HOME AND COMMUNITY CARE SUPPORT SERVICES
Hamilton Niagara Haldimand Brant

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Hamilton Niagara Haldimand Brant

Milrinone Home Infusion Order Form for Palliative Symptom Management in the Adult Population

Contact Home and Community Care Support Services (HCCSS HNHB) at 1-800-810-0000

Patient Name _____ HCN _____ VC _____ DOB _____

Address _____ City _____ Province _____ Postal Code _____

Patient Phone # _____ Contact Name _____ Contact Phone _____

Referring Hospital

Cardiologist Name _____ Phone _____

Hospital Nurse Practitioner Name _____ Phone _____

Other Physician or Designate Name _____ Phone _____

Most Responsible Practitioner (MRP) (MD or NP) for Community Management

Family Physician Name _____ Phone _____ Fax _____

Hospital MRP Transfer of Care to Family Physician Completed ☐ Yes ☐ No Contact Date _____

* STOP if MRP Information is missing. Full Completion of Form Required for Referral *

Medication Orders

IV Milrinone Start Date in Hospital _____ Patient weight _____kg Date _____

1. Milrinone _____ mcg/kg/min to be delivered by continuous IV infusion
   Milrinone continuous IV infusion to be started within _____ minutes of discharge from hospital to support a coordinated and timely discharge and initiation of therapy at home
   Duration _____ Repeats _____

IV Furosemide Start Date in Hospital _____

2. Furosemide _____ mg/hour to be delivered by continuous IV infusion ***OR***
   Furosemide _____ mg Route _____ Frequency _____
   Duration _____ Repeats _____

Vascular Access ☐ PICC Insertion Date _____ ☐ Single Lumen ☐ Double Lumen ☐ Valved ☐ Non-Valved

Fluid Restrictions _____

Nursing Orders / Instructions _____

_____

Referral Information

Medication List Attached ☐ Yes ☐ No Hospital Milrinone Protocol Attached ☐ Yes ☐ No

Advanced Care Planning discussion held with patient and family regarding palliative approach to care ☐ Yes ☐ No

Patient or Substitute Decision Maker is aware of the goals of IV Inotropic therapy at home ☐ Yes ☐ No

Physician Name _____ CPSO# _____

Phone _____ Fax _____ Pager _____

Signature _____ Date _____ Time _____

Print Clear

Version 21-001

Ontario

Patient Name _____ **HCN** _____

Eligibility Criteria
1. **Patient is currently in hospital and wishes to transition to home (community) for end-of-life care.**
2. **Patient has advanced congestive heart failure and IV inotropic therapy (milrinone) is currently providing patient with symptom relief while in hospital.**
3. **The patient or substitute decision maker is aware of the goals of IV inotropic therapy at home.**
4. **Patient has a functional central line.**
5. **Patient has family and/or caregivers that are available, reliable, teachable and interested to participate in patients care.**
6. **Family and/or caregiver(s) are trained in all aspects of therapy and condition (education with HCCSS supply is required).**
7. **Patient has a most responsible practitioner (MRP) (MD or NP) in the community actively involved in patients care.**
8. **Referring hospital site has a cardiologist involved with patients care and willing to be primary contact for any changes in patients' health status, symptom management or challenges related to IV inotropic therapy.**
9. **There is agreement from all participants in the plan of care prior to discharge.**
Referring Hospital Site
1. **Complete the HCCSS HNHB Milrinone Home Infusion Order Form for Adult Population in full, all sections must be completed.**
2. **Establish who the Most Responsible Practitioner (MRP) (MD or NP) will be for the patient in the community and provide a transfer of care report if MRP is not the referring practitioner. NOTE: Patient cannot be discharged with HCCSS without an identified MRP for this protocol.**
3. **If the patient does not have a primary care provider in the community, consult with Care Coordinator (CC) to assist with the healthcare connector process.**
4. **Contact the Most Responsible Practitioner (MRP) in the community to provide a transfer of care report.**
5. **Ensure family and/or caregivers have received any necessary training and education prior to discharge.**
6. **Participate in the Discharge Case Conference with hospital team, HCCSS HNHB and HCCSS HNHB Service Providers when requested.**
7. **Discuss end-of-life wishes, including preferred place of death, with the patient and/or substitute decision maker. Advanced Care Planning discussions should include:** • **plan of treatment regarding cardiopulmonary resuscitation,** • **plan for pronouncement and certification of death for an expected death in the home, and** • **Do not Resuscitate Confirmation (DNR-C).**
8. **Ensure medications are reconciled and a list of medications is included in the referral.**
Hospital Care Coordinator
1. **Arrange Discharge Care Conference prior to discharge with all key stakeholders including receiving care coordinator and community nursing provider**
2. **Coordinate the medication and pump delivery, and the nursing visit to ensure the patient is set up with the pump within one hour of hospital discharge. A timed nursing visit will need to be arranged prior to discharge.**
3. **Assign patient to the Palliative Care Coordination Team upon discharge**