Blackpool Teaching Hospitals
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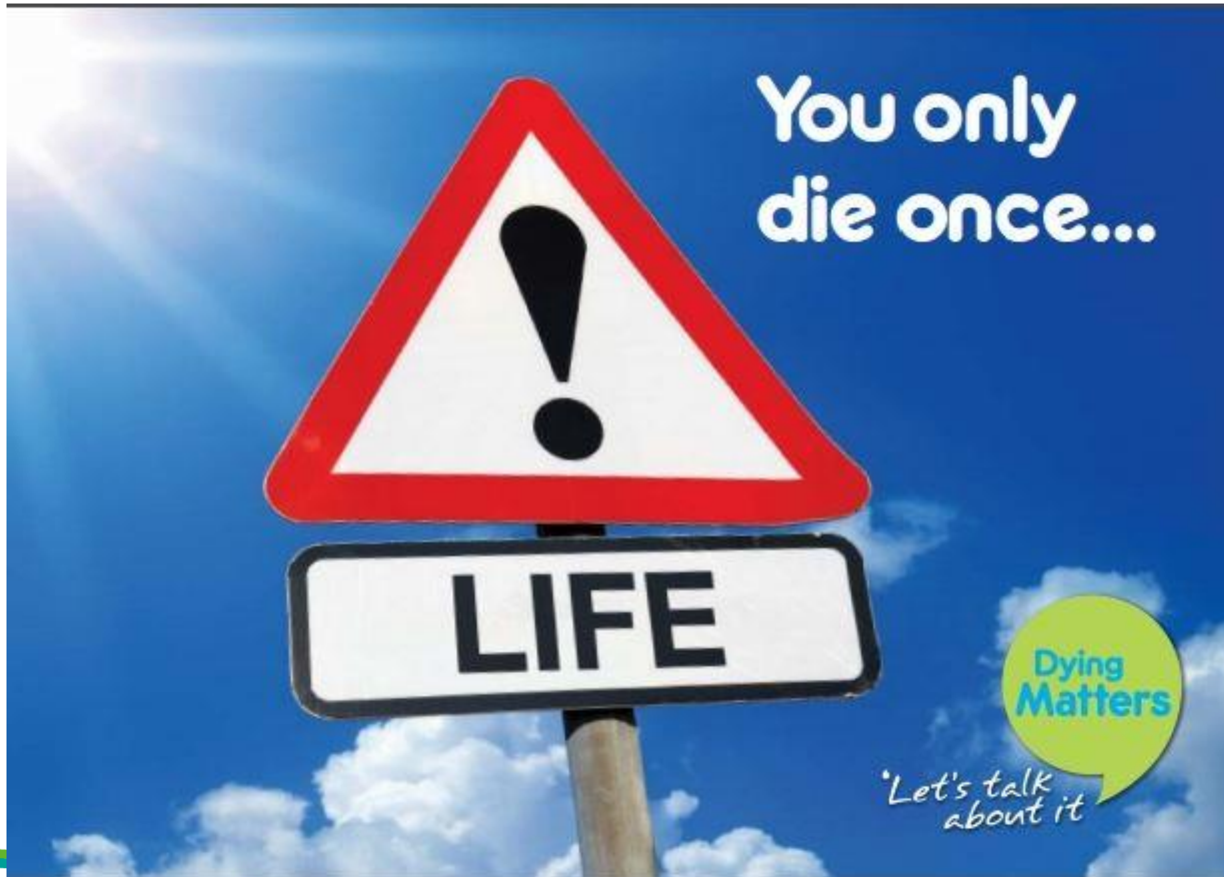
An End of Life Care Update

HPCT & SWAN team

Jan 2023

Caring • Safe • Respectful

Why talk about it?



