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# An ICU End of Life Care Ward Round to Drive Nurses Involvement in Decision-Making.

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CNS

CARDIO-THORACIC ICU (CTICU)

ST. GEORGE'S HOSPITAL, LONDON

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# Critical Care Across the World: Breaking Down Barriers.

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# Background to the Project

- COVID Pandemic resulted in high ICU mortality
- Continued staff psychological distress from 1st surge & ongoing
- Severe restrictions on Visiting & Communication
- Extreme pressures on ACC: suboptimal surge ICU environments & use of support staff
- Changes to ways of working fragmented MDT communication & relationships
- Widening of existing gap between ICU doctors & nurses EOL decision-making leading to perceived conflict
- Increasing concerns regarding withdrawing treatment: unknown disease treated with novel therapies
- Pressure on doctors from family & press/ social media
- National and Trust priorities: 'One chance to get it right'
- Inability to meet NICE guidelines NG142 & 31 or Quality Standards 13 & 144

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# Urgent need to……

…examine perceived problems & explore the reality of the lived experience of ICU staff.

…explore workable solutions to address the problems.

# Aim & Objectives

**AIM :**

To evaluate the introduction of End of Life Care (EOLC) Ward Rounds in a Surge Adult ICU during the COVID- 19 Pandemic and investigate its perceived effect on communication and EOLC decision-making.

**OBJECTIVES:**

1. Organise a stakeholder meeting to explore the concerns raised regarding EOLC communication, decision-making & MDT working during the second COVID surge.

2. Explore the EOLC experiences of ICU doctors & nurses working on Surge COVID ICUs during second surge using guided reflective sessions.

3. Derive themes from the reflective sessions to increase understanding of the underlying concerns related to EOLC.

4. Develop the format for and introduce EOLC Ward Rounds (EOLCWR) on a COVID ICU.

5. Evaluate via questionnaire the effect of the EOLCWR in improving communication between ICU doctors & nurses.

6. Recommend second cycle trial of EOLC Ward Rounds on all Adult ICUs in the directorate post COVID surge.

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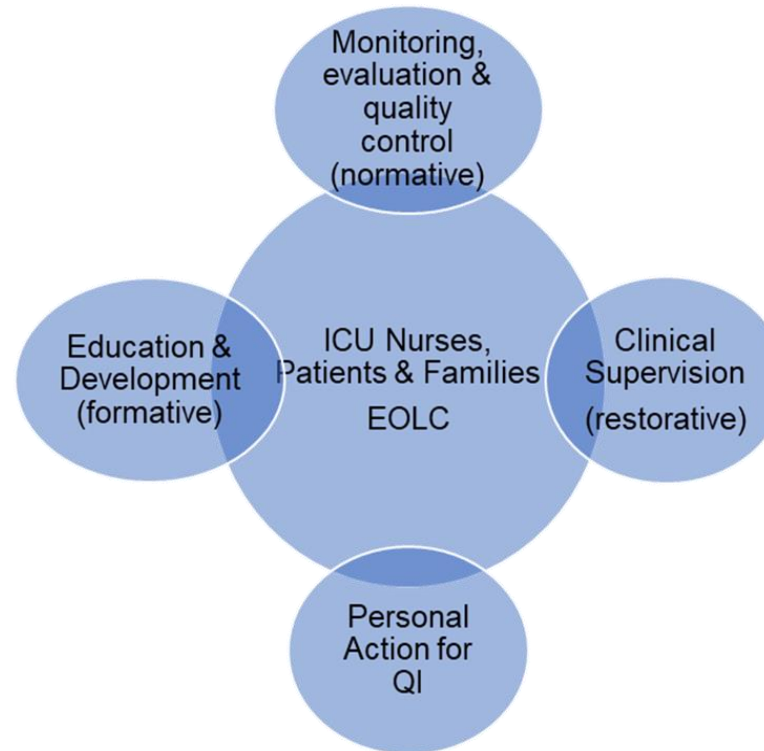
# Development of the Professional Nurse Advocate (PNA) Role in ICU based on the A-EQUIP (Advocating for Education and Quality ImProvement) Model of Restorative Clinical Supervision (NHSE, 2017)

