DETERMINING A ‘CEILING OF CARE’

MODULE: EMERGENCY DEPARTMENT

TARGET: ACCS(CT1-3), ST4-6

BACKGROUND:

Increasingly, medically complex, chronically ill patients are being managed in the community rather than as long-term in-patients. When they become acutely unwell and can no longer be safely managed at home, they are often brought to the ED for assessment.

A small number of these chronically unwell patients, in the event of a sudden deterioration, will already have expressed their wishes for treatment in the form of a care plan or ‘advanced directive’, or in the event of a cardio-respiratory arrest, a ‘DNACPR’ form. However, more often than not, no such plan exists and, where appropriate, it often falls to the Emergency physician, in conjunction with the patient and next-of-kin, to determine one.

RELEVANT AREAS OF THE CURRICULUM

CC1 History Taking
CC5 Decision-making / Clinical reasoning
CC6 Patient centre focus of care
CC12 Relationship with patient & communication in consultation
CC13 Breaking bad news
CC17 Medical ethics & confidentiality issues
CC24 Personal behaviour
INFORMATION FOR FACULTY

LEARNING OBJECTIVES

By the end of the scenario, the participant will have practiced:

• The use of verbal & non-verbal communication techniques to build an appropriate rapport with the NOK
• Using a structured approach in ‘breaking bad news’
• Identifying, validating and addressing the next-of-kin’s concerns and anxieties
• Facilitating the use of informed assent/decision-making regarding the on-going care plan/’ceiling of care’
• Identify any system failures (NOK unchaperoned entry to resus room)

SCENE SETTING

Location: Emergency Department
Expected duration of scenario: 15mins
Expected duration of debriefing: 45 mins

EQUIPMENT AND CONSUMABLES

Telemetry in place
12 lead ECG showing Fast AF
ABG trace x2
Blood results – if requested
Repeat prescription
Chest X-ray – if requested
Urinary catheter and urometer
BIPAP mask

PERSONNEL-IN-SCENARIO

Participant – EM trainee
EM nurse – faculty
Son – standardised patient

PARTICIPANT BRIEFING

It is lunch-time and your colleague in the resuscitation room has just handed over one of their patients to you while they go on break.

Anne Clarke (AC) 72 yr old
• Known COPD/LVF sufferer
• Acutely unwell with shortness of breath and difficulty in breathing.
• Diagnoses after a thorough assessment,  
  - Pneumonia  
  - Acute on chronic deterioration renal function.
• Treatments given:
  - Steroids,
  - IV antibiotics and fluids
  - BIPAP
  - Urinary Catheter

A second arterial blood gas has just been taken to assess AC’s response to her treatment. Your colleague has asked you to review the results and talk to the next-of-kin (son) when they arrive.
‘VOICE OF THE MANNIKIN’ – ANNE CLARK

AC is extremely short of breath and currently has a BIPAP face mask on her face and is essentially unable to communicate other than intermittent coughing.

IN-SCENARIO PERSONNEL BRIEFING - NOK

NEXT OF KIN – SON (MR. CLARK)

TIME: 11.55am

PATIENT NAME: Mrs. Anne Clark (mother)  AGE: 72  RELIGION: Methodist

BACKGROUND INFORMATION
• You are 48 year old office manager
• Only child so still extremely close to mother
• Until recently, you were the main carer for you mother and lived with her
• 3 weeks ago, you were forced to finally make the decision to move her to a nursing home as you couldn’t cope anymore (you have a back problem and couldn’t lift her on your own)
• The decision has left you feeling guilty that you were physically unable to continue to look after her.

EVENTS LEADING TO ATTENDING ED
• At 8am, you were contacted by the nursing home to inform you that your mother was unwell, had had a ‘bad night’ and was going to see the GP that morning.
• An hour later, a second call (from the nursing home) told you that her condition has deteriorated and an ambulance has been called.
• Since then, you have tried several times to call the Emergency department (ED) to see how she was. However, frustratingly, no-one was willing to talk about you mother on the phone (citing patient confidentiality) and instead suggested that you ought to make your way to the hospital.
• When you arrive at the ED, initially, no-one seems to know where your mother is. Eventually, a ward clerk locates your mother and takes you to the resuscitation room directly as the quiet room was full.

INITIAL ATTITUDE AND BEHAVIOUR
• Particularly anxious
• Irate/Irritated that no-one from either the nursing home or ED would tell you what is going on when you phoned
• When shown into the Resus room – you should appear extremely upset as no-one had explained to you about how ill she was/the tight fitting mask on her face.

