Healing is accomplished not by experts but by human beings.

~Rachel Naomi Remen

A PALLIATIVE CARE PRIMER FOR ALL NPs

CANP 39th Annual Educational Conference

March 2016

Presented by Karen Ayers, ACNP, ACHPN

Objectives

1. Define palliative care and primary palliative care. Identify patients that might be right for palliative care.
2. State at least 2 methods to address the following symptoms: pain, breathlessness, nausea, constipation, anxiety.
3. Utilize a basic script approach to delivering serious news to patients and to assisting them with advance care planning.

To Palliate

To make the effects of something (such as an illness) less painful, harmful, or harsh.

Palliative Care

- Palliative care is for people with **serious** illness. It focuses on providing relief from the pain, symptoms, and **stress** of serious illness, **whatever the diagnosis**.
- The goal is to improve **quality of life** for both the **patient and family**. It is provided by a **team** of physicians, nurses, social workers, chaplains and others. They **work with a patient's other providers** to give an **extra layer of support**.
- Palliative care is appropriate at any age and any stage in a serious illness and can be **provided together with curative care** (i.e., concurrent care).

Goal of Palliative Care

- Improve
  - Quality of Life
  - Medical decision making

Repeatable Themes

- Serious illness
- Stress
- Whatever the diagnosis
- Quality of life
- Patient and family-centered

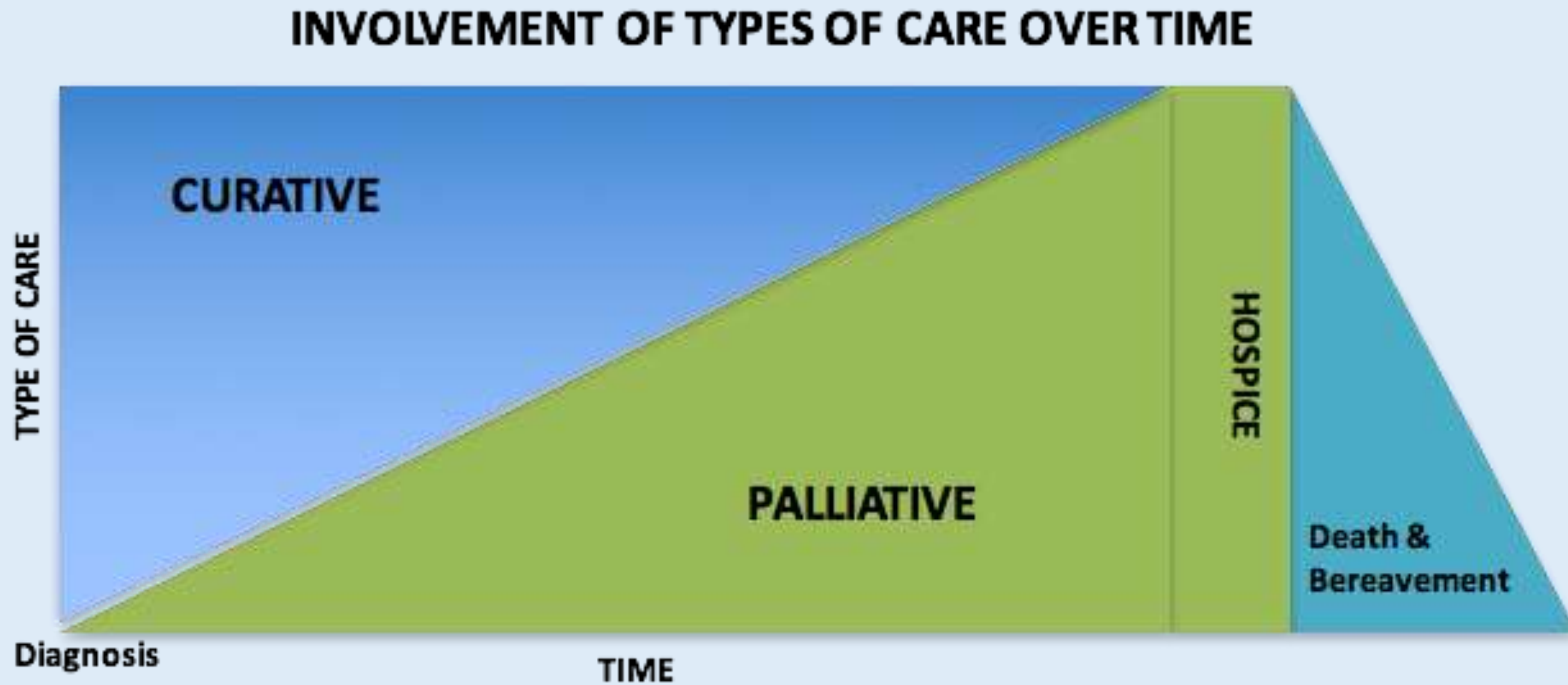
- Team
- Work with other providers
- Extra layer of support
- Provided along with curative treatment

Based on **need,** not prognosis.

Palliative Care is Not….

- For cancer only
- For old people only
- End-of-life care
- Hospice

The Continuum: Palliative vs Curative



Palliative Care as Compared with Hospice.

