The Standards

Our RPS/Marie Curie UK Quality Improvement (Daffodil) Standards, below, are based on the work completed by the Royal College of General Practitioners.

The Standards have been adapted for Community Pharmacy teams and individual/locum pharmacists. They align with the eight standards used in general practice, but reflect the way that pharmacies work.

There are areas of common ground with general practice, and therefore opportunities to work with your local practice(s).

Use Quality Improvement methodology, based on the work of the Institute for Healthcare Improvement, to address potential areas for improvement and deliver “small tests of change” using PDSA (Plan, Do, Study, Act) cycles. These will improve the quality of care you provide to patients and carers.

The Standards can be used at your own pace.

1. Professional and competent staff

Create an infrastructure in the pharmacy team which a supportive end of life strategy can be built upon.

FIND OUT MORE ›

2. Early identification

Identify patients approaching/at end of life to optimise support (and enable audits and targeted interventions).

FIND OUT MORE >

3. Carer Support before and after death

Identify other patient groups, i.e. carers, who may benefit from structured support.

FIND OUT MORE >

4. Seamless, well-planned, coordinated care

Improve proactive end of life care supported by pharmacy processes, e.g. provide information about medication changes.

FIND OUT MORE >

5. Care is based on the assessed unique needs

Improve integrated care planning through a personalised, holistic and reflective approach, e.g. medication review.

FIND OUT MORE >

6. Quality Care during the last days of life

Support patients and their carer(s) at the end of their life, particularly through robust medicines access.

FIND OUT MORE >

7. Care after death

Improve support to people experiencing bereavement.

FIND OUT MORE >

8. Community Pharmacy linking with

Compassionate Communities hub

Integrate and embed

community pharmacy into any local initiatives for Compassionate community.

FIND OUT MORE >

Standard 1

Create an infrastructure in the pharmacy team which a supportive end of life strategy can be built upon.

1. Ensure that each staff member understands their role and responsibility for Advanced Serious Illness, Life-limiting illness or end of life care
2. Ensure all staff are able and confident to communicate effectively with people who have palliative care needs (and their carers)
3. Identified pharmacy champion for Palliative and end of life care.

1.1 Ensure that each staff member understands their role and responsibility for Advanced Serious Illness, Life-limiting illness or end of life care

Pharmacy Teams

To get started:

1. Agree, as a team, which staff are involved in supporting patients and their carers
2. Discuss as a team what you currently provide and what the goals and aspirations are for improvement.

Further information

Reflect with staff (https://rcgp.org.uk/learning-resources/daffodil-standards/useful-resources) (RCGP resources) to make sure they have achieved or have a plan in place to achieve training on standards, which relate to their role. This may be done together during a team meeting. Include reflection on cases identified by staff.

Reflect on how previous experiences, attitudes, beliefs, and personal barriers may affect the way staff work – cover issues affecting each standard e.g. non-identification of patients and carers, shared decision-making, communication, etc.

1.2 Ensure all staff are able and confident to communicate effectively with people who have palliative care needs (and their carers)

Access to appropriate training for all staff will be supported by the project team working collaboratively with education providers across the UK.

Pharmacy Teams

To get started:

1. Identify the training and development needs of each team member
2. Consider how best to deliver this (learning outcomes, methods, and timescale) using the templates provided. Share the Training Needs Assessment and Training Plan
3. Ensure the learning outcomes and training are included in the induction programme for new starters.

Further information

Discuss and agree, as a pharmacy team, the key skills necessary for different staff roles.

Example reflection frameworks:

- Skills for Health EOLC Core Skills Education and Training Framework (https://www.skillsforhealth.org.uk/images/services/cstf/EoLC%20-%20Core%20Skills%20Training%20Framework.pdf)
- NHS Education for Scotland: PEOLC: Enriching and Improving Experience (https://learn.nes.nhs.scot/2452/palliative-and-end-of-life-care-enriching-and-improving-experience/palliative-and-end-of-life-care-enriching-and-improving-experience)

- NHS Wales Collaborative End of Life Care Delivery Group (https://collaborative.nhs.wales/implementation-groups/end-of-life-care/)

Consider staff understanding of how to handle:

- Complaints and complements
- Incidents, errors and near misses
- Ethical, legal and safeguarding issues, such as consent, confidentiality, capacity, or network and duty of candour
- Conflict in difficult situations
- Compassionate Communication and interpersonal skills
- Communication and information needs of people with disabilities, sensory loss, cultural and language variation
- Seeking feedback from patients, carers, and other team members. Overcome barriers to asking people what was good and what could be improved. 'You said we did'.

