



Harm Reduction using a Treatment Escalation / Limitation Plan *The Hospital ACP in NHS Lanarkshire*

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Case study

- 64 year-old lady admitted with metastatic pancreatic cancer causing ascites. It is drained 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.

Case study

- The Team decided that acute deterioration was probably due to sepsis, secondary to infected drain site.
- The Sepsis-6 protocol was initiated, including i.v. antibiotics and the insertion of a urinary catheter.
- The patient died 48 hours later.



What are the challenges that the HECT nurse faces?

What can / should be done?

What harms may have occurred?

Case study

- 64 year-old patient with pancreatic cancer underwent percutaneous drainage of a pancreatic abscess.
- Day 3: Swelling of the abdomen was 5. Hemodynamic instability.
- The Team was not aware of the patient's condition probably due to the patient's location at the site.
- The Sepsis team was not alerted and no antibiotics were given.
- The patient was not monitored closely.

The case illustrates:

- **The pre-eminence of the curative medical model**
- **Prognostic uncertainty**
- **Lack of anticipatory care and crisis management planning**
- **Discontinuity of care**

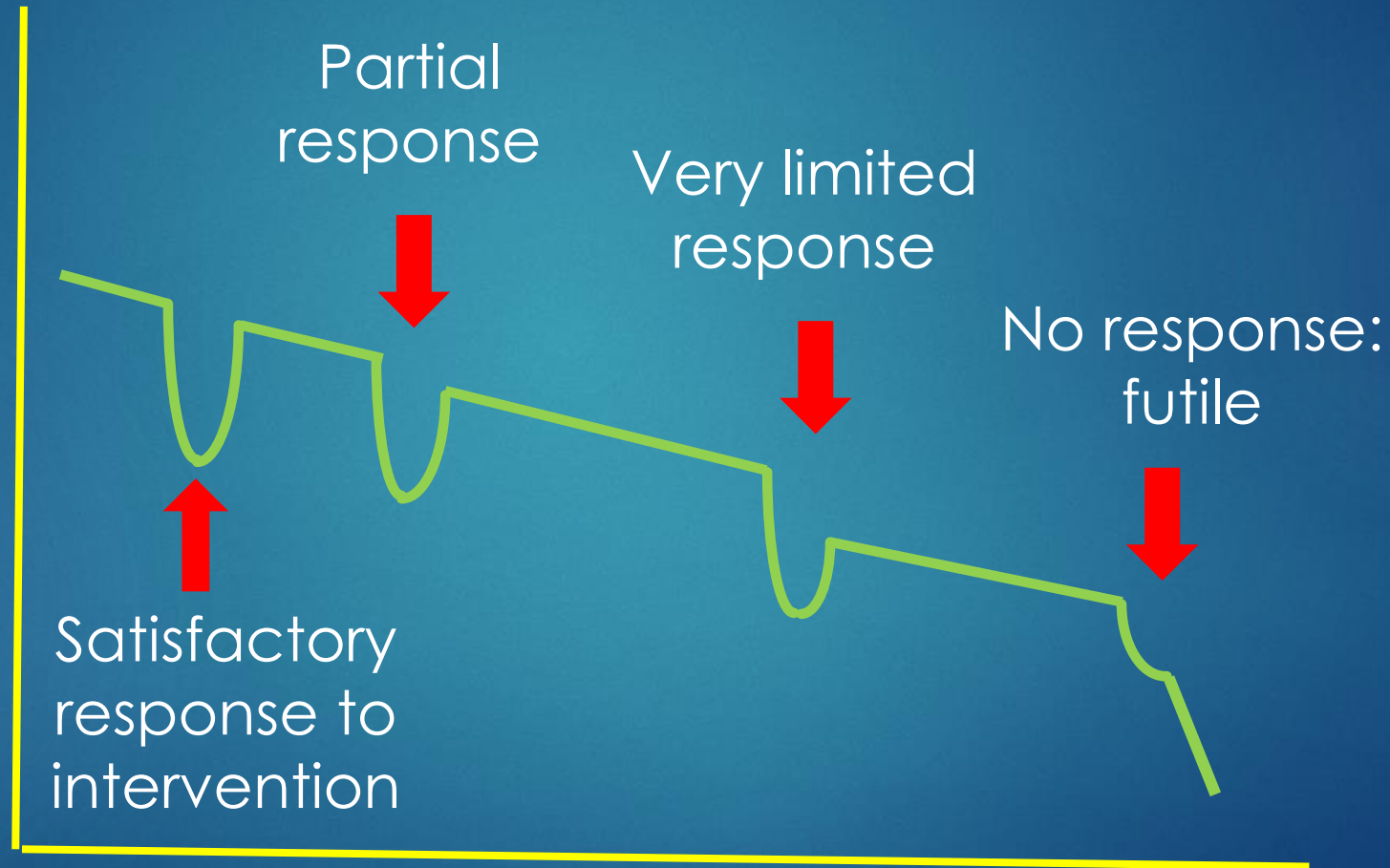
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Moral distress