Table 1. Palliative Care as Compared with Hospice.*

Characteristic	Palliative Care	Hospice
Model of care	Interdisciplinary team, including physicians, nurses, social workers, chaplains, and staff from other disciplines as needed; primary goal is improved quality of life	Interdisciplinary team, including physicians, nurses, social workers, chaplains, and volunteers, as dictated by statute; primary goals are improved quality of life and relief of suffering (physical, emotional, and spiritual)
Eligibility	Patients of all ages and with any diagnosis or stage of illness; patients may continue all life-prolonging and disease-directed treatments	Patients of all ages who have a prognosis of survival of ≤6 mo, if the disease follows its usual course; patients must forgo Medicare coverage for curative and other treatments related to terminal illness
Place	Hospitals (most common), hospital clinics, group practices, cancer centers, home care programs, or nursing homes	Home (most common), assisted-living facilities, nursing homes, residential hospice facilities, inpatient hospice units, or hospice-contracted inpatient beds
Payment	Physician and nurse practitioner fees covered by Medicare Part B for inpatient or outpatient care; hospital teams are included within Medicare Part A or commercial insurance payments to hospitals for care episodes; flexible bundled payments under Medicare Advantage, Managed Medicaid, ACOs, and other commercial payers	Medicare hospice benefit; standard hospice benefit from commercial payers is usually modeled after Medicare; Medicaid, although coverage varies by state; medication costs are included for illnesses related to the terminal illness

* ACO denotes accountable care organization.

Kelley AS, Morrison RS. N Engl J Med 2015;373:747-755.

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Primary Palliative Care

Given

- Aging population
- Advancing technology/treatment options for late stages of disease
- Increased awareness and demand

Demand far outweighs supply of PC specialists

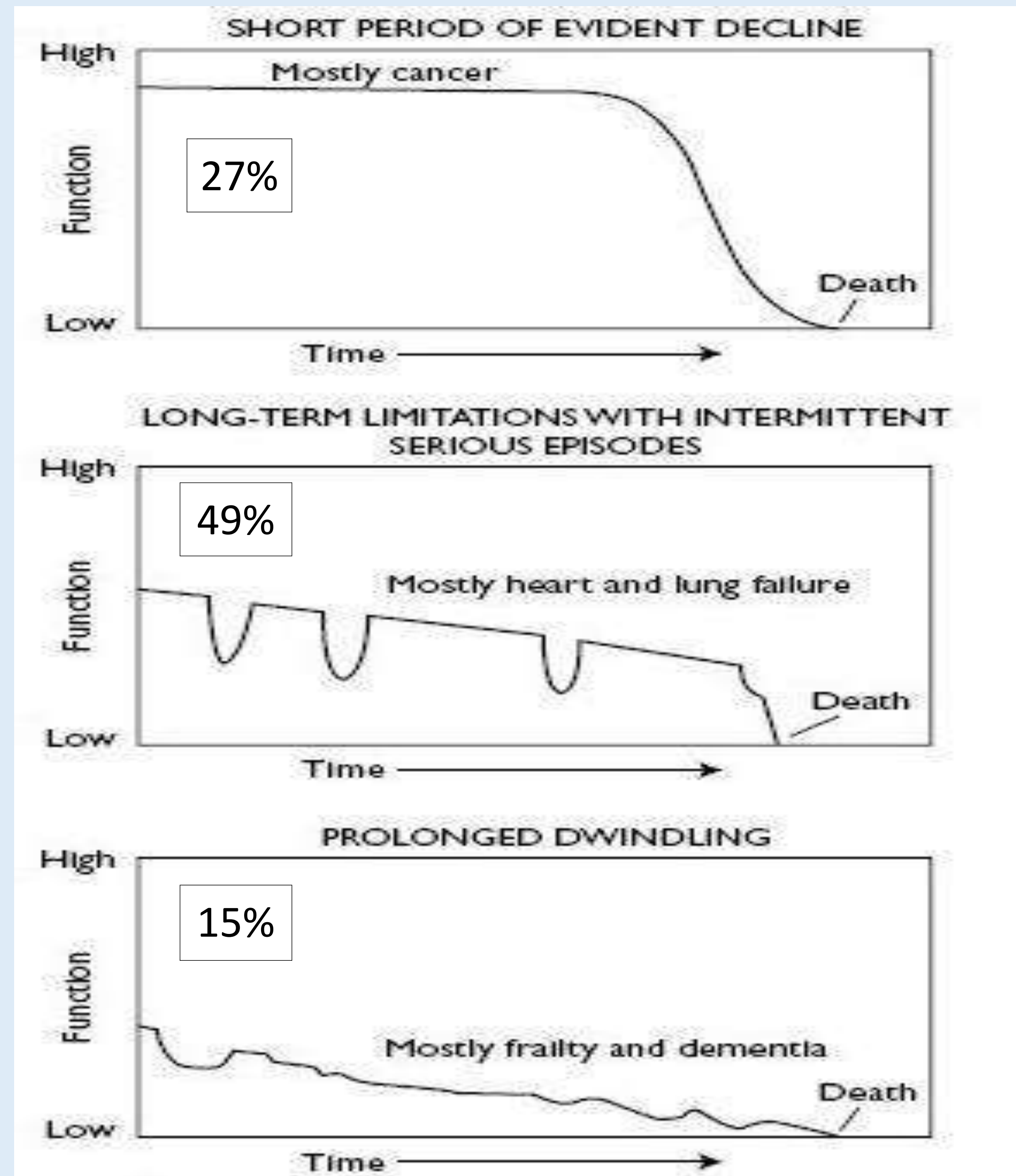
PCP is familiar and trusted….the right one to accompany patient on their (sometimes difficult) journey.

When is the right time for PC?

