Palliative Care: Fundamentals for Your Everyday Practice
Medical-Surgical Nursing Conference 2014

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Objectives

• Review definitions & misconceptions
• Palliative care assessment
• How you can use primary palliative care skills in your everyday work
• Helpful links & resources
Myths about Palliative Care

• Only for patients who are dying
• Giving up, providing less thorough care or hastening death
• The same as hospice
• Provided when there are no further treatments to be offered

*Actually, Palliative Care is about living!*
Palliative Care - definition

• Palliative care is specialized medical care for people with serious illnesses. It is 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 the family.

• Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

CAPC - Center to Advance Palliative Care
Myths about Hospice

• Hospice is a place
• Hospice means that the patient will die soon
• Hospice is only for cancer patients
• Patients can only receive hospice care for a limited amount of time
• All hospice programs are the same
• Patients can only get hospice at home
• Hospice provides 24-hour ATC care
• Must be DNR
What is Hospice?

- Hospice is a philosophy of care that focuses on comfort and quality of life, rather than extension of life or cure
- Hospice care neither prolongs life or hastens death
- Hospice is a program for patients with a prognosis of 6 months or less, who agree to forgo curative treatment
- Hospice care is a choice
- RN available by phone 24/7
- Covered by insurance
- Most commonly in home, but may be inpatient setting (SNF, residential facility, board & care)
What is Comfort Care?

• Patient no longer seeking aggressive treatment of illness
• May gradually stop interventions/treatment while transitioning to comfort care
  +/- Antibiotics, oxygen, IV fluids, artificial nutrition
• May be actively dying – prognosis hours to days
• Comfort care orders – focus on symptom management and ensuring comfort
• Dignity
Putting it all together

Alexian Brothers Health System graphic
Primary Palliative Care Assessment Components

- **Pain/Symptom Assessment**
  Are there distressing physical or psychological symptoms?

- **Social/Spiritual Assessment**
  Are there significant social or spiritual concerns affecting daily life?

- **Understanding of illness/prognosis and treatment options**
  Does the patient/family/surrogate understand the current illness, prognostic trajectory, and treatment options?

- **Identification of patient-centered goals of care**
  What are the goals for care, as identified by the patient/family/surrogate?
  Are treatment options matched to informed patient-centered goals?
  Has the patient participated in an advance care planning process?
  Has the patient completed an advance care planning document?

- **Transition of care post-discharge**
  What are the key considerations for a safe and sustainable transition from one setting to another?

Palliative Care at the Bedside: What this looks like

- Knowing your patient’s individual goals
- Recognizing physical & psychosocial distress
- Prioritizing management of symptoms/distress
- Advocating for excellent symptom management
- Optimizing the environment of care
- Empathic presence for patient & family
SBAR & Palliative Care
The NURSE Tool

<table>
<thead>
<tr>
<th>Skill</th>
<th>Theme</th>
<th>Example Phrase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naming</td>
<td>State your observation of the patient’s emotion</td>
<td>“I can see you and your husband are concerned about your current condition”</td>
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<tr>
<td>Understanding</td>
<td>Legitimize the patient’s emotion</td>
<td>“I can imagine this news may be shocking”</td>
</tr>
<tr>
<td>Respecting</td>
<td>Praise or acknowledge the patient’s work</td>
<td>“I am so impressed with your courage”</td>
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<tr>
<td>Supporting</td>
<td>Let the patient know she is not alone</td>
<td>“I want you to know that I will be with you until the end”</td>
</tr>
<tr>
<td>Exploring</td>
<td>Ask the patient to elaborate on her feelings</td>
<td>“Tell me more about what is on your mind”</td>
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</tbody>
</table>
Symptom Management

• Pain
• Dyspnea
• Nausea
• Constipation
• Anxiety
• Delirium
Pain management pearls

• Pain may sharply increase at EOL
• Pain history helps determine best treatment
• Opioid usually best choice for severe pain
• Help pt/family distinguish ALOC d/t disease progression/EOL from perceived side effects of opioid
• Understand role of long-acting & short-acting opioid
  – Long: MS Contin, OxyContin, Methadone taken on schedule (chronic pain, scheduled/ATC)
  – Short: Oxycodone, morphine elixir, IV opioid (acute/breakthrough pain, PRN)
• Opioid drips act like a basal opioid
  – Don’t increase the drip in response to acute discomfort
• Adjuvants for atypical pain
PRN vs. ATC dosing

