Quality End of Life Care in the Critical Care Setting

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Introduction

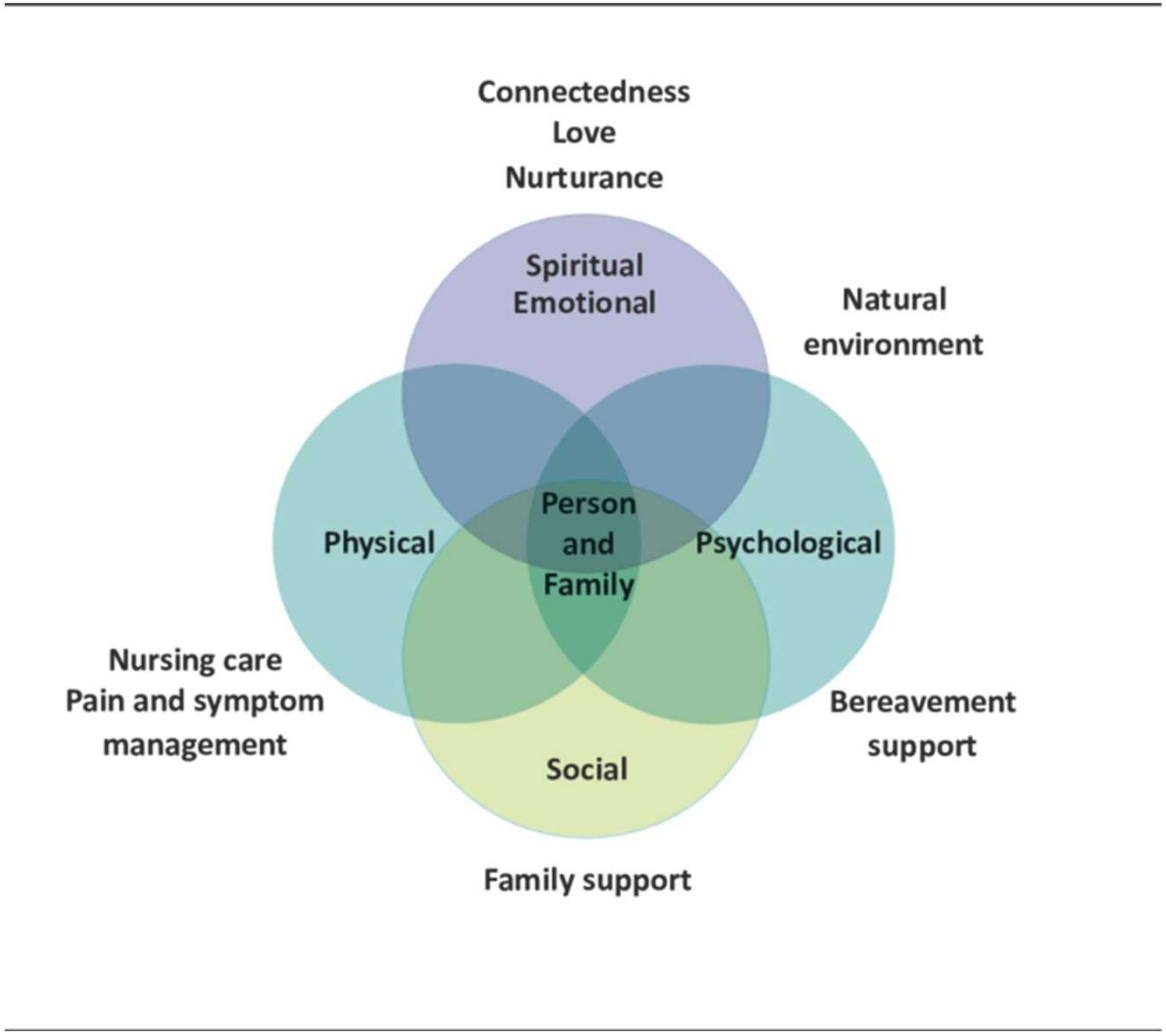
- Background into End Of Life Care in RVH RICU
- Baseline staff questionnaire
- Multidisciplinary Focus Group
- Staff Survey
- Areas identified for improvement
- Implementation of changes
- Analysis of data

Goal

Aim to improve:

- End of Life Care processes
- Staff support
- MDT Communication & knowledge

Our intent was to learn about palliative care processes to inform practical critical care guidelines to enable person-centred holistic End of Life Care.



Yalden et al., 2013

Background

Living Matters, Dying Matters (2010); GMC guidance (2010); NICE Quality Standard (2011)

Limited guidance – nothing directly relating to challenges specific to complexity of critical care environment

