Palliative Care

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Palliative care

- The oncology nurse as a palliative provider
- Symptom management tools
- Communication strategies
- Coping with distress and Self-Care

Useful Apps:

- “Vital Talk”
- “Vital Tips”
- “Fast Facts”
- “Opioids” – Conversion calculator program
Definition of Palliative Care

Specialized medical care for people with serious illnesses… focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis

The goal is to improve quality of life for both the patient and family… provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support

Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment

Center to Advance Palliative Care 2011

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Oncology Nurses as providers of Palliative Care

Important for Palliative Care tools and techniques to be incorporated into basic nursing skill sets and standards of practice.

Nurses play a crucial role in communication and symptom management in patients with advanced illness.

Nurses should have a meaningful presence in all phases of care and planning. Attend family meetings.
Guidelines for Palliative Care in Cancer Patients

- ASCO (American Society for Clinical Oncology) recommends considering palliative care + standard oncology care early in the course of treatment for patients with metastatic cancer and/or a high symptom burden.

ASCO Guidelines

- Start Palliative Care as soon as the cancer becomes advanced
- For newly diagnosed patients w/ advanced cancer, begin w/in 8 weeks after diagnosis
- Inpatients and outpatients with advanced cancer should have dedicated palliative services early in the disease course concurrent w/ active treatment

ASCO components of palliative care

- Rapport/relationships w/ patients and family
- Symptom management (Pain, dyspnea, fatigue, sleep, mental health, nausea, constipation)
- Exploring insight/educational needs about disease/prognosis
- Understanding/clarification of treatment goals and medical decision making
- Support/coping needs
- Care coordination and referrals w/ other services and providers

National Comprehensive Cancer Network (NCCN) Guidelines

- All patients should be screened for palliative care needs beginning with diagnosis and routinely afterward
- All professionals should develop primary palliative care knowledge
- Focus on interdisciplinary approach to care
NCCN Screening guidelines:

- Uncontrolled symptoms
- Moderate-to-severe distress r/t CA diagnosis &/or therapy
- Serious comorbid disease, including psychiatric conditions
- Concerns about the course of the disease and decision-making from patients and family
- Patient/family requests

Symptom Management Basics

Oral morphine equivalents

- The “1:2:3” rule:
  - 1 mg IV MS =
  - 2 mg po oxycodone =
  - 3 mg po MS

Example:
Pt. taking MS Contin 60 mg q12h + oxycodone 10 mg q6h prn, 3x/d.
How many oral morphine equivalents?
Ans:
Morphine 60 x 2 = 120
Oxycodone 10 x 5 x (3/2) = 75
Oral morphine equivalents 195

- The “30:20:10:7.5:1.5” rule:
  - 30 mg po MS =
  - 20 mg po oxycodone =
  - 10 mg IV MS =
  - 7.5 mg po hydromorphone =
  - 1.5 mg IV hydromorphone
Management of opioid side effects

**Nausea**
- Usually temporary, 3-5 days
- Antidopaminergic antiemetics (metoclopramide, prochlorperazine)
- Refractory—try corticosteroids, or ondansetron
- More constant drug levels helpful—change to long-acting, topical, or shorter dose intervals

**Constipation**
- Stimulant (Senna or bisacodyl), or osmotic laxative (polyethylene glycol; or mag. citrate, lactulose)
- Stool softeners alone ineffective

**Pruritus**
- Rare; caused by histamine release
- Switch to another opioid
- Anti-histamines

**Sedation**
- Dissipates as tolerance develops
- Dose reduction or drug rotation

**Neuropathic pain**
- Direct pathologic changes to central or peripheral nervous system
  - Nerve root compression, encroachment of fibers on nerve plexus
  - Burning, tingling, stabbing, shooting
- Corticosteroids
  - Reduce edema and pain of obstruction; improve mood/appetite/energy
  - Lyse certain tumors, enhancing analgesic effects of pain meds.
- Effective for:
  - Malignant infiltration of brachial and lumbar plexus
  - Cord compression
  - Headache from brain tumors
  - Peripheral neuropathy
- Opioids
- TCA’s
- Venlafaxine or duloxetine
- Gabapentin
- Pregabalin

**Bone pain**
- Bone metastases
- XRT
- Corticosteroids
- Bisphosponates
- Interventional procedures
- Cryoablation
- Radiofrequency ablation

