Changing Level of Care to End of Life for Individuals Appointed to State Guardianship

DEPARTMENT FOR AGING AND INDEPENDENT LIVING (DAIL)

TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Training Objectives

- Define End of Life (EOL) Care.
- Provide an overview of the process of changing the level of care status of an individual under state guardianship to EOL.
- Examine the Physician's Recommendation for End of Life Care form.
- Provide contact information for the DAIL Nurse Consultants.

What is End of Life Care? (EOL)

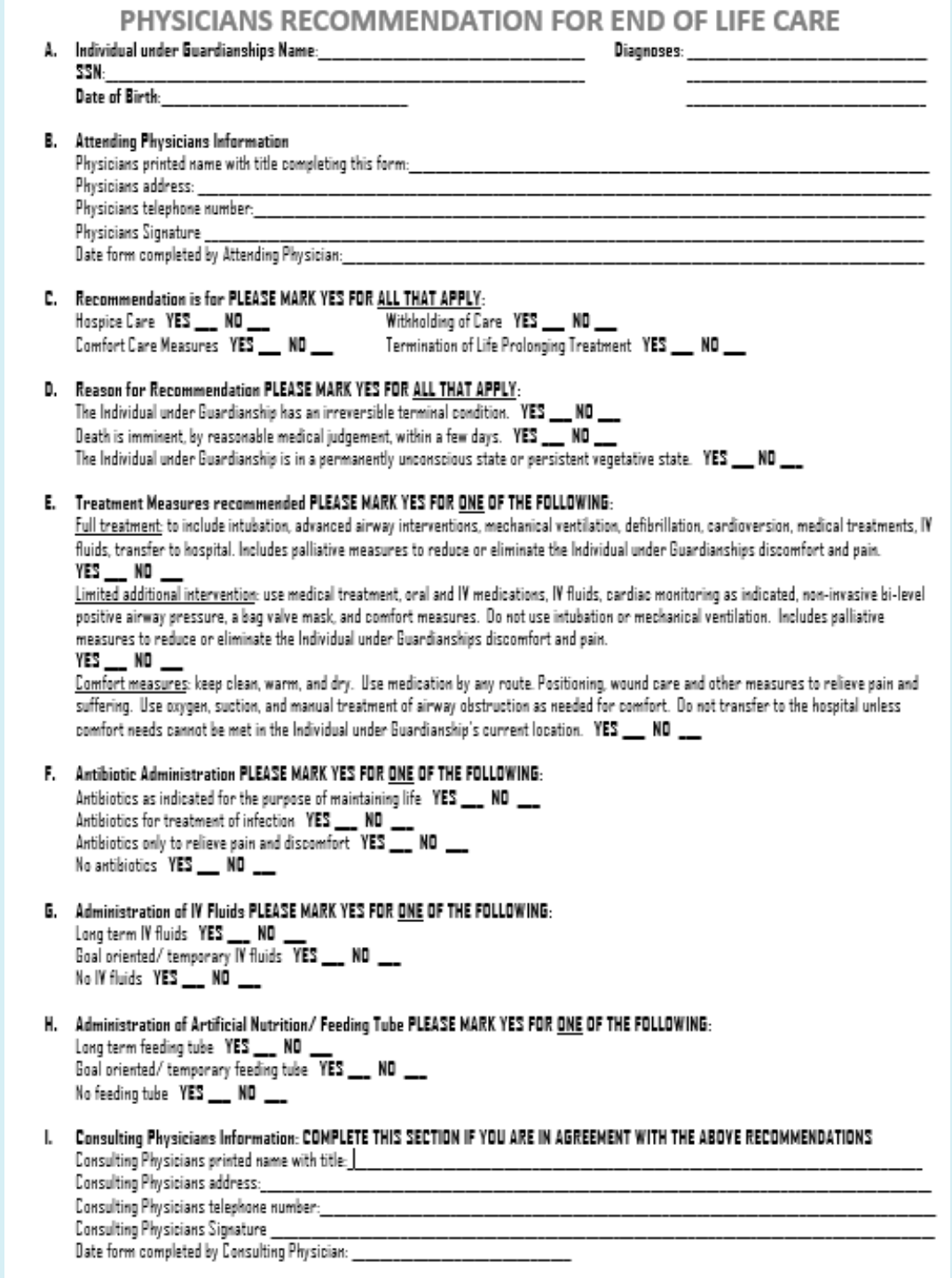
- EOL is a change in the level of care that ends the use of full, aggressive treatment.
- EOL may include the following:
  - Termination of life support
  - Withholding of aggressive, life-prolonging measures
  - Hospice care
  - Comfort measures

Who can recommend EOL?

