Advance Care Planning

Practical principles

and

Prognostication in frail elderly

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Dida Cornish
Consultant St Peter's Hospice

St Peter's Hospice
For Patients, Families and Bristol

Aims

- To improve understanding of practical aspects of ACP including:
  - What, where how and why?
  - DNACPR decisions-who decides?
  - Confusing terminology around ACP?
  - Where are we with TEPS?
- Identifying elderly/frail patients with poor prognosis

What do we mean by advance care planning?

What?
For who?
By who?
Including who?
How?
When?

Advance Care Planning

- **What?**
- A *process* of discussion between individuals and their care providers about the individual's preferences and priorities for their future care.
  - Concerns/values/goals
  - Type of care they prefer
  - Preferred place of care/death
  - Understanding of their illness & prognosis
  - Explanation of pros/cons of intensive or emergency treatments
  - Views on future hospital admission

Advance Care Planning

- **For who?** People with a life-limiting or progressive condition in anticipation of their future deterioration and loss of capacity to make decisions at that time
- **By who**? By professionals providing care (irrespective of discipline) with the necessary communication skills
- **Including who?** Individual +/- carers, friends and family
- **When?** At diagnosis or progression? Transfer to NH?
- Not everyone will want to have these discussions and they should not be forced to do so.

Plan ahead

WHY?

Why? Research EVIDENCE?

- Evidence that ACP is associated with:
  - Death in place of choice and with use of palliative care
  - Increased sense of control
  - Decreased admissions from Nursing Homes
  - Improving hope
  - Increased congruence between preferences and treatment
  - Less time in hospital in last year
  - Decreased costs of hospital treatment in last year
  - Better bereavement for carers?

HOW? ACP: Dos' and Don'ts

- **Do:**
  - Explore the patient's understanding
  - Explore if they want to talk about their illness/the future
  - Approach it in a stepwise way
  - Consider it as an ongoing process

ACP: Dos' and Don'ts

- **Don't:**
  - Force anyone to have the discussions if they don't want to
  - Do it as a tick box exercise
  - Feel you have to use a tool/produce paperwork
  - Do it in a rush

Initiating the conversation

Initiating the conversation

- ‘What do you understand about your illness/health condition and how it might affect you over time? ‘
- ‘How have you been coping with your illness recently?’
- ‘Are you the type of person who…
  - Wants to talk about you illness?
  - Wants to think about how your illness might affect you in the future?
  - Wants to think about or plan for the future?’
- ‘When you think of the future, what do you hope for?’
- ‘When you think about the future, what worries you the most?’
- ‘What goes through your mind about..’

During the conversation

- ‘Have you given any thought to what kinds of treatment you would want (and not want) if you became unable to speak for yourself?’
- ‘There are some people who want any treatment available to prolong their lives, where-as others..’
- Give patients enough information to make informed choices without overloading them
- Clarify any ambiguous statements that patients make—for example: “I don’t want heroics”

Ending the conversation

- Summarise what has been discussed or ask the patient to do so
- Screen for any other problems: ‘Is there anything else you would like to discuss?’
- Arrange another time to continue, complete, or review the discussion
- Document the contents of the discussion in the patient record (or consider patient held record e.g. PPC, TEP)
- Share the contents (with the patient’s permission) with anyone else who needs to know.

