Disclaimer
The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.
Pathway Map Legend

**Colour Guide**
- Primary Care
- Palliative Care
- Pathology
- Radiology
- Urology
- Radiation Oncology
- Medical Oncology
- Multidisciplinary Cancer Conference (MCC)
- Psychosocial Oncology (PSO)

**Shape Guide**
- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference
- Patient/Provider interaction
- Referral
- Wait time indicator time point

**Line Guide**
- Required
- Possible

---

Pathway Considerations

- Photodynamic Diagnosis (PDD) can be considered as an adjunct to Transurethral Resection of Bladder Tumor (TURBT), and Narrow Band Imaging (NBI) as an adjunct to cystoscopy if available.
- Clinical trials should be considered for all phases of the pathway.
- Counseling and treatment for smoking cessation should be initiated early on in the pathway and continued by care providers throughout the pathway as necessary.
- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway. For patients who do not have a primary care provider, Health Care Connect is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see [Person-Centered Care Guideline](#) and [EBS 19-2](#).
- Hyperlinks are used throughout the pathway to provide information about relevant CCO tools, resources and guidance documents.
- The term ‘health care provider’, used throughout the pathway, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit [EBS 19-3](#).
- For more information on Multidisciplinary Cancer Conferences visit [MCC Tools](#).
- For more information on wait time prioritization, visit [Surgery](#).
- For more information on the systemic treatment QPB please refer to the [Quality-Based Procedures Clinical Handbook for Systemic Treatment](#).
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness:
  - Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care - including restorative or rehabilitative care - or become the total focus of care.
  - Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process.
- Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient’s overall approach to care.

**Pathway Disclaimer**

This pathway map is a resource that provides an overview of the presentation and clinical work-up of a cancer diagnosis that an individual in the Ontario cancer system may receive.

The path map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader. While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an “as-is” basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information’s quality, accuracy, currency, completeness, or reliability.

CCO and the pathway map’s content providers (including the physicians who contributed to the information in the pathway maps) shall have no liability, whether direct, indirect, consequential, contingent, special, incidental, related to or arising from the information in the pathway map or its use thereof, whether based on breach of contract or tort (including negligence), and even if advised of the possibility thereof. Anyone using the information in the pathway map does so at his or her own risk, and by using such information, agrees to indemnify CCO and its content providers from any and all liability, loss, damages, and costs and expenses (including legal fees and expenses) arising from such person’s use of the information in the pathway map.

This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. CCO and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway on the same topic.

---

**References**


© CCO retains all copyright, trademark and all other rights in the pathway, including all text and graphic images. No portion of this pathway may be used or reproduced, other than for personal use, or distributed, transmitted or "mirrored" in any form, or by any means, without the prior written permission of CCO.
Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Diagnostic Procedures

Version 2018.08
Page 3 of 13

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

R Urologist

Pathology

Transurethral Resection of Bladder Tumor (TURBT) or Fluorescent Light (FL)-guided TURBT
Aim to eradicate all visible tumour, and include muscularis propria in sample & Examination Under Anesthesia (EUA)
Immediate post-operative intravesical chemotherapy Indicated for low risk, primary, small tumours

EBS #3-21

Pathological Stage

Ta:
Noninvasive papillary carcinoma
Tis:
Carcinoma in situ
T1:
Tumour invades subepithelial connective tissue
T2:
Tumour invades muscularis propria
T3:
Tumour invades perivesical tissue
T4:
Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
PUNLMP:
Papillary urothelial neoplasms of low malignant potential
LG:
Low-grade papillary urothelial carcinoma
HG:
High-grade papillary urothelial carcinoma

WHO/ISUP 2004

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

Patient Presenting with any of the following symptoms:

- Hematuria
- Increased urinary frequency, urgency, incontinence and nocturia
- Voids/Obsstructive Symptoms, e.g. dysuria
- Palpable mass on physical exam
- Pelvic or bone pain (sign of metastases)
- Bladder lesion on abdominal/pelvic imaging

In absence of UTI or other transient causes, refer all patients with:

- Single episode of gross hematuria (any age)
- Confirmed episode of asymptomatic microscopic hematuria aged ≥35yrs
- Patients with asymptomatic microscopic hematuria aged < 35 and perceived high-risk factors

Referral to a Urologist is mandated if hematuria persists despite treatment.

