Palliative Care

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Reconcile Your Personal Feelings on death and dying

“Every medical study ever conducted has concluded that 100% of Americans will eventually die.”

(Keegan & Drick, 2011)
What is PALLIATIVE CARE:

A specialized medical **approach** that improves the quality of life for patients/families facing life-threatening illness, through the prevention and relief of suffering/symptom burden.

Aimed at addressing the patient holistically physical, emotional, spiritual.

More focused on the patient and their symptoms, less focused on the disease itself.
Palliative Care vs. Hospice

• Palliative care and hospice are related but distinct forms of palliative medicine. They are not synonymous and should not be reserved only for patients who are imminently dying.

• Palliative care focuses on symptom management, quality of life, and delineating the goals of care in patients with serious illness, whether the goal is cure, life prolongation, or maximizing quality of life and function.

• Hospice is a special type of palliative care program, reserved for patients in the last 6 months of life.

Slide by Kathleen T.Grimm MD MHSc
In The Hospital...

- Palliative Care is offered everywhere in all departments.
- Hospice care is ONLY formally elected as a benefit when the patient is in a Hospice bed.
- Theses beds are often called “swing-beds”
- Patient’s in other rooms may be “comfort care” and may be dying. Hospice consult may be ordered for evaluation, but they are NOT Hospice patients.
- Please do NOT chart “Patient is receiving Hospice care” unless they are formally in a Hospice bed.
Understanding The Hospice Benefit

• Home Care
  – Patient may have 6 months (or more) to live. They will continue their maintenance medications and continue much of their medical care depending upon goals and multiple variables

• SNF/LTC
  – Hospice can provide care in ANY LTC facility
  – Hospice units opening in joined effort with many facilities

• “Swing-Bed” Hospice Hospital Bed
  – Only for patient who is actively dying or too symptomatic or sick to be home or sent to LTC, also for pt’s who are home with Hospice and then require acute care setting (inpatient unit, hospital)

• ONLY Hospice Liaison RN can approve and coordinate Hospice admission to Swing-bed! Must be done by Hospice!
Resources

• Get Palliative Care.Org
• http://getpalliativecare.org

  – Resource for clinicians
    • General referral criteria with breakdown by presence of serious illness, chronic illness, ICU, ER, Oncology
  – Resource for patients/families
Resources

• Palliative Care Fast Facts for IOS Ap
  – Excellent quick reference
    • For symptom management
    • For tips of goals of care discussion
    • For dealing with death and dying
    • Up to date information
    • FREE!!!
MOLST Directives

• “Are they Palliative?” “She’s Palliative”
  – What does that mean?
• Advanced Directives/MOLST
  – Comfort Care, but not necessarily Hospice care
  – Clarify MOLST form
• Just because “Palliative” is consulted or following does NOT mean pt is EOL or even a DNR/DNI.
• https://www.health.ny.gov/professionals/patients/patient_rights/molst/
EVOLVING MODEL OF PALLIATIVE CARE
BY DR. KATIE GRIMM

“Active Treatment”

Palliative Care

Cure/Life-prolonging Intent

Palliative/Comfort Intent

Bereavement

Death
Understanding Palliative Care

slide by Dr Katie Grimm

Palliative care + curative care

OR

Palliative care alone, when curative care is no longer helpful.
Why Palliative Care?

• Palliative care provides:
  • Time for meetings and counseling.
  • Expertise in managing complex physical and emotional symptoms.
  • Support in resolving conflicts.
  • Coordination of care across settings.
Treatment Decisions

- Tube feeding
- Cardiopulmonary Resuscitation
- Renal dialysis
- Antibiotics
- IVF
- Hospitalization
- Hip fracture repair
- Decision making capacity
Palliative Care Law NYS

• Palliative Care Information Act
  – Effective February 9, 2011

• Public Health Law section 2997-c requires the "attending health care practitioner" to offer to provide patients with a terminal illness with information and counseling regarding palliative care and end-of-life options appropriate to the patient

Palliative Care Law NYS

• Palliative Care Access Act
  – Effective September 27, 2011
  – Further defines PCIA to include Hospitals, Nursing Homes, Home Care, ALFs

• https://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/information_act.htm
Palliative Care in the Hospital

• The number of U.S. hospitals offering palliative care services is growing rapidly. US hospitals with 50 or more beds increased from 658 (24.5%) to 1,486 (58.5%) – a 125.8% increase from 2000-2008. [Source: 2002 to 2010 American Hospital Association Annual Hospital Surveys for FY 2000 to 2008; and data from the Center to Advance Palliative Care’s (CAPC) 2009 National Palliative Care Registry.

