First do no harm: Changing culture surrounding ceilings of treatment in end-of-life care

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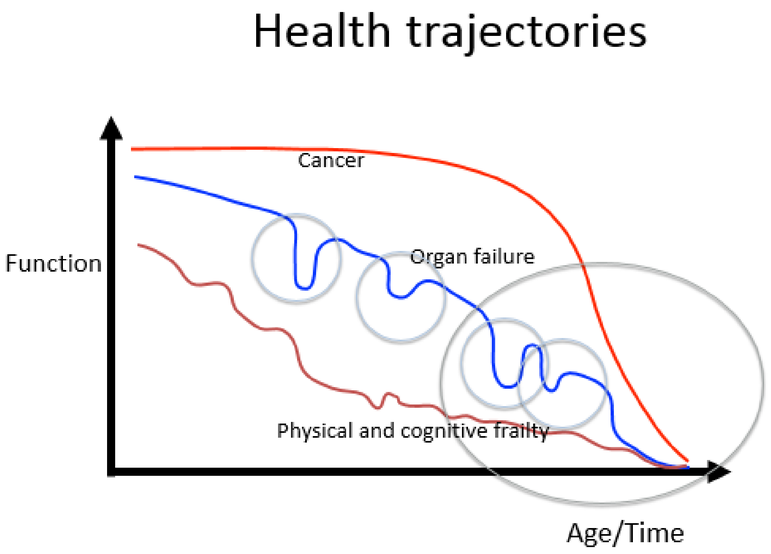
Introduction

The NICE Quality Standard for End of Life Care for adults (2011) provides a far reaching vision of how high quality end of life care should appear today. Unfortunately, people approaching the end of life may receive inconsistent care as their condition deteriorates. Failure of the team providing normal medical care to communicate patients' wishes and clearly document a personalised care plan for current and future support and treatment can expose patients to burdensome medical investigations, as well as increasing anxiety among nursing staff and 'on call' medical teams should an acute deterioration occur outside of normal working hours.



Aim Statement

By April 2017, 50% of inpatients within the Belfast City Hospital Respiratory unit, with a level of morbidity where acute deterioration could be anticipated, will have a ceiling of treatment (COT) documented.
In addition, 90% of patients with a DNACPR order will have a documented COT.

Project plan

Educational events promoted the importance of shared decision-making and prognostic conversations in end-of-life care. We redesigned and distributed a Trust approved COT form. Questionnaires examined medical and nursing staff experiences regarding end-of-life care, pre and post introduction.

