

EMERGENCY MEDICINE

Clinical Decision Support



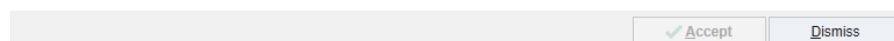
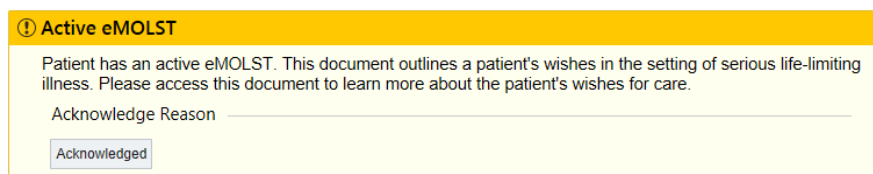
Supportive Care Workflow in the Emergency Departments for Providers, Nurses, Social Workers, Care Managers, and PUAs

Supportive Care is a workflow to quickly identify patients with serious life-limiting illnesses to:

- Identify patient/family needs early in the ED course
- Provide access to advance care planning documentation by the ED care team
- Involve all appropriate parties within the ED care team

The clinical decision support tool will assist with the identification of these patients in the ED by providing alerts such as Best Practice Alerts (BPAs) and column notifications. The goal is to quickly identify these patients and allocate appropriate resources so that care delivered in the ED is concordant to the patients' goals and ultimately, avoid unnecessary procedures and interventions.

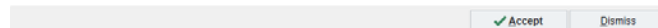
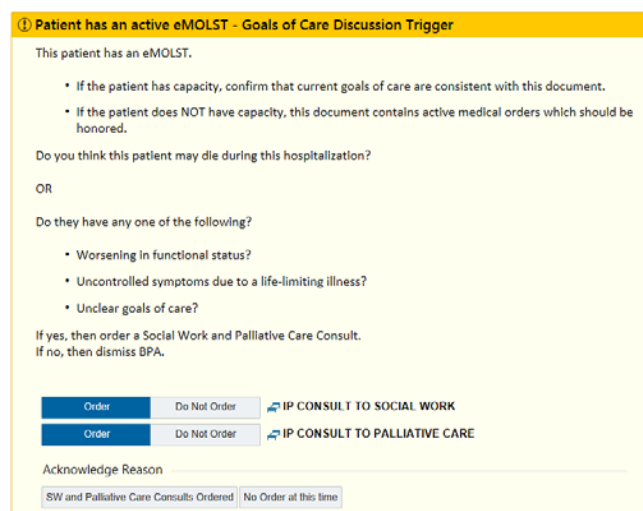
- 1) If patient has an eMOLST,
 - a. Informational BPA for RN's with Hyperlink to eMOLST site



- b. PUA column notification– the PUA should access the eMOLST registry and print the pdf of the most up to date eMOLST and place within the patient chart.



- c. Provider BPA for “Goals of Care Discussion”



Supportive Care Workflow in the Emergency Departments for Providers, Nurses, Social Workers, Care Managers, and PUAs

- 2) If patient has a previous disposition of Home Hospice or Inpatient Hospice,
 - a. BPA for Provider to place Social Work and Palliative Care Consult

ⓘ Active Hospice

This patient has previously been referred to or enrolled with hospice services. Consult Social Work and consider Palliative Care consultation.

Order

Do Not Order

IP CONSULT TO SOCIAL WORK

Order

Do Not Order

IP CONSULT TO PALLIATIVE CARE

Acknowledge Reason

SW and Palliative Care Consults Ordered

No Order at this time

✓ Accept

Dismiss

- b. Informational BPA for Social Workers and Care Managers

ⓘ Active Hospice

This patient has previously been referred to or enrolled with hospice services. Evaluate for social needs and notify hospice services, if appropriate.

Acknowledge Reason

Acknowledged

✓ Accept

Dismiss

- c. Column on track board for social work and care managers displays a flower if there was a previous disposition of Home Hospice or Inpatient Hospice

Hospice

🌸

Supportive Care Workflow in the Emergency Departments for Providers, Nurses, Social Workers, Care Managers, and PUsAs

3) If patient has no eMOLST, no previous disposition with Hospice, but screens in positive for 1 or more of the following provided criteria:

- ☐ MSQ=no during any previous hospitalization
- ☐ previous palliative consult order
- ☐ previous order for DNR
- ☐ outpatient palliative care visit in the last 6 months
- ☐ last hospitalization disposition location of nursing facility (only if rehab excluded)
- ☐ code narrator start
- ☐ active order for mechanical ventilation
- ☐ active order for non-invasive ventilation
- ☐ last hospitalization disposition location of LTAC
- ☐ Previous scanned document of Consent to Withhold/Withdraw Life-Sustaining Tx
- ☐ ECOG 3 or 4
- ☐ 1 Laboratory value of: GFR <15, Albumin <2, Bicarb <10, pCO2 >70

a. BPA for Providers for Goals of Care Discussion

Goals of Care Discussion Trigger (No eMOLST on file)

This patient **does not** have an eMOLST on file but does possibly have a serious life-limiting illness based on criteria met (see criteria in **blue** below).

Start a goals of care conversation.

Do you think this patient may die during this hospitalization?

OR

Do they have any one of the following?

- Worsening in functional status?
- Uncontrolled symptoms due to a life-limiting illness?
- Unclear goals of care?

If yes, then order a Social Work and Palliative Care Consult.
If no, then dismiss BPA.

Criteria met:

Previous Palliative Care Appointment
Previous disposition to a Long Term Care Hospital
ECOG=3, Poor functional status
Patient has had a Code Start documented

Order

Do Not Order

IP CONSULT TO SOCIAL WORK

Order

Do Not Order

IP CONSULT TO PALLIATIVE CARE

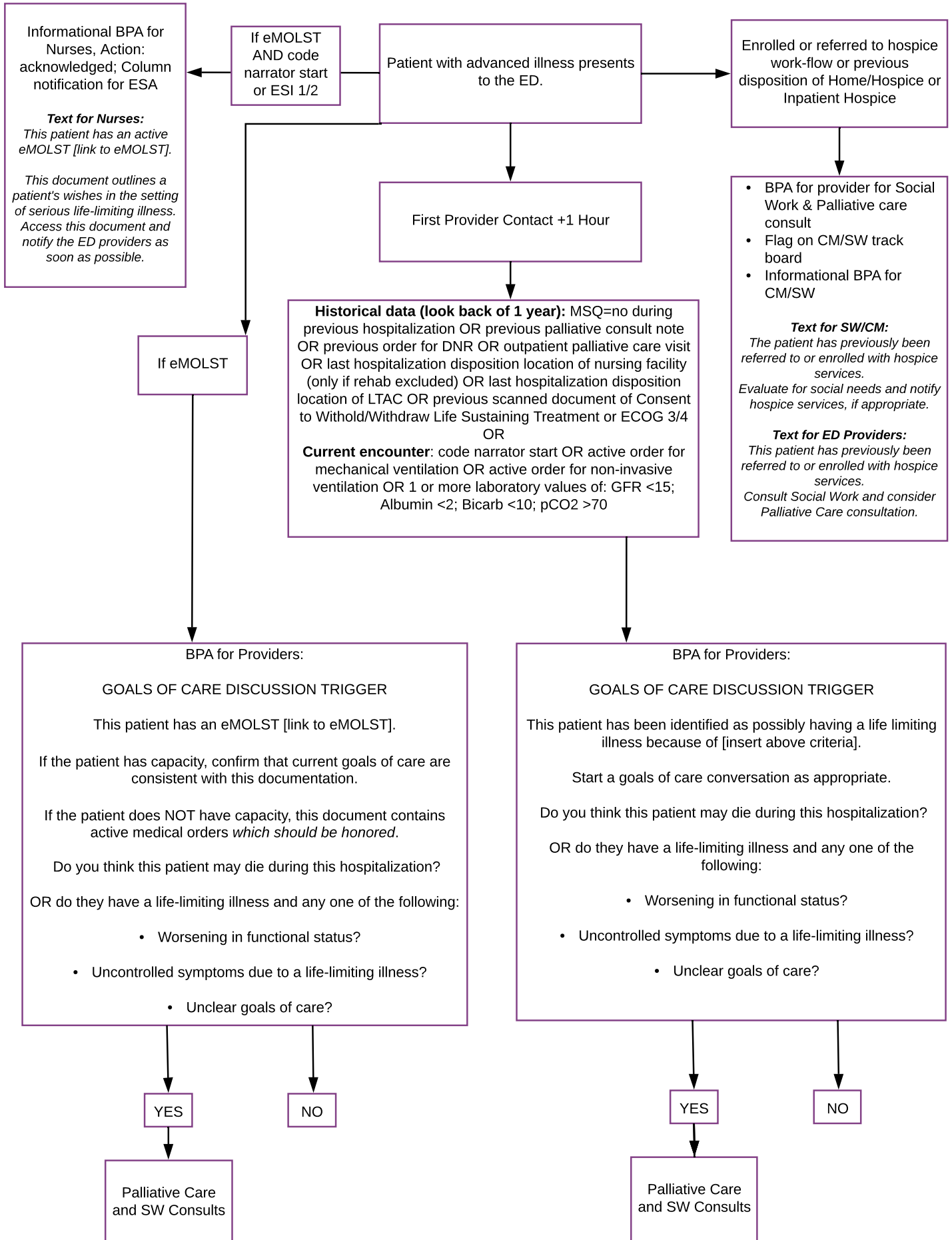
Acknowledge Reason _____

SW and/or Palliative Care Consults O...

No Order at this time

Accept

Dismiss



CME Evaluation Form – EM Talk

1. What changes will you make to how you identify patients and/or family members who may be ready to discuss goals of care and/or palliative care options
2. What changes will you make to how you counsel patients and/or family about end of life care?
3. What steps will you take to ensure that you involve all members of the ED care team to ensure a multi-disciplinary and team-based approach is used?
4. Did this activity meet the learning objectives as stated in the syllabus/handout?
☐ Yes
☐ No
5. Did this activity address factors beyond clinical care that affect the health of populations?
☐ Yes
☐ No
6. If yes, how?
7. In addition to the changes to practice described above, please list any other changes to practice you intend to make resulting from your participation in this activity.
8. Was this activity relevant to your practice?
☐ Yes
☐ No
9. If this educational intervention did not fulfill your educational needs, how could future activities address your needs better?
10. Are there any systemic barriers that would prevent you from making changes to practice?
☐ Yes
☐ No
11. If yes, select the option to change listed below that would provide the greatest systemic barrier to change.

Answer	Response Count
formulary/coverage restrictions	
Time not allotted for implementation of new skills	
Lack of resources	
Insurance doesn't reimburse for treatment/etc.	
Patient non-compliance	
Organization does not support educational efforts	
Policy issues within organization	
Other (Insert)	

CME Evaluation Form – EM Talk

12. Were the various learning formats (e.g., lecture, panel based discussion, Q&A) utilized in this activity appropriate for the achievement of the educational objectives listed?

☐ Yes
☐ No

13. If not, which of the options below would you have preferred as the main educational format for this educational intervention?

Answer	Response Count
Didactic Lecture	
Case-based discussion	
Q/A / Panel discussion	
Hands-on training	
Other (Insert)	

14. Disclosure of commercial support (if any) was clearly communicated.

☐ Yes
☐ No

15. Disclosure of relevant financial relationships of faculty were clearly communicated.

☐ Yes
☐ No

16. If disclosure of either relationships or commercial support was unclear, how can this information be clearly presented?

17. Faculty disclosed when they discussed unlabeled or unapproved uses of drugs or medical devices.

☐ Yes
☐ No

18. The activity was free of commercial bias.

☐ Yes
☐ No

19. If you perceived commercial bias in the content or presentation of this activity, please give a detailed account, including the name of the presenter and nature of the perceived bias.

20. Please indicate what knowledge gaps, practice gaps, or patient health issues you have encountered in your own practice or in the profession that NYU SOM could address with continuing medical education initiatives

CME Evaluation Form – EM Talk

21. Teaching methods/strategies/practices

Answer	N/A	1	2	3	4	5
The instructors described the educational objective for his/her presentation clearly.						
The instructors clearly explained concepts.						
The instructors presented a balanced view of therapeutic options.						
The instructors challenged my thinking on the subject matter.						
The instructors encouraged questions and/or comments.						
The instructors utilized presentation software effectively.						
The instructors used other technology effectively.						

22. Which speaker(s) stood out amongst all of the speakers and why?

23. In the space below, please reflect on your personal experience at this educational intervention

**NYU****RORY MEYERS
COLLEGE OF NURSING****Center for Continuing Education in Nursing****Evaluation Summary**

Title:	Primary Palliative Care for Emergency Medicine (PRIM-ER)
Date:	Asynchronous, on-demand learning module, on the website
Location:	Online

Name: _____

E-mail address: _____

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
After attending this activity, the learner will be able to:					
1. Identify barriers to adequate pain relief, pain assessment and treatment of pain at the end of life.					
2. Describe symptom assessment and interventions that prevent or diminish symptoms at end-of-life.					
3. Assess an imminently dying patient and list 5 physical sign and symptoms of the dying process.					
The content was organized, effective and relevant to the purpose of this session.					
How long did it take you to complete this module?	_____ minutes				
This program fair, balanced, and free of commercial bias.	YES		NO		
Did this course provide information that will enable you to change your practice?	YES		NO		
Will you encounter barriers in your work environment to apply the information gained from this program in your practice?	YES		NO		
The provider of the activity has disclosed in writing or verbally the conflict of interest or lack thereof declared by the planners and presenters/content specialists.	YES		NO		

Comments: _____

PRIMARY PALLIATIVE CARE FOR EMERGENCY MEDICINE

End-of-Life-Care (ELNEC) Training



Participate in an end-of-life training to hone your skills on communicating with seriously ill patients

Training link: http://tiny.cc/ELNEC_OSU

- **Username:** OSU e-mail address
- **Initial password:** welcome

Training must be completed by midnight on [9/25/19!](#)

- One NYU CE credit
- Receive a national education course that would typically cost hundreds of dollars for free

Having effective conversations with seriously ill patients and grieving families is challenging.

Receive a specially End-of-Life Nursing Education Consortium (ELNEC) training to hone your skills communicating and managing seriously ill patients and families. Learn best practices in approaching these challenging situations.

FAST FACTS

- One NYU CE credit
- Your participation is part of a larger national initiative housed at NYU School of Medicine and funded through the National Institutes of Health

2019

End-of-Life Nursing Education Consortium

Step 1: Login

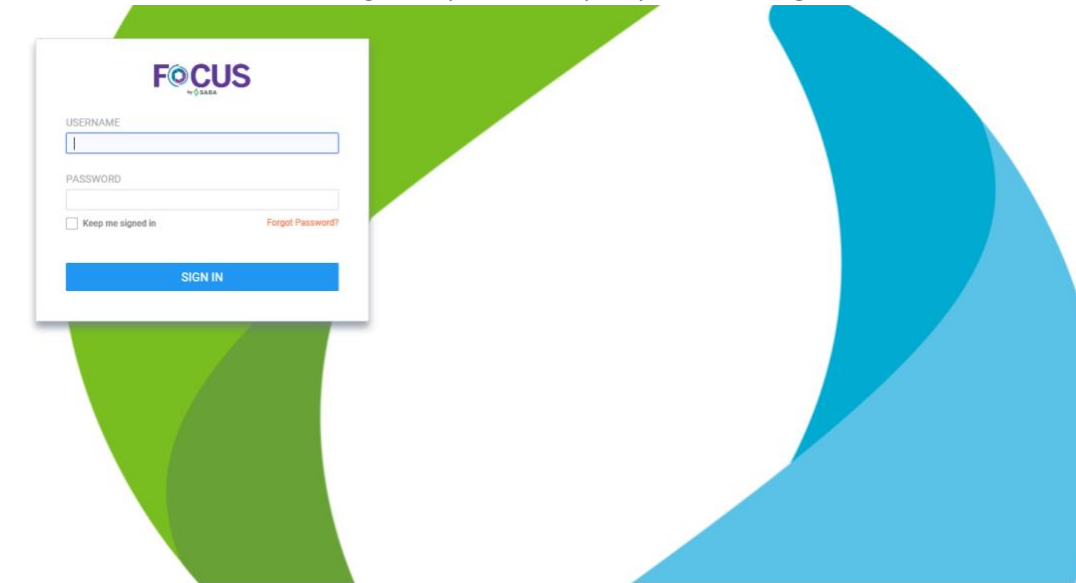
Link: [https://nyumc-](https://nyumc-primer.sabacloud.com/Saba/Web_spf/NA3P1PRD0091/common/leclassview/dowbt-000219233)

[primer.sabacloud.com/Saba/Web_spf/NA3P1PRD0091/common/leclassview/dowbt-000219233](https://nyumc-primer.sabacloud.com/Saba/Web_spf/NA3P1PRD0091/common/leclassview/dowbt-000219233)

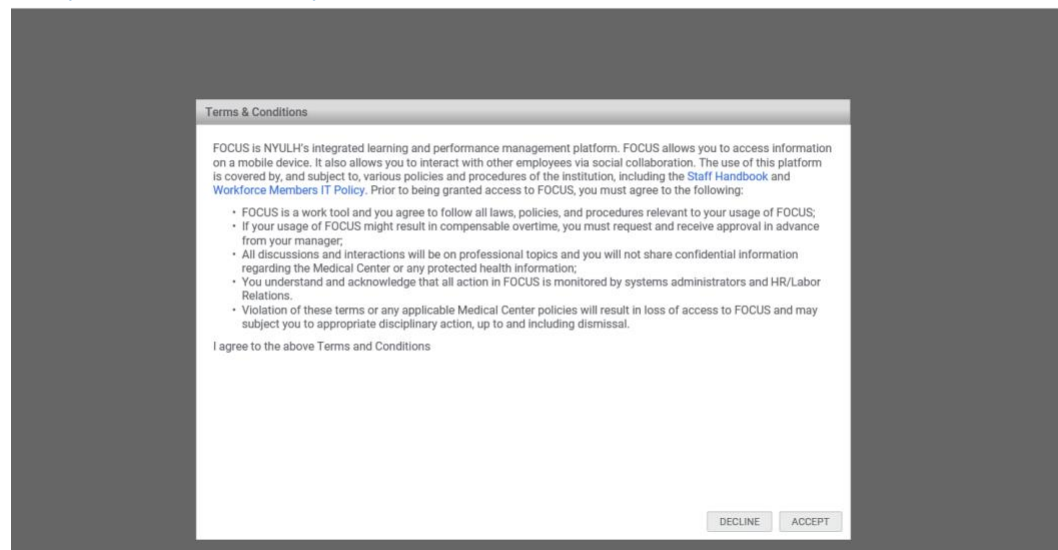
Username: Your login username will be your University Hospital email address

Password: welcome.

- You will need to change this password upon your initial log-in.



Step 2: Click Accept



Terms & Conditions

FOCUS is NYULH's integrated learning and performance management platform. FOCUS allows you to access information on a mobile device. It also allows you to interact with other employees via social collaboration. The use of this platform is covered by, and subject to, various policies and procedures of the institution, including the [Staff Handbook](#) and [Workforce Members IT Policy](#). Prior to being granted access to FOCUS, you must agree to the following:

- FOCUS is a work tool and you agree to follow all laws, policies, and procedures relevant to your usage of FOCUS;
- If your usage of FOCUS might result in compensable overtime, you must request and receive approval in advance from your manager;
- All discussions and interactions will be on professional topics and you will not share confidential information regarding the Medical Center or any protected health information;
- You understand and acknowledge that all action in FOCUS is monitored by systems administrators and HR/Labor Relations.
- Violation of these terms or any applicable Medical Center policies will result in loss of access to FOCUS and may subject you to appropriate disciplinary action, up to and including dismissal.

