Widening treatment escalation planning beyond DNACPR decisions within the Edinburgh Cancer Centre

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Background

According to the General Medical Council, it can be difficult to establish the patient's wishes or to get relevant information about their underlying condition to make a considered judgement at the time they suffer a cardiac or respiratory arrest and an urgent decision has to be made. Therefore establishing a management plan in advance will help to ensure that the patient's wishes and preferences about treatment can be taken into account and that, if appropriate, a DNACPR decision is made and recorded. This is especially relevant in the age of European Working Time Regulation compliance where often a single patient is exposed to a variety of responsible clinicians during their stay.

Aim

To assess the current standard of documentation in inpatient notes across the oncology wards relating to the discussion of resuscitation and escalation status.

Method

A 'snap-shot' study was completed across all inpatient wards within the Edinburgh Cancer Centre to assess DNACPR and escalation planning discussion and documentation, who carried out the discussions and was the DNACPR reviewed during admission and demographic data was collected to contextualise the results. This included diagnosis and extent of cancer, reason for admission – unplanned/elective, medical co-morbidities and WHO performance status.

Results

A total of 46 patients notes were reviewed over 4 wards. 9 patients (19.6%) had a DNACPR form completed in their notes, of which 66% had supporting documentation about the form within the body of their notes. Only 4 of the 46 patients (8.7%) had any documentation about escalation planning anywhere within their notes for the current admission.

There was a range of primary cancer types seen in Fig 1, with the majority being Lung and Breast which is in keeping with cancer epidemiology.

Using the demographic data collected, of the 9 DNACPR forms present; Fig 2a shows 8 were in unplanned admissions and 1 in elective. Fig 2b shows that 8 were in patients with metastatic disease and 1 without. Fig 2c shows that 8 were in patients Performance Status 3/4 and 1 in Performance Status 1 and Fig 2d shows that 6 were in patients with no medical co-morbidity, 2 with 1 co-morbidity and 1 with 2 co-morbidities. It also shows that a patient with 3 medical co-morbidities did not have a DNACPR form.