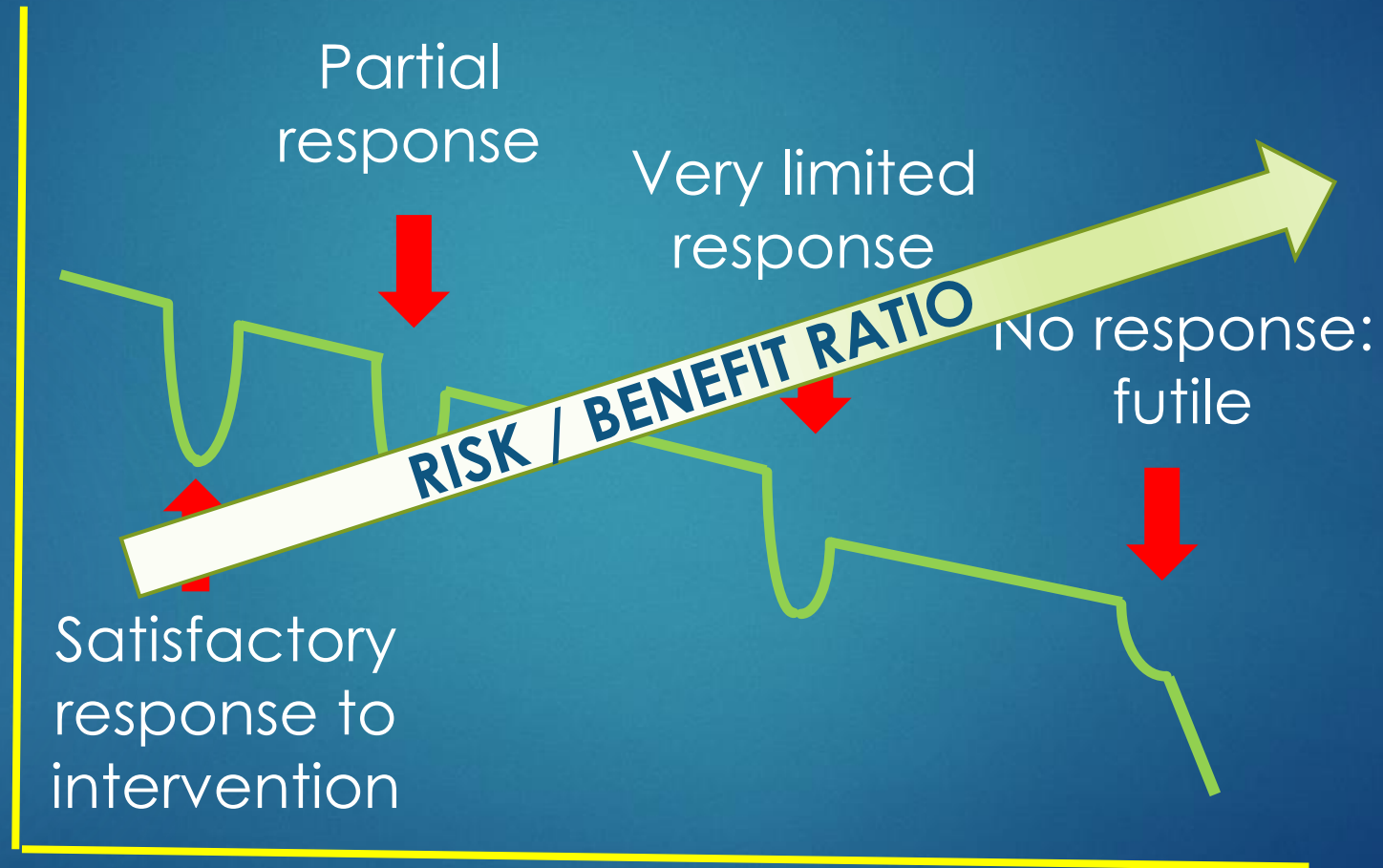
“I knew the patient was dying, but I could not find anything in the notes that said that escalation of treatment should be limited. I felt very unhappy about it, but the situation was urgent. I did what I had to do.”

