Palliative Care to the Rescue: Your Wish is My Command

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• The content and/or presentation of the information will promote quality or improvements in healthcare and will not promote commercial interests.
What Is Palliative Care?

• Palliative Care is an approach to care that focuses on comfort and quality of life for those affected by life-altering or life-limiting/life-threatening illness.

• Its goal is much more than comfort in dying; palliative care is about living, through meticulous attention to control of pain and other symptoms; supporting emotional, spiritual, and cultural needs; and maximizing functional status.

• The spectrum of investigations and interventions consistent with a palliative approach is guided by the goals of patient and family, and by accepted standards of health care.
Purpose of Palliative Care

- Enhance the ability of patients and families facing serious illness/injury to cope with their health challenges and improve the quality of their life

- Collaborate with health care providers who treat patients and families with serious illnesses/injury for well-coordinated, effective and efficient care focused on patient/family goals

- Reduce ICU days, LOS, readmissions, mortality rate
When Palliative Care is Involved

• Significant reduction in symptom distress
• Lower ED visits
• Fewer and shorter hospital and ICU admissions
• Better mood and less depression
• Better QOL
• Longer median duration of survival
• Byproduct > reduced cost of care

Has Palliative Care Improved Symptom Outcomes?

• N = 19,747
  – 27,928 episodes of care

• Significant improvements in:
  – Symptom control
  – Family care
  – Psychological care
  – Spiritual care

• Symptom Assessment Scale and Palliative Care Problem Severity Score

Currow et al., 2014.
Palliative Care, More Bennies

• Reduce inpatient costs by $2,500 to $3,426 for those dying in hospital

• 33% reduced spending on outpatient care

• More satisfied patients
  – We listen to them
  – We advocate for them
  – We help them understand and make the decisions they want

Bull & Abernethy, 2014; McCarthy, Robinson, Huq, Pilastre & Fne. 2014
• Promotes early introduction to palliative care is best practice
Palliative Care: The “What If…?” Tour Guides

• Can help inform the choice of not intervening
  – What would things look like?
  – Time frame?
  – What should the patient/family expect (perhaps demand?) regarding care?
  – How might the palliative care team help patient, family, health care team?
Definitions and Goals of Care

• Palliative Care
  – Promote possible best quality of life regardless of disease stage or treatment goals
  – Family-centered care
  – Anticipate, prevent and treat suffering
# Palliative, Hospice, and Supportive Care Compared

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>Hospice Care</th>
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<td>Curative and/or supportive care</td>
<td>End-of-life care or less than 6 months life expectancy</td>
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**Palliative Care**

- Patient/family-centered with goal to optimize quality of life
- Interdisciplinary team approach
- Curative and/or supportive care
- Life-altering or life-debilitating disease

**Supportive Care**

- Usually when curative no longer feasible
- Focus to treat symptoms for comfort
- Generally precedes hospice care

**Hospice Care**

- End-of-life care or less than 6 months life expectancy
- Addresses needs of dying person
- Grief and bereavement care is essential component
- Uses hospice benefit under Medicare
Potential Palliative Care Interventions

Hospice

Support
- Emotional
- Spiritual
- Psychosocial

Control of:
- Pain
- Dyspnea
- Nausea
- Vomiting

Variable
- Infections
- Transfusions
- Hypercalcemia
- Tube feeding
- Dialysis

Generally palliative
- CPR
- Ventilation
- Highly burdensome interventions
Who Would Benefit from Palliative Care?

• Those requiring:
  – Complex symptoms management including physical, emotional and spiritual
    • Pain, respiratory distress and anxiety
    • Ineffective coping and unclear goals of care

• Who have:
  – Curable, treatable or no treatment available/desired
  – Undefined or defined prognosis

• May precede or follow outpatient palliative or hospice
Better patient and caregiver outcomes
  – Symptom improvement, QOL, patient satisfaction and reduced caregiver burden