I agree to the above Terms and Conditions

DECLINE ACCEPT

Step 3: click Enroll and the Activity “ELNEC_Final”

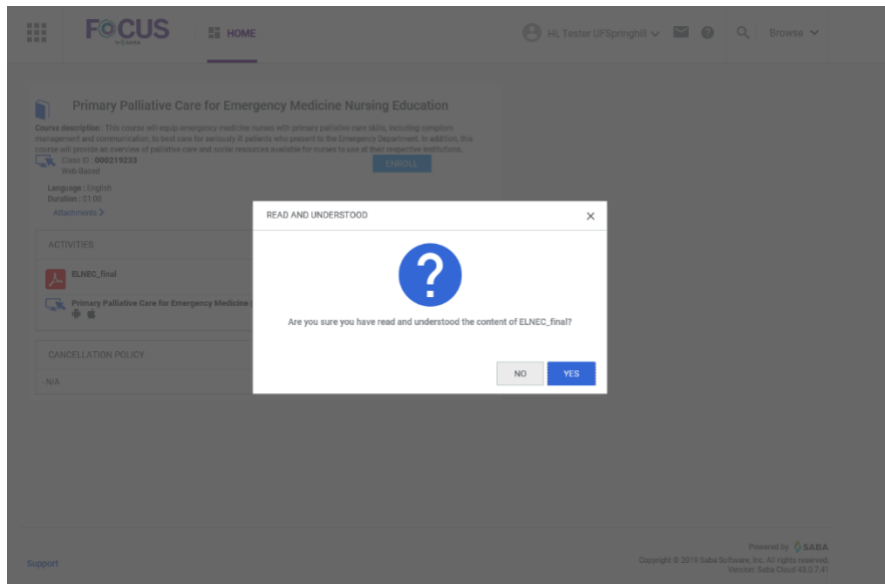
If you do not enroll you will not receive credit for the course

The screenshot shows the FOCUS LMS interface. At the top, there's a navigation bar with the FOCUS logo, a 'HOME' link, and a user profile for 'Hi, Tester UFSpringhill'. Below this, the course title 'Primary Palliative Care for Emergency Medicine Nursing Education' is displayed. A description follows, stating the course is for emergency medicine nurses. Key details include 'Class ID: 000219233', 'Web-Based', 'Language: English', and 'Duration: 01:00'. An 'ENROLL' button is prominently shown. Under the 'ACTIVITIES' section, a red document icon labeled 'ELNEC_final' is circled in red. Below this is a link for 'Primary Palliative Care for Emergency Medicine (PRIM-ER) Evaluation'. A 'CANCELLATION POLICY' section at the bottom indicates '- N/A'.

Step 4: After reviewing the course material click the “x” on the upper right to exit the course.

This screenshot shows a presentation slide titled 'Primary Palliative Care for Emergency Medicine (PRIM-ER)'. The slide features the ELNEC logo (End-of-Life Nursing Education Consortium) and the NYU Langone Health logo. It includes a photograph of a healthcare professional interacting with a patient. A yellow 'Protected View' banner at the top states that features are disabled for security. In the top right corner of the presentation window, a small 'x' icon for closing the window is circled in red.

Step 5: You will be prompted to acknowledge that you read and understood the content of the course. Click the appropriate response option.



If yes, your screen will update to show that your course has been completed successfully.

**Primary Palliative Care for Emergency Medicine Nursing Education**
(ID: 00021923)

Course description : This course will equip emergency medicine nurses with primary palliative care skills, including symptom management and communication, to best care for seriously ill patients who present to the Emergency Department. In addition, this course will provide an overview of palliative care and social resources available for nurses to use at their respective institutions.

You have registered for the following class

 **Class ID : 000219233**
Web-Based

Language : English
Duration : 01:00
[Attachments >](#)

MY STATUS

 **Tester UFSpringhill**
Registered on : 25-APR-2019

IN PROGRESS

CLASSMATES



0

Completions so far

1

Total registrations

ACTIVITIES

NAME	STATUS	ACTION
 ELNEC_final completed on: 25-APR-2019	Completed successfully	RE-LAUNCH
 Primary Palliative Care for Emergency Medicine (PRIM-ER) Evaluation	Not evaluated	LAUNCH

Step 6: Evaluation

In order to receive your 1 CEU credit and \$50 Amazon Gift Card from NYU you need to complete the course evaluation. After taking this course this step is imperative. Click “Launch” and you will be prompted to start the brief 10 question evaluation. At the end of the evaluation make sure to click “Submit”

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Duration : 01:00
[Attachments >](#)

ACTIVITIES

NAME	STATUS	ACTION
 ELNEC_final completed on: 25-APR-2019	✓ Completed successfully	RE-LAUNCH 
 Primary Palliative Care for Emergency Medicine (PRIM-ER) Evaluation 	○ Not evaluated	LAUNCH

Step 7: Print or export certificate to keep on file for personal CEU records



Primary Palliative Care for Emergency Medicine Nursing Education

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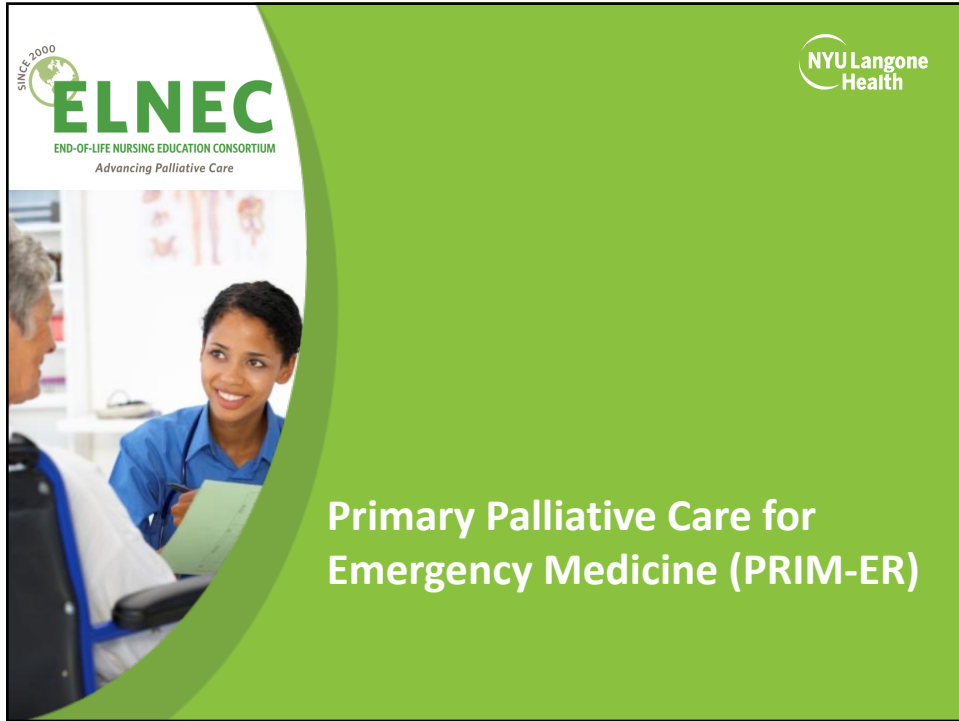
[Attachments >](#)

☒ Export Certificate PRINT CERTIFICATE

ACTIVITIES

NAME	STATUS	ACTION
 ELNEC_final completed on: 25-APR-2019	✓ Completed successfully	RE-LAUNCH ▼
 Primary Palliative Care for Emergency Medicine (PRIM-ER) Evaluation completed on: 25-APR-2019 	✓ Completed successfully	RE-LAUNCH ▼





ELNEC
END-OF-LIFE NURSING EDUCATION CONSORTIUM
Advancing Palliative Care

NYU Langone Health

Primary Palliative Care for Emergency Medicine (PRIM-ER)

New York University Rory Meyers College of Nursing Center for Continuing Education Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

To receive 1 contact hour for this training, learners must complete and submit the evaluation form at the end of this training. The contact hours are valid until September 2021.

No conflict of interest exists for any individual in a position to control the content of this educational activity.

The End-of-Life Nursing Education Consortium (ELNEC) Module Overview

- **Communication**
 - This module emphasizes the importance of good communication in end-of-life care. The complexities of communicating with patients and families at this critical time are described along with suggestions for care.
- **Pain Management**
 - This module reviews principles of pain assessment and management in the critical care setting for patients throughout illness and at the end of life.
- **Symptom Management**
 - This module builds on the Pain Management module by addressing other symptoms common in critical care, and the role of the Critical Care Nurse in managing these symptoms.
- **Final Hours of Life**
 - This module focuses on care at the actual time of death, emphasizing the preparation necessary to insure the best care at this critical event in the trajectory of illness.









COMMUNICATION

Section I: Overview of Communication in Emergency Medicine

- Communication is a fundamental tool of palliative care nursing
- Given the polarity of life saving efforts versus withdrawal of treatment in intensive and emergency units, communication is critical
- Staff are not always trained in communication
- Sharing information about illness and prognosis
- Engaging patients and families in treatment decision making
- Offering support

Dahlin & Wittenberg, 2015; Fox, 2014



Communication Needs of Patients

- Information for informed choices
- Synthesize information
- Disclosure of feelings
- Verbalization of fears
- Sense of control
- Discussion about meaning of life
- Maintain hope
- Reassurance of pain/symptom management

Communication Needs of Family

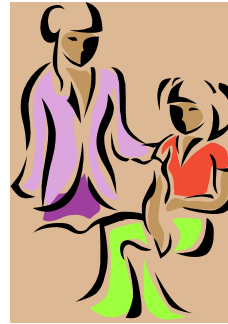
- To be with patient
- Information and frequent updates
- Permission to speak and be listened to
- Changes in patient's conditions
- Assurance of comfort
- Open and honest communication
- Provide a safe space

Seccareccia et al., 2015; Steele & Davies, 2015



Types of Palliative Care Communication in the ED Setting:

- Information sharing
- Advance care planning
 - Goals
 - Preferences
 - Wishes
- Breaking bad news
- Prognosis discussion



Barriers to Communication in Emergency Medicine

- | | |
|---|--|
| <ul style="list-style-type: none"> ● Patient Factors <ul style="list-style-type: none"> ➢ Emotions ➢ Differences in preferences ● Provider Factors <ul style="list-style-type: none"> ➢ Communication training ➢ Comfort level ➢ Timing of discussions ➢ Uncertainty of prognosis ● System Factors <ul style="list-style-type: none"> ➢ Life-sustaining treatment as default ➢ Documentation systems ➢ Approach to advance care planning | <ul style="list-style-type: none"> ● Fear of mortality ● Avoidance of emotion ● Insensitivity ● Sense of guilt ● Fear of unknown ● Difficulty accepting prognosis ● Personal grief ● Disagreement among family members ● Ethical concerns ● Non-communicative patients |
|---|--|

Bernacki & Block, 2014; You et al., 2015

Outcomes of Poor Communication

Patient:

- Futile care
- Prolonging life
- Suffering
- Psychosocial morbidity for family members
- Underutilization of palliative care/hospice

Healthcare Proxy:

- Moral distress
- Emotional Burnout
- Financial cost



Surrogate Decision Making

- Patients admitted to the ED may be incapacitated and unable to make health care decisions for themselves.
- Surrogates want to understand what is medically happening, maintain a sense of hope yet look to follow the patient wishes
- As clinicians, it is imperative that we support and actively listen to the family/surrogate.



In Conclusion...

- **Effective communication:**
 - informs, supports, comforts, guides, and sustains hope
- **Ineffective communication:**
 - confuses, disorganizes, demeans, and distresses

Thorne et al., 2013



Section II: Developing Effective Communication Skills

Basic Principles of Therapeutic Communication

- Patients want the truth about prognosis
- Talking about end-of-life issues will not harm patients
- Anxiety is normal for both patient and clinician
- Patients have goals and priorities besides living longer
- Learning about goals and priorities empowers clinicians to provide better care

Verbal and Non-Verbal Communication

- Includes body language, eye contact, gestures, tone of voice
- 80% of communication is nonverbal

Boreale, 2017; Dahlin & Wittenberg, 2015; Bernacki & Block, 2014



Use of Open-Ended Questions

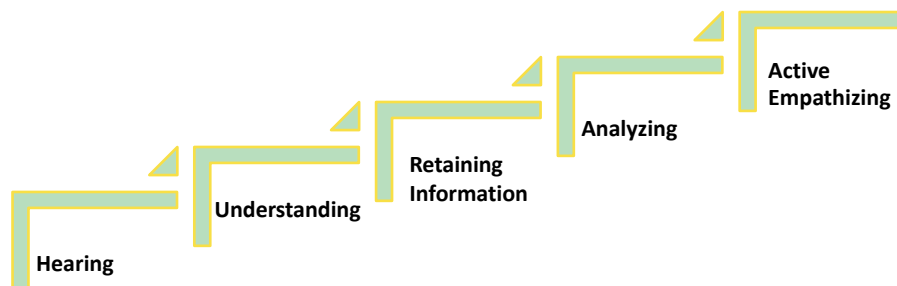
- How are things going for you/your family?
- How do you think you/your loved one is doing?
- What has the doctor told you/your family?
- What do you understand about your condition?
- How can we support you?

Attentive Listening

- Allow flow of conversation without interruption
- Encouragement to talk
- Use of silence



Listening: Occurs at 5 Levels



Adler, 2017; Ray, 1992



Mindful Presence

- Comfortable with self
- Know the person
- Connect
- Affirm and value
- Be vulnerable
- Use intuition
- Empathize
- Be in the moment
- Provide serenity & silence

Adler, 2017; Boreale, 2017



Communication Techniques: Examples in Palliative Care

- Build trust
- Offer “warning shot”
- Respond to emotions
 - NURSE mnemonic**
 - Naming
 - Understanding
 - Respecting
 - Supporting
 - Exploring
- Normalize
- Understand the emotion
- Empathize
 - *“I can not imagine how overwhelming this is”*
- Strengths/coping
 - *“Where do you find your strength?”*
- Therapeutic silence

Quill et al., 2014



Warning Shot

Warn them about the bad news to come.

Ex. "I am afraid I have some bad news for you"

Pause: Give them a moment to compose themselves and get ready to hear the news.

NURSE Mnemonic

	Examples	Notes
Name	"It sounds like you are frustrated"	In general, turn down the intensity a notch when you name the emotion
Understand	"This helps me understand what you are thinking"	Think of this as another kind of acknowledgment but stop short of suggesting you understand everything (you don't)
Respect	"I can see you have really been trying to follow our instructions"	Remember that praise also fits in here. Ex. "I think you have done a great job with this"
Support	"I will do my best to make sure you have what you need"	Making this kind of commitment is a powerful statement
Explore	"Could you say more about what you mean when you say that..."	Asking a focused question prevents this from seeming too obvious

VitalTalk, 2017




Communication Techniques: Examples in Palliative Care (cont.)

- Check that your message has been heard
 - "What have we not talked about today that is **IMPORTANT** to you?"
- Use the "D" word
 - "Because you are so ill, I believe you are dying."
- Expect conflict

- Summarize/restate your understanding
 - "Let me double-check that I understand what you said."
- Provide support
 - "I am here to work with you and support you."
- Use non-verbals

Quill et al., 2014




“I’m Sorry” versus “I Wish”

- “I’m sorry” should be used with great caution
 - Can be misinterpreted as being aloof, showing pity, or taking responsibility for outcome
- “I wish” statements demonstrates empathy, but also addresses limits of treatment(s)
 - *“I really wish we had better treatments for your disease.”*

Quill et al., 2014



Section III: The Interdisciplinary Team and Family Meetings

Promoting Family-Centered Decision Making

- Importance of shared decision making
 - Removes the burden from any one person
- Communication is empathic and informative
- Meetings are proactive
- ED nurses play a pivotal role and every effort should be made to participate in family meetings

Gay et al., 2009



The Importance of Family Meetings

- Opportunity to share information
- Identify needs and fears
- Set realistic goals
- Important forum for discussions regarding:
 - patient's condition
 - prognosis
 - care preferences
 - listening to the family's concerns
 - decision making about appropriate goals of treatment

Gay et al., 2009



Family Meeting

IMPACT-ICU video: Nurse-Family Conversation
(4:10)

<http://vitaltalk.org/topics/the-3-conversations/>



Why Family Meetings Go Wrong....

- Healthcare team talks more than listens.
- Lack of identified purpose and goals
- Poor planning/preparation
- Offers poor emotional support
- Family has little understanding of prognosis
- Unfavorable/poor understanding of palliative care
- Healthcare team lacks understanding of family cultural rituals/traditions
- Meeting is held in a noisy, busy space



Timing for Conversations is Critical

- A good time to talk?
- Is there a need to talk?
- Has someone else from the interdisciplinary team already spoken with the patient/family?
- Is there an 'overload' of information?
- Is the patient experiencing pain/other symptoms?
- Caregiver may be exhausted

Dahlin & Wittenberg, 2015



Meeting with Families

- Preparation
 - Agenda and Goals
 - Who should attend?
 - Brief meeting before with staff attending
- Introduction of participants and purpose and process of the meeting
- Assess the families understanding of the patients medical condition
- Summarize
- Breaking Bad News
 - Good communication is a vital part of this task
 - Emergency Department Nurses are in the position of providing clarification and providing support

McAdam & Puntillo, 2015



SPIKES Protocol

- S** Setting and listening skills
- P** Patient's perception of condition/seriousness
- I** Invitation from patient to give information
- K** Knowledge in giving medical facts
- E** Explore emotions and empathize as patient responds
- S** Strategy and summary

Baile et al., 2000



Team Communication

- Intra-team communication is vital, especially between RN and MD
- Should be collaborative
- Should be effective and frequent
- Document
- Expect conflicts



Communication with Physicians

Honor the relationship physicians have with their patients
Maintain professional relationships
Be specific about the reasons for the 'ask'

IMPACT-ICU video: Nurse/Physician Conversation (2:22)

<http://vitaltalk.org/topics/the-3-conversations/>



Resolving Conflict

- Try to take a step back
- Identify your own emotions
- Talk about it. Get their perspective – “Help me understand.”
- Identify your feelings – “This makes me feel...”
- Agree on patient care issues

Dahlin & Wittenberg, 2015; Thomas et al., 2015



Summary

- Communication is complex- particularly in emergency medicine environments
- Effective communication requires listening and presence
- The ultimate objective is bringing forward the patient's values, goals and preferences
- ED Nurse's play a vital role in promoting communication between colleagues, patients and family.





Section I: Introduction to Pain Management

- Definition of pain
- Malignant and Non-Malignant Pain
- Barriers to pain assessment and management

Pain Is...

- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage”

IASP, 2017

Cancer and Pain

- 1/3 receiving active treatment for cancer and 2/3 with advanced cancer experience pain

Paice, 2015

Non-Malignant Diseases & Pain

- Assess for co-morbidities that could cause pain

Paice, 2015



Effects of Unresolved Pain

- Pain associated with depression in patients with heart failure

Pantilat et al., 2016

- Inadequate pain relief may hasten death by:

- Increased physiological stress
- Decreased immunity
- Decreased mobility
- Increased possibility of pneumonia and or thromboembolism
- Increased workload of heart and lungs

Paice, 2015



Barriers to Pain Relief

- Specific barriers

- Professionals
- Healthcare systems
- Patients/families

Paice, 2015

- Why is pain not better addressed/managed?

