Quality Training Program

Project Title: Aggressiveness of Cancer Care Near the end of Life

Presenter's Name: Dra Cristina Caramés

Institution: Hospital Universitario Fundación Jiménez Díaz

Institutional Overview

General Hospital (Radiology, Nuclear Medicine, Radiotherapy…)

- 441.839 Patient volume

-689 Hospitalization beds (25 oncology, 11 palliative care)

- 2 day hospital: General oncology (21 armchairs) and phase I (7 armchairs)

- 24 hours / 7 days a week oncologist on call

13 medical oncologist

2800 new oncology patients / year

All tumor types

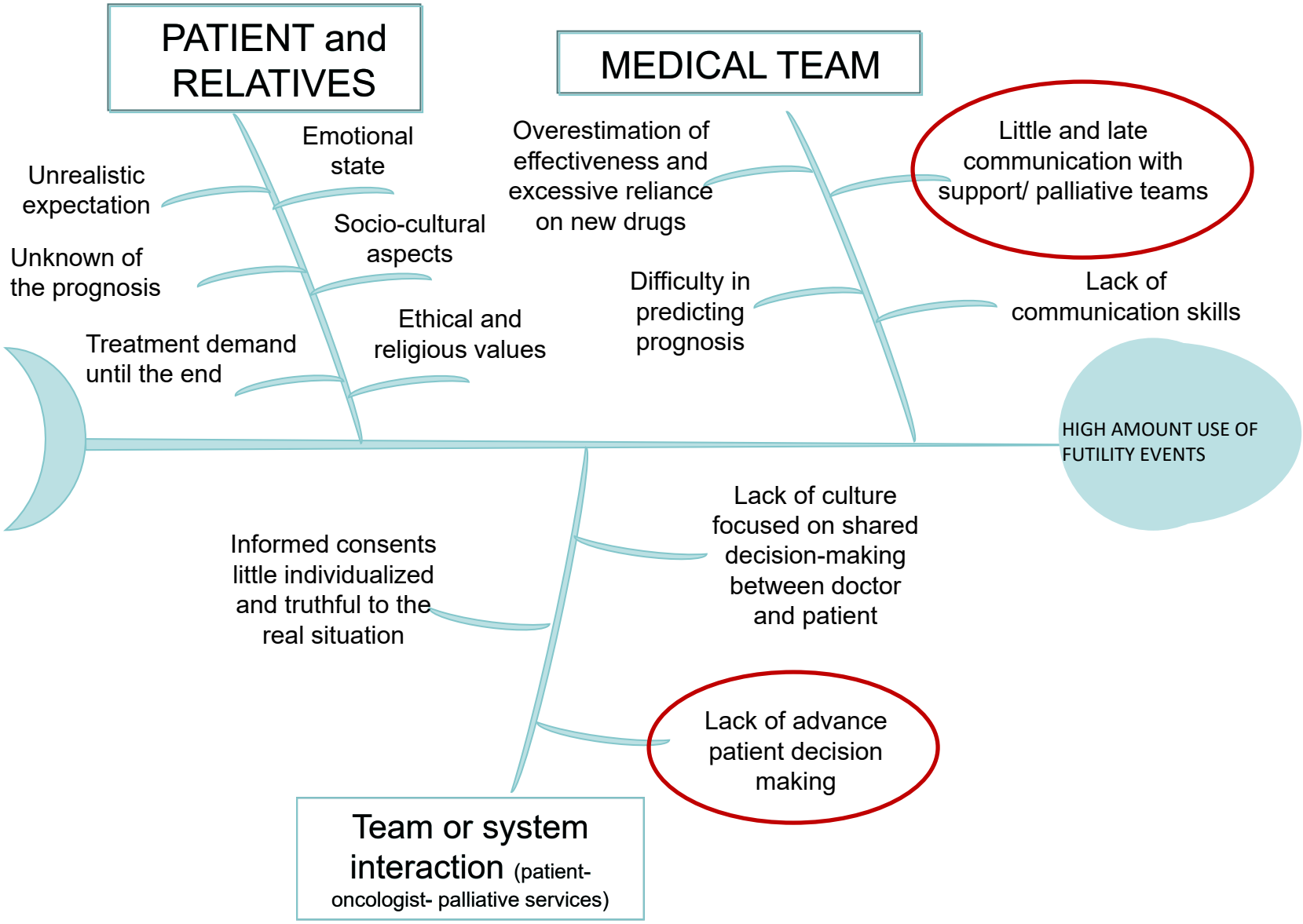
Problem Statement

Aggressive management of cancer care near the end of life is harmful, associated with decreased quality of live and increases health costs needlessly. 