• Palliative care programs link diverse hospital departments and services for effective and efficient use of hospital resources.

• Palliative care helps patients understand the nature of their illness and make timely, informed decisions about their care, together with their families. Seriously ill patients benefit from palliative care at any stage of their illness.
Hospital-Based Palliative Care Because...

- Hospitals are where the most severely ill patients are.
- Many patients need palliative care to complement their life-prolonging or curative treatments in the hospital.
- Seriously ill hospital patients are highly likely to need pain and symptom control, coordination among their providers, and assistance in transitioning between care settings.

- Hospitals are where the most money is being spent.
- Nearly all Medicare beneficiaries spend at least some time in a hospital during their last year of life.
- Enormous resources are expended on the seriously ill, putting the hospitals that treat them at financial risk if they cannot find a way to provide care that is both high quality and fiscally responsible.
Hospital Based Palliative Care
Because...

• Hospitals are the best place to plan for the next phase in the care continuum.
• Most patients are in the hospital due to a health crisis. This crisis forces confrontation with the reality of illness and the decisions that need to be made about care.
• Palliative care provides a smooth transition for the patient between the hospital and appropriate services, such as hospice, home care, or nursing homes.
• The hallmarks of palliative care — communication and coordination, combined with excellent medical care enable the patient to progress to the next phase of their care.
Family Satisfaction with Hospitals as Last Place of Care

- Did not receive enough help with
  - Pain: 19.3%
  - Dyspnea: 19.0%
  - Emotional support: 51%

- Not always treated with respect 20%

- Not enough information about dying 50%

Teno J et al. JAMA 2004; 291 (1)88-93
Medical Treatment Options

- Palliative Care
- Hospice Care
- Life Prolonging Therapy
- Pain Management

Graphic by Anne Kinderman, MD; used with permission.
Assessment at Time of Hospital Admission- Consider this:

- You would not be surprised if the patient died within 12 months
- Repeated admission for same condition within several months
- Admission for difficult symptoms or psychological need
- Functional dependence or complex home requirement support needed
- Decline in functional status, weight, or ability to care for self
- No history of completing an advance care planning document or having a discussion
- Family stress, chronic mental illness, lack of caregivers
- Metastatic or locally advanced cancer, hip fracture with cognitive impairment, or out-of-hospital cardiac arrest
Triggers for Early Integration of Palliative Care into Oncology Care

• Stage IIIB & Stage IV NSCLC, Small cell lung, Glioblastoma, Pancreatic, Unresectable esophageal, Hepatocellular, high risk acute leukemia

• Any cancer with prognosis <= 1 year, symptom burden, moderate/severe dx distress, moderate/severe cancer therapy distress, serious co-morbid physical concerns, serious psychosocial concerns, Patient/family concerns about course of disease/decision making, Patient/family request.

# 253 Palliative Care Consultation in the ICU

**Background** The Intensive Care Unit (ICU) is the setting for high-intensity health care designed to resolve life-threatening illnesses and extend life. However, risks of mortality and severe morbidity remain high and virtually all ICU patients have palliative care needs. Integration of palliative care services into ICU care is increasingly seen as a method to improve clinical care (1,10).
Palliative Care in the ICU