- >50% of all deaths in England occur in hospital
- The majority of these deaths are expected
- Approx 1/3 inpatients are in their last year of life
- Typically 80 % of care home residents

- People in their last year of life
  - have on average 2-3 hospital admissions
  - Can spend up to 1 month in hospital

- “It is morally wrong to waste a dying person’s time”

Managing clinical uncertainty

Clinicians poor at estimating prognosis, information and decision-making preferences of patients

Clinical uncertainty towards the end of life is distressing for patients and families

Inadequate explanation of clinical uncertainty can lead to poor satisfaction, mistrust and loss of confidence

Predicting EOL

- Context
- Current problems
- Prognostic indicators – general & disease specific
- Performance status /ADL's
- Any reversibility
- Rate of deterioration
- Clinical experience
- The surprise question

General indicators of poor prognosis

Co-morbidity

Advancing disease burden

Decreasing reversibility/response to treatment

Progressive weight loss >10% in past 6 months

Serum Albumin <25g/l

Declining functional performance status

Increasing dependence in ADL's

Sentinel event e.g., serious fall, move to NH

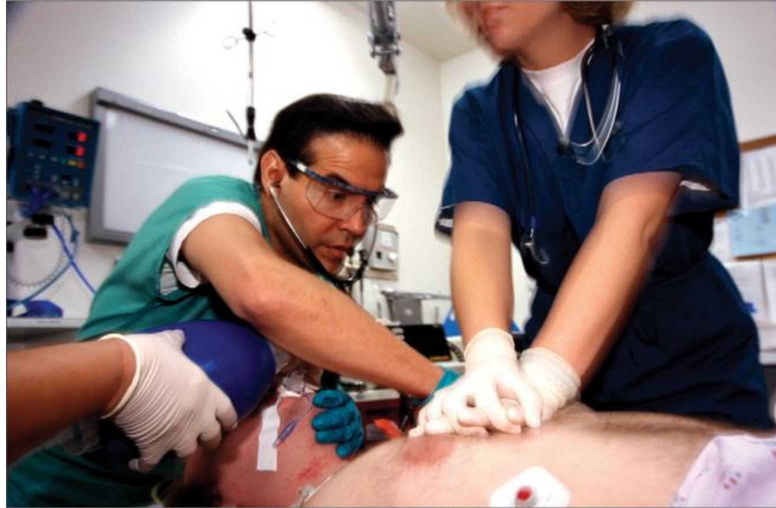
Unplanned/crisis admissions

Eligibility for DS1500

The surprise question

"Would you be surprised if this patient were to die in the next few months/weeks/days?"

What looks like a better death?



WARNING!

Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored

NOTICE

'Do not resuscitate' does not mean 'do not treat'

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Compassion in dying

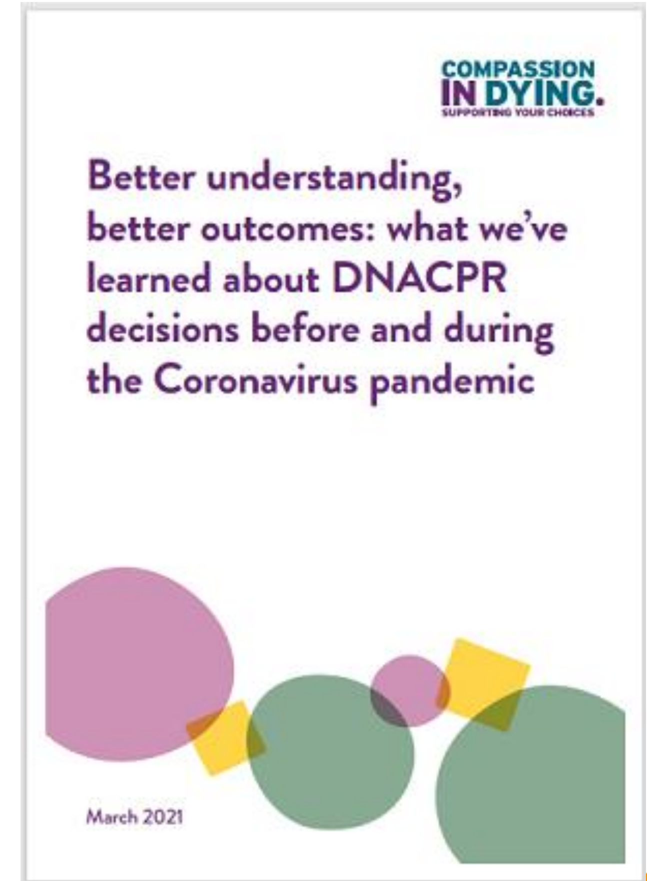
Calls to helpline 2017-20

3 common themes:

1. Protection *from* unwanted CPR

2. Unlawful practice & poor decisions

3. Poor communication



Does doctor know best……

Wishes ignored/not heard
‘blanket approach’
Confusion amongst hcp’s
Insensitive communication of decisions
Intimidating conversations
48% wrongly believed could legally make decisions on behalf of someone without capacity
Decisions communicated sensitively improve EOL experience

Or does patient?