HECT nurse, WGH

Changes in risk-benefit ratio with advancing irreversible disease



Changes in risk-benefit ratio with advancing irreversible disease



Non-beneficial (futile) treatments at the end-of-life: a systematic review

- ▶ 38 studies comprising 1.2m. subjects
- ▶ On average 33-38% of patients received non-beneficial treatments in the last year of life
 - ▶ Renal dialysis
 - ▶ Radiotherapy
 - ▶ Chemotherapy (last 6 weeks of life)
 - ▶ Blood transfusions
 - ▶ Cardiorespiratory support in ICU
 - ▶ I.V. antibiotics

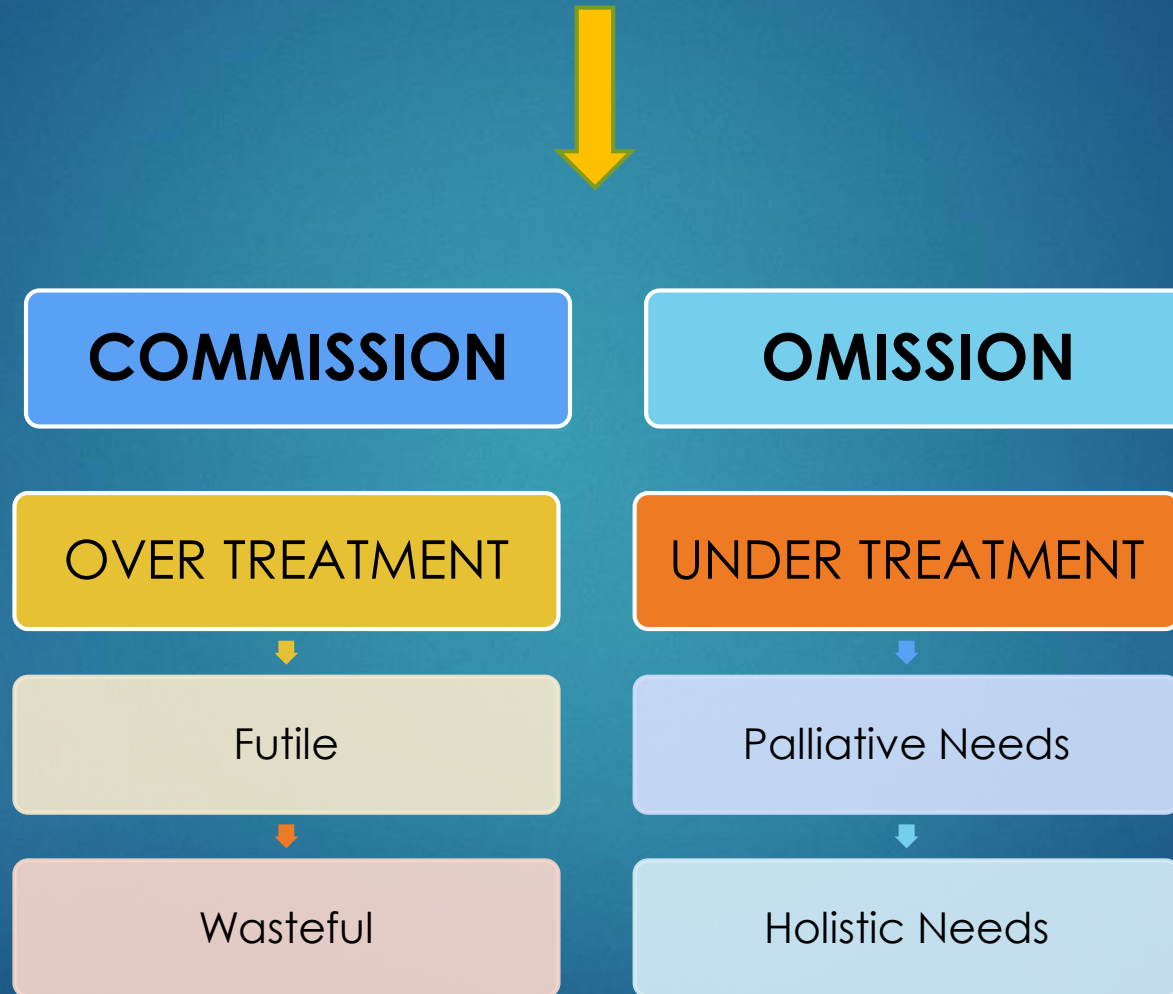


Why non-beneficial (futile) treatments?

Why non-beneficial (futile) treatments?

- Survival instincts: personal ... or projected
- The death taboo
- Scientific materialism
- The pre-eminence of the curative “fix it” medical model: trained to treat
- The public appetite for “last chance medicines”
- The blame culture: death is someone’s fault
- Discontinuity of care: unfamiliarity, protocol driven interventions

Medical harms: a broader definition



Discontinuity of care in crisis management

- What is urgent is dealt with in isolation: the context of an acute event is often neglected
- Limited treatment aims: to achieve recovery from the acute event
- Default interventions are protocol-driven and may be indiscriminate
- Risk versus benefit ratio is skewed: the risks of NOT intervening motivate inappropriate decision making by out-of-hours staff
- Contributes to avoidable HARMS

Harms associated with DNACPR

- Misunderstandings:
 - that success rate for CPR is high (in fact it's only 18% overall)
 - DNACPR perceived to be a surrogate for withholding other treatments
