 

The Daffodil Standards

# Example EOLC Death Audit/ MDT mortality review template and example SMART goals

RCGP and Marie Curie UK General Practice Core Standards for Advanced Serious Illness, End of Life Care and Bereavement

**Example EOLC Death Audit and MDT mortality review collection template for the Daffodil Standards**

**Daffodil Standards – domains:**

**1. Professional and competent staff**

**2. Early identification**

**3. Carer Support**

**4. Seamless, planned, coordinated care**

**5. Assessment of unique needs of the patient**

**6. Quality care during the last days of life**

**7. Care after death**

**8. General Practice as hubs within compassionate communities**

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| Primary Daffodil Standard | Death Audit/ MDT mortality review dataset |
| *Demographics* | *Name/ Reference* |
| *Demographics* | *Gender* |
| *Demographics* | *Age - at death* |
| *1* | *Named GP* |
| *2* | *Ethnicity* |
| *2* | *Cultural/ Spiritual beliefs* |
| *2*  | *Inequality group? e.g. LD, dementia, elderly, children, LGBTi, BAME, non-cancer diagnoses, homeless* |
| *2* | *Communication + Information needs?* |
| *2* | *Date of Death (time on the register)* |
| *2* | *On EOLC supportive care register?* |
| *2* | *Date added to EOLC supportive care register?* |
| *3* | *Care-giver or NOK identified?* |
| *3* | *Family member/ care-giver offered or signposted to holistic support before death* |
|  *4*  | *PROCESS: Look for reliability of coding across all patients e.g. flagging identification of patients and their carers on Supportive Care Register* |
| *4* | *PROCESS: Look for reliability across all patients at MDT e.g. use of template at MDT to enable consistent review of patients and their carers as well as enabling 'learning from deaths'* |
| *4* | *Benefits: Consider if coded for DS1500, Domiciliary Care, Continuing Health Care or Fast Track Continuing Health Care* |
| *4/5* | *On shared electronic record? i.e. enabling in and out of hours and emergency providers access?*  |
| *4/5* | *Cause of death OR Major Diagnoses* |
| *4/5/6* | *Death secondary to Advanced Serious Illness/Expected**OR Sudden death/ Unexpected (e.g. due to trauma, suicide) \*see definitions below* |
| *4/6* | *Known to Specialist Palliative Care team (Y/N)* |
| *5* | *Personalised Care & Support Plan/ Anticipatory Care Plan discussions sensitively offered* 1. *What Matters Most to you and yours?*
2. *Treatment Escalation*
3. *Advance Care Plan including DNACPR*
4. *Carer Support Map*
 |
| *5* | *Preferred Place of Care recorded*  |
| *5* | *Preferred Place of Death recorded*  |
| *5/6* | *PPD achieved (Y/N)* |
| *5/6* | *Reason for variance if different to PPD* |
| *5* | *Usual place of residence* |
| *5/6* | *Place of Death* |
| *6* | *5 priorities of care for the dying person - met in community?* |
| *7* | *Contact with bereaved family member/ care-giver documented* |
| *7* | *Support offered to bereaved family member/ care-giver documented* |
| *8* | *Patient/ Family or Care-Giver Feedback received?* |
| *Practice / PCN reference* | *Number of GP contacts in last 3 months of life* |
| *Practice / PCN reference* | *Number of admissions (or urgent care episodes) in last 3 months of life* |

\*Definitions: An ‘expected death’ for this purpose, is defined as a death where the patient had an associated terminal illness diagnosed, old age or frailty

An ‘unexpected death’ for this purpose, is defined as a death where the patient died following suicide or trauma or suddenly without a diagnosis of a terminal illness

**Examples of SMART goals for each Daffodil Standard**

Consider self-assessment evidence and guidance with reflective exercises where helpful to support.

Below you will find for each Daffodil Standard an example for a

1. baseline of what an EOLC audit may confirm your practice has achieved
2. SMART goal you agree that is relevant to your practice

The exact baseline figures will be determined by the results of your practice audit and the SMART goals you select should be relevant and feasible for your practice (and primary care network) to achieve.

