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Withdrawal of Life Sustaining Therapy in Critical Care- ICU Clinical Guideline – Burton Sites Only

Reference no.: CG-ICU/2020/3536

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WITHDRAWAL OF LIFE SUSTAINING THERAPY IN CRITICAL CARE
To be used in patients at or approaching the end of life
(INCLUDES ReSPECT FORM SECTIONS 4-9 and the MCA)

NARRATIVE

Taken from GPICS V2.1: Care at the End of Life, ***Authors:*** Christopher Bassford & Joseph Cosgrove

INTRODUCTION

Despite continuing improvements in intensive care survival, approximately one in five patients (20%) whose hospital stay involves intensive care will not survive (higher for COVID-19).1 The quality of life after a critical illness is diminished and shortened for many patients. Active aggressive, interventional treatments with associated pain and distress place considerable burdens on patients. When these burdens outweigh potential benefits of life-supporting treatments, intensive care may serve only to prolong death rather than life. In such circumstances, a transition to palliative care may be in patients' best interests.2

Such a transition prioritises symptom management, psychosocial support of patients and families, and alignment of treatments with individual care goals, values and preferences. It recognises philosophical as well as physiological aspects of a good life. The purpose of this document is to guide the development of individualised care plans that meet current legal and quality standards for intensive care patients in the last days/hours of their life. It is not to produce a didactic recipe for care of the dying, but rather apply current evidence and best practice to individual patients.3

Skills in quality end-of-life care are dependent on symptom management, good leadership, planning, decision making, communication and multidisciplinary working. The majority of deaths on the critical care unit follow withdrawals or limitations of treatments when failure of curative treatments becomes apparent.2, 3, 8

Recognising this change is one of the most difficult decisions clinicians face. However, it is the essential first step in ensuring that clinical teams, patients, and their loved ones work together to understand and achieve the outcomes that are best for individual patients. It is recognised that these decisions should be individualised and include a shared approach to decision making. 9

The General Medical Council (GMC) has published extensive guidance to aid

decision making in this area. It covers best practice for patients with and without capacity and takes into account relevant law.10 It seeks to clarify the law's application within the critical care unit, rather than replace or reproduce it. Where there is a lack of capacity, it may be necessary to identify a suitable patient representative, e.g. Independent Mental Capacity Advocate or IMCA in England and Wales, within a reasonable (context-sensitive and not formally defined) timeframe. 1)

STANDARDS

1. Decision making surrounding care at the end of life, including the rationale for any decisions, must be documented clearly and communicated to patients and their loved ones.4 The latter is of particular relevance if patients lack capacity (below).
2. Decision making surrounding end of life care (EoLC) must be performed in accordance with relevant statutory requirements and professional guidance:
    a. *Mental Capacity Act 2005* (MCA 2005), England and Wales
    b. *Adults with Incapacity Act (2000)*, Scotland
    c. *Mental Capacity Act (Northern Ireland) 2016*
    d. *Human Tissue Act*, England
    e. General Medical Council's *Good Medical Practice*; specifically, *Treatment and Care Towards the End of Life: Good Practice in Decision Making*.
3. Declaration of death by cardiorespiratory or neurological criteria must be done in accordance with professional guidance.4
4. Consideration must be made as to whether organ and tissue donation can be offered to every dying patient, and where appropriate the specialist nurse-organ donation (SNOD) should be contacted.5
5. In order to identify dying patients and respond to changes in their condition, those at high risk of dying must have their condition regularly reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.3,6

RECOMMENDATIONS

a) Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying.3 Best practice dictates that those close to the

patient should also be informed.3

b) Decision making related to care at the end of life should, wherever possible, involve patients and people close to them, as well as medical professionals. If the patient lacks capacity and there is no individual with lasting power of attorney, responsibility for determining treatments rests with treating clinicians.7 Previous decisions should also be taken into account, e.g. treatment escalation plans (TEP), ReSPECT (Recommended Summary Care Plan for Emergency Care and Treatment).

c) At least two consultants, supported by senior ICU nursing agreement, should contribute to the process of recommending withdrawal or withholding treatments. Such processes are decided on a case-by-case basis and clarity of communication can be improved by outlining likely burdens and benefits of acts or omissions. Once patients are recognised as being in their final days/hours of life, therapeutic goals should be reviewed and accordingly altered to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn.

