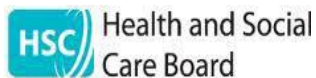
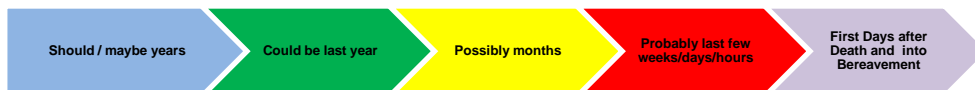


## Prompts to aid practitioners in the development of an individualised care plan



### ELCOS End of Life Care Operational System



Patient Journey —————>

Should / may be years <b>A</b>	Could be last year <b>B</b>	Possibly months <b>C</b>	Probably last few weeks/days/hours <b>D</b>	First Days after Death and into Bereavement
<p>Multi-professional Holistic Assessment completed.</p> <p>District Nursing Team informed. (see <i>Keyworker Guidance</i>)</p>	<p>Multi-professional Holistic Assessment completed/updated.</p> <p>District Nursing Team informed. (see <i>Keyworker Guidance</i>)</p> <p>On-going Symptom assessment and management</p>	<p>Multi-professional Holistic Assessment completed/updated.</p> <p>District Nursing Team informed. (see <i>Keyworker Guidance</i>)</p> <p>On-going Symptom assessment and management</p>	<p>Multi-professional Holistic Assessment completed/updated.</p> <p>District Nursing Team informed. (see <i>Keyworker Guidance</i>)</p> <p>On-going Symptom assessment and management</p>	<p>Verification of death Certification of death</p> <p>District Nursing Team and GP informed.</p>
<p>Consider Advance Care Planning</p>	<p>Consider/Review Advance Care Plan</p>	<p>Consider/Review Advance Care Plan</p>	<p>Consider/Review Advance Care Plan</p>	<p>Bereavement support offered to relatives, staff and other residents.</p>
<p>Prognostic indicators suggest patient has palliative care needs.</p> <p>Confirm with GP and develop individual care plan.</p> <p>Communicate with family or those important to them</p>	<p>Prognostic indicators suggest patient may be entering last year of life.</p> <p>Confirm with GP and develop / review individual care plan.</p> <p>Communicate with family or those important to them</p>	<p>GP review of patient who has increasing palliative care needs and develop / review individual care plan.</p> <p>Communicate with family or those important to them</p>	<p>GP review of patient who has increasing palliative care needs and develop / review individual care plan.</p> <p>Communicate with family or those important to them</p>	<p>Signpost relatives to bereavement counselling services if necessary</p>
<p>Appropriate information given to patients &amp; family</p>	<p>Appropriate information given to patients &amp; family</p>	<p>Appropriate information given to patients &amp; family</p>	<p>Appropriate information given to patients &amp; family</p>	<p>Offer bereavement information.</p>

## Prompts to aid practitioners in the development of an individualised care plan

Should / may be years A	Could be last year B	Possibly months C	Probably last few weeks/days/hours D	First Days after Death and into Bereavement
Essential equipment identified and provided.	Essential equipment identified and provided. Need for equipment reviewed.	Essential equipment identified and provided. Need for equipment reviewed.	Essential equipment identified and provided. Need for equipment reviewed.	Ensure all equipment is collected  Advise family on safe disposal/ return of medication
	DNAR-CPR status considered, documented and communicated.  Ambulance service updated	DNAR-CPR status considered, documented and communicated.  Ambulance service updated	DNAR-CPR status considered, documented and communicated.  Symptoms assessed and managed as per individual care plan.  Ambulance service updated	Notify all health and social care professionals involved in the care of the patient
	Ensure GP out of hours service is advised of the palliative care needs.	Ensure GP out of hours service is advised of the palliative care needs	Ensure GP out of hours service is advised of the palliative and end of life care needs	
		Review individual care plan, discontinue non-essential medications and therapies when appropriate	Review individual care plan, discontinue non-essential medications and therapies when appropriate	
		Anticipatory prescribing considered.  Consider if a Syringe Pump is required	Anticipatory prescribing considered.  Consider if a Syringe Pump is required	