At a local level, RICU was Consultant led in End of Life Care

Different Consultants on different days, lack of continuity, inconsistency

No Palliative Care input

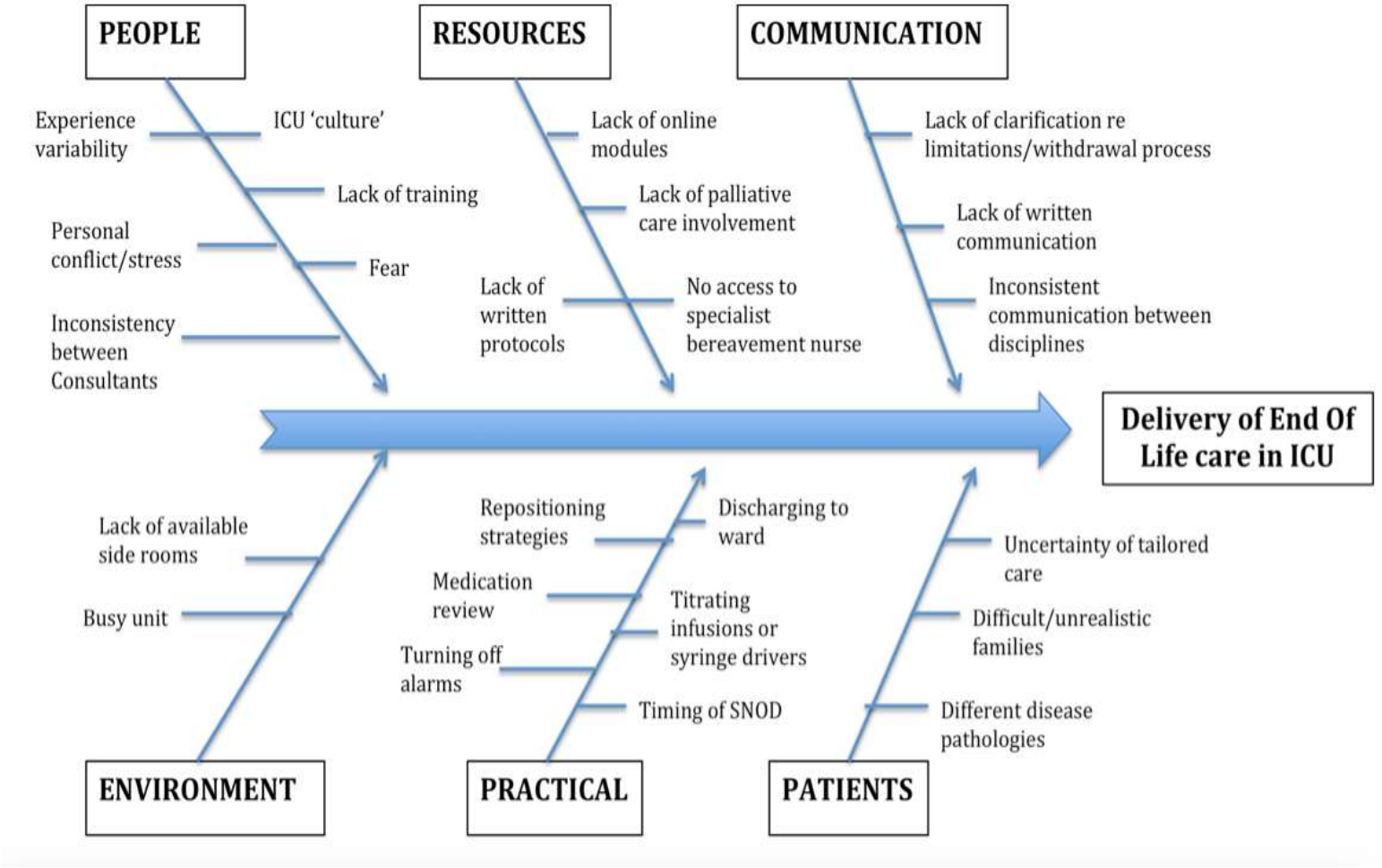
Was not embedded into the Unit

Occasions of distress and frustration within the multidisciplinary team

Poor communication, lack of planning, knowledge and understanding

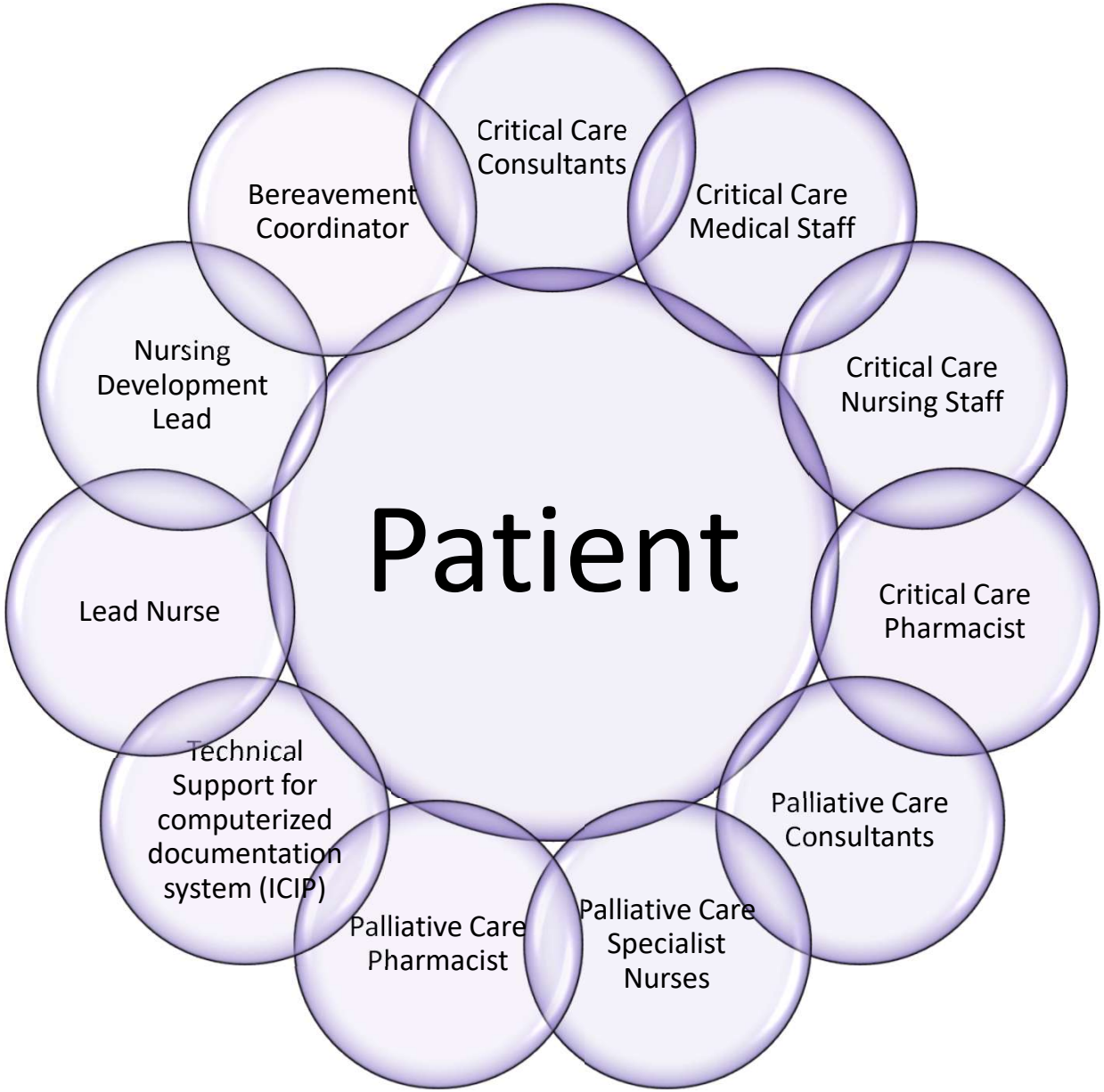
METHOD

1. Fishbone Diagram: factors impacting delivery of End Of Life Care



METHOD

2. Multi-disciplinary Focus Group

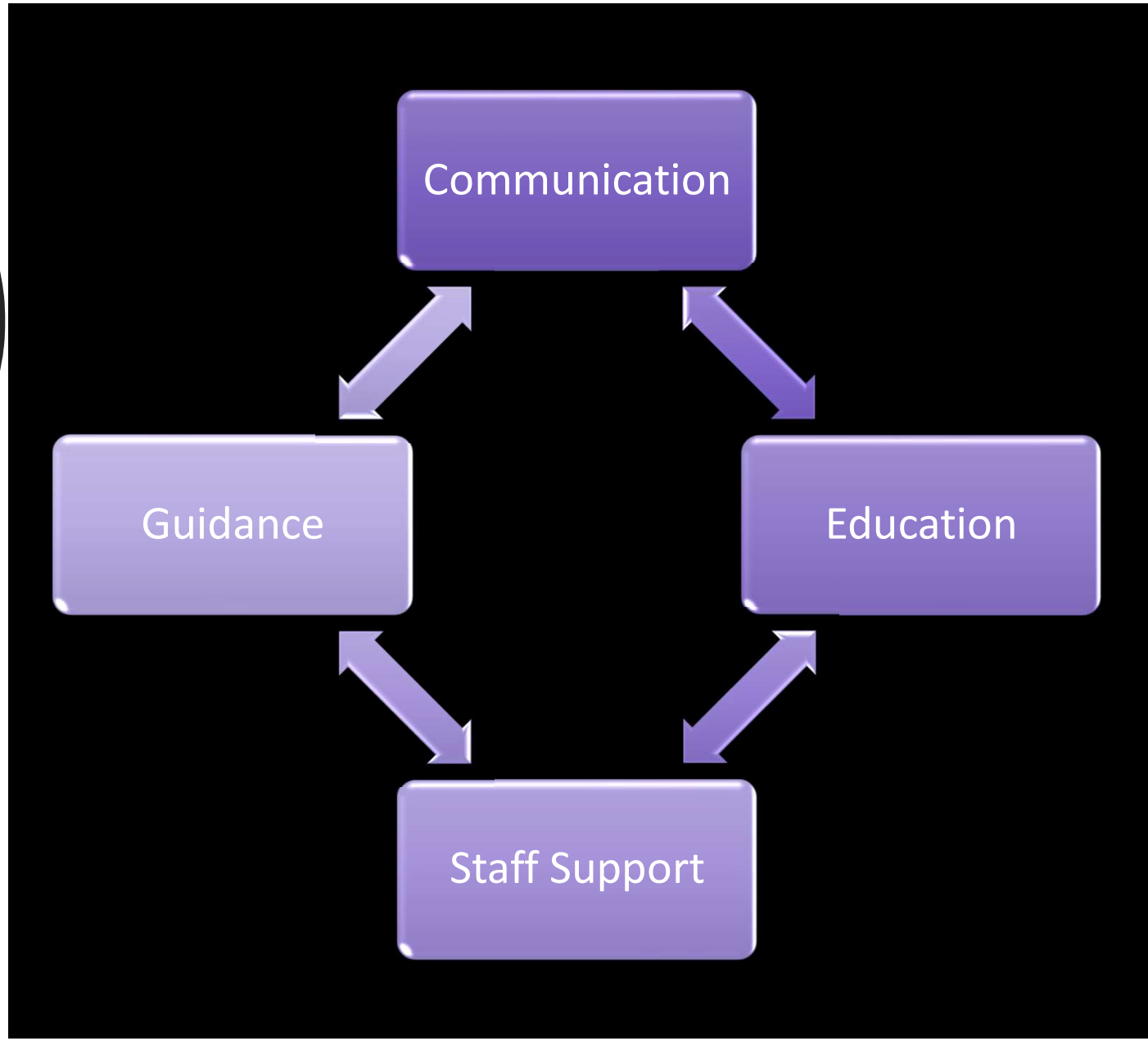


METHOD

2. Multi-disciplinary Focus Group

- Met on multiple occasions to discuss elements raised in the fishbone diagram

- **Four core themes** emerged on which to focus our improvement work…



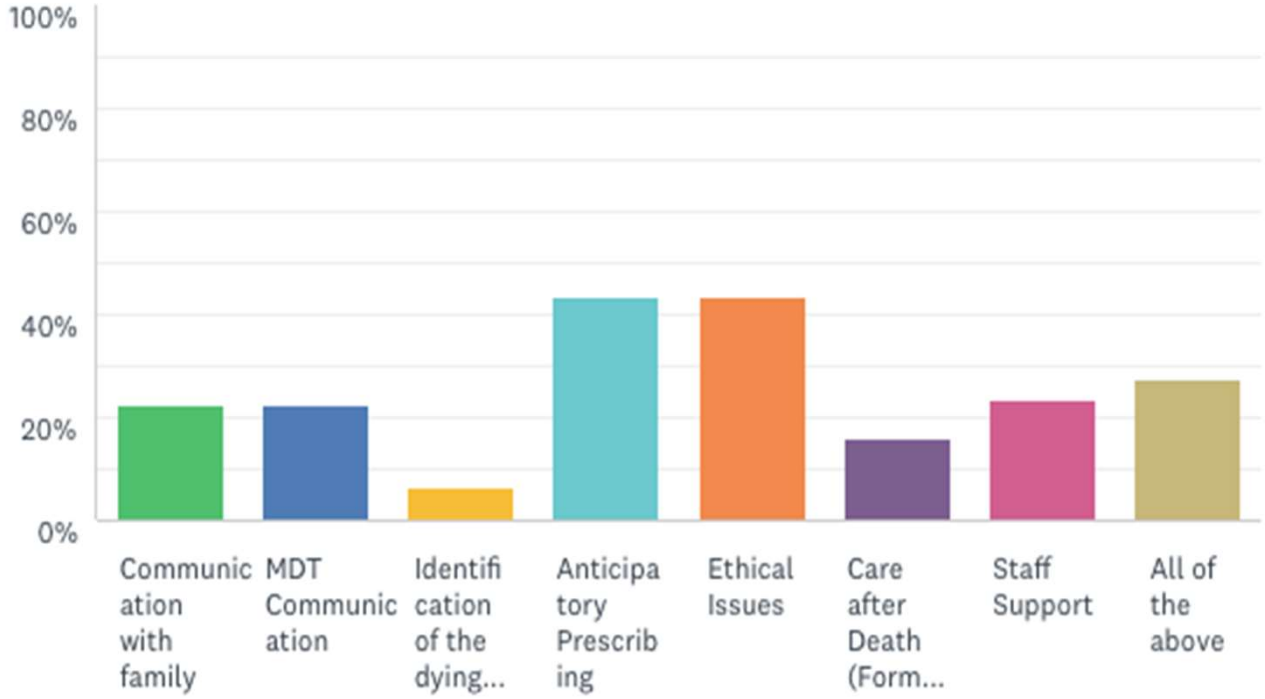
METHOD

3. End of Life, Critical Care; Staff Survey Monkey (2018)

