Facilitating Effective End of Life Communications

Beyond DRN/DNI

Thinking about death

01

Death Café

Death

02

Death

Death 2

03

Machines that go ping

More death

Ask Yourself

In many clinical encounters

ASK YOURSELF:

- Did I ask my patient about preferences for end-of-life care?
- Do I know who to contact if the patient cannot communicate their wishes?
- Did I include the family?
- Do I feel confident that I know my patient's wishes for care?
- Did I accurately document the nature of the conversation and decisions made?

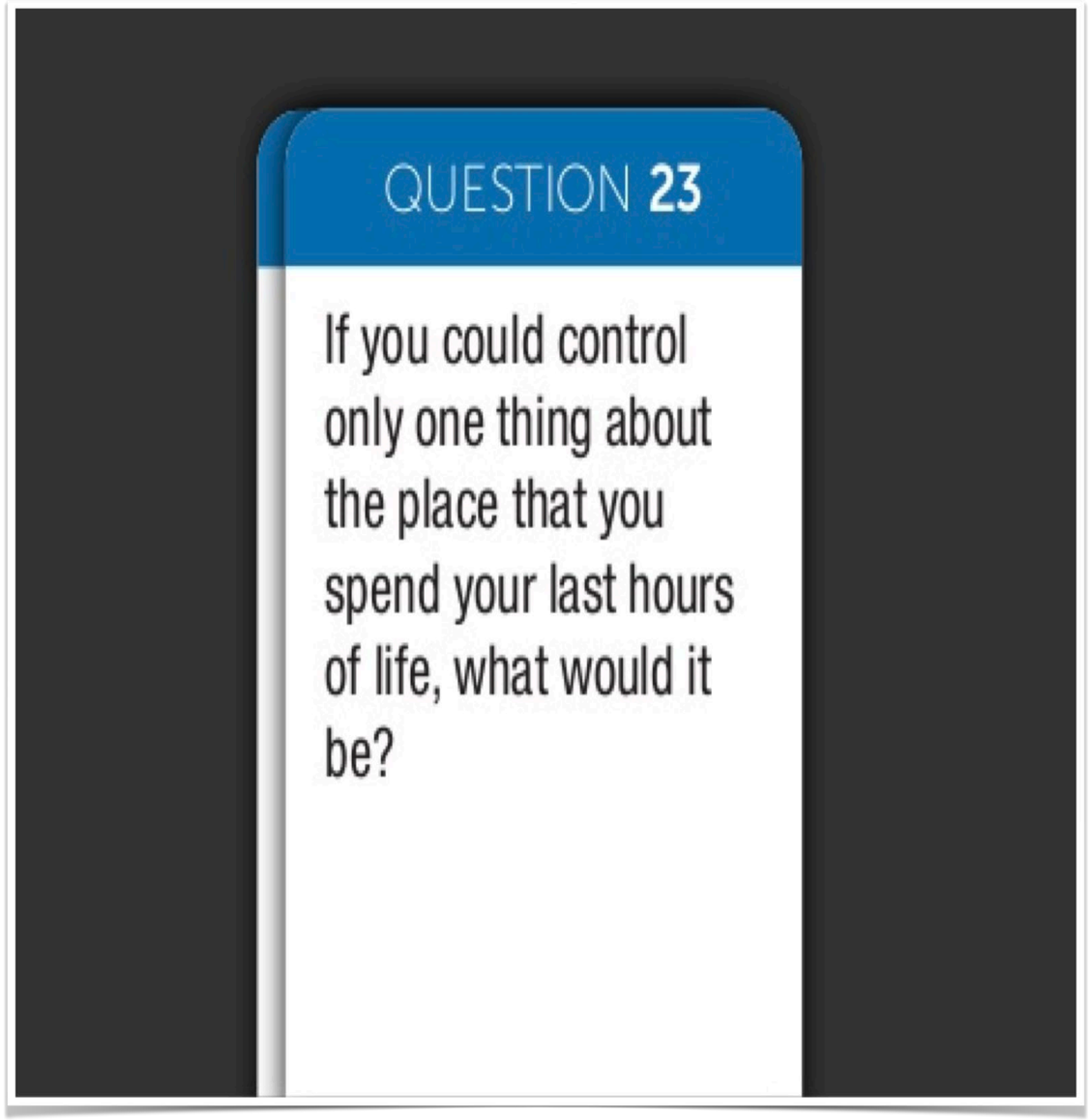
What is your answer?