d) The discussion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is intrinsic to palliative care in critically ill patients. This should be discussed with patients and families within that context. DNACPR decisions, if instituted in emergent situations for incapacitated patients, should be discussed with patients' surrogates (as defined by the MCA or equivalent) at the earliest opportunity (**see ReSPECT form sections later in this document)**. 7,10

e) Dying patients should be managed by multi-professional teams that include senior medical and nursing staff from intensive care and referring teams. This may also include specialist palliative care teams.3

f) Therapeutic plans should be made, and anticipatory medications prescribed for all patients in their final hours/days of life, enabling prompt symptom control. This includes therapeutic options for analgesia, dyspnoea, anxiety, and agitation. Doses should be titrated for symptom relief based on explicit assessments. Where appropriate, the double effect of drugs used should be transparent to patients, staff, and family (**see symptom-control guideline**).

g) Care should address dying patients' need for spiritual and emotional support and include that of their families and others close to them. The needs of loved ones to be with, care for and otherwise attend to dying patients should be met as far as is possible, noting issues relating to COVID-19. If appropriate, religious, or secular expertise should be sought (e.g. referral to chaplaincy, psychological services, or

patients' GPs). Staff should also have access to these support services.

h) If death is considered to be very close, patients should not normally be transferred out of the critical care unit unless it is to facilitate significant improvements in care.

i) If practical to do so, patients should be given the opportunity to die at home or in a hospice. Intensive care clinicians often have a responsibility for decision making and care of acutely unwell and deteriorating patients outside of the critical care unit. When reviewing such patients for potential treatment escalation, they should work with patients' existing clinical teams to ensure that decisions and communication regarding care at the end of life are made to the same standards as on the critical care unit.

REFERENCES

1. Intensive Care National Audit and Research Programme (ICNARC-CMP) [March 2019 and July 2021].
2. Kon AA, Shepard EK, Sederstrom NO et al. Defining futile and potentially inappropriate interventions: a policy statement from the Society of Critical Care Medicine Ethics Committee. *Crit Care Med* 2016; 44: 1769-74
3. Care at the End of Life, FICM 2019
4. Academy of Medical Royal Colleges: A Code of Practice for the Diagnosis and Confirmation of Death.
5. NICE CG135: Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation.
6. Bagshaw SM, Stelfox HT, Johnson JA et al. Long-term association between frailty and health-related quality of life among survivors of critical illness: a prospective multicenter cohort study. *Crit Care Med* 2015; 43: 973-82
7. Resuscitation Council UK.
8. Sprung CL, Cohen SL, Sjokvist P et al. End-of-life practices in European intensive care units: the Ethicus Study. *JAMA* 2003; 13: 790-7.
9. Kon AA, Davidson JE, Morrison W, Danis M, White DB. Shared Decision Making in Intensive Care Units: An American College of Critical Care Medicine and American Thoracic Society Policy Statement. *Crit Care Med* 2016 January; 44(1): 188–201.
10. General Medical Council (2010). Treatment and Care towards the End of Life: Good Practice in Decision Making.

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Documentation of the withdrawal

Medical treatment should be withdrawn on clinical grounds when ongoing active treatment will not benefit the patient, the expected benefits of that treatment to the patient are outweighed by its burdens to the patient or the disease process does not have a reversible cause.

A management plan should ideally be established and agreed following a Consultant/Senior Clinician-led MDT discussion. Ideally, the same decision will have been reached by at least 2 Consultants – either both in Intensive Care Medicine or involving another (e.g. from the patient's referring specialty). We recognise that this may not always be possible (e.g. out of hours) in which case discussion with others involved in the patient's care should be undertaken and their thoughts considered and recorded.

Clinician initiating process of withdrawal: **Dr…… Grade……**

Have you sought any second opinion(s)? If so, who from?.....

Other people contributing to the decision (e.g. other clinicians/nursing staff)

Name	Role

Rationale for considering withdrawal of active/invasive therapy.

Expand upon in medical record or on electronic notes and print off/insert pages here if needed

Date: **Time:**

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Communication

Does the patient have mental capacity?.....
(If not then the patient must have an advocate – either next of kin or an IMCA referral needs to be made)

If yes, then ask if the patient would like family/close friends to be involved with discussions around their end of life.
Names of any family/friends to be involved……

Do we need to involve the Palliative Care Medicine team now?

Does the patient wish to have spiritual support? (contact the relevant religious representative if so via switchboard or try extension 5666 if it is in-hours)

Do we need to speak to the Coroner, the Trust Legal Services or any other outside agency? (see Coroner referral guideline)

Organ Donation

All patients should be given the opportunity to be organ or tissue donors after their death. Some may have expressed it to be their wish in life to be a donor and we owe it to them and their families to consider this.

