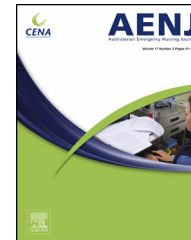




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RESEARCH PAPER

# Analysis of the impact of limitation of medical treatment orders during unplanned transfers from sub-acute care to Emergency Departments



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## KEYWORDS

Clinical deterioration;  
Do-not-resuscitate orders;  
Emergency Departments;  
Advance Directives;  
Patient transfer;  
Sub-acute care

## Summary

**Background:** The impact of limitation of medical treatment orders (LOMT) on patient outcomes following transfer from sub-acute care to the Emergency Department remains unclear.

**Methods:** Retrospective medical record review of 431 adult in-patients who required ambulance transfer following clinical deterioration during a sub-acute care admission during 2010.

**Results:** Common reasons for transfer were respiratory (18.9%) or neurological (19.0%) conditions; 35.7% (154/431) were transferred within one week of sub-acute care admission. LOMT orders were in place for 37.8% ( $n = 163$ ) patients who were older ( $p < 0.001$ ), with more comorbidities ( $p < 0.005$ ), specifically cardiac, renal and pulmonary disease than patients without LOMT. Patients with LOMT orders had more physiological abnormalities before transfer; tachypnoea (43.7% vs 28.6%), hypoxaemia (63.5% vs 48.4%) and severe hypoxaemia (27.6% vs 14.5%). There were no differences in rates of admission, cardiac arrest, Medical Emergency Team activation or ICU admission. For admitted patients, those with LOMT orders had significantly ( $p \leq 0.005$ ) higher mortality: in-hospital (21.9% vs 11.3%); 30 days (23.9% vs 12.3%) and 60 days (28.2% vs 13.4%).

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**Conclusions:** Patients with LOMT had higher levels of comorbidity and were more acutely ill during their sub-acute care admission. Once transferred those with a LOMT had similar rates of cardiac arrest, MET activation and unplanned ICU admission, but higher mortality.

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## What is known

- Patients in sub-acute care may have multiple, progressive medical conditions where it may be appropriate to make medical decisions to limit treatment.
- The use of orders to limit therapy in acute care settings has been described and over the last decade a relationship between deteriorating patients in acute care hospitals, limitation of medical treatment orders and the role of Medical Emergency Teams has been emerging.
- The impact of limitation of medical treatment orders on patient outcomes following transfer from sub-acute care to the Emergency Department remains unclear.

## What this paper adds?

- Many patients in sub-acute care have limitation of medical treatment orders in place. These patients had more chronic illness and were more acutely ill during their subacute care admission than patients without such orders.
- Transfers to the Emergency Department for patients who experienced clinical deterioration, frequently occurred within the first week of sub-acute care admission.
- Patients with LOMT had poorer outcomes following transfer to acute care, including higher mortality, highlighting the need for greater guidance regarding the transfer of patients who deteriorate clinically in sub-acute care.

## Introduction

Sub-acute care is comprehensive goal-oriented care for patients who are recovering from an injury or exacerbation of disease process, and generally of lower intensity than provided on acute care wards. Sub-acute care wards, including rehabilitation and Geriatric Evaluation and Management (GEM) units, play an important role in Australian Healthcare services as they provide for the flow of patients from acute care, with a focus on helping patients achieve their highest level of independence as quickly as possible, so they can return to their usual residence.

The most common reason for admission to sub-acute care is for rehabilitation following joint surgery and the average length of stay in public hospital sub-acute care is

20.4 days.<sup>1</sup> Patients in sub-acute care may have multiple, progressive medical conditions where it may be appropriate to make medical decisions to limit treatment. In the absence of a documented resuscitation plan, patients in an acute care health service in Australia will be treated in the event of a cardiac/respiratory arrest. Limitation of medical treatment orders (LOMT) are decisions to limit treatments that will be provided when these interventions will not be of benefit to the patient.<sup>2</sup> The most common LOMT is a "Not-for-resuscitation/Do not resuscitate" order to prevent futile or unwanted cardiopulmonary resuscitation.<sup>3</sup>

In Victoria, the Medical Treatment Act (1988) which was revised in 2012,<sup>4</sup> clarified the right of patients to refuse medical treatment and established a procedure for clearly indicating a decision to refuse medical treatment, through a 'Refusal of treatment certificate' for a current condition. A refusal of treatment certificate ceases to apply to a person if the medical condition has changed to such an extent that the condition to which the certificate was given is no longer current.<sup>4</sup> In Australia, an Advance Care Directive is now recognised as the right of patients to refuse or request medical treatment and has statutory recognition in most States and Territories.<sup>5</sup>

In acute care settings the use of Advance Directives, Resuscitation plans and LOMT orders has been increasing over recent years. Over the last decade, a relationship between deteriorating patients in acute care hospitals, LOMT orders and the role of Medical Emergency Teams (MET) has been emerging.<sup>6–8</sup> This relationship takes one of two forms: MET activation can be the catalyst for a new LOMT order; or for patients with existing LOMT orders, a MET call provides care in the event of acute clinical deterioration.<sup>6–8</sup> The use of orders to limit therapy in acute care settings has been described,<sup>9</sup> however little is known about LOMT orders in sub-acute care, especially the impact on unplanned transfers to acute care. The aim of this study was to identify differences in demographic characteristics, physiological status and outcomes of patients with and without LOMT orders who required an unplanned transfer from sub-acute to acute care.

## Methods

The study design was a retrospective cohort study, which adhered to the National Statement on the Conduct of Human Research by the Australian National Health and Medical Research Council and was approved by the Human Research and Ethics Committees at Deakin University and the health services. The study data were derived from a previously conducted study aimed to understand the timing and outcomes

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