- The “surprise” question….Would you be surprised if this patient were not alive in 1 year?
- Serious illness
  - Cancer
  - End stages of chronic condition (cardiomyopathy, COPD, etc)
  - Degenerative neurologic conditions (ALS, Parkinson’s, etc)
- Elderly
- Frail
- Dementia-particularly w/difficulties swallowing or ambulating

Patterns of Decline

Sudden Death 9%



Trajectories of eventually fatal chronic illnesses. Source: Lynn & Adamson, 2003

Helpful Tools

- SPICT
- PPSv2

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Supportive and Palliative Care Indicators Tool

Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

The SPICT™ is a guide to identifying people at risk of deteriorating health and dying. Assess these people for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status is poor or deteriorating (the person is in bed or a chair for 50% or more of the day); reversibility is limited.
- Dependent on others for most care needs due to physical and/or mental health problems.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of underlying condition(s).
- Patient asks for supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; swallowing difficulties.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/ or progressive swallowing difficulties.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Review supportive and palliative care and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2015

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Communication

- Navigation
- Care Coordination
- Understanding of situation
- Education, making sense of difficult situation
- Advance care planning
- Continuity-importance of you in PC, the trust and rapport you have with your patients
- Psycho-socio-emotional-spiritual support

What the story ended up being about is, not what a “good death” is, but what it means to lead a good LIFE when you’re mortal, all the way to the very end.

~Atul Gawande

Communication

- [Being Mortal]

Why is communication so hard?

- Hope
- Emotions
- Competence
- Resistance
- Time
- We have to stop talking and LISTEN

REMAP – a guide for delivering serious news

- **R**eframe
  - “The current plan isn’t working….”; “Tell me what your body is telling you….”
- **E**xpect **e**motion….”be” **e**mpathy.
- **M**ap
  - “Given the situation, what’s most important to you?”
  - “As you think about the future, what concerns you?”
  - For those who are hoping for a miracle….try to expand the “hope portfolio”.
    - “Wouldn’t that miracle be wonderful? We know that those miracles are few and far between, so….
    - “What else do you hope for?”
- **A**lign
- **P**lan

ASK ~ TELL ~ ASK in delivering serious news

- **ASK** patient and family's current understanding
- Give a "warning shot"… "Is there anyone else who should be here for this?"
- **TELL** the information using language easily understood.
- Don't bury the lead.
- Attend to EMOTIONS – emotional responses are a clue that patient not ready to move on with planning yet.
- **ASK** if it's ok to move on with planning, ask
  - "What questions do you have?"
  - "Sometimes I don't explain well enough; can you tell me what you understood from what I have told you."

SPIKES – another conversation guide acronym

- **S**etting up the interview (Who should be there?)
- **P**erception – what does the patient know/understand
- **I**nvitation – Does the patient want to know? How do they want to receive information? Who else should be there? Who is the decision maker?
- **K**nowledge – given in the manner that works for the patient as above
- **E**motion – expect and acknowledge it
- **S**ummarize the discussion

Table 1. Guidelines for Physicians in Discussing Values, Goals, and Preferences with Patients Near the End of Life.*

If possible, begin these conversations early in the illness, rather than waiting until a medical crisis occurs or until death is imminent. Revisit these discussions when the patient's condition changes substantially.

Ask the patient about his or her understanding of the current medical situation and about additional diagnostic and therapeutic options.

Assess the patient's and family's information-sharing preferences. What kinds of information do they wish to have, what would they prefer not to know, and who should be involved in discussions about the patient's care? Similarly, ask about their preferences for decision making. How should important decisions be handled? Will key decisions be made by the patient, family members, or the clinician, or will the decisions be made collaboratively?

Answer questions as clearly as possible and provide simple, clear, jargon-free information about the patient's condition, prognosis, and options for treatment. Clarify any misconceptions the patient or family may have. In general, patients cannot make good decisions about their care without some understanding of their prognosis.

Inquire about and address the patient's concerns. For example, ask, "What are your main worries or fears about your situation?" Ensure that attention is paid to the patient's comfort.

Ask about "unacceptable states" — that is, states of existence or losses of critical functioning that a given patient wants to avoid (e.g., a state in which mechanical ventilation would be required indefinitely or in which the patient would be unable to communicate meaningfully with family members).

After the patient has been informed about the situation and prognosis, discuss and clarify the patient's values, goals, and preferences for care.

With this shared knowledge about goals for care, recommend a plan for end-of-life care. The clinician should not simply ask, "What do you want?" nor should the clinician offer to use harmful or nonbeneficial treatments (e.g., cardiopulmonary resuscitation that will almost certainly be unsuccessful and will not serve the patient's goals[16]). When decisions need not be made urgently, allow time for the patient to reflect on choices, obtain further information, or discuss the matter further with family or other advisors.

* Recommendations in the table are based on published guidelines.[12-15]

HOPE IS NOT A PLAN.

~Atul Gawande

Advance care planning continuum

Age 18

Complete an Advance Directive

Update Advance Directive Periodically

Diagnosed with Serious or Chronic, Progressive Illness *(at any age)*

Complete a POLST Form

Treatment Wishes Honored

C O N V E R S A T I O N

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POLST vs. Advance HealthCare Directive

AHCD	POLST
• For anyone 18 and older	• For seriously ill or frail, at any age
• General instructions for ***future*** treatment	• Specific orders for ***current*** treatment
• Names medical decision maker	• Can be signed by decision maker