• **What occurs in an ICU Palliative Care Consultation**
  • Assess/treat distressing physical, psychological, and spiritual symptoms/problems.
  • Communicate information about prognosis and treatment options to patient/family in concert with ICU, primary care and subspecialty colleagues.
  • Establish/clarify goals of care that are realistic and appropriate in relation to the patient’s condition, values and preferences, and help match treatments to these goals.
  • Formulate a transition care plan that accounts for prognosis, goals of care and patient/family needs.
  • Provide support for the families.
  • Support the ICU medical team in making clinically, ethically, and emotionally challenging decisions.
Palliative Care in the ICU

• **Research Data on Benefits of Palliative Care ICU Consultation**
  • Early identification of a dying trajectory leading to decreased time to institution of patient- and family-centered, comfort-focused treatment goals (2-3).
  • Movement of appropriate patients to lower intensity care sites (ward, palliative care unit, home hospice) (5-6).
  • Reduction in ICU length of stay for adult patients (2-4, 7).
  • Reduction in the cost of care, without an increase in mortality, due to early establishment of realistic treatment goals leading to reduction in use of high-cost ICU resources/interventions (2-4, 7-8).
  • Support for staff in challenging and emotionally draining/morally distressing patient/family care situations.
  • Palliative Care consultation for hospitalized patients can reduce the need for ICU admission through establishment of treatment goals that preclude future ICU admission (7-8).
  • Continuity of care when the patient transitions from the ICU to ward or palliative care unit as the Palliative Care team follows the patient.
Palliative Care in the ICU

ICU/Palliative Care Collaboration A range of options exist for integrating palliative care services into the ICU. At one extreme, ICU staff consult a palliative care specialist team for problems the ICU staff deems appropriate for consultative advice on an ad hoc basis. At the other extreme, the ICU embeds systems in place to provide ICU-led generalist palliative care services to all ICU patients, utilizing palliative care specialists for complex problems. Embedding systems that ensure the needs of all patients are met includes screening all patients on admission and daily for unmet palliative care needs, early identification of a surrogate, timely symptom management, and routinely-scheduled family meetings to discuss goals of care (1,9,10). Quality outcomes related to patient and family experience and to health care utilization should be tracked within the framework of available resources (1,11).
When to use Specialist Palliative Care Services Consultations can either be initiated on a case-by-case basis by ICU or other primary clinicians, or triggered proactively using a system to identify patients at high-risk for unmet needs (2-4). Key indications for consultation include:

- Difficult-to-control physical symptoms despite usual treatment approaches.
- Patients/surrogates wish to explore non-ICU supportive care options such as hospice services.
- Staff have questions about the appropriateness of life-sustaining therapies in the setting of advanced complex illnesses.
- There are complex family dynamics impacting decisions about use of life-sustaining treatments.
- There are disagreements among staff or between staff and patients/surrogates about prognosis and/or use of life-sustaining treatments.
- Patients are being readmitted to the ICU more frequently within a given time frame. Additional resources: ICU Screening tools/policies. Center to Advance Palliative Care. Available at the IPAL-ICU project site: http://www.capc.org/ipal-icu/improvement-and-clinical-tools/.

References

References

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- **References**
  
  
  
  
  
  
  
  
  
  
  
Palliative Care in the ICU

- **Intensive Care Unit Criteria**
- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or difficult ventilator withdrawal
- Multi-organ failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making
  - **Source:** Get Palliativecare.org
Palliative Care in the ER

• **Emergency Department Criteria**
  - Multiple recent prior hospitalizations with same symptoms/problems
  - Long-term-care patient with Do Not Resuscitate (DNR) and/or Comfort Care (CC) orders
  - Patient previously enrolled in a home or residential hospice program
  - Patient/caregiver/physician desires hospice but has not been referred
  - Consideration of ICU admission and or mechanical ventilation in a patient
  - with metastatic cancer and declining function
  - with moderate to severe dementia
  - with one or more chronic diseases and poor functional status at baseline

  • Source: Get Palliativecare.org
Some Statistics...

