorney for health and welfare)
*Whether the dying person has understood and can retain the information given about their prognosis. Discuss the dying person's prognosis with other members of the multi professional care team and ensure that this is documented in the dying person's record of care.

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Person identified as Approaching end of Life

•Aim for early identification of patients in the last years of life – this is especially important for people with dementia.
•Use existing predictor tools eg GSF Proactive Information Guidance
•Encourage everyone in the team in all settings to ask 'Would I be surprised if this patient died in the next 12 months?' (the surprise question).
•Use other information – e.g. hospital phone calls or specialist letters, patients own concerns, patients choice e.g. patients with advanced chronic kidney disease who chooses not to have dialysis, carer concerns, other staff concerns (care homes/ nursing home, district nurses, community matrons, etc.), frequent frequent unplanned admissions to hospital, use of out of hours services (OOHS).
•Discuss with the patient and gain consent to them being added to the supportive and palliative care register, explain the benefits such as the ability to share electronic information.

Pathway reference:
top tips guide to supportive and palliative care meetings' **https://elearning.rcgp.org.uk/pluginfile.php/170657/mod_book/chapter/270/Guide%20to%20meetings.pdf**