Treatment Escalation Plans

Guidance for Charge Nurses and other nursing staff.

PROFESSOR D ROBIN TAYLOR

This is Mrs. McMillan who is
has just been admitted to HDU

Case study: Mrs. McM.

- 74 year-old lady admitted with metastatic pancreatic cancer causing ascites. Previously drained 3 times. It is drained again, and percutaneous catheter is removed after 24 hours.
- Day 3: Sweaty and pale. Pulse 130, b.p. 70/50. NEWS was 5. Hospital Emergency Care Team was called.
- The Team decided that acute deterioration was probably due to sepsis, secondary to infected drain site.
- She was transferred to the ICU. The Sepsis-6 protocol was initiated, including i.v. antibiotics, inotropes and the insertion of a urinary catheter.
- She developed acute renal failure and a shared decision was made not to treat further. She died 48 hours later.

The Rapid Response Team Nurse wrote:

"I knew the patient was dying, but I could not find anything in the notes that said that escalation of treatment should be limited. I arranged for transfer to the ICU. I felt very unhappy about it, but the situation was urgent".

Rapid Response Team Nurse

Questions

What is the context of her illness?

What is her prognosis?

What are the consequences of major intervention?

The curative medical model: death denying and death defying

What is meant by "futile treatment"?

- goal(s) of treatment is (are) unattainable
- little or no meaningful benefit
- harms: burdensome to patient
  (not necessarily classified as adverse effects)
- palliative treatments neglected
- psychological harm: illusions of potential recovery in the minds of patients / relatives
- wasteful of resources

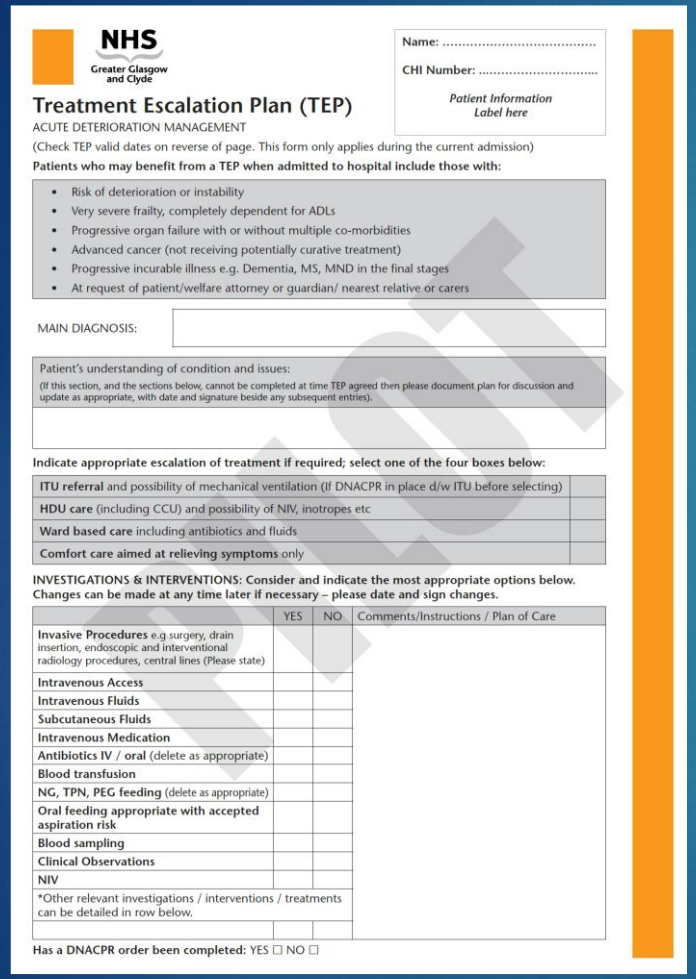
Treatment Escalation Plans

- Designed:
  a. to MINIMISE HARM due to overtreatment or undertreatment

  b. to provide CONTINUITY OF CARE and GOOD COMMUNICATION especially out of hours.

  c. to provide information about, as well as appropriate limitations to interventions which are likely to be FUTILE AND/OR BURDENSOME AND CONTRARY TO THE PATIENT'S WISHES. Interventions in these categories are UNETHICAL.
- Do not provide for the withdrawal of any treatment.
- Need to be reviewed and modified as the clinical situation evolves.

Treatment Escalation Limitation Plan (GGC)



NHS Greater Glasgow and Clyde

Treatment Escalation Plan (TEP)

ACUTE DETERIORATION MANAGEMENT

Name: .....

CHI Number: .....