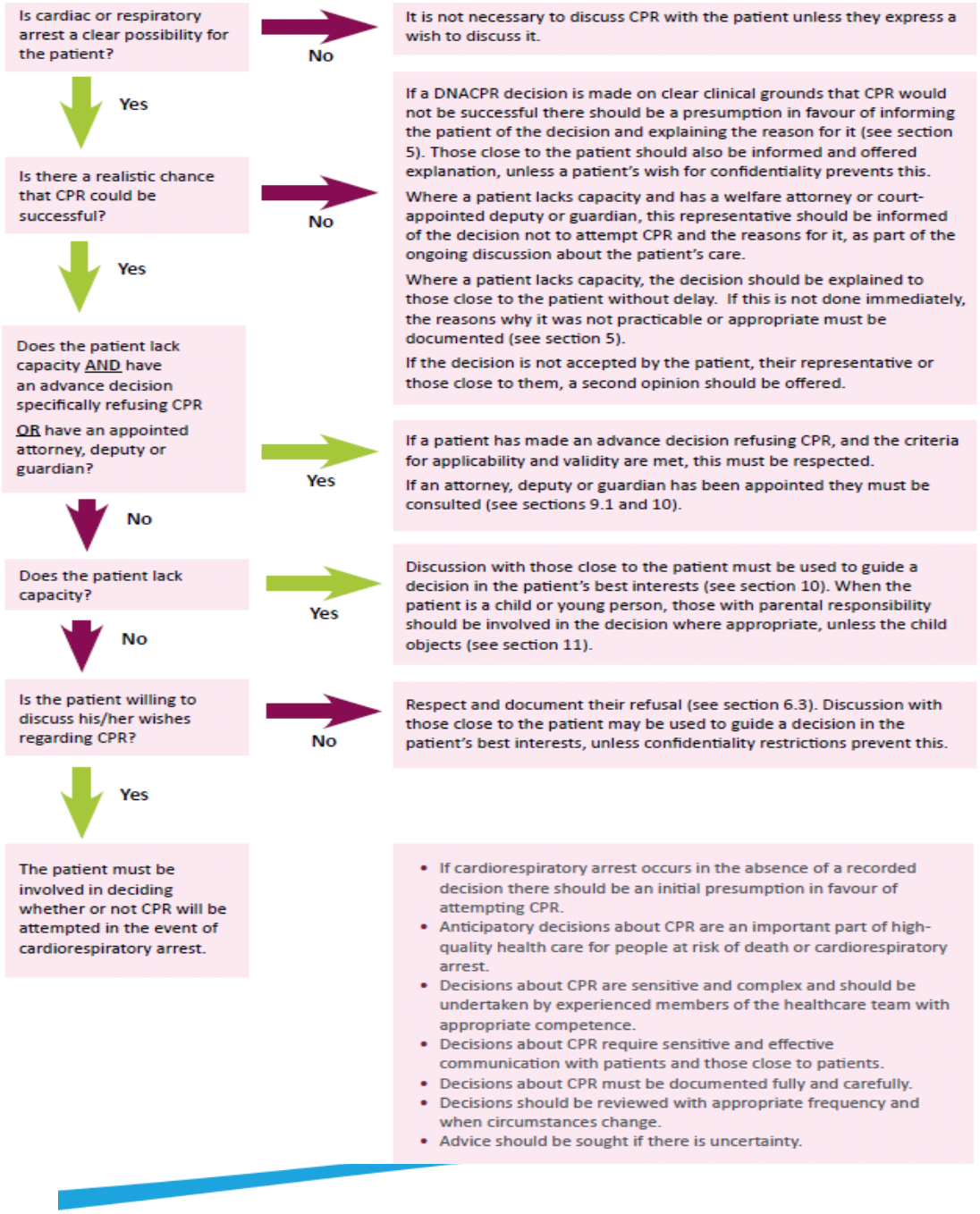
DNACPR cases

Fred is an 80 year old man with heart failure secondary to Ischaemic heart disease. He is bed bound due to dyspnoea and general frailty. He was recently discharged after a prolonged admission with heart failure and hospital acquired pneumonia. The hospital discharge letter identifies him as having a poor prognosis. His daughter requests a home visit because she has found a DNACPR form and says he wants the decision reversed.

How do you approach this?

DNACPR cases

Would your approach be different for Edith 86 an ex-smoker who has a left below knee amputation and leg ulcers on the right leg due to peripheral vascular disease who is wheelchair bound, but has no known other comorbidity?



Decisions relating to CPR

3rd edition 1st revision 2016

BMA/RCN/Resuscitation Council UK

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MCQ on ACP terminology

What is the correct legal term for a Living Will?

A. Advance Directive

B. Advance Directive to refuse treatment

C. Advance Decision to refuse treatment

MCQ on ACP terminology

What is the correct legal term for a Living Will?

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If someone has appointed a Lasting Power of Attorney for health and welfare which of the following is true?

A. They can contradict an ADRT if the patient has lost capacity
B. They can demand treatments on behalf of a patient who has lost capacity against HCP advice
C. They can always make decisions about refusal of life sustaining treatment if the patient lacks capacity

If someone has appointed a Lasting Power of Attorney for health and welfare which of the following is true?

A. They can contradict an ADRT if the patient has lost capacity

Which of the following is true about an ADRT?

A. It must be made in consultation with a doctor
B. It must be on a recognised form
C. It must include the following ‘ if my life is at risk as a result’ or similar if refusing Invasive Ventilation.

Which of the following is true about an ADRT?

C. It must include the following ‘ if my life is at risk as a result’ or similar if refusing Invasive Ventilation.

Which of the following is true of a Preferred Priorities of care document?