RESPONSES & REACTIONS
• You feels ‘let down by the system’ particularly because no-one would explain what was wrong or how ill your mother was.
• Until your concerns have been acknowledged you should remain anxious/upset/irritated about the lack of communication.
• Only when you have been offered a sincere apology should you begin to de-escalate.
• If the recent transfer of your mother to a nursing home is insensitively dealt with, due to your guilt at having to place her, you should rapidly become defensive and difficult to communicate with.
INFORMATION TO GIVE FREELY:

- Mother 72 yr old and Life-long heavy smoker (30-40/day since teenager)
- States no longer smokes (although her nails are freshly nicotine-stained!)
- Recently moved into a nursing home as you could no longer lift her alone
- Usually short of breath at rest: requires oxygen when attempting to mobilise.
- Poor mobility – deteriorating. Effectively chair/bed bound, needing two carers to help her transfer from bed to chair and commode.
- Condition has rapidly progressively over the last 10 days and now requires oxygen almost 24 hours/day
- Last week, her GP prescribed her a course of steroids and antibiotics for her chest but her condition hasn’t improved.
- Usually prefers to sleep in her armchair

INFORMATION TO GIVE IF SPECIFICALLY ASKED FOR:

- You have a copy of your mother’s repeat prescription.
- PMHX:
  - Bronchitis – was under care of respiratory team but discharged as no further options for treatment modification
  - Heart attacks x2
  - Angina
  - Atrial fibrillation (irregular pulse often feels like palpitations or ‘missing occasional beat’)
  - Chronic Kidney disease
  - High cholesterol
  - Last admitted because of chest 4 weeks ago – required ‘the tight-fitting face mask’ or ‘BIPAP’.
    Should also mention poor tolerance and wish to ‘never have that again, even if I need it’.
  - Allergic to penicillin

IN-SCENARIO PERSONNEL BRIEFING - NOK

RESUSCITATION ROOM NURSE

In this scenario, the role of the resuscitation room nurse/chaperone is essentially a passive/supportive one and will be played by a participant of a member of the faculty.

ADDITIONAL INFORMATION

See Appendices 1-3
CONDUCT OF SCENARIO

OTHER INFORMATION
If the participant is struggling, a ‘timeout’ may be called, allowing the SP to enunciate their feelings/concerns. This also gives the candidate the opportunity to alter their approach to mum.

Expected Actions: DE-ESCALATION
- Introduce
- Offer apology/explanation
- Move to quiet area to discuss care
- Arrange nurse to act as chaperone

PT HANDOVER, RESUS ROOM
Initial Settings
A: maintaining own, productive cough
B: RR30/min, SpO2 81% Poor AE, diffuse creps
C: HR 125 (AF), 89/55mmHg
D: Anxious, struggling GCS E3V4M6
E: warm peripheries, temp 39.4

UNANNOUNCED ARRIVAL OF NOK
NOK – Son, Mr. Clark enters Resus room
- No space in relatives room so brought straight to Resus room
- Unaware of situation
- Unhappy with phone communication

RELATIVES'/QUIET ROOM
With nurse chaperone and Mr. Clark

LOW DIFFICULTY
- Son is calmed by the approach taken.
- Amenable to discussing the ‘ceiling of care’ / futility of intubation/CPR
- Assents to the DNACPR status

NORMAL DIFFICULTY
- Son remains anxious / upset
- If poor communication, challenges diagnosis /futility of treatment escalation but...
- Eventually accepts the situation

HIGH DIFFICULTY
- Unhappy with approach/poor rapport development
- Becomes increasing irritated/angry
- Disagrees with ‘ceiling of care’ / DNACPR, requesting 2^{nd} opinion

Expected Actions: INFORMATION GATHERING/ DECISION-MAKING
- Listens carefully to the son’s ‘story’
- Appropriate use of pauses/non-verbal queues
- Summarisation of events
- Allows son to react, ask questions and/or express his concerns
- Empathise/validate son’s emotional response
- Explains rationale for supporting treatment and ‘ceiling of care’
- Broaches subject of DNACPR in event of cardiac arrest
- Establishes continued availability to discuss further questions
- Arranges for son to spend time with mother
- Sensitive closure of discussion.

RESOLUTION
- NOK accepts futility of treatment.
- Asks to spend time with mother
DEBRIEFING

POINTS FOR FURTHER DISCUSSION

1. SP feedback
2. Important clinical issues arising
3. De-escalation
4. What makes a good communicator?
   • Verbal & non-verbal techniques
   • Pauses, allows uninterrupted patient/NOK speech
   • Empathises – validates son’s anxieties/emotions
5. What is a ‘ceiling of care’ and how is one determined? (Was the prescription for Tamoxifen noted?)
6. DNACPR
   • Who can make this decision
   • Next of kin ‘assent’
7. Advanced Directives – what makes them valid?
8. Governance – identification of system errors and what to do about them?
   • Un-chaperoned entry of the patient’s son into the resus room