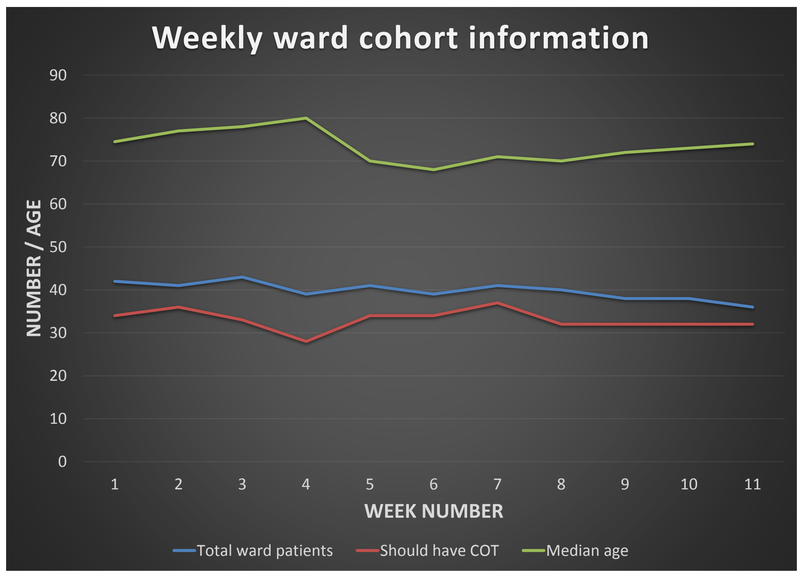
Measures

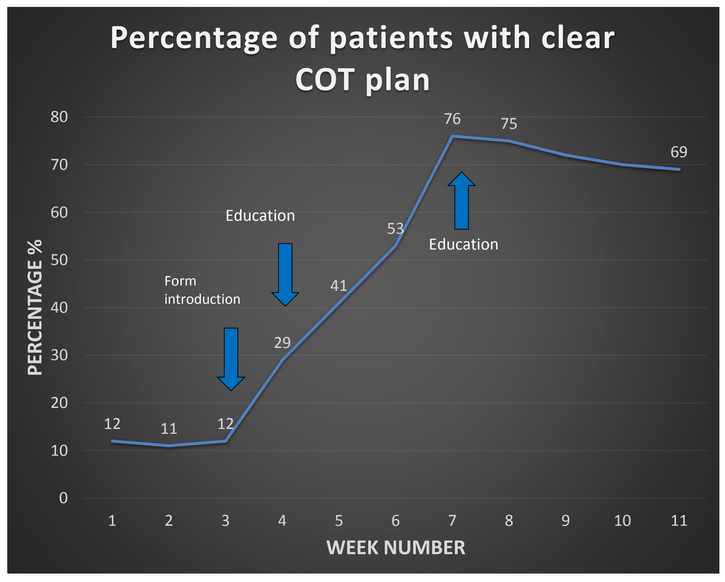
Inpatient notes in the Belfast City Hospital (BCH) Respiratory unit were reviewed weekly by three senior trainee doctors. ECOG performance status, presenting diagnosis, comorbid disease, and the 'surprise question' were all used in developing a consensus opinion as to whether a ceiling of treatment plan is important for each patient.

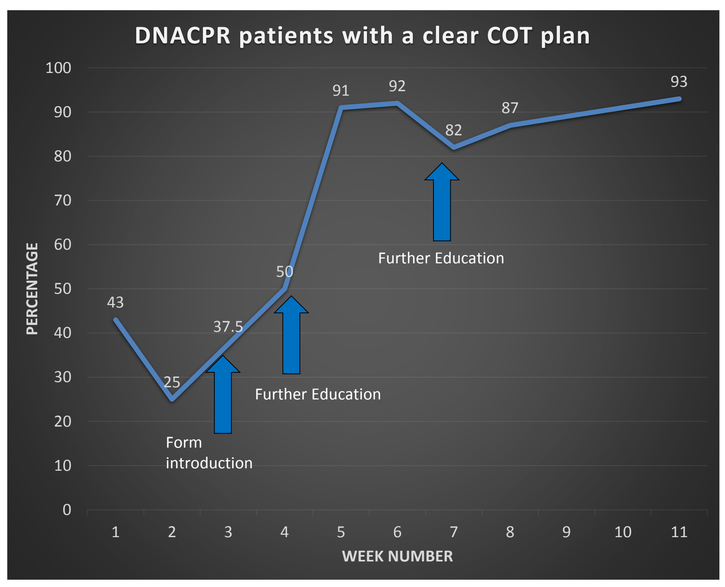
Two online survey tools were administered to examine nursing and doctors' understanding of and confidence in caring for patients approaching end-of-life care.

Referrals to ICU/ HDU and cardiac arrest calls were retrospectively reviewed for appropriateness.

Results







Of the 62 Belfast trust cardiac arrest audit sheets reviewed (over 6 months) 16% were subsequently deemed to be avoidable with appropriate forward planning.

There were 44 referrals to ICU / HDU from the medical specialities in the BCH over a 2 month period. 20% were deemed inappropriate due to frailty / co-morbidity *etc*.

90% of doctors and 73% of nurses state that they have witnessed patients undergoing treatments they consider futile/burdensome

71% of doctors and 77% of nurses state they have been left unsure what active interventions a patient is still considered for

Discussion

With the acknowledgment that as many as 10% of current acute hospital inpatients could die during their index admission and almost 30% could die within one year, the concept of 'hospital anticipatory care planning', or 'ceiling of treatments' have become increasingly topical in recent years. The Resuscitation Council (UK) have worked with a number of organisations to create and promote their 'ReSPECT' campaign and we can expect this to develop further in the next number of years.

All these pieces of work share our same core principles; the importance of good open communication with our patients, encouraging patients to be involved in decision making around their future care in the event of deterioration, and the avoidance of interventions or investigations that are futile, burdensome, or contrary to the patient's wishes.

Our work to date demonstrates a lack of forward planning for this cohort of patients. Medical emergency teams are performing futile and burdensome investigations / interventions, often as no one anticipated the deterioration or what impact this could have on the patient, their families and staff. With local education and the introduction of a pre-emptive ceiling of treatment form targeted at this cohort, we are already seeing improvement in communication, documentation, and patient involvement in their future care.

Further data collection will continue to measure the impact on ICU/HDU referrals, the number of cardiac arrest calls deemed inappropriate, and we will perform a further staff questionnaire post implementation. Work is already underway with other specialities to create similar ceiling of treatment templates which are more appropriate to their patient cohort.

Acknowledgements:

All the staff in wards 8 North and 8 South in the BCH.