QUESTION **11**

In order to provide you with the best care possible, what three non-medical facts should your doctor know about you?

QUESTION **15**

What do you fear more: experiencing the worst pain of your life or not getting a chance to say goodbye to your family?



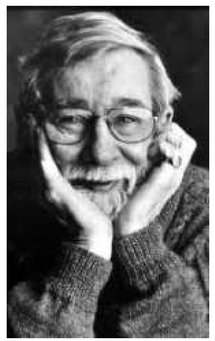
QUESTION 22

Imagine you were lost at sea and your family had to pay for the search to find you. Who should make the decision about how long to search for you?

Define palliative care

01

Who

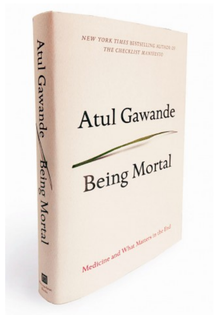


02

When

03

Why



Early enrollment in palliative care can lower risk of hospitalization in the last two weeks of life

Study shows that early palliative care is less available to people dying of non-cancer causes, suggesting that these populations could benefit most from improved early identification.

The researchers examined administrative health records from the last two weeks of life for nearly a quarter of a million Ontarians (2010-2012).

They looked to see if starting palliative care early is associated with less hospitalization in the last two weeks of life.

They grouped the population by those who started palliative care early before death (60 days or more), late (15 - 59 days), very late (14 days or less), or never.

BETTER OUTCOMES WITH EARLY PALLIATIVE CARE:

Fewer days in hospital in the last two weeks of life:

9.2 days — Early start

11.7 days — Late start

More likelihood of a non-hospital death:

40% — Early start

27% — Late start

PEOPLE DYING FROM NON-CANCER CAUSES WERE MUCH LESS LIKELY TO GET EARLY PALLIATIVE CARE:

56% people with cancer / 12% people with frailty / 16% people with organ failure

Qureshi D. et al. *Palliat Med.* 2018.

ICES *Data. Discovery. Better Health.*
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Define Goals of Care Etc.

01 ACP

02 GOC

03 Advance Directive

- Advance Care Planning (ACP) is a process of reflection and communication.
- It is a time when you reflect on your values and wishes regarding your future health and personal care in the event that you become incapable of consenting to treatment or other care.

Speak Up

Goals of care conversations consist of putting prior ACP conversations about wishes into the current clinical context, resulting in medical orders for the use or non-use of life-sustaining treatments.


Voice commands were not generated for some links; too many links on page.
Profile Tools Vocabulary Modes Audio Help
Dan Thomas on Twitter: "Here is a thread on CPR (cardiopulmonary resuscitation) and DNACPR (Do - Internet Explorer
https://twitter.com/dan26wales/status/1089398143572160518
Home Moments Notifications Messages
Search Twitter
Tweet
Dan Thomas
@dan26wales
Following
Here is a thread on CPR (cardiopulmonary resuscitation) and DNACPR (Do not attempt cardiopulmonary resuscitation), to encourage people to #havetheconversation and understand why CPR may not be appropriate
(mainly for non doctors but share if useful!)
1:42 AM - 27 Jan 2019
221 Retweets 278 Likes
8 221 278
Tweet your reply
Dan Thomas @dan26wales · Jan 27
What is cardiac arrest?
Cardiac arrest is when the heart stops (to all intents and purposes you are dead), sometimes* caused by an electrical problem
A Heart Attack is a plumbing problem, the blood supply to the heart is blocked due to a blood clot
(*more on this later)
Dan Thomas
@dan26wales Follows you
Geriatric medicine/GIM ST7 #EOLC #Deprescribing @Gerisoc clinical quality rep/deputy media editor. Run for @pennylane_1985 (tweets personal capacity)
Joined October 2011
Tweet to
Message
21 Followers you know
Following
Who to follow · Refresh · View all
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MDTea Podcast @MDTea...
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Code status strategies