55% of the patients at our hospital suffer at least one aggressiveness event at the last month of life. A substantial portion of these fact is avoidable.

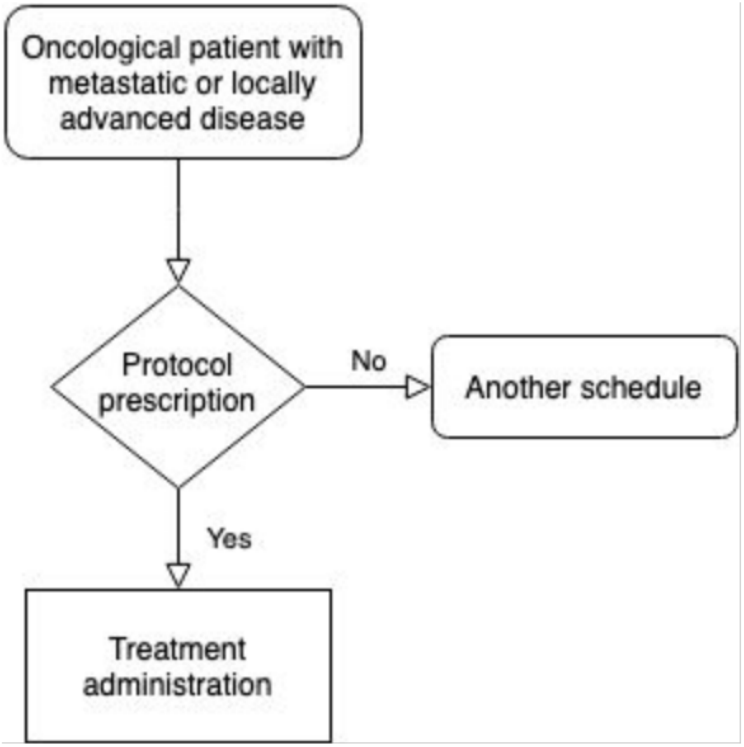
Team Members

Team member	Name	Role	Discipline
Team Leader	Jesús García-Foncillas	Head oncology department	Oncologist
Team Members	Ana León Cristina Caramés Álvaro Gándara Antonio Noguera Javier Bécares	Desing and implementation	Oncologist Oncologist Palliative care Palliative care Pharmaceutical
Project Sponsors	Ana Leal	Medical director	Doctor
Patient/ Family Members	Diego Villalón	Director “Fundación más que ideas”	Social worker

Cause & Effect Diagram



Process Map current state



Aim Statement

Improve the number of aggressive events by halving each one:

