Resources

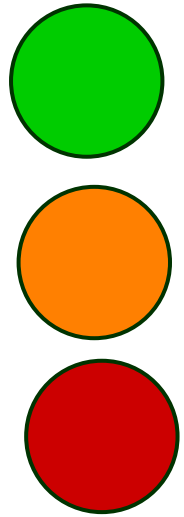
Further information, forms and all other resources are available on-line from:

http://wales.pallcare.info

This leaflet was written for healthcare professionals. It was devised and written by Dr Ian Back, Palliative Care Consultant in Cwm Taf LHB.

"Traffic Lights"

Prognostic Groups to aid Planning for End-of-Life Care



wales.pallcare.info

Prognosis less than 6 -12 months

GP Palliative Care Register
Add patient to the GP **Palliative Care Register**.

Holistic Assessment
Ensure the patient has a full holistic assessment:

- Physical - especially pain, dyspnoea, constipation
- Psychological - screen for anxiety or depression
- Social issues - consider a **DS1500** and/or other welfare benefits.

Patient's Information Needs
Ensure the patient is given the opportunity to discuss their condition and prognosis. Assess any information needs.

Advance Care Planning
Following discussion of their condition and prognosis, consider introducing the topic of Advance Care Planning.

Anticipated Care Needs
Consider especially any medical complications which are likely, or can be anticipated e.g. feeding difficulties for MND, implantable cardiac defibrillator, seizures, haemorrhage. If so, consider discussing in advance a plan of action, and informing the Out-of-Hours service.

Consider prescribing injectable medication in the home for expected complications (Targeted **Anticipatory Prescribing**) or a **"Just in Case" box** for the unexpected.

Family Needs
Assess the family's or carer's needs, including information.

Care Plan - Communicate - Review
Plan when and by whom the patient will be reviewed.

Consider if specialist palliative care referral is indicated.

Ensure that a key worker has been identified.

Communicate to Out-of-Hours service.

Reviews should take place as a minimum when there is:

- Change in focus of care e.g. curative to palliative, patient decision not to start dialysis
- Change in expected prognosis group

Prognosis of weeks

It is sometimes possible to estimate when a patient is reaching the last weeks of their life. Typically there will be a progressive change in their condition noticeable every week.

As a patient's condition deteriorates, a number of things **may** become clearer:

- Increasing acceptance of inevitable death by patient
- Changing views about the benefits / harms of treatment
- Clearer wishes about preferred place of care, or preferences about treatment options

At the same time there is an increasing chance that the patient will be less able to take part in decisions about their own care, whilst an increasing likelihood that management decisions will need to be taken.

A full review should take place when this phase is recognised, similar to the 6-12 month assessment:

In particular you should consider:

Advance Care Planning
Review any existing Advance Care Plans, or reintroduce the subject to the patient if they did not wish to discuss before. Advance Care Planning should be considered a "process" rather than a one-off activity, and patients are likely to revise their wishes as their prognosis shortens.

Prognosis of days

ICP for Last Days of Life
Use the ICP (Care Priorities) for the Last Days of Life to prompt and document patient's care.

Holistic Assessment
Ensure the patient is comfortable and not distressed. Remember simple things like a full bladder. Assess the need for fluids, and/or medication via a syringe driver.

Patient's Information Needs
Ensure the patient is given the opportunity to discuss their condition, and acknowledge when appropriate that the person is imminently dying.

Advance Care Planning
Ensure you are aware of any previously expressed wishes of the patient about their end of life care, including their preferred place of care.

Anticipated Care Needs
Ensure that injectable **medication is in the home** for common symptoms (as per the Care Priorities) and any additional expected complications e.g. seizures.

Consider who will be able to write a death certificate. If there are indications for referral to the Coroner (asbestos-related disease), warn the family/carer.

Implantable cardiac defibrillators will need to be deactivated - contact cardiology service or specialist palliative care team.

Family Needs
Ensure that family or carers are fully involved and informed, and they are explicitly aware that the patient is imminently dying. Ensure that they know who to contact for advice and support.

Care Plan - Communicate - Review
Plan when and by whom the patient will be reviewed.

Inform the Out-of-Hours service.

Ensure a DNA-CPR form is in the house. (Inform the family/carer that this is to prevent any unnecessary CPR attempts if someone new to the situation needs to attend.)