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Westminster Palliative Care info sheet

This information sheet provides a summary of resources designed to help staff supporting service users that are at end of life. **If you would not be surprised if a client were to die within the next 6 to 12 months, then you can access the following resources to support them**. Hope for the best, plan for the worst. It's not easy identifying clients that may need extra support, but when you do it is important that you alert services so they can help.

Homeless Palliative Care online toolkit

The Homeless Palliative toolkit is a must read when working with service users at end of life. Key sections are listed below:

- Identifying clients of concern – when/ how to seek support, illness trajectories,
  - SPICT tool, which provides palliative care indicators (signs of poor or worsening health)
  - the health monitoring tool can be used to monitor and record health concerns
  - The Liver Map, which lists the key indicators of the 3 stages of alcohol related liver disease, and the staff response required.
- Explaining palliative care – what is palliative care, how to access palliative, meeting challenges in enabling clients to access palliative care, parallel planning
- What is advance care planning and capacity - Advance care planning is important so that the individual can express what is important to them while they're able to. It also allows them to appoint someone as an advocate, thus increasing the likelihood of these wishes being known and respected at the end of life. The My health and the future plan document has been created to help those experiencing homelessness to advance plan.
- The importance of multi-agency working and shared care - this section aims to support your understanding of multi-agency working and why it's essential to meeting the **individual** needs of clients with advanced ill health. It also considers the **qualities** we bring to our interactions with them, and tools that may help you identify what supports are needed, and who can best support you.
- Self-care for staff - this section will help you to develop an understanding of the nature and causes of primary and secondary stress and consider some strategies for reducing stress and improving overall well-being.
- Tools to support end of life clients - includes planning care at home checklist, ECOMAP to determine what is important in client's life, multi-agency worksheet to determine the level of support needed for service user

Benefits

When a client is nearing their end of life they are entitled to an increase in benefits. The types are explained below.

- If the client has under 6 months to live, a PIP form needs to be filled out for the client
- GP should fill out an SR1 form for DWP – if estimated prognosis of 6-12 months left of life. Marie Curie provides more information here.

- GP should fill out a DS1500 form for DWP – if estimated prognosis of under 6 months. Marie Curie provides more information here.
- The client maybe entitled to continuing healthcare (which could be used to fund a carer as required) – a healthcare professional needs to assess whether they are eligible. Marie Curie provides more information here.

If client wishes to die in supported accommodation

Suggestions include:

- Think through health & safety practicalities in advance e.g., policy re: oxygen tanks and canisters. Go through the planning care at home checklist from the Palliative Care toolkit.
- Consider when it is not possible to keep someone in your service, when that is and what happens next.
- If client is in hospital and likely to be discharged to supported accommodation, staff need to **request a discharge planning meeting** – and state that discharge will not be accepted on a Friday afternoon / the weekend. This is to allow for adequate support planning.
- Consider what support will be needed for the client whilst in supported accommodation. Use the activity sheet when thinking about multi-agency working and the level of support needed for the client.
- Discuss with the person how, and whether, they will be able to keep their prescribed drugs safe
    - Coded locked boxes for controlled medication based in the hostel that palliative care and district nurses can access (hostel don't have code).
    - Daily deliveries of medication via local pharmacy.
    - Consider weekends and access to medication.
- Health professionals can consider how to provide pain management to a recovered opioid user Good practice guidance when supporting individuals with substance use issues and end of life, produced by Manchester Metropolitan University and the Community Fund. Page 14 of the document provides information on pain symptom management and prescribing.
- **St John's Hospice at home** is a respite service for anyone in Westminster (with a Westminster/ West London GP) who is end of life care, providing up to 2 weeks of care. If the person requires further support after the 2 weeks an application to continuing care will be made. Caveats are the bed may need to be a certain height for turning client/ they can't support someone who is a heavy smoker in their room. Referral form needs to be filled out by GP/ Nurse professional and staff member needs to complete a risk assessment. For further information and the referral form email nhsnwl.stjohnsreferrals@nhs.net.
- **Trinity Hospice** provides community palliative support for those in South Westminster. Referrals can be made via RTH.communityteam@nhs.net or main number 020 7787 1000 asking for the Admission and Referral nurse team.
- **Night district nursing** provides medical support overnight and can help with injectables, suppositories, catheters, wound care & dressings, canula still in the arm after self-discharged. If the client gets sick and needs help and a night nurse would be suitable to help with end-of-life medication for symptom control. If before 8pm email CLCHT.NightDistrictNursingTeam@nhs.net or telephone 0208 102 5500, if after 8pm call **07917 162679** or **07876 791266**.

