End Of Life Care
In the Emergency Department
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Cure sometimes, treat often, comfort always.

Hippocrates
‘Make a habit of 2 things: to help or at least do no harm’
Hippocrates

- Dying is a normal process
- Removing the pain and distress of a normal process is what we should aim to achieve
Priorities

• Respect wishes
• Symptom free
• Live life to the full
• Surrounded by family
Principle of Palliative Care

- Affirms life and regards dying as a normal process
- Neither hastens nor postpones death
- Provides relief from pain and other distressing symptoms
- Integrates the psychological and spiritual aspects of care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help patients' families cope during the patient's illness and in their own bereavement

BMJ 1997;315:801
End of Life Care

• ± 75% deaths expected
• 44.5% die in own home or normal place of residence
• STH ± 3300 deaths per year
• 15% occur within first 24hrs post admission
• Priorities of patients (British Social Attitudes Survey 2012)
  • Presence of family and friends
  • Pain free
  • Dying in preferred place 34% of patients
  • Information on dying
  • Decision making around dying process
NICE Guidance 2015

- Recognise when patient entering last days of life
- Communication
- Shared decision making
- Hydration
- Pharmacological interventions
- Anticipatory prescribing
European Recommendations for End-of-Life Care for Adults in Departments of Emergency Medicine
End of Life Care in the Emergency Department

Definition:
The care provided in situations in which a severe deterioration in health, due to the evolution of a disease or another cause, poses an imminent threat to the life of a patient or has resulted in his/her death.

EUSEM 2017
Key recommendations

• Clinicians receive regular training
• Access to end of life care plans
• Involve patients and families in decision making
• Inter-speciality communication
• Think about DNAR orders and discuss these with the patient/family prior to leaving the ED
• Think about organ donation
• Develop procedures for end of life care
• Provide facilities for bereaved relatives
Common themes

- Communicate
- Anticipate
- Prepare
  - ReSPECT process as an example
  - Have the conversations
  - Think about options (treatment, money, funeral)
  - Document your wishes

ReSPECT

Recommended Summary Plan for Emergency Care and Treatment
- Relevant history
- Information about other care plans
- Personal preferences of care
- Preferences for emergency care
- CPR recommendations

### 1. Personal details

<table>
<thead>
<tr>
<th>Full name</th>
<th>Date of birth</th>
<th>Date completed</th>
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<tbody>
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<table>
<thead>
<tr>
<th>NHS/CHW/Health and care number</th>
<th>Address</th>
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### 2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g., interpreter, communication aid) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g., Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

### 3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

- Prioritise sustaining life, even at the expense of some comfort
- Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

### 4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
Focus on symptom control as per guidance below

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital + receiving life support:

<table>
<thead>
<tr>
<th>CPR attempts recommended</th>
<th>For modified CPR</th>
<th>CPR attempts NOT recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult or child</td>
<td>Child only, as detailed above</td>
<td>Adult or child</td>
</tr>
</tbody>
</table>

***SPECIMEN COPY - NOT FOR USE***
National Survey of Bereaved People 2013

- 43% felt care excellent or outstanding
- Inadequacy of pain relief 13% – 53%
- Problems with service co-ordination 16%
- 16% stated lack of support
- 82% felt person died in the right place
Home or In Hospital?

• Quality of care better outside of hospital\(^1,2\)
  • Lots of variation nationally
  • Increase in unnecessary treatments in hospital
  • Increased risk of harm

• Cost of care lower out of hospital\(^3\)
  • Reduced acute care use
  • Reduced primary care use

• Most patients prefer to die outside of hospital\(^1\)

1. National Survey of Bereaved People
2. Davis C 2015
3. Dixon et al 2015
Reasons for Emergency Department Attendance

- Medical problem
- Symptom control
- Inability to cope
- Unrelated secondary problem
Patient Priorities In the Emergency Department

- Spend time with relatives
- Pain free
- Symptom control
What is Achievable in the ED?

- Recognition
- Providing care that gives the most overall benefit to the patient
- Symptom control
- Communication
- Prevention of unnecessary interventions – do what is appropriate
- Manage expectations
What is not realistic/appropriate in the ED?

- Be the first to ask the question
- Advanced care planning
- Provision of futile resuscitation
  - Is there something reversible?
  - Is this going to prolong the normal dying process?
  - Is this going to extend life?
Challenges

- Identifying the patient at the end of life
- When the question of resuscitation has not been asked
- When unrealistic treatment options have been proposed
- When ceiling of care not been discussed
- Paediatric to adult transition
- Dealing with the unknown (treatments and services)
Challenges

• Provide care to a patient that:
  • Is in a crowded environment
  • Prefers not to be there
  • Wants to spend time with family
  • Has analgesic and other symptom control needs
  • May have different expectations
  • Is unaware of the severity of the condition
  • At 2am in the morning
Teamwork

• Preventing inappropriate prehospital resuscitation
• Managing the dying process vs resuscitation
• Understanding reversibility
• What is appropriate (ie what can we do vs what is appropriate)
• ITU/ Palliative Care/ FDRT input
• Managing expectations (colleagues, patients and relatives)
• Communication
Summary

• Communicate
• Prepare
• Symptom control
• Avoid the unnecessary