Beyond DRN/DNI

Limited

Code status strategies

Beyond DRN/DNI

Oh the horror

Code status strategies

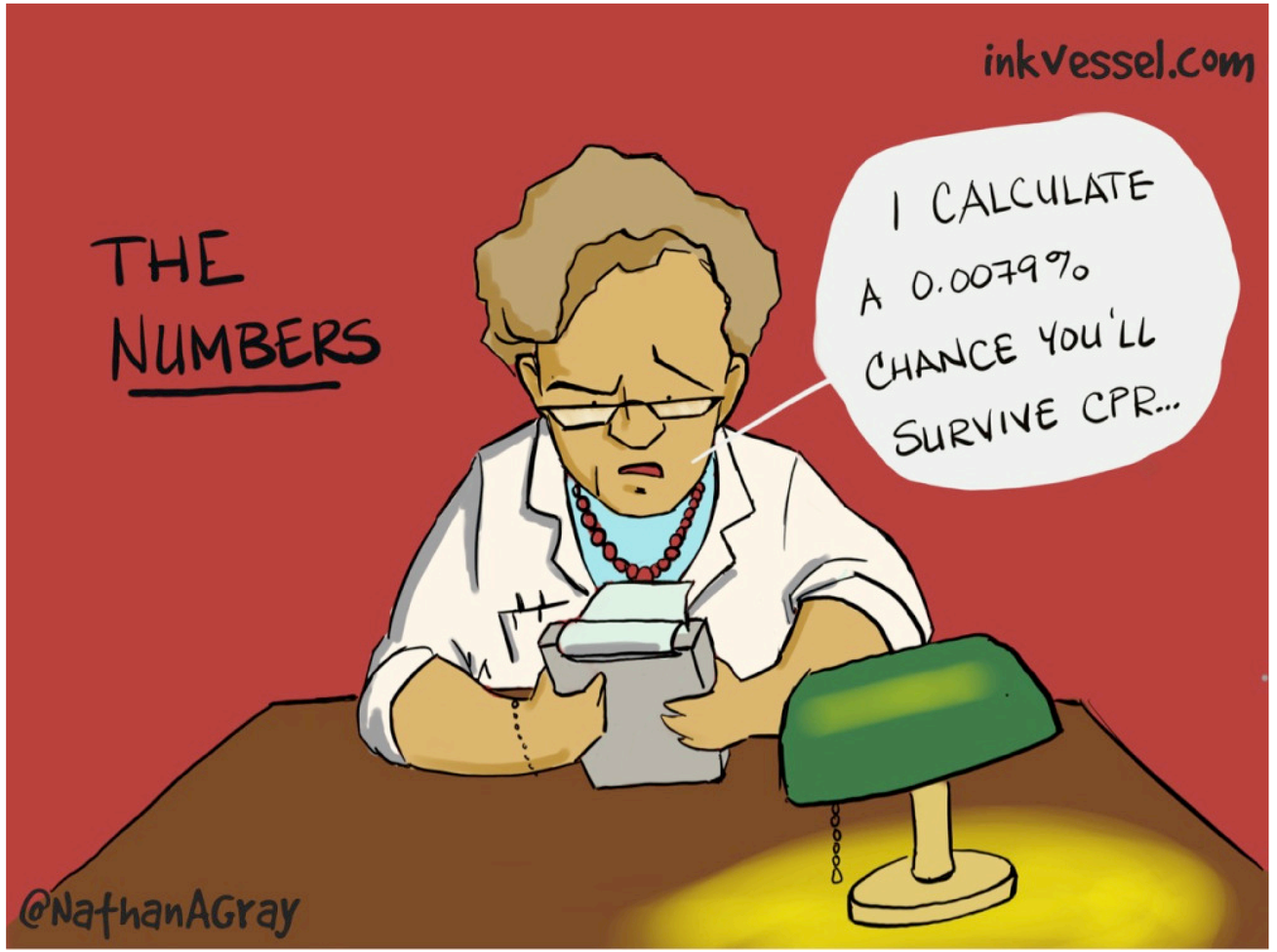
COde status strategies

BeyondDRNI

Code status strategies

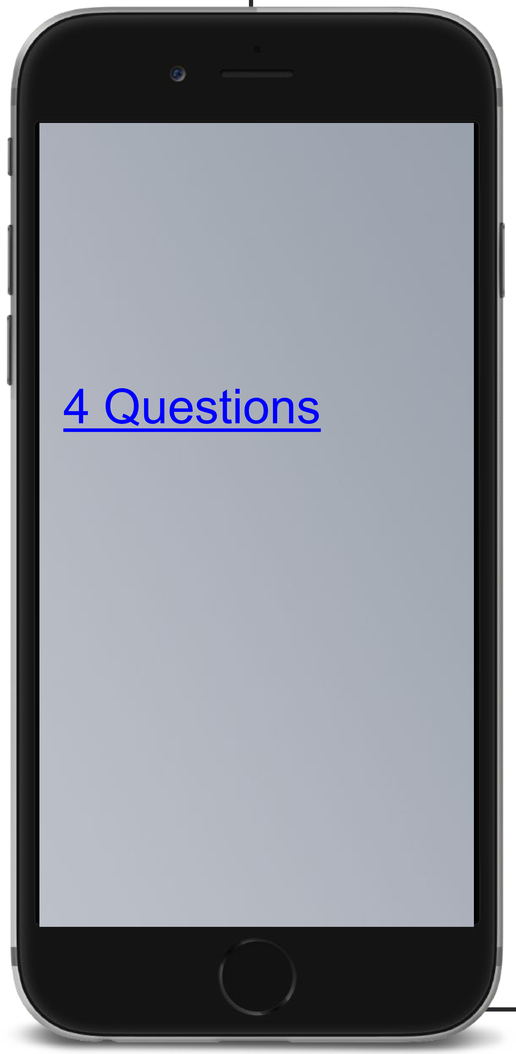
Beyond DRN/DNI

Stats



Are they capable??

Is it really consent?

