

British Columbia Nurse Line: Fraser Health Authority

After hours Access for Hospice Palliative Care Patients and Families

Della Roberts, RN, MSN, CON(HPC)
Clinical Nurse Specialist, Hospice Palliative Care
Delta/White Rock/South Surrey
Fraser Health

Diane MacCormack, RN BSN
BCNL Community Liaison Nurse

Dr. Doris Barwich, Medical Director Fraser Health Hospice Palliative Care
Dr. Brian Winsby, Medical Director BC Nurse Line

For use with a companion video briefing available from www.pallium.ca

This file downloaded from www.pallium.ca/infoware/HPCProtocolsCaseStudy_29Sept2005.pdf

Why telehealth connection FH / BCNL?

FH HPC

- Strategic plan for HPC in FH includes 24/7 access to specialized services
- Gap – no after hours service
 - Many pts “on their own” after home health offices closes
 - Often no family GP and no service overnight except for emergency room visit

Population of 1.5 million

- *2800 HPC pts annually*
- *Mix of rural, urban and rural-urban communities*

BC Nurseline

- already receiving calls from palliative patients/families in the province
- BCNL & Ministry of Health interested in developing further capacity in the area of HPC

After hours service: BCNL/FH HPC

- BCNL established designated line for FH palliative patients – identified callers only
 - Patients enrolled in FH home health for hospice palliative services
 - After admission, and entry into HPC data base, given a special phone number for BCNL for calls between 2100 and 0800

Roles in partnership

BCNL

- Specialized telehealth nurses
- Between 2100 & 0800 –first call for FH palliative patients & families
 - Use FH HPC call flow
 - Triage the call
 - Provide: symptom management, support and information
 - If indicated, transfer call to FH Palliative Response Nurse (PRN)
- Fax notes to Home Care

FH HPC

- Specialized hospice palliative care nurses on call 2100-0800 to receive calls transferred from BCNL
- Backup by HPC MD & CNS
- Documentation/phone message to Home Care

BCNL Process

- Because these patients are known FH HPC patients
 - BCNL can deviate from their usual call flow process
- Use an enhanced call process incorporating expanded HPC protocols
- Use additional protocols in the decision making tool (Health Wise Knowledge Base) reviewed by HPC CNS, signed off by HPC MD & BCNL MD
 - BCNL practice within defined parameters
 - BCNL reinforce the current medication plan
 - Deviation from plan requires transfer to FH PRN

Symptom calls

- Symptoms are identified as either new or previous/expected symptom
- Previous/expected symptom – use an enhanced assessment flow
- New Symptom – Triage with usual decision support tool, optional to use enhanced assessment

Enhanced Symptom assessment & indications in last days of life:

- Can you tell me about your/family members activity level?
- Are you/your family member spending most of your time in bed and has this changed over the last few days?
 - Do you think your family member is in the last hours of life?
 - Does your family member wish to die at home?

Is there a signed DNR/No CPR?

- **YES:** Confirms patient is close to death and has a DNR, symptoms are likely related to dying process – **Do Not Triage** symptoms, provide education/reassurance from End of Life Topic
- **NO:** If close to death but no DNR, home death is not planned, or caregiver is not coping – **Do Not Triage** symptoms, educate/reassure and transfer care to Palliative Response Nurse

FHA HPC Program - Microsoft Internet Explorer

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FHA HPC Program

Information Links

- [FAQs](#)
- [Referral Detail](#)
- [Home Care](#)
- [Protocols](#)

The Palliative Care program was launched January 17, 2004 as a joint initiative with the Fraser Health Authority.

Last Updated:
January 7, 2005

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http://bcnl.tcmtelcare.ca/FHA_HPC/PalliativeCareFAQ.htm - Microsoft Internet Explorer

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FHA HPC FAQs

In the links below, you'll find **answers** to many of the most frequently asked Palliative Care questions.