**Fatigue**
- The most common symptom
- Underdiagnosed, undertreated
- Contributors
  - Cancer, cancer treatment, anemia, mood disorders, sleep, pain/anxiety, infections, deconditioning, cachexia, hypoxia, dehydration, polypharmacy, etc.
- Treatment—aimed at underlying causes
  - Pharm: steroid, megestrol, methylphenidate, antidepressants
Dyspnea

• Causes:
  – Cardiac or pulmonary processes
  – Debilitation
  – Wasting syndromes
  – Neurodegenerative disorders
  – Progressive, chronic disease

• Potentially treatable causes:
  – Pleural effusions
  – Pneumonia
  – Severe anemia
  – Ascites

• Subjective severity correlates poorly with resp. rate, ABG, SaO2 %, use of accessory muscles

Dyspnea

• Treatment:
  – Gold standard: oral morphine, low dose 10-20 mg/day
  – Benzodiazepines NOT consistently useful, unless treating anxiety
  – O2: useful if hypoxemic, but otherwise no better than room air

Nausea: which treatment for which cause?

• Opioids: dopaminergic signaling (metoclopramide, prochlorperazine)
• Chemotherapy: serotonin antagonists (ondansetron)
• Increased intracranial pressure: corticosteroids
• Mechanical bowel obstruction:
  – Pharm: dexamethasone, octreotide, haloperidol
  – Non-pharm: venting gastrostomy; sleeve
• Radiation: serotonin antagonists (ondansetron)
• Motion sickness, cerebellar mets.: anticholinergic antihistamines (scopolamine, meclizine, diphenhydramine)
• If obstruction ruled out: metoclopramide + dexamethasone; glycopyrrolate (antichol.)
**Agitation, distress**

- Reversible causes: pain, urinary retention, fecal impaction
- Delirium: diagnosis of exclusion
- Manifestations of distress: non-specific
  - Hyperactivity vs. apathy
  - Moaning or grunting
  - Irregular breathing and tracheal secretions ("death rattle")
- Very distressing for families; clinician plays key role in educating re. signs of death and dying
- Prophylactic anticholinergics (scopolamine) during active dying reduce tracheal secretions

**Delirium**

- Definition: acute change in mental status
- R/O treatable causes: meds., pain, urinary obstruction, bowel impaction, sensory deprivation
- Treatment:
  - Small doses haloperidol; chlorpromazine (10-25 mg po or sq; more sedating)
  - Avoid benzos: paradoxical worsening
  - Non-pharm: re-orienting; bedside sitter

**Depression**

- Transiently depressed mood normal in serious, life-threatening illness
- Symptoms persisting weeks and meeting diagnostic criteria for depression are not "normal", and should be treated
  - Grief vs. depression
- Pharmacologic treatments:
  - SSRIs
  - Methylphenidate
  - Metazapine (depression w/insomnia, anorexia)
  - TCAs, duloxetine, venlafaxine (w/ neuropathic pain)

**Anorexia**

- Common in cancer and chronic disease
- Eating/enjoying food essential in social interactions
- Distressing to patients and families
  - "Giving up!", guilt for caregivers and patients
- Educating patients and caregivers
- Appetite stimulants if death not imminent
  - Progestins
    - Megestrol 400-800 mg po qd
    - Medroxyprogesterone 500 mg po bid
  - Side effects: thromboembolic, hyperglycemia, adrenal suppression, vaginal bleeding
  - Corticosteroids
    - Dexamethasone 2-4 mg po bid
    - No impact on mortality, +/- QOL
Summary: Evidence based interventions

1. Regularly assess patients for:
   - Pain
   - Dyspnea
   - Depression

2. Use therapies of proven effectiveness to manage pain:
   - NSAIDs
   - Opioids
   - Bisphosphonates (bone pain in breast ca, myeloma)

3. Use therapies of proven effectiveness to manage dyspnea:
   - Opioids
   - Beta agonists (COPD)

4. Use therapies of proven effectiveness to manage depression:
   - SSRIs, TCA's
   - Psychosocial intervention

5. Ensure advance care planning occurs:
   - Surrogate decision makers
   - Resuscitation and emergency treatment
     - Should occur early in course
     - Discussions about
       - Tube feedings
       - Malignant bowel obstruction


Issues Specific to WA (*Not practiced w/in VA-Federal system)

Medical Marijuana
- Focusing on safety

Physician Assisted Suicide
- Addressing the concerns, fears and emotions behind the question first. Educating people about all options including palliative sedation. Policy varies by facility.
- Online resources available.

Alternative Therapies

Tesla balls, Bacon Wraps, Folger’s Crystals, copper panels, light therapy, Frankinscense, photon balancing, goat testicles, shredded beets in Mexico, eating an endangered species?