Patient Information Label here

(Check TEP valid dates on reverse of page. This form only applies during the current admission)

Patients who may benefit from a TEP when admitted to hospital include those with:

- Risk of deterioration or instability
- Very severe frailty, completely dependent for ADLs
- Progressive organ failure with or without multiple co-morbidities
- Advanced cancer (not receiving potentially curative treatment)
- Progressive incurable illness e.g. Dementia, MS, MND in the final stages
- At request of patient/welfare attorney or guardian/ nearest relative or carers

MAIN DIAGNOSIS:

Patient's understanding of condition and issues:

(If this section, and the sections below, cannot be completed at time TEP agreed then please document plan for discussion and update as appropriate, with date and signature beside any subsequent entries).

Indicate appropriate escalation of treatment if required; select one of the four boxes below:

ITU referral and possibility of mechanical ventilation (If DNACPR in place d/w ITU before selecting)	
HDU care (including CCU) and possibility of NIV, inotropes etc	
Ward based care including antibiotics and fluids	
Comfort care aimed at relieving symptoms only	

INVESTIGATIONS & INTERVENTIONS: Consider and indicate the most appropriate options below. Changes can be made at any time later if necessary – please date and sign changes.

	YES	NO	Comments/Instructions / Plan of Care
Invasive Procedures e.g surgery, drain insertion, endoscopic and interventional radiology procedures, central lines (Please state)			
Intravenous Access			
Intravenous Fluids			
Subcutaneous Fluids			
Intravenous Medication			
Antibiotics IV / oral (delete as appropriate)			
Blood transfusion			
NG, TPN, PEG feeding (delete as appropriate)			
Oral feeding appropriate with accepted aspiration risk			
Blood sampling			
Clinical Observations			
NIV			
*Other relevant investigations / interventions / treatments can be detailed in row below.			

Has a DNACPR order been completed: YES ☐ NO ☐

Indicate appropriate escalation of treatment if required; select one of the four boxes below:

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Has a DNACPR order been completed: YES ☐ NO ☐

Structured Response to Deteriorating Patient: early warning scoring (EWS)

- Based on scores for:
  - resp. rate
  - SaO2
  - systolic BP
  - pulse rate
  - temperature
  - level of consciousness
- Threshold for action = score 5 or more OR single parameter measuring 3

  NB all dying patients have a rising NEWS score!
- Nurse informs charge nurse and on-call doctor and / or Rapid Response Team is called

WHAT HAPPENS THEN?

