

MAKE DISCHARGE LETTERS FOR PATIENTS RECEIVING END OF LIFE CARE G.R.E.A.T Acknowledgements to The Dudley Group NHS



**GSF Code: If you think your patient may die in <12 months or sooner, tell the GP so they can add them to the GSF Register and include their needs based coding: RED (Final Days of life), AMBER (Final weeks of life) or GREEN (Final Year of life of Life).**

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**End of life care medications: If the patient may die in < 12 weeks or there is potential for sudden deterioration consider prescribing PRN/SC anticipatory medications - guidance is available on the palliative care intranet site.**

**Resuscitation status (DNACPR): Is a DNACPR form in place? Make sure it goes home with the patient, and that the family / patient (with capacity) are aware. Communicate decisions made to the GP / Community teams.**

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**Advance Care Planning: Let the GP / Community teams know of any plans made with the patient about future care. Information about advance care planning and Information about ReSPECT Forms can be found on the Intranet.**

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**Would further hospital admissions be of benefit or not? Treatment Escalation/limitation Plan: advise the community teams re: Ceilings of Care - this information is essential to help community teams make decisions about readmitting patients.**

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**VISIT THE UHNM PALLIATIVE CARE INTRANET SITE: Trust Intranet → Clinicians → Support Services → Palliative Care**