Riverside Health

Palliative Care in the Inpatient Setting

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Disclosures

We have no financial disclosures or conflicts of interest.

Objectives

- Differentiate Palliative Care and Hospice
- Identify resources for Palliative Care and Hospice
- Initiate basic goals of care conversations
- Identify appropriate medical decision makers (MDMs)
- Know when to consult Palliative Care

What is Palliative Care???

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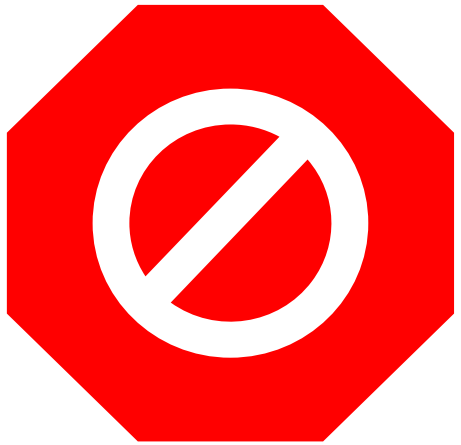
MYTHS about Palliative Care



- Not the same thing as hospice
- Not only for end of life
- You don't need to stop all treatments
- You can still see other doctors
- Goal is not to convert to DNR / comfort care

What is Palliative Care?

- It's a medical specialty
- Specialized care for people living with a serious illness
- Goal is to improve quality of life and treat symptoms and stress associated with a life-limiting condition
- Partner with patients and families to align options for medical care with personal goals and values
- Assessment and support of caregiver needs

What Can Palliative Care Do?

- Provide anticipatory guidance, education, and emotional support to both patients as well as their caregivers
- Coordinate care and clarification of goals
- Facilitate transition to hospice when appropriate
- Support other providers and healthcare team members

How Does Palliative Care differ from Hospice?

Palliative Care

- Medical specialty
- Life-limiting illness with *any* prognosis
- Goals can still include curative care
- Good quality of life and expert symptom management while still seeking treatment
- Primarily provider driven

Hospice

- A model for delivering end-of-life care
- Terminal condition with prognosis < 6 months
- Goal is comfort care
- Focus is supporting natural transition to end of life with good symptom management
- Primarily nursing driven

