

# Meeting People's End of Life Care Needs

Would you be surprised if the person died in the next year?

- For resources to support you with this [click here](#).
- See 'Identifying patients for supportive and palliative care'.
- Looking at your patients in Care homes and over 90yrs old is a good way to get started and the [prognostic indicators](#) guidance may help.

NO

Ensure person is entered onto the locality [EoLC Register / EPaCCS](#), include information regarding DNACPR/ACP etc as below. This will ensure OOH, ambulance, community and acute care can access the information. Access for social care and hospices will take longer so send any important information to them directly.

Allocate key worker from Primary Health Care team

[Keyworker/ GP assesses and care plans](#) for current needs of patient. [Assess care plan carers support needs](#). Enter carer onto carers register. Key worker adds person onto list for discussion at MDT as and when requires advice. Discusses eolc register and entitlements with [patient and carers](#). [Symptom control information](#).

Complete [DS1500](#) if appropriate



Offer the opportunity to the patient to complete an Advance Care Plan

Key worker / GP offers the opportunity for ACP using the [toolkit](#) which has public / patient info, guidance for staff and forms to use (including for Advance Decisions to Refuse Treatment). An example form for the patient to use can be seen [here](#). Training to support you in these conversations is offered in the [toolkit](#) and [here](#).



*Would you like to talk about what you can expect and what is likely in the future?*

Discuss with the patient and complete a DNACPR Form where appropriate

Electronic Form, Policy and Guidance, Guidance on the Mental Capacity Act / DNACPR / ADRTs and patient / carer information available [here](#).



Is this person entering the final stages of life?

YES

Ensure Just in Case medications are in the home, [click here for guidance](#). GP/ Keyworker offer opportunity to ACP if not previously. Ensure equipment in the home. Alert all agencies involved in care via [eolc register](#)/ [EPaCCS](#) or directly.



Following the Person's Death

Death Certification:  
Topical tips for GPs.

[Link to bereavement leaflet and advice](#) AND remember [benefits](#) are available for the bereaved.

Remember to carry out with your team and all involved in the persons death an After Death Review/ Significant Event Analysis so that lessons can be learnt. Keep a record to send to those who cant attend. A detailed template to inform these discussions can be [found here](#).