In **all** cases of withdrawal in ITU, consider referral to the Specialist Nurse for Organ Donation (SN-OD) via the national referral line on **03000 20 30 40.**

If considered appropriate that patient will become a potential organ donor, where is the withdrawal to take place? **If withdrawal is to be done in theatre, then use the withdrawal of life sustaining therapy in theatre checklists and guides (in the organ donation folder or on intranet).**

If not referred, record any reasons why not here:

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Details of conversations with the patient, family or close persons or the appointed IMCA

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Record in writing here or record in medical record if preferred (if notes are made electronically, print off and insert the printed pages in here).

Name:…….. Signature: ……Designation:…….

Date and time:……..

ReSPECT Form sections

To be completed in all cases but note that in the case of WLST then CPR attempts are INAPPROPRIATE and it should therefore be clearly documented so in this section

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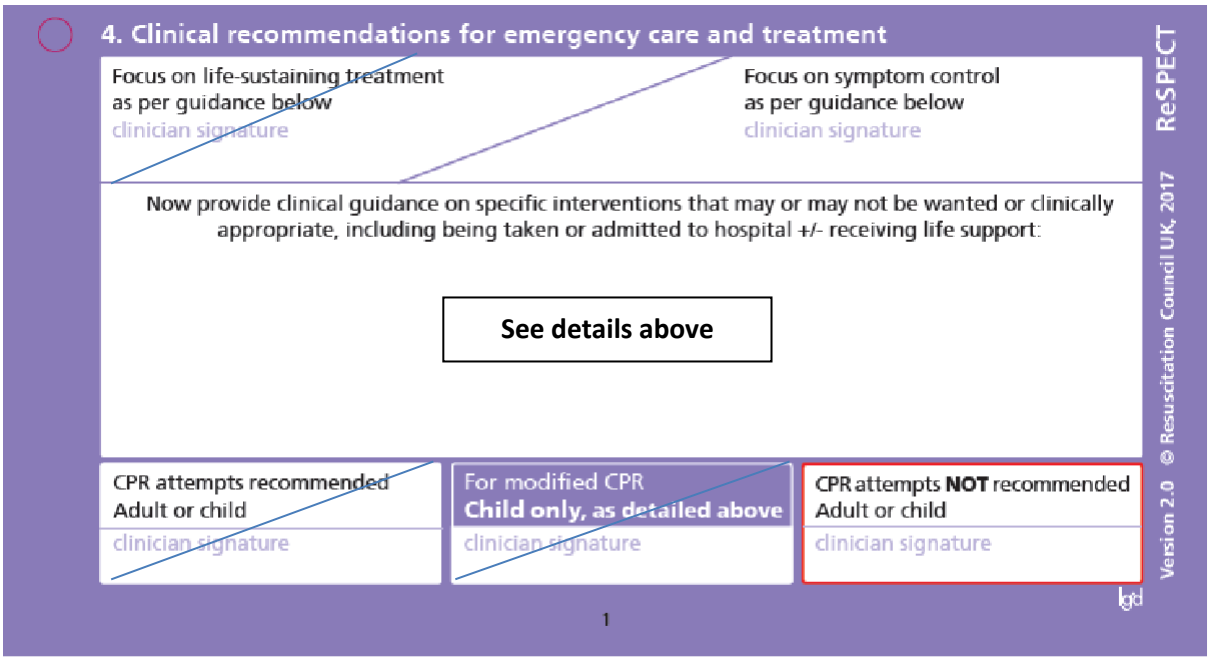
Do Not Resuscitate Order



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6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):

- ☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan.
- ☐ **B** This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
- ☐ **C** This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below):
  - ☐ **1** They have sufficient maturity and understanding to participate in making this plan
  - ☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
  - ☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.
- **D** If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record.

Record date, names and roles of those involved in decision making, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time

Senior responsible clinician

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend/other			
GP			
Lead Consultant			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

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ReSPECT Mental Capacity Assessment (MCA)

Patients are presumed to have capacity to hold ReSPECT discussions unless the following 2 conditions are satisfied:

1. Stage 1 is answered "Yes"
2. At least one of Stage 2 is identified (please tick)

Stage 1 - Patient's conscious level is impaired or there is another condition that is disturbing the mind/brain function

Yes ☐
No ☐

Stage 2 - They lack capacity to contribute to the DNACPR discussion because they cannot:

Understand information ☐
Retain information ☐
Weigh up consequences ☐
Communicate the decision ☐

If the patient lacks capacity are you aware of a valid advance decision refusing CPR which is relevant to the current condition?

