A Palliative Care Summary EHR Page

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INTRODUCTION

We sought to improve electronic health record (EHR) documentation of inpatient palliative care by creating a page to summarize relevant interdisciplinary clinical information and team care planning.

Consistent with national guidelines and The Joint Commission (TJC) requirements for Advance Certification in Palliative Care (PC), our aim was to highlight the contribution of each palliative care team member, the collaboration of the interdisciplinary team (IDT), and the patient care conference discussions.

METHODS

- Partnered with internal informatics specialists and Cerner experts to design and implement a customized palliative care meeting note and care summary in our EHR.
- Developed a PC summary page that pulls relevant information from various EHR locations (Mpage).
- Created a PC IDT meeting documentation template that summarizes the team's assessments, the patient's overall inpatient plan of care, the IDT's discussion and recommendations.
- The signed template generates a narrative inpatient progress note.

SCS IDT Meeting

Assessment Review

Medical Assessment
CURRENT SYMPTOMS (0 – none; 1 – mild; 2 – moderate; 3 – severe)
Well Being: 1 (10/04/16)
Palliative Pain: 0 (10/04/16)
Tiredness: 0 (10/04/16)
Drowsiness: 0 (10/04/16)
Palliative Nausea: 0 (10/04/16)
Lack of Appetite: 0 (10/04/16)
Shortness of Breath: 0 (10/04/16)
Palliative Depression: 0 (10/04/16)
Palliative Anxiety: 2 (10/04/16)
Palliative Performance Scale Palliative Care for MU: 50%

Advance Directives
Patient does not have an Advance Directive

Psychosocial Assessment
Marital Status 2: Married (09/13/16)
Primary Caregiver: Sandy (09/13/16)
Social Work Primary Caregiver Rel: Daughter (09/13/16)
Living Situation: Home independently (10/05/16) SW Assess Living Situation: With Family (09/13/16)
Affect Behavior SW: Other: sleeping, but wakened intermittently for short times (09/13/16)
Financial concerns: Yes (09/13/16)
Social Supports
Per report from pt's daughter Sandy: Pt. lives in Orange Co. with her husband, but he has been in a rehabilitation facility for almost 100 days. Daughter Sandy identifies herself as a cancer pt. (breast ca. with cognitive deficits caused by chemo therapy). She lives in Sanford and is in process of a divorce, so is unsure how long she can stay to care for the pt. The pt's other daughter lives in Jamaica and is in tx. for endometrial ca.

Spiritual Assessment
Chaplain Assessment: Anxiety, Difficult/new diagnosis, expressions of gratitude/faith. Hope. Other Beliefs = Christian (09/29/16).
Chaplain Assessment Freetext: (09/29/16).
Religion Preference: Christian (09/11/16).

Cultural Assessment
Language for medical information: English (09/11/16)
Describe your cultural heritage: British Expat (09/11/16)

Prognosis
☐ Good ☐ Actively Dying
☐ Guarded ☐ Other:
☐ Unknown

Patient/Family Goals of Care
☐ Prolong life with anti-cancer therapy ☐ Unknown
☐ Promote quality of life ☐ Other:
☐ Promote comfort at end-of-life

Active Interdisciplinary Plans of Care (IPOCs) **IPOCs Reviewed by** ☐ Supportive Care Services
Plan: Pain IPOC
Date Added: 09/11/16

Recommendations

Supportive Care Team suggests the following IPOCs

☐ Actively Dying Patient IPOC	☐ Depression IPOC	☐ Knowledge Opportunity IPOC
☐ Advance Care Planning IPOC	☐ Discharge Planning IPOC	☐ Pain IPOC
☐ Anxiety IPOC	☐ Fall Risk IPOC	☐ Spiritual Distress IPOC
☐ Coping IPOC	☐ Grieving Alteration IPOC	☐ Other:

Collaborate with Attending/Primary Service to

☐ Manage symptoms	☐ Provide support for adjustment to illness	☐ Address needs for continuing care after discharge
☐ Explore understanding of disease, prognosis & treatments	☐ Provide support for spiritual issues	☐ Discuss plan of care w/outpatient oncologist
☐ Explore wishes for end-of-life care	☐ Provide support for grief and/or bereavement	☐ Consult Behavioral Medicine
☐ Clarify/support goals of care	☐ Educate regarding disease process & prognosis	☐ Consult Interventional Pain
☐ Facilitate completion of Advance Directives	☐ Educate regarding benefits & burdens of treatment	☐ Refer to hospice services
☐ Facilitate a family meeting	☐ Educate regarding hospice services	☐ Other:

Comments

RESULTS

The palliative care Mpage and IDT meeting note:

- Improved communication among the interdisciplinary team members.
- Increased visibility and accessibility of the palliative plan of care to other clinicians.
- Fostered integration of the palliative care team's plan of care with the overall oncology interdisciplinary plan of care (IPOC).
- Were recognized as best practice during TJC advanced recertification in PC.

CONCLUSION

- In partnership with Clinical Informatics and Cerner Specialists, we developed a sustainable tool to condense and disseminate palliative care information via the EHR.
- By capturing and integrating timely information from the EHR, the palliative care Mpage and IDT meeting note foster collaboration and communication.

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