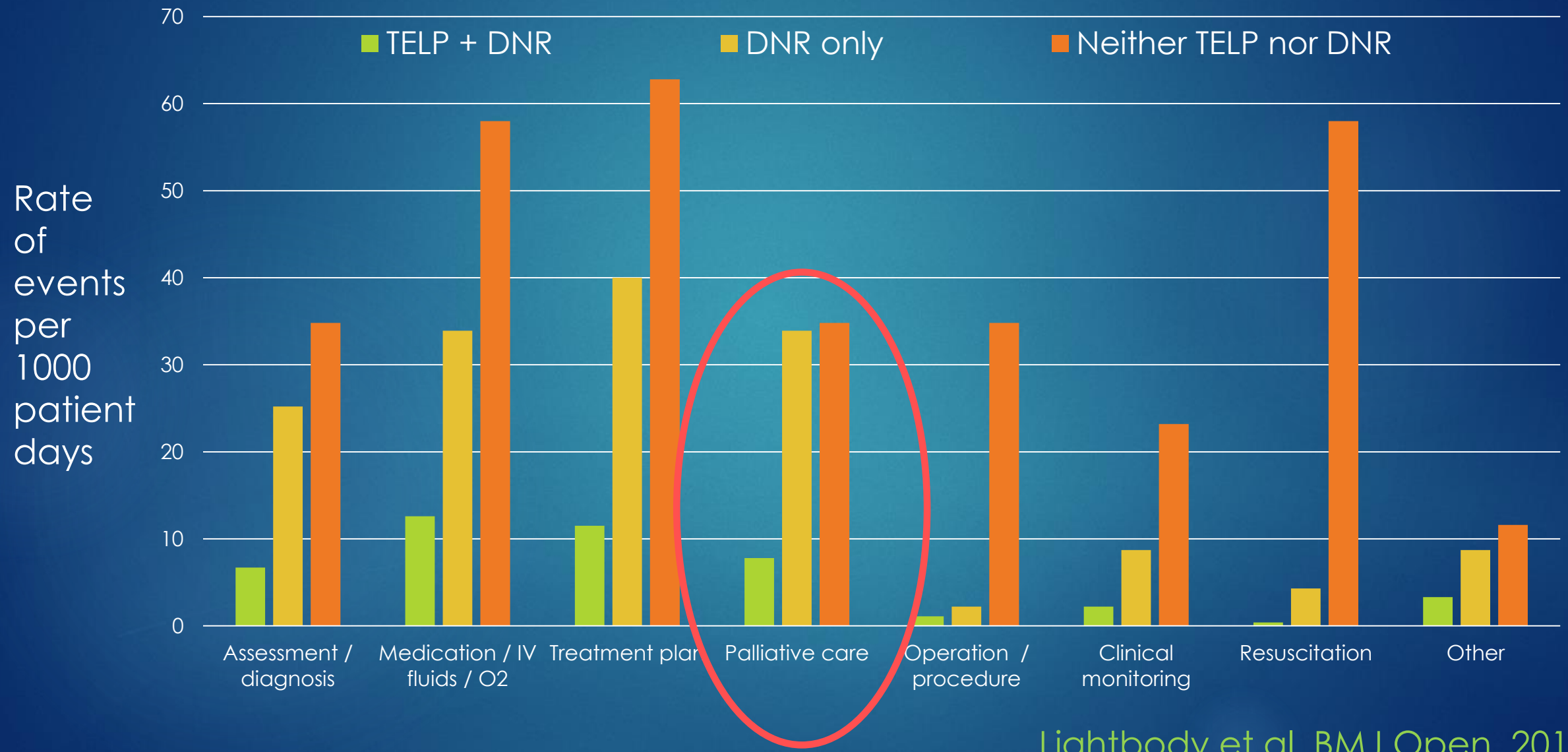
TEPS - THE EVIDENCE

TEP: reduction in non-beneficial interventions and harms. Hairmyres Hospital 2017.

Incident Rate Ratios	TELP + DNACPR N=155	DNACPR only N=113	p	Neither TELP nor DNACPR N=21	p
'Problems'	1.00	**2.05 (1.62 – 2.58)**	<0.001	**1.78 (1.19 – 2.68)**	<0.001
Non-beneficial interventions	1.00	**1.98 (1.48 – 2.64)**	<0.001	**1.44 (0.83 – 2.50)**	0.198
Harms	1.00	**2.77 (1.96 – 3.92)**	<0.001	**2.61 (1.50 – 4.55)**	<0.001

Lightbody CJ et al., Impact of a treatment escalation/limitation plan on non-beneficial interventions and harms in patients during their last admission before in-hospital death BMJ 2018;**8:**e024264. doi: 10.1136/bmjopen-2018-024264

Clinical "problems" in 289 patients, related to the 8 domains of the Structured Judgment Review Method



Lightbody et al. BMJ Open, 2018

TEPs: the evidence

- Improved concordance between patient's wishes / preferences and care delivered at end of life.

86% with ACP had end-of-life wishes respected compared with 30% among controls (P<0.001)

Family members of patients who died had significantly less stress (P<0.001), anxiety (P=0.02), and depression (P=0.002) than those of the control patients.

Detering et al. BMJ 2010;340:c1345

- Reduced likelihood of complaints by relatives following death of a patient in hospital

TEPs were used less frequently in complaint cases compared to controls (23.8% versus 47.2%, p= 0.01).

Taylor et al., Int. J. Qual. Health Care. 2020; 32: 212-218.

TEPs: the evidence

- Reduced levels of inappropriate out-of-hours care

Overall 11% of patients with TELP received inappropriate care compared to 44% without TELP

Stockdale et al., BMJ Quality Improvement 2013. Doi: u202653.w1236/bmjquality

- Reduction in inappropriate antibiotic use at end of life

2/28 patients (7.1%) with a TELP that included an antimicrobial 'ceiling' received antimicrobials on the day of death, compared to 18/53 (34.0%) among those who did not have a 'ceiling'.

Wilder-Smith et al., J R Coll Physicians Edinb 2019; 49: doi: 10.4997/JRCPE.2019.XXX

FAQ 1. If the patient lacks capacity and a family member is not present, what should be done?

- *Having a discussion with a family member / the person holding WPOA is strongly recommended. But if that is not possible, having a TEP is in the patient's best interests if they are unstable or are at risk of dying.*
- *The reasons for not having a conversation should be documented in the patient's notes.*
- *Identify patients for whom the **absence of a TEP puts them at risk of harm** from treatment overuse or underuse.*
- *Lack of capacity or absent family is **not** a contra-indication to creating a TEP. The ethical responsibility is to avoid harm.*

FAQ 2. What about DNACPR?