- Only 37% aware a decision made if a clinician thinks CPR will do more harm than good
- Only 33% aware decision needs to be communicated to the family
- Only 35% aware that will still receive other treatments
- 72% would either welcome a conversation or would be willing to talk about it if raised
- Only 6% would not want to talk about it
- People serious illness have other priorities besides prolonging life

Honesty with uncertainty compassion

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- Sick enough to die
- Some treatments will work but this won't
- Allowing a natural death
- Heart the last thing to stop not first
- May restart heart but won't restore to previous state
- CPR won't give you what you want it to

Resources

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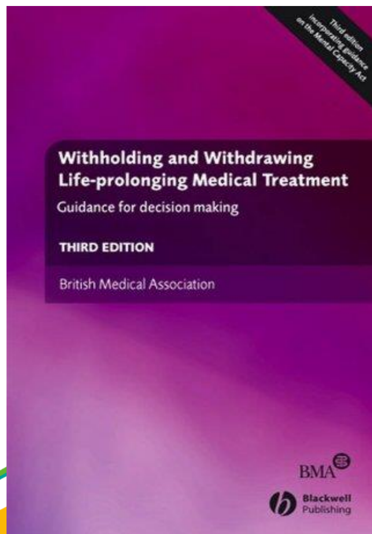
COMES INTO EFFECT 9 NOVEMBER 2020

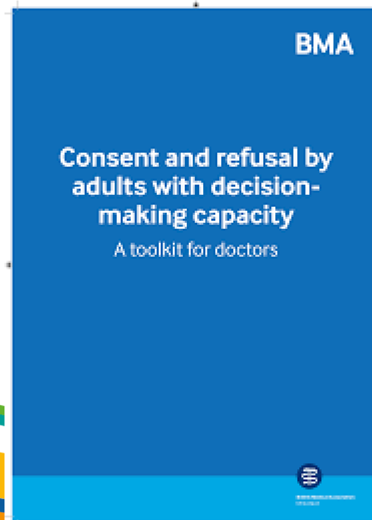
Guidance on professional standards and ethics for doctors

Decision making and consent

General Medical Council

Working with doctors Working for patients





Decisions relating to cardiopulmonary resuscitation

Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing

(previously known as the 'Joint Statement')

3rd edition (1st revision) 2016

So how are we doing?

- NACEL
  National Audit of Care at End of Life

- Nursing Care Plan Audit

NACEL 2022: Round 4

1. Organisational level audit

2. Case note review

20 Consecutive deaths between 12th-25th April & 1st -14th May (N=40)

Exclusions: ED/within 4 hrs admission/sudden catastrophic event with full escalation

2 categories:

1. It was recognised that the patient may die (97.5% vs 87.1%)
2. The patient was not expected to die

3. Quality survey (relatives & carers)

4. Staff reported measure (new)

Key themes

1. Recognising the possibility of imminent death
2. Communication with the dying person
3. Communication with families and others
4. Needs of families and others
5. Individualised plan of care
6. Families' and others' experience of care
7. Workforce/specialist palliative care
8. Staff reported measure

Case note review

- 92% admitted via ED
- 44% known to HPCT
- 94% recognised as expected to die
- 62% died 48+ hours from recognition
- YET only 48% had IPOC
- Possibility of death d/w 89% nominated persons but only 28% patients

  (68% patients unable to take part)

