

Consider

Consider whether the patient has an uncertain prognosis or is nearing end of life?

Consider:

- Rockwood Frailty Assessment
- SPICT - Supportive and Palliative Care Indicator Tool
- The 'surprise question'
- The patient's narrative
- Information from the family/carer
- Discuss at white board / MDT meetings
- Conversation Project magnet on the white board to identify patients

Have

Have conversations with the patient & their family to support Advance Care Planning (ACP):

- Think about the environment and your approach
- Check their understanding
- Acknowledge uncertainty of recovery
- Have honest conversations
- Listen compassionately to concerns, wishes and preferences
- Include discussion of TEP
- Offer 'Planning ahead' leaflet

Advise

Advise the MDT following ACP conversations:

- Share information on the patient's wishes & preferences
- Complete TEP
- Include information from ACP discussions in the plan of care
- Document ACP conversations in the MDT records - reverse of TEP and Millennium 'Conversation Project ACP template'

Transfer

Transfer information to support continuity of care:

- Offer use of 'Planning Ahead' leaflet to the patient and family
- Consider community TEP or share information on TEP decisions
- Include 'discussions had and decisions made' in the discharge summary
- Communicate with GP, DN or care home by phone

For information on the Conversation Project:

- Open the intranet and click 'P' for Palliative or 'E' for End of Life Care
- Contact the Palliative Care Team on [ext 5567](tel:5567)