Hospice Resources

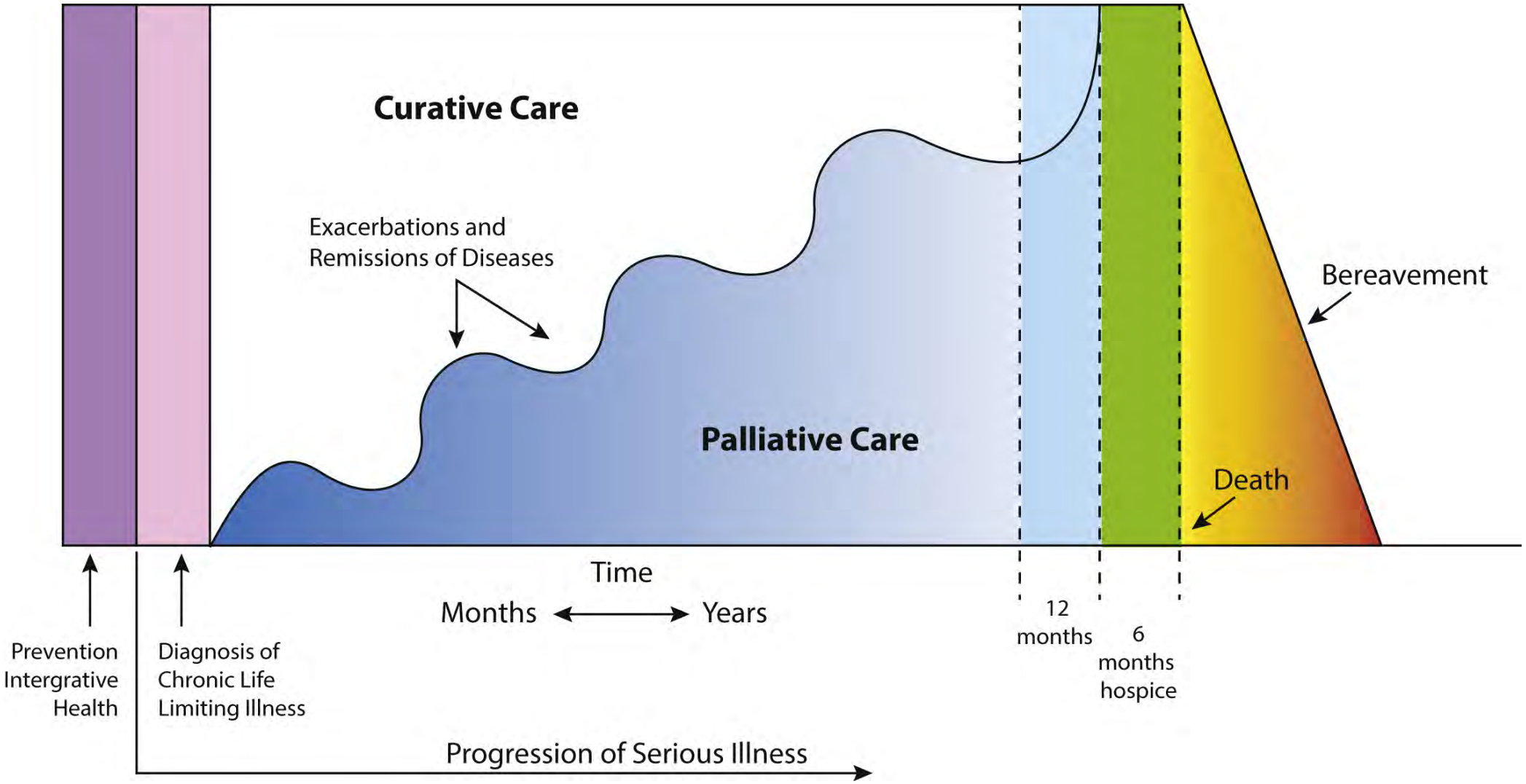
- Multi-disciplinary team including providers, RNs, SWs, CNAs, bereavement counselors, and volunteers
- Nurse and CNA visits, DME, medications
- Family caregiver support and training
- 24/7 on-call for trouble-shooting, symptom management
- Urgent nurse visits if required
- SW to assist with financial resources and care transitions

Palliative Care Resources

- Inpatient and Outpatient Options
- Community-based/clinic-based palliative can provide on-call support to proactively manage symptoms
- Team at RRMC includes 4 physicians (1 FT, 3 PT), 4 nurse practitioners, and a LMSW who are available M – F and who see patients throughout the hospital and emergency dept

When Should You Consider Consulting Palliative Care?

When Should I Consult Palliative Care?



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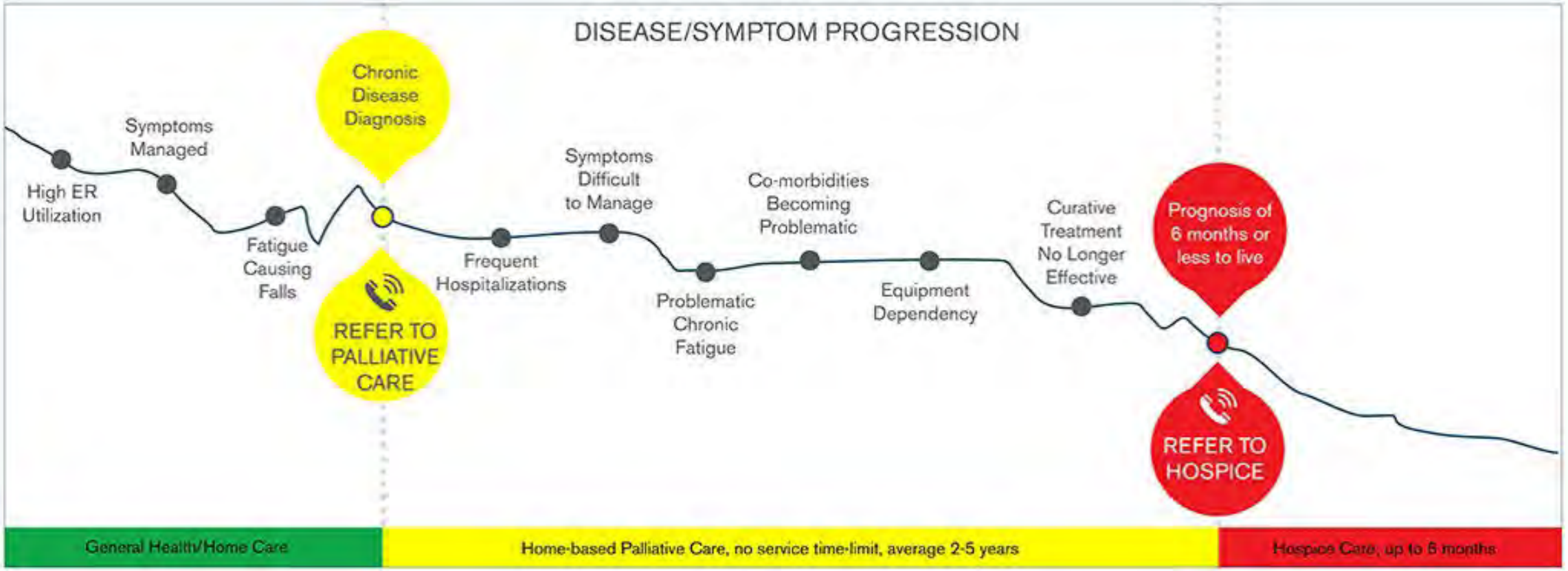


