I-Validate

Identifying Values, Listening, and Advising High-risk Patients in Acute Care
A 80-year-old female presents to the ED from home with worsening breathlessness. Background:
- CCF: severe RVF, impaired LV
- Morbid obesity (BMI 48)
- COPD
- Chronic sacral ulcers
- Home oxygen 20 hrs/day

On examination:
- GCS 15, T 36.3, RR 24, BP 90/60, edema

ABG:
- pH 7.44, CO2 57, O2 44

Renal function:
- Urea 22.5, creatinine 184

CXR:
- (Image of chest X-ray showing findings consistent with right-sided pleural effusion.)
<table>
<thead>
<tr>
<th>Patient-centred</th>
<th>Disease-centred</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognise she is frail, deteriorating health, probable progressive organ</td>
<td>• Treat with oxygen, IV fluids for hypotension,</td>
</tr>
<tr>
<td>failure</td>
<td>insert ICC for pleural drainage, trial NIV</td>
</tr>
<tr>
<td>• Talk / listen / advise, about what she wants, what is likely to happen,</td>
<td>• Refer to ICU for NIV +/- other supports</td>
</tr>
<tr>
<td>while she is competent, with her family present</td>
<td>• Don’t discuss treatment options with family or</td>
</tr>
<tr>
<td></td>
<td>patient</td>
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</tbody>
</table>
Saturday 22 hrs into presentation..

- Referred to ICU for admission
- Clinician talks to Shirley.....
- Clinician calls family and asks them to come in.

13:44 Shirley arrives ICU

14:00 Family arrive – discussion with ICU consultant “family clear she does not want further interventions, she has said before she has had enough, that her body is shutting down”. Agree to start comfort care

16:40 Shirley dies in ICU
“Nothing ever goes away until it teaches us what we need to know.”
- Pema Chodron
We hypothesized that:

1) There are many inpatients with palliative care needs (Life Limiting Illness)

2) Identification of these patients is poor

3) Discussion of goals of care is poor

4) Documentation is poor
Steps
1. Identify
2. Competence / surrogate
3. Listen – values/goals
4. Advise and agree
5. Document

Program
1. Cambridge communication training
2. Faculty of trainers
3. 16-hour course for all ICU regs/RMO/liaison nurses
4. New process driven form
5. Support
IDENTIFICATION - Life limiting illness

Average GP’s workload – average 20 deaths/GP/year approx. proportions

- Sudden Unexpected Death 1-2
- Frailty / Co-morbidity / Dementia 8
- Organ Failure 5-6
- Cancer 5

- Rapid “Cancer” Trajectory, Diagnosis to Death
  - Time – Often a few years, but decline usually seems <2 months
- Organ System Failure Trajectory
  - (mostly heart and lung failure)
  - Begin to use hospital often, self-care becomes difficult
  - Time – 2-5 years, but death usually seems “sudden”
- Onset could be deficits in ADL, speech, ambulation
  - Time - quite variable - up to 6-8 years

Plan and provide proactive care to improve coordination and communication.
i-Validate Functional and Clinical Indicators
Life Limiting Illness Disease Trajectory

1. **Cancer** — metastatic or not amendable to treatment

2. **Functional Decline**
   - **Dementia** — no consistent meaningful conversation or needs assistance with ADL
   - **Frailty** — Clinical Frailty Score 6 – 9
   - **Resides in high level care facility**

3. **Organ Failure**
   - **Congestive cardiac failure** — NYHA stage III/IV or reduced exercise tolerance
   - **COPD** — disease assessed as severer e.g. long term oxygen therapy/home oxygen or SOB at 100m on level ground or FEV1 <30% predicted
   - **Renal Failure** — stage 5 chronic renal failure or long term dialysis or not for dialysis or eGFR < 15 ml/min
   - **Neurological Disease**
     - **Stroke** — minimal conscious state or dense hemiparesis
     - **Parkinson’s Disease** — assistance with ADL or falls or difficulty swallowing
     - **Multiple Sclerosis** — dysphagia
     - **Motor Neurone Disease** — rapid decline or episode of aspiration pneumonia

Adapted from Principles and materials for The Gold Standards Framework © K Thomas, the National GSF Centre 2003 - 2012. Used with permission from the National GSF Centre in End of Life Care
2011
626 ward patients
171 (27.3%) LLI
- 35.1 % GoC form
- 13.5 % Pt centred
- 27 % discharge home
- 50 % 1-yr mortality

2013
1024 ICU referrals
649 (63.4%) LLI
- 34.3 % GoC form
- 25.6 % Pt centred
- 48 % discharge home
- 35 % 1-yr mortality

2015
i-validate course
Before and After study ICU
- GoC completion
- Patient values documented
- ICU Admissions
- 90 day Hospital readmission
- MET Calls
- Overall mortality

2017
i-validate for whole of ICU and introduce nurse initiated program to Surgical Wards
Values important to people to live well

• Dignity
• Independence
• Relationships and communication
• Free from pain and suffering
• Not Longevity alone