**Daffodil Standard 1: Professional and competent staff**

Baseline SWOT analysis revealed clinical and non-clinical staff expressed reduced confidence and knowledge having sensitive conversations with people needing planning discussions for their advanced serious illness or end of life care. Example outcome: 10% of staff had participated in communication skills training, relevant to their role, in the past 3 years. Repeat the SWOT analysis within 12 months to explore any changes in staff confidence and knowledge.

Example SMART goal: Increase from 10% to 70% of staff participating in communication skills training, relevant to their role, in the following 12 months of the SWOT analysis.

**Daffodil Standard 2: Early identification**

Baseline from retrospective audit – Example outcome: 20% of people affected by serious illness and end of life care who died, had already been identified on a practice ‘palliative/ supportive care register’.

Example SMART goal: Increase from 20% to 60% of people **affected by serious illness and end of life care who died, to be identified** on a practice ‘palliative/ supportive care register’, over the next 6 months.

Evidence base: 60-70% of people have an expected death and planning can support their needs with early identification of their needs.

**Daffodil Standard 3: Carer Support**

Baseline from retrospective audit

a) For people who died - Example outcome: 10% of family members / informal care-givers/ next-of-kin identified in patient’s notes and on the practice ‘EOLC /supportive care register’.

b) For people who died in audit - Example outcome: 20% of identified family members / informal care-givers/ next-of-kin were offered holistic support before and after death, reliably and early enough for all those who may benefit from support.

Example SMART goals: Within 6 months,

a) Increase from 40% to 60% (practice to decide) informal care-giver identification for people on Palliative Care/ Supportive Care Register

**Evidence base: 60-90% of people in the last year of life are likely to have an informal carer e.g. spouse/ partner, sibling, son/daughter, neighbour /friend**.

Notes:

Enhancing good practice and reducing variation in care. As your practice works towards consistently identifying your practice-relevant % informal care-givers, you can also consider how the practice enables carers to have their needs assessed and the care and support carers are offered.

b) Increase from 0% to 30% assessment of informal care-giver needs e.g. [CSNAT.org](http://csnat.org/)

c) Increase 0% to 15% sign-posting/ referral to support, as per care-givers need(s)

**Daffodil Standard 4: Seamless, planned, coordinated care**

This Standard focuses on reliability of your processes in practice.

For example, considering issues such as:

* consistent coding (e.g. having a set of codes that all staff use and ensuring flagging of identification, problems and care preferences are consistent – so that all staff know where to look)
* MDTs and Practice meetings – all attendees regularly attend and they are clear on their roles, responsibilities, ambition for expected outcomes and learning from deaths at each meeting for patients. This repeatability of practice can be helped by having a focused Terms of Reference and template for reviewing each patient’s needs (Appendix A)
* Systems are in place to share Personalised Care and Support Plans, in and out of hours, across provider interfaces and with patients. e.g. Electronic Palliative Care Coordination Systems (EPACCS).

Incorporating the use of a MDT Collection Template for patients on your EOLC supportive care register to support better and consistent decision-making and discussions at MDTs for patients and carers/those important to them. Use the same template to consider all patients whilst caring for them and on death if there is any learning (for people identified on the EOLC/ Supportive Care Register and people who died but were not identified).

If reflected on regularly at each MDT (e.g. monthly), this naturally helps the practice a) plan care and support for those identified and b) learn from deaths. In addition, the template forms the basis of a regular (e.g. annually) practice Retrospective Death Audit and action taken where outcomes achieved do not meet the practice accepted Standards.