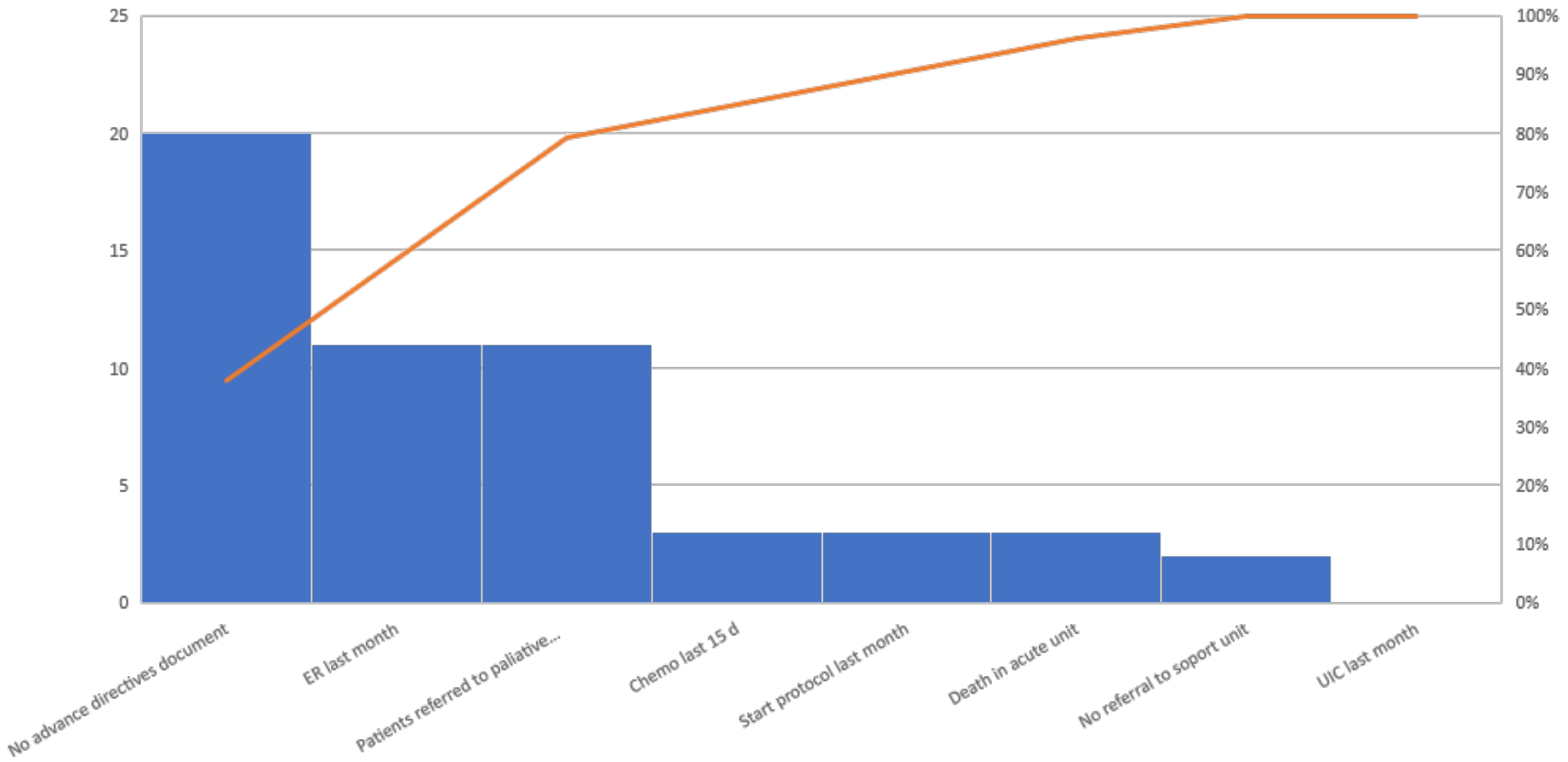
- Chemotherapy on the last 15 days of life
- Starting a new treatment protocol at the last month of life
- Emergency room admission at the last month of life
- ICU admission at the last month of life
- Patients dying in an acute unit (including oncology hospitalization, all except hospice, home with support or palliative hospitalization)
- Patients not being follow by palliative units before dying
- Patients dying in a palliative care unit only 72 hours after being known for the palliative unit

