Advanced Care Planning and Palliative Care Consultation in Acute Care Surgery

Purpose

To engage injured or ill patient's and/or families in discussions regarding goals of care and advanced care planning early and provide guidelines for Palliative Care consultation to assist in facilitating discussions surrounding goals of care and expectations of recovery following injury.

Background/Definitions

Injury and illness is sudden, unpredictable and often life-altering. Patients and families display a variety of reactions after trauma and understanding the patient's pre-existing psychosocial functioning is imperative to providing complete holistic care. Palliative care consultation can be a helpful service to patients by providing in depth discussion on goals of care related to prognosis and patient preferences, transitional planning, family support and symptom relief management.

Inclusion Criteria

- Age 55 years old or older
- ICU or SDCC admission (all ages)
- Multisystem injuries, specifically an upper and lower extremity injury
- >5 comorbidities
- Or provider discretion (consider things like homelessness, mental health, low social support, challenging injury)
- Should be done once in the inpatient setting- ie. Should not be done upon injury/in ER

Exclusion Criteria

- No absolutes

Diagnostic Evaluation

Patients should be assessed per ATLS guidelines with labs, imaging, consults, and interventions as deemed necessary by trauma team to determine extent of injuries, co-morbid conditions, and

general prognosis.

Similarly, emergency general surgery patients should be evaluated and managed as deemed appropriate for the current clinical status/diagnosis.

Practice Recommendations for Management

All acute care surgery patients: WITHIN 24 HRS OF ADMISSION

- An advanced care planning discussion should be held with patients (and/or the patient's decision-making proxy) admitted to the trauma or emergency general surgery services within 24 hours of admission.
    - For patient's less than 19 years of age, discussions should occur with the patient's legal guardian/parent.
- This initial advanced care planning discussion should be led by an acute care surgery service provider (physician or APP).
- The initial advanced care planning discussion should address the following:
    - Code status
    - Identification of health care proxy and decision maker in event patient is unable to make decisions.
    - Identification of any advanced directives
    - Prognostication based on patient's injuries, co-morbid conditions, and clinical status.
    - Goals and expectations throughout hospitalization and upon discharge.
    - Frailty assessment in all patients >60 years of age (see Table 1) or in younger patients who have more than 5 pre-existing chronic medical conditions
    - Palliative care consultation screening (see Table 2)
    - Palliative care consultation indicated/not indicated
- All advanced care planning discussions should be documented in the electronic medical record under the note type "advanced care planning".
    - Note template: .ACSACPINITIALACPDISCUSSION
- Please use the ACP as an opportunity for a therapeutic discussion about the patient's injuries and prognosis, and likely need for additional support. The goal should be to help explain the patient's injuries, and guide expectations. If they are likely to need a facility, you can set the expectation that they may not go home, but give them encouragement to return home.

Triggers for Palliative Care Consultation based on initial advanced care planning discussion:

- Palliative care consultation should be considered if any of the following are present:
    - Positive palliative care screen (Category 1 or 2)
    - Frailty score greater than 3 (based on Frail Questionnaire, Table 1)
    - Pre-existing end-stage or terminal condition
    - A diagnosis with median survival less than 6 months
    - Death expected during same ICU/hospital stay
    - GCS<8 for greater than 1 week in patients >55 yrs.
    - Multi-system organ failure

    - Family disagreement with team, advanced directive or each other (lasting >2 days)
    - Futility considered or declared by the medical team.
    - Family request
    - Acute Care Surgery attending discretion
- Palliative Care consultation ideally should occur early in patient's hospital course with a goal of assessing and managing the patient via "palliative care bundle" (see Table 3) within 72 hours of admission.

Triggers for Geriatrics Consultation for trauma patients based on initial advanced care planning discussion:

- All patients >75 years of age at admission
- Age 65-75, consider geriatric consultation if conditions listed below are present:
    - dementia
    - 10 or more home prescription medications
    - 2 or more ED visits or inpatient admission in past 6 months
    - not living independently or residents of nursing homes or assisted living facilities
    - provider discretion
- in cases where patient's meet criteria for both Geriatrics and Palliative Care consultation:
    - Request consultation of both services. Geriatrics will primarily assist with geriatric medical conditions, whereas Palliative Care will primarily assist with advance care planning/goals of care.
    - This should occur with ongoing communication between Geriatric Medicine, Palliative Care and Trauma teams.