Individualised Plan Of Care

10.00	Dr A Smith, S/N Nancy
	Recognised that Mr Wood is dying
	DNACPR in place
	Supportive Care Plan for the Dying Person
	James was happy for me to discuss his condition & care with him, his
	wife (Jane) & daughter (Debra).
	Explained to James, Jane and Debra that he is in the last few days of his
	life. The main concern was to keep James as comfortable + pain-free as
	Possible. James requested his favourite music to be brought in.
	PPC and PPD is in hospital, family would like their chaplain to visit & wish
	to be with James when he dies.
	Explained open visiting & nursing staff to update daily.
	Medical r/v daily during ward round.
	Plan
	• Discontinue all interventions ie blood tests
	• Discontinue observations
	• Discontinue current medication
	• Prescribe anticipatory medications Core End of Life Care
	Drugs/consider syringe pump
	• Discontinue O_2 therapy unless symptomatic
	• Offer oral diet & fluids as long as wanted/tolerated
	• Review need for artificial nutrition or hydration
	• Nursing team provide 4'hrly assessments
	• Daily medical r/v
	• Full MDT assessment on the 17.2.14 (3 days)
	• Consider advice from Palliative Care Team if develops complex symptom
	issues
	A Smith Consultant

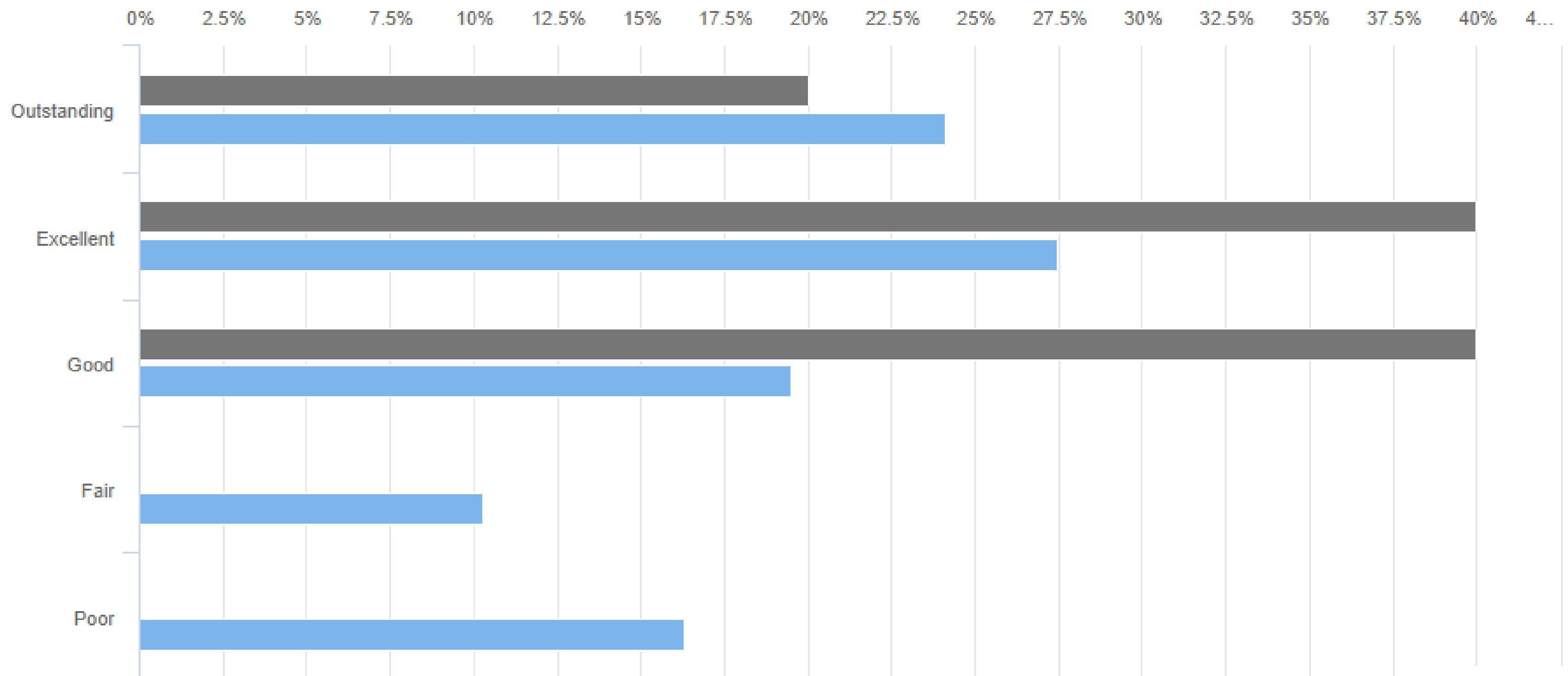
IPOC

- Only 48% patients had plan of care
- d/w 83% of nominated persons but only 12.5% patients (75% unable to take part)
- 42% documented to stop obs (79% nationally)
- 23% documented stopping blood tests (70%)
- DNACPR d/w 46% patients (40% nationally)
- 30% had DNACPR already in place

