Acute End of Life Care in hospitalised patients.

A/Prof Daryl Jones

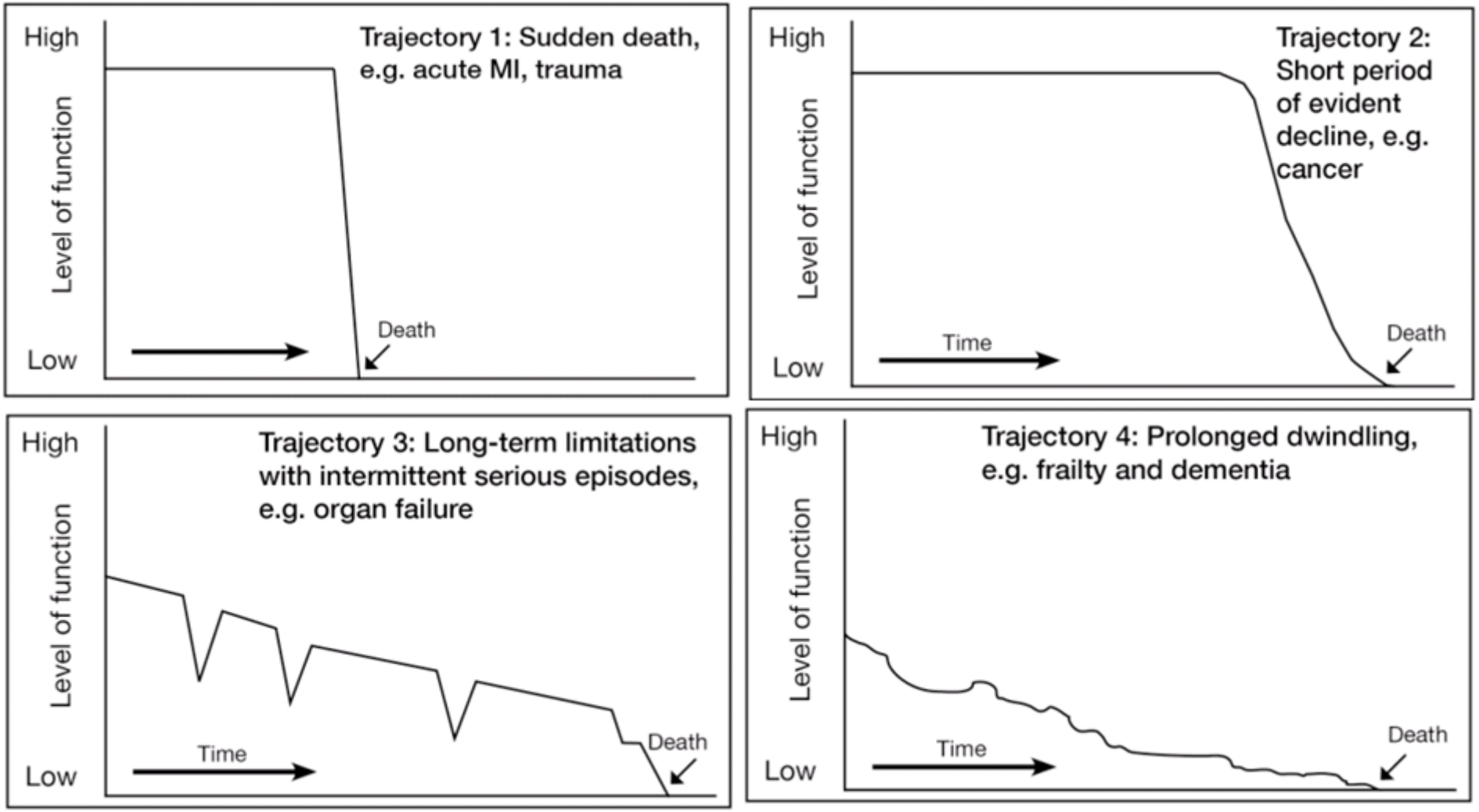
Overview

- Trajectories of dying
- Dying in the intensive care unit
- Phases of end of life
- Overview of deteriorating patients
- The Rapid Response Team & end of life care
- Uncertainty and advancing technology
- Barriers to providing end of life care
- Potential solutions