Diagnostic Data

n=20#

	n	%
Chemotherapy on the last 15 days of life (+10%)	3	15
Starting a new treatment protocol at the last month of life (+2%)	3	15
Emergency room admission at the last month of life (+4%)	11	55
ICU admission at the last month of life (+4%)	0	0
Patients dying in an acute unit (including oncology hospitalitation, all except hospice, home with support or palliative hospitalitation) (+ 17%)	3	15
Patients referred to palliative in the last admission (no from outpatient clinic)	11	55%
Patients not being follow by palliative units before dying (-55%)	2	10
Patients dying in a palliative care unit only 72 hours after being known for the unit (+8%)	0	0
No advances directives	20	100%

Pareto chart



Intervention proposal

- ✓ Intervention 1: To **standardize referral criteria** to the palliative care unit

- ✓ Intervention 2: To desing and implement a methodology to **encourage active participation of the patient in making health and therapeutic decisions**

- ✓ Intervention 3: **Promoting more psychological support**, which allows accompaniment and helps the patient adapt and face an end-of-life situation . Similarly, and with the same objective, propose to enable religious attention at the end of life. All this helps to acquire a more realistic view of the situation and make more optimal decisions with what the patient really wants and wants.

- ✓ Intervention 4: **Give greater visibility of the palliative care units.** They are very stigmatized and many people are afraid of the word "palliatives". Therefore, making informative material close, without dramatisses can be very useful. Explaining since the beginning what they contribute and how they work helps reduce the uncertainty. It is important to think that one of the main fears of death is related to fear of pain and suffering. Providing close information about the resources that exist for your control can be very useful.

- ✓ Intervention 5: More training related to **communication skills** to oncologists.

- ✓ Intervention 6: **Family-specific consultation:** It could be very useful to face of an end-of-life situation. The possibility of a consultation with the patient's family whose purpose is to give information and guidelines, that help a best coordinated work and to respect the wishes of the patient. It could serve to resolve doubts, explain treatment and care issues, and provide some situation management guidelines. Maybe this consultation shouldn't be given by a doctor, maybe nursing might be interesting. It would serve as an ideal channel of dialogue between family members and health workers.

- ✓ Intervention 7: Make written **material with information and recommendations addressed to families**. Any guidance is always welcome and if we accompany and resolve your doubts, less likely you will be to demand regarding treatments that are probably not going to help

Prioritized List of Changes (Priority/Pay –Off Matrix)

Impact	Easy	Difficult
High	- **Standardize referral criteria to the palliative care unit promoting an Early intervention** -**Give greater visibility of the palliative care units. Facilitator diptych** - **Active participation of the patient in making health and therapeutic decisions** -**Material with information and recommendations addressed to families.**	- **Training related to** communication skills
Low	- Family-specific consultation - Promoting more psychological support	**change the way professionals think**

Ease of Implementation

Intervention 1

Standardize referral criteria to the palliative care unit promoting an early intervention

Every time a new protocol is started in a metastatic patient → assessment criteria to identify risk situations for aggressive events

1. NECESSARY: In all cases the oncologist answers his/her self the **surprise question**. "Would I be surprised if the patient died over the course of next year?"