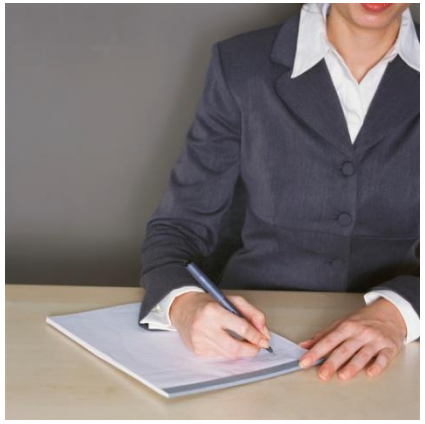
A. It should be taken into account when making a best interest decision
B. It is a type of MCA advanced statement
C. It is a legally binding document

Which of the following is true of a Preferred Priorities of care document

A. It should be taken into account when making a best interest decision

Advance Statement

- A statement reflecting an individual's preferences and/or values in relation to future treatment or care. May cover medical or non medical issues.
- May be written by the patient or recorded by a professional or carer
- Not legally binding but according to MCA must be taken into account when making treatment decisions for a patient who lacks capacity



Advance Decision to refuse Treatment

- Previously known as Living will or Advance Directive

- An advance decision must relate to refusal of a specific treatment in specific circumstances

- It will only come into effect when the individual has lost capacity to give or refuse consent.

Proxy/Lasting Power of Attorney

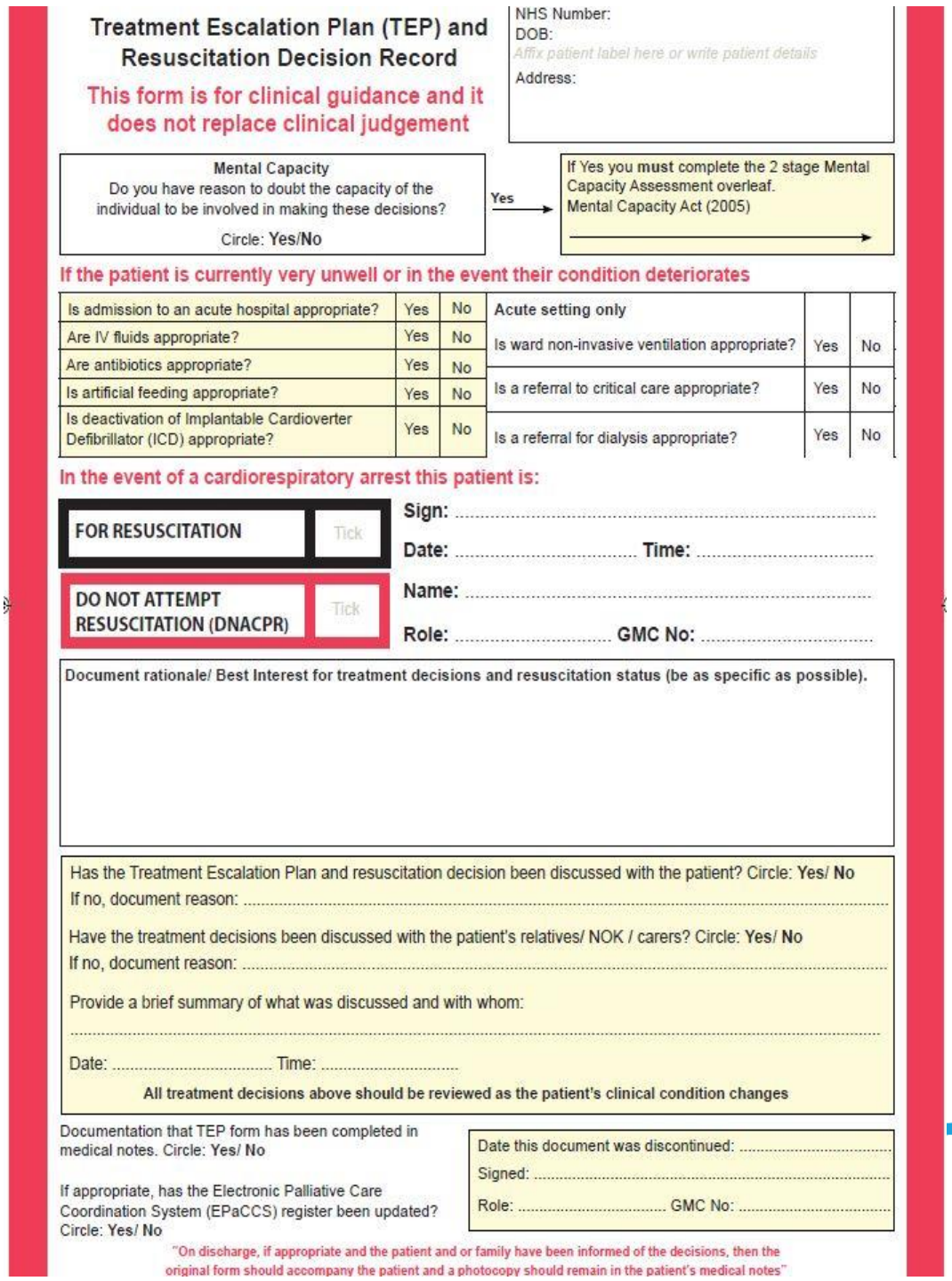
- An individual with capacity can appoint a person (an “attorney”) to take decisions on their behalf if they subsequently lose capacity