Yes ☐
No ☐

If "NO", has the patient appointed a Welfare Attorney, or deputy, to make decisions on their behalf?

Yes ☐ If "YES" they must be consulted.
No ☐

If no capacity all decisions must be made in the patient's best interests and comply with current law.

Please tick the following:	**YES**	**NO**	**N/A**
Patient is aware of the ReSPECT form?	☐	☐	☐
Relatives/carers/relevant other? aware of ReSPECT form?	☐	☐	☐
On discharge - Patient informed to keep ReSPECT form in a prominent place and bring form with them to ANY hospital attendance.	☐	☐	☐

Details of any conversation

Print name	Signature	Designation	Date

Mental Capacity Assessment

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Individualised patient plan for withdrawal of life-sustaining therapies in Critical Care.

Refer case to the Specialist nurse for Organ Donation (03000 20 30 40) before initiating this plan

Therapy		Action (leave, remove, stop, decrease, continue etc.)	Date/Time of decision to act	Action Completed (nurse or Dr to sign)	Date/time completed
Airway	ETT				
	Tracheostomy				
	NIV				
	Other				
Breathing	FiO_2				
	Vent. Rate				
	PEEP/CPAP				
	ASB/P.insp/Tidal vol.				
Circulation	Vasopressors/inotropes				
	Fluids				
	Pacemaker/ICD in-situ?	(Cardiology to deactivate)			
Nutrition/GI	NG feed/TPN				
Renal	CVVHD				
Lines/drains	Arterial				
	CVC				
	Others				
Medication/Sedation		*Refer to **Critical Care** Guideline on Symptom control			

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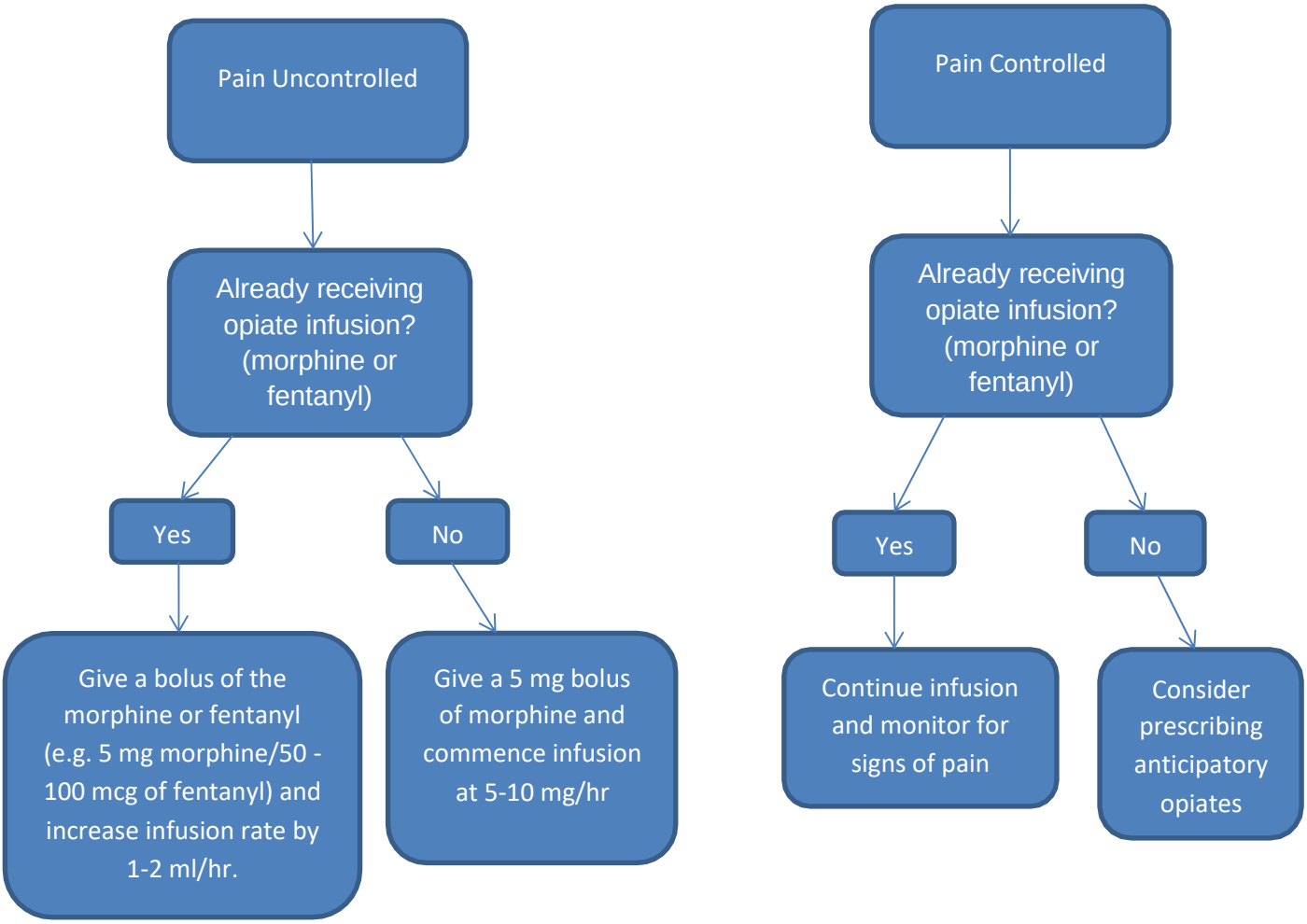
Guidelines for symptom control in the care of the dying patient