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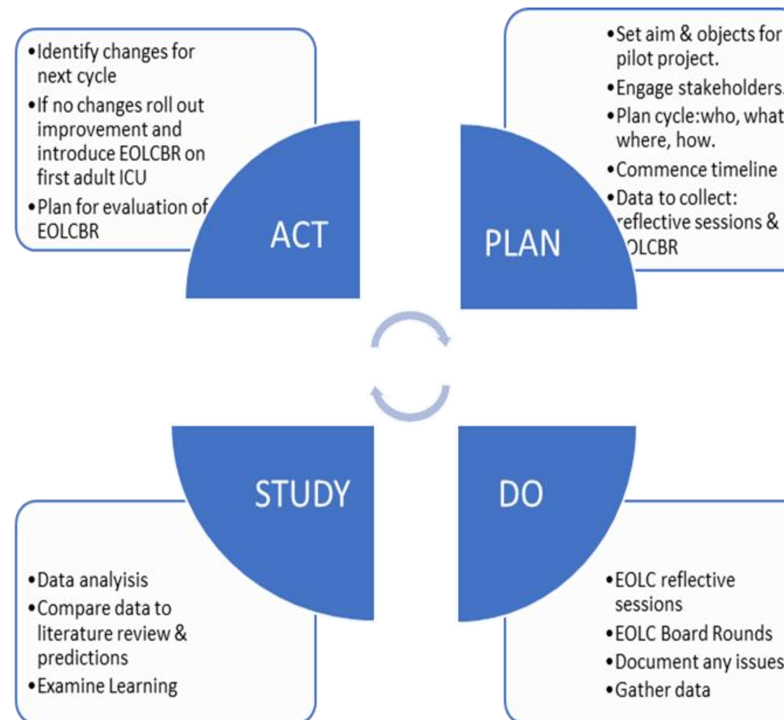
# EOLC QI Project: Cycle 1



# Methodology

## Data Collection March – April 2021: 2 COVID surge ICUs
## Ethical Considerations

| | |
|---|---|
| 5 EOLC Reflective Sessions : 47 ICU Drs, Nurses & CMTs<br>Facilitated by staff support & chaplaincy. | 3 trial EOLC Board Rounds: 18 ICU Drs, Nurses & Palliative Care Consultant |