- Discussions about DNACPR in isolation or out of context are difficult and distressing to patients, relatives and clinicians.
- CPR is about one intervention only; many others are much more relevant.

Treatment Escalation / Limitation Plan (Hospital ACP)

Is a **TOOL** 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**.

- To be guided by discussions with patient and family or POA.
- Does not provide for the withdrawal of any treatment.
- To be reviewed and modified as the clinical situation evolves.

Developing and implementing the TELP

	Responses in NHS Lanarkshire
Ownership of the TELP <i>pro forma</i>	Input from, and adaptation for, each of the major clinical areas (n=12) e.g. A and E, Psychogeriatrics, Community Hospitals Test of change methodology prior to introduction of 2016 version. Further feedback for 2018 version
Safeguarding	Each <i>pro forma</i> sets out reminders of medico-legal, ethical and patient-centred aspects of TELP delivery

Responses in NHS Lanarkshire

Culture change

Individual coaching for medical / surgical consultants (n=169) and SCNs (n=45) on the topics of treatment overuse, cognitive biases favouring non-beneficial interventions, prognostic conversations

Education

Learn Pro module
Customised TELP / HACCP training video
Routine training to HECT teams, FY1s (at induction)

Other

Incorporation into Structured Response to Deteriorating Patient *pro forma*
Incorporation into Morbidity and Mortality review documentation

TELP / HACP - video

<https://vimeo.com/204400091/>

Password NHS2017

Consultant coaching NHS Lanarkshire 2016-7 (n=169)