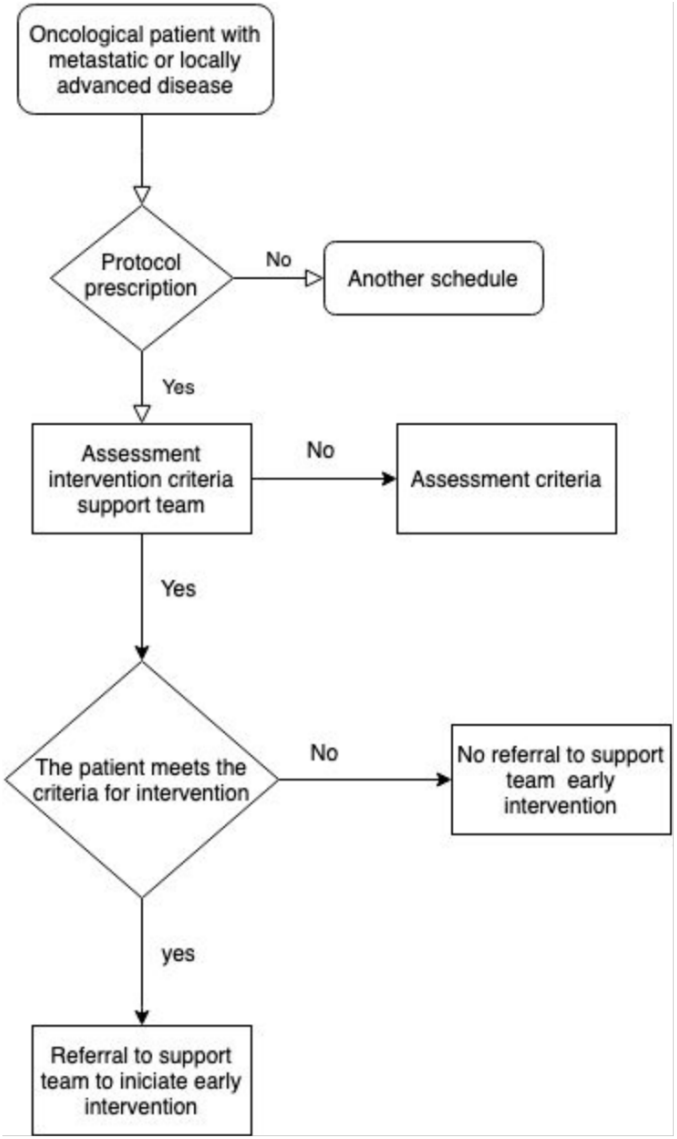
2. Disease-related aspects

a**. Difficult-to-manage physical symptoms**: pain, dyspnoea, or other physical symptomatology that doesn't respond well to your oncologist's initial treatment or that is cause of **multiple incomes in recent months**
b**. Difficulty with emotional adaptation of the patient or their families** that does not involve psychopathology : Patient suffers discouragement, loss of meaning, demoralization; Difficulty communicating, pact of silence in the family
c. **Advanced constitutional syndrome** (pre-cachexia or tumor cachexia) that involves needing to have an essential conversation about possible progression of disease
d. Severe functional impairment involving **aid for basic activities**
e. **Cognitive impairment**
f. Chronic use of oxigen

