Palliative Care

What is it?

Why it is important?

The importance of identifying these patients.

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Palliative Care

Palliative care is an approach that is meant to improve the quality of life in patients and families facing problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessments and treatment of pain, dyspnea, and other problems including physical, psychosocial and spiritual distress. This is important because it is a specialized medical care for people living with a serious illness or chronic disease of which there are no cures. This type of care is focused on relief of symptoms and stress of a serious illness, of which the goal is to improve the quality of life for both patients and their families.

Why Palliative Care is Important

- Again, it is important for people living with a serious illness or chronic disease for which there is no cure.
- This includes pain and symptom management, physical, psychosocial and spiritual aspects of care for every individual, patient and family.
- Palliative care can improve the quality of life, reduce the need for hospitalization, and in some cases prolong life compared to control groups receiving disease treatment.

Benefits of Palliative Care

- Better patient and family understanding of what to expect
- Relief of pain and symptoms
- Increased life expectancy
- Patient and family caregiver support
- Decreased crises, 911 calls, ED visits, and hospitalizations.

When is Palliative Care Appropriate?

- Palliative care is appropriate from the time of initial diagnosis of a serious disease, throughout treatment, through end of life care and bereavement.
- Eligibility for palliative care is based on patient and family need, not on prognosis
- All of the patient's treating clinicians can and should provide pain and symptom management, clear communication, caregiver support, and well coordinated care across the settings.

When is Palliative Care Appropriate? (cont.)

- Specialist–level palliative care is provided by interdisciplinary teams who address the medical, psychological, spiritual and social needs of the most complex seriously ill patients and their family caregivers.
- Specialist palliative care is provided in partnership with the patient's regular team of clinicians and concurrent with disease treatments.

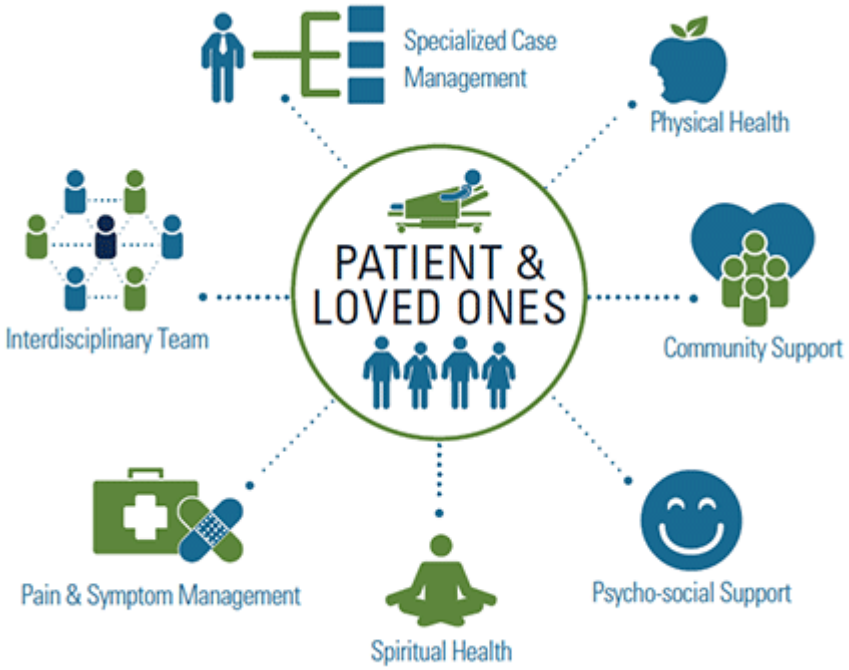
Who Needs Palliative Care?

- Declining ability-activities of daily living
- Weight loss
- Multiple hospitalizations
- Difficult to control physical or emotional symptoms related to serious medical illness
- Patient, family or physician uncertainty regarding prognosis or goals of care
- Requests for futile care
- DNR order conflicts
- Use of tube feeding or TPN in cognitively impaired or seriously ill patients
- Limited social support and a serious illness (e.g., homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

For unit specific criteria:

https://getpalliativecare.org/resources/clinicians/

Interdisciplinary Team



https://www.cambiahealth.com/sites/default/files/palcare_0.png

Social Work
Chaplain
Physician
RN/APRN
Child Life Specialist
ST/OT/PT
Bedside RN
RT
Dietary
Housekeeper
Engineering
Nurse Manager

Chronic Disease Progression & Trajectory Benefits of discussing

- Assist patient/family with feeling more “in control”
- Empower them to cope with the demands
- Enable patient/legal decision maker to make more educated decisions for advance care planning
- Help clinicians plan care to meet patient’s multidimensional needs better avoid overzealous treatment: help us do what we should do, not everything we can do.

