Evaluation

- For **the Provincial Stroke Rounds Planning Committee**:
  - To plan future programs
  - For quality assurance and improvement
  - To demonstrate compliance with national accreditation requirements
- For **You**: Reflecting on what you've learned and how you plan to apply it can help you enact change as you return to your professional duties
- For **Speakers**: The responses help understand participant learning needs, and teaching outcomes, opportunities for improvement.

New ONLINE Evaluation

http://bit.ly/PSREval

Please take 2 minutes to fill the evaluation form out.

Thank you!

Mitigating Potential Bias
(Planning Committee)

The Provincial Stroke Rounds Planning Committee mitigated bias by ensuring there was no Industry involvement in planning or education content.

To comply with accreditation requirements of the College of Family Physicians of Canada and The Royal College of Physicians and Surgeons of Canada, speakers were provided with Declaration of Conflict of Interest forms, which were reviewed by the Ontario Regional Education Group (OREG) Host member on behalf of the Planning Committee and submitted to the NOSM CEPD Office.

The Ontario Regional Education Group (OREG) Host member on behalf of the Planning Committee reviewed the initial presentation supplied by the speaker to ensure no evidence of bias.

Palliative care needs of stroke patients & families:

Practical approaches to improvement

Jeff Myers MD, MSEd, CCFP(PC)

November 1, 2017

Disclosure

- Jeff Myers
- No relationships with commercial interests

Disclosure of Commercial Support

- This program has not received support of any kind
- No conflicts of interest to disclose

Objectives

1. Discuss palliative & end-of-life care needs of patients/families prior to and following a stroke
2. Describe practical approaches to end-of-life communication & decision-making
3. Outline practical strategies for improving the stroke patient/family palliative & end-of-life care experience

Of every 100 people who have a stroke:

Quality end-of-life experience

Effective advance care planning

Palliative and End-of-Life Care

- Stroke remains 3rd leading cause of death in Canada
- Evidence of unmet needs in stroke patients who are at end of life (EOL):
  - family involvement with decision making
  - family being told when death was imminent
  - symptom control

Practical Strategies: Improving End of Life

1. Palliative care approach: used when stroke is catastrophic or significant pre-existing comorbidity:
   - optimize care for these patients, their families & caregivers
2. Regular communication to ensure needs are being met

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3. Referral process to specialist palliative care services
4. Referral process to spiritual care services
5. Communication training: supporting patients with poor prognoses and families
6. Integrate "palliative care protocols" (EOL pathways) into ongoing care delivery

10

Palliating Symptoms at End-of-Life

Need only 3 meds

Medication Class	Symptoms Treated	Drugs and Starting Doses
Opioid	Pain Dyspnea	Morphine 2.5 – 5 mg subcut q1h prn OR Hydromorphone 0.5-1 mg subcut q1h prn
Neuroleptic	Delirium Nausea	Methotrimeprazine 6.25-12.5mg subcut q4h prn OR Haldol 1-2 mg subcut q4h prn
Anticholinergic	Upper Airway Secretions	Glycopyrrolate 0.2-0.4 mg subcut q2h prn OR Scopolamine 0.3 -0.6mg subcut q1h prn

Sunnybrook
HEALTH SCIENCES CENTRE
PHYSICIAN'S ORDERS
Comfort Measures for Imminently Dying Patients

DATE: YYYY / MM / DD TIME (h): PATIENT IDENTIFICATION

See Inpatient Allergy Record | No Known Allergies | Allergies: | SIGNATURE OF NURSE

COMPLETE ABOVE ALLERGY BOX AT TIME OF INITIAL ORDERS

YES | NO | Physician Must Check Off Appropriate Orders

IMPORTANT
If at any time the GOALS OF CARE change or the patient is no longer deemed to be imminently dying, each order must be reassessed and new orders written as required.