Disclaimer

- Intensive Care specialist
- Research in deteriorating hospitalised patients
  (MD, PhD)
- Uni Melb & Monash Uni, advisor for ACSQHC
- Comments and opinions are my own
- May not represent my employer, societies, Universities, colleges with which I am affiliated
- Conflict of interest
  - Salary Melbourne public hospital for consultancy for deteriorating patients (<$10,000 over past 3 years)
  - Grant from ACQSHC ($70,OOO – all went to study)

Trajectories of dying



Lunney J, et al *Journal of the American Geriatrics Society* 2002
Lunney J, et al *Journal of the American Medical Association* 2003

Dying in the Intensive Care Unit (ICU)

- Approximately 1/10 patients die
- Death is rarely sudden and unexpected
- The clinicians often predict in advance
- “Withdrawal of curative care” staggered
- ICU doctors
  - Good understanding of which patients will respond to artificial life support
  - Adept at communication about death and dying

Intensive Care Med
DOI 10.1007/s00134-015-3815-0

WHAT'S NEW IN INTENSIVE CARE

Stephen Warrillow
KJ Farley
Daryl Jones

Ten practical strategies for effective communication with relatives of ICU patients

Intensive Care Med
DOI 10.1007/s00134-015-3712-6

WHAT'S NEW IN INTENSIVE CARE

Ken M. Hillman
Magnolia Cardona-Morrell

The ten barriers to appropriate management of patients at the end of their life

When is death *not* unexpected ?

- Prior to admission
  - Frail / needing supports
  - A lot of co-morbidity
  - Advanced organ dysfunction
  - A condition which has a known poor outcome
- At admission
  - Admitted with a diagnosis that has known poor outcome
- After admission
  - Not improving despite optimal treatment
  - Develop additional problems

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

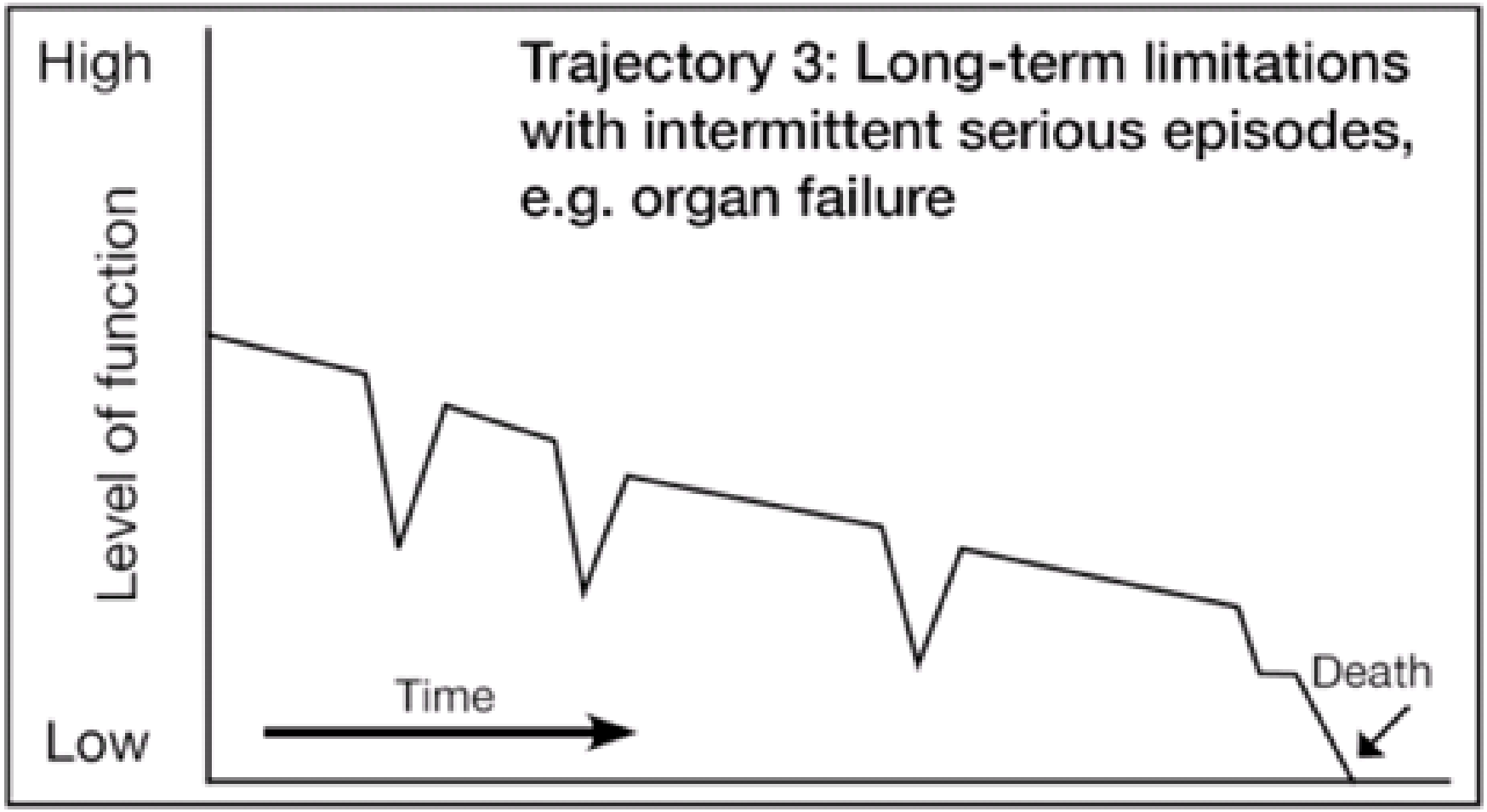
The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY
Inspiring Minds