- 70% of people say they prefer to die “at home”
- 70% die in a hospital
- 90% of us believe that it’s important to discuss end of life issues with your loved ones. Only 27% do.
- 60% of us say that it is extremely important that their family is not burdened by tough decisions. 56% have not communicated their EOL wishes
- 7% report having had an EOL discussion with their doctor
- 82% of the people say it is important to put their wishes in writing, only 23% have actually done it.
• http://theconversationproject.org/
• Receive 2.0hrs CME credit (on-line tutorial)
• The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.
The Art of Discussion

• “A family meeting is a skill, and it requires no less skill than performing an operation”
  
  Dr. Susan Block

• Not a choice between Choice X or Y, but what is most important to the pt. under the circumstances of a serious, terminal illness
  
  “If time becomes short, what is most important to you?”

Slide by Kathleen T. Grimm MD MHSc
Caring Conversations: Transitioning from Cure to Care

• Start by asking about the patient! Who are they?
• What does the pt/family already know?
• What does the pt/family want to know?
• What does the pt/family need to know?
• What they understand the prognosis to be
• What are their concerns about what lies ahead
• Whom should make decision when they can’t
• How to spend time when options become more limited
• Trade-offs they are willing to make

Slide by Kathleen T.Grimm MD MHSc
Caring Conversations: Transitioning from Cure to Care

• “Care options” rather than interventions
• DNR never DNT
• Hope and honesty
• Providing a variety of choices without guidance/evidence is not giving the patient true autonomy

Slide by Kathleen T. Grimm MD MHSc
Caring Conversations: Transitioning from Cure to Care

“Are there circumstances that you would consider “worse than death”? 

“How would life saving efforts affect your quality of life.”

Slide by Kathleen T. Grimm MD MHSc
What Happens when Healthcare Professionals Have End-of-Life Conversations with Patients?

Researchers found:

• Patients who had end-of-life discussions have a DNR and preferred medical treatment that focused on relieving pain and discomfort over life-extending therapies.

• End-of-life conversations were not associated with patients feeling “depressed,” “sad,” “terrified” or “worried.”

Broaching The Topic...

• I want to order a Palliative Care Consult for my patient but what do I say to the patient/family? I don’t want to scare them!

• See FAST FACT #42
  – 1. Why do you want assistance
  – 2. Contact Palliative Care to discuss your ideas
  – 3. Engage pt/family in discussion
    • Never say “there is nothing more to offer... so we’ll call Palliative care”
Broaching the Topic

• “To best meet some of the goals we’ve been discussing like (fill in blank) I would like to have some specialists from Palliative care help us.”
• “They are experts in treating symptoms”
• “They can help your family deal with all of the change brought about by your illness”
• THINK OF PALLIATIVE CARE AS A SPECIALIST-CALL THEM JUST AS YOU WOULD A CARDIOLOGIST OR OTHER SPECIALIST.
Breaking Bad News

• Gather information from the patient
  “What is your understanding of what your doctors have told you?”

• Provide information according to the patient’s wishes
  “Would you like me to explain things for you?” Interrupt when things aren’t clear

• Support/reduce impact

• Develop a strategy/goals of treatment
A Barrier to Acceptance of Death

• “Last week he was out at a restaurant” (rapidly debilitating, review the course)
• “He was able to walk three days ago” (mistake agitation for purposeful activity and sign of health)
• “He was awake and talking yesterday” (consistent with prior trend?)
• “He must be drugged”

Slide by Kathleen T. Grimm MD MHSc
Some strategies for beginning a dialogue about hope and goals include:

• Ask the patient, "Do you have long term hopes and dreams that have been threatened by this illness?" Support the patient in recognizing and grieving the possible loss of these hopes.

• Ask the person if there are particular upcoming events they wish to participate in – a wedding, birth, trip, etc.

• Ask "What are your hopes for the future?" and "Do you have specific concerns or fears?"

• Encourage the patient to make short, medium, and long range goals with an understanding that the course of terminal illness is always unpredictable.
“Death in America Is Getting More Painful”


• Published February 6, 2015

• Despite Palliative Care/Hospice movement, the number of Americans experiencing pain near the EOL ↑ by 12%, depression ↑ by 26%

• Majority of research focused on wiping out disease rather than long-term support/sx management

• Most physicians tend to undertreat pain and other symptoms, don’t recognize, hesitant to talk candidly about death and dying
What makes a good old age?