www.mclaren.org

When Should You Consider Consulting Palliative Care?

https://inkvessel.com/

First… have *you* discussed GOC?

- APPs can (and should) have GOC conversations
- If your patient has capacity ➡ they are the MDM
  - Capacity is a medical determination made by physician
  - APPs can still assess for it (U-CARE mnemonic)
- If your patient lacks capacity ➡ identify the correct MDM

https://www.capc.org

GOC Discussions: Capacity

- Demonstrate **understanding** of the situation
- Is **consistent** in responses/preferences regarding treatment
- Able to **appreciate** the implications of their choices and alternatives
- Give a **rationale** for choices
- Able to **express** their choice

Identification of Appropriate MDMs

- Check for valid ACP/MPOA documents
- If no ACP/MPOA documents or if MDM is unwilling...

Surrogate Decision Makers

Virginia statute § 54.1-2986 outlines the decision-making hierarchy in the event the patient can no longer make decisions for themselves and does not have any advance directives on file. The hierarchy is as follows:

1. A guardian for the patient.
2. The patient's spouse except where a divorce action has been filed and the divorce is not final.
3. An adult child of the patient; in cases where there are multiple adult children, they shall all share equal responsibility.
4. A parent of the patient; if there are two living parents, they shall share medical decision making.
5. An adult brother or sister of the patient; in cases where there are multiple adult siblings, they shall all share equal responsibility.
6. Any other relative of the patient in the descending order of blood relationship.

https://law.lis.virginia.gov/vacode/title54.1/chapter29/section54.1-2986/

Initial Goals of Care Discussions

SPIKES

Embrace a Patient-first Approach to Advance Care Planning Conversations

VITAS® Healthcare

Source: Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. The oncologist, 5(4), 302-311.

Initial Goals of Care Discussions

- One of the most basic GOC discussions is about code status and should be addressed for every patient
- "I'd like to talk with you about what your preferences are if your heart and breathing were to stop. We do this with all of our patients so that we can advocate for their wishes."
- Explain what resuscitation means and involves (CPR, intubation, etc.)
- Advise of alternative option, e.g., allow natural death
- Give a recommendation

