Impact of Treatment Escalation Plans on Shared Decision Making

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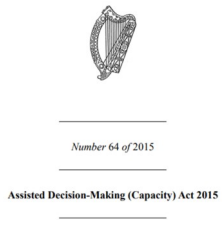
Background:

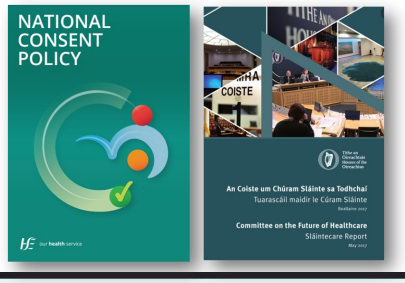
- One of the implications of the recently enacted Assisted Decision Making – (Capacity)Act has includes a statuary provision for the making and recognition of Advanced Care Directives.



- The International Liaison Committee for Resuscitation (ILCOR) and the European Convention for Human Rights have recommend that individuals with advanced illness/ multiple co-morbidities should be provided an opportunity to discuss emergency care and treatment plans with their Healthcare Providers.

- There have been a variety of such Emergency Treatment Escalation Plans developed internationally. In Ireland, most centres have focused on limitation of therapy in the form of DNA-CPR orders.

- Such strategies are akin to a STOP sign for treatment. A Treatment Escalation Plan offers an opportunity to ensure communication for ongoing treatment strategies that align with patient or service user's wishes as well as staff expectations and reducing harm, distress and enabling autonomy. In spite of recognition of need for such strategies in the National Consent Policy and the Slaintecare Report, there is no standardised national strategy currently in place in Ireland.

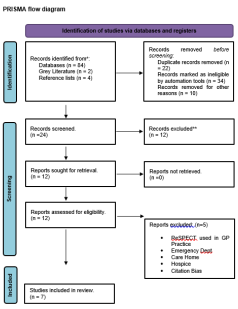


Methods

- A systematic review was conducted to compare the impact of Treatment Escalation Plans vs DNA-CPR forms on shared decision making in adult patients with acute hospital presentations.

- The primary outcome assessed was impact on patient autonomy and shared decision making. Other outcomes assessed included impact on use of non-beneficial treatments including CPR, impact on harm and complaints. A search was conducted using relevant using PUBMED and CINAHL databases.

Results



Included Studies

Authors	Setting	Design	Population	Primary Outcome	Secondary Outcome
Lightbody *et al 2018*	Hairmyres Scotland	Structured Judgement Review	n=289	n = 155 (54%) had TEP/ DNACPR forms completed n = 113 (39%) had DNACPR forms only n=21 had neither completed.	Non beneficial interventions and harm was significantly lower in the TEP/DNACPR cohort in comparison to DNACPR only cohort (per 1000 bed days) 17.1, 76.9 (p<0.001) and 197.8 (p<0.001) retrospectively.
Detering *et al 2010*	Melbourne Australia	Randomised Control Trial	n =309 Pts 80yrs or older	86% with ACP had end of life wishes respected compared with 30% among controls (p<0.001)	*Family members of patients who died had less stress (p=0.001), anxiety (p=0.02) and depression (p=0.002) than those of the control patients*
Dignam *et al* 2022	Adelaide Australia	Retrospective observational study	n= 2759 Intensive treatments	1304 pre-intervention 1455 post Intervention (TEP)	No reduction in intensive treatments post intervention of TEP
Walker *et al* 2019	Oxford England	Prospective cohort Study	n= 481 Aged 65yrs and over	105/481 (22%) had DNACPR.	Older adults with multimorbidity need the opportunity to discuss the role of CPR earlier in their care
Kohen & Nair 2019	British Columbia Canada	Single centre Qualitative Study	n = 329	MOST implementation was associated with 41% increase in documented life sustaining treatment plan at inception increasing to 100% in 8 months increasing informed decision-making.	Pts with MOST implementation less likely to experience discordance in expressed preferences for care (95% CI 2.3 to 7.1. p<0.0001)
Tuesen *et al*, 2022	Denmark	Mixed Methods Pilot Study	n = 25	A pilot study for testing the development of a Danish POLST	The Danish version of the POLST form was assessed by patients, families, physicians, and nurses and found to be beneficial when documenting Danish patients' preferences for life sustaining treatment.
Cohn *et al* 2013	Cambridge United Kingdom	Multi-source Qualitative Study	n = 103	Five key themes emerged from the study. Design & primacy of the Study Matters relating to clinical decision making. Staff reflections on how form can affect care. Inappropriate resuscitation discussions with patients/relatives about DNACPR.	DNACPR orders can act as unofficial stop signs and can signify the inappropriate end to clinical decision making. Many clinicians were uncomfortable discussing DNACPR orders with patients and families. These findings help understand why patients with DNACPR orders have worse outcomes.

The Bottom Line:

- TEPs were observed to result in less harm to patients, their families and carers, especially with regard to commencement of non-beneficial interventions (including CPR) in patients aged 65 years and above with multiple co-morbidities vs DNA-CPR as well as in the absence of escalation planning.

-Stand-alone DNA-CPR forms were associated with more harm, indecision and complaints than TEPs.

Discussion

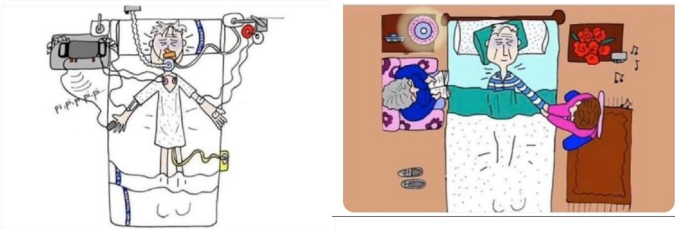
- Outcomes for the Deteriorating Patient journey incorporate more decisions than mortality and unexpected cardiac arrest, but also consideration of other interventions, including ICU admission.

- TEPs incorporate shared decision making strategies considering all such outcomes.

- There are clear benefits from international literature of TEPs as a communication tool in shared decision making for patient deterioration.

- There is no standardised system for Treatment Escalation Planning in Ireland.

When death is inevitable, the way that we die is important



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