- Per 910 KAR 2:040, an EOL recommendation must come from two licensed physicians, both of which must be MD or DO.
- Nurse Practitioners **cannot** make an EOL recommendation.

State Guardianship EOL Recommendation Form Overview

*The form and instructions can be found on the Division of Adult Guardianship's website.



PHYSICIANS RECOMMENDATION FOR END OF LIFE CARE

A. **Individual under Guardianships Name:**_____ **Diagnoses:** _____
SSN:_____ _____
Date of Birth:_____ _____

B. **Attending Physicians Information**
Physicians printed name with title completing this form:_____
Physicians address: _____
Physicians telephone number:_____
Physicians Signature _____
Date form completed by Attending Physician:_____

C. **Recommendation is for PLEASE MARK YES FOR ALL THAT APPLY:**
Hospice Care **YES** __ **NO** __ Withholding of Care **YES** __ **NO** __
Comfort Care Measures **YES** __ **NO** __ Termination of Life Prolonging Treatment **YES** __ **NO** __

D. **Reason for Recommendation PLEASE MARK YES FOR ALL THAT APPLY:**
The Individual under Guardianship has an irreversible terminal condition. **YES** __ **NO** __
Death is imminent, by reasonable medical judgement, within a few days. **YES** __ **NO** __
The Individual under Guardianship is in a permanently unconscious state or persistent vegetative state. **YES** __ **NO** __

E. **Treatment Measures recommended PLEASE MARK YES FOR ONE OF THE FOLLOWING:**
Full treatment: to include intubation, advanced airway interventions, mechanical ventilation, defibrillation, cardioversion, medical treatments, IV fluids, transfer to hospital. Includes palliative measures to reduce or eliminate the Individual under Guardianships discomfort and pain.
YES __ **NO** __
Limited additional intervention: use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. Includes palliative measures to reduce or eliminate the Individual under Guardianships discomfort and pain.
YES __ **NO** __
Comfort measures: keep clean, warm, and dry. Use medication by any route. Positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to the hospital unless comfort needs cannot be met in the Individual under Guardianship's current location. **YES** __ **NO** __

F. **Antibiotic Administration PLEASE MARK YES FOR ONE OF THE FOLLOWING:**
Antibiotics as indicated for the purpose of maintaining life **YES** __ **NO** __
Antibiotics for treatment of infection **YES** __ **NO** __
Antibiotics only to relieve pain and discomfort **YES** __ **NO** __
No antibiotics **YES** __ **NO** __

G. **Administration of IV Fluids PLEASE MARK YES FOR ONE OF THE FOLLOWING:**
Long term IV fluids **YES** __ **NO** __
Goal oriented/ temporary IV fluids **YES** __ **NO** __
No IV fluids **YES** __ **NO** __

H. **Administration of Artificial Nutrition/ Feeding Tube PLEASE MARK YES FOR ONE OF THE FOLLOWING:**
Long term feeding tube **YES** __ **NO** __
Goal oriented/ temporary feeding tube **YES** __ **NO** __
No feeding tube **YES** __ **NO** __

I. **Consulting Physicians Information: COMPLETE THIS SECTION IF YOU ARE IN AGREEMENT WITH THE ABOVE RECOMMENDATIONS**
Consulting Physicians printed name with title:_____
Consulting Physicians address:_____
Consulting Physicians telephone number:_____
Consulting Physicians Signature _____
Date form completed by Consulting Physician: _____

A. Individual under Guardianships Name:_____ Diagnoses: _____
SSN:_____ _____
Date of Birth:_____ _____

- Complete **Section A** using the individual's information. All items must be answered, writing must be legible, and the information must be accurate.
- Diagnoses listed must be pertinent to the reason for the EOL recommendation.

B. Attending Physicians Information

Physicians printed name with title completing this form:_____

Physicians address: _____

Physicians telephone number:_____

Physicians Signature _____

Date form completed by Attending Physician:_____

- **Section B** must be completed by the Attending Physician.
- All items must be answered, including physician title (MD or DO) after the printed name.

C. **Recommendation is for PLEASE MARK YES FOR ALL THAT APPLY:**

Hospice Care **YES** ___ **NO** ___ Withholding of Care **YES** ___ **NO** ___

Comfort Care Measures **YES** ___ **NO** ___ Termination of Life Prolonging Treatment **YES** ___ **NO** ___

- In **Section C**, the physician will indicate the recommended end-of-life care measures. Mark all that apply.
- All items must be marked YES or NO.