**PRN Dosing**

![Graph showing PRN dosing with cycles of relief and sedation/euphoria/dysphoria](image1)

**ATC Dosing**

![Graph showing ATC dosing with smooth Pain Relief and prolonged duration of effect](image2)
How to determine appropriate PRN opioid dose

• PRN dose should be **10-20% of the 24 hour total opioid dose**

• Taking the time to do the math will ensure most accurate dosing possible

  Example: Mr B takes MS Contin 30 PO mg q8hrs
  30 x 3 = 90 mg 24hr total
  10-20% is 9-18 mg IR morphine PO (or round to 10-20 mg PO)

  This equals roughly 3-6 mg IV morphine
Maximizing comfort with PRN meds

• Ensure adequate dose range & frequency ordered
  – IV for severe symptoms/pt unable to take PO
  – UCSF comfort care standard is opioid q15min IV PRN pain/dyspnea
  – Low threshold to increase dose, frequency if symptoms not relieved
  – Opioid equianalgesic conversions: math is your friend
Opioid Equianalgesic Conversions

<table>
<thead>
<tr>
<th>OPIOID</th>
<th>ROUTE</th>
<th>EQUIANALGESIC DOSE</th>
<th>STARTING DOSE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>PO</td>
<td>30 mg</td>
<td>5-10 mg</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>10 mg</td>
<td>2-3 mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>PO</td>
<td>20 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Hydromorphone*</td>
<td>PO</td>
<td>7.5 mg</td>
<td>2 mg</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>1.5 mg</td>
<td>0.2-0.4 mg</td>
</tr>
<tr>
<td>Fentanyl+</td>
<td>IV</td>
<td>100-200 mcg</td>
<td>12.5-25 mcg</td>
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Oxycodone to Morphine IV

Current dose \times \frac{\text{new drug equivalent}}{\text{old drug equivalent}} = \text{new drug dose}

Oxycodone 10mg PO \times \frac{10\text{mg Morphine IV}}{20\text{mg oxycodone PO}} = 5\text{mg Morphine IV}
Dyspnea pearls

- Subjective sensation of difficulty breathing
  - Dyspnea/tachypnea/air hunger
  - Use of accessory muscles, increased “work of breathing”

- **Opioid** is drug of choice
  - Opioid receptors in pulmonary tract
  - Morphine is gold standard
  - Dilaudid, Fentanyl in setting of renal dysfunction
  - IV for severe dyspnea or imminent death
  - Opioid/benzo combo=good synergy

- Fan/air circulation
- Optimize positioning
- Minimize excess fluids (IVF, parenteral nutrition)
# Nausea Pearls

## Antiemetics

<table>
<thead>
<tr>
<th>Antiemetic</th>
<th>Indication</th>
<th>Side Effect/Caution</th>
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<tbody>
<tr>
<td><strong>Dopamine Antagonists</strong></td>
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<tr>
<td>Haloperidol 0.5-2 mg po/IV/SQ q 6 h</td>
<td>Toxic/metabolic (e.g. medication-induced, renal, hepatic); for Opioid induced N/V</td>
<td>Dystonia; Sedation; QTc prolongation</td>
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<tr>
<td>Prochlorperazine 5-10 mg po/IV/pr q 8 h</td>
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<tr>
<td><strong>Anticholinergics / Anti-Muscarinics</strong></td>
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<tr>
<td>Promethazine 12.5-25 mg po/pr q 4 h</td>
<td>Inflammation of GI tract; Bowel obstruction</td>
<td>Sedation; Delirium</td>
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<tr>
<td>Scopolamine 1.5 mg patch every 3 days</td>
<td>Prevention of opiate-induced nausea</td>
<td>Sedation</td>
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<tr>
<td><strong>Pro-Motility Antagonists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metoclopramide 5-10 mg po/IV/SQ q 6 h</td>
<td>Gastric stasis</td>
<td>Sedation</td>
</tr>
<tr>
<td><strong>Serotonin (5HT3) Receptor Antagonists</strong></td>
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<tr>
<td>Ondansetron 4 mg po/IV q 6 h</td>
<td>Chemotherapy-or radiation-induced</td>
<td>Mild h/a; Constipation; Caution w/ liver failure</td>
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<tr>
<td><strong>Benzodiazepines</strong></td>
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<tr>
<td>Lorazepam 0.5-1 mg po/IV q 6 h or SL</td>
<td>Anticipatory nausea</td>
<td>Caution: Weak antiemetic; Avoid as single agent</td>
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<tr>
<td><strong>Steroids</strong></td>
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<tr>
<td>Dexamethasone 8 mg po/IV daily or divided BID</td>
<td>Increased intracranial pressure, nausea refractory to other meds</td>
<td>Mood swings; Elevated BP; Hyperglycemia</td>
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Constipation

