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

Survey results highlighted a desire for further learning.
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
- A page with options and guidelines would be helpful
- Traumatic death and family disagreement for withdrawal of care
- Would prefer written plan by medical staff in relation to withdrawal of treatment
- When a patient is aware that they will not survive and the decision is to withdraw treatment
- Sometimes there isn't enough time to debrief, sometimes it would be helpful to have someone to chat it over with
- The plan of care it was not clear when to start withdrawal and how and at what rate to start medication to provide comfort

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

So What?

PLAN ON A PAGE will be part of the end of life care pathway and has established to aid staff in the discussion and 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.

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 discussed on death.

BHSC Critical Care Two Minute Updates
Laura McMaster

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/analgiesia/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 buried in our minds.” Voou Litt.

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 ICU/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 ICU 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 (next of kin) at the 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
*Longer-term mortality should be collected on all patients admitted to critical care (GPICS, 2019)

MDT Communication
Aim to improve continuity and consistency to better facilitate patient-centered End of Life Care and reduce staff distress

Delivering Bad news
Patient/ relatives/ NOK
(SPIKES model, Bailie, W.F., 2000)

N.B. We have a ‘traumatic death’ follow-up service – most of our deaths would be passed on to our Trust bereavement coordinator to follow up.
‘Plan on a Page’

Developed by Dr Rachel Irwin

AIRWAY
- Will the patient be extubated?
- Will current airway device remain in situ? Other airway device?

BREATHING
- Wean Oxygen to 21%?
- Wean ventilator support?
- Switch off Ventilator?

CIRCULATION
- Continue vasopressors?
- Continue IV Fluids?
- Continue CRRT?

DRUGS & FEEDING
- Continue all medications?
- Anticipatory prescribing for breathing/pain/agitation/secretion?
- Continue enteral feeding?

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.
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

- Individualised patient assessment.
  Consider:
  - Pain
  - GI symptoms
  - Respiratory Symptoms
  - Skin symptoms
  - Psychological symptoms
  - Spiritual symptoms

- Anticipatory Prescribing
  - Pain - WHO analgesic ladder; consider CSCD in ward transfer (Where Opioid - also prescribe laxative & antiemetic)
  - Nausea and vomiting (Appropriate Antiemetic)
  - Agitation (Benzodiazepine *midazolam*)
  - Respiratory secretions (*Hyoscine hydrobromide*)

*1* = use drug

Guideline to symptom management:
http://diver.learns/downloads/Cons%2020110c%20%20Management%20of%20Symptoms%20in%20Adults.pdf

- Identify and treat reversible causes of breathlessness
- Breathlessness
  - Non-pharmacological management i.e. positioning, fan
  - Pharmacological management i.e. bronchodilators, opioids, benzodiazepines
- 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 butyrylhydroli/Hyoscine hydrobromide

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

Guidance for the Management of Symptoms in Adults in the Last Days of Life

This guidance provides recommendations to healthcare professionals on managing commonly experienced symptoms at the end of life.

Nausea and Vomiting

No Symptoms Present

- Prescribed regular oral antiemetics? (see Table 3)
- Yes
- No
- Anticipatory prescribing
  - Prescribe Cyclizine SC PRN (see Table 3)
  - (i.e. symptoms controlled by current prescription)
  - Stop oral antiemetics.
  - Prescribe current antiemetic by SC syringe pump over 24hrs.
  - AND
  - Suitable SC antiemetic PRN
  - Review every 24 hours
  - If nausea and vomiting not controlled go to ‘Symptomatic’ column

Symptomatic

- Give stat dose of suitable SC antiemetic.
  - AND
  - Start a SC syringe pump over 24hrs.
  - AND
  - Prescribe SC antiemetic for breakthrough symptoms
  - If nausea/vomiting persist, use maximum dose of current antiemetic
  - AND
  - If nausea/vomiting persists, replace antiemetic drugs in syringe pump with Levomepromazine
  - (A combination of Cyclizine & Haloperidol may also be used)
  - AND
  - Prescribe Levomepromazine PRN SC for breakthrough nausea
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)*

<table>
<thead>
<tr>
<th>Awareness of updates</th>
<th>Computerized Documentation</th>
<th>Guidance</th>
<th>Subcutaneous Medications</th>
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<tbody>
<tr>
<td>53.94% of staff were unaware of standards updates</td>
<td>Comments revealed a desire for improvement in documentation</td>
<td>35.53% felt confident in providing End of Life Care; 100% requested further education in various topics</td>
<td>88% yes 12% no</td>
</tr>
<tr>
<td>80% found End of Life Care teaching sessions helpful</td>
<td>66% found it useful</td>
<td>37% (nurses) and 31% (medical staff) requested further teaching/updates</td>
<td>65.12% more likely to commence following teaching session</td>
</tr>
</tbody>
</table>
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
- Changing culture - requires moral courage
- Teaching is only one aspect (‘Bite-size’ training)
- Utilize updated Guidance: GPICS (2019); Care at end of life (Faculty Intensive Care Medicine)
- Developing Leadership: Regionally developing link nurse framework
- 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
- Changing culture - requires moral courage
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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**References**