DEBRIEFING RESOURCES

End of Life Care for Adults in the ED, Best Practice Guidance (Feb 2012)
http://secure.collemergencymed.ac.uk/code/document.asp?ID=6285

www.resus.org.uk/pages/dnar.pdf


www.endoflifecareforadults.co.uk
### APPENDIX 1 – ARTERIAL BLOOD GAS RESULTS

**RADIOMETER ABL 9000 SERIES**

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<th>Parameter</th>
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<td>Patient First Name</td>
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<td>Patient Last Name</td>
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<td>Sample type</td>
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#### Blood Gas Values

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#### Oximetry Values

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<td>PO₂Hb</td>
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</tr>
<tr>
<td>RhmetHb</td>
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#### Electrolyte Values

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<td>cNa⁺</td>
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#### Metabolite Values

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#### Acid Base Status

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<tr>
<th>Parameter</th>
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<td>cHCO³⁻(P,st)c</td>
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**Notes**

↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated Value(s)
e Estimated Value(s)
### APPENDIX 1B – ARTERIAL BLOOD GAS RESULTS

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<td>Patient ID</td>
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<td>Patient First Name</td>
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<td>Patient Last Name</td>
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<tr>
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<tr>
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#### Oximetry Values

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<tr>
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<tr>
<td>sO₂</td>
<td>78 %</td>
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#### Electrolyte Values

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<td>cNa⁺</td>
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<tr>
<td>cCa²⁺</td>
<td>1.12 mmol/L</td>
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<td>cCl⁻</td>
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<tr>
<td>cLac</td>
<td>4.2 mmol/L</td>
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<tr>
<td>cBase(Ecf)c</td>
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<tr>
<td>cHCO₃⁻(P,st)c</td>
<td>21.3 mmol/L</td>
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</table>

#### Notes

- ↑ Value(s) above reference range
- ↓ Value(s) below reference range
- c Calculated Value(s)
- e Estimated Value(s)
APPENDIX 2 – PA CXR
APPENDIX 3 – MRS. AC’S GP PRESCRIPTION

Bendroflumethiazide 5mg PO od
Isosorbide Mononitrate (MR) 90mg PO od
Aspirin 75mg PO od
Salbutamol inhaler two puffs prn max 4 hrly
Candesartan 4mg od
Spiriva Handihaler 18mcg od
Atorvastatin 20mg PO od
Bisopropol 5mg PO once daily
Symbicort 100/6 turbohaler ii puffs bd
Uniphyllin continuus 250mg PO bd
Montelukast 10mg PO on
Glyceryl trinitrate spray i-ii puffs s/l prn
Tamoxifen 20mg PO od
INFORMATION FOR PARTICIPANTS

KEY POINTS

1. De-escalation

2. What makes a good communicator?
   • Verbal & non-verbal techniques
   • Pauses, allows uninterrupted patient/NOK speech
   • Empathises – validates son’s anxieties/emotions

3. What is a ‘ceiling of care’ and how is one determined? *(Was the prescription for Tamoxifen noted?)*

4. DNACPR
   • Who can make this decision
   • Next of kin ‘assent’

5. Advanced Directives – what makes them valid?

6. Governance – identification of system errors and what to do about them?
   Un-chaperoned entry of the patient’s son into the resus room

RELEVANCE TO THE CURRICULUM

  CC1 History Taking
  CC5 Decision-making / Clinical reasoning
  CC6 Patient centre focus of care
  CC12 Relationship with patient & communication in consultation
  CC13 Breaking bad news
  CC17 Medical ethics & confidentiality issues
  CC24 Personal behaviour

FURTHER RESOURCES

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www.resus.org.uk/pages/dnar.pdf


www.endoflifecareforadults.co.uk
PARTICIPANT REFLECTION

What have you learned from this experience? (Please try and list 3 things)

How will your practice now change?

What other actions will you now take to meet any identified learning needs?
PARTICIPANT FEEDBACK

Date of training session: ........................................................................................................................................

Profession and grade: ........................................................................................................................................

What role(s) did you play in the scenario? (Please tick)

- Primary/Initial Participant
- Secondary Participant (e.g. ‘Call for Help’ responder)
- Other health care professional (e.g. nurse/ODP)
- Other role (please specify): ..............................................................................................................................
- Observer

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<tr>
<th>I found this scenario useful</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>I have more confidence to deal with this scenario</td>
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<tr>
<td>The material covered was relevant to me</td>
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</tbody>
</table>

Please write down one thing you have learned today, and that you will use in your clinical practice.

..................................................................................................................................................................

How could this scenario be improved for future participants? This is especially important if you have ticked anything in the disagree/strongly disagree box.

..................................................................................................................................................................
FACULTY DEBRIEF – TO BE COMPLETED BY FACULTY TEAM

What went particularly well during this scenario?

What did not go well, or as well as planned?

Why didn’t it go well?

How could the scenario be improved for future participants?