- Fear pain may mean disease progression/recurrence
- Not wanting to appear 'weak' or 'drug seeking,' and have treatment reduced
- Not wanting to 'distract' their provider
- Patients may believe everything is being done for their pain

Syrjala et al., 2014



Strategies to Overcome Barriers in Pain Management

- Education of healthcare professionals

- Overcoming system-based issues

- Management

- Use current guidelines
- Use appropriate analgesics
- Monitor outcomes
- Attend to adverse effects

- Education of patients and families

- Set realistic goals—most pain can be alleviated
- Provide psychosocial support

Kwon, 2014



Clinical Practice Guidelines for Quality Palliative Care: Issue of Pain

- Interdisciplinary care
- Assessment should be regular and on-going
- Pain level should be acceptable to patient and family
- Document response
- Identify and address barriers
- For controlled substances, implement a risk management plan
- Consider culture
- Educate the family/caregiver
- Address suffering
- Refer to providers with specialized skill

NCP, 2013

National Consensus Project
FOR QUALITY PALLIATIVE CARE



Goals of Pain Management

- Providing adequate pain and symptom control
- Decrease distress caused by pain in the patient and family
- Provide an acceptable sense of control
- Relieve caregiver burden
- Strengthen relationships
- Optimize quality of life (QOL)
- Enhance meaning of life and illness, providing personal growth

NCCN, 2017



Pain: Suffering and Existential Distress at End of Life

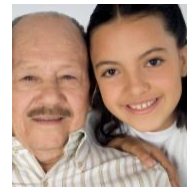
- Pain relief is contingent on adequate assessment and use of both drug and non-drug therapies
- Pain extends beyond physical causes to other causes of suffering and existential distress
- Requires Interdisciplinary care and approach

Ferrell & Coyle, 2008



Patients at Risk for Undertreatment

- Children and older adults
- Non-verbal or cognitively impaired
- Patients who deny pain
- Non-English speaking
- Cultural considerations
- History of addictive disease



Section II: Pain Assessment

- Pain History
 - Acute
 - Chronic
- Physical examination
- Laboratory/diagnostic evaluation
- Psychological/Social
- Substance Abuse History
- Determine Pain Diagnosis
 - Etiology of pain
 - Response to pain interventions
- Quality of Pain
 - Nociceptive Pain
 - Somatic pain syndrome such as bone metastasis, mucositis, and skin lesions
 - Visceral pain syndromes
 - Neuropathic pain
 - Injury to the peripheral or central nervous system



Pain Experience

- Patient's description of pain
- Language used: Ache, Hurt, Pain
- Location(s), intensity, quality, timing, aggravating/alleviating factors
- Meaning of pain
- How pain impacts quality of life
- Cultural considerations for pain
- Medication use history
 - Current
 - Past
- Psychosocial history
- Substance use history
- Goals of care

Paice, 2015



Physical Examination

- Observation
- Palpation
- Auscultation
- Percussion

Functional Assessment

- Muscle tone, Reflexes
- Walking and Coordination
- Ability to perform self-care
- Activities of Daily Living

Laboratory/Diagnostic Evaluation

- Rule out potentially treatable causes
- Need for additional laboratory or radiographic evaluation is directed by the goals of care



Clinical Practice Guidelines: Assessing Pain

- Pain should be routinely monitored
- Valid and reliable behavioral pain scales should be utilized
- Vital signs or observational pain scales may be used as a cue for further assessment of pain
- Reassess changes in pain and response to analgesics (relief vs. adverse effects)

Barr et al., 2013; Paice, 2015; Pasero & McCaffery, 2011



Communicating Assessment Findings

- Communication improves pain management
- Describe location, intensity, limitations, and response to treatments
- Describe effect on function
- Document medications, efficacy, and adverse effects
- Ask for suggestions, but be ready to make recommendations
- Be objective

Fink et al., 2015;
Paice, 2016



Section III: Treatment of Pain

- Structured Approaches to Pain Management
- Clinical Practice Guidelines
- Pharmacologic Management
- Non-Pharmacologic
- Interdisciplinary Approaches to Pain Management
- Interventional methods

APS, 2016; Pasero & McCaffery, 2011



Structured Approaches to Pain Management

- Reflects principles of interdisciplinary collaboration
- Implementation of evidence-based guidelines and algorithms that address:
 - Need for analgesia
 - Prevention as the hallmark of recommendations
 - Procedural, operative, and trauma pain
- Referral and consultation



Clinical Practice Guidelines: Treatment of Pain

- Pre-emptive analgesia and/or non-pharmacologic interventions prior to invasive or potentially painful procedures
- IV opioids should be considered as first-line drug class of choice to treat non-neuropathic pain
- Non-opioid analgesics considered to decrease amount of opioids administered and to minimize potential opioid-related side effects

Barr et al., 2013



Routes of Administration

- Oral
- Transmucosal
 - Buccal
 - Sublingual
 - Nasal (Nebulized opioids)
- Rectal
- Transdermal
- Topical
- Parenteral
 - Intravenous
 - Subcutaneous
 - Intramuscular (not recommended)
- Spinal
 - Epidural
 - Intrathecal

Pharmacological Therapies

- Nonopioids
- Opioids
- Adjuvants
- Anesthetics



APS, 2016

Nonopioids

- Acetaminophen
 - Analgesic and antipyretic
 - High doses can cause liver dysfunction
 - Use cautiously with older adults
- NSAIDS
 - Ketorolac-potent
 - Limit to 5 days use
 - Antipyretic, anti-inflammatory, and analgesic
 - Toxicity, Adverse effects

Pasero & McCaffery, 2011



Opioids: Most Commonly Used in Palliative Care

- | | |
|-----------------|---------------|
| ● Buprenorphine | ● Morphine |
| ● Codeine | ● Oxycodone |
| ● Fentanyl | ● Oxymorphone |
| ● Hydrocodone | ● Tapentadol |
| ● Hydromorphone | ● Tramadol |
| ● Methadone | |

Mechanism of action: Opioids block the release of neurotransmitters that are involved in the processing of pain



Opioids: Issues

- Primarily given via IV route, other routes acceptable
- Balancing sedation with analgesia
- Opioid use and neurological evaluation
- Agonists

Opioids: Adverse Effects

- Respiratory depression
- Constipation
- Sedation
- Urinary retention
- Nausea/vomiting
- Pruritus
- Myoclonus

ANTICIPATE, PREVENT, TREAT!!!



Important Considerations for Opioid Therapy

- Opioid Rotation
 - Use when one opioid is ineffective even with adequate titration
 - Use when adverse effects are unmanageable
- Tolerance
- Physiologic dependence
- Addiction
- Substance Use Disorder



Treatment of Pain in Persons With Established Addictive Disease

- Team meetings with interdisciplinary approach
- Set realistic goals
- Set limits
- Use non-opioids as able and if on methadone for maintenance
- Consider tolerance (avoid parenteral injections)
- Prevent withdrawal
- Manage psychiatric comorbidities (treat depression or other disorders)



Adjuvant Analgesics

- Antidepressants (Tricyclic, SNRIs, atypical)
- Anticonvulsants (Gabapentin, Pregabalin)
- Local Anesthetics (Topical, Lidocaine gel/prilocaine cream/lidocaine 5% patch)
- Corticosteroids
 - Indication, Activates/Increase Appetite
 - Proximal muscle wasting, Administer in AM
- Other Agents (Propofol, Ketamine, Benzodiazepines)



Interventional Management of Pain

- Surgical procedures
 - Stents
 - Debridement
 - Stabilization
- Cancer Therapies
 - Radiation
 - Chemotherapy
 - Hormonal therapy
 - Bisphosphonates
- Neuroablative therapies
 - Neurolytic blocks
 - Neuroablative procedures



Non-Pharmacologic Strategies

Physical

- Rehabilitation
- Exercise
- Heat or cold
- TENS
(transcutaneous electrical nerve stimulation)
- Cognitive-behavioral therapy

Psychosocial

- Relaxation
- Meditation
- Hypnosis
- Music
- Biofeedback
- Systematic desensitization

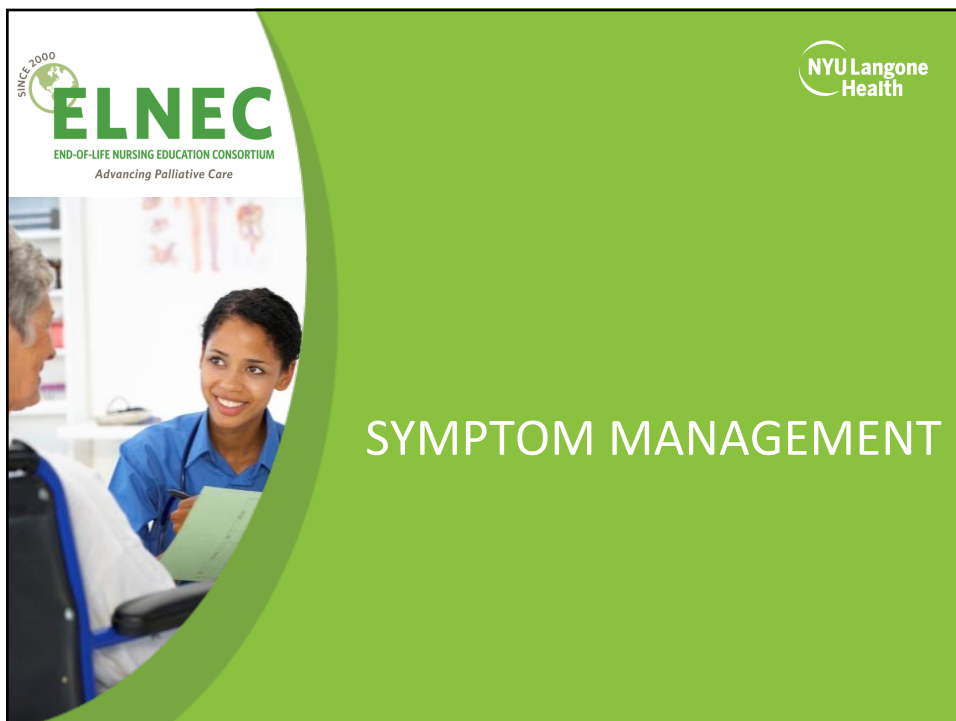
Complementary & Integrative

- Acupuncture
- Qigong
- Therapeutic massage
- Reiki



Conclusion

- Pain is prevalent, intense and distressing
- Pain extends beyond physical causes to other causes of suffering and existential distress
- Pain relief is contingent on adequate assessment and both drug/non-drug therapies
- Interdisciplinary team approach
- Nurses play a key role in the assessment, prevention and management of pain
- Prevention through early recognition and control leads to better patient outcomes



Section I: Introduction

Essential Elements of Symptom Management

- Assess, plan, intervene, evaluate
- Ongoing assessment and evaluation
- Requires interdisciplinary teamwork
- Reimbursement concerns (affordable options)
- Research is needed

Symptoms and Suffering

- Symptoms create suffering and distress
- Psychosocial intervention is key to complement pharmacologic strategies
- Need for interdisciplinary care

Coyne et al., 2015



Symptom Management in the Older Adult

- May have several symptoms with multiple co-morbidities
- Majority of hospice diagnoses are non-cancer related, associated with heavy symptom burden
 - Congestive heart failure (CHF)
 - Chronic obstructive pulmonary disease (COPD)
 - Dementia
 - Other
- Social isolation



Common End-of-Life Symptoms

- Respiratory
 - Dyspnea, cough
- GI
 - Anorexia/cachexia, constipation, diarrhea, nausea/vomiting, xerostomia
- Psychological
 - Depression, anxiety, post-traumatic stress disorder, delirium/agitation/confusion
- General/Systemic
 - Fatigue/weakness, wounds, seizures, sleep disturbances, lymphedema, and urgent syndromes

Section II: Respiratory Symptoms

- Dyspnea
- Cough
- Subjective experience
- Most reported symptom
- Promotes disability, poor quality of life, and suffering



Causes of Dyspnea

- Major pulmonary causes
- Major cardiac causes
- Major neuromuscular causes

Assessment of Dyspnea

- Clinical assessment: Physical exam, Diagnostic tests, Patient experience
- Use subjective report
- Underlying cause

Treatment of Dyspnea

- Non-pharmacologic
 - Non-invasive ventilatory support (oxygen, positive pressure ventilation) if hypoxic
 - Interventional therapies
 - Counseling, Positioning, Elevation, Fans
 - Pursed lip breathing, Energy conservation
- Pharmacologic Treatments: Opioids and Non-opioids

Broglio, 2016; Kravits, 2015; Dudgeon, 2015



Section III: GI Symptoms

- Anorexia/cachexia
- Constipation
- Diarrhea
- Nausea/vomiting
- Xerostomia
 - Dry mouth
 - Difficulty in mastication, swallowing, and speech
 - Causes: medications, radiation, and systemic diseases



Blush & Larsen, 2015



Anorexia and Cachexia

- Anorexia: loss of appetite, usually with decreased intake
- Cachexia: lack of nutrition and wasting
- Primary cause is under investigation
- Disease related
- Psychological
- Treatment related

Assessment

- Physical findings
- Impact on function and QOL
- Calorie counts/daily weights
- Lab tests
- Skin breakdown

Treatment

- Dietary consultation
- Medications
- Parenteral/enteral nutrition
- Odor control
- Counseling

Wholihan, 2015; Smeltz, 2016



Constipation

- Infrequent or difficult passage of stool
- Frequent symptom in palliative care
- Prevention is key

Causes

- Disease-related (obstruction, hypercalcemia, neurologic, inactivity)
- Treatment-related (e.g. opioids, other meds)

Assessment

- Bowel history
- Abdominal assessment
- Digital rectal assessment
- Medication review

Treatment

- Medications
- Other approaches
- Prevention

Economou, 2015



Diarrhea

- Frequent passage of loose, nonformed stool
- Effects (e.g. fatigue, caregiver burden, skin breakdown)

Assessment

- Bowel history
- Medication review
- Infectious processes

Causes

- Disease or Treatment Related
- Malabsorption
- Psychological

Treatment

- Treat underlying cause
- Dietary modifications
- Hydration
- Pharmacologic agents



Nausea and Vomiting

- Common in advanced disease
- Assessment of etiology is important
- Acute, anticipatory, or delayed

Assessment

- Physical exam
- History
- Lab values
- Dehydration

Causes

- Physiological (GI, metabolic, CNS)
- Psychological
- Disease or Treatment Related

Treatment

- Anticholinergics
- Antihistamines
- Steroids
- Prokinetic agents

Chow et al., 2015; Lynch, 2016



Section IV: Psychosocial Issues

- Depression
- Anxiety
- Post-Traumatic Stress Disorder (PTSD)
- Delirium/agitation/confusion



Assessment of Depression

- Situational factors/symptoms
- Previous psychiatric history
- Other factors (e.g., lack of support system, pain)
- Risk factors for suicide
- History of declining functionality
- Psychiatric evaluation

Pasacrete et al., 2015



Depression

- Ranges from sadness to suicidal
- Cluster; Often unrecognized and undertreated
- Occurs in 25-77% of terminally ill
- Distinguish normal vs. abnormal

Causes

- Disease-related
- Psychological
- Medication-related
- Treatment-related
- Social issues

Pharmacologic Interventions

- Goal: Focus on symptom control
 - Antidepressants (Amitriptyline)
 - Takes 4-6 weeks to be effective)
 - Steroids (Dexamethasone)

Non-Pharmacologic Interventions

- Promote autonomy
- Grief counseling
- Draw on strengths
- Use cognitive strategies

Fulcher, 2014; Pasacrete et al., 2015



Anxiety

- Subjective feeling of apprehension
- Often without specific cause
- Categories of mild, moderate, severe
- Assessment: Physical symptoms & Cognitive symptoms

Causes

- Physiological changes
- Medications/Substances
- Pre-existing anxiety
- Risk factors

Pharmacologic Interventions

- Benzodiazepines
- Antipsychotics
- Antidepressants

Nonpharmacologic Interventions

- Empathetic listening
- Assurance and support
- Concrete information/warning
- Relaxation/imagery

APA, 2013; Gatto et al., 2016; Pasacrete et al., 2015



Symptom at a Glance: Post-Traumatic Stress Disorder (PTSD)

- PTSD is characterized by persistent/severe reaction to a traumatic event
 - Combat
 - Terrorist attacks
 - Sexual or physical assault
 - Accidents
 - National/natural disasters
- Symptom clusters
 - Avoidance
 - Re-experiencing the event
 - Hyper arousal
- Implications for End of Life



Delirium/Agitation/Confusion

- Delirium - Acute change in cognition/awareness
- Agitation or withdrawal - Accompanies delirium
- Confusion - Disorientation, inappropriate behavior, hallucinations

Heidrich & English, 2015



Delirium/Agitation/Confusion

Risk Factors

- Medications
- Infection
- Hypoxemia
- Bladder distention
- Unrelieved pain

Assessment

- Physical exam
- History
- Spiritual distress
- Other symptoms

Treatment

- Maintain Safety
- Pharmacologic
 - Neuroleptics
 - Monitor for side effects, withdrawal
 - Eliminate non-essential/contributing medications
- Reorientation
- Relaxation/distraction
- Hydration

Heidrich & English, 2015



Section V: General/Other Symptoms

- Fatigue
 - Subjective, multidimensional experience of exhaustion
- Wound
- Seizures
- Sleep disturbances (at a glance)
- Lymphedema (at a glance)
- Urgent syndromes



Wounds

- Loss of skin integrity
- Pressure injuries (ulcers)
- Malignant wounds
- Kennedy Terminal Ulcers

Assessment of Wounds

- Characteristics
- Pain
- Psychosocial
- Caregivers

Treatment of Injuries

- Frequent position changes
- Injury cleaning
- Dressings
- Provide analgesia
- Seek consultation
- Prevention is key



Dilemma: Assessing/Treating Injuries or Wounds in Patients with Life-Limiting Illness

- Assess underlying cause
- What are the goals of care?
- Is it realistic that the wound will heal?
- Prevent further pressure injuries/ulcers/wounds
- Manage pain and odor
- Pressure injury (ulcer) may indicate organ failure



Seizures

- Definition
- Causes: Infections, Trauma, HIV, Tumors, Medications, Metabolic imbalances

Assessment

- Manifestations
 - Aura
 - Mental status changes
 - Sensory changes
- Physical exam
- Labs

Treatment

- Limit trauma
- Anticonvulsant treatments
 - Phenytoin
 - Phenobarbital
 - Lorazepam, diazepam
 - Levetiracetam



Symptoms at a Glance

Lymphedema

- Chronic, progressive swelling due to failure of lymph drainage
- Patients at risk
- Side effects
- Assessment
- Management



Sleep Disturbance

- Affects quality of life for both the patient and caregiver
- Assessment
- Management

Fu & Lasinski, 2015



One Final Reminder: Be Aware of Symptoms of Urgent Syndromes

- Superior vena cava obstructions
- Pleural effusion
- Pericardial effusion
- Hemoptysis
- Spinal cord compression
- Hypercalcemia

Bobb, 2015



Conclusion

- Multiple symptoms are common
- Coordination of care with the interdisciplinary team
- Use drug and nondrug treatment
- Patient/family teaching and support





Preparing for the Final Hours of Life

- Advance care planning
- Recognizing the transition to active dying
- Care for the dying
- Post death care

Common Terminal Conditions

- Global cerebral ischemia S/P cardiac arrest
- Multiple organ system failure
- Refractory single organ failure
- Ischemic or hemorrhagic stroke
- Sepsis



Resuscitation in Terminal Conditions

- Sudden, unexpected event
- No advance care planning
- Unrealistic beliefs regarding survival
- Outcomes are usually poor
- Hypothermia
- Family presence



Describe a Recent Death You Have Observed

- What went well?
 - Were the patient and family's wishes honored?
 - Describe any cultural traditions that were honored
 - Was pain controlled, as well as other symptoms?
 - Was interdisciplinary care evident?
- What could have been improved?
 - What issue(s) could have been prevented?
 - Are there policies/procedures that need to be developed to provide better direction?



