

## Comfort Care in the Emergency Department: Resource

This document is intended to be a guide when caring for patients who present to the Emergency Department, have a terminal diagnosis, and have either decided themselves, or have a surrogate decision maker that has decided on their behalf that the patient's goals of care are for comfort based care only and not life prolonging care. The palliative care team would still be happy to consult on any and all of these patients that present to the ED, and this document is meant to be of help during times when consults are not immediately available.

### **Highlights**

- The Adult Comfort Care order set in power chart provides help with medication choices for symptom management and practical patient care.
- When possible, the OBS unit is the ideal locations for comfort care patients boarding in the ED.
- The Palliative Care team is available to help. Feel free to leave a message after hours at **272-4868**.
- Pastoral Care has a chaplain on-call 24 hrs/day at **951-9955**.
- If a patient was previously on hospice as an outpatient, contacting the hospice is often very helpful for both understanding why the patient ended up in the ED and for patient disposition help. When available, recruit social works help with hospice patients.
- Opiates given for comfort care are not intended to hasten death, but we recognize that double effect in theory, may occur. None the less, we are obligated to provide excellent pain control for our patients. Opiates are also the evidence based medication of choice for dyspnea in dying patients.

### **DNR/DNI orders:**

Remember that DNR/DNI does not mean do not treat. It only refers to CPR. Any patient presenting to the ED who is confused or obtunded and requires aggressive care needs to have a surrogate decision maker contacted to clarify goals of care. It may be that the patient would want comfort only care, especially if they have previously requested to be DNR/DNI, but comfort care only must be clarified and aggressive care up to the point of CPR should be continued until this is discussed. DNR/DNI orders should be both placed in the power chart order set and documented in a timely fashion in the providers charting.

[www.capc.org/fast-facts/23-discussing-dnr-orders-part-1/](http://www.capc.org/fast-facts/23-discussing-dnr-orders-part-1/) is an excellent resource for having a discussion with a patient or surrogate decision maker regarding code status if a patient presents that does not have a previously known code status.

### **Surrogate Decision Makers:**

There is a surrogate decision maker note available for use in power chart to assist with documenting

who either the patient designates as surrogate or who New Mexico law designates if none has been appointed.

Per The New Mexico Uniform Health Care Decisions Act

A. A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined according to the provisions of Section 24-7A-11 NMSA 1978 to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

B. An adult or emancipated minor, while having capacity, may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as surrogate:

(1) the spouse, unless legally separated or unless there is a pending petition for annulment, divorce, dissolution of marriage or legal separation;

(2) an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other's well-being;

(3) an adult child;

(4) a parent;

(5) an adult brother or sister; or

(6) a grandparent.

(7) If none of the individuals eligible to act as surrogate under Subsection B of this section is reasonably available, an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values and who is reasonably available may act as surrogate.

### **Comfort Care Order Set:**

The **Adult Comfort Care** order set in power chart is intended to be a general guideline for starting comfort care orders as it addresses many symptoms that occur during end of life care. Some specifics regarding the order set are below are meant to clarify the purpose behind those orders.

Vital signs and monitoring- We recommend turning the monitor off in the patient room. Continuous monitoring can add to patient and family anxiety at the end of life

Skin care and positioning- if moving the patient causes significant distress and death is likely imminent (hours to days) then minimal turning is appropriate as relevant skin break down is not likely. Wound care should be minimized to what is necessary to reduce odor or drainage.

Lines and tubes- For patients with active symptoms or who cannot take oral medications an IV may be appropriate. IV fluids are overall not necessary for comfort. It is sometimes helpful to remind families that if the body is shutting down, and kidney function is poor, that this additional fluid may make edema worse or breathing more difficult. Swabbing the mouth with water or giving sips of water is much more effective at treating the sensation of thirst. If the patient is incontinent or has pain with turning a condom catheter or foley may be appropriate to minimize wetness and need for frequent changing.

Nutrition- The patient should be allowed to eat what they want if they are able. For people who are not able to take PO often families worry that their loved one is experiencing hunger or is "starving to death". The most common complaint is actually dry mouth, not hunger, as the metabolism has typically slowed significantly when someone is near death.

Oxygen- For patients with dyspnea, having air blowing on the face can provide comfort. This can be accomplished with a fan or with O2 via 2 L nasal cannula. Overall, supplemental oxygen is not considered a comfort measure. For some patients and families who are accustomed to home O2, they

may feel anxious about the idea of not continuing to provide supplemental oxygen, and if this is the case then continuing O2 may provide emotional comfort. Pulse oximetry however, is not recommended as this alarm or value may increase anxiety and distress for the patient or family.

Agitation or terminal delirium- It is strongly recommended that an antipsychotic, most commonly haloperidol, is used to treat agitation or delirium with additional or increasing doses if needed. Benzodiazepines, especially in the elderly, increase the risk of delirium. It is recommended that benzodiazepines be reserved for refractory agitation or for true anxiety without signs of delirium.

**Opiates:**

Many patients who present for comfort care are already on opiates at home. For this reason, there is not a standard order included in the comfort care order set. For patients with pain or dyspnea a starting dose of 1-2 mg morphine IV q 15 minutes prn pain or dyspnea is appropriate.

