Improving communication in acute care

When asked, most people say that they would like to die at home. However, in the UK, most people die in acute hospitals, usually in old age and following chronic illness (National Confidential Enquiry into Patient Outcomes and Death (NCEPOD), 2009). An NCEPOD report, *Caring to the End*, highlighted the need for significant improvement in end-of-life care in the acute setting (NCEPOD, 2009). A whole systems approach across health and social care, and society in general, is also required both to improve our preparedness for death and also the quality of end-of-life care that we can expect to receive in the place of our choice (Department of Health, 2008).

NCEPOD report findings

Caring to the End (NCEPOD, 2009) evaluated the process of care for patients dying within 4 days of acute hospital admission by reviewing 3059 casenotes. Half of these patients were not expected to survive on admission to hospital, and clinical and organizational factors were identified which might have improved patient and family outcomes. Key skills required for better patient care were improved recognition that the patient was entering end of life, diagnosis of dying, and more effective communication with patients and families (NCEPOD, 2009).

Recognition that the end of life is approaching permits advance care planning by the patient (often with his/her family) and health-care team. Discussion with the patient regarding preferences, priorities and goals, including preferred treatment approach, place of care and death is then possible (Royal College of Physicians, 2009). Tools such as the Gold Standards Framework (2010) – a general practice-based system to streamline and improve the quality and organization of care for patients in the last year of life – can also be adopted.

Only 15% of people die suddenly (Lunney et al, 2003). Many patients will have been very frail with multiple co-morbidities and will not have deteriorated completely unexpectedly. Prognostication is often difficult; however, changes may become apparent in the last months to weeks of life that are dependent on the underlying disease process and are recognizable to specialists, for example, loss of ambulatory function and impaired speech in advanced dementia, reduction in muscle mass and development of cor pulmonale in end-stage chronic obstructive pulmonary disease, and systolic hypotension and arrhythmia development in chronic heart failure.

Care home residents are often frail with a heavy burden of diseases. Often they, their families and health-care team feel that aggressive treatments would not be beneficial. When such patients might benefit from acute hospital admission this must be offered, but equally admitting a frail, dying patient to pass away in a potentially uncomfortable or undignified manner on an admissions unit must be avoided. GPs and community geriatricians are central to advance care planning with care home residents, but hospital specialists play a key role in sharing prognostic information with primary care for individual patients when available. Retrospective data suggest that the admission of 6–40% of terminally ill patients could have been avoided (Abel and Rich, 2009; NCEPOD, 2009).

Of the quarter of patients assessed on admission to be imminently dying, there was no evidence of discussion of this with one in six patients and relatives (NCEPOD, 2009). Nearly a third did not have a do not attempt cardiopulmonary resuscitation order, and only a third were cared for on an end-of-life care pathway (NCEPOD, 2009), such as the Liverpool Care Pathway (Marie Curie Palliative Care Institute, 2010). This raises concern about skills in making and communicating a diagnosis of dying, without which quality terminal care is impossible, and patient preferences for location of care cannot be elicited. Signs of imminent death include progressive reduction in conscious level with altered breathing pattern, reduced urine output and cool extremities.

Increasingly complex medical interventions are available ever later in life, either for palliation or with life-prolonging intent. Experience may be critically important in recognizing when the transition between an emphasis on active life-prolonging treatment should move appropriately to comfort and supportive care. However, frequently such decisions are not escalated to seniors, possibly because the complexity is not recognized (NCEPOD, 2009). Specific training is needed in recognition of dying, and when to ask for senior support in decision making.

Benefits of effective communication

The benefits of effective, timely communication with patients and relatives are clear. Seriously ill patients value the opportunity to be involved in decisions about treatment, to prepare for death and to achieve a sense of completion (Steinhauser et al, 2000). Once bad news has been absorbed, concerns can be raised, patient priorities and goals can be identified, and an agreed care plan can be documented. However, doctors may feel apprehensive about initiating end-of-life discussions. The subject matter is difficult, and frailty, fatigue and delirium are prevalent and may be a real or perceived barrier.

Patient preferences for information and discussion vary widely, and doctors may fear removing hope and causing distress. Patients may be hesitant, perceiving doctors to be too busy, and doctors may feel that they are too busy or lack the necessary skills (Knauft et al, 2005). Doctors may underestimate patients' desire for information and discussion but overestimate patients' desire to make decisions (Robinson and Thomson, 2001). End-of-life discussions are facilitated by having a trusting ongoing relationship with the doctor, previous discussion about end-of-life care, experience of being very ill, and a health system that expects doctors to have end-of-life discussions with patients (Knauft et al, 2005).

Challenges for practice

The European Working Time Directive has resulted in doctors working fewer hours with detrimental impact on continuity of care. Clearly there is potential for less effective end-of-life care when different doctors are caring for patients and communicating with them and their families, and poor communication between and within clinical teams was identified as an important issue in 13.5% of patients (NCEPOD, 2009). A concise, structured handover with protected time, away from the busy ward to minimize interruption, is essential, and excellent written documentation is more important than ever.

Trigger 'early warning score' systems may allow earlier recognition of a deteriorating patient so that an appropriately senior assessment and management plan can be initiated. Validated measures of condition severity at presentation (such as 'CURB-65' for patients suffering from pneumonia; Lim et al, 2003) may be helpful in identifying those patients who are most severely ill. Trainees can hone communication skills by observing skilful practice of seniors if ward rounds are structured to permit this.

Electronic communication systems, operating across health and social care economies, offer opportunities to ensure that the up-to-date information vital to decision making for patients towards the end of life is transmitted to and from primary care, ambulance services, acute hospitals and hospices. Such 'palliative care registers' are in the early stages of development. However, the need for skilled communication from one person to another will remain paramount.

Conclusions

Good end-of-life care requires skills in assessment, prognostication, symptom management, communication and advance care planning, and organizational expectation. Hospital doctors have a vital role to play in identifying patients who have reached the last year of life, in starting this conversation with them, and in communicating the diagnosis and progress of discussion with the primary care team.

The care of dying patients in hospitals has been undermined by changes in the hospital team structure over recent years. Continuity of care now relies on effective communication and documentation of comprehensive care plans rather than on individual clinicians. The complexity of decision making required at the end of life may also be underestimated by those lacking experience in the management of dying patients. This highlights the need for specific training and role modelling in end-of-life care, improved communication, documentation and handover processes, and ongoing evaluation of the impact of significant changes in health-care delivery on patient experience. **BJHM**

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KEY POINTS

- Hospital doctors have a vital role in end-of-life care planning.
- Systems of communication, documentation and handover within and between teams must improve, particularly between grades of doctors.
- Consultants have an important role in identifying the urgent and important issues and goals of treatment in a patient's management, and may provide continuity.
- Medical curricula need to incorporate the recognition and care of the dying patient, with prompts to seeking senior support. Role modelling in end-of-life care discussions can be helpful for juniors, although consultants may also have training needs.
- Care of dying patients should be better planned and coordinated across all health and social care providers and locations.