N= 76 Reponses (out of 180 staff) grouped and themed within the following categories derived from the fishbone diagram.

Survey results highlighted a desire for further learning.

Categorised learning requests in End of Life Care



METHOD

3. End of Life, Critical Care; Staff Survey Monkey (2018)

Do you have any areas of concern regarding End Of Life Care in critical care?

Yes every consultant decides on different methods of withdrawal

Management of symptoms whilst dying

The plan of care It was not clear when to start withdrawal and how and at what rate to start medication to provide comfort

A page with options and guidelines would be helpful

Withdrawing care, Communication with family. Last offices

When a patient is aware that they will not survive and the decision is to withdraw treatment

Traumatic death and family disagreement for withdrawal of care

Sometimes there isn't enough time to debrief, sometimes it would be helpful to have someone to chat it over with

Would prefer written plan by medical staff in relation to withdrawal of treatment

Guidance

Education

Critical care specific End of Life/palliative care education session developed, focusing on categories highlighted in the survey monkey.

Delivered to n=180 nursing staff across 3 ICU sites within the Belfast Trust.

A critical care consultant developed and delivered education to ICU medical staff; weekly M&M meetings are open to MDT.

Other resources: 2 minute update, a teaching tool

Education

Critical Care Two Minute Update

WHAT? End of Life Care in RICU

In an effort to improve end of life care for patients, families and staff within the critical care setting, this update will provide a focus on key aspects of EOLC care in the critical care setting.