If this dosing is very frequent then a PCA can be used to administer a continuous infusion. A basal rate of 1mg/hr morphine IV can be started via PCA and continue bolus dosing every 10- 15 minutes if needed. This infusion requires frequent nursing evaluation. The basal rate should not be adjusted more frequently than every 6 - 8 hours.<sup>1</sup> We recommend a provider assess the patient with each increase, rather than writing titration orders. "Titrating to comfort" is subjective and not appropriate in any circumstance. With either IV push or PCA dosing, avoid dose stacking. For patients who are on opiates at home, very high doses may be required to relieve pain or dyspnea. The purpose of these medications are to provide comfort, not hasten death.

**Who to Call:**

Besides contacting palliative care, for any patient or family wanting comfort care social work and chaplain services should be called to assist with patient and family support. If a patient is imminently dying in the ED remember to also contact donor services as restrictions on donation are becoming more liberal all the time.

Palliative Care (please put consult in computer orders as well): 272-4868

Chaplain on-call pager: 951-9955

**Disposition:**

Any patient placed on comfort care orders in the ED should have a service (IM/FM/onc ect.) contacted for admission as soon as possible to obtain a hospital bed. Placing the patient in the observation unit, although not in observation status, is recommended to provide a quieter environment for the patient and family.

If the patient appears stable enough for transport it is appropriate to ask the patient or family if they are interested in a hospice evaluation. If you are not comfortable with the details of what hospice can provide it is appropriate to simply contact social work to discuss this with family. Social work can arrange for a hospice company to evaluate the patient (to decide if they are eligible for inpatient hospice care vs. home hospice and to see if they have adequate hospice benefits). The patient should still be admitted to the hospital as this process does not always proceed quickly, however, letting social work know that this is what the goal is while the patient is still in the ED can significantly expedite this transfer.

**Hospice Patients Presenting to the ED:**

There are times when patients enrolled in hospice present to the ED. Often there is an inciting event

that leads to these presentations such as inadequate symptom management, or delay in response on behalf of the hospice staff that leaves families or nursing home staff feeling unable to adequately care for the patient. It is important to clarify what the goals of care are when these patients present as they may still desire comfort only care despite coming to the ED. Contacting the hospice is also helpful as they may be able to clarify why the patient is presenting to the emergency department. Patients are temporarily signed off of hospice when they present to the ED, but can easily be signed back on if they do not desire or need admission.

### **Pronouncing a Patient:**

Ideally, a patient on comfort care in the ED will be admitted to a team. This team should be notified by nursing staff when the patient dies, but any physician can pronounce the patient dead. If there is difficulty or delay in getting a hold of the team caring for the patient then an ED physician should pronounce the patient. The admitting team is still responsible for the death packet for their patient regardless of who pronounces the patient.

### **Extubation and Comfort Care:**

If a patient was intubated in the field or in the ED and family is requesting terminal extubation or ventilator withdrawal, a MICU consult to see if there is bed availability is appropriate to allow for intensive comfort care to be provided. An alternative would be to arrange with a medicine team to facilitate extubation once the patient arrives in a room in SAC level. However, there are times when this is not possible. The emergency department is not the appropriate place to care for this event. Although we always warn families that the patient may die quickly after terminal extubation, this does not always happen and at times patients may live for hours or days after extubation. There for, this possibility should be prepared for and patients should be admitted and in a place where appropriate nursing care can be provided to the patient and family. In addition, if recent paralytics have been administered, return of motor function must be demonstrated before extubation. Extubation and the consent for extubation should be documented as a procedure.

The following guideline is an excellent resource from [www.SupportiveOncology.net](http://www.SupportiveOncology.net) for the steps to take for withdrawing ventilator support.

### **Stepwise Approach to Removing Ventilatory Support From the Dying Patient<sup>2</sup>**

#### STEP 1: DECISION AND DOCUMENTATION

- Document goals of care; discuss them with all team members.
- Establish date and time for removal of mechanical ventilation.
- Encourage family to initiate cultural rituals/ceremonies in preparation for death.
- Discontinue tests, medications, etc, that do not meet the goals of care.
- Confirm/document do-not-resuscitate order.

#### STEP 2: PREPARATION FOR REMOVAL OF MECHANICAL VENTILATION

- Discontinue artificial fluids and feeding.
- Provide counseling to families; decide whether family wish to be present during extubation; provide time for family to say good-bye.
- Discuss organ donation with family.
- Contact respiratory therapist to assist with procedure.
- Ensure presence of senior physician for extubation.
- Decide on method of removal of mechanical ventilation.
- Administer pre-medication to ensure comfort including opiates for dyspnea and a benzodiazepine for anxiety

- Remove restraints and other medical devices.
- Have suction equipment and towels available.
- Write order to discontinue ventilator.

#### STEP 3: REMOVAL OF MECHANICAL VENTILATION

- Silence ventilator alarms.
- Remove mechanical ventilation.
- Monitor patient for signs of discomfort.

#### STEP 4: FOLLOW-UP

- Invite family into the room.
- When/if patient dies, allow family time to say good-bye.
- Debrief staff; provide support.
- Initiate family bereavement plan.

1. Portenoy RK. Continuous Infusion of Opioid Drugs in the Treatment of Cancer: Guidelines for Use. *J Pain Symptom Manage.* 1986; 1:223-228.
2. Marr L, Weissman DE. Withdrawal of ventilatory support from the dying adult patient. *J Supp Onc.* 2004; 2:283-288.