Chronic Disease Forecast

- Chronic disease epidemic continues in upward trajectory
- 48% (171 million) U.S. Residents live with one or more chronic condition (2% increase or 30 million people from 2010)
- National health spending accounts for 22% of gross domestic product (GDP) (increased 4% from 2010)
- Improved access to care leads to increased diagnosis of chronic disease
- Cuts in Medicare/Medicaid reduce health care spending to 17% of GDP as many will forgo care.

Public Health 2030

End of Life in the Hospital

- One-quarter of hospital deaths were > 85 years old
- 2010-2.5 million die each year while hospitalized
- Longer hospital stays than the average patient (7.9 days vs 4.8 days)
- Most Americans prefer to die at home.

NCHS Data Brief

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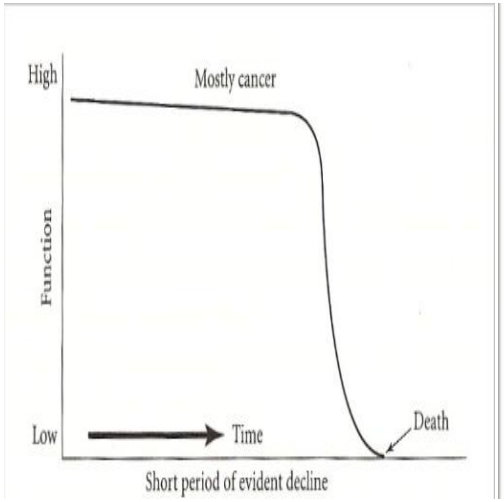
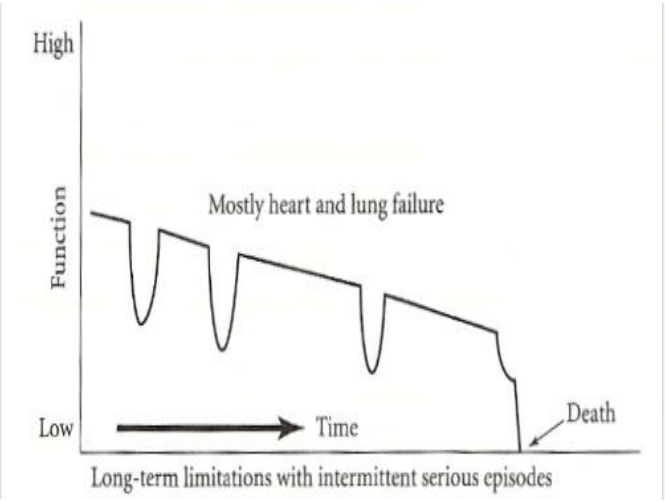
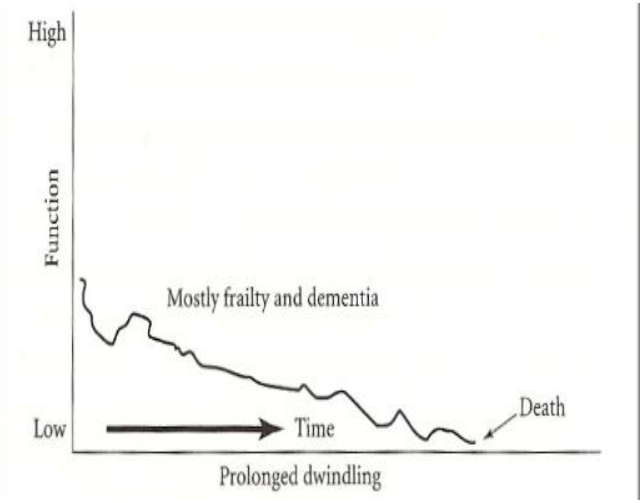
Illness Trajectories of Progressive Chronic Disease







Major Disease Processes

- Cancer
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Renal failure
- Dementia

Cancer

- 1,249 patients-Functionally independent (94%) until 18 weeks before death, 63% at 12 weeks, and 49% at 6 weeks before death. Short decline trajectory
- Spiritual distress typical at diagnosis, recurrence, & terminal stage.
- Hospice Criteria: Stage 4 Metastatic Disease, no longer desires curative treatments, functional decline (more rapid as disease progresses)

BMC Cancer 2008

Congestive Heart Failure

- Long term limitations with intermittent serious episodes
- shrinking social world, increasingly more dependent
- Feel better on treatments
- More “wear and tear” on caretaker
- Poorer insight to EOL
- Spiritual distress more uniformly throughout trajectory with gradual loss of identity and growing dependence
- Hospice option: NYHA Class IV (symptoms at rest), EF
- < 20% or ACC/AHA Stage D (symptoms despite max therapy)