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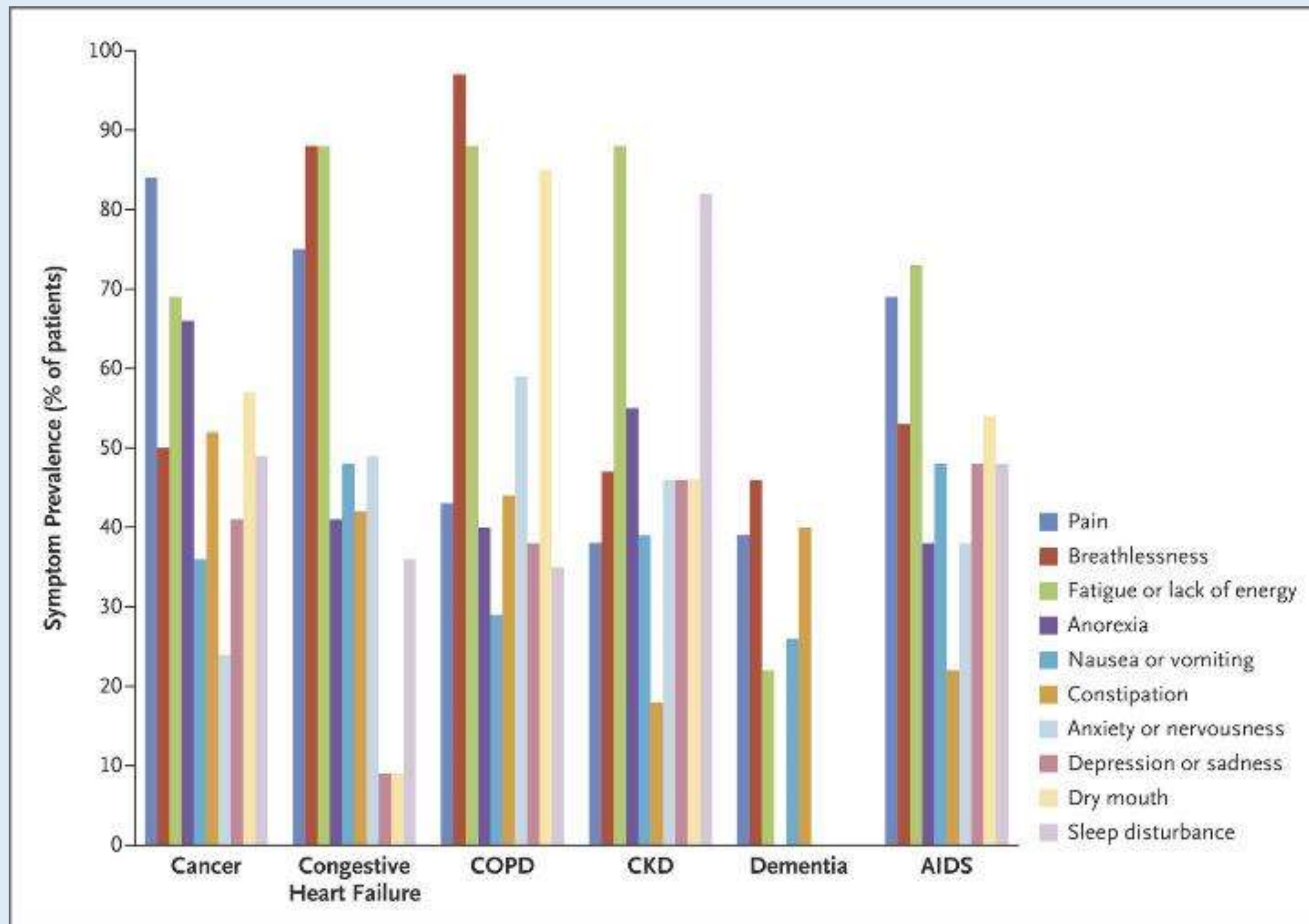
Symptom Prevalence in Advanced Illness.



Kelley AS, Morrison RS. N Engl J Med 2015;373:747-755.

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Pain

ASSESS

- **O**nset
- **P**alliate, precipitate
- **Q**uality
- **R**adiate, region
- **S**everity
- **T**emporal nature

DDX

- Nociceptive
  - Bony mets?
- Neuropathic
- Acute vs chronic
- Malignant vs nonmalignant

Nociceptive Pain

- Mild Pain
  - Acetaminophen 500 mg q4h prn, NTE 4 gm/d, 2gm if liver disease. Caution with APAP combo meds (Norco, Percocet).
  - NSAIDS: (usually ibuprofen or naproxen) 400-600 mg q6h prn. Caution with renal disease, gastritis concerns.
- Moderate to Severe Pain
  - Opioids

Opioids

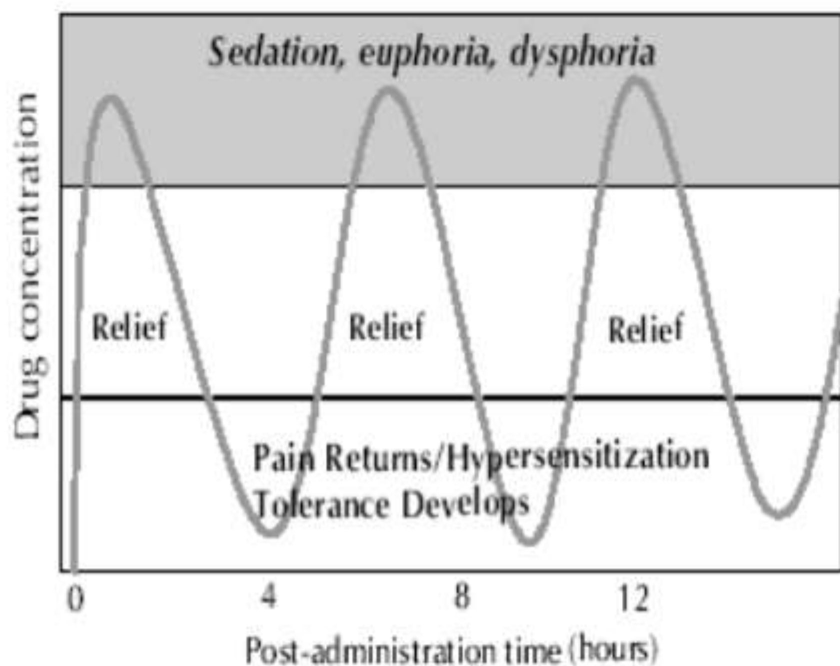
- Agent of choice for most pain syndromes in serious illness.
- Must initiate a regimen to prevent constipation – don’t wait to see if it occurs, as it will if no preventive measures are taken from day 1.
- Pain from bone metastases may also be treated with XRT, bisphosphonates, NSAIDS or glucocorticoids.