Dying is an Individualized, Personal Experience

- There is no typical death
- Patient Preferences
- Nurses advocate for choices
 - Setting of death
 - Support
- Psychological & emotional considerations
- Honoring Dying Patients: Dignity Conserving Care
 - Attitude
 - Behavior
 - Compassion
 - Dialogue



Advocacy for Optimum End-of-Life Care

- Advocate for the patient/family in the ED setting
- Provide a supportive environment with open and honest communication
- Provide information in simple terms and prepare patient/family for the dying process
- Avoid changes at the final stage and provide privacy for the patient/family
- Maintain presence to convey care, sensitivity, and compassion



Psychosocial, Spiritual, and Cultural Considerations When Death is Imminent

- Fear of dying
- Feelings of loss
- Death Rites
- Rituals
- At end of life, patient may be more introspective



Symptoms Associated with Imminent Death

● Common Symptoms

- Pain
- Dyspnea
- Insomnia
- Hunger/Thirst
- Anxiety/Depression
- Terminal secretions
 - ✧ Respiratory Congestion
 - ✧ Distressing and frightening to family

● Interventions

- Initiation of steroids
- Opioid adjustment
- Antiemetics and antipsychotics
- Discontinue sedating medications
- Withdrawal of mechanical ventilation or BIPAP
- Discontinue Total Parenteral Nutrition (TPN)



Artificial Nutrition & Hydration at the End of Life

- Perceptions of “starving to death”
- Enteral feeding does not reduce risk of aspiration or mortality
- Hydration does not decrease “dry mouth”
- Patients who fasted at the end of life experience peaceful death

Fainsinger, 2015; Gabriel & Tschanz, 2015;
Prince-Paul & Daly, 2015



Physical Symptoms Vary

- Confusion, Disorientation, Delirium versus Unconsciousness
- Weakness and Fatigue versus Surge of Energy
- Drowsiness/Sleeping versus Restlessness/Agitation
- Physical Considerations:
 - Fever
 - Bowel changes
 - Incontinence
 - Decreased intake
 - Pain



Myoclonus

- Assess potential etiologies
- Benzodiazepines can be helpful (i.e., diazepam)
- Switch opioids
- Can lead to seizures



Pain During the Final Hours of Life

- Diminished ability to self report
- Behavioral cues – grimacing, muscle tension, clenched fists, moaning, “silent scream” when intubated
- Dosing & Titration of opioids in last hours
- Intractable Pain/ Palliative Sedation



Opioids

- Dosing of opioids given during last hours based on appropriate assessment and reassessment.
- Dose may be decreased or increased
- Principle of Double Effect
 - Intent
 - Morally Permissible
- Consider other routes:
 - Oral
 - Rectal
 - Subcutaneous



Controlled/Palliative Sedation for Refractory Suffering

● Consider

- All possible etiologies and treatments
- Educate patient/family regarding goals and outcomes
- Interdisciplinary team approach

● Medications

Benzodiazepines

- lorazepam
- midazolam

Neuroleptics

- haloperidol
- chlorpromazine

Barbituates

- pentobarbital
- phenobarbital

Other

- ketamine
- propofol



National Comprehensive Cancer Network (NCCN): Guidelines for Treating Pain Weeks to Days Before Death

- Titrate to comfort
- Recognize and treat toxicities
- Analgesia vs. reduced LOC
- Use equianalgesic dose conversions
- Consult
- Consider sedation for refractory pain



Withdrawal of Life Support, NOT Withdrawal of Care

Decisions are made when:

- The capable patient requests withdrawal
- Prognosis for recovery to acceptable baseline is poor
- Death is near and inevitable
- Coma expected to persist
- Prepare in advance
- Brain Death



Cardiac Deactivation Procedures

- Pacemakers
- Implantable cardioverter defibrillator (ICD)
- Left ventricular assist devices (LVAD)

Discontinuation of Dialysis

- When burdens outweigh benefits and/or,
- When dialysis is no longer prolonging life or only prolonging death



Organ and Tissue Donation

- Regulations
- Talking to the family about organ/tissue transplantation
- What can be donated?
- Death declared on the basis of cardio-pulmonary criteria versus neurological criteria in “brain death”
- Can cause ethical and moral angst for witnessing healthcare providers



Death Vigil

- Family presence
- Common fears
 - Painful death
 - Being alone with patient
 - Time of death
- Provide comfort

Death Pronouncement

- Death pronouncement procedure needed
- Nurses should be aware of their setting and state policies
- Moment of Silence



Bereavement Care Following Death

Respectful care of Body

- Removal of tubes/equipment
- Respect family rituals
- Allow family to provide physical care
 - Comb hair
 - Wash face/body
 - Hold hand, kiss, hug

Berry & Griffie, 2015

Bereavement support

- Attend to the family
- Reflect importance and value of the patient
- Follow up
 - Other staff
 - Bereavement services
- Evaluate circumstances



Conclusion

Family members will always remember the last days, hours, and minutes of their loved one's life. Nurses have a unique opportunity to be invited to spend these precious moments with them and to make those moments memorable in a positive way.



ELNEC Curriculum Copyright

The End-of-Life Nursing Education Consortium (ELNEC) Project is a national end-of-life educational program administered by City of Hope (COH) and the American Association of Colleges of Nursing (AACN) designed to enhance palliative care in nursing. The ELNEC Project was originally funded by a grant from the Robert Wood Johnson Foundation. Additional funding has been received from the Cambia, Millbank, Oncology Nursing, Open Society, Aetna, Archstone, California HealthCare, and Stupski Foundations, American Association of Colleges of Nursing, National Cancer Institute (NCI), US Cancer Pain Relief, and the Department of Veterans Affairs (VA). Materials are copyrighted by COH and AACN and are used with permission.

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PRIMARY PALLIATIVE CARE FOR EMERGENCY MEDICINE

EM Talk Training Sessions



Learn from master clinicians leading the field in palliative care in an engaging high-yield session focusing on navigating difficult conversations with ease.

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- Receive a course that would typically cost \$500 dollars for *free*
- Build institutional capacity to provide patient-centered care
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Learn about specific resources available at your institution and the changes coming to your electronic health record system.

Do you find it challenging to deliver news and talk about goals of care with seriously ill patients and their families?

Work with specially trained EM Talk instructor(s) to hone your skills managing seriously ill patients and families. EM Talk is four hour didactic and simulation based communication training whereby learners practice techniques to approach these challenging situations.

Topics include:

- Effectively providing information assessing family member's understanding
- Discussing goals of therapy
- Communication skills practice

FAST FACTS

- **\$500 course now FREE**
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The EPECTM-EM

Education in Palliative and End-of-life Care – Emergency Medicine

Project

Module 1: Trajectories & Prognoses

*E
P
E
C
EM*

Objectives (knowledge) ...

- **Understand which common situations should prompt consideration of a global/end-of-life trajectory.**
- **Know the 4 common global end-of-life trajectories that underpin palliative care.**

Objectives (performance)

- **Be able to formulate and record a prognosis for common terminal conditions**
- **Create a care plan based on formulation of prognosis**

Introduction

- **EOL phase is not always well understood**
- **Process may seem time-consuming**
 - **largely mental recognition & tool-based computation**

Global trajectories ...

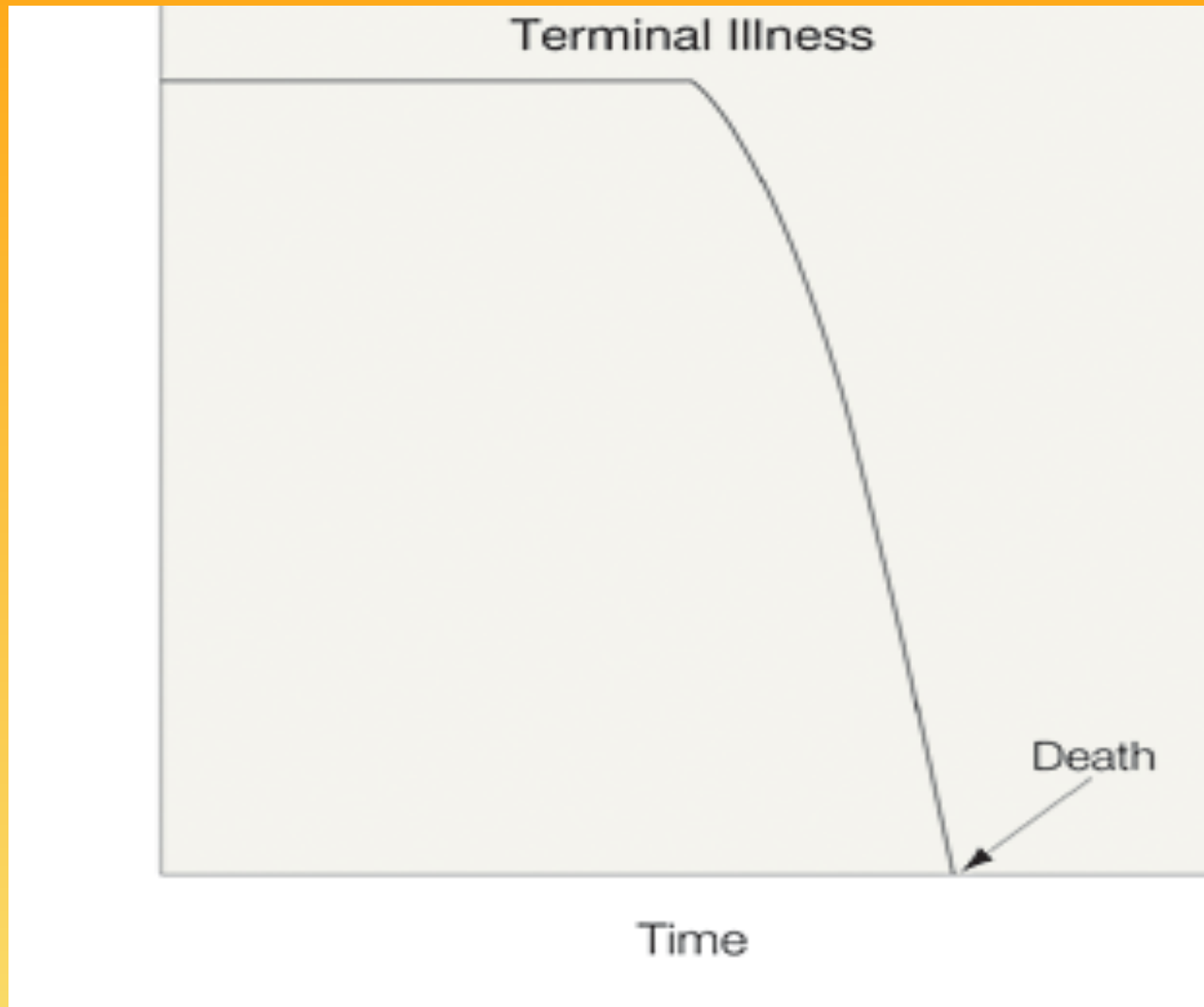
- **Terminal illness**
- **Organ failure**
- **Frailty**
- **Sudden death**

... Global trajectories



Lunney, Lynn, Foley et al., 2003

Terminal illness ...



Lunney, Lynn, Foley et al., 2003

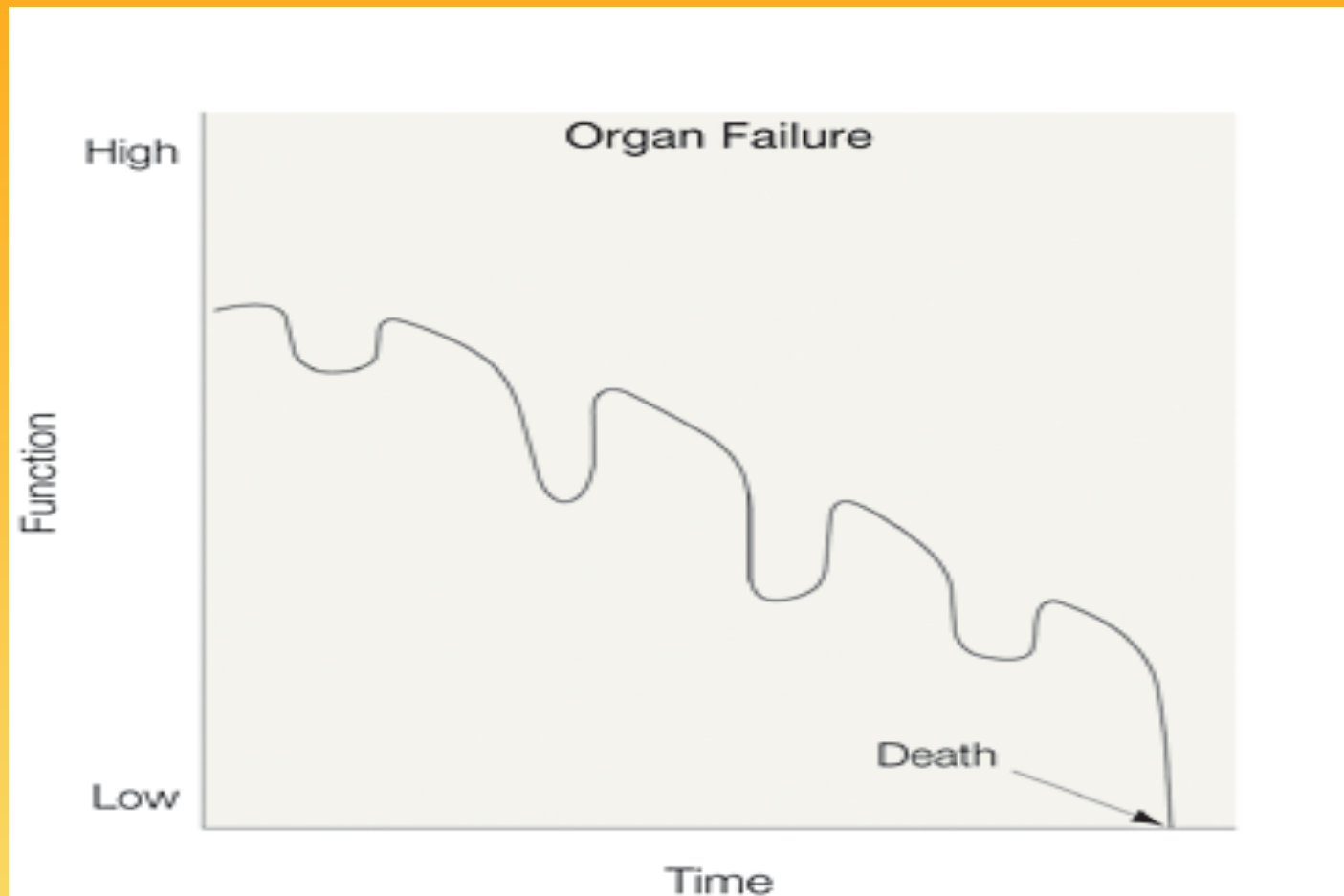
... Terminal illness

- **Lengthy disease trajectory with sharp decline in function**
- **Advanced solid tumor malignancy**
 - **progressive inability to function**
 - **signals end-of-life phase**
- **Hematologic malignancy**
 - **unpredictable course with profound episodes of poor function**

Organ failure ...

- **Common causes of death**
 - **advanced heart failure, renal failure, liver failure, and lung disease**
- **Sharp functional decline with intermittent severe symptom crises**
- **Not always immediately evident**
- **ACP & hospice referral often difficult**

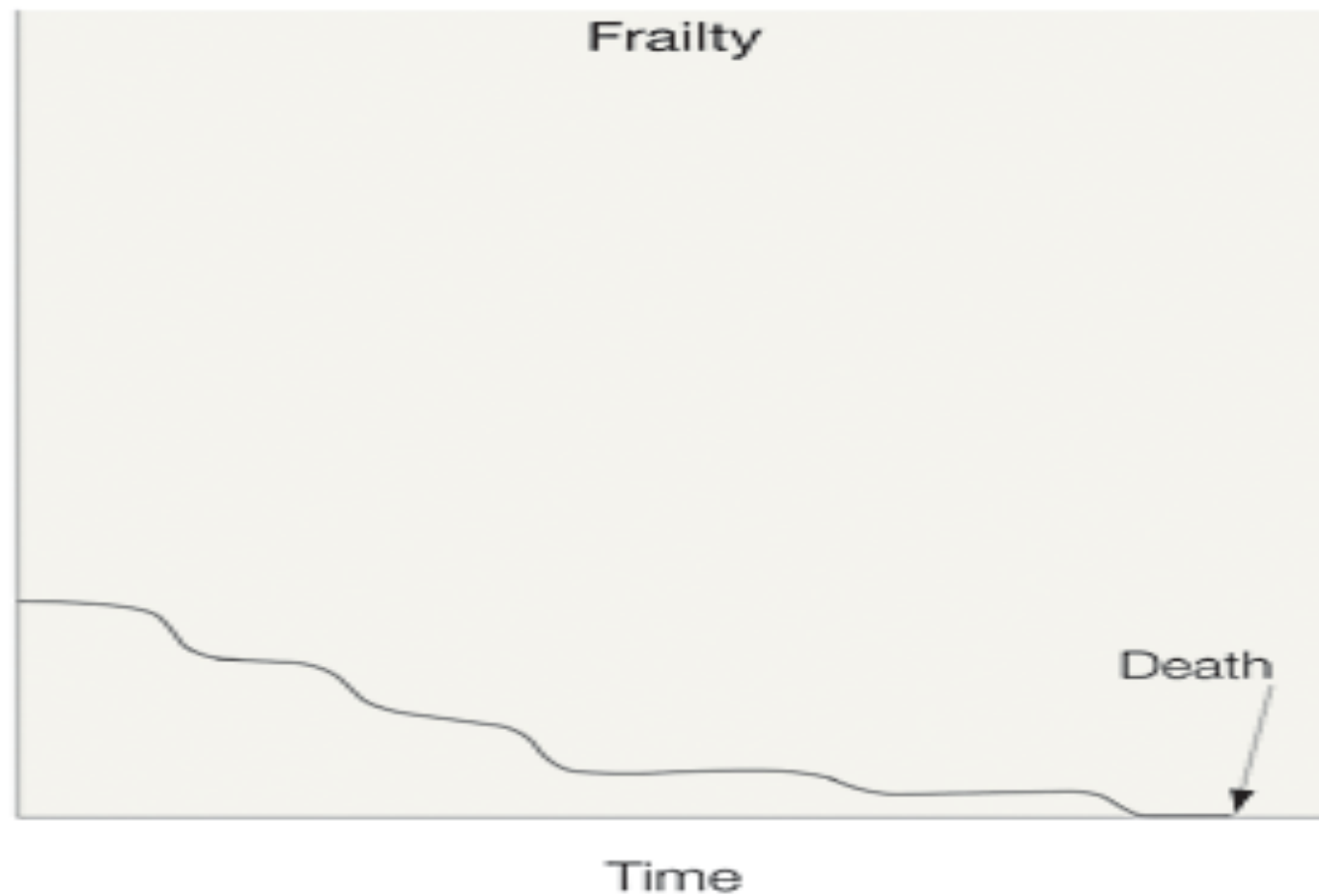
... Organ failure



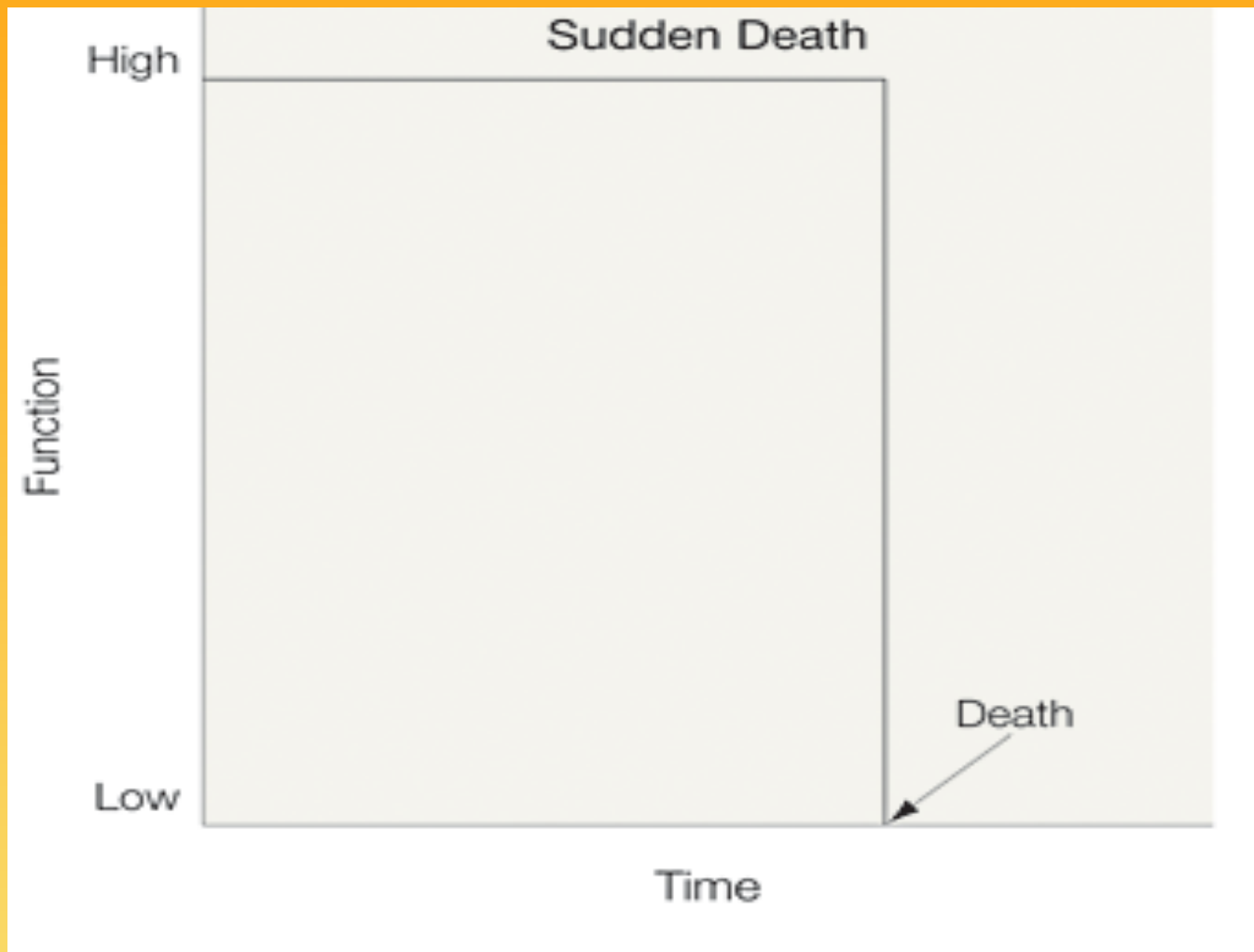
Frailty ...

