TOP TIPS- Identifying Patients for Advance Care Planning

1. Consider your Care Home Population (the average life span of someone admitted to registered 24 hour care setting is 18 months)

2. Speak to your Care Home staff – they may have identified their own patients nearing end of life, especially if they have done GSF or Six Steps Programmes

3. Consider patients with long term conditions who may be nearing end of life – your practice nurses may be particularly good at identifying these patients. Also consider those patients with recurrent admissions to secondary care.

4. Involve other members of your health care team as well as they may be able to identify appropriate patients e.g. district nurses, allied health professionals, community matrons etc.

5. Think about putting patients who may lose capacity or ability to communicate as part of their disease on the GSF register early to aid care planning e.g. patients with dementia, patients with motor neurone disease

6. Patients with a Frailty score on the Rockwood scale of 7 or higher should be considered for advanced care planning discussions.

7. Use the 'Surprise' question ('would I be surprised if this person dies within the next year?") However remember prognostication is not an exact science and it will not do patients any harm to be on the register for longer than a year.

8. Once identified make sure you code the patient with one of the GSF codes on EPaCCS to allow this information to be shared with other health and social care professionals involved in the patients care.

9. Coding of these patients also allows you to identify them easily for your palliative care meetings and to audit their care to allow quality improvement (QI) work to be done within the practice.

10. Look at www.cheshire-epaige.nhs.uk for more tips and tools to help identify patients who may be approaching the last year of life.

For more information visit http://eolp.co.uk/ or http://www.cheshire-epaige.nhs.uk/