(For use in Critical Care only)

***Please see advice on care during the end of life at the Palliative Care Intranet site for useful information: http://bhftintranet.burtonft.nhs.uk/Departments/palliative-care/ or look in the hard covered loose leaf file holders covering Palliative Care in the coffee room cabinet.**

***Contact for hospital Macmillan Palliative Care Clinical Nurse Specialists: Extension 5748 or 5034.** Out of hours advice on any of these problems can be sought from the Palliative Medicine Consultant on call at St. Giles Hospice on #6236 or 01543 432031.

1: Control of pain



***Consider referral to Palliative Care Team for further advice if at all unsure.**

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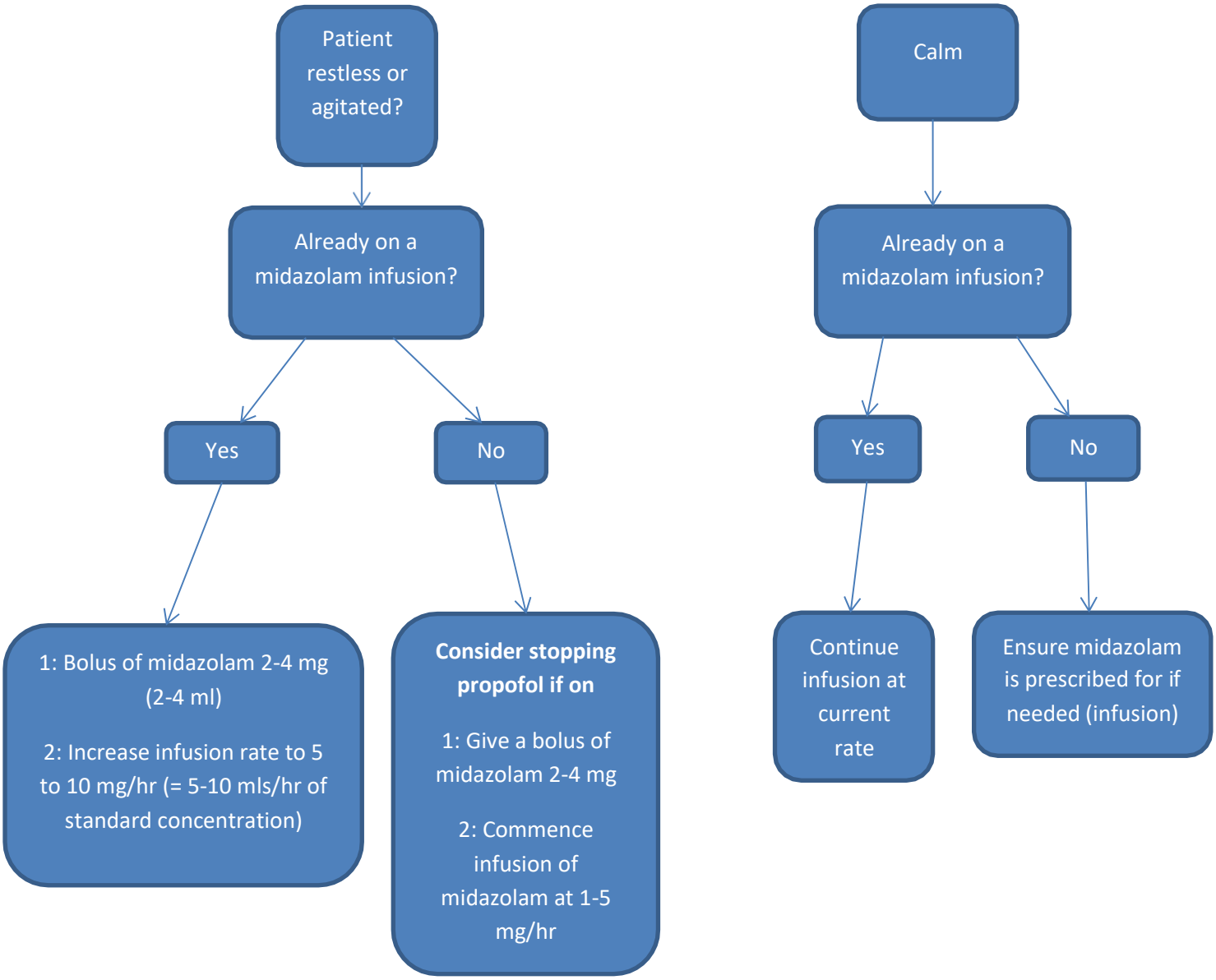
2: Control of Terminal Restlessness and Agitation