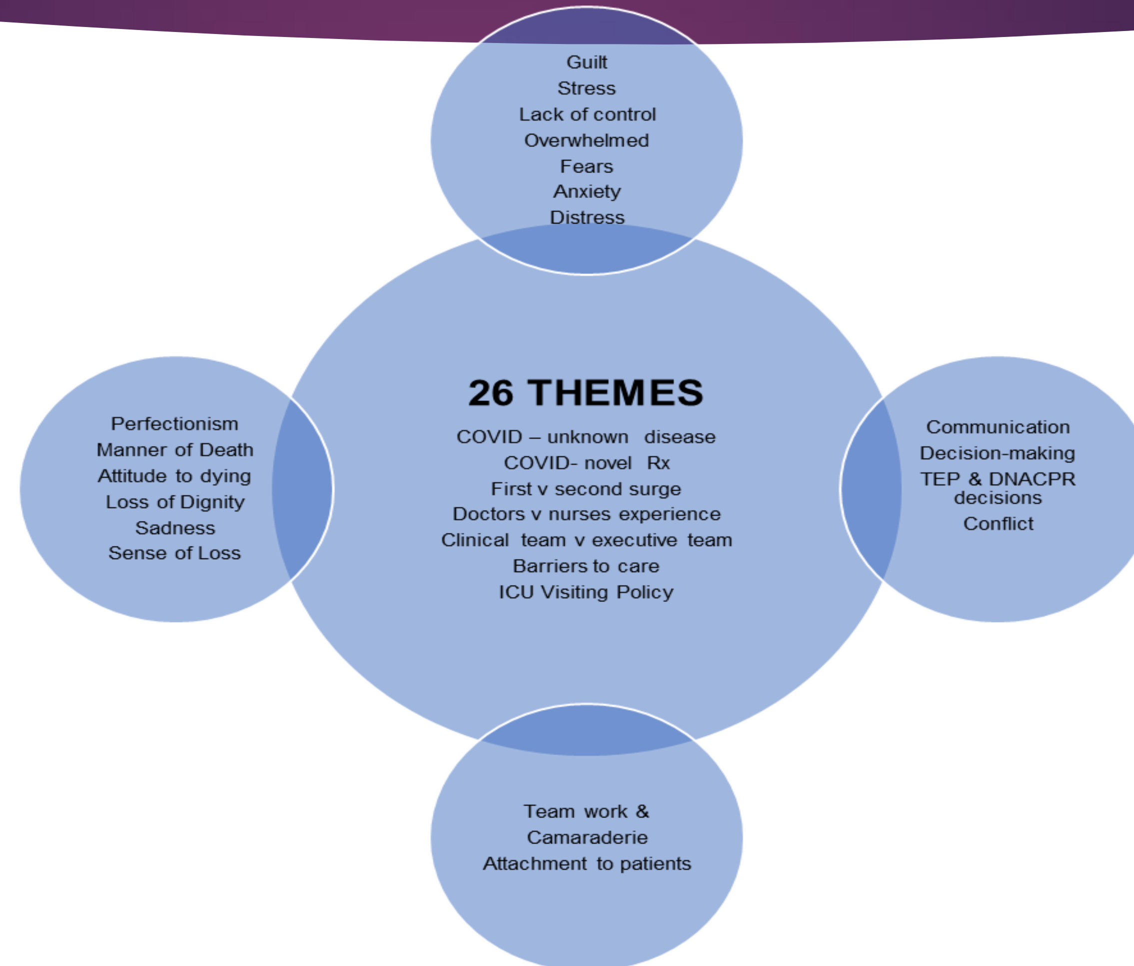
## Data Analysis

| | |
|---|---|
| Thematic Analysis: qualitative coding- transcription, assembly, categorization & thematic sorting | Analysis of quantitative demographic data and consistency/ frequency of qualitative responses from 8/13 questionnaires: 4 consultants, 3 nurses, 1 Palliative Care Consultant |

## Reliability & Validity

| | |
|---|---|
| 26 Themes | EOLCBR : empowered staff, inclusive, improved communication, agreement on format & participation.<br>Lack of consensus on logistics of introduction. |