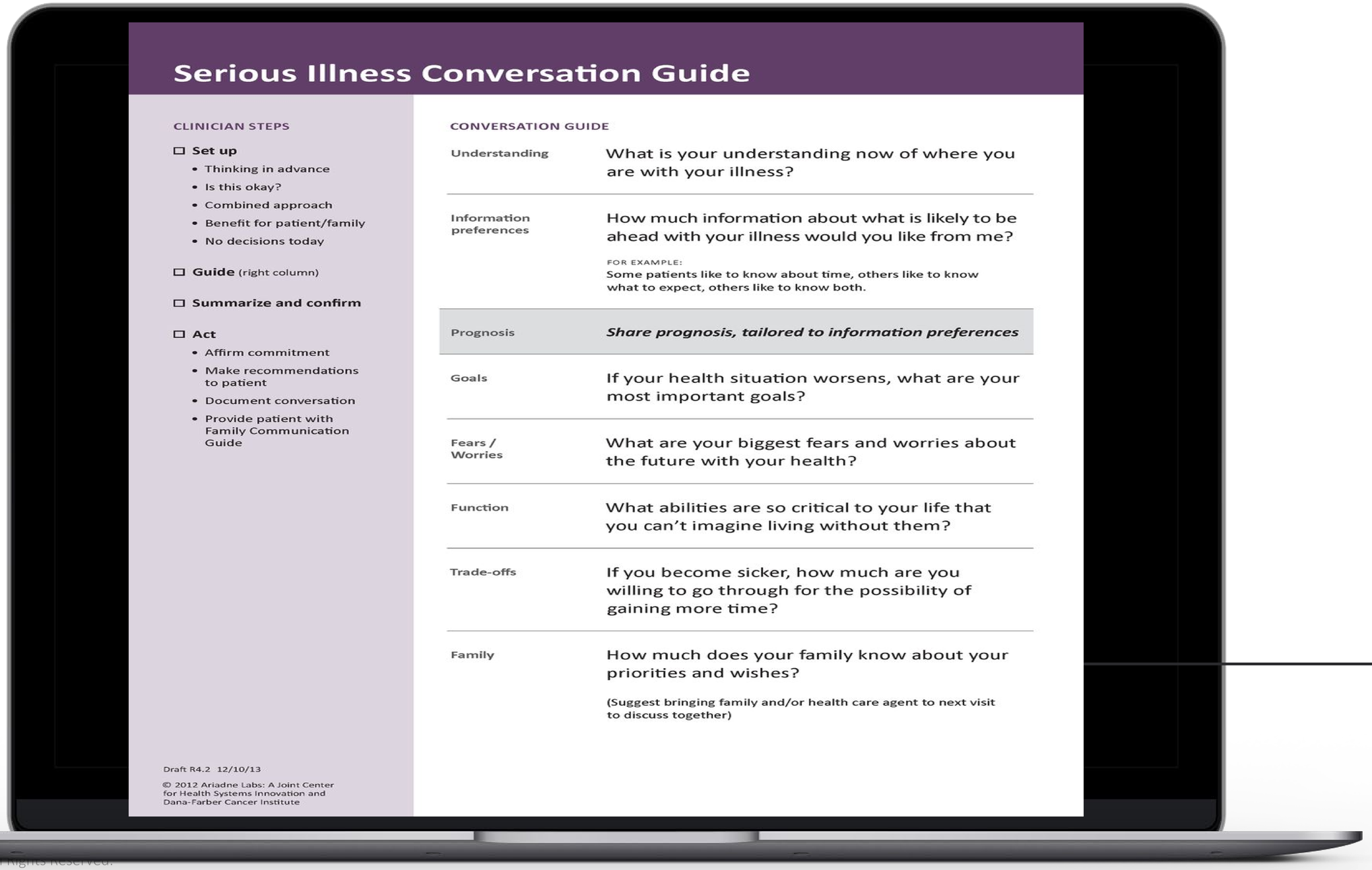


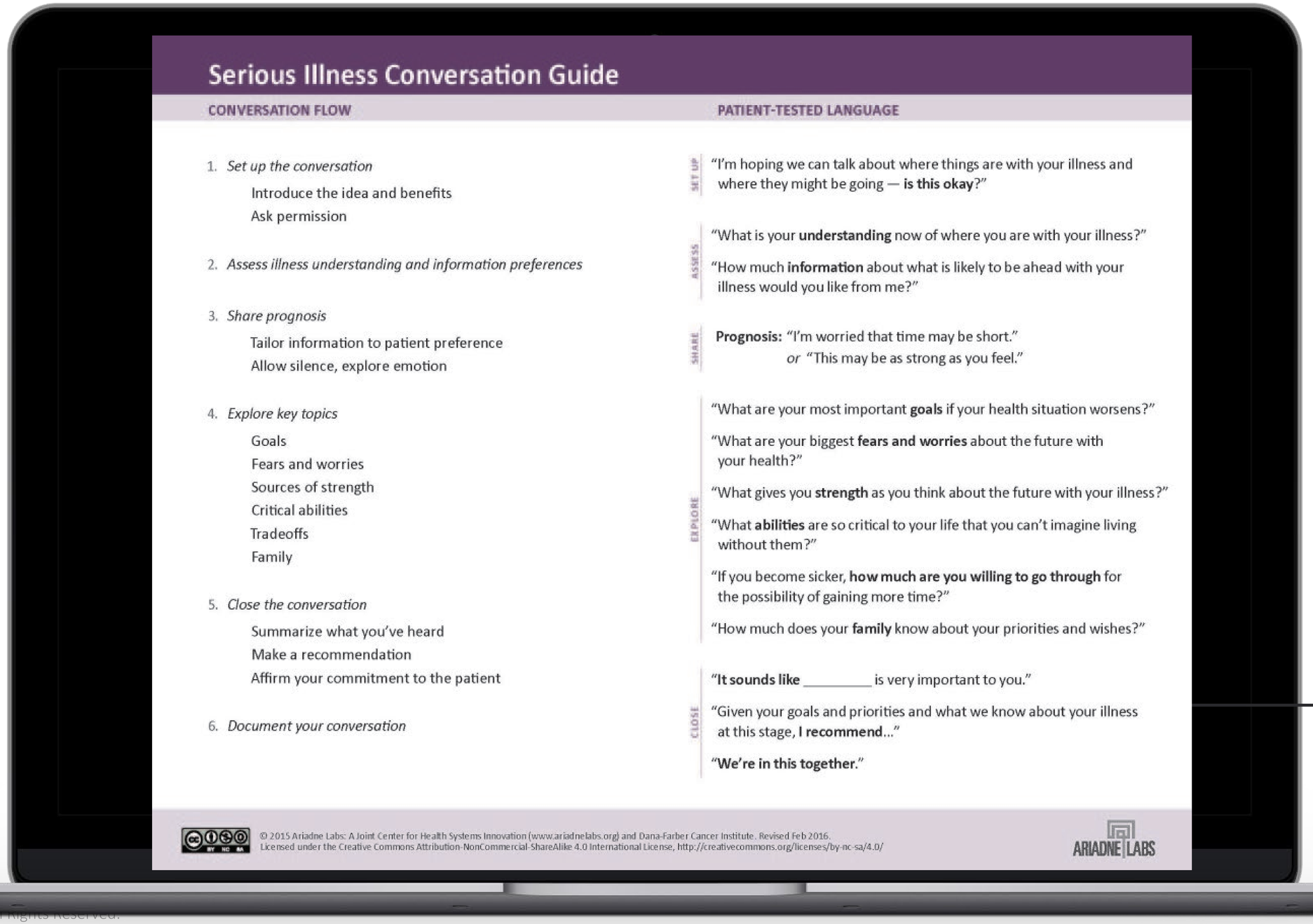