Understanding the Words

Palliative Care: Identify those who require palliative care; Forward, holistic planning; Consider MDT discussion to identify appropriate referrals. ***N.B. For ward transfer, please refer the patient to the Palliative care team (MON-FRI 9-5pm): further guidance can be found in the End of Life Care document on Sharepoint under 'Ward Transfer'. It is essential to include family communications from ICIP on ward handover.***

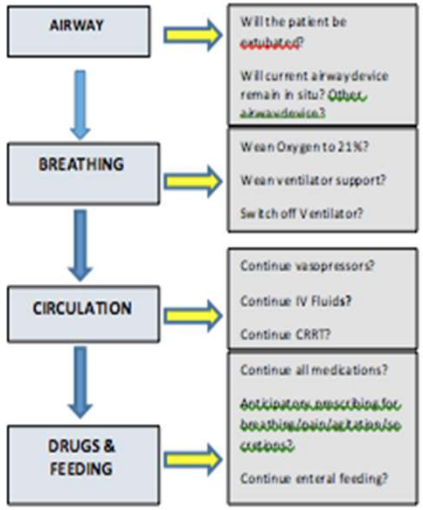
End of life care: Identify goals of care; Discuss, plan and establish and communicate plan.

N.B. Brown tape with details continues to be applied to deceased on death.

BHSCT Critical Care Two Minute Updates
Laura McMaster

So What?

PLAN ON A PAGE will be part of the end of life care pathway and has been established to aid staff in the discussion and the planning of the process of withdrawal of life saving interventions for the individual patient to which it applies. *This document was established with a teaching document to support it and is available on Sharepoint in EOLC.*



Has the DNACPR documentation been completed, signed and dated?

Has the patient been referred to Organ Donation?

Please also refer to End of Life Documentation on Sharepoint for further information.

What Now?

The Belfast Trust PALLIATIVE CARE TEAM are involved in multidisciplinary departmental teaching sessions on a regular 6 monthly basis. Keep you eye out for further communication for the next date. **All welcome!** Topics will include: Communication; Issues around limits of treatment e.g. feeding/hydration/analgesia/sedation; Anticipatory prescribing / withholding unnecessary meds; Syringe drivers.

"The "crescendo effect" of moral distress is real and dangerous. It can linger for months and years. We all have a difficult case burned into our minds." Vicki Lett

Heather Russell, the Belfast Trust ***BEREAVEMENT CO-ORDINATOR,*** has implemented an open door policy for staff on specified dates as communicated through the safety brief for anyone who wishes to discuss difficult deaths within RICU/HDU.

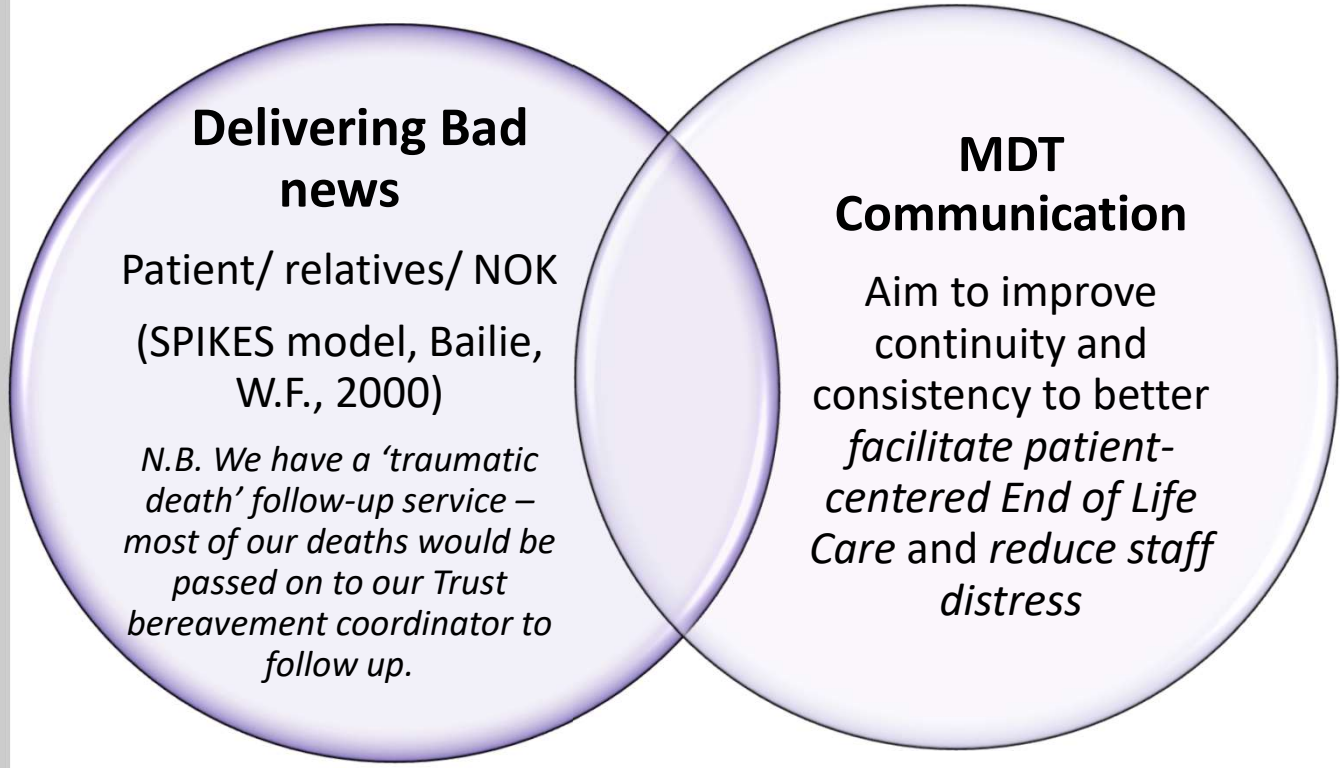
If you have been involved in the care of someone at death, sympathy cards are sent to families one month after death. These are located in the box at the back base and are available for you to sign.