Malignant Pain

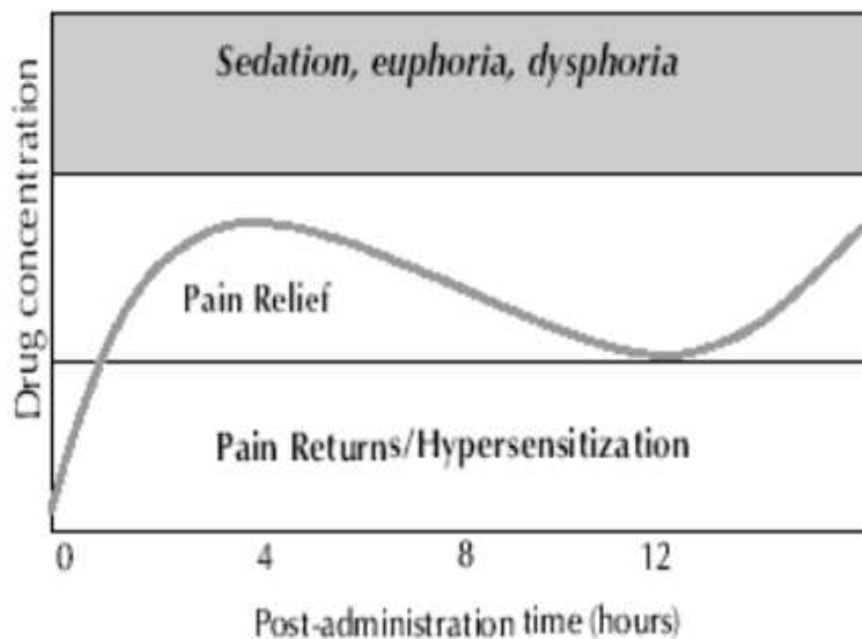
- Not the same type of pain as that occurring from acute injury.
- Once a ballpark estimation of total dose of short acting opiates needed in a day is known, good to change to long acting preparations with short acting just for breakthrough pain (BTP).
- Set BTP dose at ~10% of total daily dose of opiate.

PRN vs ATC Dosing

PRN Dosing



ATC Dosing



Drug	PO	IV
Morphine	30 mg	10 mg
Hydrocodone	30 mg	--
Oxycodone	20 mg	--
Hydromorphone	7.5 mg	1.5 mg
Fentanyl*	See chart	0.1 mg (100 mcg)

Peak analgesic effect:

Oral= 60-90 minutes

SQ= 30 minutes

IV= 6-15 min

Opioid Side Effects

Side effect	Time to Tolerance
Constipation	Never
Nausea/vomiting	7-10 days
Pruritus	7-10 days
Sedation	36-72 hrs
Respiratory depression	Extremely rare when opioids are dosed appropriately

Neuropathic Pain

- Some neuropathic pain syndromes may be treated with interventional procedures such as regional blocks.
- Medications to consider are gabapentin (should be titrated up to 2700 mg/day if tolerated before abandoning this as no help, and it should be stopped if it is not helping), SNRIs, and TCA.
- These medications are not effective for everyone and should not be continued if they are not helping.

Additional Therapies

- Interventional pain management
- Palliative radiation
- Medical cannibis
- Accupuncture/accupressure
- Psychotherapy (e.g. CBT)
- Guided imagery/mindfulness

Breathlessness

- Dyspnea
  - Subjective sensation of feeling difficulty breathing
  - Not related to objective findings such as observation (WOB) or oximetry readings, ABG results etc.
  - Patient self report
  - Explore how this is affecting patient with ADLs, what the dyspnea signifies to them in relationship to their disease process, concerns they may have about treatments, whether psycho-socio-spiritual issues may be contributing

Diagnose and Treat Underlying Cause

- Anxiety
- Airway obstruction
- Bronchospasm
- Hypoxemia
- Pleural effusion
- Pneumonia
- Pulmonary edema
- Pulmonary embolism
- Thick secretions
- Anemia
- Metabolic
- Family / financial / legal / spiritual / practical issues

Dyspnea Management

- Opioids
  - Small doses
  - Safe in multiple studied populations inc cancer, CHF, COPD, pulmonary fibrosis
  - No significant change in O2 sats
  - Survival time is unrelated to opioid administration
  - Central and peripheral action
    - Relief not related to respiratory rate
  - Improved sensation of breathlessness
    - Based on 9 crossover trials* many in COPD patients.