# Themes from EOLC Reflective Sessions



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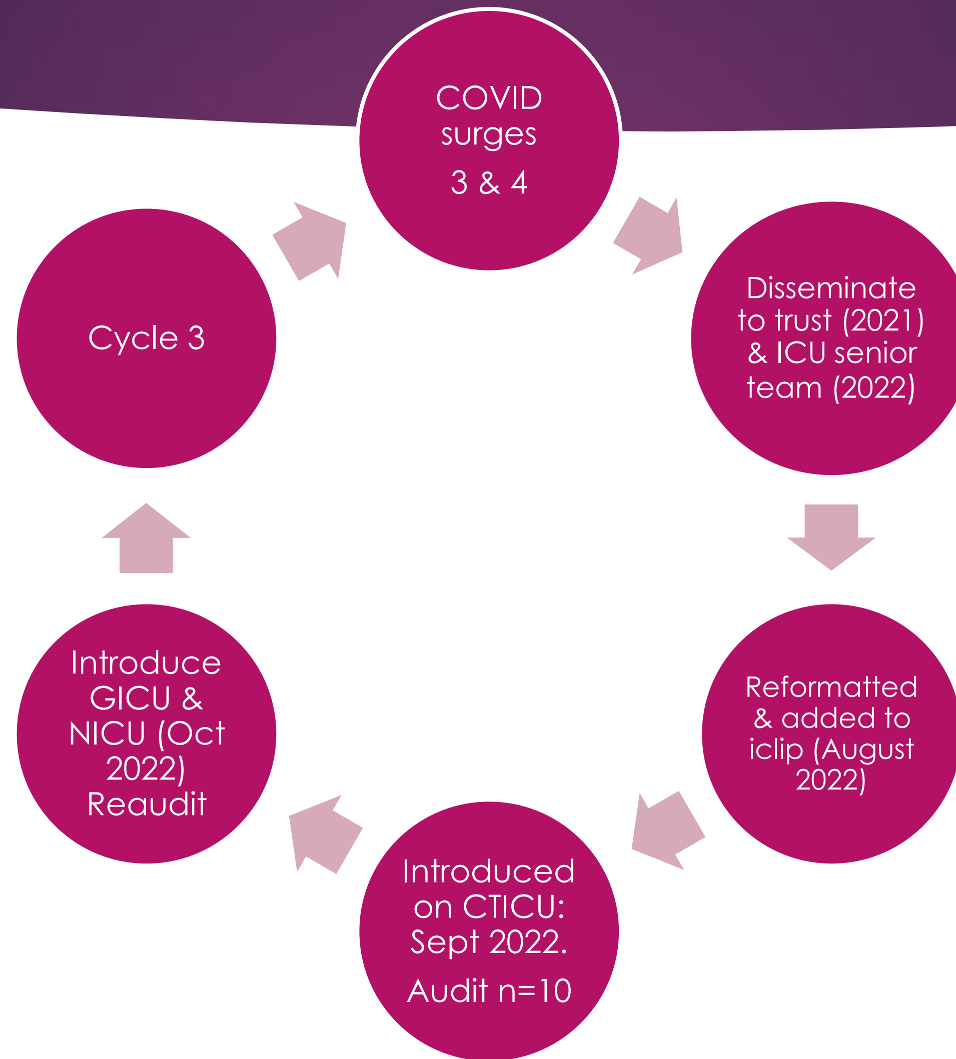
# EOLC QI Project: Cycle 2

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# Current Format of EOLC Ward Round

| End Of Life Care Ward Round Summary |
|---|
| Members of MDT present: |
| Parent Team aware: |
| Date first discussed on EOLCWR: |
| |
| Reason for inclusion in EOLCWR (patient in the last days and hours of life, expected to die, complex EOLC situation): |
| |
| Summary of discussion (including discussion of TEP/DNACPR): |
| |
| Record of patient/ family/ carer wishes: |
| Summary of Family Communication and/or Issues (include consultant communication): |
| |
| Plan (include limitation and with drawl of treatment plan if applicable): |
| Review Date: |
| Documentation Check: |
| DNACPR in place (iclip): y/n Date: |
| TEP in place (iclip): y/n Date: |
| Limitation of Treatment Form in place: y/n Date: |
| With drawl of Treatment Form in place: y/n Date: |
| Additional Comments: |

| Referrals Required and date: |
|---|
| Spiritual care: |
| Palliative Care: |

| referral made & date: |
|---|
| patient reviewed y/n: |
| Palliative Care summary (include plan for anticipatory meds/ syringe driver): |
| EOL Nursing Care Plan Initiated: |
| Psychology Support: |
| SNOD referral & Plan: |
| Translator Required: |
| Visiting Plan: |
| Virtual Visiting Plan: |
| Safeguarding: |
| Hospital Letter provided: |

