

FAST FACTS AND CONCEPTS #246 EMERGENCY DEPARTMENT MANAGEMENT OF HOSPICE PATIENTS

Sangeeta Lamba MD, Tammie E Quest MD, David E Weissman MD

Background Patients enrolled in hospice programs will occasionally be transported to the Emergency Department (ED). Emergency medicine training focuses on life-prolonging measures and may fail to address hospice as a system of care. This *Fast Fact* provides information for clinicians practicing in EDs on management issues when a hospice patient arrives. *Fast Fact #247* discusses initiating hospice care from the ED and #298 addresses Palliative Care Consultation in the ED.

Why do Hospice Patients come to the ED? ED providers should never assume that arrival in the ED equates a desire for aggressive/life-prolonging treatment. Even when a patient/family requests such services, an assessment is needed to understand the concerns that prompted a shift in care goals. Frequently such requests arise from fear about the dying process or guilt about prior medical decisions to limit life-prolonging treatments. Common triggers for an ED visit include:

- Stress/inability to cope with impending loss of life. This may be expressed as a request to start a life-prolonging treatment previously used and discontinued (e.g. chemotherapy) or never begun (e.g. renal dialysis).
- Poor symptom control.
- Malfunction/loss of a support device such as a gastrostomy tube.
- Failure of the hospice program to provide timely patient support and communication.

Management Guidelines

1. **Notify hospice** staff as soon as possible. Under the Medicare Hospice Benefit, hospice agencies are legally/financially responsible for the patient's plan of care and all medical costs related to the terminal illness. See *Fast Facts # 82, 87, 90*.
2. **Determine the trigger** for the ED visit. Pay attention not only to distressing physical signs and symptoms but also emotional and psycho-social issues. Involve social services, chaplaincy, and Palliative Care consultative services early if needs are identified.
3. **Treat distressing symptoms.** See *Fast Facts* for specific symptom treatment guidelines.
4. **If deterioration is imminent** and rapid decisions are needed regarding the use of life-sustaining treatments (e.g. intubation for respiratory failure) a focused discussion around goals of care must occur in the ED
 - Determine the legal decision maker if available and review any completed advance directives.
 - Complete a rapid goals of care discussion (see *Fast Facts #223-227*).
 - *Make recommendations.* For example, 'According to what you want for [the patient], I would/would not recommend....'
5. **If the patient is actively dying** (see *Fast Fact #3*) assess for cultural/spiritual needs; assure privacy and endeavor to identify if there are any preferred locations a patient can be safely transferred to to die (e.g. back home; to a private hospital room).
6. **Laboratory tests/diagnostics** should be limited or withheld until discussion with the patient's hospice care team. Testing should be based on patient-defined goals of care. Generally, low burden, non-invasive methods which may reveal reversible pathology or clarify prognosis should be used first.
7. **Therapeutic modalities** should be based on patient-defined goals of care rather than automatic 'ED indications' (e.g. antibiotics for pneumonia should only be used if they meet a patient or surrogate defined goal of care).
8. **Disposition** should be planned *after* discussion with hospice staff based on the patient's goals. Returning home or a direct admission to an inpatient hospice facility may be the best disposition rather than hospital admission. At times, hospices can arrange 24h professional support in the home for patients with difficult to manage symptoms who wish to remain home ('continuous care' – see *Fast Fact #87*).
9. **Notify** the inpatient palliative care service if the patient is to be admitted to the hospital. Hospice agencies may revoke a patient's enrollment in hospice care if care goals have changed, or may continue a patient under hospice care during an admission for palliation (see *Fast Fact #87*).

Summary Patient-centered care for hospice patients may be enhanced by emergency clinicians who acquire skills to quickly adapt to a supportive role in the care of a terminally-ill patient. Recognizing common triggers for the ED visit, using a multi-disciplinary approach with early involvement of hospice, social services and palliative team consults may assist in providing optimal care for ED patients under hospice care.

References

1. Chan GK. End-of-life and palliative care in the emergency department: a call for research, education, policy and improved practice in this frontier area. *J Emerg Nurs*. 2006. 32(1):101-3.
2. Smith AK, Fisher J, Schonberg MA, et al. Am I doing the right thing? Provider perspectives on improving palliative care in the emergency department. *Ann Emerg Med*. 2009. 54(1):86-93.
3. Reeves K. Hospice care in the emergency department. *J Emerg Nurs*. 2008. 34(4):350-1.
4. Lamba S, Quest TE. Hospice care and the Emergency Department: rules, regulations and referrals. *Ann Emerg Med*. 2011; 57:282-290.

Author Affiliations: University of Medicine and Dentistry of New Jersey, Newark, New Jersey (SL); Department of Veterans Affairs, Emory University School of Medicine, Atlanta, GA (TEQ); Medical College of Wisconsin, Milwaukee, WI (DEW).

Version History: Originally published October 2011; Copy-re-edited August 2015.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the [Palliative Care Network of Wisconsin](#) (PCNOW); the authors of each individual *Fast Fact* are solely responsible for that *Fast Fact's* content. The full set of *Fast Facts* are available at [Palliative Care Network of Wisconsin](#) with contact information, and how to reference *Fast Facts*.

Copyright: All *Fast Facts and Concepts* are published under a Creative Commons Attribution-NonCommercial 4.0 International Copyright (<http://creativecommons.org/licenses/by-nc/4.0/>). *Fast Facts* can only be copied and distributed for non-commercial, educational purposes. If you adapt or distribute a *Fast Fact*, let us know!

Disclaimer: *Fast Facts and Concepts* provide educational information for health care professionals. This information is not medical advice. *Fast Facts* are not continually updated, and new safety information may emerge after a *Fast Fact* is published. Health care providers should always exercise their own independent clinical judgment and consult other relevant and up-to-date experts and resources. Some *Fast Facts* cite the use of a product in a dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.