*Being pain-free doesn’t top the list*

WASHINGTON (Religion News Service)

People often say they want a good “quality of life” in their older years. (Nov. 21, 2013 ed.)

“But we don’t know what that means to people,” says Cary Funk, a senior researcher at the Pew Research Center’s Religion & Public Life Project. So when Pew explored end-of-life decision-making for a new survey released Thursday (Nov. 21), Funk included questions on the “measures of a good life.”
Good Old Age

• It turns out that perhaps the most obvious choice — living without “severe lasting pain” — wasn’t at the top of the “quality of life” list. It came in at No. 4.

• No. 1 was the ability to talk or communicate with others: 93 percent rated this extremely or very important.

• Next: The ability to get “enjoyment out of life,” 90 percent

• The ability to feed yourself, 89 percent
Good Old Age

• Living without severe pain, 87 percent

• Retaining long-term memory, and feeling worthwhile in what you do, tied at 83 percent

• Being able to dress yourself, 81 percent

• Retaining short-term memory for events of the day, 71 percent
LET’S TALK
SYMPTOM MANAGEMENT
THINK ABOUT THE BASICS

• HAS YOUR PATIENT BEEN MOVING THEIR BOWELS?
  – “how would you feel if your last BM was 7 days ago”

• HAS YOUR PATIENT VOIDED? IS THEIR FOLEY PATENT?
Pain Management Pearls

• OPIOIDS:
• Long Acting VS Short Acting
  – Long acting agents should NOT be suddenly stopped without the expectation of withdraw and withdraw may be delayed
  – If short acting agents have been used ATC expect a more rapid withdraw if these meds have been held
  – Methadone – baseline EKG? Consider QTC interval
• In Comfort Care/EOL patients, why ATC dosing
• Why we don’t **hold** scheduled doses (most of the time)
• Risks of Opioid Use
  – Constipation, delirium/AMS, hypotension- but these issues can be balanced
Pain Management Pearls

- Adjuvant medications (think types of pain: Nociceptive vs Neuropathic)
- Is it really pain? (Vs Delirium)
- Existential pain/Non-pharm interventions
  - SW, Chaplain, Family/Visitors, Psychiatrist
- Fast Fact #008 “Morphine and Hastened Death, 2nd ed
- Very rarely is it necessary/appropriate to utilize a “morphine drip” or q2h dosing- consider adjuvant
Renal Failure

- **AVOID MORPHINE!!**
  - Build up of active metabolites/high risk for neurotoxicity
  - Proven to exert poor analgesic qualities
  - Also avoid codeine, demerol

- **DILAUDID BETTER TOLERATED**
  - Start small doses, allow for greater frequency between doses
  - Fentanyl, Methadone, Acetaminophen, Gabapentin, Pregabalin also well tolerated

- **CAUTION**
  - Tramadol – limit 50mg BID
  - Hydrocodone, Oxycodone – lack of evidence proving safety however literature available reports use without major adverse effects

- **Source:** Core Curriculum for the Advanced Practice Hospice & Palliative Care Nurse, 2nd ed. HPNA publication.
Renal Failure

• Itching/Pruritis:
  – Sarna Cream BID (scheduled or PRN)
• Nausea
  – Consider Haldol 1-2mg PO/SQ q4h PRN or even scheduled dosing
  – Zyprexa also effective but more sedating
• Delirium
  – Very common as pt declines and HD poorly tolerated or pt has declined further HD, actively dying. Haldol, Zyprexa very effective
Delirium

• An acute confusional state brought on by a host of contributing factors (multifactorial)
• NOT dementia!!
• Hyperactive
• Hypoactive
• Mixed
• Terminal
• Safety/Suffering (for pt and family)
Delirium

Treatment:

• **Correct underlying causes** (dependent upon pt/family goals)
  – Constipation? Urinary Retention? Sleep disturbance?