Goals of Care Resources

Center to Advance Palliative Care™ capc

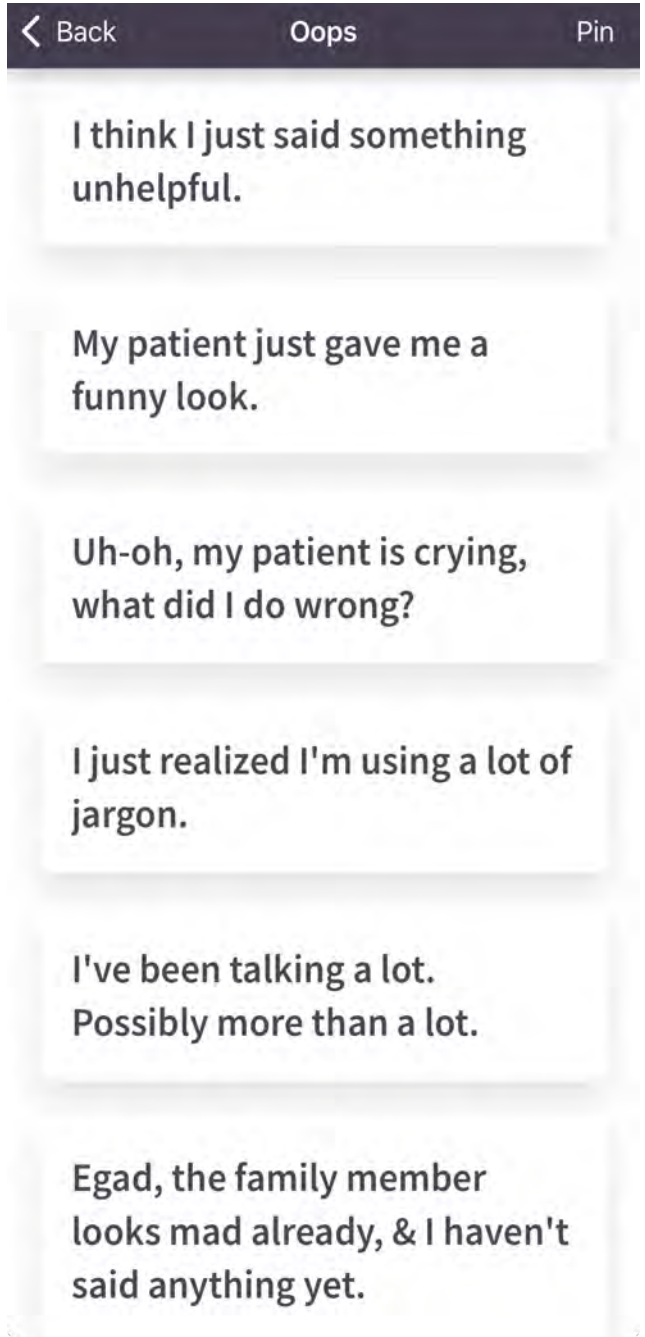
https://www.capc.org/

VITAL talk

HOSPICE & PALLIATIVE NURSES ASSOCIATION
HOSPICE & PALLIATIVE NURSES FOUNDATION
HOSPICE & PALLIATIVE CREDENTIALING CENTER

https://www.advancingexpertcare.org/

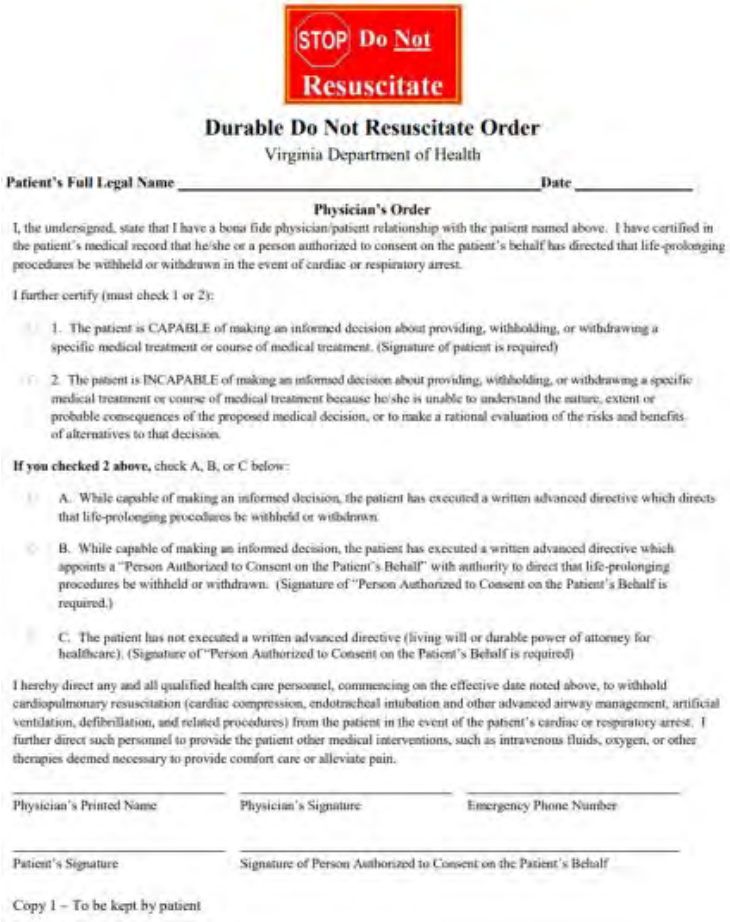
Project ECHO®
Virginia Commonwealth University