Structured coaching exercise comprising

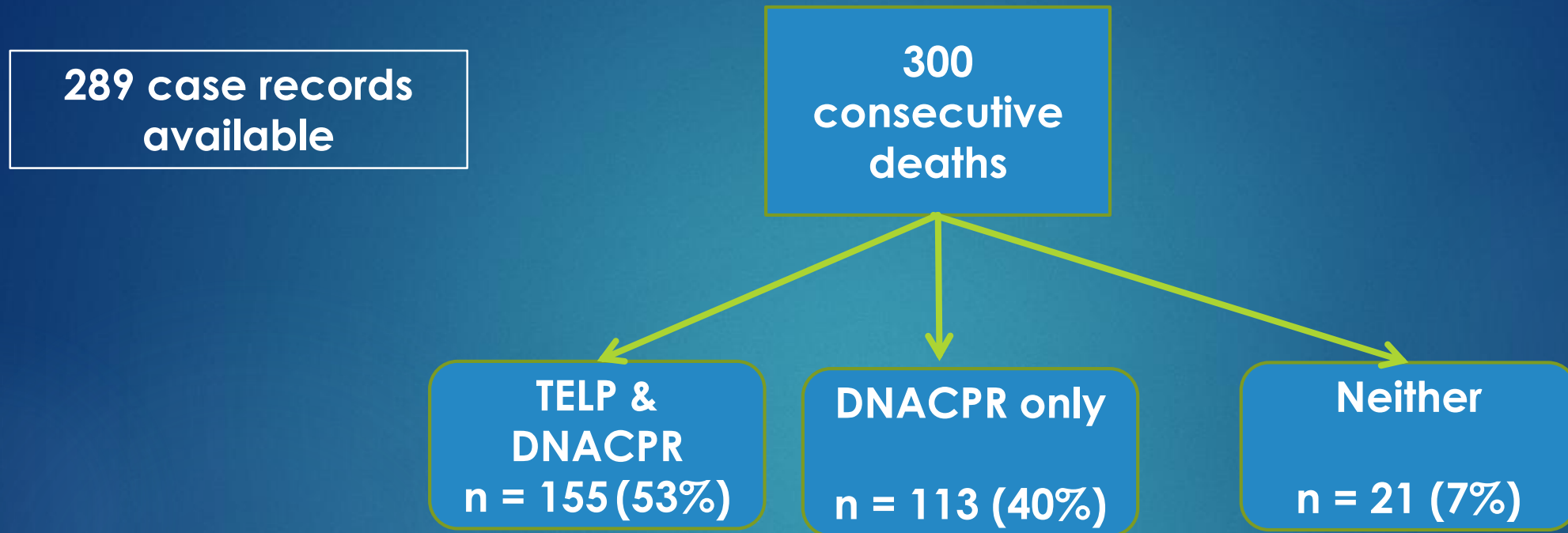
- Case study: extract from Ombudsman Report – illustrating discontinuity of care, poor communication, conflicted goals of care at EOL
- Abstract of academic paper on non-beneficial treatments
- Futility: reflection on personal cognitive biases
- Prognostic conversations – “what does the future hold?”
- Introduction to HACCP

Futility in medical decision-making

Cognitive bias

- aversion to death and dying, “doom and gloom”
- intolerance of uncertainty, ambiguity
- personality traits ... “I like to be a positive person”
- personal experiences ... “last chance medicine”
- risk aversion (memorable failures, audits, criticisms and conflict)
- information bias
- time pressure
- moral self-justification for doing everything ... “last chance medicine”

The TELP study: methods



- Determination of “expected death” made for each case using Gold Standards Framework Prognostic Indicator Guidance (n=247, 85.5%)
- Identification of Non-Beneficial Treatments and Clinical Harms using Structured Judgement Review Method

The Structured Judgement Review Method (Royal College of Physicians, London)

Category	Description of 'problem'
1	Assessment, investigation or diagnosis
2	Medication / IV fluids / electrolytes / oxygen
3	Treatment and management plan
4	Palliative or end-of-life care
5	Operation/invasive procedure
6	Clinical monitoring
7	Resuscitation following a cardiac or respiratory arrest
8	Any other type not fitting into the categories above

The Structured Judgement Review Method (example)

1A. Problem in assessment, investigation or diagnosis

(e.g. arterial blood gas sampling or CT scans that did not change management):

Yes (1)

No (2)

1A

1B. Was the problem associated with non-beneficial intervention / treatment?

Yes (1)

No (2)

Possibly (3)

1B

1C. Did the problem lead to harm?

