From admission to end-of-life care: Communication and care planning for front door patients with advanced disease

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BACKGROUND

Currently in Lothian, the majority of patients with advanced illness die in hospital. Communication with these patients should include medical information and exploration of their values[1] based on a shared understanding of prognosis. Specialist Palliative Care presence in front door areas may help. We explored the impact of a QI project at WGH involving the Hospital Palliative Care Team (HCPT) seeing patients with advanced disease soon after admission.

METHOD

Retrospective data were collected of 45 patients seen by the HPCT at the front door of MAU at WGH who died within 7 days of admission. Demographics, advance care plans, communication documentation and the language used were analysed from both the medical and palliative care teams.

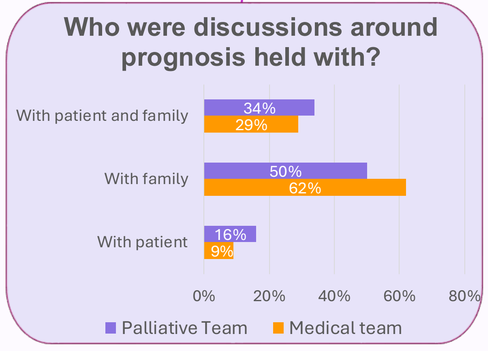
RESULTS

PATIENT PROFILE
- mean age 78yrs
- 58% female, 42% male

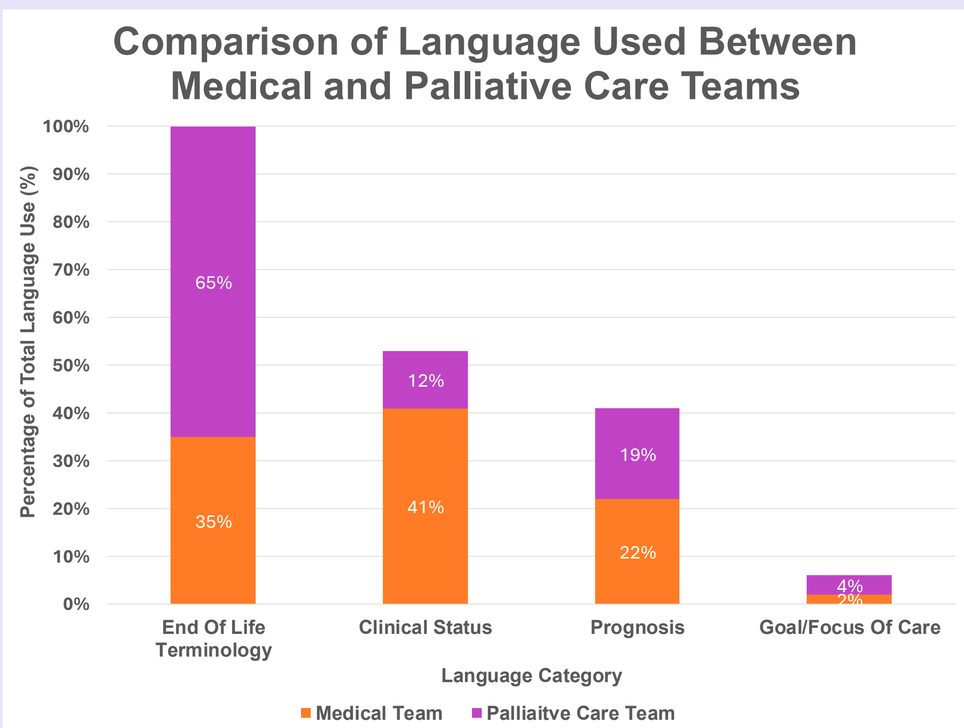
CLINICAL PROFILE
- 56% had cancer as main diagnosis
- mean frailty score = 7
- 100% met SPICT[2] criteria
- 71% had a DNACPR from previous admission
- 42% admitted due to carer/social care issues

KEY FINDINGS

COMMUNICATION & DOCUMENTATION
- 47% of patients had conversations on their preferences at first medical assessment
  - "does not wish to know how much time they have left"
  - "prefer to die at home"
  - "wouldn't want aggressive treatments"
- 60% given warning shot to either patient/family about possibility of deterioration at first medical assessment



LANGUAGE USED



- **'End-of-Life' terminology:** explicitly mentions dying or focuses on comfort/supportive care
- **Clinical Status:** describes patient's current condition or disease state
- **Prognosis:** predicts future disease course or likelihood of recovery
- **Goals / Focus of Care:** addresses patient-centered aims, priorities, or treatment decisions

Medical Team

Palliative Care Team

Word clouds displaying most common language documented by Medical vs. Palliative Care teams during conversations around prognosis

LIMITATIONS AND CONCLUSIONS

- Small, single-center cohort but no reason to believe these findings are not generalisable
- Retrospective design → relies on existing documentation and some communication may not have been recorded → possible underestimation
- Language category coding subjectively interpreted

Admissions may be unavoidable in spite of anticipatory care planning.
Implementing a change in medical admission proforma to include routine assessment of patient's goals & wishes may be a step toward achieving values-based care for all and a less medicalised approach to end-of-life care for those who die during the admission.
Ongoing collaboration with the HPCT at the front door may facilitate role modelling of clearer communication around prognosis.

References

1) Engel M, Kars MC, Teunissen SCCM, van der Heide A. Effective communication in palliative care from the perspectives of patients and relatives: A systematic review. Palliat Support Care. 2023 Oct;21(5):890-913.

2) Supportive and Palliative Care Indicators (SPICT) Tool. Available at https://www.spict.org.uk/the-spict/