Blog of the Month

Dr Conal Corr is an Internal Medicine Trainee currently based in Northern Ireland. For this month's edition of the APMJ blog he talks us through a recent Quality Improvement Project he has completed on Advanced Care Planning and hopes to hear from others on the subject- contact details can be found below!

Advanced Care Planning: What Can We Build On?'

In early 2020, I decided to take on a QI project looking at enhancing advanced care planning discussions in a care of the elderly (COE) inpatient unit. This project was motivated by some discrepancies in documentation of ceilings of treatment (COT) in a number of inpatients. I could see that very appropriate conversations were being shied away from, with phrases like, "resuscitation status not discussed" written in notes with no further action being taken. This showed that ceilings of treatment were being thought of but not acted upon. I had also experienced elderly patients deteriorating quickly and unexpectedly. This left out of hours teams making difficult decisions with patients they were unfamiliar with. The families of these patients were then subject to difficult conversations, without warning and often in the middle of the night.

I gathered baseline data from some doctors working out of hours on medical wards. Nine FY1 doctors, four medical registrars and fourteen doctors working on the SHO rota responded to the survey. There was a resounding agreement with the statement that clearly documented ceilings of treatment would aid decision making out of hours. There was a mix of responses when the respondents were asked about their confidence making COT decisions out of hours. If I were to run the project again, I would rephrase that question to check if respondents believed that COT decisions should ideally be made during the day by senior clinicians in charge of patient care.

The project itself involved creating a document which would depict important ceilings of treatment and whether these would be appropriate. Within two months, 100% of patients had clearly documented ceiling of treatment plans visible in their medical notes. Admittedly this number was enhanced with the promise of a monthly audit! A Driver Diagram (Appendix 1) demonstrates the many small steps which had to be taken to achieve the overall aim of the project.

Blog of the Month

At a local presentation, this undertaking was well received by the care of the elderly team. The positive change in the project was mostly demonstrated through the initial data as clear COT documentation was identified to be important. Ideally, some follow up would have been extremely beneficial. I especially wanted to hear from doctors working out of hours who had found this documentation useful when seeing acutely unwell patients. This could have been done through focus group discussion, but pandemic restrictions and rotational nature of posts prevented this.

The project did however evoke thought and discussion among the COE team. I would hope that sharing this blog post would give the project the closure it missed out on.

Discussion points included.

1. Appropriateness of discussions. At times, patients and their relatives were taken aback by these discussions. Most were very amenable once the reasoning was explained but it did raise the question of whether having these conversations was of benefit in patients who would quite probably remain stable throughout their admission. My thought process here was that a patient's acute clinical condition may not accurately reflect their overall frailty and chance of a full recovery. This could well be overlooked by those less familiar with clinical frailty scoring (1). This project also sought to ensure that no patient was undertreated for this reason. Perhaps we need to tackle the taboo around discussions regarding treatment options and what is appropriate. I feel that linking in with the general public about DNACPR orders and what this entails would break down many barriers and I wonder how best this could be achieved.

2. Timing of review and conversation. Originally, we had hoped that these decisions could be made on a post take ward round by senior clinicians in charge of a patient's care. The point was raised by a COE consultant that these decisions should wait until patients have had more time in the unit so we can get to know them better. This is of course understandable but is complicated by the fact that increasing age is a strong risk factor for acute deterioration in the first 24 hours after admission despite normal vital signs at presentation (2). I would also suggest that these COT decisions shouldn't be based on clinical course but on overall frailty and co-morbidities.

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Blog of the Month

3. Educational opportunities. As mentioned, these conversations are often a taboo subject for the general public and often the cause of distress. In the same regard, it has been identified in a trust where I previously worked that junior doctors are shying away from these discussions even when they are entirely necessary. Could we be doing better in terms of active teaching for junior doctors regarding COT discussions?

I would love to hear the thoughts of my peers on the above project and some of the challenges that it raised. If you would like to get in touch, I am more than happy to be contacted on either of the following platforms.
Twitter: @conalcorr
Email: conalcorr@hotmail.com

References

1. More than a number; the limitations of the Clinical Frailty Scale for patient escalation decision making in COVID-19. Halpin S, Jundin A. *ACNR* 2020;19(3):10-11
2. Prognosis and Risk Factors for Deterioration in Patients Admitted to a Medical Emergency Department. Henriksen DP, Brabrand M, Lassen AT. PLoS One. 2014;9(4):e94649 Epub 2014/04/11. 10.1371/journal.pone.0094649

Blog of the Month

Appendix 1. Driver Diagram showing required steps to achieve project goal