Adapted from CUAJ Recommendations, see reference [1] in Pathway Preamble

Type of Cancer

Ta:
Noninvasive papillary carcinoma
Tis:
Carcinoma in situ
T1:
Tumour invades subepithelial connective tissue
T2:
Tumour invades muscularis propria
T3:
Tumour invades perivesical tissue
T4:
Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
PUNLMP:
Papillary urothelial neoplasms of low malignant potential
LG:
Low-grade papillary urothelial carcinoma
HG:
High-grade papillary urothelial carcinoma

WHO/ISUP 2004

1 High risk factors include past tobacco use, history of pelvic irradiation, cyclophosphamide or other carcinogenic alkylating agent exposure, and exposure to occupational hazards such as dyes, benzenes, and aromatic amines.

2 Consider review by pathologist with genitourinary expertise when: variant histology, lamina propria/muscle invasive tumours with minimal invasion, or ambiguity as to whether muscularis propria is involved or a mismatch between clinical/cystoscopic findings is noted.
The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

From Page 3, 7, 9, 11

Low Risk
Primary, solitary, Ta (LG, <3cm, no Tis)

Follow up at 3 and 12 months
Cystoscopy 3 months post TURBT
Urine Cytology

Intermediate Risk
Ta >3 cm, multiple, or multi-recurrent low grade tumours

Relapse
Evidence of disease?

No

Yes

High Risk
TaHG or Tis

Intravesical therapy (Induction)
Bacillus Calmette–Guérin (BCG)
or
Mitomycin C (MMC)
or
Other Chemotherapy

Cystoscopy 3 months post TURBT
Urine Cytology

Evidence of disease?

No

Yes

Intravesical Maintenance Therapy (BCG)
Follow up every 3 months for 2 years, then every 6 months for 2 years
Cystoscopy Urine Cytology

Evidence of disease?

No

Yes

Late relapse

Follow up with specialist 4

Cystoscopy 3 months post TURBT
Urine Cytology

Follow up every 12-24 months
Ultrasound Abdomen & Pelvis or CT Urogram

Evidence of disease?

No

Yes

Therapy failure/
Early relapse

Consider every 2 years
Ultrasound Abdomen & Pelvis or CT Urogram

Early relapse

Follow up with specialist

Evidence of disease?

No

Yes

CT Urogram

Late relapse

Follow up with specialist

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools.

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care.

Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of Cis)

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months

Late relapse 12+ months

Adapted from CLPA Guidelines (2015) [2]

* Cystectomy should be strongly considered for highest risk pathology (T1HG+CIS, Multiple T1HG, T1HG > 3 cm, micropapillary, nested/large, plasmacytoid, sarcomatoid, microcystic, small tubules or lymphoepithelioma-type urothelial carcinoma variants, LV+). Review by a pathologist with genitourinary expertise should then be performed if not already done so.
Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG or disease progression (in grade, stage or appearance of Cis)

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months
Late relapse 12 + months

Adapted from CUA Guidelines (2015) [2]
Definitions

**Failure**: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of CIs)

**Relapse**: Recurrence of tumour after being disease free at 6 month evaluation
- Early relapse 6-12 months
- Late relapse 12+ months

Adapted from CUA Guidelines (2019) [2]

---

Follow up every 3 months for 2 years, then ever 6 months for 2 years

**Annual Surveillance**

*Cystoscopy* or *Urine Cytology*

Consider every 2 years

*Ultrasound Abdomen & Pelvis* or *CT Urogram*

---

**Non Muscle Invasive - Late relapse**

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

---

Follow up every 2 years

*Ultrasound Abdomen & Pelvis* or *CT Urogram*

---

Failure or Relapse

**Intravesical Maintenance Therapy (BCG)**

Follow up every 3 months for 2 years, then every 6 months for 2 years

*Cystoscopy* or *Urine Cytology*

---

**Follow up** with specialist

---

**Pathology**

**TURBT**

CT Urogram

If not recently performed

---

**Pathological Stage**

**Ta LG**

---

**Pathological Stage**

---

**Definition**

- *Muscle Invasive Disease*
- *Metastatic Disease*
- *Non Muscle Invasive Disease*

---

*Consider other salvage intravesical agents, clinical trials or MCC if patient has repeatedly failed induction (>2 times)*
Invasive Bladder Cancer (T2, T3, T4a)

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Treatment Decision

Cystectomy selected

CT Abdomen and Pelvis

Cystoscopy

Cisplatin-based Neoadjuvant Chemotherapy (NAC)

