Algorithm to discuss end of life planning in hospital

Start

Chronic factors

General

- · Patient initiation
- Surprise guestion
- Would I be surprised if the patient died in the next 6-12 months?
- Clinical indicators
- Weight loss >10%
- Karnofsky <50
- Albumin <25%
- Gen. Phys. Decline

Disease specific categories

- Cancer
- Organ failure COPD
- CHF
- CRF
- Hepatic
- Neurological
- endocrine / metabolic
- Frailty

Validated markers, or agreed prognostic

- International
- National
- Validated or agreed prognostic markers

Hospital clinicians to consider and begin communicating the potential for fatal deterioration within the MDT and across care settings

Care Planning and discussion of end of life planning with patient

Discuss and decide what, when, how & who to lead discussion; explore patient and carer insight; initiate appropriate discussions about future care planning to emphasise choice and planning for increasing uncertainty and not a specific or narrow prognosis.

Timely discussion

Be sensitive to patient's need & wish for discussion Key prompts:

- · Recovery from life-threatening episode;
- Care home admission
- · As part of the process of breaking bad news

High risk

high risk

When registering a Lasting Power of Attorney for health

Low risk

Expected survival > 6 months = low risk

A Longer timeline allows the active consideration of worst and best scenarios

Consider actively a disease's trajectories as part of routine practice, case review and discussion.

Log the development of:

- Disease markers
- · Your views

Log what:

- · Was said to the patient
- Was not said to the patient

Communicate with

- · Your team
- Primary care

Emerging consensus over time of likely

- Disease trajectory
- · Margins of uncertainty over best and worst prognosis
- · Risk of losing capacity

Palliative care advice or support?

Other elements that make need for discussion increasingly urgent:

- Notify PHC
- · Conversation now?

Incidental events suggesting increased uncertainty

- Severity?
- Reversibility?
- Assoc. organ failure?

Disease specific Examples

- · Repeated hospital admissions
- · Progressive organ failure
- · Metabolic disturbances becoming refractory
- Repeated sepsis
- Reducing performance status
- Increasing frailty

Trials of treatment

- · Recognise actively any potential for severe risks, deterioration or dying during treatment
- Discuss impact on patient's care plan

Elements that make need for discussion & planning essential:

General examples

· Repeated hospital admissions

Expected survival < 6 weeks,

conversation essential and urgent =

- Escalating frailty
- · Massive neurological / cardiac event

Cancer

- Multiple mets (brain, liver or lung)
- Refractory hypercalcaemia
- · Tumour bleeding,
- Bone marrow failure

Organ failure

- · Repeated hospital admissions
- Requiring inotropic support
- · Progressive renal insufficiency
- · Respiratory failure
- · Discontinuation of dialysis
- · Severe hyperkalaemia without treatment

Frailty

- · Repeated hospital admissions
- · Sepsis, bedridden

Any situation where a trial or escalation of treatment may become futile

Any coma where fluids may not be given

Assess capacity, plan content, deliver and record

Involve patients in decision making

whenever possible because the patient knows their own best interests and you do not

Act in patients' best

Cardinal duties of

If disease progresses without

the risk of breaching these

begins to rise exponentially.

A breach increases in likelihood as

excessively burdensome, intrusive or

The default is to disclose both best

and worst futures because a patient

cannot be autonomous unless they

disease progresses because

interventions may become

Respect autonomy

harmful in themselves

are informed

interests

Avoid harm

adequate, timely communication,

care

Initiate (advance) care planning process. Regular review and revision of ACP/EoL care

record

Access to specialist palliative care at any time

Choose when to discuss end of life planning with patient

Allows for time to discuss with GP who, when and how one should be introducing this to the patient and allows for palliative care advice or support

Regular review and revision = better outcome and patient satisfaction

Imminent death, inform GP and discuss wishes with patient if possible

No time to discuss with GP who, when and how one should be introducing this to the patient

Choices reduced = good outcome unlikely, dissatisfaction likely