Yes (1)

No (2)

Possibly (3)

1C

Comments

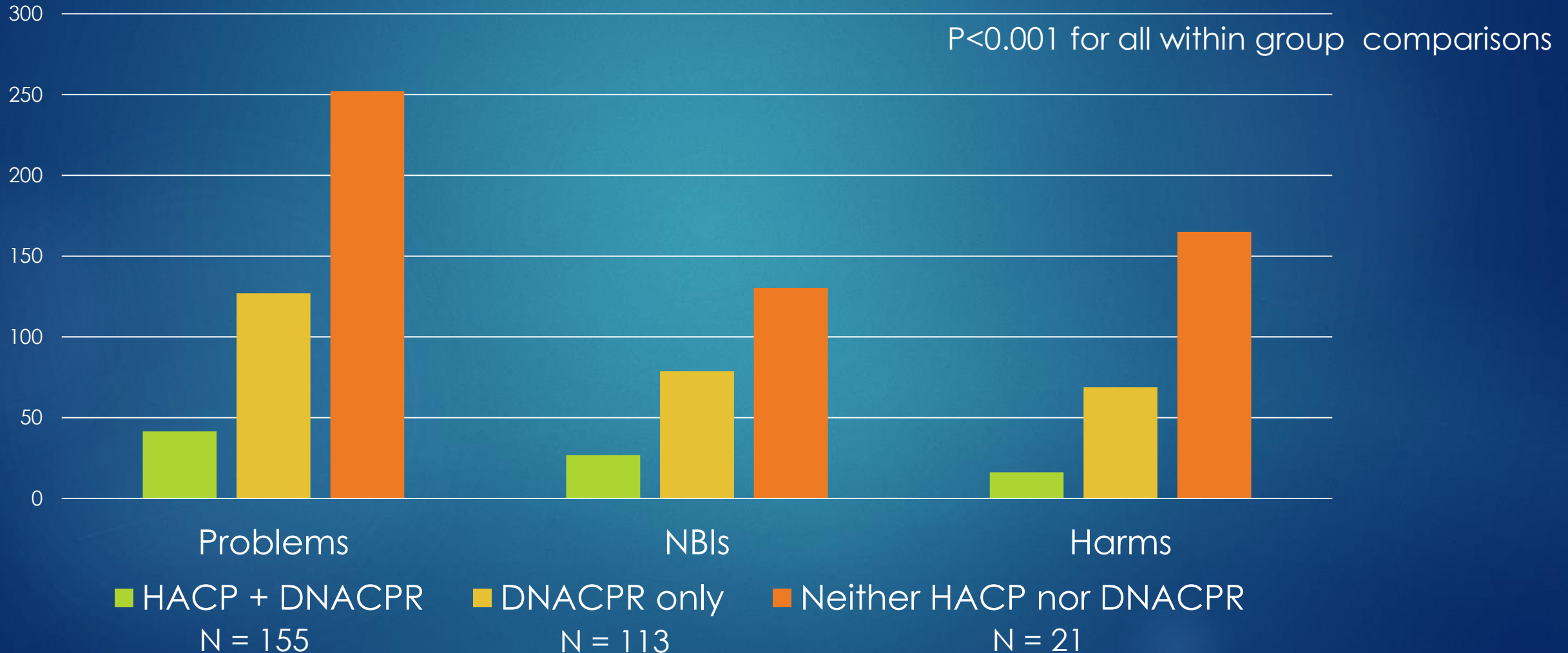
Incident Rate Ratios: all patients (n=289)

	HACP + DNACPR N=155	DNACPR only N=113	p	Neither HACP 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