What Happens when Palliative is Consulted?

- Palliative provider will discuss with attending team and also with other staff (nursing, CM, PT/OT, SLP)
- Chart review, including locating any ACP documents and ID'ing medical decision makers/MDMs
- Assess the patient, review medications and PMP
- Coordinate with patient and/or appropriate MDM
- Discuss GOC as able and accepted
- Completion of ACP documents

ACP Documents, POLST, DDNR forms



STOP Do Not Resuscitate

Durable Do Not Resuscitate Order

Virginia Department of Health

Patient's Full Legal Name _____ **Date** _____

Physician's Order

I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest.

I further certify (must check 1 or 2):

1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)

2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision.

If you checked 2 above, check A, B, or C below:

A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn.

B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)

C. The patient has not executed a written advanced directive (living will or durable power of attorney for healthcare). (Signature of "Person Authorized to Consent on the Patient's Behalf is required)

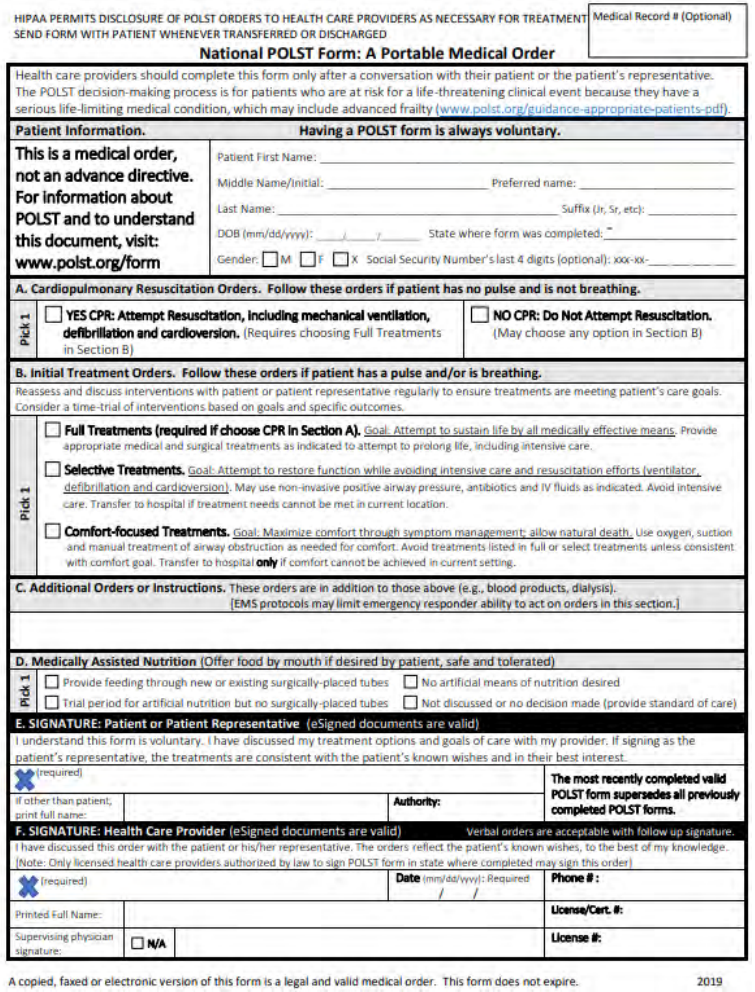
I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

Physician's Printed Name | Physician's Signature | Emergency Phone Number

Patient's Signature | Signature of Person Authorized to Consent on the Patient's Behalf

Copy 1 – To be kept by patient

https://www.vdh.virginia.gov/content/uploads/sites/23/2023/01/AuthorizedDurableDNRForm-2017_508c.pdf



HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ___/___/_____ State where form was completed: _____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-_____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis). (EMS protocols may limit emergency responder ability to act on orders in this section.)