- **Clinical syndrome characterized by Fried et al. (2003)**
- **Slow decline in physical function**
- **Progressive disability**
- **Death often occurs from complication**

... Frailty



Sudden death ...



... Sudden death

- **Usually reserved for patients not chronically ill**
- **10-15% of US population follows this trajectory**

ED presentations

- **Chronically ill or frail**
- **Known terminal illness**
- **Critical/unstable with high potential for aggressive intervention**
- **Active or post CPR**

Terminal illness exacerbation

- **Many reasons to come to the ED**
 - **need for reassurance**
 - **discomfort with death at home**
 - **treatment and life extending measures**
- **Patient/family need understanding and clear disclosure**

Critically ill / unstable

- **Heightens sensitivity of ED team**
- **Often get the most aggressive care**
- **Lack of advance directive requires consensus among clinicians/family**

Prognosis ...

- Probable outcome of a disease
- Prognosis formulation does not always need to be immediately communicated

4-step plan

- **Assess ED trajectory**
- **Assess global end-of-life trajectory**
- **Formulate a prognosis**
- **Make a care plan**

Step 1: assess ED trajectory

- **Begin with patient, family or caregiver supplied information**
- **Unstable situation**
 - **vital signs**
 - **airway, breathing, circulation (abc)**
 - **clinical appearance**

Step 2: assess global trajectory

- **Terminal illness**
- **Organ failure**
- **Frailty**
- **Sudden death**

Step 3: formulate prognosis

- **Formulation alone may improve patient care**
- **Qualitative**
 - **curable/incurable**
- **Quantitative**
 - **statistical formulation avoids false sense of certainty**

Step 4: make a care plan

- **Immediate action plan**
- **Match between prognosis, goals for care, and interventions**

Prognosis drives goals & interventions

Prognosis	Days	Weeks	Months	Years
Goals	Comfort only	Prioritize quality of life over longevity	Try Interventions but stop if they are not working	Full efforts to cure
Interventions	Pain control Family presence by bedside Refer to hospice	Treat for comfort Refer to hospice	Attempt resuscitation; Stop if signs of Instability persist after reasonable Efforts	Full resuscitation efforts; maximal efforts to stabilize; transfer to ICU For follow up

Future planning

- **Next days, weeks and months of care**
- **Scenarios for future illnesses**

Working w/ care network

- **Coordinate with primary physician when prognosis discussion with patient/family is difficult**
- **Avoid assuming that prognosis has never been discussed with patient**
- **Follow up when possible**

Pearls

- **Care guided by trajectory, prognoses and goals equals higher quality care**
- **Recognize ED presentations and link to global trajectories**
- **Prognoses can be done using simple tools that involve lists and simple algorithms**

Potential pitfalls

- Care unguided by trajectories and prognoses is often misguided care

The EPECTM-EM

Education in Palliative and End-of-life Care – Emergency Medicine

Project

E
P
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C
EM

Module 14: Last Hours of Living

Objectives (knowledge)

- **Recognize natural dying**
- **Identify key physical symptom areas**
- **Identify ED challenges in caring for patients in their last hours**

Objectives (performance)

- **Provide effective symptom relief in the last hours of living**

Presentation in last hours

- **The patient/caregiver neither expects nor recognizes imminent death**
- **The family/caregiver become distressed during the final hours and call 911 for help**
- **The patient develops symptoms that the family/caregiver cannot handle**

Common questions

- **Is my loved one in pain; how would we know?**
- **Aren't we just starving my loved one to death?**
- **What should we expect; how will we know that time is short?**
- **Can my loved one hear what we are saying?**

Physiologic changes

- **Increasing weakness, fatigue**
- **Pain**
- **Decreasing appetite/fluid intake**
- **Decreasing blood perfusion**
- **Neurologic dysfunction**
- **Respiratory changes**

Pain ...

- **Fear of increased pain**
- **Assessment of the unconscious patient**
 - persistent vs. fleeting expression**
 - grimace or physiologic signs**
 - incidental pain vs. resting**
 - distinction from terminal delirium**

... Pain

- **Management when no urine output
stop routine dosing
breakthrough dosing as needed (prn)
least invasive route of administration**

Decreasing appetite / food intake

- **Can cause panic in family/caregiver fears: “giving in,” starvation**
- **Reminders for families**
food may be nauseating
anorexia may be protective
risk of aspiration
clenched teeth express desires, control
- **Help find alternative ways of caring**

Decreasing fluid intake ...

- **Oral rehydrating fluids**
- **Family/caregiver fears of dehydration, thirst**
- **Remind families, caregivers
dehydration does not cause distress
dehydration may be protective**

... Decreasing fluid intake

- **Parenteral fluids may be harmful
fluid overload, breathlessness, cough,
secretions**
- **Mucosa/conjunctiva care**

Decreasing blood perfusion

- **Tachycardia, hypotension**
- **Peripheral cooling, cyanosis**
- **Mottling of skin**
- **Diminished urine output**
- **Parenteral fluids will not reverse**

Neurologic dysfunction

- **Decreasing level of consciousness**
- **Communication with the unconscious patient**
- **Terminal delirium**
- **Changes in respiration**
- **Loss of ability to swallow, sphincter control**

Decreased consciousness

- **“The usual road to death”**
patient becomes more somnolent over time
sleepy → lethargic → obtunded → semicomatose → comatose
- **“Difficult road”**
agitation, hallucinations,
tremulousness, seizures, myoclonus
frightening to caregivers & clinicians

Altered breathing patterns

- **Diminishing tidal volume**
- **Apnea**
- **Cheyne-Stokes respirations**
- **Accessory muscle use**
- **Last reflex breaths**

Changes in respiration

- **Family/caregiver fears of suffocation**
- **Management**
 - family support
 - oxygen may prolong dying process
 - breathlessness

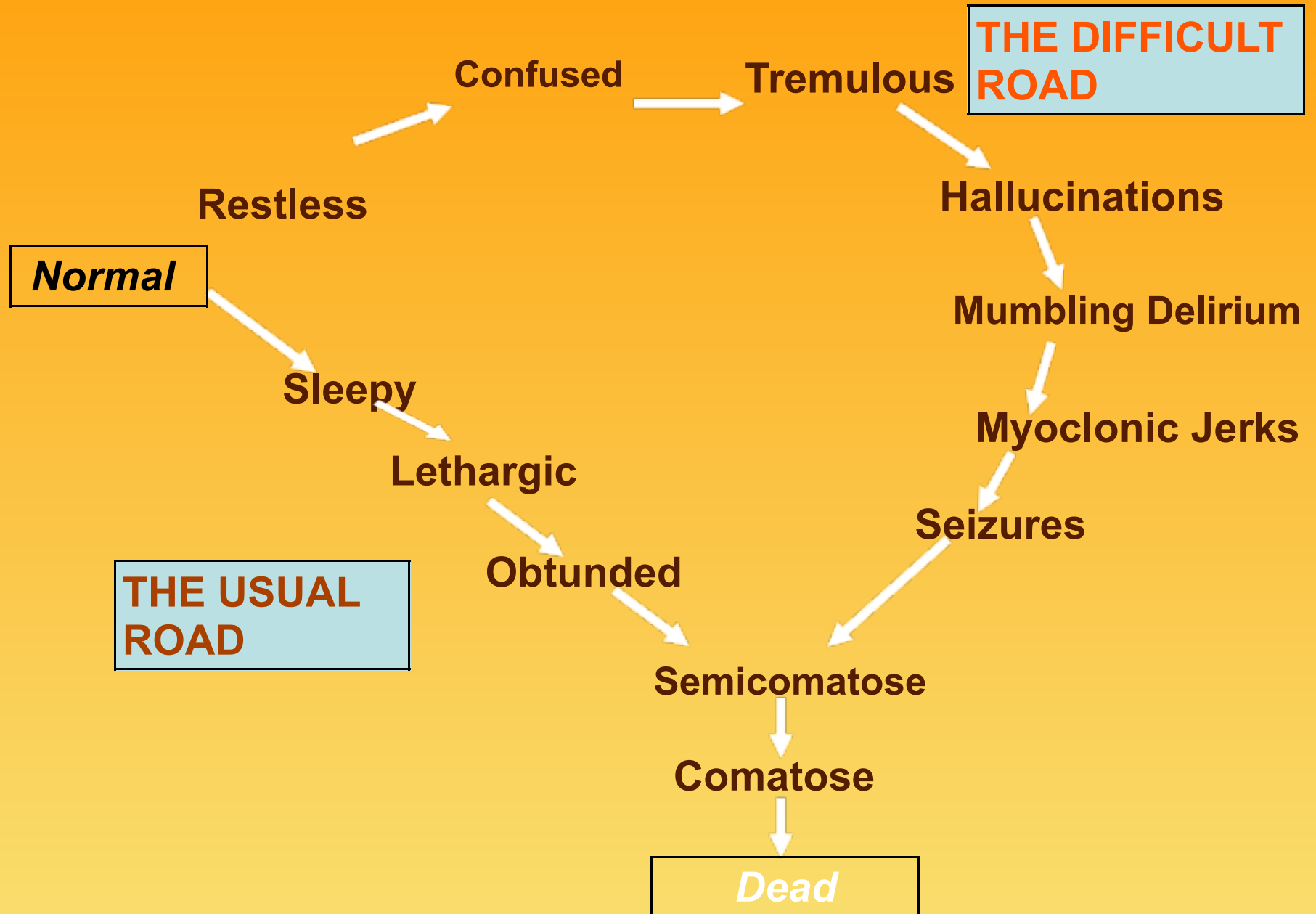
Loss of sphincter control

- **Incontinence of urine, stool**
- **Family needs knowledge, support**
- **Cleaning, skin care**
- **Urinary catheters**
- **Absorbent pads, surfaces**

Loss of ability to swallow / death rattle

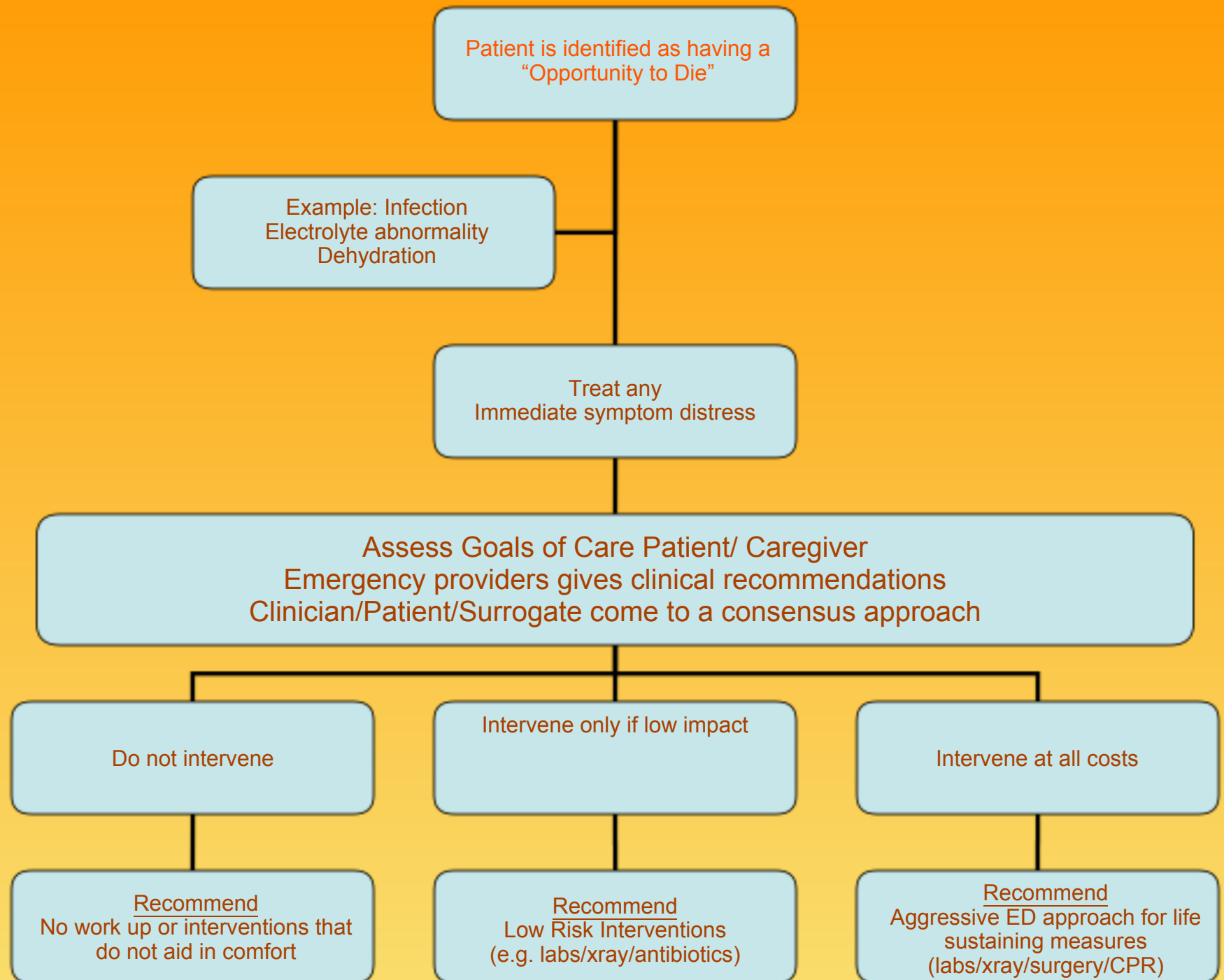
- **Loss of gag reflex**
- **Buildup of saliva, secretions**
 - scopolamine to dry secretions**
 - postural drainage**
 - positioning**
 - suctioning**

Two roads to death



Last hours in the ED

- **Present with a natural opportunity to die**
 - infection**
 - dehydration/renal failure**
 - electrolyte abnormality**
- **Do we intervene?**



Death approaches ...

- **Discuss**
status of patient, realistic care goals
role of physician, interdisciplinary team
- **What patient experiences what
onlookers see**

... Death approaches

- **Reinforce signs, events of dying process**
- **Personal, cultural, religious, rituals, funeral planning**
- **Family support throughout the process**

No IV access

- **Most symptom medications can be given orally or rectally**
- **Insert 25g butterfly SQ in abdominal area**
 - can infuse opioids, benzos, antiemetics**
 - parenteral fluids up**

Terminal delirium

- **Medical management**
 - benzodiazepines (active dying)
 - lorazepam, midazolam
 - neuroleptics (non-active dying)
 - haloperidol, chlorpromazine
- **Seizures**
- **Family needs support, education**

Management ...

- **Imminent death**

lorazepam

**1-2 mg as an elixir, or the tablet
predissolved in 0.5-1.0 mL of water
and administered against the buccal
mucosa q 1 h prn up 2-10 mg/24 h**

midazolam

**Infusion of 1-5 mg SC or IV q 1 h,
preceded by repeated loading boluses
of 0.5 mg q 15 min to effect**

... Management

- **Less imminent
haloperidol
0.5–2.0 mg q hs to q 6 h to start and
titrated IV, SQ or rectal**

Management of secretions / death rattle

Drug	(Trade Name)	Route	Starting Dose	Onset
hyoscyamine hydro.	Scopolamine	patch	1 (~1 mg/3 days)	12 hrs
hyoscyamine sulph.	Levsin	drops, tabs	0.125 mg	30 min
glycopyrrolate	Robinol	pills	1mg	30 min
glycopyrrolate	Robinol	injection (SC,IV)	0.2 mg	1 min
atropine	Atropine	injection	0.1 mg	1 min
atropine	multiple	eye drops/SL	1gtt (1%)	30 min

Last hours preparation ...

- **Time course unpredictable**
- **Any setting that permits privacy, intimacy**
- **Anticipate need for medications, equipment, supplies**
- **Regularly review the plan of care**

... Last hours preparation

- **Caregivers**
awareness of patient choices
knowledgeable, skilled, confident
rapid response
- **Likely events, signs, symptoms of the dying process**

Pearls

- **Recognize that the dying patient may not be able to move**
- **Know that dehydration in last hours of life does not cause distress**
- **Explain to family/caregiver that decreased oral intake is normal in last hours of life**

Potential pitfalls

- Do not confuse pain with terminal delirium
- Do not continue oral intake once the patient is unable to swallow
- Do not order excessive tests or procedures when the goal is comfort management

2019

NYU EM Talk Facilitator & Actor Booklet

FALL 2019

PRIMARY PALLIATIVE CARE FOR EMERGENCY MEDICINE (PRIM-ER)
A NATIONAL INSTITUTES OF HEALTH FUNDED PROJECT LED BY NYU SCHOOL OF
MEDICINE

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Case 1. Respiratory Insufficiency in a Lung Cancer Patient

Background

Patient: John Jacobs

John Jacobs is a 59 year-old-male with history of non-small cell lung cancer who presents to the emergency department via ambulance due to shortness of breath and chest pain.

John was diagnosed with non small cell lung cancer about two years ago. At that time, he presented to the hospital with fever and shortness of breath. He was found to have a right middle lobe obstructive pneumonia and a CT scan revealed an underlying mass. As his disease was stage I, he was treated aggressively a RUL lung resection and radiation to the chest and recovered well.

Last year, however, John developed back pain and imaging revealed diffuse spinal metastases. A biopsy confirmed that his lung cancer had returned and was now stage IV. He was started on chemotherapy and underwent radiation to his spine. Despite aggressive treatment, repeat imaging showed progression of his disease. In the last several months, he has also developed recurrent right malignant pleural effusions that have required frequent thoracenteses.

Three weeks ago, he was admitted for neutropenic fever and developed septic shock secondary to MSSA bacteremia. He was in the ICU though ultimately stabilized with antibiotics, fluids and pressors. Palliative care was consulted to address goals of care. There was a family meeting during which John's oncologists recommended discontinuing chemotherapy and encouraged John to enroll in hospice. They documented in their note that his performance status was poor, that his cancer was not amenable to novel immunotherapy agents and that further chemotherapy was likely to do more harm than good. He was discharged home 5 days ago with home health as he and his brother/sister wanted a few days to think about it and said they would reach out to the oncology social worker when ready to transition to hospice.

This morning, John awoke with severe shortness of breath and right sided chest pain. His brother came over to the house to check on him and found him clammy and gasping for air, so he called 911.

