

Brief Communication Strategies when opening a DNACPR conversation

The incorporation of advance care planning into end of life care means that we are all facing the challenge of having difficult conversations with patients about issues such as Do not attempt resuscitation, and patient preferences at end of life. The following guidance may help to open discussions, lead to open and honest conversations, and result in greater likelihood of achieving the patient's wishes and guiding sound clinical practice.

If you find opening discussions about end of life difficult, the following conversation openers might help:

"What are your thoughts about the future? How do you see things going?"

"In thinking about the future, have you thought about where you would prefer to be cared for as your illness gets worse?"

"What do you see happening with your illness over the next few months?"

"It would be good to discuss what kind of medical care you would want if you should get sick again. How do you feel about talking about this?"

Introducing a conversation about resuscitation may lead on from discussions about prognosis and the patient going on your GP Palliative Care register, or discussing the patient's understanding of the course of their illness. It may however require the professional to ask **open direct questions** in order to raise the issue specifically.

"You said you haven't been feeling as well the last few weeks, what is your understanding of what is happening?"

Within the conversation look for cues from the patient, on which you can pick up to steer the conversation in the direction you need it to go.

"You said earlier that you feel things are getting worse, shall we talk more about that?"

"You said you are anxious about the future, would it help to discuss what kind of things can be put into place to make sure your choices are upheld?"

Where cues are given, pick up on them specifically and use them to take the conversation forward:

"You said you are finding things very hard, is it ok if I ask you more about that?"

"You said you don't want to go back into hospital, would it help to write down your priorities in an advance care plan?"

Patient's who don't give specific cues:

Within your consultation ask the patient specifically about their view of the future, eg:

"In thinking about the future, have you thought about where you would prefer to be cared for as your illness gets worse?"

"It would be good to discuss what kind of medical care you would want if you should get sick again. How do you feel about talking about this?"

When you need to raise the subject specifically:

"It is important that we put things in place to keep you safe, I wonder if I could talk to you about that?"

“Can we discuss the important issue of resuscitation?” If they respond with “No”, you would need to follow-up with another direct *“It is important that we make sure things are in place to help you and those looking after you”*

When talking about patient priorities for future care, use the skills of empathy and acknowledgement explicitly, eg:

“You are obviously concerned about how things may go in the future? What would help you to feel more confident about the future?”

“You said your health worries you, what is it that is most worrying?”

“You don’t think your husband would be able to manage, although you would like to stay at home?”

That must be hard for you?”

Use clarification to check their understanding:

“Can you explain to me what you understand about your condition?”

“Can you tell me what you feel may happen in the future?”

“If you do not ask your patients to record their preferences for care and death, then you are not leaving this choice up to your patient, instead potentially leaving their fate to chance.”

Many of us find it difficult to initiate advance care planning discussions, however, once established as integral to best practice in end of life care, the benefits outweigh the initial hesitation. The following case studies may provide helpful guidance www.dyingmatters.org

1. By Dr P Nightingale, GP in Lancaster

Ron Smith (not real name) was a well known patient to me. He was an 82-year-old retired teacher with diabetes, peripheral neuropathy and ischaemic heart disease. He developed heart failure and was admitted to hospital after a convulsion caused by hyponatraemia. He saw me 4 months ago requesting no further hospital admissions and expressing a desire not to be resuscitated.

We discussed future planning and he agreed to look at advance care planning documentation.

He was content to complete a preferred priorities of care (PPC) document and a Do Not Attempt Resuscitation (DNACPR) form. He took these documents away, discussed them with his family and brought them back to me a week later. I notified the out of hours GPs and the local ambulance service and all my partners. We added him to our practice palliative care register.

A dignified death

Four months later, Ron started to decline. He was offered acute admission but he requested to stay at home. One morning, having eaten breakfast with his wife, Ron suddenly collapsed, as is common in chronic heart failure. He died in his home and the last words he heard were those of his loving wife.

Without advance care planning, Ron could so easily have had a hospital death, with a futile and undignified attempt at resuscitation. After Ron's death I sat with his wife in the lounge. Ron's PPC was on the coffee table. We flicked through it and realised that Ron had achieved the death he had wished for months before. This was of great comfort to his wife and professionally satisfying for me. Without advanced care planning, the bereavement experience of this family would have been very different.

2. By Professor Mayur Lakhani, GP & appraiser, Leicestershire, Chair of Dying Matters

He talks about an elderly patient who wanted to die at home, and the measures he put in place to help ensure the patient had his wishes met.

Last year, I saw an 80-year-old man, for acute exacerbation of COPD. He was accompanied by his family, who expressed concern that he was becoming frail. His wife, who was also his carer, reported that he had developed faecal incontinence. He had complex co-morbidities.

The basis for putting him on the EOLC register was as follows: my answer to the 'Surprise question' was 'No'. He had progressive life-limiting illnesses; spent the majority of his time chair or bed-bound, needing more care; he had multiple medical conditions - short of breath at rest, low BMI; two recent unplanned admissions; worsening dementia and faecal incontinence.

What happened next

I initiated discussion (week 1) and arranged a meeting with his family (week 2), followed by a home visit (week 3). I simultaneously referred the patient to the community matron. Preferred Priorities for Care (PCC), which stated the patient wanted to be cared for at home. A Do Not Resuscitate order was signed, as was the Out of Hours and Ambulance Service.

What difference did this make?

The patient and his family welcomed having an open discussion and were relieved that the subject had been raised. Putting the patient on the register and creating a plan of care transformed the situation, giving both the patient and the family a great sense of relief. The patient's quality of life improved, and support for his wife, who was his primary carer, also improved through Marie Curie nurses.

After my first consultation with the patient, he had two out of hours contacts but no hospital admissions. He died, in his own home, in May of the following year surrounded by his family.