Chronic Obstructive Pulmonary Disease

- Long term limitations with intermittent serious episodes
- Progress from mild-very severe
- Symptom burden surpass those with lung CA
- Hospice Criteria: dyspnea at rest, oxygen dependent, increased hospitalizations for disease progression

Renal Failure

- As disease progresses from asymptomatic (stage 1) to kidney failure (stage 5), impact on quality of life and treatment is dramatically different
- 2 months prior to death, sharp increase n symptoms and health-related concerns
- Stage 1-5, based of glomerular filtration rate
- Hospice Appropriate: stopping HD, creatinine clearance <10c/Mon or 15 c/minute, serum creatinine >8mg/dl for DM, uremic pericarditis, HRS, intractable hyperkalemia

(CJASN, Trajectories of Illness in Stage 5 CKD)

Dementia

- Prolonged dwindling
- Loss of activity, social withdrawal and emotional distress increase with loss of cognitive function
- Loss of capacity is inevitable
- Negative behaviors increase physical/emotional distress of family members

Comorbid conditions

- DPS Health research-adults diagnosed with one chronic condition will, on average, develop an additional chronic condition in 3 years.
- We need to move beyond separate treatment paradigms by disease stage/condition to a holistic view of health trajectory.
- Multiple disorders with two trajectories, more rapidly progressing takes “center stage.”

Future Care: Understanding Disease Trajectories in Chronic Disease (2017)

Symptom Management
Pain Management

- Pain Management-Thorough pain assessment needed to allow for safe and appropriate pain management
  1. Pain characteristics
  2. Functional history
  3. Review prior medications. (what are the using at home?)
  4. Patient exam
- Always uses the same pain intensity scale, in the same way, each visit for consistency.
- Undertreated pain in the cognitively impaired patient can contribute to functional impairment, agitation, delirium, repeated emergency room visits, and hospitalizations.
  1. Always ask the patient first about pain – even people with significant dementia can tell you or show you where it hurts.
- Ensure a bowel regimen – constipation will occur.

Symptom Management
Opioid Side Effects

- Sedation – consider hydration, psychostimulants or adjuvant analgesics
- Nausea/vomiting – consider anti-emetics
- Dizziness – consider non-sedating antihistamines
- Itching – consider non-sedating antihistamines
- Constipation – treat prophylactically from onset of opioid treatment with stimulants or osmotics.

Symptom Management
Nausea/Vomiting

- The root causes of nausea and vomiting transmit signals to the brain via emetic pathways
  1. Chemoreceptor trigger zone (CTZ)
     a. Stimulated by biochemical abnormalities:
        Hypercalcemia
        Hyponatremia
        Hepatic failure
        Renal failure
     b. Sepsis
     c. Medication
  2. GI Tract
     a. Can include anything that irritates, obstructs, or slows down the GI tract.
        Gastric compression

Symptom Management
Nausea/Vomiting (cont.)

- Delayed gastric emptying
- Bowel obstruction
- Constipation
- Biliary obstruction
- Chemotherapy/radiation
- Gastritis

3. Vestibular tract - motion sickness, vestibular tumor, inflammation (vestibular neuritis)

4. Cerebral cortex - anxiety, unpleasant sights, smells, and tastes, elevated intracranial pressure, meningeal irritation, psychiatric disorders

Symptom Management
Dyspnea

- Dyspnea refers to the sensation of difficult of uncomfortable breathing.
- Dyspnea on exertion may occur normally (e.g. during exercise), but is indicative of disease when it occurs at a level of activity that is usually well tolerated.
- Opioids are the mainstay for first line treatment of dyspnea after therapeutic options are optimized.
- Always start with a very low dose opioid for treatment of dyspnea. Patients will respond variably to opioid therapy, start low and titrate to achieve the lowest effective dose based on patient response. The dose of an opioid required to relieve dyspnea is typically much lower than that needed for pain. 1-2 mg of concentrated liquid oral morphine would be an appropriate starting dose.

Symptom Management
Benzodiazepines for Dyspnea

- A few small studies have shown that adding benzodiazepines in combination with opioids can be effective for treatment of dyspnea
- Caution must be used because of the risk of respiratory depression and mental status changes.
- Benzodiazepines should only be added when titrated opioid therapy has failed to control symptoms.

Symptom Management
Oxygen for Dyspnea

- Oxygen therapy has demonstrated both survival and quality-of-life advantages for patients who have hypoxia at rest

- The benefit of oxygen therapy for patients who do not have resting hypoxia is unclear. For a patient without hypoxia oxygen therapy should be trialed for an agreed-upon time period (2-3 days) to determine efficacy in reducing dyspnea

- Oxygen needs to be used with care because patients with a baseline CO2 greater than 45 have a risk for hypercarbia with supplemental oxygen. Oxygen use in exacerbations should only be considered if O2 saturation and CO2 are known.