High
Level of function
Low
Trajectory 3: Long-term limitations with intermittent serious episodes, e.g. organ failure
Time
Death

Phase of end of life care

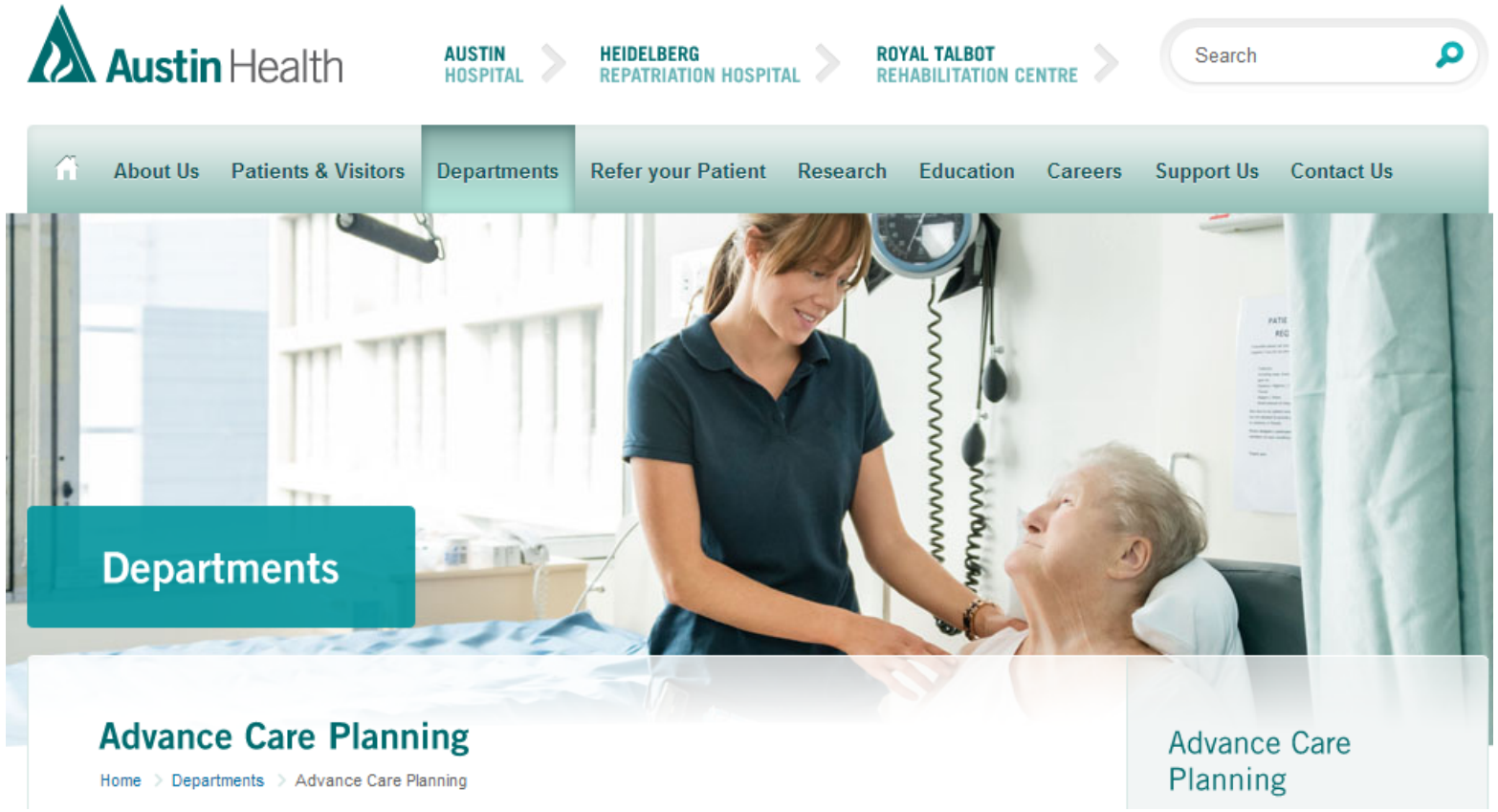
Palliative Care Service

Advance care planning

RRT / ICU

Advance care planning

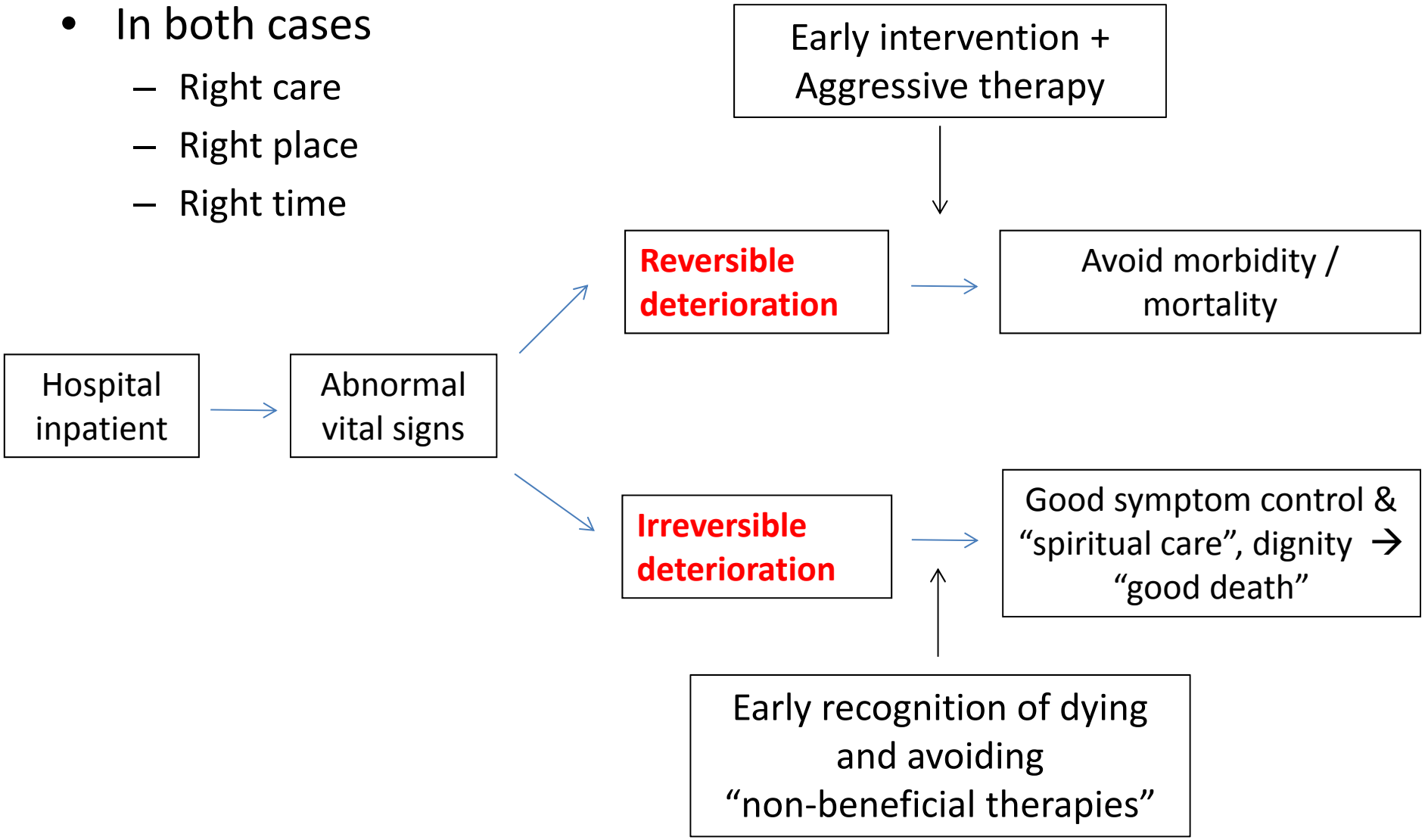
- Dr Karen Detering



Focus = patient value + choices

Acutely deteriorating patients

- In both cases
  - Right care
  - Right place
  - Right time



Rapid Response Teams & End of life care

- Rapid Response Team
  - Senior / expert clinicians
  - Experienced at assessing deteriorating patients
  - Often from Intensive Care Unit
  - Called when a patient is deteriorating
    - Abnormal vital signs
    - Severe pain / problems breathing
    - Change in conscious state

MET

MEDICAL EMERGENCY TEAM

Call **7777** state

"MEDICAL EMERGENCY TEAM

AUSTIN HOSPITAL WARD ....."

Austin Health

if you notice any acute changes in

AIRWAY

- Obstructed airway
- Noisy breathing or stridor
- Problem with a tracheostomy tube

BREATHING

- Any difficulty breathing
- Breathing <8 breaths a minute
- Breathing >25 breaths a minute
- SpO2 ≤90%, despite 10L/min oxygen

IF PATIENT IS NOT BREATHING, CALL RESPOND BLUE

CIRCULATION

- Pulse <40 beats a minute
- Pulse >120 beats a minute
- Low blood pressure (systolic < 90mmHg)
- Urine output <50mls over 4 hours

IF PATIENT HAS NO PULSE, CALL RESPOND BLUE

CONSCIOUS STATE

- Sudden change in conscious state
- Patient cannot be roused
- Prolonged or uncontrolled seizures