Triggers for Family Meeting WITHIN 72 HRS OF ADMISSION

- All Category II patients require a family meeting within 72 hrs of admission.
- Any patient lacking an advanced directive or healthcare proxy AND potential for challenging hospitalization or disposition.
- Family meeting may be led by Palliative Care, Geriatric Medicine or Trauma.
    - An acute care surgery provider should be present for this discussion regardless of who leads the meeting.
- This advanced care planning discussion should be documented in the electronic medical record under the note type “advanced care planning”.
    - Note template: .ACSACPFOLLOWUP
- The 72hr family meeting/follow-up discussion should address the following:
    - Update on patient’s current clinical status with prognostication based on patient’s injuries, co-morbid conditions, and clinical status.
    - The patient and/or family’s insight into the current problem(s).
    - Hopes and fears for current hospitalization.
    - Focused care plans based on patient’s injuries, co-morbid conditions, and clinical status (i.e. best case scenario, more-likely scenario, worst case scenario) with a set time-frame for when we will re-evaluate the situation.

    - This should also include potential “what if’s” (e.g. trachs, PEGs/Feeding tubes, etc)

Follow-up Care

- Significant changes in a patient’s clinical status, should prompt additional advanced care planning discussions as needed.
- If consulted, palliative care will continue to follow the patient throughout his/her hospital course as indicated.

Outcome Measures and Guideline Adherence

- Timing and documentation of initial advanced care planning discussions will be monitored on 80% of all trauma patients
- Timing and utilization of palliative care services will be monitored on all trauma mortalities and hospice/CMO discharges.
- Pathway will be re-assessed following a 3 month pilot study.

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References

1. American College of Surgeons. Trauma Quality Improvement Program Palliative Care Best Practice Guidelines. https://www.facs.org/media/g3rfegcn/palliative_guidelines.pdf
2. American College of Surgeons. Trauma Quality Improvement Program Geriatric Trauma Management Guidelines. https://www.facs.org/media/314or1oq/geriatric_guidelines.pdf
3. Fiorentino M, et al. Palliative care in trauma: Not just for the dying. *J Trauma and Acute Care Surg.* 2019:87(5):1156-1163.

Appendix and Supplemental Materials

Figure 1. Model for advanced care planning discussions and consultation of palliative care in trauma.