» J Pain Symptom Manage 1999;17(4):256–65.
» BMJ 2003;327(7414):523–8

Additional Therapies

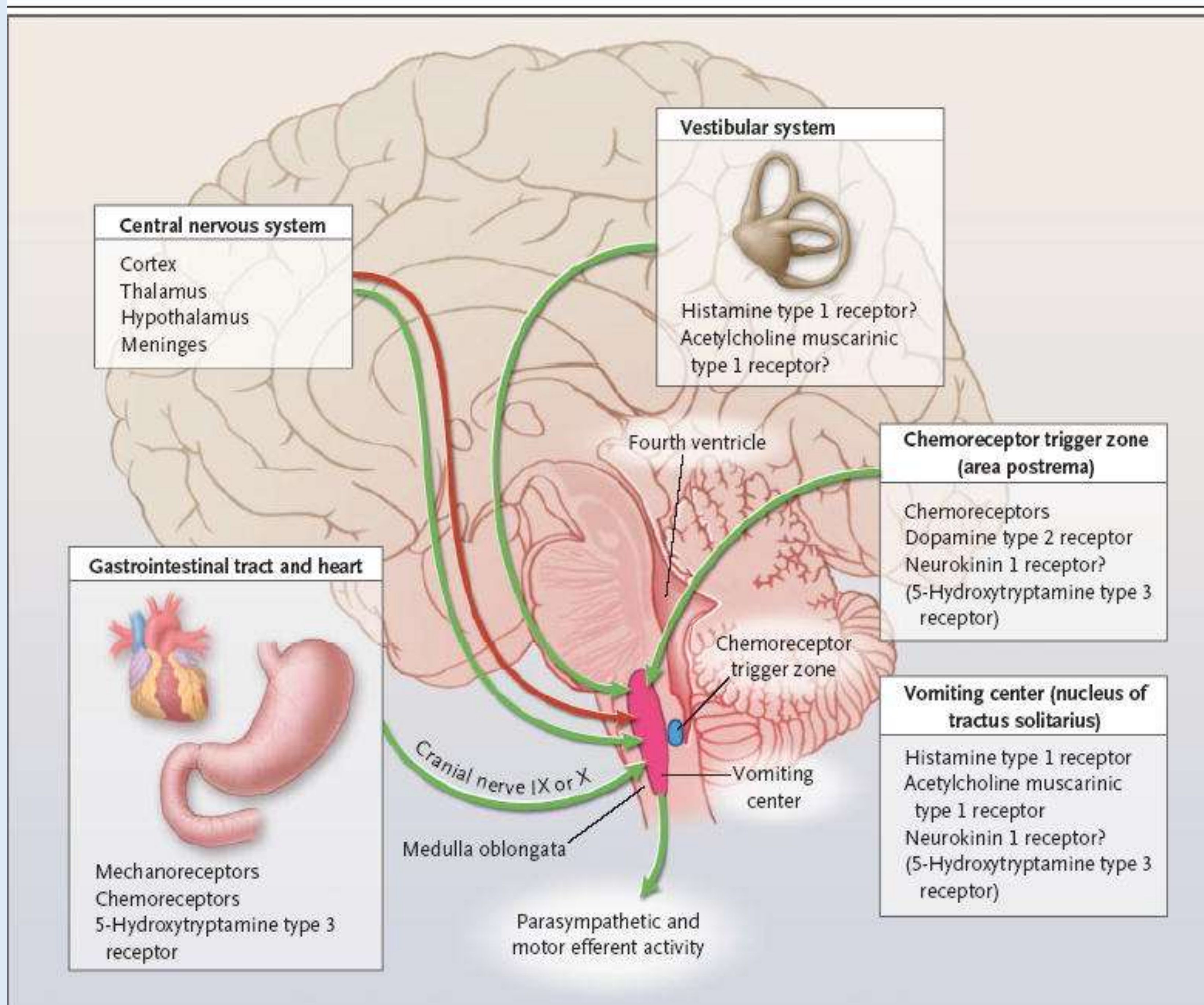
- Oxygen - helpful only if hypoxia present
- Positioning
- Air movement
  - Fan and/or windows open
- Reduce clutter and avoid room being over crowded
- Cool temperature
- Reduce stimuli/irritants
- Pursed lip breathing
- Benzodiazepines if anxiety component
- Reassurance and behavioral approaches (relaxation, distraction, hypnosis)
- Acupuncture
- NIPPV in some cases

Sudden Breathlessness Crisis Algorithm

Sudden Breathlessness Crisis

- **C** — **Call for help.** Calm the person.
- **O** — **Observe** the person closely. Evaluate how severe their shortness of breath has become.
- **M** — **Medication** like morphine, inhaled bronchodilator and/or medication for anxiety may help.
- **F** — **Fan** to create air movement on the face. Open a window. Cool the room.
- **O** — **Oxygen.** Increase the amount of oxygen or give oxygen if ordered.
- **R** — **Reassure.** Help the person relax, provide reassurance.
- **T** — **Take** your time, don't rush.

Nausea & Vomiting



Krakauer E. NEJM 2005;352:817-825

Mechanisms of Nausea and Vomiting

Higher cortical structures

Chemoreceptor trigger zone
(4th ventricle)
D2, 5HT3, NK1

Vestibular system
Achm, H1

Vomiting Center:
(Medulla)
Achm, H1, 5HT2

N/V

Mechanical stretch, GI irritation
5HT3 in GI tract, mechanoreceptors,
vagal, splanchnic and glossopharyngeal nerves

ETIOLOGIES

- CENTRAL
  - Tumor, mets, bleed, edema, infection
  - Mind: emotions, memory/anticipation
- VESTIBULAR
  - Tumor, mets to base of skull, middle ear disease, CVA
- MECHANICAL STRETCH, GI IRRITATION
  - Constipation, gastroparesis, obstruction, candidiasis, gastritis
- CHEMORECEPTOR TRIGGER ZONE
  - Medications, chemo

THE INSTITUTE FOR PALLIATIVE MEDICINE
at San Diego Hospice

NAUSEA MANAGEMENT

12 "Ms" OF EMESIS

Metastases	**M**echanical Obstruction
Meningeal Irritation	**M**otility
Movement	**M**etabolic
Mentation (e.g. Anxiety)	**M**icrobes
Medications	**M**yocardial
Mucosal Irritation	**M**aternity

ASSESSMENT

Determine likely cause or causes. Conceptualize likely neurotransmitters. Select agent. Do not overlap mechanisms of action. Titrate to effect. Combine agents from different classes. Be aggressive. Dopamine antagonists are first choice.