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References

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2. Imminence of death among hospital inpatients: Prevalent cohort study. Clark D et al. (2014). Palliative Medicine, 28(6), 474-479
3. The Parliamentary Ombudsman's Report 2015: Dying without Dignity
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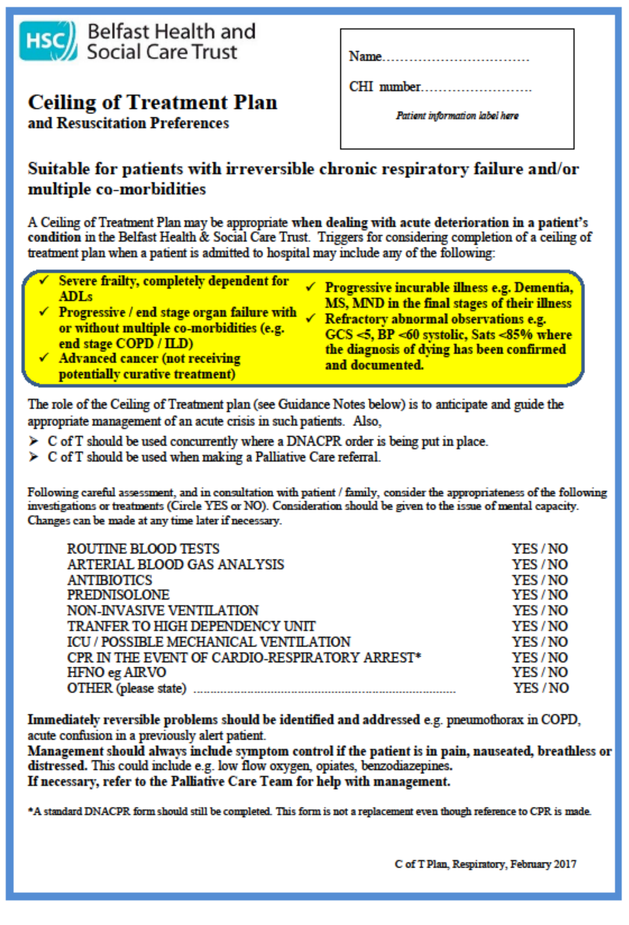


HSC Belfast Health and Social Care Trust

Name.....

CHI number.....

Patient information label here

Ceiling of Treatment Plan
and Resuscitation Preferences

Suitable for patients with irreversible chronic respiratory failure and/or multiple co-morbidities

A Ceiling of Treatment Plan may be appropriate **when dealing with acute deterioration in a patient's condition** in the Belfast Health & Social Care Trust. Triggers for considering completion of a ceiling of treatment plan when a patient is admitted to hospital may include any of the following:

- ✓ **Severe frailty, completely dependent for ADLs**
- ✓ **Progressive / end stage organ failure with or without multiple co-morbidities (e.g. end stage COPD / ILD)**
- ✓ **Advanced cancer (not receiving potentially curative treatment)**
- ✓ **Progressive incurable illness e.g. Dementia, MS, MND in the final stages of their illness**
- ✓ **Refractory abnormal observations e.g. GCS <5, BP <60 systolic, Sats <85% where the diagnosis of dying has been confirmed and documented.**

The role of the Ceiling of Treatment plan (see Guidance Notes below) is to anticipate and guide the appropriate management of an acute crisis in such patients. Also,

- C of T should be used concurrently where a DNACPR order is being put in place.
- C of T should be used when making a Palliative Care referral.

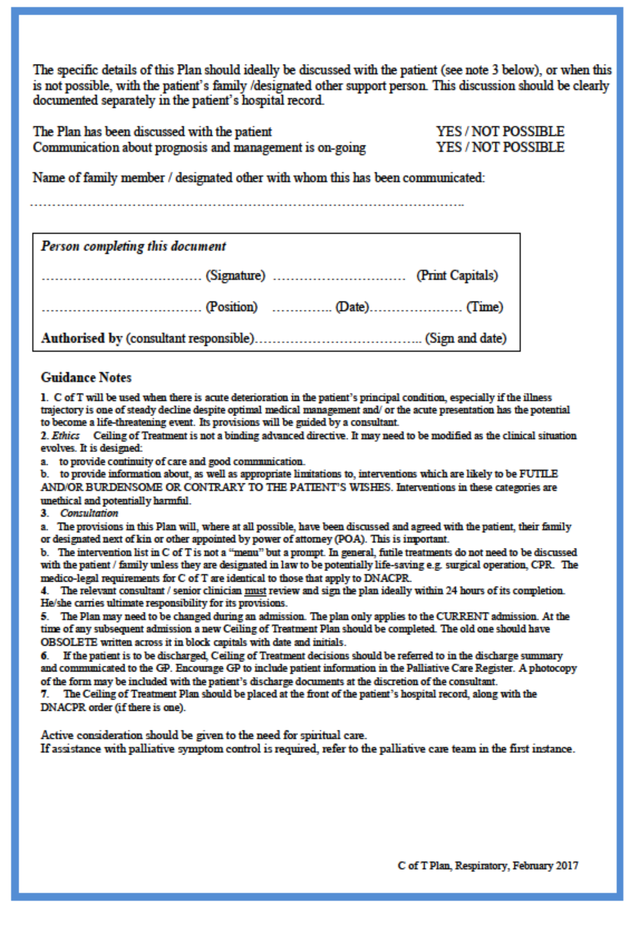
Following careful assessment, and in consultation with patient / family, consider the appropriateness of the following investigations or treatments (Circle YES or NO). Consideration should be given to the issue of mental capacity. Changes can be made at any time later if necessary.