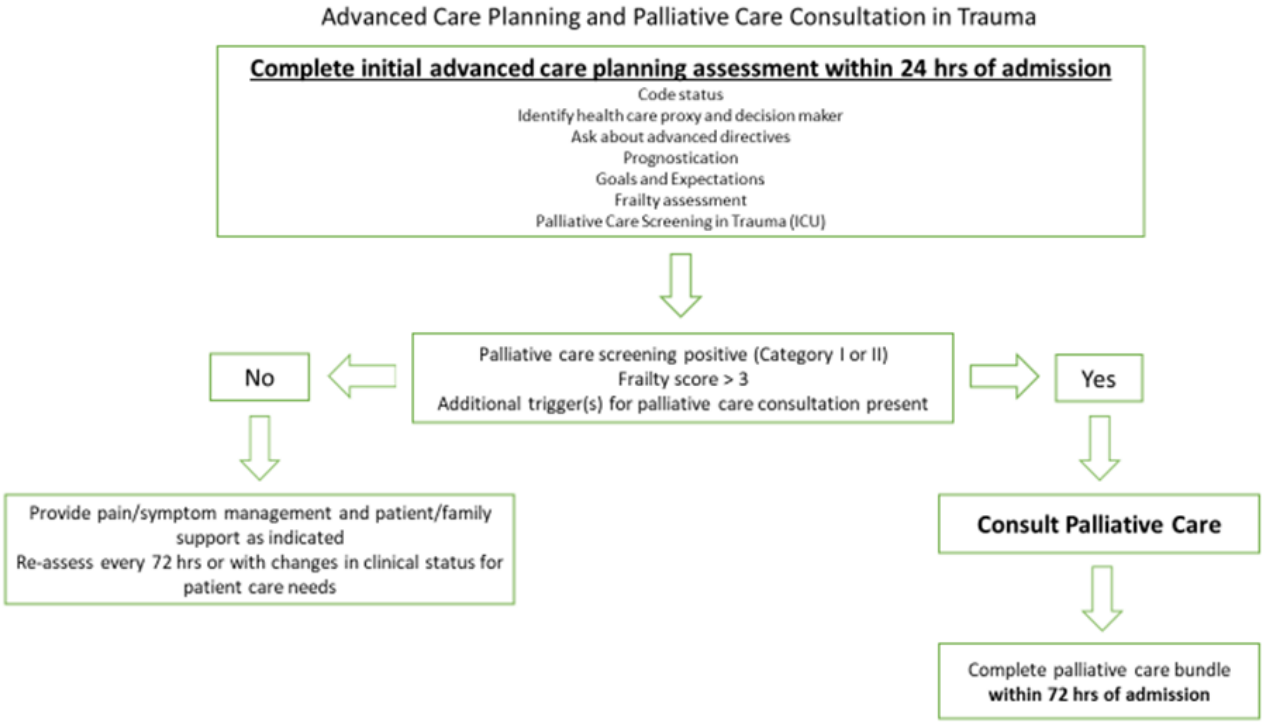


Table 1. 5 item FRAIL Questionnaire

F: Fatigue	Does the patient fatigue or get exhausted easily?
R: Resistance	Does the patient have difficulty walking up one flight of stairs independently?
A: Ambulation	Does the patient have difficulty walking one block (several hundred yards)?
I: Illnesses	Does the patient have 5 or more illnesses (comorbidities, including hypertension, diabetes, cancer [other than minor skin cancer], chronic lung disease, heart attack, congestive heart failure, angina, asthma, arthritis, stroke, and kidney disease)?
L: Loss of weight	Has the patient lost weight (5 to 10 percent) over the last six months to one year?

- 3 or more "Yes" answers indicates possible frailty
- 1 to 2 "Yes" answers indicates possible pre-frailty

Source: Morley JE, Malmstrom TK, Miller DK. A simple frailty questionnaire (FRAIL) predicts outcomes in middle aged African Americans. *J Nutri Health Aging*. 2012;16(7):601-608.

Table 2. Palliative Care Screening in Trauma

	Negative Screen	Category 1: Positive Screen	Category 2: Positive Screen
Traumatic Injury Severity	Non-life-threatening injuries	Potentially life-threatening injuries	Anticipated high risk of hospital mortality due to injury
Disability	Non-disabling trauma injuries	Potentially disabling injuries	Permanent disability or functional outcome incompatible with patient's wishes
Previous Functional Status	Healthy, no serious chronic illness	One or more serious illness, frailty, older age	Chronic serious illness, frailty, older age
Surprise Question	Surprise question: YES	Surprise question: MAYBE or NO	Surprise question: NO
Example: Young Patient	Young with… • Multiple fractures • Mild TBI • Abdominal GSW • Pneumothorax	Young with … • Spinal cord injury • Moderate TBI • Amputation • Any trauma plus shock	Young with… • Severe TBI • High spinal cord injury • Major hemorrhage • Multiple amputation
Example: Older Patient		Older or chronically ill with… • Mild TBI • Multiple fractures • Chest trauma • Low spinal cord injury	Older, frail, or end organ failure with… • Mild TBI • Multiple rib fractures • Any spinal cord injury • Any injury requiring surgery

Adapted for trauma patients from: Weissman DE, et al. *Patient Screening and Conversation Categories, Improving Generalist palliative care for hospitalized seriously ill patients.* The Palliative Care Network of Wisconsin. Available at: https://www.mypcnow.org/about1-c22s6. Accessed May 3, 2017.

*Surprise question example: "Would you be surprised if the patient died in the next 12 months?"

