Background   Adults with chronic illnesses visit the emergency department (ED) several times in their last months of life, with over half of older Americans presenting in their last month and many dying in the ED. Hence, the ED serves many patients with unmet palliative care needs. Initial care decisions made in the ED also set the future hospital trajectory of care. Early palliative care (PC) engagement in the ED has the potential to impact these decisions. In this Fast Fact we discuss the opportunities and challenges of the PC consultations in the ED.

Indications for Palliative Care consultation in the Emergency Department

• Difficult-to-manage pain or other symptoms
• Symptom management for an actively dying patient
• Rapid consensus for goals of care (e.g. intubation decision) or complex decision making
• Clarify provisions in an advance directive
• Withdrawal of non-beneficial treatments (e.g. help with terminal extubation)
• Bereavement support (e.g. after sudden deaths in victims of trauma or death of a child)
• Challenging dispositions requiring care coordination (e.g. home hospice)

Consultation Etiquette   ED clinicians are charged to provide excellent and efficient patient care, with a mandate to keep patient encounters as expedient as possible. ED providers often expect in-person consultation time within 30-60 minutes. Palliative programs should proactively discuss the consultation processes with the ED leadership to clarify when and how palliative care team members will be available for an ED consult, by phone or person. To best serve the ED staff, palliative care clinicians are encouraged to follow these principles of consultation etiquette:

1. Determine the question: What is needed from the ED team? Orders for symptom control, dialogue with family, guidance with disposition planning? Certain issues, such as symptom control, may be initiated or handled over the phone whereas more complex issues such as urgent goals of care discussions may need in-person support.

2. Establish urgency: Be explicit in asking the ED team for the timeline of expectations.
   • Emergent (e.g. clinical status unstable; decision to intubate, decision to withdraw ventilator)
   • Urgent (e.g. patient relatively stable; help needed for disposition planning)
   • Routine (e.g. patient is being admitted, has non-urgent needs, can be seen as inpatient).

3. Who is needed and when? Clarify care issues to determine which IDT member is best suited to address the ED query. Be honest about timelines for in-person support and initiate telephone support as soon as feasible.

4. Personal contact: discuss your findings and/or recommendations with the appropriate member of the ED staff before initiating any definitive patient/family communication or intervention. Recognize that this ED clinician may not be the one who initiated the palliative team consult due to shift schedules.

5. Gather additional data: To offer high quality care, the consultant will need to gather data independently.

6. Brevity: A verbal 2-4 minute summary of recommendations is useful immediately after the consult.

7. Specificity: Be explicit in disposition and treatment directions (e.g., “begin with Morphine 5 mg IV and repeat every 15 minutes until pain is less than 5”). Make sure your recommendations are feasible to implement and fit the ED policies and protocols. Clarify who will be contacting other stakeholders (home care, caregivers, etc) and what messages will be communicated.

8. Teach with tact: e.g. provide a Fast Fact, a protocol for pain, or an opioid equivalency table.
9. Provide continuity: Communicate the established plan of care to the patient, family, ED clinician and the provider for the patient’s next place of disposition (e.g. the hospitalist for a patient being admitted).

10. Honor the ED environment: Appreciate the patient load and competing emergency care demands of the ED staff. Expect and anticipate shift changes and the need to orient new staff to your role and plans.

Summary  Often a consult initiated in the ED does not have ample time to fully address patient needs or change immediate outcomes. PC collaboration still serves a vital role in the ED as initial discussions begun in the ED (clinician discussions about poor prognosis and introducing palliative team as part of the next steps of care) can help prepare the patient and family for future care discussions with the palliative team. PC clinicians are encouraged to learn about the ED culture and develop positive relationships by joining in ED care rounds, serving as educational resources, and working collaboratively on institutional protocols.

References:

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