- May be appointed to make decisions about personal welfare matters as well as property and affairs

- May be appointed to make all or specific health and welfare decisions on their behalf

TEP, ReSPECT, EPaCCs

- Treatment Escalation Plans are used within hospital and in some parts of the SW
- National Team is trialling a new form called **Re**commended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment
- A local group is working on an Electronic Palliative Care Co-ordination System which will be based within EMIS but accessed in other settings through Connecting Care.



Treatment Escalation Plan (TEP) and Resuscitation Decision Record

This form is for clinical guidance and it does not replace clinical judgement

NHS Number:
DOB:
Affix patient label here or write patient details
Address:

Mental Capacity
Do you have reason to doubt the capacity of the individual to be involved in making these decisions?
Circle: **Yes/No**

Yes → If Yes you **must** complete the 2 stage Mental Capacity Assessment overleaf.
Mental Capacity Act (2005)

If the patient is currently very unwell or in the event their condition deteriorates

Is admission to an acute hospital appropriate?	Yes	No	**Acute setting only**		
Are IV fluids appropriate?	Yes	No	Is ward non-invasive ventilation appropriate?	Yes	No
Are antibiotics appropriate?	Yes	No	Is a referral to critical care appropriate?	Yes	No
Is artificial feeding appropriate?	Yes	No			
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	Yes	No	Is a referral for dialysis appropriate?	Yes	No

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION	Tick
DO NOT ATTEMPT RESUSCITATION (DNACPR)	Tick

Sign: .....
Date: ..... **Time:** .....
Name: .....
Role: ..... **GMC No:** .....

Document rationale/ Best Interest for treatment decisions and resuscitation status (be as specific as possible).

Has the Treatment Escalation Plan and resuscitation decision been discussed with the patient? Circle: **Yes/ No**
If no, document reason: .....

Have the treatment decisions been discussed with the patient's relatives/ NOK / carers? Circle: **Yes/ No**
If no, document reason: .....

Provide a brief summary of what was discussed and with whom:

.....

Date: ..... Time: .....

All treatment decisions above should be reviewed as the patient's clinical condition changes

Documentation that TEP form has been completed in medical notes. Circle: **Yes/ No**

If appropriate, has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/ No**

Date this document was discontinued: .....
Signed: .....
Role: ..... GMC No: .....

"On discharge, if appropriate and the patient and or family have been informed of the decisions, then the original form should accompany the patient and a photocopy should remain in the patient's medical notes"