In RICU we offer palm prints and hair cuttings at the CONSENT of the patient's next of kin. However we cannot keep hair cuttings e.g. in CD cupboard for legal purposes – they must immediately be passed to NOK (equipment pack kept at back base).

"How people die remains in the memory of those who live on"
Dame Cicely Saunders (1918 - 2005)
founder of the modern hospice movement

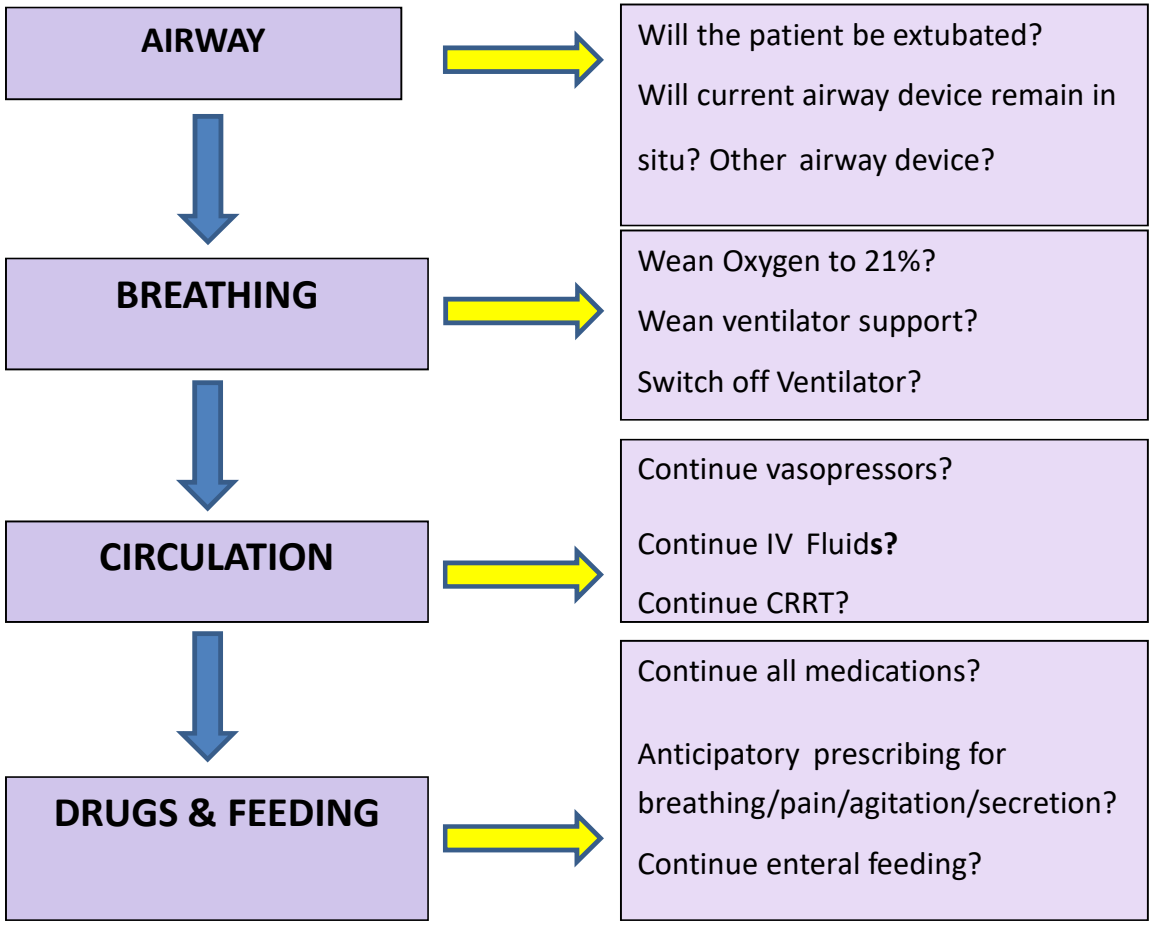
Communication

*Longer-term mortality should be collected on all patients admitted to critical care (GPICS, 2019)



‘Plan on a Page’

Developed by Dr Rachel Irwin



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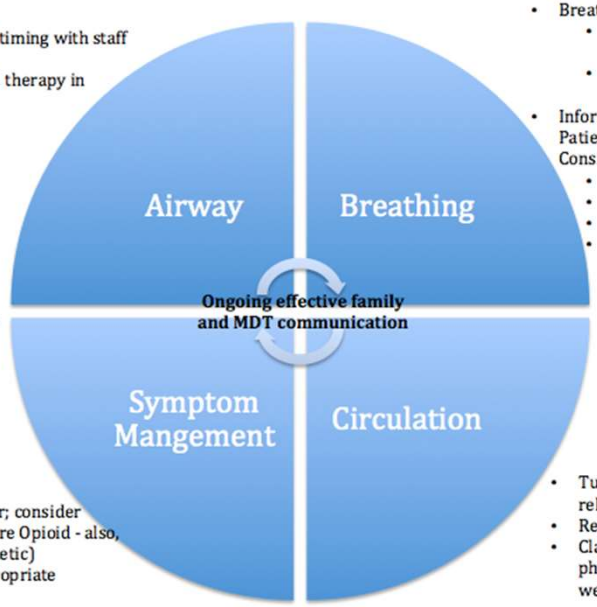
Guidance: Critical Care End of Life Care Standards