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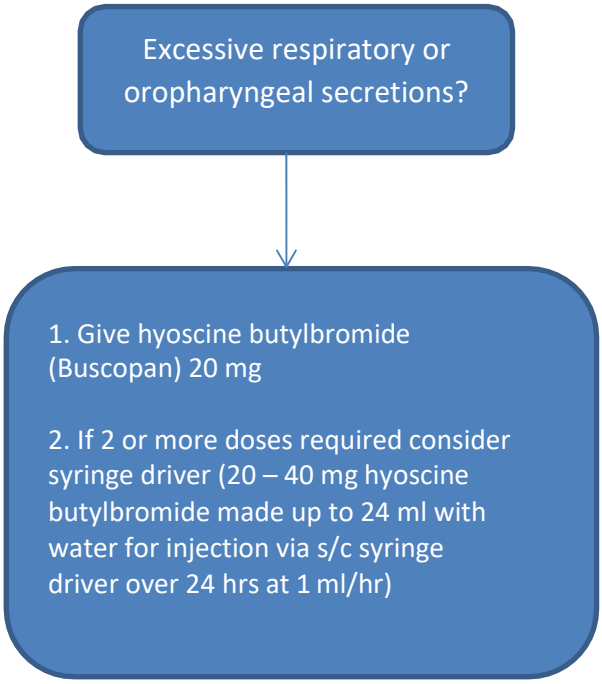
3: Control of excessive secretions (e.g. if extubated)