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required) | **The most recently completed valid POLST form supersedes all previously completed POLST forms.**

If other than patient, print full name: | **Authority:**

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. (Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order)

✖ (required) | **Date** (mm/dd/yyyy): Required ___/___/_____ | **Phone # :**

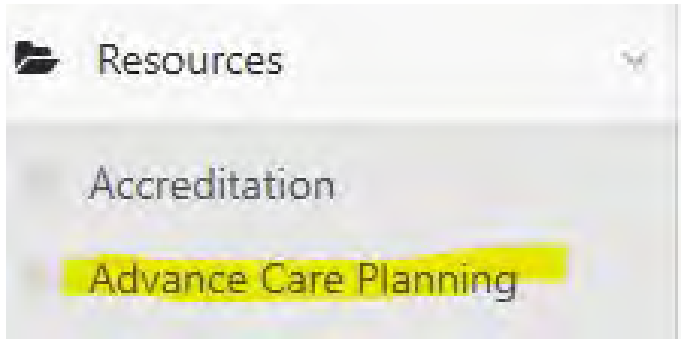
Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

https://www.vdh.virginia.gov/content/uploads/sites/23/2023/05/POLST-Form.pdf

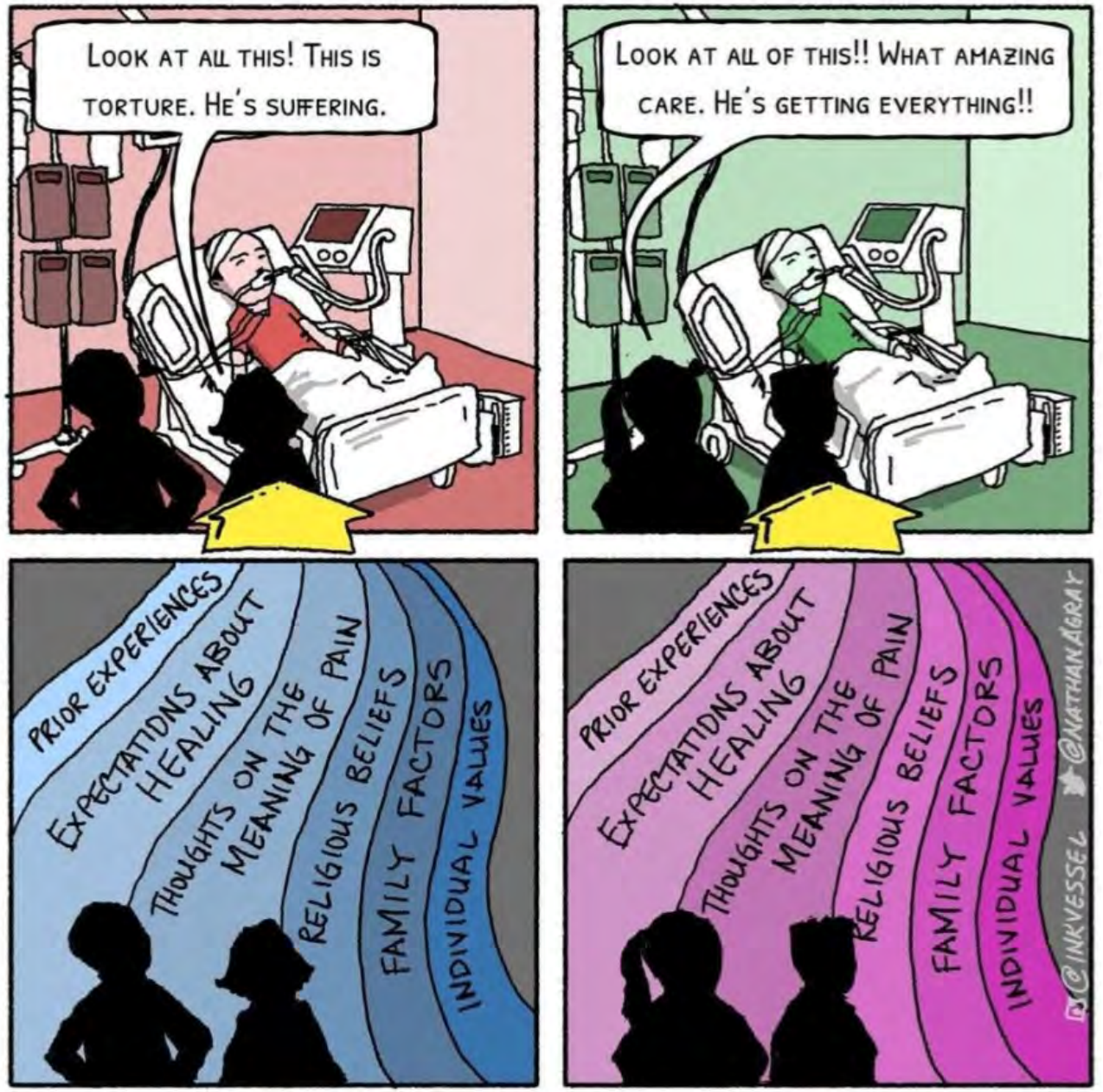
ACP Documents, POLST, DDNR forms



Links to forms and resources:

- Advance Care Plannig Policy
- Advance Directive form
- Assignment of a Health Care Agent Form
- Durable DNR form
- National POLST Model Form

Perspective Matters...



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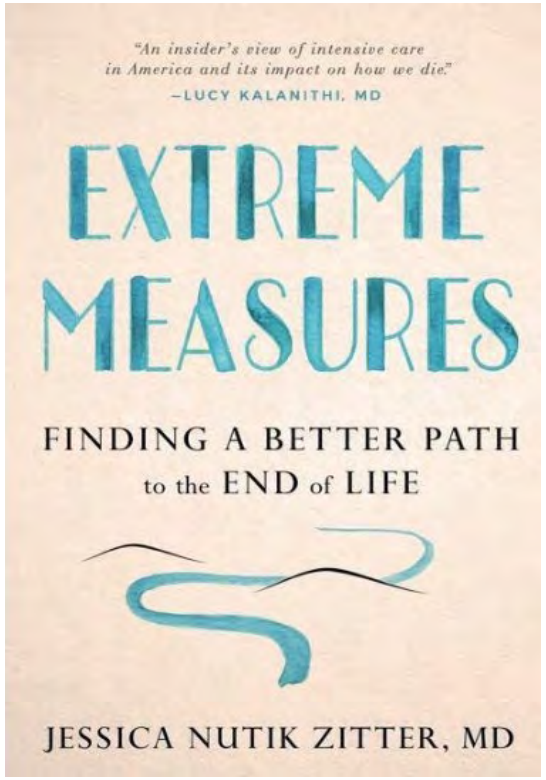
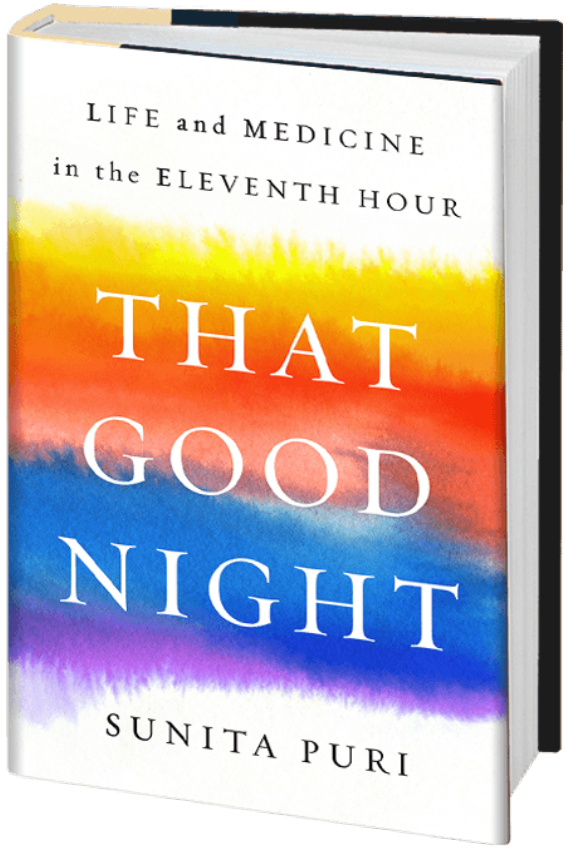
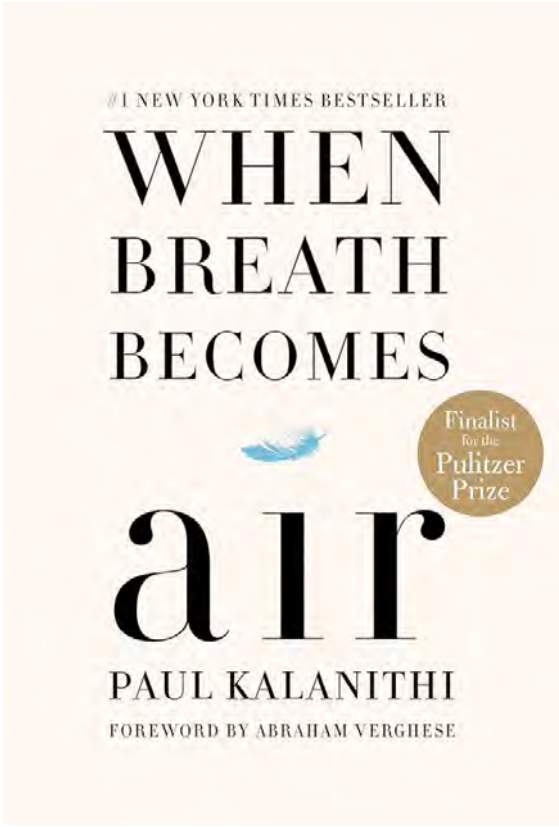
Additional Resources