Considerations in withdrawal of life saving interventions



- Individualised assessment
- Clear communication of plan and timing with staff and next of kin i.e. extubation
- Extubate to room air; consider O2 therapy in symptomatic hypoxaemia
- Provide regular mouthcare

- Identify and treat reversible causes of breathlessness
- Breathlessness
  - Non-pharmacological management i.e. positioning, fan
  - Pharmacological management i.e. bronchodialtors, opioids, benzodiazapines
- Inform relatives of death rattle, give reassurance. Patient's rarely distressed by noisy secretions. Consider:
  - Positioning
  - Regular mouth care
  - Limit suctioning
  - Pharmacological (often cause dry mouth): Glycopyrronium bromide/Hyoscine buytlbromide/Hyoscine hydrobromide*

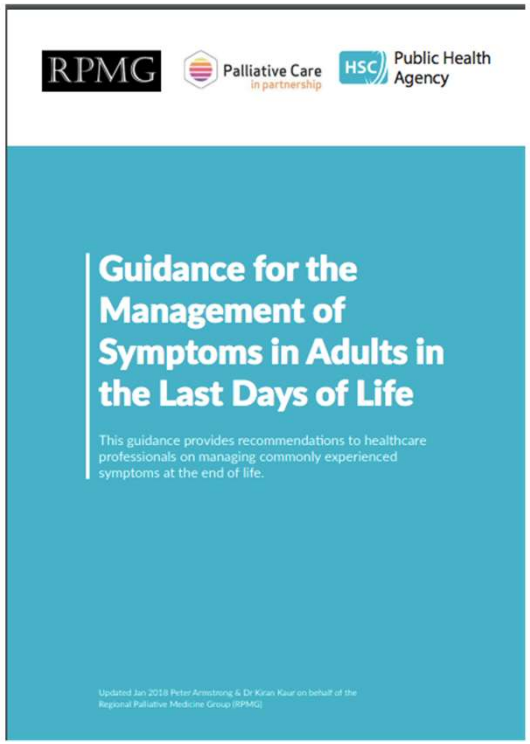
- Individualised patient assessment. Consider:
  - Pain
  - GI symptoms
  - Respiratory Symptoms
  - Skin symptoms
  - Pshycological symptoms
  - Spiritual symptoms
- Anticipatory Prescribing
  - Pain - WHO analgesic ladder; consider CSCI in ward transfer (Where Opioid - also, prescribe laxative & antiemetic)
  - Nausea and vomiting (Appropriate Antiemetic)
  - Agitation (Benzodiazapine *midazolam*)
  - Respiratory secretions (*Hyoscine hydrobromide*)

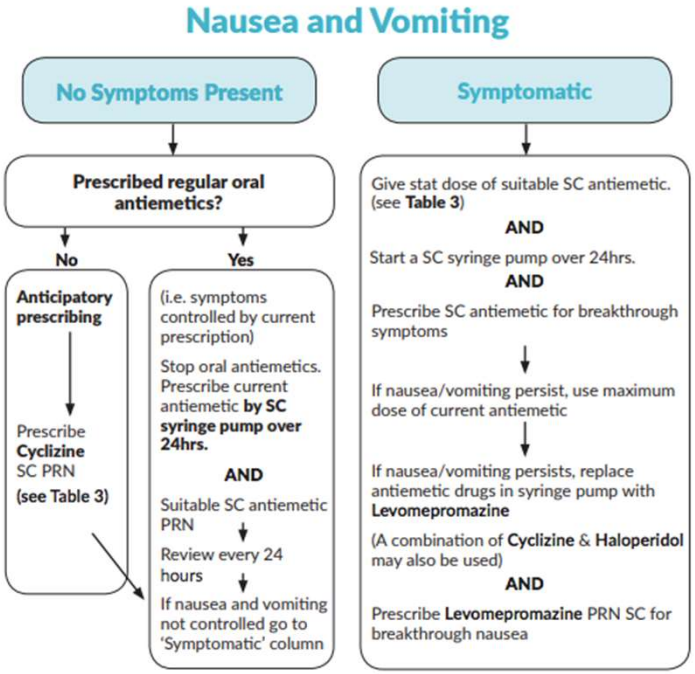
- Turn monitor off/away from patient & relatives
- Review intake i.e. fluids/feeds
- Clarify and communicate plan of pharmacological circulation managment e.g. wean noradrenaline vs turn off.

*1st line drug

Guide to symptom management:
file:///Users/laura/Downloads/Last%20days%20of%20life%20-%20Management%20of%20symptoms%20in%20Adults.pdf

Guidance: Anticipatory Prescribing





Staff Support

Education sessions:

increase knowledge and understanding

Support mechanisms in place in the Trust

Resilience Training

Comparative Staff Surveys

Initial Survey (n=76 responses)
versus
Review Survey (n=43 responses)

Awareness of updates

53.94% of staff were unaware of standards updates

80% found End of Life Care teaching sessions helpful

Computerized Documentation

Comments revealed a desire for improvement in documentation

66% found it useful

Guidance

35.53% felt confident in providing End of Life Care; 100% requested further education in various topics