Do they know their prognosis

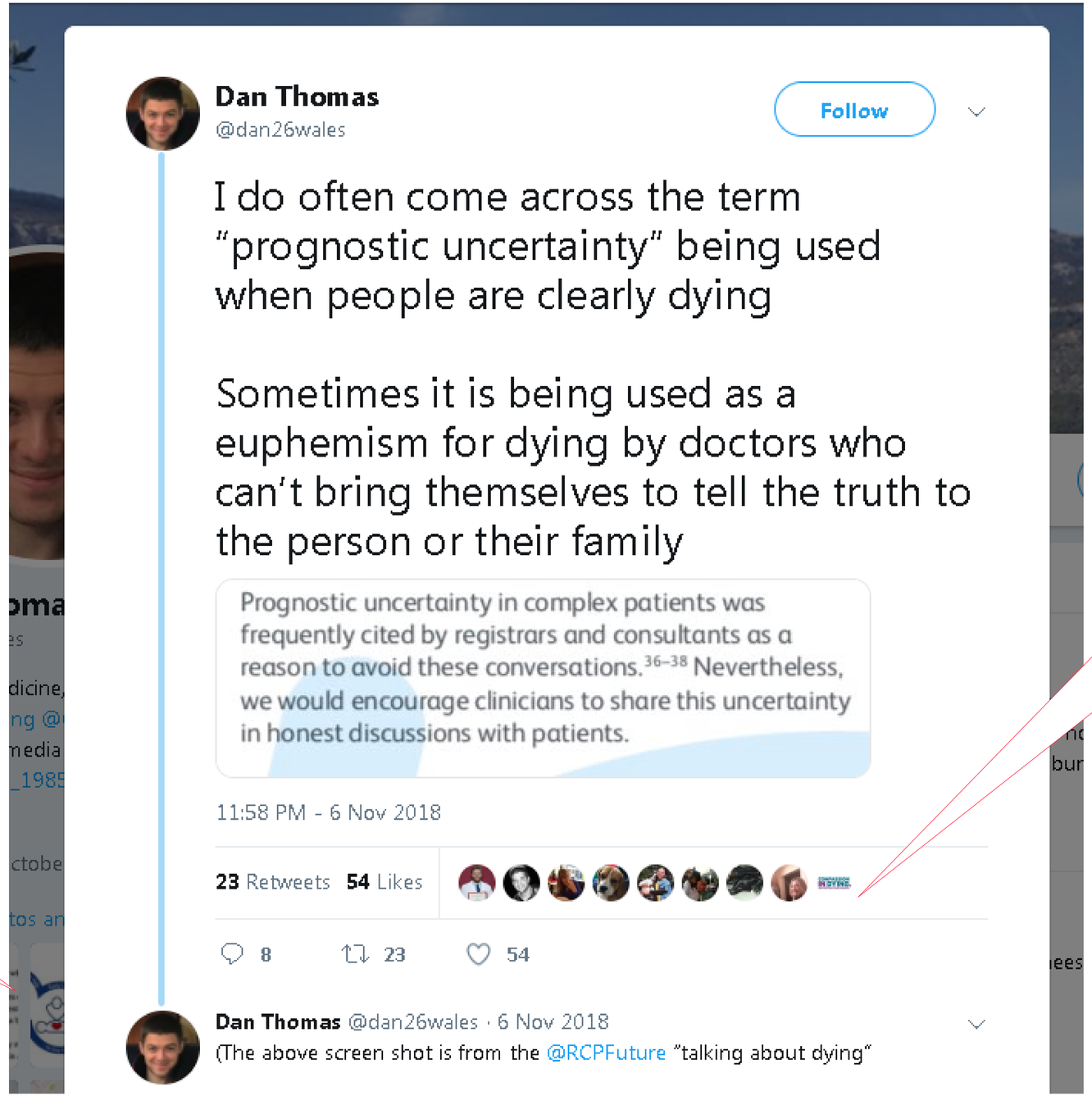
What are their goals for the time they have left