- *There should be no DNACPR without a TEP. This is bad practice.*
- *CPR is rarely a key consideration in most acutely ill patients. Major interventions apart from CPR (e.g. operation, sepsis protocol, NIV) are much more relevant.*
- *Avoid conversations about DNACPR in isolation. They spook patients and are often misunderstood. Some members of the public think DNACPR is code for "do not treat".*
- *The use of TEPs has been shown to reduce patient complaints about DNACPR.*

FAQ 3. Is filling in a TEP that states “for full escalation” not a bit superfluous? After all, full escalation is the default position anyway.

- *It is very helpful to on-call / out-of-hours staff to know that full escalation is appropriate for a deteriorating patient.*
- *In response to an increasing NEWS score, having a TEP provides a secure basis for emergency treatment.*
- *The greatest fans of the TEP are rapid response team members!*

FAQ 4. I thought that the TEP was meant to be used only for patients who are terminally ill.

No, the scope for using a TEP is wider. This has been made clearer through the COVID experience. GOALS OF TREATMENT should be determined for every patient. Any patient who has the potential to deteriorate, expectedly or unexpectedly, should have a TEP.

The TEP is not an end of life care plan. Terminally ill patients may benefit from such a Plan (RELC), and it should be put in place to complement the TEP.

FAQ 5. I have heard of instances where members of staff have been criticised for using the TEP. Will I receive support if I use the TEP?

The Health Board fully supports the use of the TEP and endorses it as good medical practice. All members of staff should facilitate the use of the TEP and provide receive encouragement to do so.

This is Mrs. McMillan's family:
they have just had a conversation with the doctor

COPING WITH CRISIS

Critical illness is always challenging. There is the suffering that comes with the illness itself. But particularly if the illness is life-threatening or is the latest in a series of health-related events, uncertainty and threat can intensify the pressures.

Making decisions for the best when the emotional pressure is high needs good communication and clear thinking. Coping with Crisis aims to help. It is not just an information source. It's about doing some preparation, thinking hard things through in an atmosphere of calm.

Easy-to-grasp brief chapters outline key topics that patients and families have to face ...

- the meaning of prognosis: "what does the future hold?"
- processing uncertainty and scenario planning
- having a conversation with doctors: being truthful and being realistic
- letting go or clinging on when there is the possibility of dying
- shared decision making and anticipatory care planning

Coping with Crisis

Navigating the challenges of medical decision-making in critical illness

copingwithcrisis.org

Why are conversations so difficult?

- Patients and families distressed, anxious
- Fears of catastrophe, medical trauma, death
- Intimidating environment
- Meeting with unfamiliar, ever-changing professionals
- Expectations and hopes: differences between generations
- Complex information about the patient's condition and treatment: hard to take in

Coping with Crisis

- What is meant by …
  - Prognosis
  - Goals of care
  - Anticipatory care planning
- Information
  - about DNACPR
  - Power of Attorney
  - Informed consent

Coping with Crisis

Guidance about …

- How to cope with medical uncertainty
- Realistic expectations
- The importance of truthfulness
- Scenario planning: best / worst case scenarios
- Making your wishes known / shared decision-making
- Letting go or clinging on?
- Withdrawing treatment
- The tensions of decision-making

Coping with Crisis: quotes

If death is inevitable, making the transition from "clinging on" to "letting go" is usually helpful. … Coming to terms with dying often lessens the physical struggle and paves the way for a more peaceful and dignified death.

Fussy and unnecessary medical treatment can get in the ay of personal reconciliation – to the past, to the future, and perhaps concerning some relationships.

For family members, "letting go" can also mark the beginning of the bereavement process. Grieving can be made easier by getting beyond the agonies of "clinging on" and being reconciled to the nearness of loss.

Coping with Crisis: patient feedback, n = 22

Question (numbers = % of respodents)	Very much	Quite a lot	Not really	Not at all
I found Coping with Crisis interesting	**50**	**45**	**5**	**0**
The booklet provided me with information that I did not know about previously.	**38**	**52**	**8**	**0**
It was helpful in guiding my thinking and the decisions that I might have to make.	**36**	**41**	**23**	**0**
It used language that I could understand clearly.	**67**	**33**	**0**	**0**

Coping with Crisis: patient feedback, n = 22

Question	Very much	Quite a lot	Not really	Not at all
I would now feel more prepared to discuss my treatment with a doctor and express my own opinions.	**57**	**33**	**19**	**0**
It was the sort of booklet that I would be happy to share with my family members.	**68**	**14**	**18**	**0**
I would recommend this booklet to other friends / neighbours.	**64**	**23**	**9**	**4**

COPING WITH CRISIS

THANK YOU

Any questions?