3. Complexity of care. Social complexity or Institutionalized or non-primary caregiver available

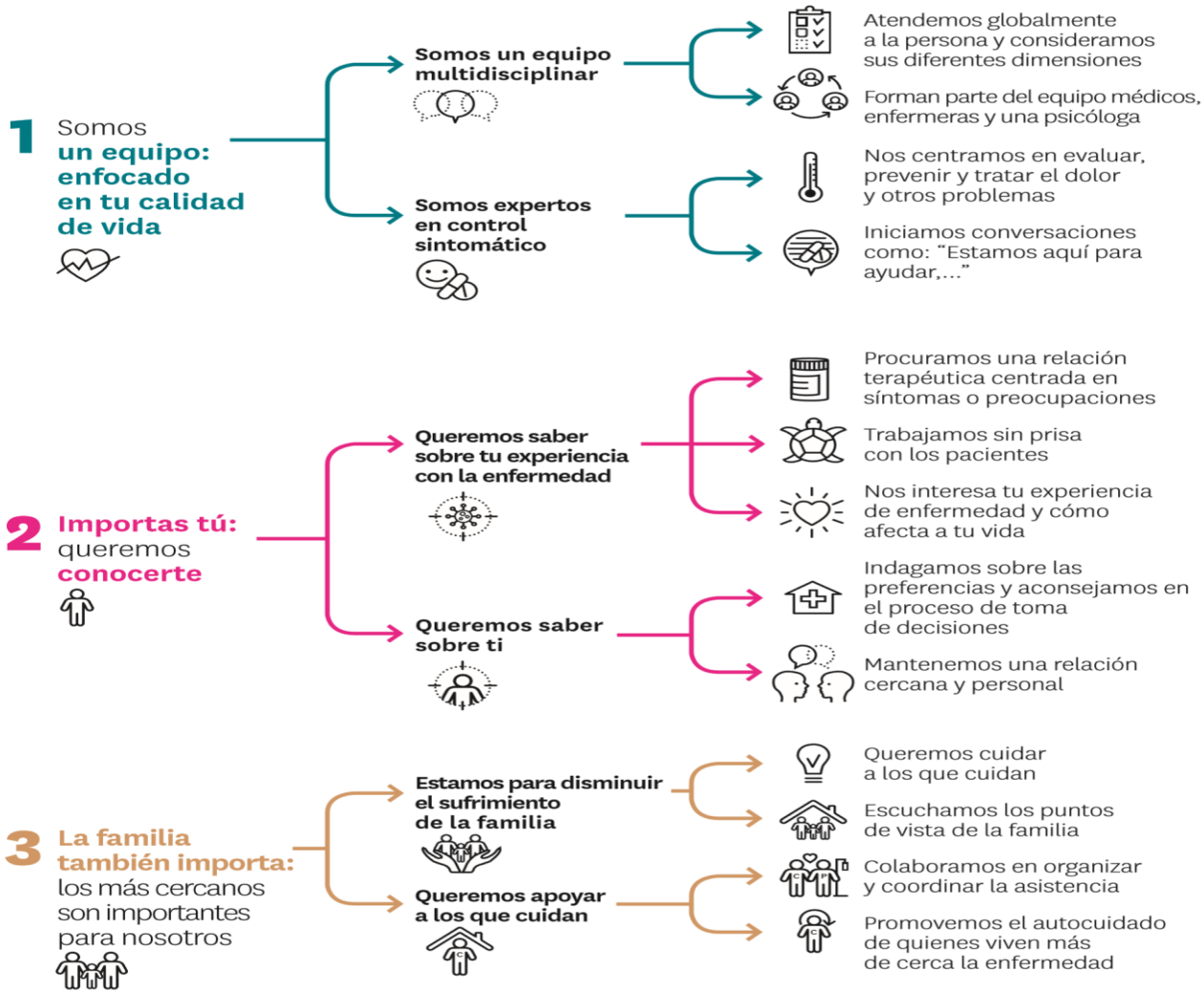
Meet one criteria → referral → first visit together (patient-oncologist-PCU)

Process map future state



Intervention 2

Give greater visibility of the palliative care units. Facilitator diptych



Intervention 3

Active participation of the patient in making health and therapeutic decision

advance care planning ladder

1st step

Disease knowledge exploration and patient values

1) want to know aspects related to the evolution or pronostic of your disease?
2) do you want to actively participate in decisions or do you prefer others to?
3) in the current situation, what's important? quality of life? is autonomy important?
4) do you have experitual or ideological beliefs that we should take into account?

2nd step

Sharing treatment decisions and goals

1) treatments that try to control the progression of the disease, can cause significant side effects, what is the limit of side effects that you are willing to assume?
2) it is important that symptom control through "palliative care" is integrated as part of cancer treatment. Would you like to receive these cares?
3) if there was a serious, emergency situation, what do you want in terms of medical interventions?