• **Non-Pharmacologic:**
  – Sleep hygiene (TVs off please!)
  – Reorient to date/time, day/night
  – Allow a calming family visitor to stay through eve/night
Delirium

• Pharmacologic Treatment
  – Haldol
    • **NOT** sedating- allows for sleep
    • Contraindicated in Parkinson/LBD population
    • Avoid IV if QTC prolongation/cardiac concerns
  – Seroquel/Zypraxa
    • Sedating
    • Seroquel PO Only
    • Zypraxa ODT, SQ (YES... can be given SQ instead of IM)
  – Ativan/Benzodiazepine
    • Will **often increase** agitation when used a sole agent but is an effective adjuvant (Haldol + Ativan)
    • Appropriate for delirium tremors/CIWA protocol
    • Give SQ instead of IM (be kind)
Dyspnea

• Subjective experience of breathing discomfort
  – Sensations such as work/effort, tightness, air hunger
  – Can ONLY be reported by patient

• Respiratory Distress
  – Physical and emotional suffering from disruption in breathing.
  – Observable, measurable
Dyspnea

Treatment:
• Patient centered approach
• Pts who are NOT hypoxemic obtain no relief from O2
  – End-stage removal of highflow/Bipap/ETT
• Opioids
  – Dilaudid Vs Morphine
• Steroids
• Benzodiazepines
Anxiety

• Often secondary to dyspnea
• Sometimes acute on chronic
• Chronic use of benzodiazepines
  – Do NOT stop abruptly unless you would like to add seizure to your patient’s list of issues
• Sleep Disturbance
• Difficult to articulate
• Some patients (particularly elderly) do not relate to term: Anxious/Anxiety (may understand “unsettled”)
Nausea & Vomiting

- **Cause - Vestibular**
  - Receptors Involved - Cholinergic, Histaminic
  - Drug Class Useful - Anticholinergic, Antihistaminic
  - Drug Examples - Scopolamine patch, Promethazine (Phenergan)

- **Cause - Obstruction of Bowel by Constipation**
  - Receptors Involved - Cholinergic, Histaminic, likely 5HT3
  - Drug Class Useful - Stimulate myenteric plexus
  - Drug Examples - Senna products

- **Cause - Dysfunction of upper gut**
  - Receptors Involved - Cholinergic, Histaminic, 5HT3, 5HT4
  - Drug Class Useful - Prokinetics which stimulate 5HT4 receptors
  - Drug Examples – Metoclopramide (Reglan)

- **Cause - Infection, Inflammation**
  - Receptors Involved - Cholinergic, Histaminic, 5HT3, Neurokinin 1
  - Drug Class Useful - Anticholinergic, Antihistaminic, 5HT3 antagonists, Neurokinin 1 antagonists
  - Drug Examples – Promethazine (e.g. for labyrinthitis), Prochlorperazine (Compazine)

- **Cause - Toxins stimulating the chemoreceptor trigger-zone in the brain such as opioids**
  - Receptors Involved - Dopamine 2, 5HT3
  - Drug Class Useful - Antidopaminergic, 5HT3 Antagonists
  - Drug Examples - Prochlorperazine, Haloperidol, Ondansetron

**Source:** Fast Fact #005
Nausea & Vomiting

• 5HT3, 5HT4 refer to the serotonin receptors, subtypes 3 & 4.
• Promethazine and prochlorperazine are very different drugs. Promethazine is most useful for vertigo and gastroenteritis due to infections and inflammation. Prochlorperazine is preferred for opioid related nausea.
• There is no evidence supporting the use of lorazepam as a sole agent for nausea. Sedated patients are more prone to aspiration.
• ‘O’ here relates to ‘obstruction’ of bowels by constipation, not mechanical blockage (see Fast Facts #45, 119 for management of mechanical obstructions).
Oral Secretions

• Focus on EOL population ("death rattle")
  – Type 1: primarily salivary secretions
  – Type 2: primarily bronchial secretions
  – Mean time from onset of rattle to death 16hrs

• Treatment
  – Repositioning
  – Suctioning (rarely helpful)
  – Reduction of fluid intake
  – Muscarinic receptor blockers (anti-cholinergics)
Oral Secretions