Perform midway through NAC (Pre Day 1 Cycle 3)

Consider patient preference, performance status, co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant)

Enterostomal Therapist

Radical Cystectomy with Bilateral Lymph Node Dissection

Consider Urethrectomy for T4a, urethral disease, and/or positive urethral margins

Urinary Diversion

Bone Scan

Positive imaging (metastatic disease or T4b)

Cisplatin-based Neoadjuvant Chemotherapy

If not previously given

CT Abdomen and Pelvis

Cystoscopy

Cisplatin-based Adjuvant Chemotherapy

If patient was not given NAC

Medical Oncologist

Radiation Oncologist

Repeat TURBT to achieve complete resection

Observation

From Page 10

T4b and/or pelvic N+

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

From Page 3, 5-7, 9, 11

Cisplatin-based Neoadjuvant Chemotherapy (NAC)

EBS #3-21

Concurrent External Beam Radiation Therapy (EBRT)

EBS #3-21

Cisplatin-based Adjuvant Chemotherapy

EBS #3-21

Cisplatin-based Chemotherapy

Repeat TURBT to achieve complete resection

Positive imaging (metastatic disease or T4b)

Bone Scan

EBS #3-21

Consider one of the following:

Cisplatin-based Adjuvant Chemotherapy

If patient was not given NAC

Medical Oncologist

Radiation Oncologist

Repeat TURBT to achieve complete resection

Observation

From Page 9 (Post cystectomy)

Proceed to Page 10

X

Y

Z

8 Highly recommending radiation oncology opinion for small tumours without hydronephrosis and CIS in patients with a desire to pursue bladder conservation

9 Indicated if symptoms present or alkaline phosphatase and calcium levels are elevated as per guideline EBS #3-21

10 Consider patient preference, performance status, co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant)

11 Refers to pT3-4 or N+

12 EBRT can be performed alone if not a candidate for chemotherapy
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care

---

**Note:**

- Urethral washings in high risk patients or urethral symptoms
- Aggressive variant pathology: micropapillary, nested, plasmacytoid variant
- Follow up with primary care provider may be considered after initial disease-free period

---

**Diagrams and Flowcharts:**

- [Flowchart for Urine Cytology and Follow-up](#)
- [Flowchart for Cystectomy Follow-up](#)
- [Flowchart for Metastatic Disease Management](#)
- [Flowchart for Intravesical Recurrence Management](#)
- [Flowchart for Pelvic Lymph Node Positive Management](#)
- [Flowchart for Metastatic Disease Management](#)
**Bladder Cancer Diagnosis, Treatment & Follow-up Pathway**

Metastatic Disease/T4b

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

**Bladder Cancer Diagnosis, Treatment & Follow-up Pathway**

**Disease Characteristic**

**De novo metastatic disease or T4b**

**From Page 6-9**

**Intractable hematuria**

**Radiation Oncologist**

**Urologist**

**Consider the following:**

**Radiation Oncologist**

**Palliative Radiation Therapy**

**Palliative Cystectomy**

**Palliative TURBT**

**No**

**Palliative Care**

**Not a candidate for chemotherapy**

**R**

**End of life care planning**

**Proceed Page 12 to (End of Life Care Pathway)**

**Follow up with specialist**

**Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools**

**Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care**

**S W Z AA EE**

**Yes, less than 6 months prior**

**No or Yes, but more than 6 months prior**

**Yes**

**Candidate for definitive or radical local therapy**

**MCC**

**No**

**Follow up with specialist**

**PSO**

**Palliative Radiation Therapy**

**Follow up with specialist**

**Medical Oncologist**

**From Page 6-9**

**Previous Neoadjuvant Chemotherapy or Adjuvant Chemotherapy given?**

**Yes**

**No**

**No response/Progression**

**MCC**

**Candidate for definitive or radical local therapy**

**No**

**Yes**

**Follow up with specialist**

**PSO**

**End of life care planning**

**Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools**

**Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care**

**Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools**

**Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care**

**Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools**

**Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care**
Positive Cytology, Negative Cystoscopy

Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care

<table>
<thead>
<tr>
<th>Type of Cancer</th>
<th>GG</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary tumour in prostatic urethra</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pT0: No evidence of primary tumor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pTa: Non-invasive papillary carcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pTis: Carcinoma in situ involving the prostatic urethra or periurethral or prostatic ducts without stromal invasion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pT1: Tumor invades urethral subepithelial connective tissue immediately underlying the urothelium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pT2: Tumor invades the prostatic stroma surrounding ducts either by direct extension from the urothelial surface or by invasion from prostatic ducts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pT3: Tumor invades the periurethral fat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pT4: Tumor invades other adjacent organs (e.g., extraprostatic invasion of the bladder wall, rectal wall)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from College of American Pathologists (CAP) Staging Protocol for Prostatic Urethra (2017) [3]