Clinical 'problems', NBIs and harms

Lightbody et al. *BMJ Open*, 2018

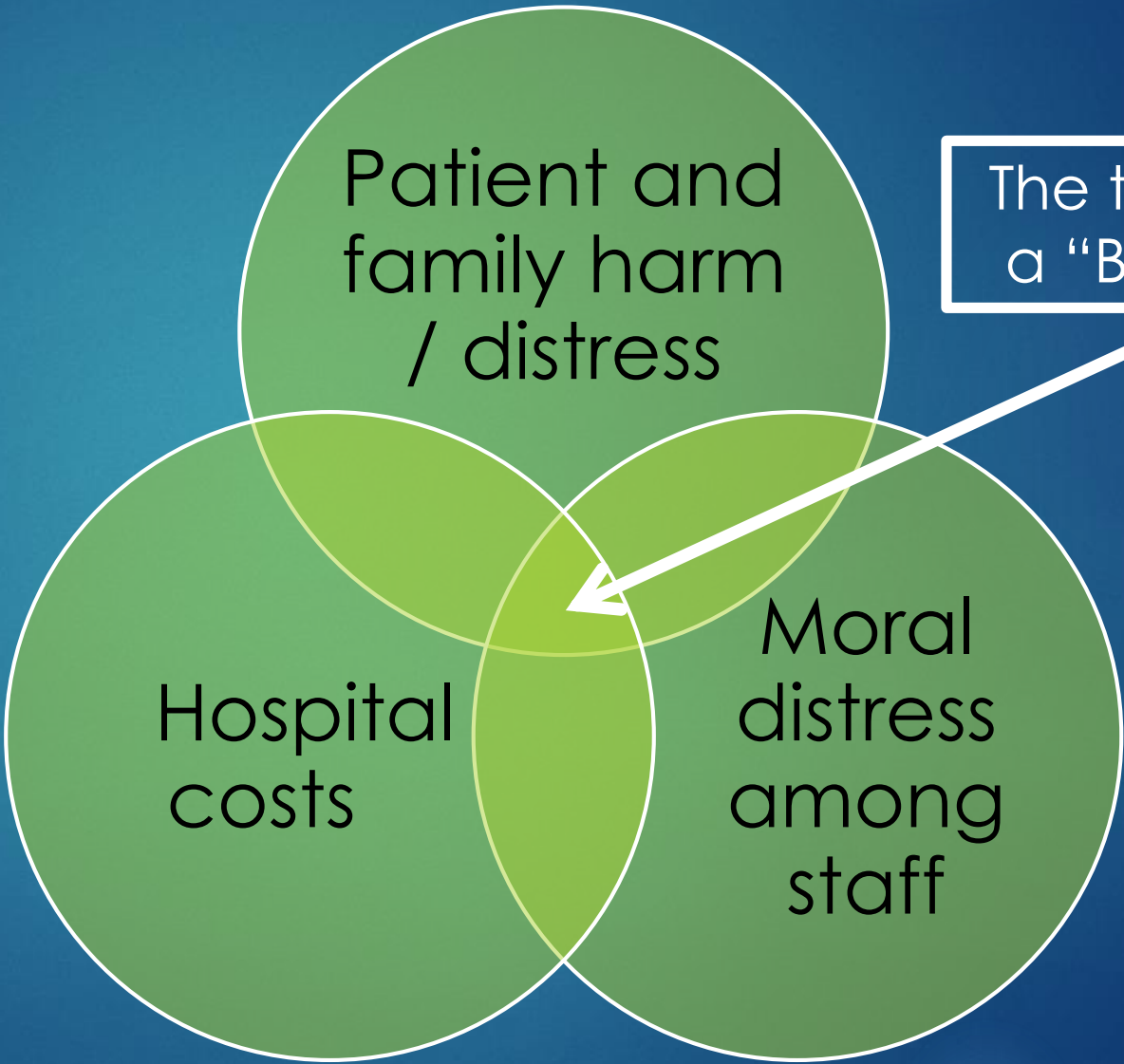
Rate per 1000 patient days



Description of clinical 'problem' as per Structured Judgment Review		All patients N=289	TELP and DNACPR N=155	DNACPR only N=113	Neither TELP nor DNACPR N=21
1	Assessment, investigation or diagnosis	12.5	6.7	25.2	34.8
2	Medication / IV fluids / electrolytes / oxygen	19.5	12.6	33.9	58.0
3	Treatment and management plan	21.3	11.5	40.0	92.8
4	Palliative or end-of-life care	15.8	7.8	33.9	34.8
5	Operation/invasive procedure	2.8	1.1	4.4	34.8
6	Clinical monitoring	4.5	2.2	8.7	23.2
7	Resuscitation following a cardiac or respiratory arrest	2.8	0.4	4.3	58.0
8	Any other type not fitting the categories above	5.0	3.3	8.7	11.6

Rate of events per 1000 patient days

The real cost of NBIs and harms



The total cost of a "Bad Death"

Thank you