

**Derek - a case study with cancer**

Derek is 62 and has been in your care home for three months now. He was admitted following a diagnosis of malignant brain tumour; he has previously had surgery and radiotherapy and chemotherapy was offered but Derek declined. Derek appears to be deteriorating as he is occasionally confused and suffering with frequent headaches. His wife Betty has visited every day but has looked increasingly tired recently.

Derek and Betty have two sons. Derek had his own business but this has been taken over by his sons since Derek was diagnosed. Both sons run the business which is situated many miles from the care home preventing them from visiting.

One day whilst you are attending to Derek, Betty starts to cry and she begins to tell you about her concerns. She asks that should Derek become poorly he stays with you and doesn’t go to hospital. Betty says she feels that after being married to Derek for so long she knows him best and that previously when in good health he had talked of not wanting to end his days, like his father had, in hospital. She adds that he would hate for his sons to witness his demise.

**1** Identify where this resident would be on your end of life care register and state your rationale.

**2** How would you facilitate an advance care planning discussion?

**3** Who would you involve in this discussion?

**4** Who would be the most appropriate person(s) to undertake and lead on this discussion?

**5** How would you communicate the outcome of this discussion?

**Notes for Facilitator**

**1 Identify where this resident would be on your end of life care register and state your rationale**

Derek is in phase 2 (rapid decline) of the North West Model for Life Limiting Conditions. The rationale for this is:

* Brain tumour
* Admission to care home
* Undergone surgery and radiotherapy refused further treatment
* Rapid deterioration
* Frequent headaches may indicate raised intracranial pressure due to tumour

**2 How would you facilitate an advance care planning discussion?**

*Consider: cues, timing, and environment*

Betty has opened the discussion by telling you her concerns. Although this may not be the best time to develop an advance care plan as Betty may be too distressed, it would be a good cue to address Derek’s future care by suggesting a meeting to discuss this in more depth.

Remember advance care planning is a process and it may take more than one meeting to develop an advance care plan.

Enquire on Betty’s support; does Betty wish to bring someone for support to the meeting?

There is a need to establish to what extent Derek is able and/or wishes to contribute to the discussion by any means i.e. communication aids if required. A mental capacity assessment may be required.

Try to involve the two sons if possible; if they are unable to attend a meeting are they contactable by phone to update them on developments; would e mail be preferred?

**3 Who would you involve in this discussion?**

*Consider: Mental Capacity Act*

Derek, if possible, and in agreement, Betty, his two sons, his GP and any other professional involved in Derek’s care.

It may be difficult for the sons to visit with business commitments or it may be too difficult for them emotionally. Different methods of communication should be considered and offered.

**4 Who would be the most appropriate person(s) to undertake and lead on this discussion?**

*Consider: knowledge and skills required*

This may be the home manager, the key nurse or you may wish to nominate the GP

**5 How would you communicate the outcome of this discussion?**

*Consider: who needs to know, how would you review?*

Inform all involved in Derek’s care of the discussion outcome and review date.

Think about processes you could put in place to aid this communication.

Think about systems in place to aid communication in your care home or what could be applied i.e. a main file for advance care plans, brightly coloured advance care plans, referring to advance care plans in daily handover (always think, “how an agency nurse would know?”).