Example SMART goals: Over the next 6 months,

1. review baseline coding practice and update staff on expected practice coding for patients and their carers, that will help the practice monitor and reflect on achieving practice relevant SMART outcomes for each Daffodil Standard. Have system to monitor use. Repeat review after 6 months and share outcomes with staff.
2. Review baseline use of MDT collection template for all patients on the Supportive Care Register. Implement use of MDT collection template and use to 90% review patients and learning from ALL deaths.
3. For practices with MDT template consistently in use, continuous monitoring relevant template criteria e.g. For people on the Supportive Care Register and with a Personalised Care and Support Plan documented, review preferred place of care and death achieved (e.g. plot on a line graph monthly). Increase from X% to Y% over a 6-12 month period, (practice to decide) the number/% of people on Supportive Care Register and with a Personalised Care and Support Plan documented, review preferred place of care and death achieved

**Daffodil Standard 5: Assessment of unique needs of the patient**

Baseline from retrospective audit – Example outcome: 10% of people **affected by serious illness and end of life care who died**, had been sensitively offered timely and relevant personalised care and support plan / anticipatory care plan discussions and these were **documented and shared electronically** (if available locally).

Example SMART goals:

1. In month 1, identify areas for improvement in personalised care and support plan/ anticipatory care plan from practice process map
2. Retrospective audit of people who have a CPR/ DNACPR status recorded and quality of decision making. Noting best practice guidance DNACPR status is not recorded in isolation but as part of wider PCSP/ ACP process and It is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need. See RCGP joint statement [here](https://www.rcgp.org.uk/about-us/news/2020/april/joint-statement-on-advance-care-planning.aspx)
3. Over 6 months, increase from 10% to 50% (% relevant to the practice) of people on Palliative /Supportive Care register to be offered ‘What Matters Most’ and ‘Goals of Care’ conversations with resulting personalised care and support plan/ anticipatory care plan, created and shared electronically(if available locally).

**Daffodil Standard 6: Quality care during the last days of life**

Baseline from retrospective audit – Example outcome: 10% of people **affected by serious illness and end of life care who died**, had documentation of **‘Plan, Involve, Goals, Shared electronically + documented’** for people on the EOLC Supportive Care Register.

Example SMART goal:

Over 12 months, increase from 10% to 50% of people who died on palliative/ supportive care register, to have had documented the 5 key principles of [Priorities for Care of the Dying](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf) (England) - ‘CRISP’ – Communicate, Recognise, Involve, Support, Plan & Do / [Care Decisions for the Last Days of Life](https://wales.pallcare.info/files/docs/Care%20Decisions%20Toolkit/A-D%20docs%20Generic%20Care%20Decisions%20v10%20%20June%202019.pdf) (Wales)

**Daffodil Standard 7: Care after death**

Baseline from retrospective audit, Example outcome: 10% of family members / informal care-givers/ next-of-kin identified on the practice ‘palliative/ supportive care register’ were contacted and offered information on dealing with grief and bereavement within 1 month of the person on the register dying.

Example SMART goal:

1. In month 1, agree process for increasing identification and coding of bereaved people known to the practice – to cover all deaths, including expected, unexpected/sudden, all ages, all causes including miscarriage and SIDS.
2. Over 12 months, increase from 10% to 60% of family members / informal care-givers/ next-of-kin identified on the practice ‘supportive care register’ to be contacted **and** offered condolences/ sign-posted to information on dealing with grief and bereavement within 1 month (practice to decide) of the person on the register dying. (Note these will only cover expected deaths)

**Daffodil Standard 8: General Practice as hubs within compassionate communities**
In order that lessons can be learned from the experience of advanced serious illness, EOLC, caring responsibilities, death and bereavement. Lessons can be shared with the relevant people.

Example SMART goals:

Over 12 months, assess whether practice staff/ patients/ carers feedback the practice is meeting the end of life care needs, and show how any information provided is used to help improve care and support by achieving a minimum of:

1. 2-5 family/care-giver or patient interviews e.g. semi-structured discussion, using an agreed template or annual carer survey relevant to EOLC needs.
2. Staff feedback to support the QI planning e.g. survey, debriefs, SEAs
3. MDT feedback to support the QI planning e.g. survey, discussion at MDT
4. Annual evaluation of compassionate organisational culture