***Consider referral to Palliative Care Team for further advice if at all unsure.**

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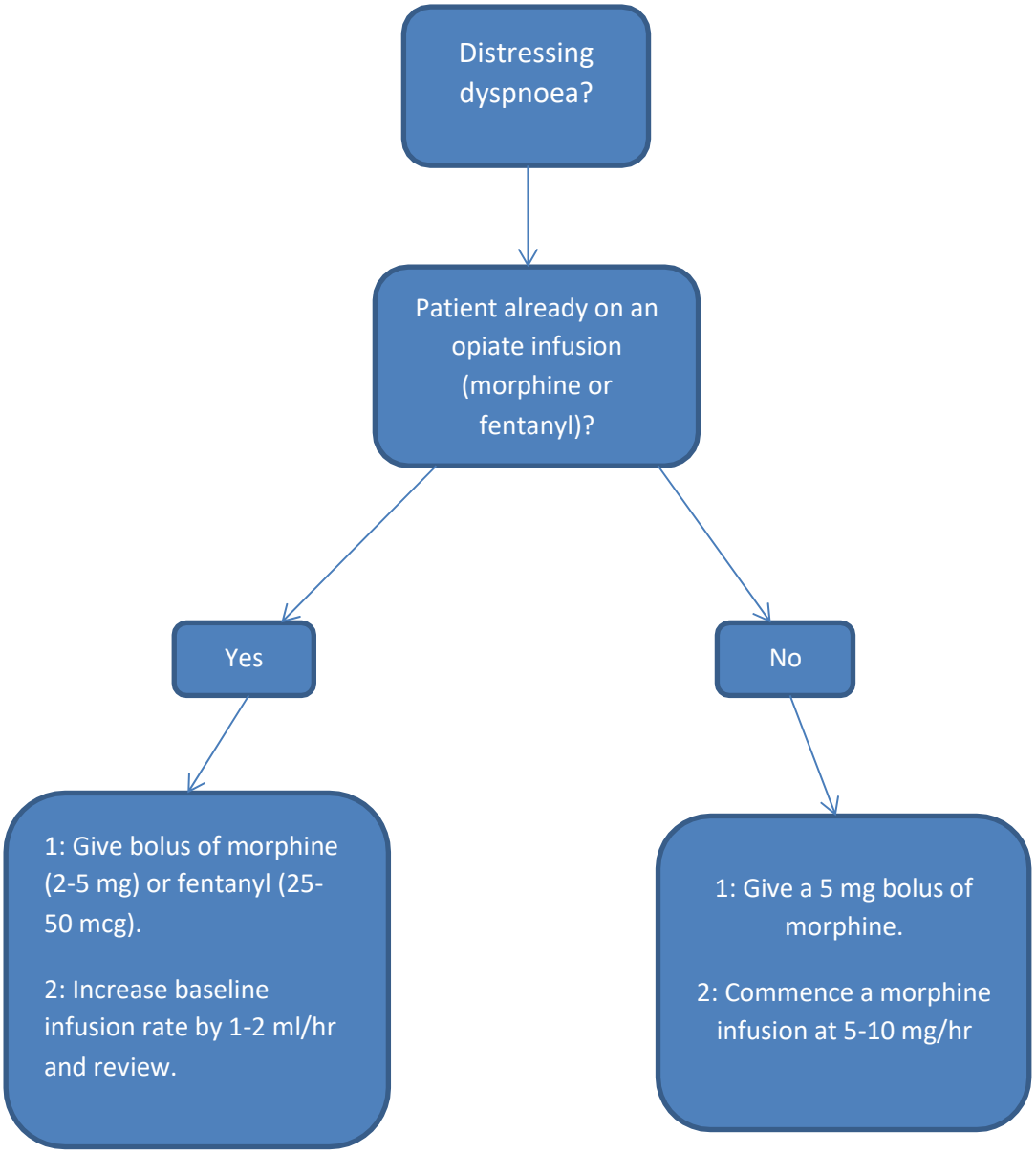
4: Control of terminal dyspnoea



