GSF Factsheet 1: Community Nurses

What is the Gold Standards Framework in Primary Care?

the gold standards framework in primary care

1 Aim – GSF is a framework to deliver a 'gold standard of care' for all people nearing the end of life

'It's about living well until you die'

GSF is a systematic common-sense approach to formalising best practice, so that quality end of life care becomes standard for every patient. It helps clinicians identify patients in the last year of life, assess their needs, symptoms and preferences and plan care on that basis, enabling patients to live and die where they choose. GSF embodies an approach that centres on the needs of patients and their families and encourages inter professional teams to work together. GSF developed originally for primary care and is now extensively used by GP practices throughout the UK. The GSF Care Homes Training Programme was developed from this in 2004 and is widely used, the GSF Acute Hospitals work is well underway and spread continues to other settings in the UK and worldwide. The Next Stage GSF Primary Programme from June 09 has new tools, resources, quality improvement training and even more focus on aligning with the needs and choices of patients and carers.

"Its less about what you know and more about what you do and how you do it"

3 Simple Steps

1 Identify

Patients who may be in the last year of life and identify their stage

Use of the surprise question + prognostic guidance + needs based coding

2 Assess

Current and future clinical needs and personal needs

Use of assessment tools, Advance Care Planning, etc

3 Plan

Develop an action plan of care

Use 7 C's key tasks, Needs Support Matrix, passport information etc

Key Messages

- End of Life Care is important. It affects us all
- 1% population die/year- mainly elderly non-cancer patients.
- Too few people die at home or their place of choice.
- Hospital admissions and deaths are expensive and may be preventable - care must be brought closer to home.
- Everyone is involved in end of life care - most care is from the usual generalist provider
- GSF helps improve the quality and coordination of care provided by generalists across different settings.

5 Goals of GSF

To provide for patients with any final illness:

1. Consistent high quality care
2. Alignment with patients' preferences
3. Pre-planning and anticipation of needs
4. Improved staff confidence and teamwork
5. More home based, less hospital based care

7 Key Tasks - the 7 Cs

Needs based coding – using the 'surprise question' to predict main areas of need and support required

A - Blue 'All'	B - Green 'Benefits' - DS1500	C - Yellow 'Continuing Care'	D - Red 'Days'	Navy
from diagnosis Stable	Unstable / Advanced disease	Deteriorating	Final days / Terminal care	'After Care'
Year plus prognosis	Months prognosis	Weeks prognosis	Days prognosis	

For details contact the National GSF Centre, based at Walsall tPCT
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'GSF is the bedrock of generalist palliative care'
DN Norfolk

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Gold Standards Framework for Nurses in the Community

What does GSF mean to you?

STOP! THINK! - IS THIS PATIENT IN THE LAST YEAR OF LIFE? What difference can I make?
IDENTIFY, ASSESS and PLAN care according to the needs of the patient and carer.

GSF is about pre planning, working smarter not harder, avoiding duplication

How can we help people as they approach the end of their lives? Key issues for you

Working in the community, you will see many people in the last year of their life, with a life limiting illness. You have a key role in caring for these people, their families and carers, in optimising care and ensuring it is 'Gold Standard' every time. You can make a great difference. The aim is to avoid 'crises' and unnecessary admissions and to reduce the length of hospital stay.
"GSF has helped me work as a District Nurse as I have always wanted to do" DN, Yorkshire

3 Simple steps - Identify, Assess, Plan

IDENTIFY:
- **Identifying** patients in the final year of life is important e.g. using the 'Surprise question' or Prognostic Indicator Guidance. 'Would you be surprised if this person were to die in the next year?' If you wouldn't be surprised, what should you do to ensure that everything is ready, just in case they deteriorate quickly?
- **Including** them on the GSF register to have early focussed discussion allows better care, more patient control and choice.
- **Identify** approximately where they are on their end of life trajectory using the GSF Needs Based Coding (see overleaf), this helps estimate their likely stage and possible current and future needs, to be able to better plan and provide best care.

ASSESS Needs:
- **Assess the likely needs** of patients, clinical and personal, current and future. The GSF Needs Support Matrices can help anticipate areas to consider, and be guided by the advance care planning discussion.
- **Holistic assessment** of the patient's needs - tools to help you include: PEPSI COLA, PACA, SPARK or your locally agreed tools. Many more patients can claim non - means tested benefits than currently do e.g. DS 1500.
- **Advance care planning** - encourage early discussions to understand what is important to patients, their thoughts, wishes and plans for future care. This can be informal, but it helps to discuss this with carers or family, and to write things down using one of the ACP tools e.g. Thinking Ahead, PPC etc. Nurses play a key role in ensuring these preferences are attained. N.B. The usual rules of patient confidentiality apply at all times.
- Consider **Carers needs early** - practical, supportive and financial. Written information may help e.g. in GSF Home Packs and local leaflets, or facilitated sessions e.g. see **www.omega.uk.net** for Caring with Confidence sessions. Carers are entitled to a formal assessment and may be entitled to benefits, which cannot be claimed retrospectively.

PLAN for better care:
- You can take the lead on End of Life Care (EOLC) within your team
- Plan to avoid crises and unnecessary admissions, especially during out of hours and holiday periods.
- Anticipate patients' likely needs.- anticipate medication, equipment and support needs of patients and carers.
- Pre-plan to enable a dignified 'good' death in the patient's place of choice.
- Remember fulfilling the patient's wishes is a priority.
- Practice multi-disciplinary meetings - minuted with action points to focus effort and plan for better care.
- Keyworkers - You can be the ideal key worker for patients, e.g. liaising with hospital wards to facilitate early discharge.
- Team-working is central to good EOLC. District Nursing teams working together with the practice along with Clinical Nurse Specialists, Community Matrons, CPNs and others as needed for maximal patient benefit.
- Reflect as a team how care might be improved. Use audit e.g. After Death Analysis, traffic lights/ significant event audit etc

How can GSF help you with your role?

GSF affirms your important role within the community:
- Improves team working with GPs, community services and colleagues
- Improves earlier planning of care leading to fewer admissions
- Simplifies your work and makes it clearer and easier
- Improves your confidence, job satisfaction and morale,
- Further learning with the GSF Quality Development Pack
- See the Focus on Nurses section on the website

Toolkits and resources

Useful resources, tools and guidance especially for nurses:
- GSF Nurses Toolkit
- Prognostic Indicator Guidance
- Quality Improvement Learning Resource
- Further work developing RCN

And much more available on GSF website:
www.goldstandardsframework.nhs.uk

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