D. Reason for Recommendation PLEASE MARK YES FOR ALL THAT APPLY:

The Individual under Guardianship has an irreversible terminal condition. **YES __ NO __**

Death is imminent, by reasonable medical judgement, within a few days. **YES __ NO __**

The Individual under Guardianship is in a permanently unconscious state or persistent vegetative state. **YES __ NO __**

- **Section D** addresses the reasons for the EOL recommendation.
- All items must be marked YES or NO.
- At least one item must be marked YES to meet criteria for approval.

E. Treatment Measures recommended PLEASE MARK YES FOR ONE OF THE FOLLOWING:

Full treatment: to include intubation, advanced airway interventions, mechanical ventilation, defibrillation, cardioversion, medical treatments, IV fluids, transfer to hospital. Includes palliative measures to reduce or eliminate the Individual under Guardianships discomfort and pain.

YES ___ NO ___

Limited additional intervention: use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. Includes palliative measures to reduce or eliminate the Individual under Guardianships discomfort and pain.

YES ___ NO ___

Comfort measures: keep clean, warm, and dry. Use medication by any route. Positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to the hospital unless comfort needs cannot be met in the Individual under Guardianship's current location. **YES ___ NO ___**

- **Section E** addresses the treatment recommendation. This section is similar to a Medical Orders for Scope of Treatment (MOST) form.
- One item must be marked YES; the other two must be marked NO.

F. Antibiotic Administration PLEASE MARK YES FOR ONE OF THE FOLLOWING:

Antibiotics as indicated for the purpose of maintaining life **YES** ___ **NO** ___
Antibiotics for treatment of infection **YES** ___ **NO** ___
Antibiotics only to relieve pain and discomfort **YES** ___ **NO** ___
No antibiotics **YES** ___ **NO** ___

G. Administration of IV Fluids PLEASE MARK YES FOR ONE OF THE FOLLOWING:

Long term IV fluids **YES** ___ **NO** ___
Goal oriented/ temporary IV fluids **YES** ___ **NO** ___
No IV fluids **YES** ___ **NO** ___

H. Administration of Artificial Nutrition/ Feeding Tube PLEASE MARK YES FOR ONE OF THE FOLLOWING:

Long term feeding tube **YES** ___ **NO** ___
Goal oriented/ temporary feeding tube **YES** ___ **NO** ___
No feeding tube **YES** ___ **NO** ___

- **Sections F, G, and H** are for recommendations regarding antibiotics, IV fluids, and artificial nutrition.
- One item in each section should be marked YES, and the other items marked NO.

I. **Consulting Physicians Information: COMPLETE THIS SECTION IF YOU ARE IN AGREEMENT WITH THE ABOVE RECOMMENDATIONS**

Consulting Physicians printed name with title:_____

Consulting Physicians address:_____

Consulting Physicians telephone number:_____

Consulting Physicians Signature _____

Date form completed by Consulting Physician: _____

- **Section I** is to be completed by a Consulting Physician who has assessed the individual, reviewed sections A-H, and agrees with the Attending Physician's recommendations.

- All items must be completed and legible, including the physician's title (MD or DO) after the printed name.

Additional information that *must* be included with the completed EOL form:

- Medical records that support the diagnoses. These may include diagnostic test results, labs, consult notes, etc.
- The individual's most recent history and physical. This should include a complete list of diagnoses.
- Physician progress notes from the Attending and Consulting Physicians stating they have assessed the individual and their recommendations for end-of-life care.
- The recommendations must be **very clear**. For example:

I am recommending [termination of life support, withholding of care, hospice, comfort measures] for _____ due to _____.

Submitting the EOL Recommendation

- The request can be emailed to DAILRN@ky.gov or faxed to 502-564-1203, Attn: DAIL Nurse Consultant.
  - If the request is faxed, please include a cover sheet listing contact name, telephone number, and a fax number or email address.
  - A telephone number is required.
  - If additional information is needed, a DAIL Nurse Consultant will follow up by email, fax, or telephone.
- If information is missing or the form is incomplete, the **entire request** (history & physical, request form, progress notes, etc.) must be resubmitted.

Review & Approval Process

- Once the complete request has been received, a response can be expected within 12-24 hours.
- Delays in approval may occur when requests are received after hours or on weekends, or when there is difficulty reaching family members. A DAIL Nurse Consultant will make contact if a further delay or additional information is needed.
  - When delays occur, approvals may take up to 72 hours.
- Once the review is complete, **an approval will be sent to the fax or email provided**.

Questions?

Please contact the DAIL Nurse Consultants at DAILRN@ky.gov or by telephone:

Mary Ailiff 502-226-0578	Leanna McGaughey 502-229-5992