1. [Is there a cancer-related pain that is different than other types of pain?](#)
2. [Can the doctor order medications for persistent pain that will give relief?](#)
3. [What is breakthrough pain? My nurse said to use the medication plan for breakthrough pain. What do I do?](#)
4. [What is incident pain? Is there a medication available and how do I use it?](#)
5. [What medications would be on a medication treatment plan?](#)
6. [What if I vomited the medication? Can I take another pill?](#)
7. [What if I forgot to take the medication?](#)
8. [What do I do if I can't swallow the medications?](#)
9. [I think that I am having a reaction to my medication?](#)
10. [I cannot give the medications by the port. What should I do?](#)
11. [Can I get a medication refilled after hours in the FHA?](#)
12. [Can I have a narcotic refilled at the drug store?](#)
13. [Can I take OTC with my regular medications?](#)

Is there a cancer-related pain that is different than other types of pain?

Yes. This pain has been described as an acute persistent pain. It is important to treat this pain aggressively as it responds well to treatment 85% of the time. This pain can have a huge impact on a patient's quality of life. Pain management does not shorten someone's life if it is properly monitored.

Can the doctor order medications for persistent pain that will give relief?

Yes. If the pain is persistent, regular medication can be taken to keep the pain under control.

What is breakthrough pain?

Breakthrough pain occurs despite use of regular analgesics. Most medication plans will include the use of breakthrough (also called rescue or PRN) medication when pain 'breaks' through. This is usually the same medication and is usually 10 -20 % of the total daily

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Examples protocols enhanced for HPC...

- Advanced Directives/ End of Life Planning
- Bowel Obstruction
- Confusion/ Hallucinations
- Coughing/ Secretions
- Dehydration
- Death has occurred at home
- Pain management
- Breakthrough pain
- Incident pain
- Skin problems
- SQ site
- Suicide ideation
- Swallowing problem
- Tracheotomy



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End Call Notes History Fulfillment Alerts Help

end of life Search All Symptoms Pediatrics Drugs Tests Self Help List A-Z

2004/2005 Flu Clinics | BC Health Services and Phone Numbers | BC NurseLine TeleLinks | BCHealthGuide Online | FHA HPC

Topic Contents

- Overview
- Health Tools
- FAQs
- Important Decisions
- The Dying Process
- After Death
- Other Places to Get Help
- Related Information
- References
- Credits

End-of-Life Care

Overview

What is end-of-life care?

End-of-life care is treatment given to have any more treatment to cure or enhance the quality of your remaining life.

If you choose end-of-life care, you manage the problems you are facing.

Ideally, end-of-life care is compassionate and relief from pain. Caregivers may provide care in a hospital, home, or hospice. End-of-life care focuses on your comfort.

As you prepare for the end of life, your needs must be taken care of, social and financial issues resolved.

The more you and your family members know about end-of-life issues and planning, the better prepared you will be when you are facing death.

What type of end-of-life care choices will I need to make?

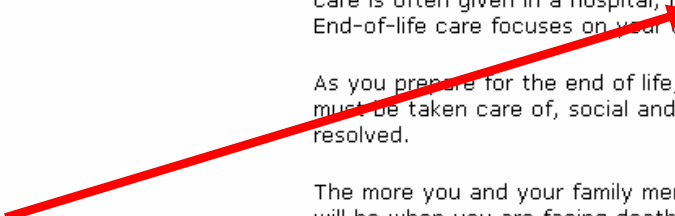
Making decisions about end-of-life issues is one of the most important things you will ever have to do. Many

Alerts - Microsoft Internet Explorer

Alerts

2004-12-29 - End of Life Care

- Call Type: FHA Palliative
- [Advanced Directives/End of Life Planning](#)
- [Bowel Obstruction](#)
- [Caregiver Needs](#)
- [Confusion/Hallucinations](#)
- [Coughing/Secretions](#)
- [Dehydration](#)
- [Death has occurred at home](#)
- [Feeding Tube](#)
- [IV problems](#)
- [Sore Mouth](#)
- [Agitation](#)
- [Bleed/Exsanguination](#)