3rd step

end-of-life strategy

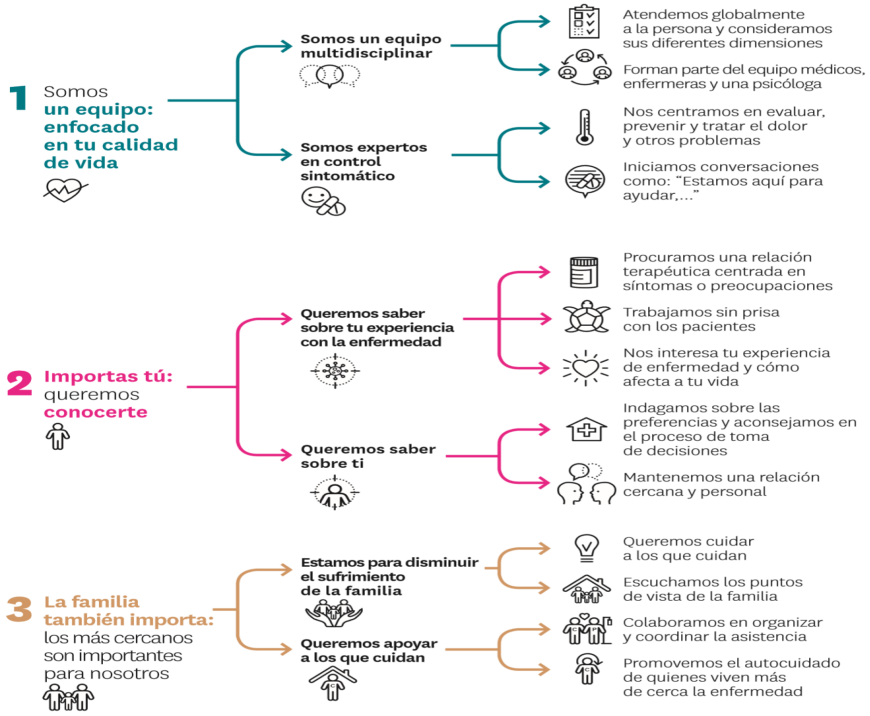
1) have you thought about how to consider care when the time comes when chemotherapy doesn't work?
2) have you thought about how to consider care when the time comes when chemotherapy doesn't work?
3) have you talked to your relatives about how to cope with the disease when it progresses and there are no options to stop it?
4) in case you can't express yourself, who is the person you want me to speak for you? have you spoken to that person?
5) where would you like to be careful if there comes a time when you are no longer independent? and in the last few days?
6) if symptom control could not be achieved with available treatments, would you prefer "palliative sedation"? Would you like to be asked this situation?

PDSA Plan (Test of Change)

Date of PDSA Cycle	Description of Intervention	Results	Action Steps
1-2-2020 15-9-2020	Analysis of the causes responsable of agressive events	Identification of main problems	Redifine circuit, and created a cheklist that recognizes risk situations
1-9-2020 1-12-2020	**-Implementation of the cheklist that recognizes high risk situations in all oncology visitis**	New process map done	Periodic meetins and staff training
Ongoing	**-Active participation of the patient in making health and therapeutic decisions** -Give greater visibility of the palliative care units. -Material with information and recommendations addressed to families.	Indicators analysis	Continous training

Materials Developed (optional)

informative diptych to give visibility to palliative care units



structuring of the clinical interview for planning end-of-life care

Escalera de Planificación Anticipada de Cuidados LagunAdvance (E-PAL)

Cáncer

Primer escalón

Exploración del conocimiento de la enfermedad y de los valores del paciente

1. ¿Quiere conocer aspectos relacionados con evolución/ pronóstico de su enfermedad?
2. ¿Quiere participar activamente en las decisiones acerca de su tratamiento, o prefiere que lo hagan otros?
3. En la situación actual, ¿Qué es lo importante? ¿Esto ha cambiado? ¿Es importante la calidad de vida? ¿La autonomía?
4. ¿Tiene creencias espirituales o ideológicas que debamos tener en cuenta?

Segundo escalón

Compartiendo decisiones y objetivos de tratamiento

5. Los tratamientos que intentan controlar el avance de la enfermedad, pueden ocasionar importantes toxicidades. ¿Cuál es el límite de estos efectos secundarios que estaría dispuesto a asumir?
6. Es importante que el control de síntomas a través de los "Cuidados paliativos" se integren como parte del tratamiento oncológico ¿Quisiera recibir Cuidados Paliativos?
7. Si hubiera una situación grave de emergencia vital, ¿Qué quiere en cuánto a intervenciones médicas?