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# EOLC Ward Round on CTICU

**EOLC Ward Round Summary (Trial of EOLC ward round MDT meeting in CTICU)**

**Members of MDT present:** Dr AD, Charge Nurse RT, Staff Nurse OD, CNS MS

**Parent Team Aware:** cardiology - will be discussed with cardiology after conversations with family.

**Date first discussed in EOLCWR:** 1/9/22

**Reason for inclusion in EOLCBR (is the patient in the last days and hours of life, expected to die or there is a complex EOLC situation) :** From the start of the week the rehab team and nursing team have felt that unfortunately Mr H is not progressing but continues to deteriorate with ongoing episodes of sepsis. Dr AD spoke to Mrs H on Monday and informed her that staff are concerned about his lack of progress, his repeated infections, line sepsis, ongoing difficulty in maintaining venous access for RRT and that overall he has not improved since his high risk PCI and Impella. Dr AD is planning to treat this episode of sepsis but in the mean time the priority is to start discussions with the patient and family as to whether escalation of treatment is appropriate.

**Summary of discussion ( including discussion of TEP/DNACPR):** Discussion as above with a plan to:
1. Continue treatment until conversation with patient regarding his wishes (documented below).
2. Further discussions with wife and daughter today and with patient's sister on Sunday.

**Record of patient/family/carer wishes:** Patient and family discussion at the bedspace, asked patient if he understand that painful procedures etc were in line with rehabilitation, he nodded and understood. He is happy to continue if that means he will get some rehabilitation. I asked him whether he felt he was getting better, he felt this was not the case. He also acknowledged that each set back is making him weaker. I did not approach any further discussion re: limiting care or resuscitation. He was tearful and family present, I felt it was appropriate to leave the discussion there. (RT Charge Nurse)

**Summary of family Communication and/or issues (include consultant communication):** Dr AD has informed Mrs H that the patient will be unlikely to survive his stay in ICU due to the reasons documented above. Ongoing communication with NOK will be documented and the patient will be reviewed daily.

**Plan (include limitation and withdrawl of treatment plan if applicable):** no plan as yet for limitation of treatment until all conversations with the patient and family are completed.

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# EOLC Ward Round on CTICU

**EOLC Ward Round Summary (Trial of EOLC ward round MDT meeting in CTICU): continued**

**Review date:** Friday 2/9/22

**Documentation check:**
DNACPR & TEP not completed yet - awaiting further discussion with patient and family
No Limitation or with drawl of treatment forms in place yet.

**Referrals Required & date:**

**Spiritual Care:** review 2/9/22
**Palliative Care:** not referred yet.

**EOLC care plan:** continues on ICU care plan
**Psychology support:** n/a
**SNOD:** SNOD to be informed when patient formally moves to EOLC pathway
**Translator Required:** no
**Visiting plan:** family visit daily and can be increased if patient moves towards EOLC.
**Safeguarding:** n/a
**Hospital Letter for family:** not requested by family

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| End Of Life Care Ward Round Summary |
|---|
| Members of MDT present: |
| NS (consultant ICU & ACG (Cons ICU], VB (Snr Sister), T M (SSN-bed side nurse) |
| Parent Team aware: T & O |
| Date first discussed on EOLCWR: written record 27.09.22 |
| Reason for inclusion in EOLC Ward Round (patient in the last days and hours of life, expected to die, complex EOLC situation): Severe hypoxic brain injury & planned withdrawal of treatment |
| Summary of discussion (including discussion of TEP/DNACPR: |
| 17 th Sept 2022 initial discussion about possibility of severe hypoxic brain injury and withdrawing life support if the diagnosis is confirmed |
| Between 17th and 27th Sept -several discussions regarding likelihood of severe brain damage |
| 27/09/2022 discussion with the family. Decision made for DNAR and TEP. family wanted more time to speak to patient son regarding EOL. |
| 27/09/2022 Family referred for counselling (particularly the son), & psychological support, |
| 28/09 Trauma team aware of the DNAR and TEP |
| 28/09 Palliative consultation |
| 29/09 Family meeting with NS (cons) & TM (SSNurse) - they were updated and plan moving forward discussed. EOL to commenced tomorrow for extubation and queried whether son will be present |
| Record of patient/ family/ carer wishes: |
| Family will discuss with patient's son, to see whether he would like to be present at extubation or after. Other family members to also decide if they would like to present when extubation |
| Summary of Family Communication and/or Issues (include consultant communication): |
| Family asked how long it would take for patient to die. This was explained that this may take number of hours or days. |
| Some family members would like to be present, for open visit post extubation |
| Plan (include limitation and withdrawal of treatment plan if applicable): |
| As discussed, & agreed with family, withdrawal of treatment to commence on 30th September between 1 & 2pm |
| Review Date: 30/09/20222 |