When used instead of traditional tx for treatable/curable cancers, can have much greater risk of death.

How do you support hope and desperation and individual choice and how do you protect vulnerable patients from con artists and hucksters.

When Specific to WA

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Miracles

- Emotional adaptation
- Avoidance mechanism
- Expression of religious beliefs
- A test of faith
- Last hope
Belief in Miracles

- 57% believed God could save patient even if MDs declared treatment futile
- 1 in 5 MDs & medical workers believed God could reverse a hopeless outcome
- 61% of 1006 adults believed a person in a vegetative state could be saved by a miracle
- 20.2% of trauma professionals believed the same

Factors contributing to effective coping
- Good communication
- Trust among patient, family, and clinical team
- Opportunities to share fears and concerns
- Meticulous attention to physical symptoms
- Attention to psychological and spiritual concerns

Communication Challenges

Effective communication skills
- To family, more important than clinical skills
- Only 1/3 of families understand basic information
- Use simple explanations
- Use the words “dying” and “death”
- Use a professional interpreter

Words to avoid:
- Withdrawal of CARE
- There’s nothing more we can do
Words that Work

- **Ask**
  - What do you understand?
  - What do you want to know?
- **Tell**
  - Necessary information
- **Ask**
  - Their understanding
- “I wish”
- “I worry”

Guided Narrative

*Stu & Lu Farber 2013, may use for education only, all other uses require permission*

What do you already know?
- What is your understanding of your situation?
- How do you see things?
- What is important to you right now?
- What is important to discuss today?
- What do you see as your future?

What are your experiences?
- Have you ever cared for someone who is seriously ill?
- What are your experiences with loss?
- How do you cope with difficulties?
- Where do you draw strength to get through each day?

Guided Narrative

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- What are your social supports?
  - Who would speak for you if you can’t?
  - Who will you depend on for help?
- What are your goals for care?
  - What are you hoping for?
  - What are you concerned (worried) about?
  - What do you feel is really important to do in the time left to you?
- What else do you want me to know about who you are or what you believe?

Allowing time

- 64% doubted prognosis
- <2% based their belief on MDs prognosis
- 32% chose life support with < 1% chance of survival

*Zier LS et al. Chest 2009;126:1 Jul 2009, 110-117*
What about you?

**Self care:**
- Recognize how patient’s death impacts you
- Recognize signs of moral distress
- Recognize signs of compassion fatigue
- Know signs of Burnout: Oncology nursing one of the top areas for nursing burnout

**Resources:**
- Chaplain
- Preceptor / mentor
- Co-workers
- Manager
- Palliative Care team
- Employee Assistance Programs
- Professional counselling

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**Mindfulness Technique:** (becoming less reactive)

**Facing crisis or tough problem:**

- Recognize you've already made unwarranted assumptions (Something is going to happen; that something will be bad)
- Give yourself 3 reasons that if it does happen and turn out bad, good things will also happen (what are the good outcomes in addition to the bad)

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**What does Saving Lives Mean?**

Redefining our perspective

- Physical recovery to meaningful life?
- Patient/family definition may be ok with what we ourselves perceive as "good" quality of life
- May have alternative meanings: Peace of mind, creating meaningful living and dying experiences, closing, recognizing and validating a life well lived (or endured) developing story or narrative about past, healing relationships, not letting people get lost in fear and loneliness, being there to hear and recognize and validate their experience.
Learning the backstory...

- Fully understanding the patient and family experience, knowing who they are
- Motivations and choices gleaned from a life story
- Eliminate assumptions and prejudice
- Read multidisciplinary notes, share the story with the entire team, develop care plan accordingly
- Pictures, “getting to know you” poster, life review, and reminiscence questions
- Create an understanding of why people make specific choices, based on their own complex life experiences

Self Care:

- Consider grief resolution, rituals/ceremonies
- Debriefing for stressful cases or loss
- Peer-supported story telling, group outings/gatherings

Self Kindness

- Cultivate an awareness of when you are self-criticizing, blaming or condemning and STOP
- Remind yourself of the good nursing practices you engaged today
- Give yourself three compliments about what you’ve done well
- Celebrate and share the little moments of success, humor, teamwork

"In the practice of our art it often matters little what medicine is given, but matters much that we give ourselves with our pills."
Bibliography


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Gratitude to Michelle Whitney, MA, WHNP-BC, ACHPN for lend of slides 2, 18, 20–22, 37, 46.

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