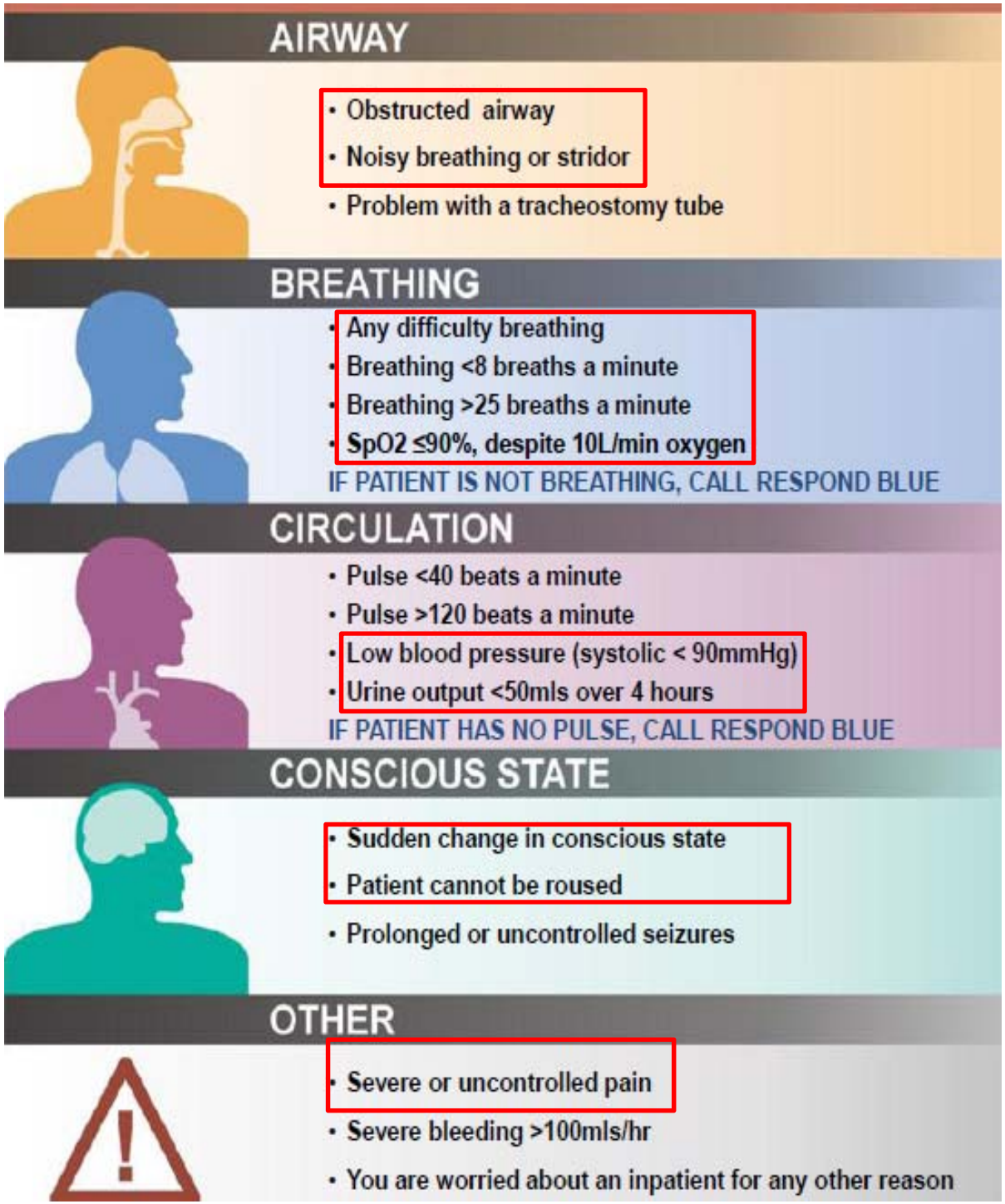
OTHER

- Severe or uncontrolled pain
- Severe bleeding >100mls/hr
- You are worried about an inpatient for any other reason

Deteriorating Patient Committee, April 2012

Original aim = prevent cardiac arrests / adverse events

Provide end of life care in hospital patients



Deterioration

versus

Dying

Seven hospital study

- 7 centre study
  - Examined a number of LOMT (not just NFR)
  - Five Australian, one each Canada and Sweden
  - 652 RRT calls in 518 patients over one month
  - 68.9% for full care = in-hospital mortality = 12.3%
  - 31.1% of calls associated with a LOMT
    - 20.3% pre-existing before call
    - 10.8% newly implemented after RRT calls

48.4%

1. Jones etal CCM 2012

- Differences patients with LOMT vs those without
  - Older (80 vs 66 years)
  - Medical patients (70.2% vs 51.3%)
  - Less likely to be from home (74.5% vs 92.2%)
  - Less likely to go home (22.4% vs 63.6%)
  - More likely to die in hospital (48.4% vs 12.3%)

The scale of RRT calls

- 10 year study 35 Australian hospitals
  - 4.91 million hospital admissions
  - 196,488 ICU admissions
  - 99,377 RRT calls.
- 70 924 RRT patients mortality = 24.3%
- RRT reviewed 17 260 of 79 476 patients (21.7%) who died in hospital over the study period

- Data from 2013/2014 Australian ICU-equipped hospitals
  - RRTs present in 138/143 (95.5%)
  - At least 92,858 RRT calls in Australia

Jones etal CCR 2013; 15: 273

Strengths / limitations of this approach

- Advantages
  - Rapid symptom relief
  - Senior decision making
  - Clearer communication
  - Avoids “non-beneficial care”
  - If uncertain → “trail of ICU treatment”
- Disadvantages
  - Reactive approach
  - Family / parent unit may not be present out of hours
  - Patient unwell → variable participation in discussions
  - Decisions deferred to family / relatives

Uncertainty and improving technology

- In the past what could be offered was less
  - "Patient not strong enough for anaesthetic"
  - "Nothing more we can do"
- In 2015
  - People living longer
  - Available therapies broader
  - Surgical and anaesthetic technique improved
  - Intensive care can "prevent death"

Barriers to providing end of life care

- Uncertainty of
  - Prognosis
  - Response to therapy
- Patient / NOK / societal expectations
  - “Want everything done”
  - “Unrealistic expectations” – misleading TV programs
- Sub-optimal consideration of patient’s choices
  - “I don’t want to die on machines”
- Doctors not wanting to “fail”