Emotion & Personality:

He is a personable and sociable guy, was a high school biology teacher before he got sick and was very active in the school community both through his teaching and running several extracurricular clubs including a Health Careers club. He also loved tennis and enjoyed being the assistant coach of the JV team at his school. Because he did not have children of his own he always said that his students were like his own children and really prided himself on helping set them up for success in the future. He also loves animals and has spent some time volunteering locally at the animal shelter especially to get his mind off his divorce a few years ago. That is when he got his rescue dog,

Roscoe, who has since been a steadfast companion for him during treatments and while he's home.

Since John lives alone, his progressive weakness and fatigue have been particularly distressing to him. He has had increasing difficulty getting around the house, bathing himself and even making it to the bathroom on his own. His brother/sister has tried to get him to move in with he/she and his/her family but John is stubborn and prideful and does not want to be a burden on them.

Spirituality

- Raised Catholic but does not go to church except at Christmas, not spiritual.

Family/ Social History

- John lives alone, his sibling Michael/Michelle about 2 miles away in the same town
- Mother died of complications from diabetes in her 70s, and father died of MI in his 70s.
- Divorced 8 years ago, no children, has a 4 year old golden retriever named Roscoe

Surrogate: Michael/Michelle

Emotion & Personality:

Michael/Michelle is John's middle age sibling and only other family in the city.

Michael/Michelle is an architect with a firm that designs commercial spaces for new environmentally friendly buildings. S/he is Michael's medical and financial power of attorney.

As an architect and an MBA Michael/Michelle is analytical, data driven, detail oriented and prides themselves on having kept track of all the care John has been getting.

Michael/Michelle is protective of John. S/he has been very detailed-oriented about all of John's medical care and has avoided dealing with the emotional pain of John's impending loss. S/he always has a lot of questions for the health care team and can be perceived as a bit aggressive and anxious when there are a lot of options presented, getting "into the weeds" with what they all mean.

Spirituality

Protestant

- Family goes to church on holidays, not religious

Family

- Married, they have 2 children, 8 and 10 year olds

Main life concerns

- S/he and their spouse have a good relationship, and Michael/Michelle is devoted to providing for their family and being there for their kids activities.

- With John's illness, s/he has struggled with time management, being able to spend time with John, go to the doctor's appointments, and be able to be with their own family.
- John's ex-wife Donna is not involved and Michael/Michelle is the primary point of contact to update their extended family. Michael/Michelle's way to cope with anxiety and sadness has been control.
- His/her workplace is busy with new contracts and development in converting a new area of town into green buildings and s/he has turned down some overtime this past year
- S/he visits John every day for at least an hour, and has been bringing meals over most nights as John has declined.

Social

- They have not had a chance to establish many other relationships because they are either working, or spending time as a family.

Session I

Patient/family Profile:

- Emotions – anxious + frustrated + focused on details after news is given

Medical facts:

- Arrives on CPAP with improved respiratory rate, fairly confused, lacks decisional capacity

Communication Environment:

Where: Outside ED treatment room

When: 1 hour after presentation

Communication Challenge/ Task(s): *discuss goals of care*

Interaction issues/ Hurdles

Sibling Michael/Michelle

- S/he is processing cognitively, repeating same questions about lab results and asking when they can do another thoracentesis or start chemo again
- S/he is not sure about what the next steps will look like and is focused on getting another thoracentesis done and maybe restarting chemotherapy since “it made him better the last time”
- If the learner gives a lot of medical facts with jargon or doesn’t deliver the message that “we are in a different place” s/he will remain focused on details asking about medical options like re-starting chemotherapy or doing another thoracentesis. He will not “absorb” the bad news if it is delivered without skill and empathy
 - If the learner delivers a clear headline “this isn’t like the last time”, “he is much sicker than before”, “the chemo isn’t working anymore and I’m worried the cancer is worse,” “I’m worried he is dying” Michael/Michelle will become more receptive to the idea and dials down the emotion level
- If the learner responds to emotions “I can only imagine how painful this must be for you?” “You must be so disappointed by everything that has happened.” “I can only imagine how sad you must be.” Michael/Michelle will let their guard down and share how scared they are
 - If the learner doesn’t respond to the fear and shock, Michael/Michelle will continue to express denial about the news that John may die soon. Anxiety will increase.
 - If the learner doesn’t respond to the emotions, s/he will continue to escalate, “Don’t you people even know what you’re doing?”
- If the learner asks about John as a person, “what is he like”, “tell me more about him” “What does John think about all of this.” “What would John tell us if he was standing next to me right now?” or even direct questions would be ok “Have you and John had a chance to talk about what’s most important to him at this point in his illness?” Michael/Michelle can start giving details of his personality and goals
 - If asked what John might say or think about the future Michael/Michelle may disclose that they were approached about starting hospice in the hospital last week but just weren’t “ready to give up” even though they thought it sounded like it might be more in line with John’s goals
 - They may also acknowledge that the medical team told them the chemo wasn’t working and the pleural effusions will continue to increase in frequency
 - He/she may note how distressed John was about not being able to take care of himself. He/she will describe John as someone who values his physical strength and independence. He will also verbalize that John had just mentioned when they got home that he’s tired of being in the hospital and “fighting” and was giving more thought to enrolling in hospice but that Michael/Michelle had tried to talk him out of it
- If he/she able to give info above about John not wanting to fight anymore/wanting to enroll in hospice, learner can recommend that they re-focus efforts on John’s comfort and not escalate to invasive therapies, instead focus on allowing him to die with comfort and dignity
- Michael/Michelle will agree that this is what John wants at this point

Case 1: Learner Presentation

Patient: John Jacobs

Sibling/Surrogate: Michael/Michelle Jacobs

CC: SOB

This is a 59-year-old male with complaints shortness of breath and chest pain

Paramedics were called to the patient's house by his sibling who found the patient acutely dyspneic and more confused. They panicked and called 911

Initial vitals: HR 120 ST BP 170/60 RR 35 Sats 78% on RA

Patient was found to be in significant respiratory distress appearing chronically ill and confused. Medics started CPAP, gave an albuterol neb, and started an IV with some improvement.

Vitals on arrival to ED: HR 115 BP 155/60 RR 28 Sats 89% on BIPAP settings 15/5 100% FiO2 Temp 37.2

In the ED a stat CXR shows nearly 75% white out of the right lung with pleural effusion. Labs are near the patient's recent baseline.

On chart review you find the patient has a history of non-small cell lung cancer, initially stage I at time of diagnosis 2 years ago, treated with radiation and a lung resection. Last year, spinal metastases were discovered and the patient subsequently developed recurrent right pleural effusions. He was been treated with chemotherapy and his effusions have been managed with frequent thoracenteses. Recent imaging has demonstrated progression of his disease.

Three weeks ago, he had a complicated hospital course during which he developed septic shock secondary to MSSA bacteremia in the setting of neutropenia. During this hospital stay his oncologists noted that he was no longer a candidate for more chemotherapy due to his weakened state and infections. Along with palliative care, they had a family meeting at which time hospice was recommended, but the family "wasn't ready". He was discharged home 5 days ago with home health care/nursing.

Patient remains fairly confused on BIPAP able to follow commands intermittently but not able to converse and appears somewhat delirious. You start arranging admission to the ICU but they are full and read the notes about hospice in the chart from last time so want you to address goals of care with the family before they come down.

His sibling Michael/Michelle Jacobs arrives 1 hour after ED presentation & wants an update.

Your task is to update John's sibling on the situation and discuss goals of care

Case 2. Goals of care in frailty/dementia patient with decline

Background

Patient: Timothy Whitehouse

Timothy Whitehouse is an 85 year-old-male with multiple medical problems including dementia, diabetes, hypertension, coronary artery disease, atrial fibrillation who comes to the emergency department with altered mental status. He has had 5 admissions in the last 6 months from his skilled nursing facility for UTIs, altered mental status, dehydration, and aspiration pneumonia.

Timothy has had a progressive functional and cognitive decline over the past year and the last 2 admissions involved recurrent aspiration pneumonia. Despite attempts at rehabilitation with speech and physical therapy, a PEG tube was ultimately placed for nutritional support during his last admission to the hospital. He was discharged 1 month ago and since then hasn't been able to get out of bed. He is incontinent. He seems to have lost interest in participating in any activities. Jamie, his 40 year-old child is most involved with his medical care, lives locally and is also Timothy's power of attorney for healthcare.

This past week, the nurses have noticed that Timothy has been sleeping more hours of the day and when awake is less interactive.

This morning the nurses checked on him and found him more confused and agitated, with a temp of 102 and mild respiratory distress with an O2 sat of 90%. They called the patient's daughter who said she wanted the patient transported to the hospital. 911 was called.

When he arrived to the ED, a sepsis work-up was initiated and he was ultimately determined to have a UTI and AKI. He was treated aggressively with IV fluids and antibiotics but 2 hours into his ED stay, he became hypotensive and his breathing became more labored, likely representing septic shock. Decisions about the use of central lines/intubation need to be made.

Emotion & Personality:

- Timothy was known as a comedian, a flirt and a jokester and is a retired attorney for local regional banking firm.
- He and his wife Millie were very active and went on yearly family vacations; they especially liked taking guided tours of different countries in Europe and Asia. He prided himself on being great at Jeopardy and trivia and loved the NYT crossword.
- In retirement he got into gardening and he and Millie volunteered with the local community garden. He was learning how to cultivate Bonsai trees in retirement.

He hung out with his old law school buddies and played golf at least once a week where they would hang out at the clubhouse and have lunch.

Spirituality

Raised Protestant, previously active in his church, went to 1 mission trip to Honduras after he retired from work.

Family/ Social History

- Married to Millie, his high school sweetheart. Millie is currently residing in the assisted living section of the nursing facility and has some mild cognitive impairment, has been involved with Timothy's care and stays with him during the day but defers the medical decisions to her daughter who is his Power of Attorney
- Served in Vietnam
- Has 3 children, Jamie (who lives in town and helps them the most), Veronica (38 year old lives in NYC investment banker), and Beth (34 year old who lives in town with Jessica, is single, and is an administrative assistant).

Son/Daughter: Jamie Millhouse

Emotion & Personality:

Jamie Millhouse is the 40 year-old eldest child of the patient, Timothy. She is a security guard in a small community hospital. S/he is married with 2 children, a 3 and 5 year-old, with a spouse that travels for work a lot (pharmaceutical sales), so sometimes s/he feels overwhelmed trying to take care of both her parents, her kids, and work.

Over the past year, Jamie took on the medical power of attorney for his/her parents' care, his/her sister Veronica in DC was listed as the financial power of attorney. S/he and the siblings have a good working relationship, mostly through FaceTime and texting because of the distance. S/he is grateful for her sister Beth who lives in the same town and has regular 9-5 work hours. She can help out with her children their work schedule gets too complicated or Jamie's spouse is out of town.

The past year has been very trying for Jamie: s/he is irritable, anxious, and tearful quickly. S/he takes a lot of pride in having kept Timothy and Millie together and helped them with their care but the stress has taken a toll.

Education

Jessica has an associate's degree in psychology and has worked for 10 years at the local community hospital as a security guard.

Spirituality

- Protestant
- Jamie's family goes to church every Sunday, and they get support from the church community and takes comfort in a bible study group that they attend when they can

Family

- Sisters Veronica 38 years old in DC and Beth 34 years old in town
- Spouse works in pharmaceutical sales for 10 years with two children 3 year old Robert “Bobbie” and 5 year old Rachel

Other stresses/ Main life concerns

Works as a security guard in a community hospital that is pretty busy, always coordinating schedules with his/her spouse who travels most of the time for work in pharmaceutical sales.

Session I

Patient/family Profile:

Emotions – initially anxious, sad/tearful, all related to anticipatory grief

Secondary hurdle of guilt, s/he was just trying to be a good child to dad and feels like s/he is failing – worried there’s something she could have done to prevent his current situation

Communication Environment:

Where: outside ED treatment room

When: 2 hours after presentation

Interaction issues/ Hurdles

Power of attorney/adult child Jamie

Jamie initially seems reasonable but anxious, putting on a “strong” front, “staying positive”, “we can get through this, he’s been able to get through things before” and using faith based support “we’ve been praying for him” “It’s in God’s hands”

- S/he is anxious and sad that he continues to have set backs, but doesn’t seem to “get it” as she states that he will likely bounce back after some IV antibiotics
- If the learner starts by giving a big picture update (recurrent infection, 2/2 dementia, critically ill,) she will listen; if the learner uses lots of jargon and details to start, she will become detail oriented, too, and start to ask about WBC counts and renal function
- If the learner attempts to learn about Timothy, in terms of his QOL, personality (very independent, his intellectual abilities were critical to his QOL), she will respond honestly and admit that recently he has had a terrible QOL
 - She will disclose that her father “never wanted to be this way” and that his current existence would be “his worst nightmare”
- She will respond even better if the learner gives her emotional support for her caregiver role (acknowledges how hard this all must be on her/tells her what an incredible job she’s been doing managing all of her parents’ medical issues) – she might even cry, say “thank you. I’ve been feeling like this was in some way all my fault because I put him in a NH” and ask the learner “what do you think we should do?”
- If code status type questions are brought up too soon, s/he will escalate and get defensive/mistrustful, get stuck in medical details, refer to religion and miracles – but if code status/use of life-sustaining interventions like central line/intubation are discussed AFTER QOL and/or emotional issues have been addressed, daughter will be ok discussing and will say that her father would never want “heroic things used” in his current condition.

Case 2: Learner Presentation

Patient: Timothy Whitehouse

Child/surrogate: Jamie Whitehouse

CC: Altered mental status

EMS arrives with an 85 y/o m, who has a h/o dementia, CAD, DM, HTN, a fib. They were called to the NH for AMS and fever. They report VS of temp 102 HR 120. BP 90/50. RR 30 O2 sat 88% in the field. They started an IV, gave a 500 cc fluid bolus and placed him on a NRB en route.

On arrival, the patient is awake, responsive to verbal stimuli, able to follow simple commands. He is ill-appearing in moderate respiratory distress. His VS on arrival are temp 102, BP 80/50, RR 25. O2 sat 97% on NRB.

PMH: dementia, HTN, CAD, DM, BPH

Home Meds: Aricept, Amlodipine, Aspirin, HCTZ, Metformin, Terazosin

Review of the Nursing Home paperwork reveals that Timothy is dependent in all his ADLs. His baseline cognitive status: he is oriented to self but not time or place. There are no advance directives.

ED Course:

You initiate a sepsis work-up on Timothy in the Emergency Department. Your work-up reveals a UTI (+blood +LE +nitrites +WBC), CXR with no infiltrate, Cr 2.2 (up from 1.2 last admit) and a WBC of 16. Timothy is given 2L crystalloid, Tylenol, and broad-spectrum antibiotics are initiated to cover urosepsis.

2 hours into his ED visit, the nurse calls you to the bedside because his BP is 70/30 despite receiving 2500ml NS so far. His oxygen saturation is 85-88% on a NRB. You are considering initiation of BIPAP vs intubation and whether a central line should be placed.

At the same time his medical POA Jamie Whitehouse arrives and wants an update.

Your task is to update Jamie on the medical information and discuss goals of care

Actor Training Roadmap

1. Ask the actor if they have questions about the medical aspects of the case. Don't spend too much time on this step, the medical details of the case are important to lead the actor's emotional state, motivation, and backstory.
2. Ask the actor if they have questions about what kind of person their character is in terms of biography or personality. Can they articulate their main emotion in a few words or a sentence?
3. Talk to the actors about what you need from them:
 - 1) To set the emotional temperature of the room by inhabiting the character.
 - 2) To help learners see that if their response changes, the patient will change too.
 - 3) To respond genuinely to the learners. Explain how this is different than being a standardized patient.
4. Walk through the case – have the other faculty person do a “bad” job (e.g. the faculty should not show the skills you are trying to teach). Start rehearsing, actors need to learn by doing, not by being told what to do.

Start with a less skilled doctor.

 - a) Does the actor show the emotion that you want addressed?
 - b) Does the actor show an appropriate level of emotion?
 - c) Does the actor raise the emotional intensity in the face of less skilled behavior, and then lowering intensity, in response to more skilled behavior?
5. Walk through the case again - have the other faculty person do a “skilled” job (e.g. the faculty should show the skills you are trying to teach).
 - a) When the faculty person uses the skill does the actor decrease emotion or give more information - even if the skill is not done “perfectly”? (e.g. reward the learner for behavior)
 - b) Does the actor have a sense of where to go in the story if the learner uses the desired skill(s)? (e.g. does the learner know where the story is going and what the limits of the story are?)
6. Check-in to see what questions the actor has about their character after the training. These questions may lead you to make modifications in the case that should be sent to the actors.
7. Show the actors the entire sweep of a teaching encounter (time out, feedback, finding educational opportunity, redo and summary) so the actor sees the rhythm of the teaching session. Talk to them about going into neutral during the non-acting time, the importance of coming back to the encounter in the redo with the same emotionality
8. Give feedback to the actor.
 - a) Focus on their mind-set or character more than specific words
 - b) It often helps to direct them to show emotions through their non-verbal physicality
 - c) Tell them what you like about what they are doing!
 - d) Remind them that even if the fellow does not do the skill perfectly, they should respond (One way to indicate this to them in “actor-speak” is to make a parallel with working with a “bad actor” to improve).
 - e) Talk about what to do if they see the participants outside of the session during the course
 - f) Talk about the logistics of when to show up, etc.

REMAP Mnemonic Explained

REMAP

GOALS OF CARE, LATE IN THE ILLNESS

STEP	WHAT YOU SAY OR DO
REFRAME why the status quo isn't working.	<i>"There is something I'd like to put on our agenda today."</i> <i>"We're in a different place."</i> <i>"This is a point where some treatments could do more harm than good."</i> You may have needed to give serious news first; that's a separate task.
EXPECT EMOTION respond with empathy.	<i>"It sounds like you are worried about [your family]."</i> <i>[Name the patient's emotion]</i> <i>"I can see how much you love your [son]."</i> <i>"You have worked so hard to do the right thing."</i>
MAP OUT big picture values, what's important.	<i>"Can we step back, think about what you are hoping for, and try to find a good option for you?"</i> <i>"Given this situation, what's most important for you now?"</i> <i>"Have you ever thought about what if things don't go the way you want?"</i>
ALIGN yourself & team with the patient's values.	<i>"It sounds like the most important issues to you are [spending time with your family, being comfortable, and enjoying your garden]"</i> <i>"By planning ahead, we can avoid some things you said you didn't want."</i> Reflect the patient's values.
PLAN medical treatments that match the patient's values.	<i>"Thank you for talking to me about this. I will talk to your team and come back later today with a plan."</i> <i>"For this situation, here are some things that I can do now..."</i>



NURSE Mnemonic

NURSE statements for articulating empathy

	Example	Notes
Naming	"It sounds like you are frustrated"	In general, turn down the intensity a notch when you name the emotion
Understanding	"This helps me understand what you are thinking"	Think of this as another kind of acknowledgment but stop short of suggesting you understand everything (you don't)
Respecting	"I can see you have really been trying to follow our instructions"	Remember that praise also fits in here eg "I think you have done a great job with this"
Supporting	"I will do my best to make sure you have what you need"	Making this kind of commitment is a powerful statement
Exploring	"Could you say more about what you mean when you say that..."	Asking a focused question prevents this from seeming too obvious

Three fundamental skills

	Example	Notes
Tell me more	"Tell me more about..."	Use when you are not sure what someone is talking about (rather than jump to an assumption).
Ask-tell-ask	"What do you think about..." "Here's what the tests show" "Does that make sense...?"	Related to Assess-Knowledge-Respond in SPIKES. Think of this as one unit of information transfer
"I wish" statements	"I wish I could say that the chemo always works"	Enables you to align with the patient while acknowledging the reality of the situation



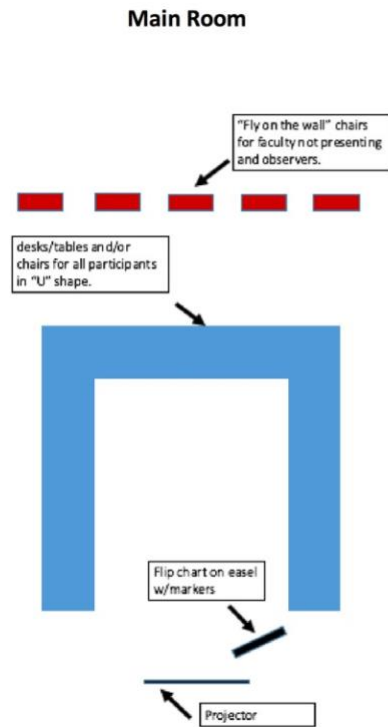
For Facilitator's Only

Room Configuration Guide

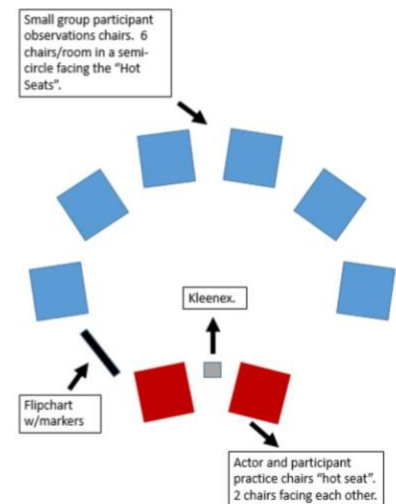
Please use the suggested guide for setting up the rooms

Main Room

- The main room should have enough space to comfortably seat all participants and faculty/staff.
- We ideally like to have a “U” shape for participants to sit in; if this isn’t possible another “open” style arrangement is preferred, as opposed to rows of chairs/desks.
- Make sure projection is available with audio capabilities (use a microphone if necessary).