More appropriate hospice use and referrals

No harm or excessive costs to patient

Auto referral with metastatic NSCLC

Auto referral for metastatic cancer and/or high symptom burden

More research on impact of palliative on patient and caregiver outcomes

High Risk Patients for Palliative Care

- Diagnosis of metastatic cancer
- Admitted from a skilled-nursing facility
- Serve baseline cognitive dysfunction
  - Non-ambulatory
  - Bed sores due to dementia
  - Minimal (< 6) intelligible words during assessment
  - Dependent in all ADL’s
- Two or more hospitalizations within 3 months for same/similar diagnosis
- More than one ICU admission during same hospitalization
• >50% ED visits resulted in hospital admission within last 6 months of life (Lawson, Burge, McIntyre, Field, & Maxwell, 2008)
  – Symptoms: Pain and SOB
  – Risk factors: Weight loss and recent hospitalization (Brink & Partanen, 2011)
Characteristics of Those Using ED at End of Life

• Did not wish to die at home
• Did not wish to die now
• Did not have advance directive
• Married
• Less than 75 years old
• Believed physical function could improve

Salam-White, Hirdes, Poss, & Blums, 2014
• 52.2% (n = 399) had 1 or more ED visits
• 75.3% resulted in admission (n = 284)
• 60.1% of those admitted died in hospital

Salam-White, Hirdes, Poss, & Blums, 2014
Patient’s Choice of Where to Die

- $N = 433$ pancreatic carcinoma
  - 2008 to 2011
  - Retrospective analysis

- Males in hospital, females in PCU

- Live near cancer center: home
  - Live further away: hospital

- More likely to choose BSC: PCU
  - Non standard chemo: hospital
  - CAM: hospital

- Case worker involved: home

Kondo et al., 2014.
If Advance Directive Completed...

• More likely to die where patient chooses
  – Majority choose home

• Hospital death rates
  – 11% if have Advance Directive
  – 26% in no Advance Directive

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<th>WHO PROVIDES?</th>
<th>INPATIENT PALLIATIVE</th>
<th>OUTPATIENT PALLIATIVE</th>
<th>HOSPICE</th>
<th>HOME HEALTH CARE</th>
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<tbody>
<tr>
<td>St. Vincent/St. Mary’s Palliative Care Program</td>
<td>Unity’s Palliative Care Program</td>
<td>Unity Hospice</td>
<td>St. Vincent HHC</td>
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<th>MAJOR BENEFIT</th>
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<tr>
<td>Complex symptom management: Physical, emotional and spiritual</td>
<td>Link to community resources; coordinate services/symptoms; case management of physical, emotional and spiritual needs; anticipate future needs; and educate on disease progression</td>
<td>Expert end-of-life symptom management; case management of physical, emotional and spiritual needs; anticipate future needs; and educate on disease progression</td>
<td>Skilled nursing therapies, home assessment and wound care</td>
<td></td>
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<tr>
<th>DISEASE TREATMENT VS. PATIENT SYMPTOM TREATMENT</th>
<th>INPATIENT PALLIATIVE</th>
<th>OUTPATIENT PALLIATIVE</th>
<th>HOSPICE</th>
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<tr>
<td>Curable, treatable or no treatment available</td>
<td>Curable, treatable or no treatment available; patient is hospice-eligible, but does not want it</td>
<td>No or ineffective treatment available or patient chooses not to treat</td>
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<th>PROGNOSIS</th>
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<td>Any length of time</td>
<td>Life limiting disease; could decrease emergency, hospital or clinic utilization</td>
<td>6 months or less if diagnosis runs a normal course; patients 21 years or younger may be on hospice while seeking aggressive care</td>
<td>Admissions based on skilled need</td>
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<th>POSSIBLE CARE SETTINGS</th>
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<td>Inpatient</td>
<td>Home, CBRF, ALF, RCAC or group home</td>
<td>Inpatient for limited time if unstable condition, Meng Residence, home, and CBRF or SNF that have hospice contract</td>
<td></td>
<td>Home, CBRF, ALF, RCAC or group home</td>
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<th>COMBINATION OF SERVICES</th>
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<td>May precede or follow outpatient palliative care or hospice</td>
<td>May precede or follow inpatient palliative or hospice; *may be combined with home health if different diagnosis</td>
<td>May be combined with private pay services in the home or Medicaid reimbursement in a SNF</td>
<td></td>
<td>*May be combined with outpatient palliative if there are more than one eligible diagnoses</td>
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Hospice

• 1/3 patients die within one week
• Average LOS 71.8 days in 2012
• Median LOS 18.7 days
• Palliative care increased access to hospice services

Our Work

• Determine decision-making capacity
  – Need for activation of Advance Directive
  – Determining decision making capacity

• Have Goals of Care been established?
  – Care vs. family meeting

• Resuscitation status
  – In hospital and in community

• Advance Directive completed and valid
• The overall goal of the plan of care is to assist the patients and families with establishing and implementing individualized goals, including advance care planning. Other goals include:

  – Educating the patient and family to increase understanding about their underlying disease.