ROUTINE BLOOD TESTS	YES / NO
ARTERIAL BLOOD GAS ANALYSIS	YES / NO
ANTIBIOTICS	YES / NO
PREDNISOLONE	YES / NO
NON-INVASIVE VENTILATION	YES / NO
TRANFER TO HIGH DEPENDENCY UNIT	YES / NO
ICU / POSSIBLE MECHANICAL VENTILATION	YES / NO
CPR IN THE EVENT OF CARDIO-RESPIRATORY ARREST*	YES / NO
HFNO eg AIRVO	YES / NO
OTHER (please state)	YES / NO

Immediately reversible problems should be identified and addressed e.g. pneumothorax in COPD, acute confusion in a previously alert patient.
Management should always include symptom control if the patient is in pain, nauseated, breathless or distressed. This could include e.g. low flow oxygen, opiates, benzodiazepines.
If necessary, refer to the Palliative Care Team for help with management.

*A standard DNACPR form should still be completed. This form is not a replacement even though reference to CPR is made.

C of T Plan, Respiratory, February 2017



The specific details of this Plan should ideally be discussed with the patient (see note 3 below), or when this is not possible, with the patient's family /designated other support person. This discussion should be clearly documented separately in the patient's hospital record.

The Plan has been discussed with the patient YES / NOT POSSIBLE
Communication about prognosis and management is on-going YES / NOT POSSIBLE

Name of family member / designated other with whom this has been communicated:

.....

Person completing this document

..... (Signature) ..... (Print Capitals)

..... (Position) ..... (Date)..... (Time)

Authorised by (consultant responsible)..... (Sign and date)

Guidance Notes

1. C of T will be used when there is acute deterioration in the patient's principal condition, especially if the illness trajectory is one of steady decline despite optimal medical management and/ or the acute presentation has the potential to become a life-threatening event. Its provisions will be guided by a consultant.
2. *Ethics* Ceiling of Treatment is not a binding advanced directive. It may need to be modified as the clinical situation evolves. It is designed:
   a. to provide continuity of care and good communication.
   b. to provide information about, as well as appropriate limitations to, interventions which are likely to be FUTILE AND/OR BURDENSOME OR CONTRARY TO THE PATIENT'S WISHES. Interventions in these categories are unethical and potentially harmful.
3. *Consultation*
   a. The provisions in this Plan will, where at all possible, have been discussed and agreed with the patient, their family or designated next of kin or other appointed by power of attorney (POA). This is important.
   b. The intervention list in C of T is not a "menu" but a prompt. In general, futile treatments do not need to be discussed with the patient / family unless they are designated in law to be potentially life-saving e.g. surgical operation, CPR. The medico-legal requirements for C of T are identical to those that apply to DNACPR.
4. The relevant consultant / senior clinician must review and sign the plan ideally within 24 hours of its completion. He/she carries ultimate responsibility for its provisions.
5. The Plan may need to be changed during an admission. The plan only applies to the CURRENT admission. At the time of any subsequent admission a new Ceiling of Treatment Plan should be completed. The old one should have OBSOLETE written across it in block capitals with date and initials.
6. If the patient is to be discharged, Ceiling of Treatment decisions should be referred to in the discharge summary and communicated to the GP. Encourage GP to include patient information in the Palliative Care Register. A photocopy of the form may be included with the patient's discharge documents at the discretion of the consultant.
7. The Ceiling of Treatment Plan should be placed at the front of the patient's hospital record, along with the DNACPR order (if there is one).

Active consideration should be given to the need for spiritual care.
If assistance with palliative symptom control is required, refer to the palliative care team in the first instance.

C of T Plan, Respiratory, February 2017