37% (nurses) and 31% (medical staff) requested further teaching/updates

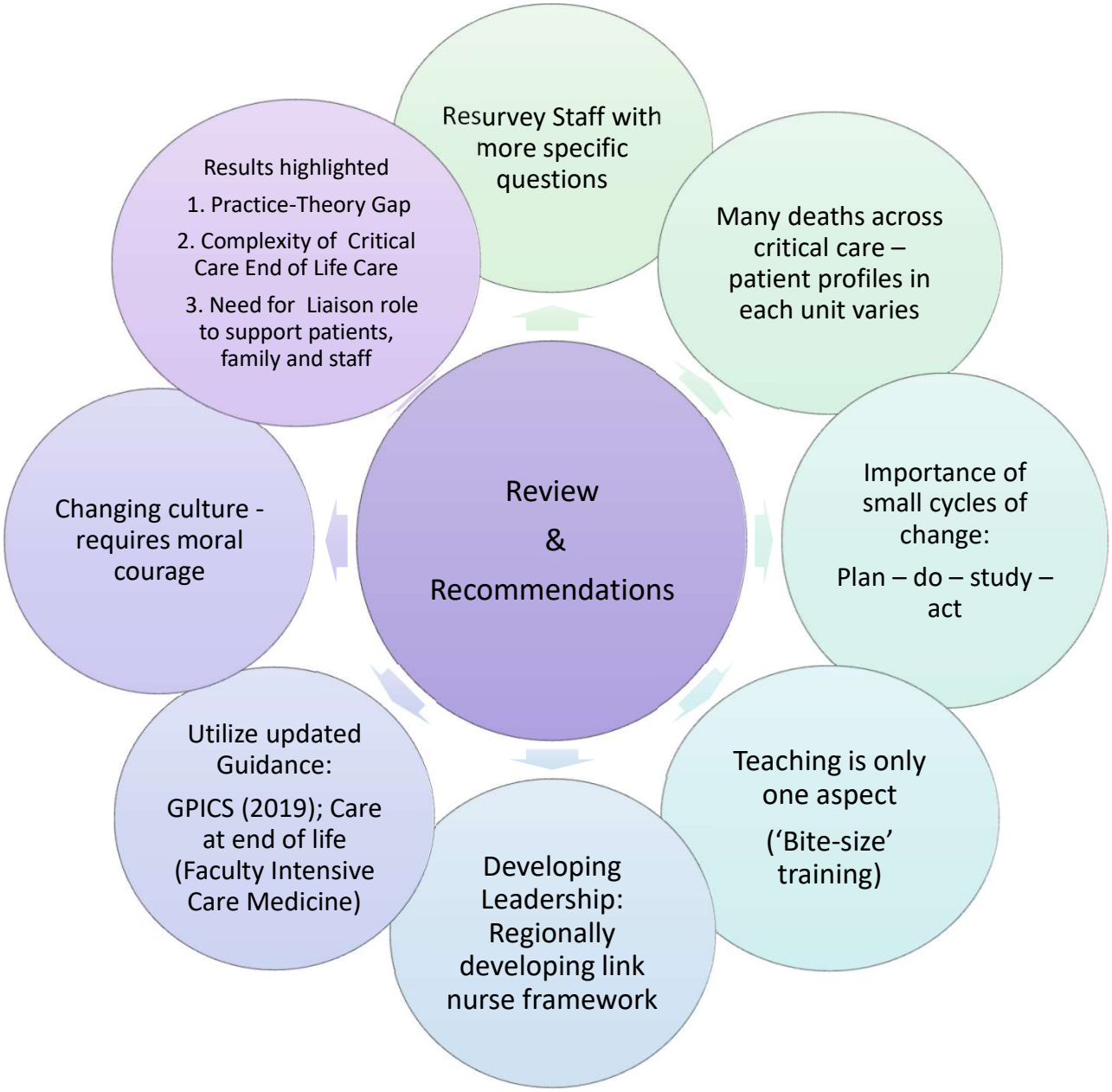
Subcutaneous Medications

88% yes
12% no

65.12% more likely to commence following teaching session

Limitations

- SMALL SURVEY RESPONSE
- IN RETROSPECT, QUESTIONS COULD BE BETTER TARGETED
- LIMITED TEACHING TIME AVAILABLE FOR COMPLEX TOPIC
- CULTURE OF THE WORKPLACE
- RESPONSE TO CHANGE


Review
&
Recommendations
Resurvey Staff with more specific questions
Many deaths across critical care – patient profiles in each unit varies
Importance of small cycles of change:
Plan – do – study – act
Teaching is only one aspect
('Bite-size' training)
Developing Leadership: Regionally developing link nurse framework
Utilize updated Guidance:
GPICS (2019); Care at end of life (Faculty Intensive Care Medicine)
Changing culture - requires moral courage
Results highlighted
1. Practice-Theory Gap
2. Complexity of Critical Care End of Life Care
3. Need for Liaison role to support patients, family and staff

Conclusion

The MDT displayed moral courage in changing the culture and overcoming barriers to palliative care in critical care.

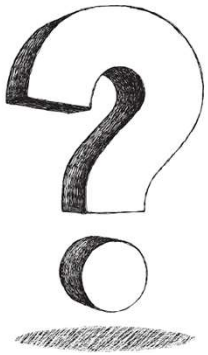
This is a process, we aim to continue to work on to best meet the challenges facing patients, their relatives and our staff.

"YOU MATTER BECAUSE YOU ARE YOU, AND YOU MATTER TO THE END OF YOUR LIFE"

Dame Cicely Saunders

"HOW PEOPLE DIE REMAINS IN THE MEMORIES OF THOSE WHO LIVE ON"

Dame Cicely Saunders



Thank you for listening

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