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Hospices

If the client would like to access a hospice, there are 3 available. These are Trinity Hospice (South Westminster), Pembridge (North Westminster) and St John's Hospice (North Westminster). Access to palliative care is via GP referral, although Trinity Hospice accepts direct referrals here.

If hospice staff are unsure of how to work with those with addictions alert them to this best practice example, page 2 End of Life Care Substance use; where the client was allowed to leave the hospice for a couple of hours to use, so they could remain an inpatient.

When client passes away in accommodation

When a client passes away due to an overdose, physical health complications, or by suicide then we would normally call the ambulance and the police who will inform the coroner. If a client is identified as palliative care, then an ambulance services and the coroner will not collect the body.

- Contact the GP to confirm death and sign the death certificate.
- If family are not available to arrange a funeral, contact the local authorities contracted funeral directors for collection of the body: publichealthfunerals@westminster.gov.uk.
- You can also call Sherry's the funeral directors (020 8994 5474) for collection of the body (if over a weekend)

Palliative care training

St Mungo's Palliative Care Coordinator runs training every year to support staff working in the homeless sector. When this training is run it is advertised via the HHCP training newsletter.

Royal Trinity Hospice runs palliative care training for staff (for a cost) and can deliver training for staff working in homelessness https://www.royaltrinityhospice.london/training-and-education.

Further information

- St Mungo's Homelessness and end of life care guidance provides a downloadable toolkit with details on what is palliative care, knowing when a resident may require end of life care, assessing a resident's end of life care needs, communicating about death, and dying, and tools and templates.
- Marie Curie's webpage on Caring for people experiencing homelessness with palliative care
- CQC and Faculty for Homeless and Inclusion Health document on: "Exploring the barriers and championing outstanding end of life care for people who are homeless".

Podcasts from End of Lifecare Substance use:

- Supporting homeless people that using substances and are seriously unwell
- Substance use and serious ill
- Symptom and pain management

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BEST PRACTICE ACTIONS TO COMPLETE

If you would not be surprised if a client were to die within the next 6 to 12 months, then you can follow actions below to support them

1 Complete the SPICT 4 All tool.
Inform manager and team if health concerns identified.

IMMEDIATE ACTIONS

1. Contact GP to discuss concerns/ investigations/ **pain management if needed/ referral to palliative care community team? Ask for the local contact details of the local palliative care community team.**
2. Contact Find and Treat / Hep C for liver scan? Lorna Harrison at St Mary's
3. If a life limiting diagnosis is given alert services that support client about your concerns – start a multi-disciplinary team meeting.
4. If it is not possible to get a diagnosis, continue to monitor the client's health using the health monitoring tool, continue to weigh weekly.

ACTIONS IF CLIENT IN HOSTEL

1. Use the health monitoring tool and record health concerns – or use service's monitoring system. Share these notes with health professionals.
2. Weigh the client each week and record.
3. Continue checking in with multi-disciplinary team supporting client.
4. Discuss end of life with client
5. Ask them if they have family they would like to contact
6. Help support the client with advance care planning

BENEFIT ACTIONS

- If prognosis of 6-12 months, GP should fill out an SR1 form.
- If prognosis of under 6 months, GP should fill out a DS1500 form.
- The client maybe entitled to continuing healthcare (which could be used to fund a carer as required) – a healthcare professional needs to assess whether they are eligible.

ACTIONS IN HOSPICE

- If needed alert staff to best practice example, page 2 End of Life Care Substance use; if substance use is endangering their placement.

ACTIONS IF CLIENT TO BE DISCHARGED TO SERVICE FROM HOSPITAL

1. Request a discharge planning meeting immediately. Make it clear you can't accept client back on Friday evening or weekend.
2. Request Occupational therapy assessment if client is struggling to mobilise.
3. If the client if diagnosed as end of life, ask for a healthcare professional to assess whether they are entitled to continuing healthcare before discharge.

ACTIONS IF CLIENT DIES

- If a client is identified as palliative care, then an ambulance services and the coroner will not collect the body.
- Contact GP to confirm death and sign the death certificate.
- Contact family if known – they may wish to organise the funeral.
- Contact the local authorities contracted funeral directors for collection of the body.