Table 3. Palliative Care Bundle

ALL Trauma Patients within the First 24 hours	CATEGORY I: Trauma Patients with a Positive Screen Within 72 hours	CATEGORY II: Trauma Patients with a Positive Screen Within 72 hours
• Identify health care proxy • Identify existing advance directives • Identify whether a DNR order or POLST exists	• Advance care plan • Goals of Care Conversation • Code status discussion	• Consider comfort measures • Consider focused Goals of Care Conversation • Consider DNR order and withdrawal of life-sustaining therapy
• Assess and treat pain, manage symptoms • Support the family	• Assess and treat pain, manage symptoms • Support the family	• Assess and treat pain, manage symptoms • Support the family • Offer bereavement, spiritual support
• Continue with full trauma care unless outcomes are clearly inconsistent with patient wishes	Care plan options: • Time-limited trials • Palliative care consultation	Care plan options: • Hospice • Transitions in care • Organ donation
• Begin palliative screen with prognostication based on injuries, frailty, and possible outcome(s); apply "surprise question"		

Guideline Algorithm

Advanced Care Planning and Palliative Care Consultation in Trauma

ALL TRAUMA ADMISSIONS

An advanced care planning discussion led by trauma provider to be held with all patients (and/or the patient's decision-making proxy) admitted and documented within 24 hours of admission.

This advanced care planning discussion completed before 24 hrs should be documented in the electronic medical record by trauma provider under the note type "advanced care planning" using .ACSINITIALACPDISCUSSION

- Code status
- Identification of health care proxy and decision maker in event patient is unable to make decisions.
- Identification of any advanced directives
- Prognostication based on patient's injuries, co-morbid conditions, and clinical status.
- Goals and expectations throughout hospitalization and upon discharge.
- Frailty assessment in all patients >60 years of age (see Table 1) **or** younger patients who have more than 5 pre-existing chronic medical conditions
- Palliative care consultation screening (see Table 2) where Surprise question is: "Would you be surprised if the patient died in the next 12 months?"
- Yes/no if patient triggered for Palliative Care consultation

Table 1: Frailty Assessment

F: Fatigue	Does the patient fatigue or get exhausted easily?
R: Resistance	Does the patient have difficulty walking up one flight of stairs independently?
A: Ambulation	Does the patient have difficulty walking one block (several hundred yards)?
I: Illnesses	Does the patient have 5 or more illnesses (comorbidities, including hypertension, diabetes, cancer [other than minor skin cancer], chronic lung disease, heart attack, congestive heart failure, angina, asthma, arthritis, stroke, and kidney disease)?
L: Loss of weight	Has the patient lost weight (5 to 10 percent) over the last six months to one year?

- 3 or more "Yes" answers indicates possible frailty
- 1 to 2 "Yes" answers indicates possible pre-frailty

Source: Morley JE, Malmstrom TK, Miller DK. A simple frailty questionnaire (FRAIL) predicts outcomes in middle aged African Americans. *J Nutri Health Aging.* 2012;16(7):601-608.