  – Establishing an environment of comfort and healing.

  – Planning discharge to the appropriate level of care and in a timely manner.

  – Assisting actively dying patients and their families, so they may prepare for and manage self-determined life closure.

  – Staff support
Referrals

• Originate from physicians, nurses, family members, patients, case managers and previous admissions to the palliative care service

• The physician or advanced practice nurse writes an order for a palliative care consult noting specific palliative care needs.

• When the order is entered into EPIC, the palliative care advanced practice nurses are notified and respond within 24 hours, Monday through Friday, or the following Monday for late Friday and weekend referrals.
The palliative care team consists of the patient/family, referring physician/advanced practice nurse, collaborating physician, advance practice nurses, psychotherapist, massage therapist, child life specialist, psychiatrist, pharmacist, speech and physical therapist, pastoral care associate and case manager.

Unity Hospice, a palliative care RN and social worker are also part of the team, especially as patients transition to hospice or outpatient palliative care.
Other members of the palliative care team are consulted based on the plan of care.

Patients are reviewed with the palliative care team on a weekly basis.

Case Management is consulted on every patient on the palliative care service to promote continuity of care from inpatient to post hospitalization care.
Discharge Process

• If a referral is not appropriate for palliative care, the immediate symptom management for the patient is addressed, the referring physician notified and the patient is discharged from the palliative care service.

• Patients may be discharged from the palliative care service when the patient’s goals are met, when the patient is discharged from the hospital, from inpatient status or upon patient request.
Massage Therapy

• Integral part of palliative care team
• Offers light massage, touch, relaxation and aromatherapy
Pain Management

• Acute pain crisis

• Complex pain management issues
  – History of chronic pain
  – History of addiction
  – Variables limiting ability to manage pain adequately

• Evidence-based pain management
Frequency of Symptoms Addressed in Palliative Care

- 1,067 consultations on 922 patients
- 56% pain
- 34% delirium
- 25% dyspnea
- 14% fatigue
- 12% end-of-life psychosocial issues
Palliative Care Myths

- They’re not ready for palliative yet
- The patient isn’t dying
- I don’t want the patient to think he/she is dying
- I don’t want to scare the patient
- I’ll check with the family and see if they want palliative or if they are ready
Communication

- Clarify goals and expectations
- Relay information
- Ensure that patient needs are met
- Enhance relationships
- Facilitate coping

Lack of communication skill:
- Likely to thwart future exchanges
- Negate the trust involved in an enduring medically-based relationship
- Deter realistic hope
- Enhance emotional distress
Improve Communication

• Sit at eye level
• Focus on patient
• Eye contact
• Short sentences
• Simple language with pauses
• Drawings/pictures
• Verbal feedback
• Share written summary
Improve Communication

• Acknowledge feelings
• Ascertain level of participation
• Social and financial concerns
• Do not interrupt
• Allow silence
• Hide cues that you are in hurry
• Don’t use, ‘Do you understand?’
Communicating Bad News

• Nurse
  – Naming emotions
  – Expressing understanding
  – Showing respect or praise for patient’s behavior
  – Articulating support for the patient
  – Exploring the patient’s emotional state
Communicating Bad News

• Spikes
  – Setting
  – Perception
  – Invitation
  – Knowledge
  – Empathy
  – Summarize/strategize
• Palliative care is one of the newest recognized nursing specialties

• Palliative care refers to the science of caring for patients and families confronted with life threatening disease that is unresponsive to only conventional evidence-based medical interventions

• Hospice is one component of palliative care that focuses on issues proximal to the end-of-life

• The evidence-base to direct individualized planning in palliative care has evolved slowly
Conclusion

- Palliative care and hospice nursing is an integral part of nursing
- Growing field in nursing, based on the aging of our population and ability to keep people alive with more chronic illnesses
- More empiric research is needed to identify and test effective interventions in palliative and end-of-life care
Thank You

Any questions?