HISTAMINE ANTAGONISTS

- Diphenhydramine 25–50 mg PO/IV/SC
- Meclizine 25–50 mg PO q6h
- Hydroxyzine 25–50 mg PO q6h

ACETYLCHOLINE ANTAGONISTS

- Scopolamine patch 1-3 TD q72h
- Scopolamine 0.1-0.4 mg SC/IV q4h

DOPAMINE ANTAGONISTS

- Haloperidol 0.5-2 mg PO/SC/IV q6h
- Metoclopramide 10-20 mg PO/SC/IV q6h
- Prochlorperazine 10-20 mg PO q6h
- Prochlorperazine 25 mg PR q12h
- Promethazine 25 mg PO/PR q6h
- Promethazine 12.5-25 mg IV q6h
- Olanzepine 5-10 mg PO daily

CENTRAL ACTION

- Dexamethasone 2-20 mg PO/SC/IV daily
- THC 2.5–5 mg PO q8h
- Lorazepam 0.5–2 mg q8h

SEROTONIN ANTAGONISTS

- Ondansetron 4-8 mg PO q6h
- Granisetron 1 mg PO daily or q12h
- Dolasetron 200 mg PO daily
- Palonosetron 0.25 mg IV daily

INOPERABLE OBSTRUCTION

- Octreotide 100-400 mcg or more SC q8h

NB: These are guidelines only and do not replace careful clinical judgment specific to each patient/family situation. ©The Institute for Palliative Medicine at San Diego Hospice (IPM) 2009.
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Constipation

- Senna – laxative – is the mainstay.
- Everyone who gets an opiate gets put on a bowel regimen.
- Stool softeners not necessary most of the time and add to pill burden.
- Methylnaltrexone very helpful but very expensive.
- Look for s/s obstruction (large volume infrequent emesis that relieves nausea, colicky pain).
- One potential SE of ondansetron is constipation.

Medications

- #1 STIMULANTS - Senna, bisacodyl, metoclopramide
- OSMOTICS - Miralax, MOM, lactulose, sorbitol, mag citrate
- ENEMAS - fleets
- EMOLLIENTS - mineral oil, glycerine supp
- BULKING AGENTS – methycellulose, psyllium
- PERIPHERAL OPIOID ANTAGONIST - methylnaltrexone

Anxiety

- Beware of “therapeutic nihilism”: “Oh, you’re dying, of course you’re anxious/depressed, etc.”
- 80% of psychiatric symptoms in cancer patients go under diagnosed and under treated.
- Anxiety often presents as worry interfering with life.
- Benzodiazepines can often be a “back pocket” medication – just knowing they have it to use just in case things get too bad, and may make them more likely to try techniques such as CBT.

Adjustment Disorder vs Depression

Adjustment disorder : normal response to an abnormal life situation

Depression: abnormal response to a normal life situation

Table. A Model of Dignity and Dignity-Converting Interventions for Patients Nearing Death

Factors/Subthemes	Dignity-Related Questions	Therapeutic Interventions
	Illness-Related Concerns	
Symptom distress		
Physical distress	"How comfortable are you?" "Is there anything we can do to make you more comfortable?"	Vigilance to symptom management Frequent assessment Application of comfort care
Psychological distress	"How are you coping with what is happening to you?"	Assume a supportive stance Empathetic listening Referral to counseling
Medical uncertainty	"Is there anything further about your illness that you would like to know?" "Are you getting all the information you feel you need?"	Upon request, provide accurate, understandable information and strategies to deal with possible future crises
Death anxiety	"Are there things about the later stages of your illness that you would like to discuss?"	
Level of independence		
Independence	"Has your illness made you more dependent on others?"	Have patients participate in decision making, regarding both medical and personal issues
Cognitive acuity	"Are you having any difficulty with your thinking?"	Treat delirium When possible, avoid sedating medication(s)
Functional capacity	"How much are you able to do for yourself?"	Use orthotics, physiotherapy, and occupational therapy
	Dignity-Conserving Repertoire	
Dignity-conserving perspectives		
Continuity of self	"Are there things about you that this disease does not affect?"	Acknowledge and take interest in those aspects of the patient's life that he/she most values See the patient as worthy of honor, respect, and esteem
Role preservation	"What things did you do before you were sick that were most important to you?"	
Maintenance of pride	"What about yourself or your life are you most proud of?"	
Hopefulness	"What is still possible?"	Encourage and enable the patient to participate in meaningful or purposeful activities
Autonomy/control	"How in control do you feel?"	Involve patient in treatment and care decisions
Generativity/legacy	"How do you want to be remembered?"	Life project (eg, making audio/video tapes, writing letters, journaling) Dignity psychotherapy
Acceptance	"How at peace are you with what is happening to you?"	Support the patient in his/her outlook Encourage doing things that enhance his/her sense of well-being (eg, meditation, light exercise, listening to music, prayer)
Resilience/fighting spirit	"What part of you is strongest right now?"	
Dignity-conserving practices		
Living in the moment	"Are there things that take your mind away from illness, and offer you comfort?"	Allow the patient to participate in normal routines, or take comfort in momentary distractions (eg, daily outings, light exercise, listening to music)
Maintaining normalcy	"Are there things you still enjoy doing on a regular basis?"	
Finding spiritual comfort	"Is there a religious or spiritual community that you are, or would like to be, connected with?"	Make referrals to chaplain or spiritual leader Enable the patient to participate in particular spiritual and/or culturally based practices
	Social Dignity Inventory	
Privacy boundaries	"What about your privacy or your body is important to you?"	Ask permission to examine patient Proper draping to safeguard and respect privacy
Social support	"Who are the people that are most important to you?" "Who is your closest confidante?"	Liberal policies about visitation, rooming in Enlist involvement of a wide support network
Care tenor	"Is there anything in the way you are treated that is undermining your sense of dignity?"	Treat the patient as worthy of honor, esteem, and respect; adopt a stance conveying this
Burden to others	"Do you worry about being a burden to others?" "If so, to whom and in what ways?"	Encourage explicit discussion about these concerns with those they fear they are burdening
Aftermath concerns	"What are your biggest concerns for the people you will leave behind?"	Encourage the setting of affairs, preparation of an advanced directive, making a will, funeral planning

Chochinov, H. JAMA. 2002;287(17):2253-2260.