Tercer escalón

Estrategia para el final de vida

8. ¿Ha pensado cómo plantear los cuidados cuándo llegue el momento en que la quimioterapia no funcione? ¿En ese momento, le gustaría participar en las decisiones o preferiría que lo hicieran otros (familiares/equipo médico)?
9. ¿Ha hablado con sus familiares de cómo afrontar la enfermedad cuándo ésta avance y no existan opciones para pararla?
10. En el caso de que usted no pudiera expresarse por sí mismo, ¿Quién es la persona que quiere que hable por usted?, ¿Ha hablado ya con esa persona?
11. ¿Dónde le gustaría ser cuidado si llega un momento en que ya no es independiente? ¿Y En sus últimos días de vida?
12. Si el control de síntomas no se pudiera conseguir con los tratamientos disponibles, ¿Preferiría una "Sedación paliativa"? ¿Querría que se le preguntara en esta situación?

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measuring results

Compare the number of aggressive events before and after the interventions

- Chemotherapy on the last 15 days of life
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Measuring intervention impact in

QoL→ PREMS and validated questionaries of patient satisfaction

OS → with and without intervention

Change Data

Date	N first oncology dx	N early referral to PCU	% referrals
1-9-2019/ 30-11-2019	418	70	16%
1-9-2020/ 30-11-2020	383	80	20%

Conclusions

Identifying risk situations for suffering aggressive events and providing patients and healthcare professionals with the resources to avoid them, will reduce aggressive events at the end of life.

Next Steps/Plan for Sustainability

-Consolidate the standardization of referrals to palliative care units

- Consolidate the structured clinical interview methodology for end-of-life care planning

- Results measurement and continuous improvement plan

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Hospital Universitario Fundación Jiménez Díaz

Project Title: Aggressiveness of Cancer Care Near the end of Life

AIM: Improve the number of aggressive events by halving each one (list at presentation) in a period of 6 months

INTERVENTION:

- To **standardize referral criteria** to the palliative care unit promoting and early intervention
- To desing and implement a methodology to **encourage active participation of the patient in making health and therapeutic decisions** at the end of life
- **Give greater visibility of the palliative care units and facilitate material with information and recommendations addressed to families.**

TEAM:

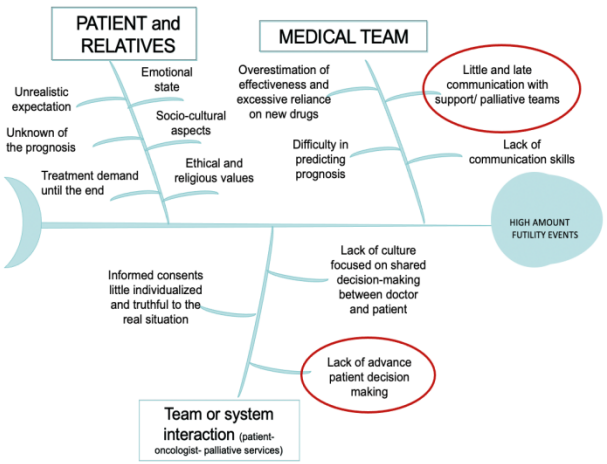
- Department 1: Palliative care unit
- Department 2: Pharmacy
- Department 3: Patient
- Department 4: Social worker
- Department 5: Psychologist

PROJECT SPONSORS:

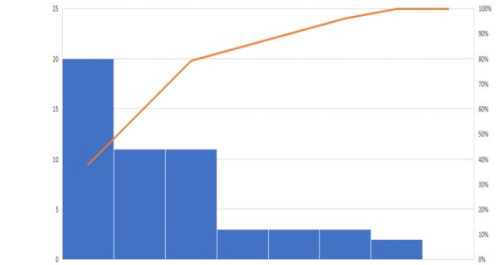
- Medical director

RESULTS:

Cause and effect diagram



Pareto chart



Num of aggressive events: pending

CONCLUSIONS:

- **Identifying risk situations for suffering aggressive events and providing patients and healthcare professionals with the resources to avoid them, will reduce aggressive events at the end of life.**

NEXT STEPS:

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Thank you

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Grupo quirónsalud

Oncohealth Institute