What are their biggest fears

What are they willing to sacrifice for the sake of more time







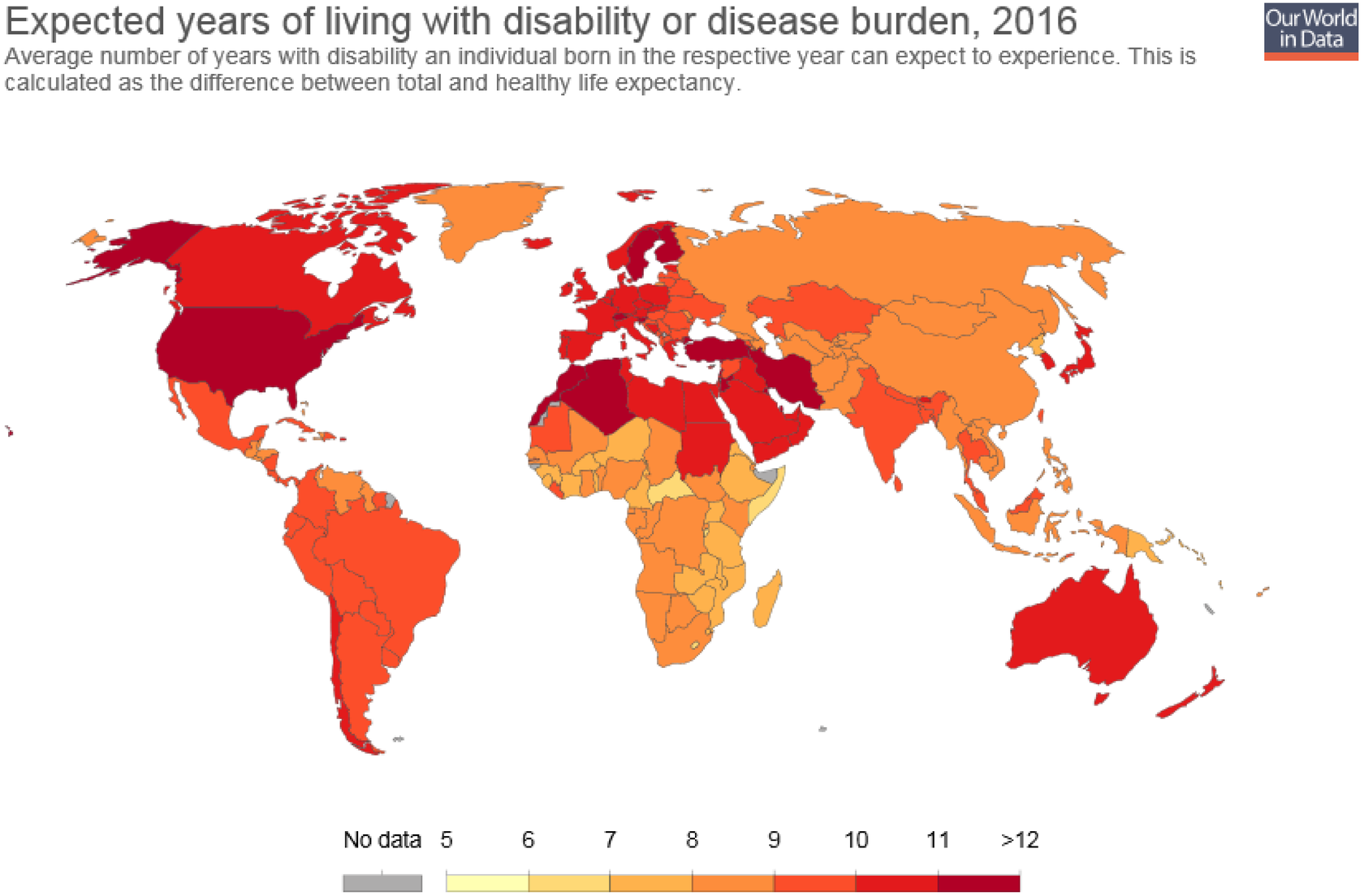
CPR is useful if the heart is "the first organ to stop", not "the last organ to stop"!