Break out Rooms



Breakout rooms

- The breakout rooms should only have chairs in a semi-circle facing 2 chairs, which are for the patient and the learner (“hot seat”). No tables or desks should be used.
- If possible, use a room where you can tape flip chart paper to the walls.

Other considerations

- When selecting an event location, consider a place that will provide a quiet atmosphere that is conducive for intimate learning. The rooms should be separate from “other activities” as sometimes simulated patients can be loud.
- Travel between the main room and break-out rooms should be simple.
- Meals: consider having a space for meals, if this is going to be in the main room, make sure set up/take down can be done at break times as to not disturb any meeting times in the main room.
- Breaks: we suggest building in breaks throughout the course, with a clear space for participants to congregate.
- Green Room: Actors will need a space they can go to when they are not in session. This can be another room or just a lounge area that is away from the main event.

Small Group Start-up Guide

This guide was designed to help successfully set your small group up for learning.

Step	What you say or do
Introductions	• Ask for: Name, Location, Role, Something silly or interesting about yourself. What are you hoping to get out of this course? • Review schedule
Learning Environment/ Ground Rules	• Explain the structure in brief (hot seat, timeouts) • No pager, cell phones • Try to only take breaks assigned. • “Vegas Rules” (what happens in this room stays in this room) • Spirit of curiosity and play – be open to trying something new • The learning environment is structured, expect that the facilitator will keep things moving. • Only the facilitator and the person in the Hotseat can timeout
Note Taking/Giving Feedback	• Observers should take notes and give appropriate feedback • How to take notes: two columns (one clinician one patient) • Write down exact phrases • Feedback should be specific and succinct (when you did x, she responded by y)
Group Exercise: “Why I hate role-play”	• Use a flipchart to brainstorm with the group “Why do you hate role play” • Explain why role play is important as a learning tool
Gather Learning Objectives	• Ask each learner to state a learning objective for the course. Write these on a flipchart and post in the room for reference throughout the course.



Facilitation Map v7.0

STEP	WHAT FACILITATOR IS DOING
ESTABLISH a learning goal	Understand what the learner wants to do better <i>What is challenging about this case for you?</i> <i>What skills could you use to help with that challenge?</i>
RUN the encounter	Collect conversation data <i>Group, watch for how he/she uses that skill and what the patient says or does right afterward.</i>
TIME OUT	Stop if learner is uncomfortable/stuck or for time <i>Let's time out.</i>
WHAT WENT WELL	Give learner a moment to gather his/her thoughts <i>How is it going?</i> <i>What went well?</i> <i>Can we go to the group so they can tell you what went well?</i> <i>Group, can you tell him/her what he/she did that you liked?</i>
AFTER THE TIME OUT Find a learning opportunity	Pick a discrete moment to work on <i>Looking back, is there anything you wish you had done differently?</i> 1. <i>Great. You picked up on a cue.</i> 2. <i>Right before I timed out, how was the patient responding?</i> 3. <i>{Learner can tell you.}</i> 4. <i>Right before I timed out, how was the patient responding? {Learner can't tell you what patient was doing before the time out. You have to point it out.}</i> <i>I noticed that when you did X, she got Y.</i> <i>Let's brainstorm how to respond when . . .</i> <i>Do you want to start first or ask the group?</i>
REWIND AND REPLAY	See how the patient responds to the skill <i>How was the replay different?</i> <i>How exactly was the patient different?</i> <i>What did you do to make the patient respond differently?</i> <i>When you did X, the patient changed to Y.</i>
TAKE HOME POINT	Find out what the learner is taking away <i>What did you learn from this encounter that you can use in the future?</i>

Facilitator Skills Glossary

Facilitation Skills Glossary for VitalTalk Faculty

Version 1.0, created 1 Jan 2018

Purpose

The goal of this doc was to create a teaching skills vocabulary that is specific, unambiguous, and distinct from the clinician communication skills vocabulary (the more these terms signal teaching skills, the less confusion there will be at the Faculty Development course in facilitation skills practice session).

The doc focuses on facilitator skills only. Although there are a number of other pedagogical terms that we use, putting everything into one doc was too much to start with, and we decided to create a different kind of glossary for pedagogical concepts. The primary author for v1.0 was Tony; James + the curriculum team (Bob, Holly, Gordon, Steve) provided comments,

Please feel free to add comments or suggestions, and we will come up with a process to incorporate them into the next version.

Skill name	Definition + Example	Comments
Acknowledge	A verbal signal to a hot seat learner or group member that you heard what they said. Example: "I hear you."	Most often used as a compound (grouped) skill: Acknowledge-Pivot-Return. Acknowledge signifies that the facilitator has heard the learner; it does not connote agreement (see Reinforce) or praise (see Precise Praise).
Pivot	An internal shift that the facilitator makes from a learner concern (see Acknowledge), usually back to the facilitator map. The facilitator generally doesn't speak a Pivot out loud. Example: "I hear that you felt you could have done something different. [Pivot]. What did you do well?"	The example to the left illustrates the compound skill Acknowledge-Pivot-Return. Note that the facilitator speaks a specific instruction following a Pivot, usually a Return or Redirect.
Return	A verbal request from the facilitator to a hot seat or group learner that takes them back to the facilitator map.	Most often used as a compound (grouped) skill: Acknowledge-Pivot-Return. Return is used to go back to the

Describe	Facilitator provides exact language from encounter, usually after asking the learner to recall and learner was unable. Example: 'What i heard was that the patient said "I don't know what to do."'	The facilitator will need to have a near-complete recollection or notes of the moment being discussed. Often used in a skill sequence: Point, Describe, Brainstorm. Previously called "Show Data" (which we are retiring.)
Brainstorm	Facilitator asks hot seat learner, then the group, to provide alternative language for a specific moment to rewind back to.	Brainstorms are most effective when the facilitator can Describe the patient's language, which provides the moment where the Rewind will start. Often used in a skill sequence: Point, Describe, Brainstorm.
Bracket	Indicate to learner that you would like to address their question or concern later. Ex: "I hear that you thought you could have said something different. Could i bracket that for now?"	Bracket involves a commitment from the facilitator to come back to the point (either as a brief comment at the end of the encounter or in the parking lot to addressed later in the workshop).
Refine goal	Generally for Step 1 in facilitator map, when learner has given a diffuse, vague, or non-skills-based goal, and facilitator asks to sharpen. Example: "What skill could you use to do that?" Further example: "How would we know that you've used the skill?"	After a facilitator uses Refine Goal, the hot seat learner should have a goal that is an observable behavior that the group can watch for.
Take home point	For the end of the facilitator map, when learner has finished encounter, as learner leaves hot seat, facilitator asks for one actionable insight or learning from the encounter.	The take home point prompts the learner to construct an actionable insight, and provides the facilitator with instant feedback about the learning that has occurred.

	Example: "what is something you learned just now that you want to do when you get back to clinic?"	If the learner has a take home point that is not linked to the encounter, the facilitator should consider their use of Describe and Link (see below).
Reinforce	Facilitator endorses a learner's observation or insight. Example: "I agree, the patient got sad at that point."	Most often used to verify the accuracy of an observation. Reinforce represents a positive endorsement (unlike Acknowledge, which does not), but is less strong than Precise Praise (see below).
Precise praise	Facilitator gives judgment of a skill performed well AND gives behavioral data to support, to recognize performance that was above & beyond basic competence. Example: "That was a great example of naming, when you said 'I get the feeling you are sad about this.'"	Note: there is NO plain 'praise' in this glossary, praise is only used as 'precise praise.
Quick coaching	Facilitator provides learner with alternative language to try, often when a learner is stumbling, often when learner stumbles on skill language they were planning to use. Also used when meta-facilitating, to remind a facilitator of the facilitation map. No explanation or analysis is given-- just the target phrase.	Often used with a low tone of voice, to suggest one-on-one advice.
Replay Outcome	After a rewind/replay time out, to have the hot seat learner compare the replay to the initial encounter. Example: "How was that replay different?"	Often used in a skill sequence: Replay Outcome, Learner Action, Link.
Learner Action	After the Replay Outcome, to have learner name the action (usually a	Often used in a skill sequence: Replay Outcome, Learner Action, Link.

	new skill they tried) that led to the Replay Outcome. Example: "What did you do to make that happen ('that' refers the outcome that the facilitator elicited using Replay Outcome)?"	
Link (action to outcome)	Usually done after a successful replay to make visible how the learner's use of a skill led to a different patient Replay Outcome. Example: "When you said, 'that's sad,' the patient responded with 'Of course,' then the patient went on to tell you something important."	Previously called "Crystallize" (which we are retiring).

Edits

2 Jan 2018: Fixed comment on Return.
Fixed comments about skill sequence on Replay Outcome and Learner Action.

Welcome to EMTalk!

<program name>
<date>



Faculty Introductions

- ▶ Dr. <> (institution)
- ▶ Dr. <> (institution)



Primary Palliative Care for Emergency Medicine (PRIM-ER)

Grant funded by the National Institutes of Health and housed at NYU School of Medicine focusing on delivering multiple intervention components across 33 Clinical EDs across the United States

1. Evidence-based, multidisciplinary primary palliative care education (EPEC-EM, ELNEC);
2. **Simulation-based workshops on communication in serious illness (EM Talk); Course curricula taught today was developed by EM Physicians**
3. Clinical decision support; and
4. Provider audit and feedback.



PRIM-ER Principal Investigator: Dr. Corita Grudzen

PRIM-ER Program Manager: Allison Cuthel
Allison.Cuthel@nyulangone.org



POWERED BY
VITALtalk

Agenda

Paste a screenshot of your agenda here

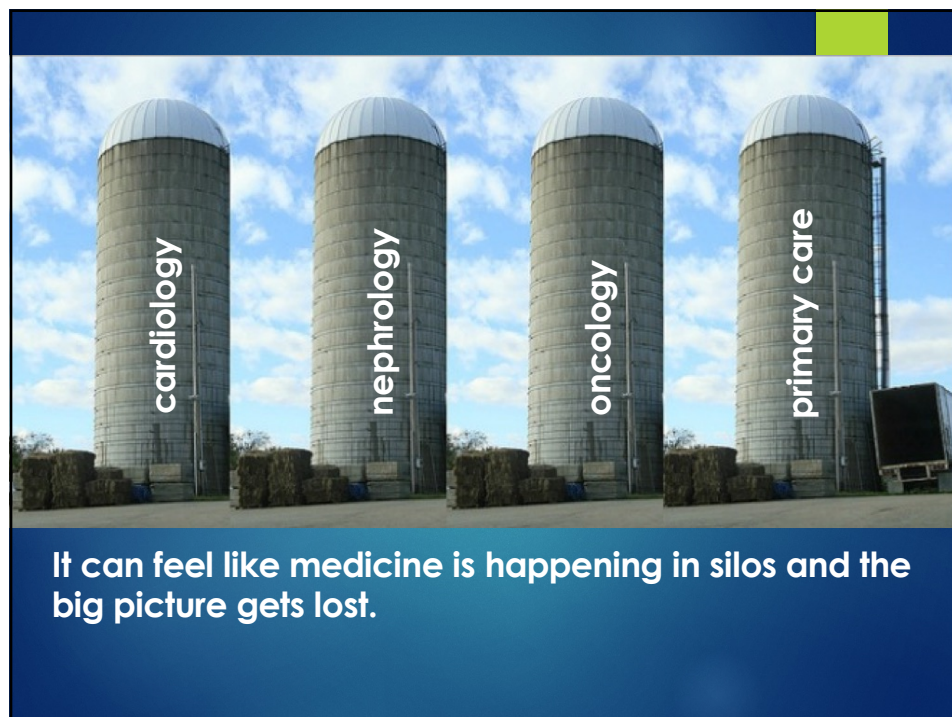
Dying in America is complicated

- ▶ **The healthcare system doesn't always work for patients with serious illness or at the end of life**
 - ▶ Most people die of chronic diseases
 - ▶ >80% of patients with chronic diseases say they want to avoid hospitalization and intensive care when they are dying
 - ▶ 70% of Americans would prefer to die at home
 - ▶ 25% of Americans actually die at home

TIME

Source: CDC, NCHS, National Vital Statistics System, Mortality

Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life (2015)



Shouldn't _____ be doing this?

Yes!

Every patient with serious illness should be surrounded by clinicians trained to elicit what matters most.

Why the ED?

- ▶ We have the “breakpoint” conversations
- ▶ Families gather in times of crisis
 - ▶ *(not at the day to day appointments)*
- ▶ We set the stage and decide trajectories
- ▶ We are the place where your advance directive might get carried out

Why it's hard

“So you're giving up?”

*The opposite of “doing everything” feels like
doing nothing.*

Not just a “soft skill”



effective communication
facilitates decision making

**“Good communication takes time,
bad communication takes longer.”**

-Bob Arnold



DEFAULT STRATEGY FOR FAILED RSI IN ADULTS

Plan A: Initial tracheal intubation plan

- maximum 2 attempts in 2 mins
- re-oxygenate if SpO₂ <90% with 2 person BVM + OPA + NPA
- CALL ANAESTHETICS IF PLAN A FAILS (ext: 3186)

Plan B: Secondary tracheal intubation plan

- maximum 2 attempts in 2 mins
- re-oxygenate if SpO₂ <90% with 2 person BVM + OPA + NPA

Plan C: maintenance of oxygenation/ventilation

- maximum 2 attempts in 2 mins
- plan D if SpO₂ <70%

Plan D: rescue techniques for "can't intubate can't ventilate" situation

RSI CHECKLIST

- pre-oxygenate
- position: "bar to sternal notch"
- "RAM" if obese
- "analgesia & sedation for all"
- "cricoid pressure for all initially but release if poor view and apply External Laryngeal Manipulation 'bougie' for all"

direct laryngoscopy

video laryngoscopy

LMA

scalpel/cricothy

tracheal intubation

tracheal intubation

tracheal intubation

Physio Issues (HOP) Considered

- ☐ Induction Agent/Muscle Relaxant
- ☐ Post-Tube Analgesia/Sedation
- ☐ Push-Dose Epi
- ☐ Failed Plan Verbalized
- ☐ Cric Evaluation

Denitrogenated ≥ 3 minutes

- ☐ ApOx with NC @ 15
- ☐ Oxygenated ≥ 95% (± CPAP)
- ☐ Look in Mouth - Dentures - Range Neck
- ☐ Positioning
- ☐ Pulse Ox Visible or Audible
- ☐ Access - Reliable & Tested

Kit Dump on Table

- ☐ BVM (± PEEP Valve) on Oxygen
- ☐ Waveform Capnograph on BVM
- ☐ Video Laryngoscope
- ☐ Backup Laryngoscope
- ☐ OPA, Bougie, SGA, Scalpel
- ☐ Suction x 2



How did you learn these conversations?

THE HORRORS

AND THEN... WE CRACK YOUR RIBS!!

THE MENU

...AND HOW MANY SHOCKS WOULD YOU LIKE WITH THAT?

THE TRANSCENDENT

WOULDN'T YOU RATHER GO PEACEFULLY INTO THAT GREAT VOYAGE BEYOND??

THE NUMBERS

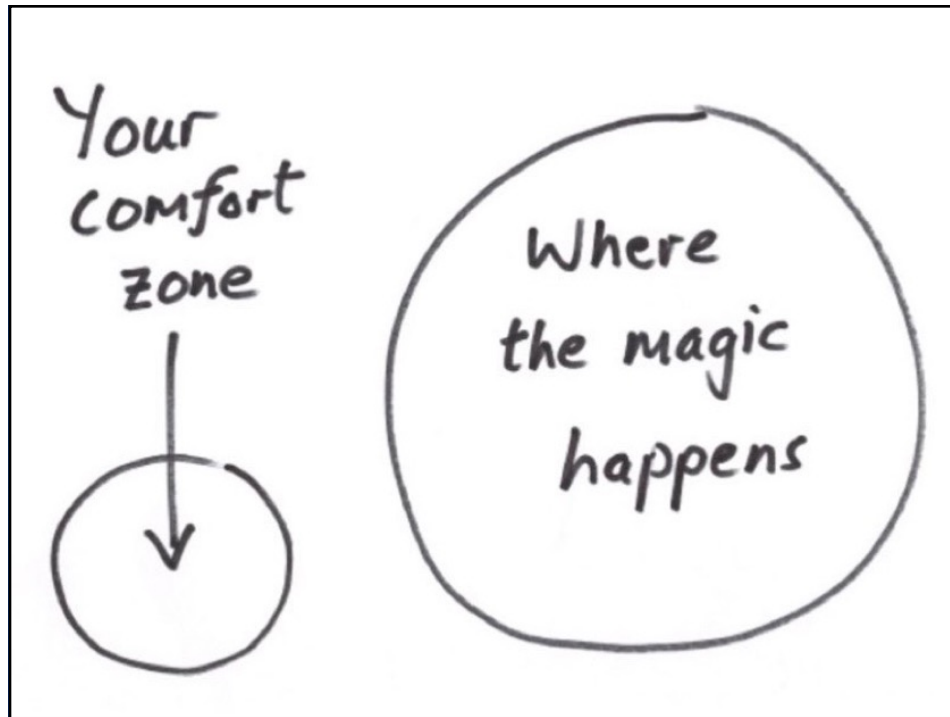
I CALCULATE A 0.0079% CHANCE YOU'LL SURVIVE CPR...

Instead of winging it, bring a map



Top 5 Tips for EMTalk Success

- ▶ 1. Come curious. This is a cool opportunity to coach each other.
- ▶ 2. Learn to name your skills. You can give better feedback!
- ▶ 3. Play. Try something that you think you will never do again. Failure is where the learning happens.
- ▶ 4. Observe the teaching structure, you might use it later.
- ▶ 5. Think about some new tools for your toolbox.



EM Talk: REMAP for Goals of Care

<site name>

<date>



What is the indication for the procedure?

(who needs a goals of care conversation in the ED?)

- progressive, life-limiting illness & functional decline
- acute unexpected illness
- current hospice/limited treatment
- “no” to the surprise question

How do you approach “the conversation”

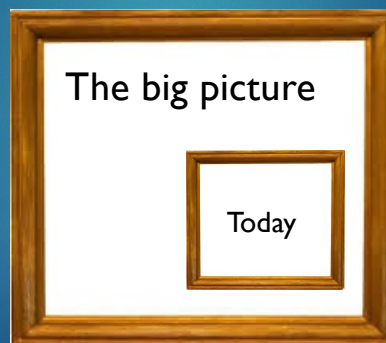


REMAP

1. **REFRAME** Get on the same page
2. **EXPECT EMOTION** NURSE.
3. **MAP** out important values.
4. **ALIGN** with those values (show your work)
5. **Propose a PLAN** of treatment to match values

1: REFRAME

We are in a different place.