| Documentation Check: |
|---|
| DNACPR in place: Yes Date: 27/09/22 |
| TEP in place: Yes Date: 27/09/22 |
| Limitation of Treatment Form in place: Yes: Date: 27th Sept 2022 |
| With drawl of Treatment Form in place: Y/N: No Date: |
| Additional Comments: |
| Referrals Required and date: |
| Spiritual care: To discuss with family |
| Palliative Care: Yes |
| referral made & date: 27th Sept 2022 |
| date patient first reviewed: 28th September 2022 |
| Palliative Care summary (include plan for anticipatory meds/ syringe driver): |
| Team to contact palliative team tomorrow regarding further management |
| End of Life Care Nursing Care Plan Initiated: Y/N: No |
| Psychology Support: 28th Sept 2022 |
| SNOD Referral & Date: |
| SNOD Plan: Excluded from organ donation (as discussed with MS) |
| Translator Required: No |
| Visiting Plan: Open visit post withdrawal |
| Virtual Visiting Plan: no plans yet |
| Safeguarding: none |
| Hospital letter for family required: none currently requested |

# Example of EOLCWR completed independently by ICU MDT

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# Evaluation Post PDSA Cycles 1 & 2

- Importance of senior MDT engagement
- EOLCWR in addition to BAU Ward Round : timing crucial
- Protected time & safe space for MDT discussion of EOLC decision making
- Ensured bed side nurse involved & empowered to advocate for patients
- Increased involvement of Palliative Care Team
- Incorporated NICE EOLC guidelines
- Record of Family Communication & wishes
- Checklist for EOLC referrals

Cycle 2:

- Staff initiated independently
- Include safeguarding/ social services/ IMCA/ hospital letters
- Used by parent team
- SNOD inclusion
- Discussed in M & M

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# Next Steps : Paediatric EOLCWR

- Safeguarding/ social services/MASH (Multi-Agency Safeguarding Hub) referrals
- PICU Bereavement Sister
- PICU Psychology Support
- Spiritual Support
- Bereavement Charities: Winston's Wish, The Harvey Hext Trust: A Siblings Wish
- Red Thread
- Dept of Health & Social Care/ D for E: Child death review: statutory and operational guidance (England).
- Trust Death of a Child Policy: St. George's Child Death Review Team / CDOP (Independent Child Death Overview Panel) Team/ JAR (Joint Agency Response) meeting determined by circumstances of death.

# Sustain & Disseminate

**CNS & PNA role**

- PNA & CNS role: drive QI projects and facilitate reflective forums, resilience training & coaching
- Importance of research & audit despite the challenges of working in a pandemic / current pressures

**Staff engagement**

- Directly address conflict
- Recognise & explore COVID related moral injury and psychological upset
- Support staff to provide quality EOLC
- Dissemination to Trust / ICU staff & empowerment

**Good practice**

- Improve patient and family care
- Continued collaboration with key stakeholders
- Integration of a robust EOLCWR to foster MDT working & communication
- Importance of promoting NICE and Trust EOLC guidelines
- Publication

“ How people die remains in the memory of those who live on.’

Dame Cicely Saunders
Founder of the Modern Hospice Movement
July 2008 ”

A heartfelt thank you to all of the staff in Adult Critical Care including surge support staff and CMTs, Staff Support, Chaplaincy, Palliative Care and SNOD. Thank you to the incredible ICU doctors and nurses from McKissock and Ben Weir COVID surge ICUs for their trust and honesty.

Thank you to the Adult ICUs at St. George's for welcoming this ongoing innovation to improve care.

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