- Clinicians don’t appreciate disease in context of patient’s overall condition
- Lack of confidence / self-perceived competence in having discussion
- Perceptions of lack of time
- Deterioration often occurs out of hours
  - Least resources
  - Most senior doctors available are junior
- Multiple teams involved in one patient’s care
  - No one team taking overall responsibility about end of life care

DIAGNOSING DYING: SYMPTOMS AND SIGNS OF END-STAGE DISEASE

Sue Haig

Table 1

The four types of awareness of dying

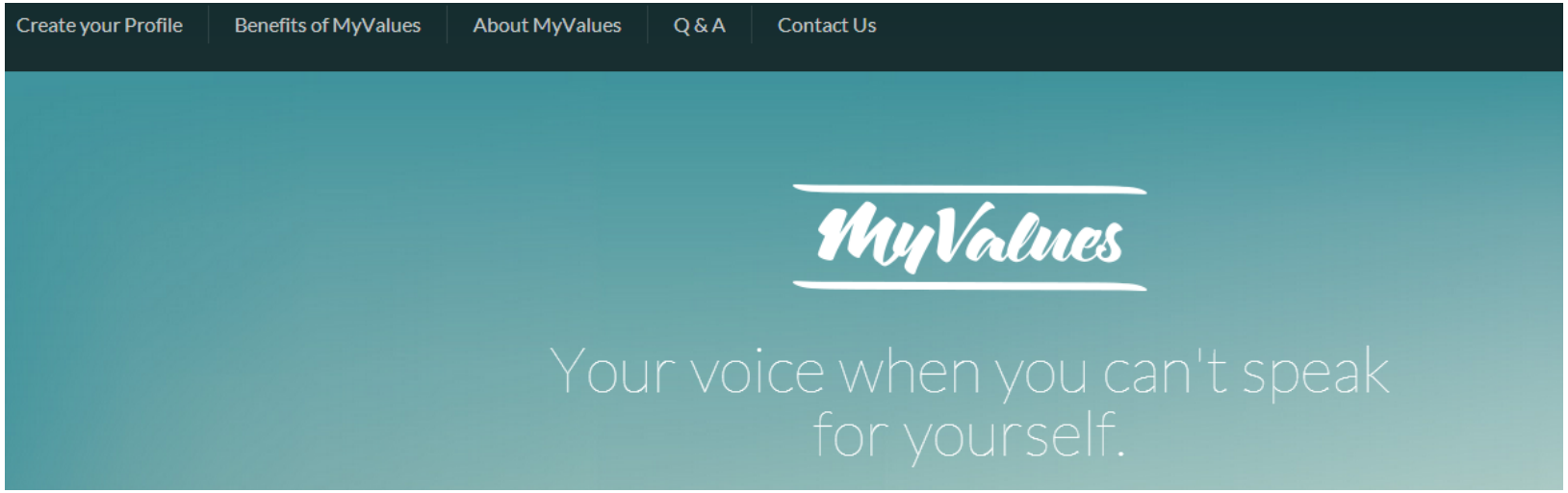
Closed awareness: the patient is not aware they are dying but clinicians are aware that this is the case
Suspected awareness: patient tries to find out if they are dying because they suspect that this is the case
Mutual pretence: the patient and staff do not acknowledge openly with each other that the patient is dying although both parties believe this to be the case
Open awareness: this is when the patient, staff and family/friends can acknowledge, in their interactions with each other, that the patient is dying

Source: Glaser and Strauss (1965)

Potential solutions

- Improved senior medical staff leadership
- CLEARx decisions
  - Consultant Leadership EOLC, ACP, Rx decisions
- Education clinicians
  - Especially doctors = starting at medical school
    - Comfort care = not failure
    - “A good death” = success
    - Communication skills
    - Start the conversation early in the course of decline
  - Nursing and allied health
    - Spend time with family / patient
    - Should contribute to discussion
- Coordinated response
  - End of life care coordinator

- Linking the RRT with palliative care
- Education community
  - Comfort in discussion of death and dying
  - Discussion about how and where they want to die
  - E.g. Charlie Corke
    - “In the end”



Summary

- Many patients have a predictable decline
  - Death and dying should not be a surprise
- Hospital clinicians often cannot diagnose “patient is dying”
  - May be left up to intensive care staff
- Several barriers to providing good end of life care
- Need for
  - Coordinated approaches – especially in hospitals
  - Education – clinicians and community
  - Increased comfort with talking about death and dying