• **Always** need bowel regimen in setting of opioid use
• Docusate - least effective, most commonly prescribed, inadequate as single agent
• Senna dosing – up to 4 tabs BID
• Dulcolax suppository
Delirium & Anxiety Pearls

• Delirium common at EOL- hyperactive/agitated or hypoactive
• Anxiety may be component of acute or chronic pain, dyspnea, nausea, cardiac arrhythmias, psych disorder, adverse drug effect
  – Address possible untreated symptoms as underlying factor
  – Haldol, Lorazepam
• Existential/psychosocial concerns about dying, disability, loss, legacy, family, finances, and religion/spirituality
  – Empathic communication, NURSE tool
• Near death awareness vs. delirium
Care at End of Life: Comfort Care

• Minimize invasive monitoring
  – Treat symptoms, not numbers
  – Numbers often add to patient/family anxiety level & don’t provide useful information regarding comfort level
• Consider reducing or stopping:
  – Vital signs (standard comfort care vitals are pain, resp rate, anxiety/agitation level)
  – IV fluids as leads to increased secretions, edema
  – Needle sticks (lab draws, routine IV changes, etc)
  – Deep suctioning
  – Painful repositioning
  – Painful or invasive aspects of physical exam
• Promote calm, peaceful environment
• Ensure code status has been addressed
Comfort oriented approach to routine medications

• Review medications, consider stopping those not related to comfort
  – Reduce pill burden, allow patient to focus on comfort-oriented meds (pain, nausea, anxiety, bowel regimen)
  – Prioritize administration of pain meds/comfort-oriented meds
  – Continue long-acting pain meds if patient able to reliably swallow
  – Request ATC IV pain meds if patient unable to swallow
  – Avoid regimens that wake patient up to provide dose
Minimizing excess fluids

• Volume overload is common at EOL & can cause significant discomfort
  – Consider organ dysfunction (CHF, renal failure etc)
  – Fluid third spaces into lungs & extremities
  – Exacerbates dyspnea, gurgling/rattling & edema, ascites

• Maintenance IVF is unnecessary
  – Will not reduce thirst or oral dryness
  – Instead emphasize oral intake for pleasure, mouth swabs, frequent oral care
Individualizing the experience

• Continue to assess what is most:
  – Important
  – Pleasurable
  – Comforting
• Encourage families, friends, pets, music, etc
• Support psychosocial/spiritual dimension
• Eating & drinking:
  – Liberalize if safe & benefits outweigh risks vs.
  – Reassure that food/drink less necessary, give permission to decline
What is primary palliative care nursing?

• Integrates the philosophy of palliative care into your daily nursing practice
• Practiced in any setting, day or night
• Provided whether or not the PCS is involved with patient
• Excellent opportunity to individualize patient care & act as advocate
• Educating your colleagues about PC
• Provides an enhanced sense of meaning & satisfaction in your work
Resources

- EPERC (End of Life/Palliative Education Resource Center)
  www.eperc.mcw.edu
- HPNA (Hospice & Palliative Nurses Association)
  www.hpna.org
- CAPC (Center to Advance Palliative Care)
  www.capc.org