1. Ensure "No Cardiopulmonary Resuscitation Order Set PR 14187" is complete.

Patient and Family Education

2. Provide patient and family with information and support resources:
   - "What to Expect in the Last Hours of Life" booklet

Investigations

3. Discontinue all lab work
4. Discontinue all imaging

Monitoring

5. Comfort assessment q2h and prn (see back of order sheet)
6. Discontinue vital signs
7. Discontinue O_2 saturation monitoring
8. Does patient have an internal cardiac defibrillator (ICD device)? ☐ Yes ☐ No
   If yes, ICD 'shock' therapy to be disabled
   Call Pacemaker Clinic (ext. 1555) Mon - Fri between 0900 - 1700 hrs
   *After hours – see back of order sheet for instructions

Interprofessional Referrals (please indicate reason for referral)

9. Spiritual care (pager # 7139)
10. Palliative care consult team
11. ☐ Nutrition for
    ☐ Social work for
    ☐ Clinical ethics for
    ☐ Other:

Physician's Signature: PRINT NAME: Pager:

QDI: Phase 2

Comfort at EOL

- Standardized Practices
  - Comfort Measures Order Set
  - No CPR Order Set
  - Comfort Measures Assessment
- Family Member Education:
  - Standardized Info
- Professional Development & support for Clinical Staff
  - Multiple educational modalities
- Evaluation, feedback, CQI and metrics

Palliative & EOL Care Indicators
Advance Care Planning Indicators

1. % of stroke pts who have participated in ACP or who have a documented conversation with an HCP about resuscitation, hydration or feeding preferences
2. % of stroke pts identifying substitute decision-maker
3. % of stroke pts who complete a personal or advance care directive documented on their chart

"…process through which a patient, in consultation with HCPs and family members, makes pre-determined decisions regarding their healthcare in the event they should become incapable of participating in decision making at a later time.

Often in patients with stroke, the direction of these decisions is unclear for the family when the patient is unable to participate in decision making."

"…primary goal of ACP conversations is to determine the individual's goals of care"

Effective ACP leads to…

- Improved patient & family experience
- Less caregiver distress and trauma
- Fewer unwanted investigations, interventions & treatments
- Fewer unwanted hospitalizations & critical care admissions
- More likely to be cared for in preferred setting
- A health care system that can be sustained

This was not always the case…what changed?

- …discussion of the patient's preferences and the medical appropriateness of therapies such as:
  - feeding tubes
  - hydration
  - treatment of the current illness
  - admission to intensive care
  - ventilation
  - cardio-pulmonary resuscitation

For most, this approach will not be the most effective route to decision-making

Person Centred Decision-Making

Person Centred Decision-Making

Advance Care Planning

- In Ontario, ACP is part of the Health Care Consent Act, BUT,

ACP ≠ Consent for Treatment

- Health care professionals must obtain informed consent from the appropriate person BEFORE providing treatment
  - Capable patient
  - SDM if the patient has been found incapable

Consent

- Consent comes from a CAPABLE PERSON
  - Person <u>OR</u> the person's SDM(s)
- NOT a document or any form of ACP
- Consent is required for EACH offered treatment or plan of care
- Informed consent - risks, benefits, side effects, alternatives, what happens if patient refuses treatment

Capacity

- Determine if a person is CAPABLE i.e. has the CAPACITY to make a decision about consent for a treatment

Definition of Capacity:

- Ability to UNDERSTAND the information relevant to decision about treatment

AND

- Ability to APPRECIATE the reasonable foreseeable consequences of a decision

Substitute Decision Maker Hierarchy

Confirm automatic SDM(s)

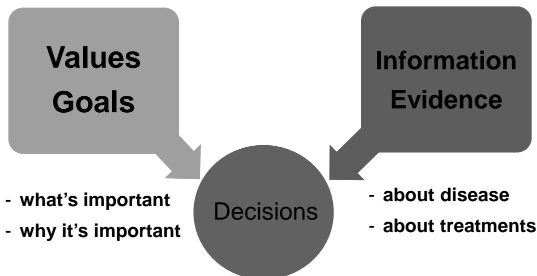
OR

Choose SDM(s) and Complete document e.g. Power of Attorney for Personal Care

Court Appointed Guardian
Attorney for Personal Care
Representative appointed by Consent and Capacity Board
Spouse or Partner
Parents or Children
Parent with right of access only
Siblings
Any other relative
Public Guardian and Trustee

The Health Care Consent Act contains a hierarchy that ensures every person has automatic SDM(s)

HOW a person makes healthcare decisions



Two parts of the equation

BOTH are needed to be effective

Values
Goals

- We give lots of information and evidence about disease and treatments
- Often neglect 'person' side of the equation

How can values and goals be applied to treatment decisions?

