Care Team Guide:
Transition from Dialysis Treatment to Palliative Care

BCRenal
Provincial Health Services Authority

<table>
<tr><th rowspan="2">PHASE</th><th colspan="4">MAJOR TASKS</th></tr>
<tr><th>HD, PD, HHD Team</th><th>Completed</th><th>Copy to Family Physician</th><th>Copy to PC team</th></tr>
<tr><td rowspan="5">Identify Patient</td><td>Surprise Question
• Would you be surprised if your patient died in 6-12 months?</td><td></td><td></td><td></td></tr>
<tr><td>Frailty scale 4 and above
https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html</td><td></td><td></td><td></td></tr>
<tr><td>General Indicators
• Has the patient asked for treatment withdrawal?</td><td></td><td></td><td></td></tr>
<tr><td>Examples of key statements may include:
• “I am tired of doing dialysis”
• “I don’t know if I can do this for much longer”
• “I feel that this is not how I want to spend the rest of my life.”</td><td></td><td></td><td></td></tr>
<tr><td>Clinical Indicators
• Multiple vascular access issues
• Sentinel events (falls, serum albumin, weight loss, poor BP control)
• Hospitalizations
• Dependence on others
• Bed or chair bound?
• Multiple co-morbidities</td><td></td><td></td><td></td></tr>
<tr><td rowspan="4">Serious Illness Conver-sation</td><td>**For clinicians trained in Serious Illness Conversation Only
http://www.bcrenalagency.ca/resource-gallery/Documents/ClinicianinterprofessionalReferenceGuide_v4_2018_01_19.pdf</td><td></td><td></td><td></td></tr>
<tr><td>Ask for permission to have Serious Illness Conversation
• “I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want- is that ok?”</td><td></td><td></td><td></td></tr>
<tr><td>Assess Patient’s Understanding of Illness
• What is your understanding of where you are at you are with your illness?
• How much information about what is likely to be ahead with your illness would you like from me?</td><td></td><td></td><td></td></tr>
<tr><td>Share Prognosis
• “I want to share with you my understanding of where things are with your illness.”
• “I wish we were not in this situation, but I am worried that time may be as short as____”
• “I hope that this is not the case, but I’m worried that this may be as strong as you will feel, and things will likely become more difficult”</td><td></td><td></td><td></td></tr>
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<tr><td rowspan="4"></td><td>Explore Key Topics
• “What are your most important goals if your health situation worsens?”
• “What are your biggest fears and worries about the future with your health?
• “If you become sicker, how much are you willing to go through for the possibility of gaining more time?”</td><td></td><td></td><td></td></tr>
<tr><td>Close conversation
• “I’ve heard you say that ____ is really important to you.”
• “I recommend that we______.”
• “How does this plan seem to you?”</td><td></td><td></td><td></td></tr>
<tr><td>Communicate with key clinicians</td><td></td><td></td><td></td></tr>
<tr><td>Document Serious Illness Conversation</td><td></td><td></td><td></td></tr>
<tr><td rowspan="9">Advance Care Plan</td><td>If appropriate, provide the patient BC Renal documents:
• Stopping Dialysis Treatment: What you need to know before deciding
• Frequently Asked Questions about stopping dialysis treatment: A guide for patient and families
Documents can be found at: http://www.bcrenalagency.ca/health-info/managing-my-care/palliative-care</td><td></td><td></td><td></td></tr>
<tr><td>Discuss what is important to the patient (e.g. beliefs, values, spiritual & cultural needs, treatment preferences)</td><td></td><td></td><td></td></tr>
<tr><td>If patient is open to &/or appropriate, review desires at end of life, including place of death</td><td></td><td></td><td></td></tr>
<tr><td>Document ACP discussion in patient record</td><td></td><td></td><td></td></tr>
<tr><td>Update ACP documentation in PROMIS</td><td></td><td></td><td></td></tr>
<tr><td>Discuss substitute decision maker. For more information on Substitute Decision- Making please refer to:https://www2.gov.bc.ca/gov/content/family-social-supports/seniors/financial-legal-matters/substitute-decision-making</td><td></td><td></td><td></td></tr>
<tr><td>Update MOST and DNR forms and place copy in patient record (hard copy &/or electronic file)</td><td></td><td></td><td></td></tr>
<tr><td>If available, place copy of ACP & related documentation in patient record (hard copy &/or electronic file)</td><td></td><td></td><td></td></tr>
<tr><td>When patient/family ready, encourage patient to update will, power of attorney & other relevant forms (e.g. organ donation, bequest forms). For more information on Estate Planning, please refer to: https://www2.gov.bc.ca/gov/content/family-social-supports/seniors/financial-legal-matters/wills-and-estate-planning</td><td></td><td></td><td></td></tr>
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PHASE	MAJOR TASKS			
	HD, PD, HHD Team	Completed	Copy to Family Physician	Copy to PC team
Goals of Care	Provide education on palliative care services available in local community. Confirm referral sent to appropriate services			
	Confirm BC Palliative Care Benefits Program Application form has been submitted https://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/palliative-patientinfo.pdf			
	If home death desired, confirm "Notification of Expected Death in the Home" form has been signed by the patient if the patient/family opts for no pronouncement. https://www2.gov.bc.ca/assets/gov/health/forms/3987fil.pdf			
	Ensure patient/family has copies of No CPR & Notification of Expected Death at Home" forms if relevant https://www2.gov.bc.ca/assets/gov/health/forms/302fil.pdf			
	Assess symptoms using My Symptom Checklist (mESAS) http://www.bcrenalagency.ca/resource-gallery/Documents/My%20Symptom%20Checklist.pdf			
	Enter results of mESAS into PROMIS			
	Review symptom management plan with patient/family & provide relevant handouts. For more information on symptom management handouts, please refer to: http://www.bcrenalagency.ca/health-professionals/clinical-resources/symptom-assessment-and-management			
	Contact PC team to discuss kidney specific symptoms, include providing copies of mESAS			
	As appropriate, link patient with spiritual care. • Assess spiritual suffering /existential distress assessment • Religious beliefs/cultural considerations explored			
	As appropriate, offer psychological/emotional counselling. Provide resources for funeral packages, community supports & local counselling			
	As appropriate, discuss the care required for a spouse or family member who may not be able to care for themselves.			
	As appropriate, discuss arrangements for pets. For more information on pet adoption, please refer to: BC SPCA https://spca.bc.ca/faqs/relative-died-pet/			
Bereave-ment Support	Acknowledges death with phone call, letter or card to family			
	As appropriate, offer brief grief & bereavement counselling to the family/caregiver & provide resources such as funeral package, community supports & grief counselling resources e.g. BC Bereavement Helpline (www.bcbereavementhelpline.com) local counselling/grief support resources, local hospice society & PCP.			
Reflection with team	Discuss and reflect on patient's death as a team			