Who should have Palliative Care?

- All patients with serious illness and life limiting conditions should have access to quality palliative care.
- Palliative care should be introduced at the onset of new diagnosis.

To get there we need to:

- Expand access to quality palliative care
- Train clinicians in:
  A. Pain and symptom management
  B. Communication about achievable goals
  C. Care coordination across the settings
  D. Advanced care planning

Advanced Care Planning Objectives

1. Define Advanced Care Planning and discuss components of this process, including advanced directives
2. Discuss the role of the acute care healthcare provider in the advanced care planning process
3. Explain MOST and implications for the acute care setting

Advanced Care Planning

- Learning about the types of decisions that might need to be made, considering those decisions ahead of time
- Letting others know about your preferences, often by putting them into an advance directive

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Advanced Care Planning

- Ongoing
- Depends on current health status and location of patient
- Physicians may provide best information regarding treatment options, while nurse may know the patient's needs and preferences better
- Social work or spiritual care may have closest contact with the patient
- Consider interdisciplinary family meetings

Step Wise Approach

- Consider emotional state of patient
- Determine capacity
- Assess understanding & educational need surrounding disease processes
- Initiate conversation & identify need for advanced care planning
- Discuss values & defining characteristics of quality of life

Capacity for Medical Decision Making

- Demonstrate ability to reason
- Deliberate “material information”- risks, harms, benefits, potential benefits of recommended treatments, and reasonable alternatives
- Outcomes of all options
- Choose within a framework of personal goals, values, & beliefs
- Communicate their decision

Disease Understanding

- Assess knowledge
- Discuss disease progression
- Expected trajectory
- Realistic expectations with decreasing reserves

Where to Begin

"You are in excellent health and taking good care of yourself, but you never know what can happen in life. What if an accident left you without the capacity to make your own health care decisions? What would you want to have happen? Who would you want to make decisions for you? Advance care planning deals with those kinds of questions."

"I want you to understand that our first priority is to make sure you get the very best care we can provide. Every person is unique, so it's not possible to predict when your condition may change because of the illness you have. But it is important to talk about what might happen in the future and to know how you feel about it."

“Gray Areas” of Healthcare

- AICD
- Organ/tissue donation
- Surgery
- Chemo/Radiation
- Life sustaining medications
- Artificial nutrition
- Hemodialysis
- Ventilator support
- CPR

Documentation

- Advance Directive
  - Medical Power of Attorney (MPOA)
  - Durable Power of Attorney for Health Care
  - Out-of-Hospital Do-Not-Resuscitate
  - Directive to Physician / Living Will
- MOST --- Not yet recognized as legal document in state of Texas
  - “How I Wish to Live My Life” --- Not legal document

Why is this needed?

- 4 in 10 Americans ages 65 and older do not have advanced directives or have not written down their own wishes for end-of-life medical treatment
- Personal values are key
- Advances in medicine and technologies
- Reduce ethical dilemmas and moral distress
- Save WASTED money

“The life which is unexamined is not worth living.”

~ Socrates ~

References

Advanced Care Planning
www.advancecareplanning.ca/wp-content/uploads/2015/10/acp-curriculum-module_2008.pdf

British Medical Journal: Concept of trajectories at the end of life: physical and other dimensions (2010)

CAPC
www.CAPC.org

CaringInfo
www.caringinfo.org

Costantini, Massimo, et al (2008). Cancer Trajectories at the End of Life: is there an effect of age and gender? BMC Cancer, 8:127.

Hall, M.J., et al (2013). Trends in Inpatient Hospital Deaths: National Hospital Discharge Survey, 2000-2010, No.118

Murray, Scott A., et al (2005). Illness Trajectories and Palliative Care, British Medical Journal, 1007-1011.

References (cont.)

Murtagh, Fliss E.M., et al (2011). Trajectories of Illness in Stage 5 Chronic Kidney Disease: A Longitudinal Study of Patient Symptoms and Concerns in the Last Year of Life, American Society of Nephrology, 6: 1580-1590.

National Institute on Aging (NIA) | National Institutes of Health www.nia.nih.gov/health/publication/advance-care-planning

National Public Radio (NPR)www.npr.org/sections/money/2014/03/05/286126451/living-wills-are-the-talk-of-the-town-in-la-crosse-wis

Public Health 2030 @ www.altfutures.org/pubs/PH2030/PH2030_Chronic_Disease_Driver_Forecasts_2014.pdf

Understanding Disease Trajectories in Chronic Disease @ www.himssfuturecare.com/print/9291

Up-To-Date www.uptodate.com/contents/advance-care-planning-and-advance-directives/print?source=see_link

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