ED Comfort Care Transitions

AAEM Palliative Care Interest Group

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Rephrasing Comfort Care as an Aggressive Intervention

Offering an alternative approach of "aggressive comfort care," meaning attentive medication titration for symptom management, may help families feel assured that their loved ones are receiving the best care possible. Similarly, there is never "nothing more that can be done"; emergency physicians and staff can always make mitigate suffering, both physical and psychological, and for both patients and their surrogates. Families will remember that they chose "aggressive care" instead of "pulling the plug." Word choice matters in creating the narrative that families carry with them after the ED.

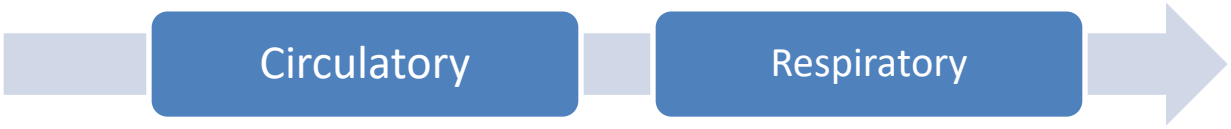
Avoid these phrases	Better phrases to use
"Do you want us to do everything possible?" "Would she want heroic measures?"	"What is most important to your loved one right now?" "What were they like before the illness?"
"Do you want us to push on her chest, use electricity, and put her on a breathing machine?"	"Based on what you've told me about her, do you think she would want to die a natural death?"
"I wouldn't want this for my mother."	"Tell me about your mother."
"There is nothing more we can do."	"May I suggest another option?" "We will aggressively make her comfortable."

Symptom Management

SYMPTOM	THERAPY	DOSE	TIPS
Pain or dyspnea	Opioids	Double IV bolus dose q10min prn	Infusions require 5 half-lives (10+ hours) to reach steady-state effect
Dyspnea	Midazolam	2-5mg IV q5min prn	Second-line
Terminal delirium	Haloperidol	0.5-2mg IV q1hr	
	Lorazepam	0.5-1mg IV q30min prn	
Nausea/ Vomiting	Haloperidol	0.5-2mg IV q1hr	Second-line
Terminal secretions	Glycopyrrolate	0.4mg IV q1hr prn	Give 1hr prior to extubation Does not dry up existing secretions, only prevents further

- Opioid infusions take too long to be effective in the ED
- Appropriate opioid titration to comfortable breathing does not expedite death (no "double effect")
- Terminal delirium is often under-recognized and usually precedes the patient's ED presentation

Order of Intervention De-Escalation



DC IVF, pressors, and mechanical support because cerebral hypoperfusion reduces dyspnea. (exception can be made if families wish to restore patient's "natural face" prior to death)

- IVF doesn't make "softer landings"; it prolongs the dying process
- Place ring magnets over AICDs; native pacemaker function is negligible
- LVADs can be disconnected by removing battery or disconnecting driveline from controller unit. Ensuing symptoms may mirror flash pulmonary edema from acute heart failure. Bolus meds **in advance** anticipating dyspnea/anxiety because reduced drug circulation thereafter leads to unpredictable and delayed times to effect.

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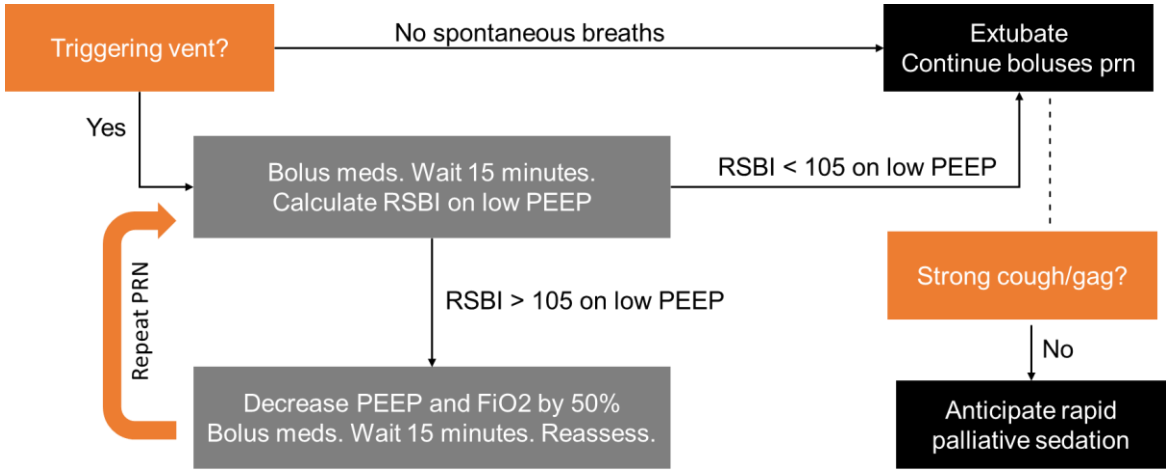
Compassionate Extubation (or BiPAP removal)

Two key questions: Does the patient trigger breaths? Is there a cough or gag?



- Use interdisciplinary checklist to ensure that nursing staff and respiratory therapy coordinate next steps
- Absence of cough/gag in conscious patient indicates likely aspiration. Airway edema or obstruction may also indicate imminent airway loss. Be prepared for palliative sedation with rapid and large boluses of opioids/benzos, or even induction agents (propofol, etomidate, barbiturates, etc.)

Team-Based Support and Disposition

- Liberalize visitation policy. Turn off monitors, vitals, and alarms (prn remote tele). Signage on door.
- Reassess to prevent sense of abandonment (and increases family satisfaction).
- Offer social work and chaplaincy support early
- Consider protocols for medication titration by nurses and short-stay transfer'