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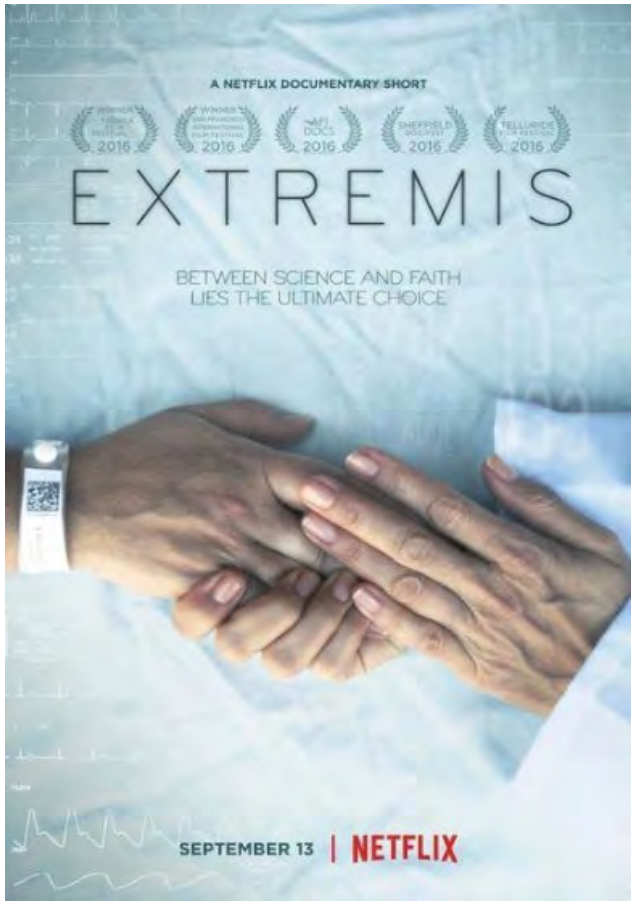

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Questions?

References

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https://www.capc.org/about/palliative-care/

https://www.medicare.gov/coverage/hospice-care

https://intranet.rivhs.com/RHS/AdvanceCarePlanning/index.cfm

https://www.vitas.com/for-healthcare-professionals/education-and-training/talking-to-your-patients-about-end-of-life