Treatment Escalation Planning- Introducing systematic senior clinical decision making

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Background

• Patients with long term/ end stage conditions sometimes receive treatments which are inappropriate. This is burdensome to patients, families and the health economy. The National Audit Office identifies significant possible savings by reducing hospital use in the last year of life1.
• Many of these patients are well known to individuals/ teams with a clear idea how to manage changes BUT the deterioration is more likely to happen out of hours when decision making is more challenging.
• The focus of this project is on creating a systematic structure for anticipatory clinical decision making to improve out of hours decision making when clinical deteriorations occur.

Aims

• To pilot the introduction of treatment escalation decision making across an acute trust.
• To evaluate the effectiveness of the process: feedback, decision making and determine whether Treatment Escalation Planning should be introduced across the trust and the process.

Treatment Escalation Plans

• Treatment escalation planning (TEP) is a mechanism of planning the care of a patient likely to deteriorate.
• Patients with end stage diseases predictably deteriorate suddenly even if the timing is unpredictable.
• TEPs enable healthcare professionals to document a range of clinical decisions with a patient, deciding which ones a patient could benefit from and wants.
• In other studies TEPs are popular with patients and staff because they cover issues other than resuscitation, meaning that a discussion can cover treatments which may help, rather than just being about those treatments which will be excluded2.
• Treatment escalation decisions are about deciding on a patient’s ability to benefit from a treatment combined with their preferences.

Method

• Treatment escalation planning was introduced as a pilot in the following inpatient settings: Respiratory, Cardiology, Care of the Elderly, Acute and General Medicine, Critical Care, a community hospital and Palliative Care.
• Baseline audits were carried out in each setting, looking at out of hours decision making, before and after the pilot were carried out.
• The outcomes were measured and feedback obtained from staff in relation to ease of use, issues encountered and practicalities of the form.

Results

• Pre-TEP implementation, some discussions around ceilings of care occurred, but clearly documented plans were mostly absent or hard to identify.
• Data is presented for the acute wards and community hospital. 66 patients’ notes were analysed on the introduction of TEPs.
• Mean time for discussions was 8.3 minutes. Mean time to complete the form was 5.5 minutes.

Discussion and next steps

• Treatment Escalation Plans enabled clear decisions to be made in advance of a deterioration. Clinicians were good at predicting those who were likely to deteriorate- only 1 patient for full active care experienced an acute change in condition. In the other group a significant majority of patients experienced acute deteriorations for which the TEP was relevant.
• Treatment Escalation Plans were popular with all staff, especially junior doctors who felt TEPs gave them a language to discuss decision making.
• Completion of the forms was good except for the communication section. This reflected a dilemma for clinical staff about the discussion of decision making and the level of patient involvement, especially where the decisions were clear-cut. Our trust is clear that these decisions should be discussed.

Next steps

• Treatment Escalation Planning is a potentially powerful tool in trying to deliver appropriate levels of patient treatment, avoiding under and over treating. They allow positive discussion of treatments that could help as well as those that will not.
• Our trust has decided to adopt it for all admissions to create a culture of thinking ahead using a simple but relevant form, and looking towards piloting in community settings. In the community hospital the form was back to an acute setting, reduced. Most patients are for full active treatment making the forms irrelevant. The form has been modified so it can be completed quickly for these patients. The form will be for all patients to avoid missing patients.
• The decision making, discussion and form completion do take extra time early on for patients who are more complex, but should save time later on.
• Treatment Escalation Plans are advisory and need to be applied sensibly by those assessing a patient at a time of deterioration.
• A project team has been established to implement trust-wide

References