Balancing empathy and truth...

- ▶ I wish
- ▶ I hope
- ▶ I worry
- ▶ I wonder

"I wish I had different news, I'm worried that she might not recover."

Say the news, then stop

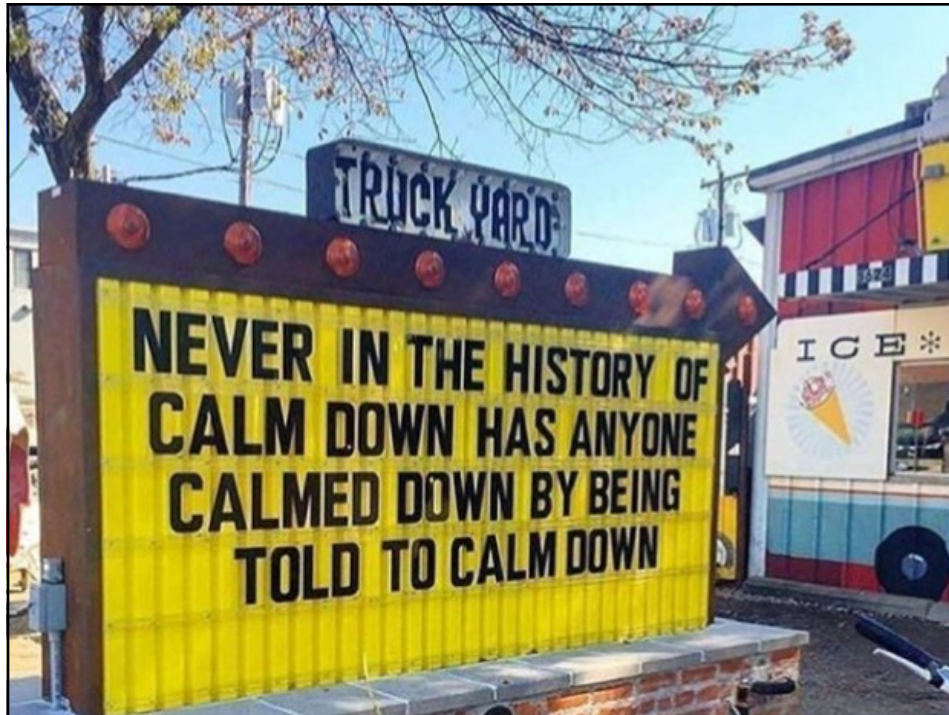


2: Expect Emotion

Emotion happens faster than rational thinking.

Your "lizard brain" is involuntary and it takes time for your cognitive brain to catch up.





NURSE

statements for articulating empathy

Name	"I can see this is overwhelming" "I can see you're upset"
Understand	"I can't imagine what this is like...."
Respect (and praise)	"She is so lucky to have you here." "You are doing such a good job." "I can see how important he is to you."
Support	"We are here to help you."
Explore	"Tell me more"

3: MAP preferences and values

“Given this situation, what is most important?”

“As you think about the future, what worries you most?”

“...what are you hoping for?”

“...what else? ...what else?”

3: MAP

[surrogate]

“If your father could see this & understand the situation, what would his reaction be?”

3: MAP

"Have you ever talked about what would happen if you/they got sicker?"

"Any paperwork? Decision makers?"

"Have you ever had a similar experience with another family member?"

4: ALIGN *show your work*

"As I listen, a couple of things stand out..."

"I can help you with these important things."

4: ALIGN

Affirming their values
explicitly shows you listened.



5: PLAN

*"Is it OK if I talk about where to go
from here?"*

*"Here are things we can do now
that match your values."*

5: PLAN

Talk from the positive frame first, so they know the plan.

Then you can talk about what you might withhold.

Tips

- ▶ This doesn't always happen in a single encounter
- ▶ If you get stuck or can't get to a plan right away, suggest a timed treatment trial
- ▶ You can set up the next team for success!
- ▶ Always maintain alignment

Summary

- 1.Reframe why status quo isn't working.
- 2.Expect emotion, respond with empathy.
- 3.Map out what's important.
- 4.Align with patient values.
- 5.Plan to match values.

Demonstration

Put your "fishbowl" case here if you're doing one

Small Groups

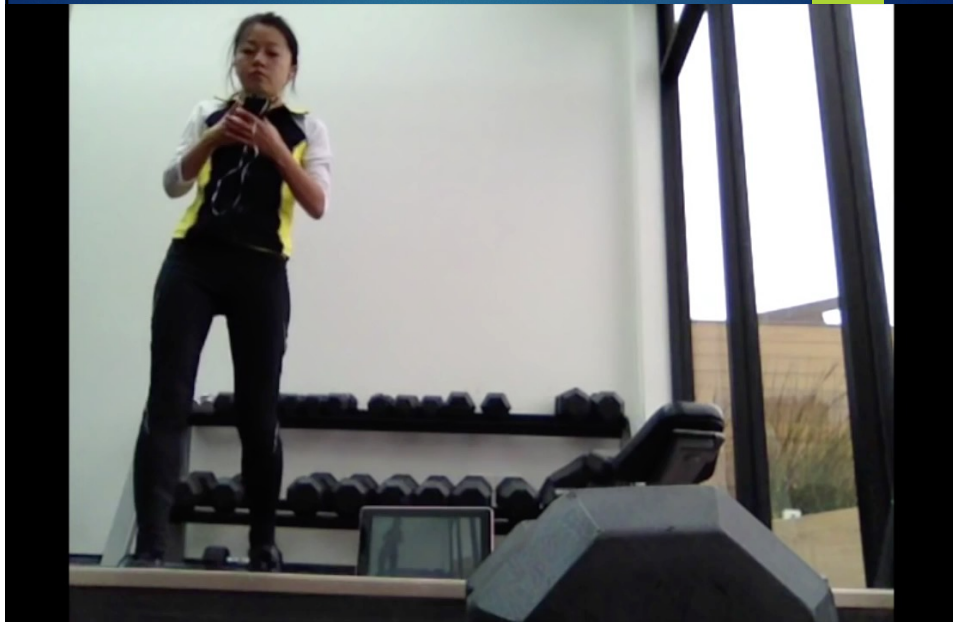
EM Talk: Taking Skills Back Home

<hospital>
<date>



Local Resources

How does it look when we learn something new?



Reflecting on today

- ▶ One thing that surprised you
- ▶ One way to practice these skills on a shift
- ▶ One phrase you will add to your toolbox
- ▶ One thing you're still noodling on

The screenshot displays the VitalTalk website at www.vitaltalk.org. The header includes the VitalTalk logo, a search bar, and a faculty login link. The main navigation menu lists: CLINICIANS, FACULTY, INSTITUTIONS, RESOURCES, COURSES, BLOG, and ABOUT US. The central banner features a woman and a man, with the text: "VitalTalk makes communication skills for serious illness *learnable*. Our evidence-based trainings empower clinicians and institutions."

Below the banner are three columns for joining the program:

- Grow as a CLINICIAN**: We equip clinicians with expert strategies.
- Join our FACULTY**: We develop clinicians into advanced educators.
- Strengthen your INSTITUTION**: We build your capacity to provide patient-centered care.

At the bottom, there are "iPhone Screenshots" of the mobile app. One screenshot shows the "VitalTalk Tips" section with a green circular graphic and the text: "VitalTalk Tips", "Vital Talk", "★★★★★ 4.8, 8 Ratings", "Free". Another screenshot shows a "Conflict" module with the text: "Conflict is **inescapable**, it's how you handle it that matters." and a list of steps: "The steps are: Notice; Prepare; Start softly; Invite; Hold judgment; Empathize; Create new options." A third screenshot shows a "Culture" module with the text: "If the family says, please don't tell the patient..." and a quote: "Could we ask the patient together about how to proceed?"

PRIM-ER Housekeeping

- ▶ CME credit
 - ▶ In the next few weeks you will be receiving an e-mail from "NYU Continuing Medical Education cme@nyulangone.org" with instructions on how to claim your 5 CME credits
 - ▶ Please complete the course evaluation
- ▶ \$67 electronic Amazon gift card will be e-mailed to you in the coming weeks

Thank you!



Supportive Care Workflow for Emergency Department - Providers, Nursing, Social Workers, Care Managers and PUAs

October 29, 2021 - This information is proprietary and should not be reproduced or redistributed.

Supportive Care is a workflow to quickly identify patients with serious life-limiting illnesses to:

- Identify patient and family needs early in the ED course
- Provide early access to advanced care planning documentation by the ED care team
- Involve and notify members of the ED care team to ensure multidisciplinary and team-based approach for these patients.

The clinical decision support tool will assist with the identification of these patients in the ED by providing alerts such as BPA's and column notifications.

The goal is to quickly identify these patients when they present to the ED so that appropriate resources can be allocated, physical and emotional symptoms can be addressed quickly, and patients' goals of care are discussed early in the course. This helps to ensure ED treatment goals are concordant and unnecessary procedures and interventions may be avoided.

1. Patient Has + eMOLST

- a. Informational BPA for Providers and RNs

b. PUA column notification– the PUA should access the eMOLST registry and print the pdf of the most up to date eMOLST and place within the patient chart.

c. Provider BPA for "Goals of Care Discussion"

ⓘ Patient has an active eMOLST - Goals of Care Discussion Trigger.

This patient has an eMOLST on file. Please confirm the patient's code status on this visit.

Would this patient benefit from expedited palliative care and/or hospice referral (e.g. high predicted mortality within 48 hours)?

If yes, consider placing a Palliative Care and/or Social Work Consult.

Order	Do Not Order	 IP CONSULT TO SOCIAL WORK
Order	Do Not Order	 IP CONSULT TO PALLIATIVE CARE

Acknowledge Reason

 **Accept**

2. Patient has a previous disposition of Home Hospice or Inpatient Hospice or Referral made

- a. BPA for Provider to place Social Work and Palliative Care Consult

ⓘ Active Hospice

This patient has previously been referred to or enrolled with hospice services. Consult Social Work and consider Palliative Care consultation.

Order	Do Not Order	➡ IP CONSULT TO SOCIAL WORK
Order	Do Not Order	➡ IP CONSULT TO PALLIATIVE CARE

Acknowledge Reason _____

No Order at this time

✓ Accept

b. Informational BPA for Social Workers and Care Managers

ⓘ Active Hospice

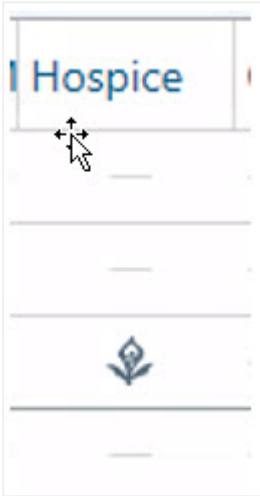
This patient has previously been referred to or enrolled with hospice services. Evaluate for social needs and notify hospice services, if appropriate.

ⓘ Acknowledge Reason _____

Acknowledged

✓ Accept

c. Column on track board for social work and care managers displays a flower if previous disposition of Hospice



PRIM-ER: Palliative Care Knowledge and Attitudes Survey

Name _____

Email _____

Please kindly take this survey prior to completing PRIM-ER education components as this is a Baseline assessment. All responses will be deidentified and remain anonymous.

Palliative Care Attitudes and Knowledge Survey

Where do you work? *(Please check all that apply)*

- | | |
|--|---|
| ☐ Allegheny General Hospital | ☐ NYU Brooklyn |
| ☐ Baystate Franklin | ☐ NYU Winthrop |
| ☐ Baystate Medical Center | ☐ Ochsner Medical Center |
| ☐ Beaumont Royal Oak | ☐ Ohio State University-Wexner |
| ☐ Beaumont Troy | ☐ Hospital of the University of Pennsylvania |
| ☐ Bellevue Hospital Center | ☐ Penn Presbyterian Medical Center |
| ☐ Brigham and Women Faulkner | ☐ Pennsylvania Hospital |
| ☐ Brigham and Women Hospital | ☐ UCSF Medical Center |
| ☐ Christiana Hospital | ☐ Zuckerberg San Francisco General |
| ☐ Henry Ford Fairlane | ☐ UF Health Shands Hospital |
| ☐ Henry Ford Hospital | ☐ UF Kanapaha |
| ☐ Henry Ford West Bloomfield | ☐ UF Springhill |
| ☐ Mayo Clinic Austin-Albert Lea | ☐ University of Utah Hospital |
| ☐ Mayo Clinic Health Mankato | ☐ Yale New Haven Hospital |
| ☐ Mayo Clinic St. Mary | |
| ☐ MD Anderson Cancer Center | |
| ☐ Mount Sinai Beth Israel | |
| ☐ Mount Sinai Hospital | |
| ☐ Mount Sinai West/St Lukes | |

What is your age in years? _____

Ethnicity *(Please choose only one option)*

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race *(Please choose only one option)*

- ☐ American Indian/Alaskan Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ More than One Race
☐ Unknown
☐ Prefer not to Answer

Gender *(Please choose only one option)*

- ☐ Male
☐ Female
☐ Other

Provider Type *(Please choose only one option)*

- ☐ Nurse
☐ Nurse Practitioner
☐ Physician
☐ Physician Assistant
☐ Resident
☐ Other _____

Years in Practice Post-Training *(Please choose only one option)*

- ☐ < 2
☐ 2-5
☐ 5-10
☐ 10-15
☐ >15

Continued on Back

Please rate the extent to which you agree/disagree with the following:

Choose only one response per question

I am well trained to take care of the symptoms of terminally ill patients.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

I feel knowledgeable enough to discuss hospice care with patients and families.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

Many patients would benefit if hospice care were initiated earlier in the course of their illness.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

Most patients' symptoms, such as pain, shortness of breath, and nausea, are not controlled any better with hospice care than with care I would otherwise provide for them.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

Hospice care generally meets the needs of the family better than conventional care.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

An interdisciplinary team approach can interfere with patient care.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

I often disagree with recommendations made by home hospice nurses.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

Telling patients and family members that the patient is dying is difficult for me.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

When I first discuss the possibility of hospice care, patients and families often lose hope.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

I think it is essential for a dying patient to be told his/her prognosis.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither Agree nor Disagree
- ☐ Disagree
- ☐ Strongly Disagree

Thank you for your participation!

Fidelity Checklist

Teaching Method Feedback Tool v 2.0

Last Updated: 8/17/18

Facilitator: _____

Observer: _____

Date: _____

Course: _____

Facilitator Behavior	Learners							
	1	2	3	4	5	6	7	8
Volunteer: asked learner to volunteer								
Challenging: asked learner what they found challenging								
Skills: asked learner what they wanted to work on								
Notes: asked the other learners to take specific notes								
Time out reminder: stopped the simulation								
Run Encounter → Time out								
Going: asked the learner how it was going								
(Bracket)* asked learner to go back and think what went well								
You well: asked the learner what they did well								
Permission: asked the learner's permission to involve the group								
Group well: asked the group what went well								
Looking back: anything you could've done differently?								
(Point):								
(Describe):								
Idea or permission: asked the learner if they knew how to address the situation differently								
Brainstorm: the learner and facilitator made suggestions								
Group brainstorm: asked suggestions from the group								
(Say exactly?): asked the group to make specific suggestion								
Options: asked the learner what resonated best with them								
Restart: restarted the simulation								
Replay → Time Out								
Different outcome: asked the learner what they noticed when they tried a new skill								

Fidelity Checklist**Last Updated: 8/17/18**

Teaching Method Feedback Tool v 2.0

(Patient different): asked the learner if the patient reacted differently								
(Your action?): asked the learner what they did differently								
Crystallize learning point: asked the learner to specify what they learned/emotions								
Take home: asked the learner what they took away from the exercise								
End								
Notes: Timing of time out: ■ Encounter ■ Replay Acknowledge pivot return:					Other notes:			

*() indicates it is optional depending on learner response to previous question

PRIM-ER

PRIMARY PALLIATIVE CARE FOR EMERGENCY MEDICINE

OVERVIEW

For this intervention, we will tailor Primary Palliative Care for Emergency Medicine (PRIM-ER) for implementation in a diverse group of 35 emergency departments (EDs) that vary in specialty geriatric and palliative care capacity, geographic region, payer mix, and demographics. The overall approach involves ongoing asynchronous learning and technical support to bolster skills conduct interdisciplinary case reviews and reinforce clinical pathways and protocols via provider audit and feedback.

PROVIDER EDUCATION

Full-time emergency medicine Attendings, Physician Assistants, and Nurse Practitioners will receive *5 CME* credits and a *\$67 Amazon Gift Card* as a token of NYU's appreciation for participation in:

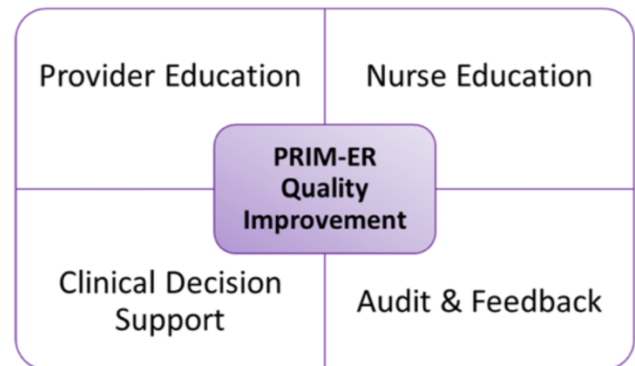
- 2-minute Baseline Palliative Care Knowledge, Attitudes, and Beliefs survey
- EPEC-EM pre-reading
- EM-Talk: a four-hour didactic and communication skills simulation training to help navigate difficult conversations with ease

NURSE EDUCATION

Full-time emergency medicine nurses will receive *1 CE* credit and a *\$50 Amazon Gift Card* as a token of NYU's appreciation for participation in:

- 2-minute Baseline Palliative Care Knowledge, Attitudes, and Beliefs survey
- End-of-Life Nursing Education Consortium (ELNEC): a one-hour training

KEY COMPONENTS



CLINICAL DECISION SUPPORT (CDS)

Tailor and deploy a CDS tool that addresses palliative care needs among ED patients.

AUDIT AND FEEDBACK

Create a provider dashboard and/or report to give clinicians and or administration real-time feedback on performance and CDS usage.

BENEFITS

- Build institutional capacity to provide patient-centered care
- Improve patient and family satisfaction by delivering goal-concordant care
- Deliver care at home when it meets patient and family needs
- Reduce admissions for ED patients who will experience more harm than benefit from a hospitalization
- Decrease penalties for readmissions and safety events

Study Aim: This project builds upon existing research to implement and evaluate PRIM-ER on ED disposition, healthcare utilization, and survival in older adults with serious, life-limiting illness by analyzing Medicare Claims Data.

Addressing Goals of Care: "REMAP"

We designed this talking map to give you a just-in-time route through a complex conversation. Think of it as a series of signposts—you might find that not all apply to a particular patient.

Step	What you say or do
1. Reframe why the status quo isn't working.	You may need to discuss serious news (eg a scan result) first. "Given this news, it seems like a good time to talk about what to do now." "We're in a different place."
2. Expect emotion & empathize.	"It's hard to deal with all this." "I can see you are really concerned about [x]." "Tell me more about that—what are you worried about?" "Is it ok for us to talk about what this means?"
3. Map the future.	"Given this situation, what's most important for you?" "When you think about the future, are there things you want to do?" "As you think towards the future, what concerns you?"
4. Align with the patient's values.	As I listen to you, it sounds the most important things are [x,y,z].
5. Plan medical treatments that match patient values.	Here's what I can do now that will help you do those important things. What do you think about it?
EXTRA: Expect questions about more anticancer treatment.	Here are the pros and cons of what you are asking about. Overall, my experience tells me that more chemo would do more harm than good at this point. It's hard to say that though.
EXTRA: Talk about services that would help before introducing hospice	We've talked about wanting to conserve your energy for important things. One thing that can help us is having a nurse come to your house to can help us adjust your medicines so you don't have to come in to clinic so often. The best way I have to do that is to call hospice, because they can provide this service for us, and more.