

IMPLEMENTATION OF A LIFE-SUSTAINING MANAGEMENT AND ALTERNATIVE PROTOCOL FOR ACTIVELY DYING PATIENTS IN THE EMERGENCY DEPARTMENT

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Problem: The aging population and the growing number of home hospice patients have resulted in increased utilization of emergency departments. This situation poses a clinical challenge to the ED staff in determining when lifesaving treatment is indicated and when end of life care begins.

Methods: Through a shared governance model, ED physicians and nursing staff aimed to implement a best practice model for the care of dying patients. An ED interdisciplinary team identified gaps and brainstormed methods to improve palliative measures and comprehensive care for actively dying patients.

Results: A best practice initiative called "Life Sustaining Management and Alternatives" was developed and imple-

mented to provide palliative care services and comprehensive care for patients who are actively dying in the emergency department.

Implications for Practice: The emergency department became better equipped to handle end of life care, providing adequate pain management, optimal comfort measures, and emotional support with respect and dignity for the dying patient and family. The practices implemented resulted in improved patient care, increased patient satisfaction, and reduced overall hospital admissions.

Key words: Emergency department; Palliative care; Hospice care; End of life; Family; Geriatric

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A 45-year-old man with athetoid, spastic quadriplegia was transferred to the emergency department from a long-term care facility because of shortness of breath and coffee ground emesis. His medical history included a seizure disorder, mental retardation, gastrointestinal reflux disease, and dysphagia, and he required a percutaneous endoscopic gastrostomy tube for delivery of nutrition. In the emergency department, the patient was diagnosed with aspiration pneumonia, gastrointestinal bleeding, sepsis, and respiratory failure. The patient required intubation, and an epinephrine drip was started. A palliative care consultation was obtained. The patient's mother decided that she wanted her son to be comfortable and did not want life support measures to be used, and she notified other family members. The patient was transferred to the Life Sustaining Management and Alternative (LSMA) room, where the lights were dim, medical equipment had been hidden by a curtain, and additional seating for family members was provided. The patient was extubated after the family arrived and, as per LSMA protocols, received morphine, atropine, and midazolam. Medication was titrated to keep the patient comfortable. Ongoing psychosocial support was provided to the family by the nurse and pastoral

care services. The patient died peacefully with his family at the bedside.

Description of the Problem

Death and dying can be a complex process for patients, their families, health care providers, and the health care system.¹ The aging population and growing number of home hospice patients have resulted in increased utilization of emergency departments, which poses a clinical challenge to ED staff. Health care providers must identify patients who would benefit from transitioning the focus of management from life-sustaining treatment to the provision of supportive care and a dignified end of life (EOL).

Development of the LSMA program was an evolving process that began with ED staff recognizing the need to offer palliative care in the emergency department based on the clinical situations they face with patients in the terminal stage of life. During 2008 and 2009, before the development of the LSMA program, more than 100,000 patients were being seen in our emergency department annually, and an average of 10% of these patients were older than 65 years. A retrospective review of these 2 years showed that approximately 76 patients who were older than age 65 years might have benefited from the LSMA protocols. Staff recognized the suffering these patients experienced during EOL and verbalized this observation on several occasions during monthly unit council meetings. The ED staff, especially nurses, believed it was difficult to advocate for their patients' EOL wishes. This recognition inspired the development of the LSMA program.

Available Knowledge

A literature search of databases including CINAHL, SAGE, Medline, and Cochrane was completed using the following key words: end of life, palliative care, and hospice care in the emergency department. An examination of the findings revealed a lack of research on EOL care specific to the emergency department. The literature supported palliative consultations and care anywhere in the care continuum when appropriate, but there were no standardized protocols for care of actively dying patients in the ED setting.

Traditionally, emergency departments are fast-paced clinical environments that focus on rapid identification of illness and lifesaving interventions. Despite the growing number of aging, palliative care, and hospice patients seeking emergent care, the needs of this population are often overlooked among candidates who would benefit from such a care approach. One study of patients with cancer during

their EOL indicated that as many as 40% presented to the emergency department at some point during their final 2 weeks of life.² Another study suggested that approximately 25% of patients at the EOL spend their last days on ventilators, and 40% die in pain.³ Families bring their loved ones to the emergency department even though the patient's preference for EOL care may be at home.^{3,4} When a patient's condition deteriorates and symptoms are inadequately managed, family members' anxieties result in the patient's transfer to the emergency department.^{2,5,6} The result is intense and costly efforts to prolong life, sometimes resulting in greater discomfort, loss of function, and decreased quality of life.¹

Methods

CONTEXT

The LSMA program was initiated in an urban, 88-bed emergency department of an academic level II trauma center in New Jersey. This emergency department is one of the busiest in the country, treating 158,458 patients in 2014. The LSMA program was designed to meet the needs of the aging and hospice population through comprehensive, palliative, and EOL care in the ED setting.

DEVELOPMENT OF THE LSMA PROGRAM

An interdisciplinary team consisting of an advanced practice geriatric nurse, a board-certified palliative care physician, 2 emergency medicine physicians, an ED case manager, and ED staff nurses identified where gaps in care existed and where changes were needed. Through a shared governance model including ED physicians, nurses, and other interdisciplinary staff, the LSMA program was developed. Because buy-in was critical to successfully implement the LSMA program, the team identified key stakeholders, including ED leadership and administration, primary care physicians (PCPs), home hospice care providers, and the ED nursing staff as a whole. ED leadership and administration approved the appropriation of resources, such as payroll for staff to take advanced classes and complete bedside training, and supported the nursing staff who were spearheading the program. The role of the PCP and home hospice care providers was to provide continuity of care if the patient was going to be admitted to inpatient hospice. Home hospice care providers were also instrumental in providing input into the development of the LSMA medication protocol and instruction on additional care needed for the actively dying patient. The ED staff was crucial in the implementation of the program, because they work bedside carrying out the medication protocol and caring for LSMA patients. To

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