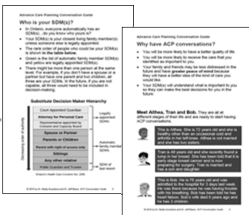
- The following footage is from real ACP conversations with a healthy person, Bernie Halligan
- Following the clips, details of a future scenario will be given. A decision about consent for an offered treatment needs to be made by Bernie's SDM
- YOU are in the role of Bernie's SDM and will need to make a decision about consent for an offered treatment plan

The Halligans

The Halligans

- Bernie & Frances are healthy and ACP conversations occurred for both at the same time
- Focus today is on Bernie
- His perspective is shaped through personal experience and those of family and friends

Bernie & Frances were each provided the "ACP Conversation Guide" ahead of time



Remember…you are Bernie's SDM

What's your understanding of what will be discussed today?

Bernie is asked about his values.

The two most important values to him are family and dignity.

Expanding on dignity, the role of family in providing care is very important to Bernie.

What do you value about family?

What are the mental or physical states you consider intolerable?

What do you consider acceptable?

Bernie expands further.

Bernie stated he “does not want to be kept alive on machines”.

What if machines were used temporarily and there was a chance you would recover?

If you were near the end of your life, what might make it meaningful or peaceful?

Two years later…

Bernie is unconscious in the ED with a ruptured cerebral aneurysm

YOU are his substitute decision maker

His only chance of survival is with neurosurgery

Based on his current status, the neurosurgeon outlines best case scenario with surgery:

Two years later…

- Small chance he'll be able to recognize family members
- Almost no chance he'll be able to tell stories
- Very small chance he'll be able to speak a few words

Do you consent to proceed with surgery?

OR

Do you consent to focus on comfort?

For Bernie, I...

Respond at **PollEv.com/acp2017**

Text **ACP2017** to **37607** once to join, then **A or B**

Answers to this poll are anonymous

- consent to proceed with surgery **A**
- consent to focus on comfort **B**

I rely on the medical profession, they know their job…if doctors feel it's a hopeless case…

'Hopeless' is subjective, open to interpretation and can only be defined by a person

Wants life to end naturally i.e. not hooked up to machines

Hooking me up to machines to keep me going for a couple of days, I don't want that

A 1% chance? Yes, I suppose. You want to live as long as you can

Focus on treatments often leads to confusing and conflicting statements

Broad Statements tend to NOT be helpful to SDMs…

Commonly used
"No heroics and no machines"
"No tubes"
"Do everything"

Helpful to SDMs…

"No heroics and no machines"
"No tubes"
"Do everything"

We gain clarity with Bernie during a follow up ACP conversation

Rachael paints a clear picture of the scenario outcome for Bernie, which helps him becomes clear

Frances, Bernie's SDM, expresses relief about coming to an understanding

A person values potential outcome of a treatment… not the treatment itself

For some, the outcome of losing some degree of physical independence is unacceptable or intolerable

For others, the outcome of losing some degree of mental independence (i.e. cognitive ability) is unacceptable or intolerable

Broad statements are often made in ACP. Most of the time these do NOT help guide decision-making

When a broad statement is made, it should trigger an exploration of WHY

This ensures person's values are part of ACP and a greater likelihood SDMs will have the right information

Advance care planning Conversation Guide

1. What do you understand about your health or illness? What have you been told?
2. What information would be helpful or important to you?
3. What do you value? What gives life meaning?
4. If critically ill, what worries & fears come to mind?
5. What would you be willing to trade for the chance of more of what's important?
6. If you were near the end of your life, what would make this meaningful?

http://www.speakupontario.ca/resource/repository-best-practice-projects-initiatives-ontario/

Three Pearls

1. Relationship build and partner with your local palliative care team to establish and measure the impact of care model
2. Potential outcomes of treatments are more likely to matter to a patient than the treatments themselves.
3. Standardized person-centred advance care planning
   speakupontario.ca (Repository Best Practices)

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Final Remarks

- Return attendance sheets to admin assistant contact at bottom of form (fax or scan)
- CME Certificates will be sent from NOSM if name and email are provided clearly, within 6-8 weeks
- Next Provincial Stroke Rounds:

December 6, 2017 – Southwestern Ontario Stroke Network Hosting

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Or QR Code

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