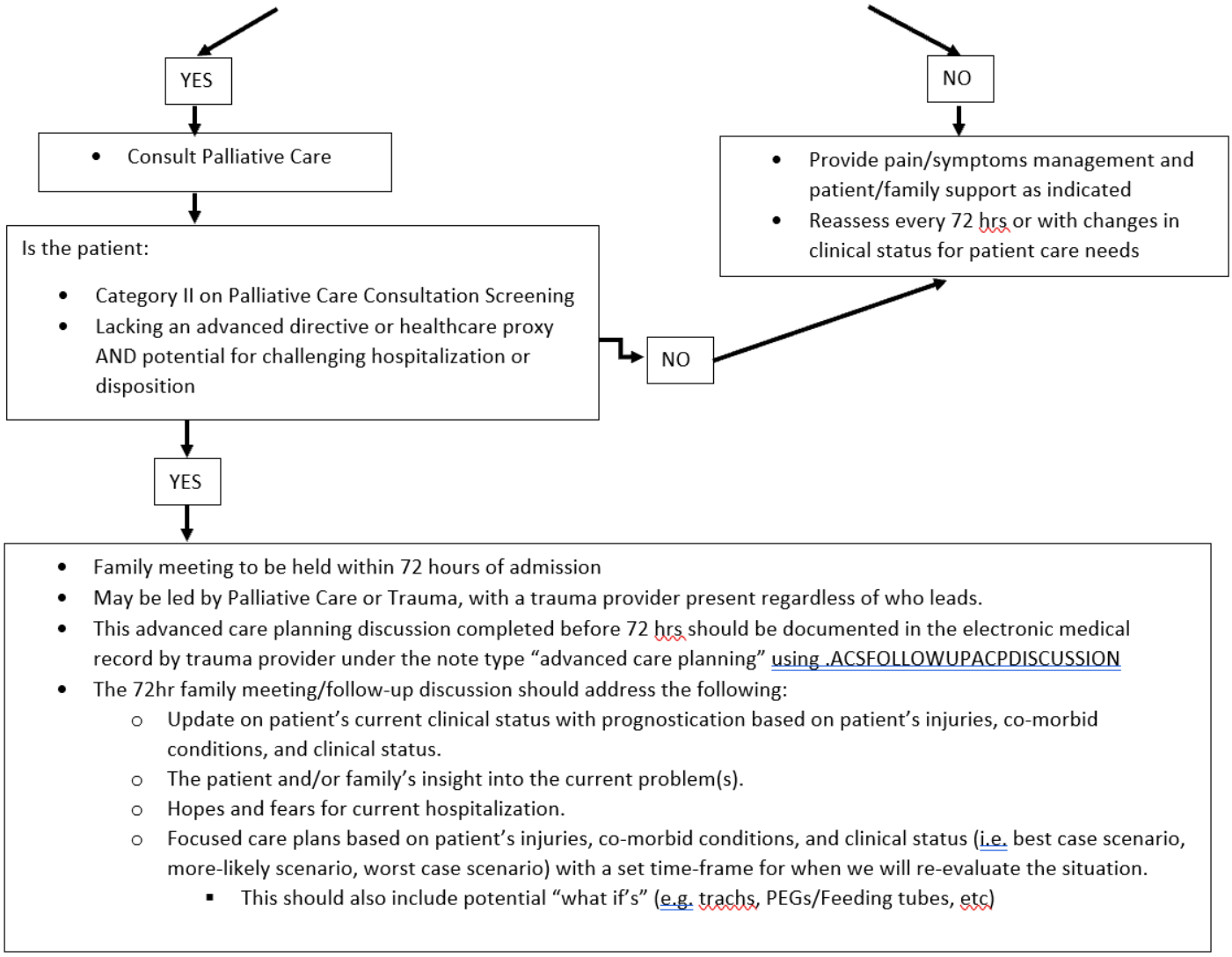
Table 2: Palliative Care Consultation Screening

	Negative Screen	**Category 1: Positive Screen**	**Category 2: Positive Screen**
Traumatic Injury Severity	Non-life-threatening injuries	Potentially life-threatening injuries	Anticipated high risk of hospital mortality due to injury
Disability	Non-disabling trauma injuries	Potentially disabling injuries	Permanent disability or functional outcome incompatible with patient's wishes
Previous Functional Status	Healthy, no serious chronic illness	One or more serious illness, frailty, older age	Chronic serious illness, frailty, older age
Surprise Question	Surprise question: YES	Surprise question: MAYBE or NO	Surprise question: NO
Example: Young Patient	Young with… • Multiple fractures • Mild TBI • Abdominal GSW • Pneumothorax	Young with … • Spinal cord injury • Moderate TBI • Amputation • Any trauma plus shock	Young with… • Severe TBI • High spinal cord injury • Major hemorrhage • Multiple amputation
Example: Older Patient		Older or chronically ill with… • Mild TBI • Multiple fractures • Chest trauma • Low spinal cord injury	Older, frail, or end organ failure with… • Mild TBI • Multiple rib fractures • Any spinal cord injury • Any injury requiring surgery

Adapted for trauma patients from: Weissman DE, et al. *Patient Screening and Conversation Categories, Improving Generalist palliative care for hospitalized seriously ill patients.* The Palliative Care Network of Wisconsin. Available at: https://www.mypcnow.org/about1-c22s6. Accessed May 3, 2017.

Based on first assessment (within 24 hrs of admission), are any of the following true?

- Palliative care screening positive for Category II or III
- Frailty score > 3
- Pre-existing end-stage or terminal condition
- A diagnosis with median survival less than 6 months
- Death expected during same ICU/hospital stay
- GCS<8 for greater than 1 week in patients >55 yrs.
- Multi-system organ failure
- Family disagreement with team, advanced directive or each other (lasting >2 days)
- Futility considered or declared by the medical team.
- Family request
- Acute Care Surgery attending discretion



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