Follow up as appropriate

Consider repeat diagnostic assessments including fluorescent TURBT every 2-3 years, or if cytology remains positive

<table>
<thead>
<tr>
<th>Pathology (refer to ‘Type of Cancer’ table on left)</th>
<th>Pathological Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>T0, Tis, T1</td>
</tr>
<tr>
<td>Pathology</td>
<td>T2 or greater</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CT Urogram</th>
<th>If not recently performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments</td>
<td>Pathology</td>
</tr>
<tr>
<td>Retrograde pyelogram</td>
<td>If CT not performed</td>
</tr>
<tr>
<td>Random Bladder Biopsies</td>
<td>Prostatic Urethral Biopsy</td>
</tr>
<tr>
<td>Retrograde Ureteral Washings</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive for upper tract disease</th>
<th>Treatment as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive for bladder disease</td>
<td></td>
</tr>
<tr>
<td>Positive for prostatic disease</td>
<td>Transurethral Resection of the Prostate (TURP)</td>
</tr>
</tbody>
</table>

Follow up as appropriate

Proceed to Page 3 (Diagnosis)

Follow up as appropriate

Proceed to Page 4 (High Risk)

Follow up as appropriate

Proceed to Page 8

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey Click here for more information about palliative care
The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Pathway Map Target Population:
Individuals with cancer approaching end of life, and their families.

While this section of the pathway map is focused on the care delivered at the end of life, the palliative care approach begins much earlier on in the illness trajectory. Refer to Screen, Assess & Plan within the Psychosocial & Palliative Care Pathway Map.

Screen, Assess, Plan, Manage and Follow-Up

---

End of Life Care

- Revisit Advance Care Planning
  - Ensure the patient has determined who will be their Substitute Decision Maker (SDM)
  - Ensure the patient has communicated to the SDM his/her wishes, values and beliefs to help guide that SDM in future decision making

- Discuss and document goals of care with patient and family
  - Assess and address patient and family’s information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
  - Introduce patient and family to resources in community (e.g., day hospice programs)

- Develop a plan of treatment and obtain consent
  - Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
  - Develop a plan of treatment related to disease management that takes into account the person’s values and mutually determined goals of care
  - Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes:
    - Setting for care
    - Resuscitation status
    - Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)

- Screen for specific end of life psychosocial issues
  - Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
  - Consider referral to available resources and/or specialized services

- Identify patients who could benefit from specialized palliative care services (consultation or transfer)
  - Discuss referral with patients and family

- Proactively develop and implement a plan for expected death
  - Explore place-of-death preferences and assess whether this is realistic
  - Explore the potential settings of dying and the resources required (e.g., home, residential hospice, palliative care unit, long term care or nursing home)
  - Anticipate/Plan for pain & symptom management medications and consider a Symptom Response Kit (SRK) for unexpected pain & symptom management
  - Preparation and support for family to manage
  - Discuss emergency plans with patient and family (who to call if emergency in the home or long-term-care or retirement home)

- Home care planning
  - Connect with Home & Community Care early (not just for last 2-4 weeks)
  - Ensure resources and elements in place
  - Consider a Symptom Response Kit (SRK) with access to pain, dyspnea and delirium medication
  - Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

---

Triggers that suggest patients are nearing the last few months and weeks of life

- ECOG/Patient-ECOG/PRFS = 4 OR
- PPS ≤ 30
- Declining performance status/functional ability
- Gold Standards Framework indicators of high mortality risk
At the time of death:

- Pronouncement of death
- Completion of death certificate
- Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- Implement the pre-determined plan for expected death
- Arrange time with the family for a follow-up call or visit
- Provide age-specific bereavement services and resources
- Inform family of grief and bereavement resources/services
- Initiate grief care for family members at risk for complicated grief
- Encourage the bereaved to make an appointment with an appropriate health care provider as required

Bereavement Support and Follow-Up

- Offer psychoeducation and/or counseling to the bereaved
- Screen for complicated and abnormal grief (family members, including children)
- Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief

Provide opportunities for debriefing of care team, including volunteers