Agree realistic **SMART** objectives (Specific, Measurable, Achievable, Realistic and Timely); for reviewing training needs of staff.

The induction procedure should be pitched to the appropriate level for different staff. It would discuss the principal commitment to quality improvement as well as the ambition that 'every contact counts', including respect and dignity.

Download the training needs and assessment template (https://www.rpharms.com/Portals/0/RPS document library/Open access/Daffodil Standards (palliative care)/Training Needs Assessment.docx?ver=OuOMsgKzTjgCg9GAJZSl1g%3d%3d)

1.3 Identified pharmacy champion for Palliative and end of life care

Named champion could be a pharmacist, pharmacy technician or dispenser.

Pharmacy Teams

To get started:

1 Agree the lead for the pharmacy and communicate to all staff.

Further information

The lead should be known to the whole team and act as the link to the Daffodil standards and other external groups, e.g. the primary care cluster or network.

If possible, some protected time may be allocated to allow the lead to drive service and quality improvement activities, with support from the project team.

Lead to consider:

- How to demonstrate that quality improvement activities result in continuous improvement in practice
- Communication of learning within the practice, primary care cluster, networks, or federations and wider system
- Free Quality Improvement module: e.g. West of England Academic Health Science Network Education Pathway (https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci1580-palliative-care-co-ordination-core-content) or NHS Scotland. The Life Science Hub Wales provides quality improvement learning and tools, as well as advice via Improvement Cymru (https://lshubwales.com/improvement-cymru). End of life care leads can also consider registering their quality improvement ideas as NHS Wales Bevan Commission Exemplar projects
- A recent overview has been published which describes the quality improvement philosophy, the common methods, tools, and approaches used, with pharmacy examples showing how it can continuously improve practice Quality improvement in pharmacy practice - The Pharmaceutical Journal (pharmaceutical-journal.com) (https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fpharmaceutical-journal.com%2Farticle%2Fld%2Fquality-improvement-in-pharmacy-practice&data=05%7C01%7CDarrell.Baker%40rpharms.com%7Ce1d3a20157f9490763fe08da8749abf6%7C99193c61658d4076952f07c345a3be97%7C0%7C0%7C637971047721651458%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=YDWf60g3u0hDU9Hys7Ut9purPl9jmpwvCK5XWvtLSg0%3D&reserved=0)
- Demonstrate evaluation and improved outcomes.

Standard 2

There is early identification and recording that a person, has an Advanced Serious Illness, or EOLC needs.

1. Develop multidisciplinary team working so that pharmacy is aware at an early stage of a patients' status, potential support needs and their identified multidisciplinary team members and how to access them
2. Ensure appropriate documentation and sharing information within the pharmacy to help identify and prioritise the needs of a patient

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2.1 Develop multidisciplinary team working so that pharmacy is aware at an early stage of a patients' status, potential support needs and their identified multidisciplinary team members and how to access them

A common challenge facing pharmacies is a lack of communication and "IT system" interoperability for sharing health information. Access to electronic health records and the ability to record pharmaceutical interventions and information gleaned from patients or their carers, remains limited. This results in the pharmacy team having to rely on informal systems and often being unable to provide the most effective contribution.

Pharmacy Teams

To get started:

1. An agreed protocol for sharing identified people with palliative EOL care needs
2. Identify contact details for the MDT members providing care for an individual and/or local cohorts of patients (including OOH teams, local GP champion).

Further information

Lack of knowledge about whether an individual has palliative care needs often leads to the pharmacy "second guessing" from prescriptions for symptom management or engaging at a late stage and therefore missing opportunities to provide support at an earlier contact.

Download a template to share the specific local contact details (/Portals/0/RPS document library/Open access/Daffodil Standards (palliative care)/Daffodil standards- Local contact details template.docx?ver=91G55mumvr7PHLE5XX-Hwg%3d%3d)

Understand your practice population and varying cultural, psychological and access needs taking into account; long term health conditions, disabilities (including learning disabilities), BAME, deprivation, elderly, care home residents, homelessness, prisons, etc.

