City of Westminster

Westminster Palliative Care info sheet

(updated February 2025)

This information sheet summarises resources to assist staff in supporting clients experiencing homelessness at the end of life. If you would not be surprised if a client were to pass within the next 6 to 12 months, you may access the following resources to provide them with appropriate care. Remember to "hope for the best and plan for the worst."

Palliative care supports people with advanced, incurable illness by addressing physical, psychological, emotional, spiritual, social and cultural needs. It also supports family, friends, carers and staff involved in the person's care. A range of services may provide palliative care, including GPs, district and community nurses, social care, palliative medicine consultants, community palliative care teams and hospices. Support is provided as needs change.

When a client receives a life-limiting diagnosis, you can request a palliative care referral via their GP. Timing can be difficult to judge because illness progresses differently for everyone. Missed appointments, unclear diagnoses, or conditions that may improve (for example with lifestyle changes such as stopping drinking) can affect eligibility. If palliative care is not considered appropriate at first, this may change as the client's condition develops, so concerns can be raised again.

Homeless Palliative Care toolkit

The Homeless Palliative toolkit is extremely useful when working with those experiencing homelessness. Key documents from this toolkit are listed below.

Identifying clients of concern

- Use the activity sheet: identifying clients of concern – it helps you gather your thoughts in identifying clients potentially approaching end of life.
- Use the health monitoring tool, including regular weight checks if possible, to help track any concerns to share with medical professionals.
- SPICT 4 All tool provides palliative care indicators (signs of poor or worsening health). This has been created for non-medical professionals to help ensure that signs are identified and discussed early. This way, patients can receive better-coordinated care and support, regardless of where they live.
- The Liver Map which lists the key indicators of the 3 stages of alcohol related liver disease, and the staff response required.

Advance care planning is important so that the individual can express what is important to them while they're able to. The client's plan can be a very useful tool for you and others within the multi-agency team.

- My health and the future plan document has been created to help those experiencing homelessness to advance plan.
- Government guidance on how to make a will here.

Shared care - multi-agency working is 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.

- There is a who can support you document to determine which agencies can help the client
- The HHCP multi-disciplinary case conference toolkit is available here, along with an information sharing & confidentiality template that you can ask attendees to sign in the meeting.

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.

Having conversations about death

Talking about death can feel uncomfortable, but avoiding it can lead to unmet wishes. Use your judgement about whether you or another staff member should start the conversation.

Here are some pointers and things consider when talking about death with clients.

- Know yourself – you are not a blank canvas; you will have your own experience of death.
- There is a questions to consider tool that can be asked to clients about their physical health, substance use, relationships, treatment and care, emotional health, hopes for the future and social/practical issues.
- **Death cafés** are run at various places, and these are where people meet to discuss death. Find your local Death café or there is a guide you could use to run one at your service. Research on the considerations required to run a Death café can be found here.
- Everyone is different and no one size fits all when talking about death:
  - Consider difference in identity: religious beliefs, gender, age, ethnicity, sexuality.
  - Consider difference in preferences: relationships with authority, faith in the system, desire for support (from you or the wider system), relationship with staff.
  - Consider difference in ability: mental health issues, substance use, intellectual disability/difficulties, brain injury.
- The attitudes we bring are also very important. They are what enable us to focus on what the client wants at any moment in time, rather than what we may want for them, e.g. striving to ensure a client goes to detox when this may not be what they want or able to achieve at this time.

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 extra living costs due to a long-term physical or mental health condition and has difficulty doing certain everyday tasks or getting around due to their condition then, a PIP form needs to be completed.
- If prognosis is less than 12 months to live then the GP should fill out an SR1 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.

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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 to identify what else will be needed to support the client whilst in supported accommodation.
- Consider what are the policies for your service around substance use? Might these need to be revised? E.g. when a dependent drinker is too unwell to get their alcohol and susceptible to dangerous withdrawals.
- 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 shortly to supported accommodation, staff should **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.
- 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.
- Good practice guidance when supporting individuals with substance use issues and end of life, Page 14 provides information on pain symptom management and prescribing for those with current or historic problems with substance use.

Organisational support for palliative care in supported accommodation

- **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.

- **Royal Trinity Hospice** provides community palliative support for those in South Westminster. Referrals can be made via rth.referrals@nhs.net or main number 020 7787 1060 asking for the Admission and Referral nurse team. Trinity Hospice accepts direct referrals to their hospice here.

- **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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When the 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.

However, if a client is identified as palliative, and expected to die, then the ambulance services and the coroner may not collect the body. As per page 14 of this NHS guidance, let the ambulance service know the death was expected or unexpected. If the ambulance/coroner don't collect the body, you will need to:

- Contact the GP to confirm death and sign the death certificate.
- Contact the family to arrange the funeral. If the family is unavailable, contact the local authority's contracted funeral directors for the collection of the body at: publichealthfunerals@westminster.gov.uk.
- If the death occurs over a weekend, call the funeral directors (Sherry's on 020 8994 5474) for collection of the body.

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 run palliative care training for staff, which is available on a paid basis.

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Palliative care best practice checklist

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. Inform manager, if haven't already.
2. 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.**
3. Contact Find and Treat / Hep C for liver scan.
4. If a life limiting diagnosis is given alert services that support client about your concerns – start a multi-disciplinary team meeting.
5. If it is not possible to get a diagnosis, continue to monitor the client's health using the health monitoring tool, 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.

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.

BENEFIT ACTIONS

- If prognosis of under 12 months, GP should fill out an SR1 form.
- The client maybe entitled to continuing healthcare – 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 DIES

- If a client is identified as palliative care, then an ambulance services and the coroner may 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/ funeral.