Quality survey

- 80% felt communication was timely enough to enable them to be with the dying person
- **All** respondents either strongly agreed or agreed that they were communication with in a sensitive manner
- 80% strongly agreed that they felt supported by staff after death (33.3% nationally)
- Majority agreed that the location and place of death was appropriate

Overall impression of care for the dying person



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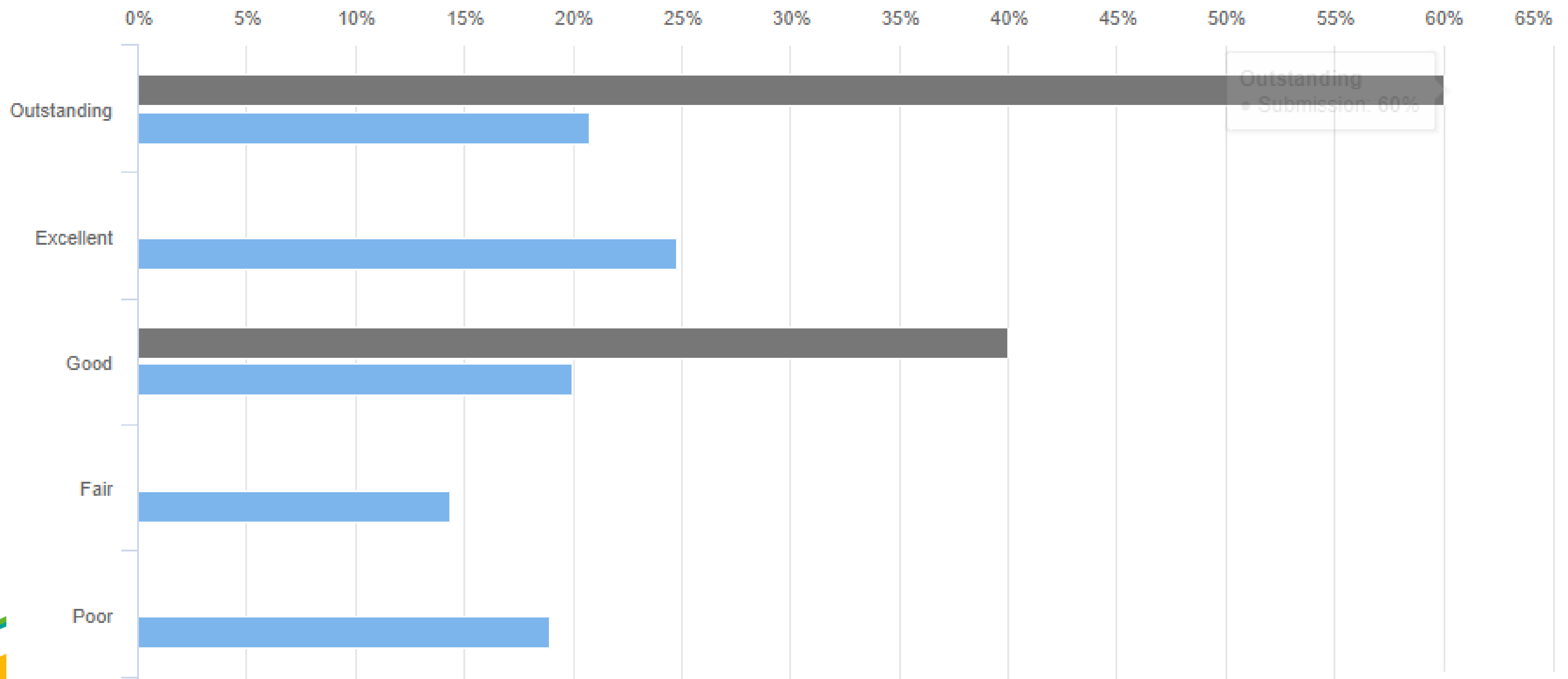
Overall impression of care for family and others