Understand different disease trajectories, for example, BMJ: Palliative Care from Diagnosis to Death video (https://www.youtube.com/watch?v=vS7ueV0ui5U) and article (https://doi.org/10.1136/bmj.j878).

2.2 Ensure appropriate documentation and sharing information within the pharmacy to help identify and prioritise the needs of a patient, e.g. PMR, other?

Pharmacy Teams

To get started:

1 Communication and documentation in place for pharmacy team members (including temporary/locum staff) aware of the identified patient and/or carer support needs.

Further information

Recognises the need for all pharmacy team members to be able to offer support and “make every contact count”.

Standard 3

Carer Support – before and after death.

1 Identify any carer(s) in a timely fashion
2 Structured approach to identification of carers’ needs.

3.1 Identify any carer(s) in a timely fashion

The carer is often required to manage a complex medicines regimen and pharmacy support with advice and information can improve quality and safety of medicines administration.

Pharmacy Teams

To get started:

1 An agreed protocol for identifying carers of people who have advanced serious illness or who may be approaching the end of life.

Further information

Consider how all members of the team can contribute to carer identification.

Record the patient's main carer(s) and their details, for example, name, address, contact number, relationship to patient, for example, spouse, neighbour, son (state if young carer) or paid carer.

In agreement with carer, ensure ‘Is a Carer’ is documented appropriately and highlighted in the record of the carer.

When the patient dies and the person is no longer a carer, their record should be updated. In agreement with the carer, update record to acknowledge the bereavement. Staff should think about any bereavement support they could provide.

See also Standard 7

3.2 Structured approach to identification of carers’ needs

The project team will develop tools to support a structured approach.

Pharmacy Teams

To get started:

1 Where possible, record a holistic carer assessment, that is, to identify problems from their perspective: both in terms of their needs as 'clients'(a patient) and their needs as 'co-workers'(caring for a person).

Further information

Often the pharmacy will have close contact with the carer, collecting medicines etc.

Consider how the Pharmacy supports carers to preserve their own psychological and physical health, as 'clients' (directly or signposting).

Consider how the pharmacy provides information, knowledge and skills to carry out their role as 'co-worker' more effectively (directly or signposting)

Many HCPs report being fearful of opening up 'a can of worms' by asking carers what support they feel they need, but evidence (https://journals.sagepub.com/doi/abs/10.1177/0269216315596662) shows that it is often quite simple things that make a difference and even just being asked is in itself supportive.

The Carers Support Needs Assessment tool website is https://csnat.org/ (https://csnat.org/) and the online training and implementation toolkit is at https://arc-gm.nihr.ac.uk/training/login (https://arc-gm.nihr.ac.uk/training/login). The toolkit hosts a full set of training videos as well in Learning Unit 1, Module.

A conversation about potential carer needs relating to "Managing symptoms including medicines" might include understanding different medicines, being involved in discussion about symptom management, arranging supply including delivery, "Just in Case" medicine supplies, learning practical skills e.g. giving injections and accessing help with symptom management out of hours (see the Marie Curie Just in Case medicines page (https://www.mariecurie.org.uk/help/support/terminal-illness/medication-pain-relief/just-in-case-medicines)).

Standard 4

Seamless, well-planned, coordinated care

1. Provide information to patient/carer re: use of medicines (new and existing)
2. Engage with multi-disciplinary team meetings and/or local communication systems where in place (and share information across MDT)

3 Collect (and share) data on medicines-related issues for individual patients.

4.1 Provide information to patient/carer re: use of medicines (new and existing)

Patient/carer understanding of medication, any changes and how to optimise.

Pharmacy Teams

To get started:

1 Ensure routine provision of information to patients and/or carer(s) about medicines stopped, changed to started.

Further information

Medication changes in palliative and EOL care can result from changes in benefit:risk, or be the result of the need to manage new symptoms. Good quality information to patients/carer(s) will improve understanding and support effective and appropriate adherence and optimise patient outcome.

Identify information leaflets on medication.

Check medication still appropriate, e.g. opioid switches.

4.2 Engage with multidisciplinary team meetings and/or local communication systems where in place (and share information across MDT)

Recognition of care contributions across all settings.

Pharmacy Teams

To get started:

1 System in place to raise awareness of local MDT meeting structure and invitation to engage, as appropriate.

Further information

Recognising the wide range of HCP that may be involved in the care of the individual is important, but can bring communication challenges and the potential for varying messages to patient and their carer(s). Effective engagement and sharing management plans and priorities will minimise this risk and ensure care is coordinated and optimal.