If doctors can't prevent your heart from stopping when you are alive, then it's extremely unlikely that they can restart it when you are dead

Using the frailty lens

"Give it to me nuanced, Doc."

“…for what lies ahead”



Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

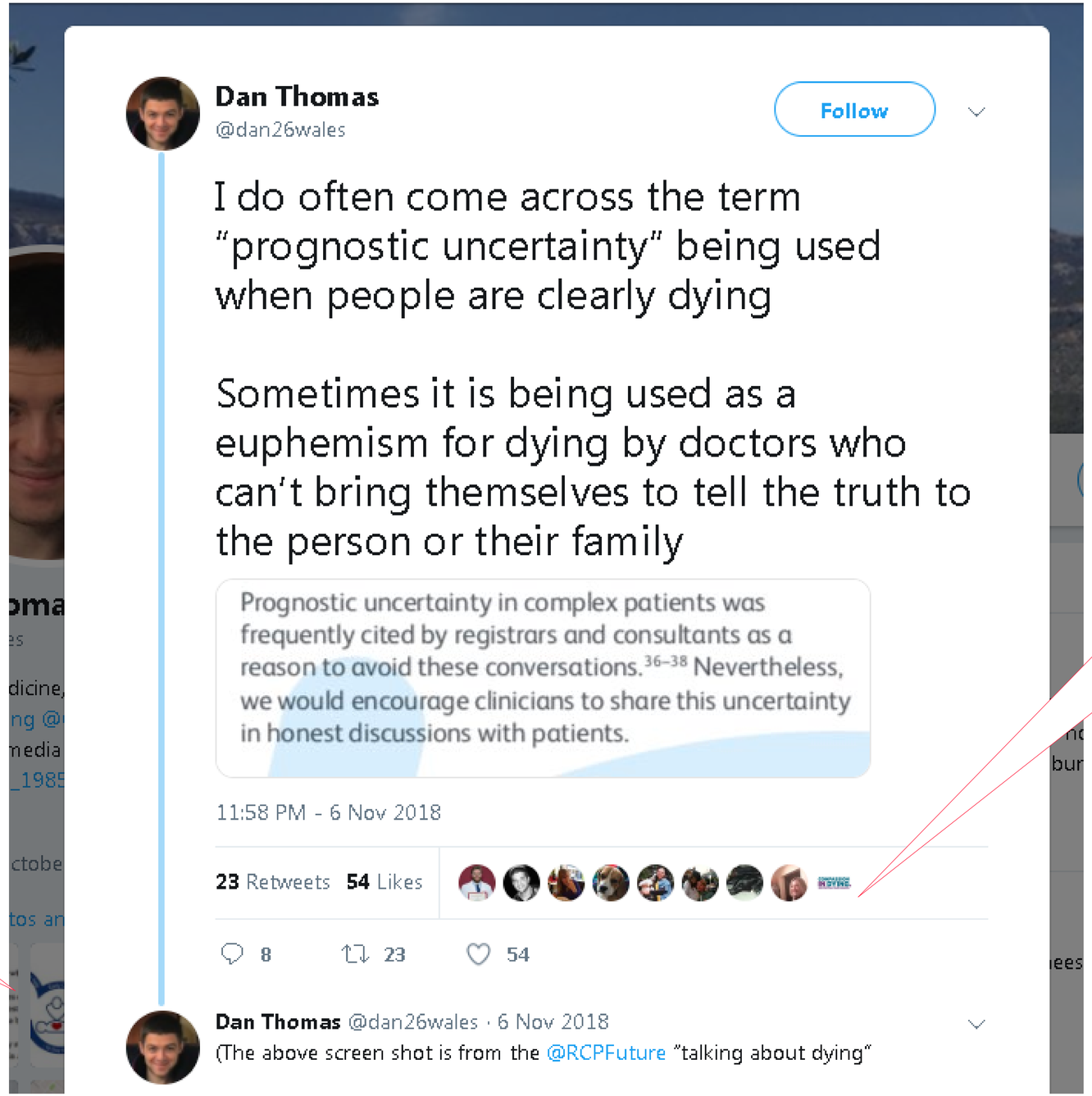
Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.



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Fill this in triplicate

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