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In the circumstances, the hospital was the right place for the person to die

0% 5% 10% 15% 20% 25% 30% 35% 40% 45%

Strongly agree

Agree

Neither agree nor disagree

Disagree

Strongly disagree

Staff reported measure

- Majority of staff felt confident in recognising and communicating sensitively imminent death
- ?? Why then only 48% had IPOC
- However majority of respondents either nursing staff or HCA's
- Training

Nursing Care Plans

Nursing Care Plan to support the individualised plan of care for the dying person

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FILE IN SECTION 3

Write patient details or affix identification label
Hospital Number:
Name:
Address:

Postcode:
Date of Birth:
NHS Number:

Care Plan: **Nutrition and Hydration**

DATE	TIME (24 HOUR CLOCK)	NURSING CARE PLANS	REVIEW DATE	NURSES SIGNATURE AND DESIGNATION	PRINT NAME
		The patient is supported to eat and drink for as long as they want or are able to. Offer regular mouth care to promote patient comfort (this could be offering mouth and lip care, sips of fluid/ice). Relative or carer could be involved in care giving as appropriate. Patient is assessed as to their dietary needs and any special diet discussed if appropriate. Consider artificial nutrition and hydration if in the patient's best interest. Food chart to be completed if appropriate. Consider Feeding at Risk and complete relevant documentation. …………………………………………… ……………………………………………			

1. Pain
2. Nausea & Vomiting
3. Breathlessness
4. Respiratory tract secretions
5. Nutrition & Hydration
6. Elimination
7. Skin integrity
8. Agitation & restlessness
9. Communication
10. Psychological, social and spiritual support

NCP audit Results

- Majority of wards represented (AMU,ASRU & 10)
- 52% of the case notes from the sample had NCP's (26/50)
- a slight reduction from 58% in the 2021 audit.
- 16 of the patients were known to the HPCT (61%)
- 73% of patients had an IPOC. (81% of those known to HPCT)
- 88% of patients had a pink sheet in the case notes

- Personalisation of care evident for only 46% patients (80% in 2021 audit).
- Documented evidence of 4 hourly review for only 77% (95% in 2021 audit).
- NCP had replaced documentation in the patients case notes in 11% (85% in 2021).
- There was evidence of communication booklets having been given in only 11% of the sample (18% of those known to HPCT)

What can you do ?
How can we support you ?

- Early discussions and decision making involving patient and loved ones wishes and any advance care plans
- Ensure clear plans for treatment, treatment escalation and individualised plan of care is in place
- Ensure care is planned and documented on care plans in accordance with patient and loved ones and in line with Swan Model
- Early refer to palliative care and or swan if needed
- Ensure wishes discussed including spiritual care, preferred place of care
- Discharge plans are well documented and communicated with district nurses, community teams
- Bereavement Support is offered and referral to swan is made
- Access education and training

Swan Model End of Life & Bereavement Care

The Swan model of care is about providing excellent, individualised end of life and bereavement care for every patient and every family, every time. What matters most to the person and their loved ones is at the heart of all we do. It’s how we care.

Identify and instigate swan model when person in in their last days

Advance care plans are understood and effort made to provide care in accordance with wishes

Swan Model of Care

- **S**igns – Is the patient felt to be entering the last phase of their life? Start the EOL plan of Care and provide individualised. Use swan signage where appropriate.
- **W**ords- Sensitively communicate with the patient and those important to them, and those caring for them.
- **A**ctions-Step outside of the box to facilitate what’s important to the patient and those around them.
- **N**eeds?- Are the needs of the patient and those around them being reviewed regularly and documented?

Care as we would our own provide comfort, memory making and offer condolences and support (NICE 2021)

Handprints	Hair locks	Matching holding hearts	Teddies if more appropriate
Condolence card	Candle	Forget me not seeds	Anything else that's deemed appropriate

EDUCATION

&

TRAINING

END OF PRESENTATION
NO QUESTIONS THANK YOU!