Knowledge of local MDT meetings and how/when/what to input is important (local Health Board may need to help with this).

4.3 Collect (and share) data on medicines-related issues for individual patients

Pharmacy Teams

To get started:

1. Mechanism is in place to share information about medicines-related issues for individual patients
2. Achieve consistent data collection within local cluster or network, etc.

Further information

Community pharmacy is well-placed to help identify any issues the patient or their carer is having with symptoms, medicines use or other concerns. This needs to be fed into the overall MDT to ensure issues are addressed and also contribute to local care systems where appropriate.

Contributing to local data collection will make audit processes more robust.

Standard 5

Care is based on the assessed unique needs of the patient, carer and family.

1. Requests sharing of advance/future care plan (where available/relevant)
2. Implement individual medication review and medicines optimisation-personalised, holistic and reflective approach.

5.1 Requests sharing of advance/future care plan (where available/relevant)

Pharmacy Teams

To get started:

1 Sharing agreement in place with local multidisciplinary team.

Further information

As described above, engagement with the local MDT and agreement from the patient/carer that an advance care plan will be shared, helps ensure that the patient with palliative care needs and their carer(s) get the benefit of collaborative multidisciplinary working including consistent messages and clear rationale for care plan(s).

Share what's relevant, CPs may only need diagnosis, prognosis, swallowing and comms issues.

Training of CPs on why this info is useful and can help them provide better care.

5.2 Implement individual medication review and medicines optimisation- personalised, holistic and reflective approach.

A clear and structured medication review is desirable to address the individual needs.

Holistic support, including home situation, non-medicinal needs e.g. oral hygiene.

Pharmacy Teams

To get started:

1 Medication review undertaken where appropriate, triggered by hospital/hospice discharge or transfer of care, patient/carer request or changes to medication. Review follows structured format (within commissioned service)

Further information

Fully engaged medication review facilitates understanding and treatment adherence. This will support optimal outcomes from medicines use, aligned with shared decision-making and patient

priorities. Consider What Matters Most Conversations (https://www.whatmattersconversations.org/) within conversations.

Standard 6

Quality care during the last days of life.

1. Proactively manage medicines supply chain- stock holding/access or signpost as locally agreed
2. Identify and advise/address (within own level of competence or refer) any issues with medicines use and administration e.g. swallowing, formulations
3. Reflect on lessons from individual care to improve (and share within pharmacy and MDT).

6.1 Proactively manage medicines supply chain- stock holding/access or signpost as locally agreed

Robust and timely medication supply is a key concern from carers.

Local/national challenges re: supply availability and robust local information sharing.

Pharmacy Teams

To get started:

1. Clear and well publicised local arrangements in place for the "critical" list of medicines
2. Local understanding of communication needs when "unusual" medicines in use at transfer of care, to ensure stock available ahead of need
3. System for sharing information on local or national supply chain problems with prescribers to minimise disruption to optimal prescribing practice and patient care.

Further information

It is well-recognised that timely access to palliative and EOL care medicines is a major concern. A recent research report from Marie Curie's Better End of Life programme

(https://www.mariecurie.org.uk/policy/better-end-life-report) highlighted the scale of this challenge across 24/7 and the added problem of timely medicines' administration.

Commissioned services vary across the UK and are highlighted here

Consider setting up WhatsApp group or similar with local pharmacies to locate medicines in short supply and for peer support. Check local information governance (no patient info shared)

6.2 Identify and advise/address (within own level of competence or refer) any issues with medicines use and administration e.g. swallowing, formulations

Pharmacy Teams

To get started:

1. Ensure respond to patient or carer(s) need for support with identified medicine-related issue e.g. suitable formulation where swallowing difficulty; referring to specialist or accessing specialist support as appropriate.

Further information

Access to NEWT guidance (https://www.newtguidelines.com/)

6.3 Reflect on lessons from individual care to improve (and share within pharmacy and MDT)

Pharmacy Teams

To get started:

Record individual lessons and share with local MDT as part of audit or service improvement systems.

Further information

Understand the importance of the Five Priorities for Care for the Dying Person (Wales: Care Decisions Guidance

Active involvement and discussion of the five priorities of care for the dying person. This includes consideration of how to avoid preventable problems with medicines use.