Pharmacological pearls

• Glycopyrrolate (Robinul) has five times the anti-secretory potency compared to atropine, does not cross blood-brain barrier (less risk of CNS toxicity: sedation, delirium)

• The scopolamine patch releases ~1 mg over 72 hours. It takes 24 hours to reach steady state and for acute symptoms other drugs should be used. The patch should be placed on hairless skin just behind the ear, is changed every 72 hours, and more than one patch can be used at a time.
Sleep Disturbance

• EYES CLOSED, LAYING STILL, DOES NOT EQUATE TO SLEEPING! This is why Night RN report is only of limited value

• Loss of deep, restorative night sleep will increase risk of delirium, confusion, magnify sx burden (pain, anxiety, dyspnea)

• Important to properly assess and treat
  – Benzodiazepining (short term), Benzodiazepine Receptor agonists (Ambien – not in elderly), Atypical antipsychotics (seroquel, zyprexa, but not risperdol), Antidepressants (mirtazapine, trazodone), Antihistamines (NOT in the elderly, increase sleep duration but not qulaity).
CONSTIPATION

- Consider Opioids (methadone least of the offenders)
- Patients who are eating/drinking very little or not at all still make stool
- Poor appetite, nausea, abdominal pain, dyspnea, anxiety, agitation/delirium

Treatment:
- Bowel regimen (maintenance)
- Dulcolax, Enema, High/Hot
- Relistor (Opioid induced)
- He/She who orders the opioid MUST order the bowel regimen
  - Colace alone NOT effective, all mush, no push!!
Dysphagia

• Due to advancing disease, dementia, advanced aging?

• Feeding Tube Discussion
  – Consider etiology of dysphagia
    • Aspiration?
    • Saliva as culprit?

• Palliative Introduction of Diet
  – Assumed Risk
  – Seldom reason to pursue further antibiotics
Dementia at the End of Life

• 5th leading cause of death in persons over the age of 65

• Centers for Disease Control and Prevention 2000-2004
  – Dementia deaths rose by 33%
  – Deaths from cardiac disease and many cancers decreased

• Roughly 1 in 10 persons dying with dementia enrolled in hospice
The Dementia Decline

- Progressive loss of functionality, personhood
- Withdraw, loss of interest in eating, interaction
- Recurrent infection (aspiration pneumonia, UTI, wounds)
- Falls, fractures/bleeds
- Dysphagia, Wt loss, poor oral effort
- “She was fine last week”
Syndrome of Imminent Death

• Stages
  – Early (bedbound, loss of interest)
  – Middle (brief awakenings, death rattle)
  – Late (coma, fever, mottling, altered resp)

• Time Course
  – 24hrs to 14 days

• Family Concerns

• Proper Documentation ("patient is dying" not "prognosis is poor")

• Death is a moment, dying is a process
  – help families to understand that we do not control the EOL time-frame. We allow for as much comfort during this time as possible.
Some Reading to Consider:

• THE BEST CARE POSSIBLE
  – Ira Byock, MD
• End of Life; Nursing Solutions for Death with Dignity
  – Lynn Keegan, Carole Ann Drick
• BEING MORTAL
  – Atul Gawande
• On Death and Dying
  – Kubler-Ross
• HOW WE DIE
  – S. B. Nuland
• LIVING WITH DYING
  – J Berzoff, P.R. Silverman
Wisdom from Ira Byock, MD
Leading Palliative Care physician in USA

“Dying is not medical... it is personal... it is not about when... it is about how”

The Four Things That Matter Most:
1.) Please Forgive Me
2.) I Forgive You
3.) Thank You
4.) I Love You

http://www.thefourthings.org/excerpt.htm
Final Thoughts...

It is an honor, a sacred privilege, to be part of a patient’s final life chapter.

As much as we all want to advocate and do the right thing for our patients, we must understand that Palliative Care is not always wished for by every patient/family- each patient has the right to refuse Palliative Care and to continue to pursue aggressive care.

Sometimes...we have to let go...

“The only way a clinician can become expert in the practice of palliative medicine is one patient at a time” – Ira Byock, MD