FH HPC Telehealth

- Developed on call PRN
- Developed call flow process for on call Palliative response nurse
- Developed decision support
- Established communication systems between PRN and all home health offices
- Consistent hours & after hours information across FH 13 Home Care sites
- Created data base of all home health patients that the PRN can access

BCNL and FH project findings: May 2005

- Started Jan 05
 - Approximately 500 potential callers at any time
 - of approximately 750 HPC Home care patients
- 75 calls to BCNL
 - 42% managed by BC Nurseline only
 - 58% referred to FH Palliative Response Nurse
- Average 4.2 calls per week
 - 60% 2000-2400 & 0600-0800

Triage results of calls

Acute 30%

- Immediate care (911): 9%
- As soon as possible: 21%

Emergent 16%

- Care within 12 hours: 13%
- Care within 24 hours: 3%

Home treatment: 25%

Last days/death 28%

- Last days: 18%
- Death at home: 10%

Case Study: New symptom – Not end of life – triage as normal

- Man with pancreatic cancer
 - Vomited brownish blood on pillow – size of washcloth
 - Pain more severe than normal when walking
 - Increased weakness

 - New symptom / DNR – not signed
 - 911 triage
 - Plan – will call friend to take patient to ER

 - Limitation: No DNR signed, 911 disposition, not transferred to FH PRN, as need to maintain highest level of safety for patient and not delay care in potential emergency.

Case Study: New symptom with DNR

- Man with thyroid cancer with lung mets
- DVT left leg, fracture left femur, brain tumor
- Blue big toes (rt & lt), feet cold, fingers cold

- DNR signed. Goal – home death.
- Disposition – 911
- Transfer caller to FH PRN (versus transfer to ER)
 - No further intervention/investigation wished. Did not want to go to hospital again.
- Review FH patient summary, further assessment re distress, goals. Provided reassurance, anticipatory guidance.
 - Home care visit next morning
 - 24 hours: still at home

Expected symptom – Red

- Woman with severe abdominal pain- unrelieved with passing gas/BM
- Fentanyl patch and prn Morphine: has taken breakthrough as ordered already – little relief
- Dizzy & weak, able to get out of bed & go to bathroom
- Nauseated, taken Gravol with HS meds
- No DNR
- Q: What can I do for abdominal pain?
- Disposition: As soon as possible care (Red)
- Action: Transfer to FH PRN

Expected symptom – Red

FH PRN

View patient information, complete additional assessment

Noted: Breakthrough amount – small compared to dose of Fentanyl patch

Instructed to take another breakthrough now, pain easing in 20 minutes – patient now comfortable/reassured, nausea improved with pain reduction. Reinforced to take breakthrough q1h as needed.

Home care to follow-up in am. (written notes faxed & verbal message)

Patient stayed home. (versus directed to see doctor immediately – at night = ER visit)

24 hours: still at home

Communication to HPC team - Yellow

- Woman with breast cancer
- Problems passing urine
 - Frequency with little urine produced
 - No fever, no pain with urination
 - Hx – in hospital with similar symptoms. Foley in hospital, removed, no problems for last week at home
 - Up and around (assumption – not in last days)
 - Disposition – seen within 12 hours, Plan see Dr. in am
 - BCNL – increased fluids, reassurance, information – indications for worsening scenario
 - Fax to Home care nursing for follow-up

Symptom - Last days of life

- Woman with late stage breast cancer, spread to liver and lungs, DNR in place
- Vomiting once a day for last week
- Physician aware, medication plan. Home care visiting/calling daily.
- Vomited 15 minutes after taking Gravol. Can she have Gravol suppository?

- Disposition – no need to triage symptom. Provided advise from frequently asked questions. Vomited tablet medication – if vomited within 15 minutes of dose, may repeat.

Symptom - Last days of life

- Referred to FH PRN –
 - Caller reassurance needed.
 - Pharmacy line transfer not an option as do not give direction in this situation. BCNL – without protocols in place would not have been able to give this direction in this situation.