<table>
<thead>
<tr>
<th></th>
<th>No LLI</th>
<th>Organ failure</th>
<th>Frailty</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. (1024)</td>
<td>419</td>
<td>305</td>
<td>196</td>
<td>104</td>
</tr>
<tr>
<td>Pre-hospital ACP</td>
<td>12 (2.9%)</td>
<td>28 (9.2%)</td>
<td>27 (13.8%)</td>
<td>13 (12.5%)</td>
</tr>
<tr>
<td>Hospital GoC form</td>
<td>14 (3.3%)</td>
<td>72 (23.6%)</td>
<td>108 (55.1%)</td>
<td>42 (40.4%)</td>
</tr>
<tr>
<td>Discharge to independent living</td>
<td>328 (78.3%)</td>
<td>183 (60.8%)</td>
<td>48 (24.5%)</td>
<td>47 (45.2%)</td>
</tr>
<tr>
<td>Hospital mortality</td>
<td>15 (3.6%)</td>
<td>46 (15.3%)</td>
<td>55 (28.1%)</td>
<td>23 (22.1%)</td>
</tr>
<tr>
<td>1-year mortality</td>
<td>32 (7.6%)</td>
<td>72 (23.6%)</td>
<td>91 (46.4%)</td>
<td>62 (59.6%)</td>
</tr>
</tbody>
</table>

## LLI3 Effect of i-validate training

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>119</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>LLI Cancer</td>
<td>28 (23.5)</td>
<td>23 (22.3)</td>
<td></td>
</tr>
<tr>
<td>LLI frailty</td>
<td>48 (40.3)</td>
<td>43 (40.7)</td>
<td></td>
</tr>
<tr>
<td>LLI organ failure</td>
<td>43 (36.1)</td>
<td>37 (35.9)</td>
<td></td>
</tr>
<tr>
<td>GoC form</td>
<td>59 (49.6)</td>
<td>74 (71.8)</td>
<td>0.001</td>
</tr>
<tr>
<td>Values and goals</td>
<td>19 (16.0)</td>
<td>33 (32.0)</td>
<td>0.005</td>
</tr>
<tr>
<td>ICU admit</td>
<td>25 (21.0)</td>
<td>30 (29.1)</td>
<td>0.16</td>
</tr>
<tr>
<td>MET calls</td>
<td>104 (87.4)</td>
<td>75 (72.8)</td>
<td>0.009</td>
</tr>
<tr>
<td>90-day readmission</td>
<td>46 (38.7)</td>
<td>32 (31.1)</td>
<td>0.24</td>
</tr>
<tr>
<td>90-day mortality</td>
<td>56 (47.1)</td>
<td>35 (34.0)</td>
<td>0.05</td>
</tr>
<tr>
<td>GoC in decedent</td>
<td>36/56 (64)</td>
<td>35/37 (95)</td>
<td>&lt;0.001</td>
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</tbody>
</table>

Whole Unit Program
Initiating the session
- Preparation
- Establishing initial rapport
- Identifying the reasons for the consultation

Gathering information
- Exploration of the patient’s problems to discover the:
  - Biomedical perspective
  - Patient’s perspective
  - Background information – context

Physical examination

Explanation and planning
- Providing the correct type and amount of information
- Aiding accurate recall and understanding
- Achieving a shared understanding: incorporating the patient’s illness framework
- Planning: shared decision-making

Closing the session
- Ensuring appropriate point of closure
- Forward planning

Providing structure
- Make organisation overt
- Attending to flow

Building the relationship
- Using appropriate non-verbal behaviour
- Developing rapport
- Involving the patient
Nurses can remind, assist and explore
<table>
<thead>
<tr>
<th>SET THE AGENDA</th>
<th>EDUCATE ON EXPECTATIONS (ABOUT THE REST OF THE CONVERSATION)</th>
<th>AIM TO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Educate on expectations (about the rest of the conversation)</td>
<td>For this conversation I’m going to talk to you about ... To make the best decisions for your care, we’re going to talk about what is important to you, outside of hospital. If I can talk to you about what life was like before hospital, a little bit about what’s been happening in hospital, and what you hope for after hospital, we’ll be able to get a good sense of the best care for you.</td>
</tr>
<tr>
<td></td>
<td>• Invite to participate</td>
<td>Would it be ok to do this now?</td>
</tr>
<tr>
<td></td>
<td>• Screening: Reduces uncertainty being very clear</td>
<td>Before we start, are there any concerns you have? Anything you would like to ask the treating team?</td>
</tr>
<tr>
<td>SUMMARISE (and negotiate if necessary) the agenda</td>
<td>So... You’ve told me you’re worried the drip isn’t working and I’ve asked to talk to you about how we can best care for you. Can we talk first and then I’ll get the resident to check out your drip? Would that be ok?</td>
<td></td>
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</table>
END OF LIFE CONVERSATION

I declined further treatment and chose to die with dignity.

I chose heroic measures and don't regret it at all.

I listened to my congressman and got so angry about 'death panels' that I burst an artery.