Five Priorities of Care are:

- Timely recognition of imminently dying person
- Care is safe, effective, responsive and appropriate
- Care plans are developed, implemented and reviewed regularly to support people who are imminently dying, their families and carers
- Timely symptom control assessments using best-practice guidance and tools
- Evidence that patients, family and carers are provided with information and support in accessible ways.

Understand your local prescribing formulary for opioids and other palliative drugs (Just in Case or anticipatory prescribing).

Understand the process to access palliative drugs in and out of hours.

- Consider NICE (NG31) (https://www.nice.org.uk/guidance/ng31/resources/care-of-dying-adults-in-the-last-days-of-life-pdf-1837387324357) and Scottish Palliative Care guidelines (https://www.palliativecareguidelines.scot.nhs.uk/).
- The agreement to include palliative drugs covering issues such as:
  - Symptom control: pain, breathlessness, nausea and vomiting, noisy secretions, terminal agitation and delirium
  - Clinically assisted hydration and nutrition where required.
  - Consider reviewing and stopping medications where appropriate- consider creating review templates for Just in Case medication and linking to personalised care plans.

Understand best practice prescribing for syringe drivers (not always EoL).

Be aware of resources.

Awareness of the legal framework for providing treatment, e.g. best interest decisions under the Mental Capacity Act.

Consider how to meet the communication and information needs of patients' with disabilities and sensory loss, in line with NHS England's Accessible Info (https://www.england.nhs.uk/ourwork/accessibleinfo/).

Consider:

- NICE (NG31) (https://www.nice.org.uk/guidance/ng31/resources/care-of-dying-adults-in-the-last-days-of-life-pdf-1837387324357)
- Wales: Care Decisions Guidance (https://collaborative.nhs.wales/implementation-groups/end-of-life-care/all-wales-care-decisions-guidance-for-the-last-days-of-life/).

Standard 7

Care after death and Bereavement Support.

1. Have understanding and be able to provide individuals or signpost to grief and bereavement support (using appropriate local resources)
2. Stop repeat medication supply, as appropriate
3. Handle returned medicines compassionately.

7.1 Have understanding and be able to provide individuals or signpost to grief and bereavement support (using appropriate local resources)

Pharmacy Teams

To get started:

1. Acknowledge death with carer(s)
2. Signpost as needed.

Further information

Providing a card to the identified carer(s) to express condolences will demonstrate empathy and ongoing support.

Having leaflets available of how to access bereavement support may be welcomed by some carers.

Consider children and adolescent specific support groups – either following loss of a parent/adult or for parents following loss of a child.

Identify local support systems and resources.

Consider culturally specific support groups.

7.2 Stop repeat medication supply, as appropriate

Pharmacy Teams

To get started:

1 Systematice process in place (e.g. using PMR) to ensure further medicines supplies including home deliveries are not made.

Further information

Communication – timely transfer of notice that patient has died.

Stopping ongoing arrangements for medicines supply will help avoid further distress following the patient's death

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7.3 Handle returned medicines compassionately

Pharmacy Teams

To get started:

1 System in place for dealing with returned.

Further information

Take an early opportunity to explain what needs to happen to any unused medicines, including controlled drugs.

Ensure information on this on JIC leaflet? Highlight how pharmacy can help.

Standard 8

General Practice being hubs within Compassionate Communities.

1 Support the development of compassionate communities.

8.1 Support the development of compassionate communities

Compassionate communities is a specific initiative currently under development.
Working with MDT and also addressing any wellbeing needs of staff members.

Pharmacy Teams

To get started:

1 Aware of any local initiatives, whether led by health or spiritual or cultural leaders
2 Ensure staff members supported following death of an individual who was well known to them.

Further information

Consider:

- Current compassionate culture within the pharmacy and how important it is and how/why this may be improved
- Different experiences of staff in relation to death, crisis, loss and how this may influence behaviour and reactions
- How staff feel valued, 'Bereavement Friendly Work Place' and opportunities for sharing and support after difficult situations
- A clear open mechanism for both staff and patient/ carer feedback, actively and sensitively encouraging participation
- How the pharmacy shows compassion to staff and other colleagues, affected by a bereavement.

Scottish bereavement friendly workplaces toolkit: Good Life, Good Death, Good Grief (https://www.goodlifedeathgrief.org.uk)