- FH PRN –
 - Directed to give supp / family reassured. Family managing high level of acuity at home.

FH Access to Physician Advice

- Patient taking 150 mg Methadone q8h by rectal route (0600, 1400, 2200). Methadone 50 mg prn. No longer swallowing. In last days of life.
- Wife gave Methadone dose at 1 am, thinking it was 0600 am.
- What to do now?

- Medication question – no resource – Transfer to FH PRN

Access to specialized direction – beyond scope of Nurse Line

- FH PRN – view patient information in data base.
 - Reassurance – no ill effect for patient.
 - Reviewed potential for death during night, if death occurs will be unrelated to medication dosing. (reassurance)
 - Hold 6 am dose
 - Wait for Home care nurse call in am for next dosing.
 - Use PRN methadone as usual in interim if in pain.
 - Call to MOCAP physician. Medication direction reinforced direction given, relayed to Home care for communication to patient in am. Resume normal dosing at 2pm dose.

Case Study: Death at home

- My wife just died, and we have a signed DNR. What should I do?
 - BCNL – refer to alert & advised caller
 - 5 of 7 calls at time of death – required further reassurance from PRN, in first 4 months. More calls managed now by the BCNL independently.
 - **Avoided calls to 911/ambulance**

Key Message:

Although the timing of a death can be expected or unexpected, when you have a signed a 'No CPR' or 'No DNR' form in the home, the same instructions are followed.

Both Registered Nurses and Physicians can pronounce death.

In some areas, funeral home requires that the body has been pronounced before they will transport the body from the home.

The family may have instructions re how to contact the physician.

So check with your chosen funeral home –

contact physician or home care nurse during home care hours.

Nursing Action:

Families need extra emotional support at the time of death.

What to do at the time of Death?

The same instructions apply whether the patient has a signed a "No CPR" or DNR

- No immediate action needs to be taken.

- The time of death is an intimate time for those present

- If the person is alone with the dead body,

- they may want to call a friend/other family/ spiritual support person to be with them

- Typically, a plan for time of death has been developed

- and discussed and should be supported where possible

Pronouncing Death

If pronouncement is required, the family should call their physician or they can call the Home Care nurse to come to the home during home care hours

If the death occurs during the night and a physician is not available to pronounce, the family should be provided emotional support and told that they can wait until the morning to contact the home care nurse or their family physician to come to the home to pronounce the body

Distress

If the caller is very distressed, then transfer the call to the FHA PRN.

Originator: FHA HPC Dr. Barwich & Della Roberts RN MSN

Date: Sept 1, 2004

Application to Saskatchewan Case

- Initial call – sharp stabbing chest pain. (Ambulance transfer) **If registered patient, known pain – refer to after hours HPC**
- Suicide ideation with medications – (Mental health/Ambulance transfer) **Referral to after hours HPC**
- No pain medications left /no prescription – (No recommendation) **Refer to after hours HPC**
- Seizure – new symptom – To ER – **Same**
- Multiple calls for pain – Complex caller – **Create care plan with FH HPC team**

Lessons learned

- BCNL – very different calls for nurses
 - 1 FH HPC call of 900 calls/day
 - Discomfort of BCNL staff in managing calls with such emotional overtones.
 - Confidence builds over time, but requires ongoing reinforcement
 - Areas of improvement:
 - Call Flow refined into 4 major areas: expected, new, last days of life & death at home
 - Pain crisis – continued development to go directly to transfer
 - On line resources for ongoing learning
- FH -
 - Able to manage all after hours resource across 13 communities with 1 RN on call 2100-0800. (Visits are not required, they are based on the decision of the PRN - 2 visits in 43 calls).
 - Challenge to incorporate on call efficiently into the FH HPC delivery system & have attractive positions for nurses with appropriate skill – achieved by HPC CRN on call.
 - Challenge to establish the same after hours processes across 13 different home health sites
 - Areas of improvement:
 - Direct admission to Hospice/Tertiary.
 - Increase consultation role of the HPC Physicians on call.