TEP form

in place in N.Somerset, BANES and SW

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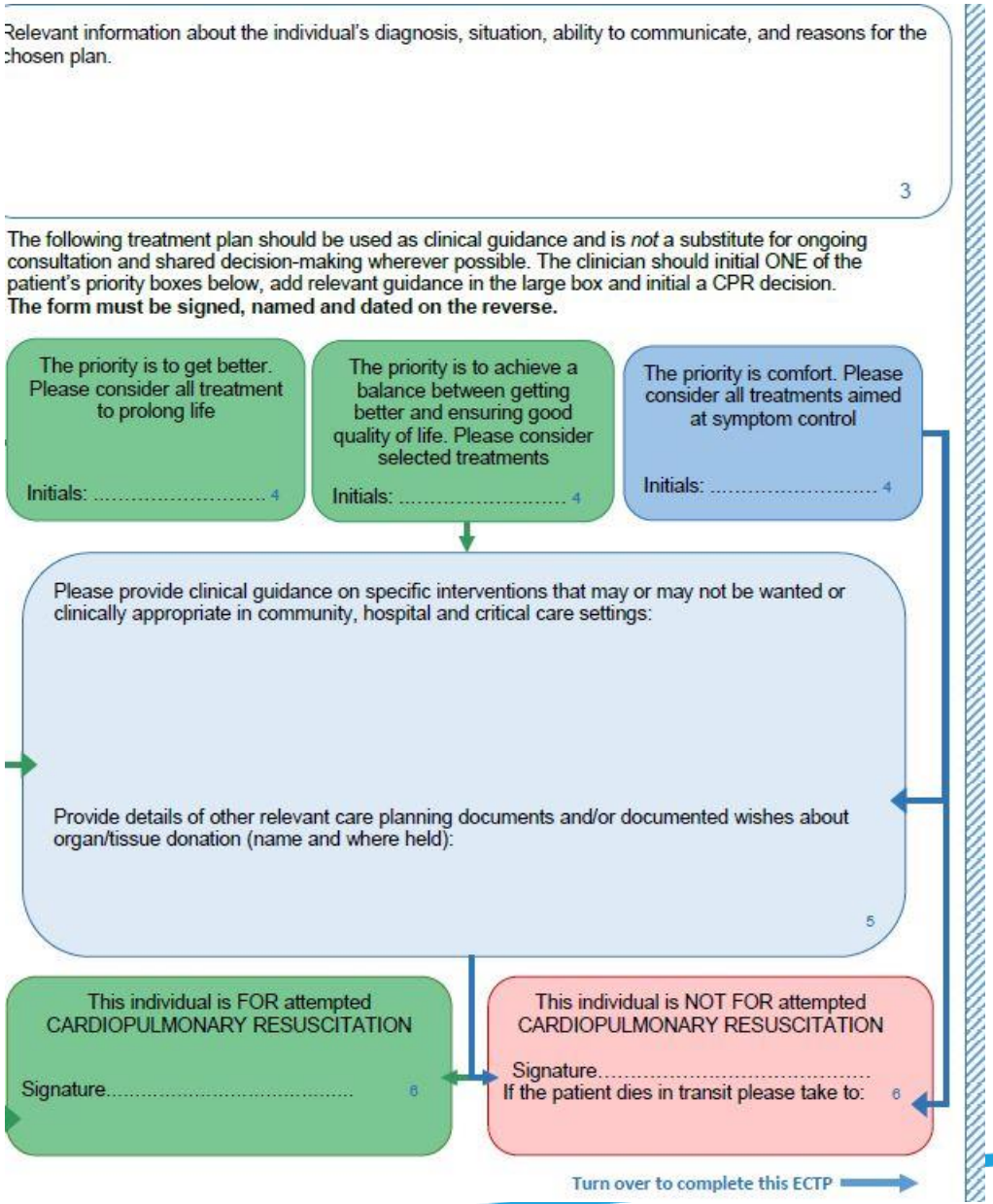

1st DRAFT National ReSPECT Form

Pilot in progress outcome soon

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Identifying the last year of life in frail elderly/dementia

- Prognostic Indicator Guidance
- General Predictors of poor prognosis

Prognostic Indicator Guidance

- General Predictors of poor prognosis
  - Weight loss >10% in 6 months
  - Multiple co-morbiditues
  - Declining performance status
  - Albumin <25
  - General decline

Hospital Initiatives

- Identify patients in their last 6-12 months is everyone's business (Bristol CQUIN 2015)
- Acute trusts are identifying and communicating with GP's about these patients on discharge
- UHBristol: Poor prognosis letters, should identify if conversations have started in hospital
- NBT: Tick box on discharge letter 'suitable for GSF meeting'
- Both trusts using locally adapted Prognostic indicator Guidance.

Dementia

- All of:
- Immobile
- Urinary and faecal incontinence
- No consistently meaningful verbal communication
- Reduced ability to perform activities of daily living Barthel <3
- Other complications e.g. pressure ulcer

Frailty

- Multiple comorbidities with deteriorating day to day functioning
- Combination of at least 3 symptoms of: weakness, slow walking speed, low physical activity, significant weight loss, exhaustion

Anticipatory Prescribing

- Community Palliative Care Drug charts
  - Paper charts
  - EMIS based protocol with decision aid and alerts to produce chart and FP10
  - Prepopulated form for opioid naïve patients
  - Form with drop downs for all others
- Different in frail/dementia?
  - Less likely to need syringe driver and NH less knowledge about drivers
  - PRNS only? NO RANGES?

Resources

http://www.stpetershospice.org.uk/healthcare-professionals/clinical-guidelines/

- Care of Dying adults in last days of life

https://www.nice.org.uk/guidance/ng31/chapter/Recommendations

An introduction to advance care planning in practice: Mullick et al. *BMJ* 2013;347:f6064 http://www.goldstandardsframework.org.uk/cd-content/uploads/files/ACP/An%20intro%20to%20advance%20care%20planning%20in%20practice.pdf

- Education

http://www.e-lfh.org.uk/programmes/end-of-life-care/

PLAN : dying matters

www.stpetershospice.org

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