frequency with the team can influence the extent of monitoring and surveillance. For example, if they opt for less frequent reviews, this could prevent proactive review, thereby increasing the likelihood of a crisis.

It is important to discuss these tools with the team before they are used, explaining the aims of using them. Once implemented, use of the tools in practice could be identified during audit of deceased patients’ records and the findings acted on accordingly.

While end of life care tools are extremely valuable in any assessment, practitioners also need to use high level communication skills in sensitive areas. Training should be available to enable them to be competent and confident in difficult situations.

## Establish communication methods

Patients with palliative care needs have conditions which are vulnerable to change. To ensure continuity of care, effective communication between services across all care settings is essential.

The GSF advocates clear and concise communication between out of hours and regular services to enable seamless, timely and appropriate care (Thomas, 2003). Effective communication can ensure needs and preferences are known, to support proactive planning, crisis aversion and prevent unnecessary hospital admission. Reciprocal communication is also necessary between care settings where admission and/or discharge is planned or has already taken place, to ensure services are fully updated about patients’ needs and preferences.

### Ensure proactive planning

Anticipatory and proactive planning is crucial to avoid crises or ensure they are managed effectively.

One controversial consideration is whether ambulance services should be informed of patients who are receiving palliative care and have an agreed “do not attempt resuscitation” order in their records. However, careful consideration should be given to who initiates such discussions with patients and carers, as well as how and where the outcomes are documented and the review process. Other considerations include ensuring anticipatory prescribing and equipment is available in patients’ homes if their clinical needs indicate treatment should start without delay or if difficulties are anticipated.

It is vital to audit out of hours incidents to enable the team to consider how they might address any issues that arise, and to improve patient experience, team effectiveness and collaborative service delivery. Audit findings may indicate that investment in rapid response services is needed to manage emergency episodes in the community.

### Develop the workforce

A range of methods can be used to enable practitioners to improve their skills in symptom assessment, such as:

- Expert supervision involving shadowing or being shadowed by more experienced colleagues when assessing patients;
- Clinical supervision;
- Joint visits with specialist colleagues;
- Spending time at hospice/specialist palliative care units;
- Discussion and reflection at team meetings.

Identify strengths and weaknesses within the team. This will help to highlight where knowledge and skills need to be improved and enable such issues to be addressed in personal development reviews.

Carry out significant event and after death analysis: such analysis at MDT meetings is vital to enable the team to reflect on what has gone well and what did not go so well to learn good practice (GSF, 2005c). The GSF team recommends these activities to promote shared learning (Thomas, 2003), so it is crucial to invite staff who may add value to discussions. Such analysis should be done in a place that promotes an open culture.

### Measure success

Once implementation has begun, it is vital to evaluate the GSF’s impact (Gopee and Galloway, 2009; Barr and Dowding, 2007) before progressing to the next stage and to establish whether it has had any impact on patient care and service delivery.

The methods in Box 1 could be used to determine this, and data can be made available to the team, with successes recognised and a constructive approach taken to areas where improvements are still needed (Ellershaw and Wilkinson, 2003; Thomas, 2003).

The DH (2008a) also requires organisations to provide evidence of their quality, and advocates the GSF as an effective programme, in conjunction with other end of life care tools (Liverpool Care Pathway and Preferred Priorities for Care).

## LEVEL 3

### Support carers and provide information

Patients with advanced disease often become dependent on their families as their functional ability declines.

Family members or friends may become the main caregivers, playing a crucial role in providing palliative care and in determining whether the patient dies at home (Docherty et al, 2008). Carer breakdown is often the key factor leading to patients moving into institutionalised care, and ideally carers should be viewed as integral members of the team, taught or enabled to do as little or as much as they wish for patients, and consulted and informed at every stage (Thomas, 2003).

It is therefore vital to provide carers with appropriate information to enable them to perform aspects of care effectively and safely, as poor knowledge impacts on care standards. This can help carers to feel supported, enabled and empowered in delivering informal care, a responsibility that inevitably affects their own quality of life. Carers are also entitled to an assessment, independent of the person they care for (DH, 2008b) as their own needs are often neglected (King et al, 2003). Also, patients may be anxious about their carers’ welfare and fearful of becoming a burden (Hasson et al, 2008; Jones et al, 2004).

However, in reality, services are not wholly aligned to support carers in the community as most are deployed as visiting services and often patients at the end of life are admitted to acute care (National Confidential Enquiry into Patient Outcome and Death, 2009), with 10% dying within 24 hours of admission (NHS North West, 2008). The likelihood of this may be reduced if rapid response and

| **TABLE 1. THE PEPSI-COLA CHECKLIST** |
|-----------------|----------------|
| **P** Physical | **E** Emotional |
| **P** Personal | **S** Social support |
| **I** Information/communication | **C** Control |
| **O** Out of hours/emergency | **A** Afterwards |

### BOX 2. KEY FOR PACE SYMPTOM ASSESSMENT TOOL

| 0 – absent | 1 – present, not affecting daily life | 2 – present, moderate effect on daily life | 3 – present, daily life dominated by problem/concern |

Source: GSF (2005b)

Source: GSF (2005a)