**End of Life Protocol**

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| **Version:** | **Review date:** | **Edited by:** | **Approved by:** | **Comments:** |
| v1 | 29/10/2024 | Niné Taylor  | Munira Mohamed |  |
|  | November 2025 |  |  | Next review |
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**End of Life Protocol**

Patient is identified as end of life and living back at own residence by:

* GP in practice
* hospital discharge letter
* palliative care team letter/email

GP receiving information should nominate themselves as that patient’s **End of** **Life GP** (unless better known by a different GP in practice) and add their name in the alert on patient record (‘Manage’ option in blue box)

That GP is responsible for meeting with that patient (**preferably by home visit**) to discuss End of Life wishes with patient and/or relatives and complete associated documentation.

Explain to relatives next steps e.g. Possible visit from DNs, how to contact DN team (UCR team 0330 726 033), actions to take in the event of death at home (i.e. do not call 999 or 111 as death is expected but call DN team).

1. Proactively enquire about power of attorney, advanced care planning so that preferred place of death can be achieved

2. Complete RESPECT Form

3. Send a task to reception to code immediate family as carers

4. Issue Anticipatory medications and complete both PRN and Syringe Driver Medication sheets

5. Complete Expected Death Form

6. Leave Documents 1,2 and 3 with patient and/or relative

7. Record resuscitation status in notes

8. Refer patient to Palliative care service and/or District nurse team detailing what you have discussed, forms you have completed and ask visiting team to sign Expected Death Form.

9. GP to arrange review in 4 weeks’ time

Aim to book any future appointments with named GP for continuity of care.

Named GP should contact relative after death to express condolences.