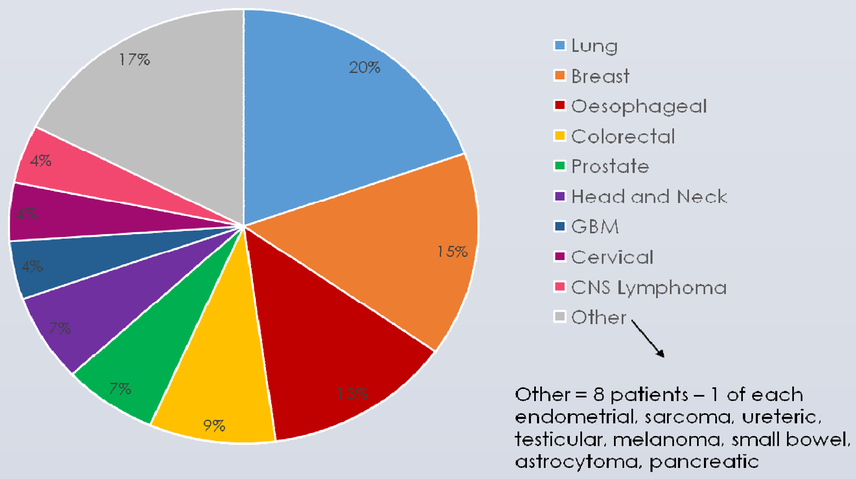

Fig 1: No. of patients included by primary disease site

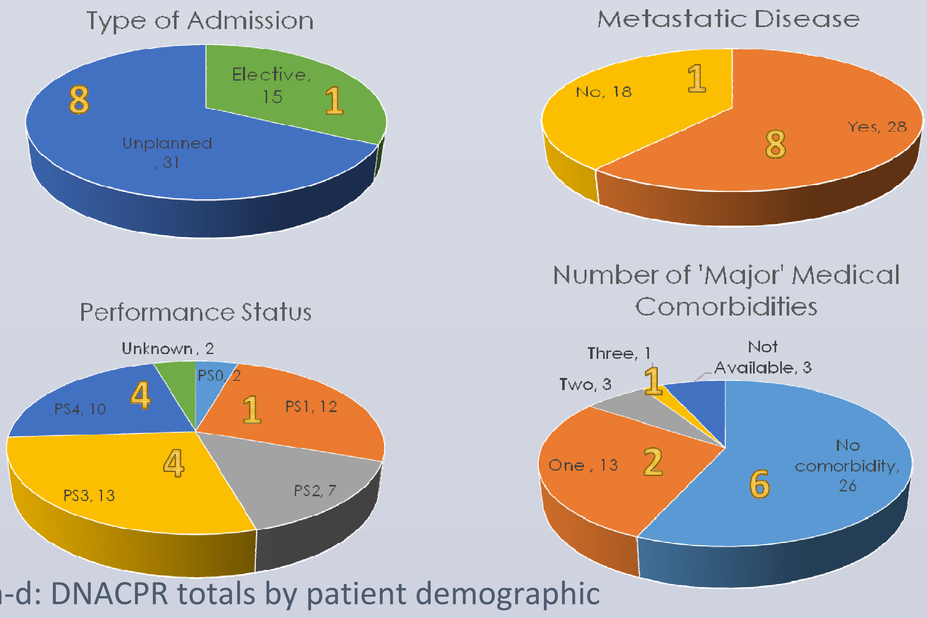

Fig 2 a-d: DNACPR totals by patient demographic

Conclusion

From our data, it can be concluded that once a DNACPR is in place in the ECC there is often supporting documentation within the patients notes. The majority of DNACPR forms were authorised by a consultant and patients with PS 3/4 are more likely to have a DNACPR in place. Finally it suggested that perhaps other medical co-morbidities in the oncology population should be given more weight in discussions about escalation planning and DNACPR.

It is widely accepted that clarity around escalation status and resuscitation status will aid the provision of patient-centred care in the event of acute deterioration. Overall, it was felt that 8.7% of patients having evidence of treatment escalation planning was not consistent with accepted good-practice and could be improved. As such, a number of proposed solutions were considered to structure these discussions with our patients, including our favoured solution of a Treatment Escalation Plan document.

Ongoing Work

A Treatment Escalation Plan is a dedicated clinical guidance tool which aims to set out appropriate treatment options reflecting the individual needs, situation and wishes of the patient for whom it has been completed, including a decision regarding CPR status .

They have the advantages of being evidence based (variations of this have been used in other NHS Trusts e.g. the UFTO in Cambridge), involve the patients and their families in the process of their completion and form a standardised easily accessible way of communicating escalation plans.

Potential disadvantages include time taken to complete the form over and above current practice, as well as the need to ensure robust systems for initial introduction to patients as well as for regular review of the forms content. This is currently being developed within the ECC using a quality improvement approach and we look forward to presenting further data regarding its use in due course.

ECC TREATMENT ESCALATION PLAN v4

TEP SHOULD BE REVIEWED AT LEAST WEEKLY ON THE CONSULTANT WARD ROUND AND RE-DATED TO CONFIRM REVIEW.
IF ANY CONCERN REGARDING CHANGE IN CONDITION SINCE TEP COMPLETED AND APPROPRIATENESS OF INTERVENTIONS THEN DISCUSS PATIENT URGENTLY WITH THE RELEVANT ONCOLOGY SPR/CONSULTANT.

Surname:
First Name:
CHI Number:
DOB:
Affix patient label here or write patient details clearly

Diagnosis: _____

Current Treatment: SACT/Radiotherapy/Chemoradiotherapy/Nil
Treatment Intent: Curative/Neo-adjuvant/Adjuvant/Radical/Palliative

Consultant: _____

☐ This patient is for **CARDIOPULMONARY RESUSCITATION**, **FULL ESCALATION** and all active interventions

☐ DNACPR YES ☐ NO ☐ (if YES please ensure DNA CPR form completed)

This patient is suitable for:

Consideration of escalation to Critical Care	YES/NO
Consideration referral to another inpatient specialty	YES/NO
Oncology Ward Level Care only	YES/NO

Ward Level Care

IV antibiotics	YES/NO
IV fluids for resuscitation	YES/NO
IV fluids for maintenance	YES/NO
NG insertion (for medication)	YES/NO
Routine calculation of SEWS score	YES/NO
Regular blood tests	YES/NO
_____	YES/NO
_____	YES/NO

Further Patient Specific Instructions

☐ This patient has a **DNACPR** form completed and is **not for escalation.**
Symptom control is the priority – review drug kardex & prescribe anticipatory meds as appropriate.
This patient is not for further routine calculation of SEWS score or blood tests and no new interventions should be made unless specifically requested by senior medical staff (ST3 and above only).
Medication Review ☐ (Consider stopping LMWH & rationalise existing medications)
Venflon to be resited if tissues YES/NO
IV Antibiotics to continue YES/NO

Signature of doctor completing form _____ Designation _____ Date _____
Signature of own-team consultant _____ Date _____ (must be signed within 48 hours)
Discussed with patient? YES / NO Date: Discussed with NOK? YES / NO Date:
If unable to discuss, please give reason _____

Review	Date Reviewed	Outcome	Signature/Designation
1		No Changes / New Form Completed	
2		No Changes / New Form Completed	
3		No Changes / New Form Completed	

References

http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_ contents.asp
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