***Consider referral to Palliative Care Team for further advice if at all unsure.**

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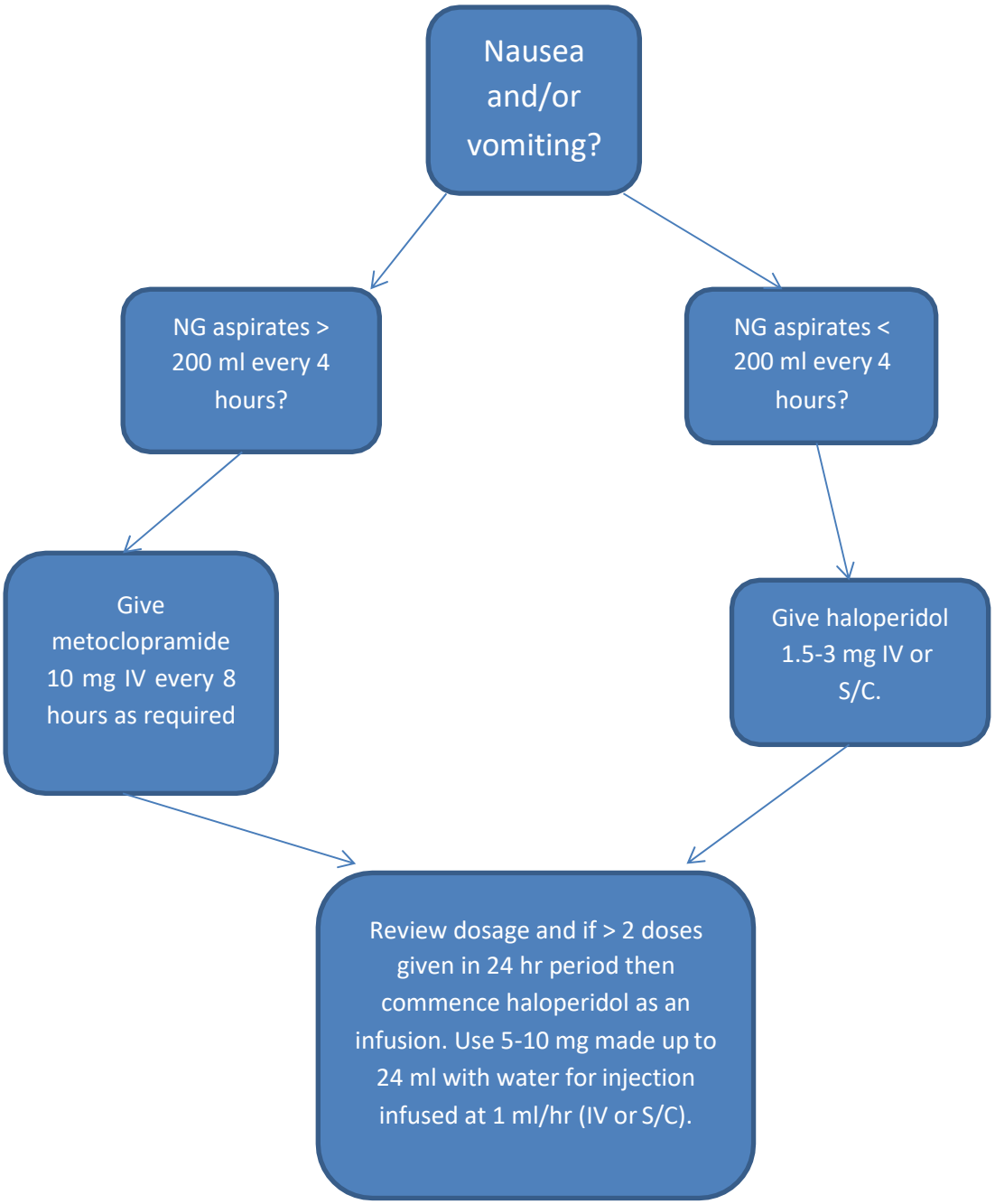
5:Control of nausea and vomiting in the dying patient in Critical Care



***Consider referral to Palliative Care Team for further advice if at all unsure.**

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After Death

Use the separate diagnosis of death forms and complete the deceased documentation including death certification as appropriate. Leave notes for Bereavement Services with Bev (Unit Ward Clerk) or on the nursing station.

Reporting a death to HM Coroner

Stephanie Fisher (Coroner's Officer): 07870 684969
Office: 01785 235615

Report any death where:

1. The cause of death is not known.
2. Cause of death may be due to trauma or unnatural cause. e.g. Road traffic collision, possible suicide, poisoning, self-harm, fracture.
3. Cause of death may be related to an industrial disease. e.g. pneumoconiosis, (deceased was a miner), mesothelioma, farmer's lung.
4. Patient had been in hospital for less than 24 hours.
5. Cause of death is due to a fall or there has been a fall in the three days prior to death.
6. At death, grade 3 or 4 pressure sore present, or more than one grade 2 pressure sore.
7. Surgery or invasive procedure involving general or local anaesthetic performed within the preceding 12 months (including endoscopies).
8. A medical procedure or treatment which may have caused or contributed to the death. For the avoidance of doubt, a medical procedure includes chemotherapy, radiotherapy, biological/hormonal therapies, stem cell and bone marrow transplants.
9. Patient is a prisoner or is otherwise legally detained, including detention pursuant to Mental Health or other legislation. This includes all patients who are subject to Deprivation of Liberty Orders after such orders have been approved by the court.
10. Alcohol or any prescribed or non-prescribed drug is mentioned as contributing to the cause of death in part 1 of the death certificate.
11. Death during pregnancy or within a year of giving birth.
12. All deaths that would be referred to the Child Death Overview Panel (CDOP) i.e. deaths of all minors under the age of 18 years
13. Death is associated with or occurs after a clinical incident.
14. Where allegations of negligence have been made against the hospital or others involved in the nursing or medical care of the deceased, regardless of whether it is considered such allegations have merit.
15. Death may be due to the neglect of others.
16. Any other unusual circumstances.

If there is **any** doubt about whether a Coroner's referral is required, the first point of contact should be the **Consultant in charge**. The Consultant has the ultimate responsibility for decisions on referral; if in doubt, refer to the Coroner/Coroner's Officer .

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Approved - Surgery Division March 2023
Review Date - March 2026

Contact - Adilah Miraj - Consultant Anaesthetist