Compassion is
your grief
in my heart.

~ Ken Druck, PhD

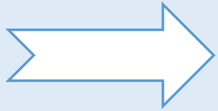


Table 2. Guidelines for Physicians Providing Comfort Care for Hospitalized Patients Who Are Near the End of Life.

Ideally, the dying process should never entail sustained severe pain or other physical suffering. The physician should assure the patient and family that comfort is a high priority and that troubling symptoms will be expertly treated.

When possible, involve an interdisciplinary team that offers comprehensive, coordinated care for both the patient and the family. Promote good communication among the members of the clinical team.

Nursing interventions (e.g., oral care, skin and wound care, application of heat or cold packs) can be critical in addressing the full range of the patient's and family members' needs, as can attention from mental health providers, social workers, music therapists, volunteers, and others.

Inquire about the patient's spiritual and religious needs ("Is religion or spirituality important to you?") and offer chaplaincy services when appropriate.

Discontinue diagnostic or treatment efforts that are likely to have negligible benefit or that may cause harm by diminishing the patient's quality of life and his or her ability to interact with loved ones. Monitoring of vital signs is rarely useful in the final days of life, especially when obtaining this information involves the use of noisy, distracting monitors in the patient's room. Unnecessary treatment with medications not intended for comfort (such as statins for hyperlipidemia) should be discontinued.[19] Mouth and skin care and changing the patient's position in bed may enhance comfort in some situations, but in other situations these measures may bother the patient and contribute to suffering and should be discontinued.

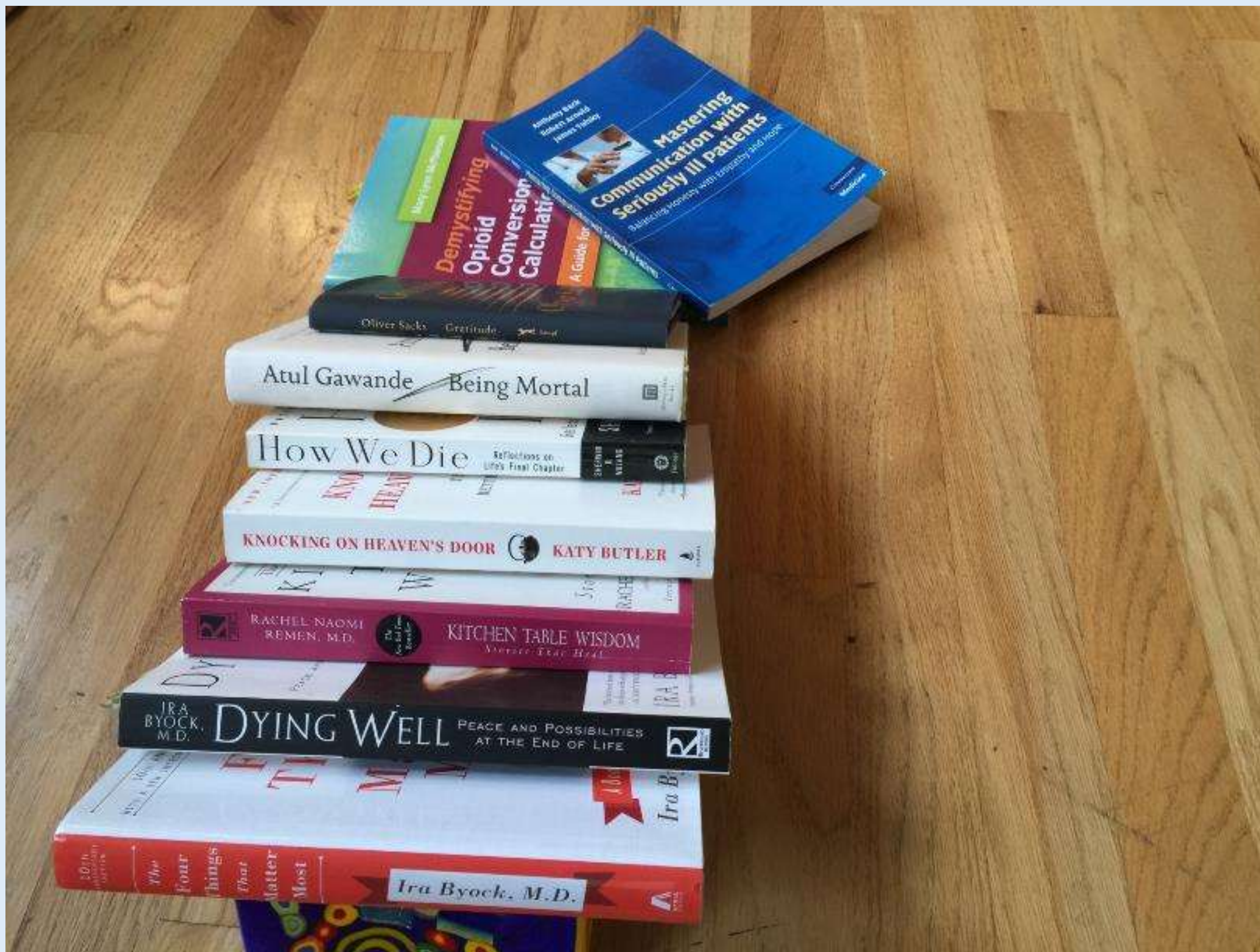
Prophylactic analgesia or sedation should be administered before distressing procedures are performed (e.g., removal of a chest tube,[20] withdrawal of mechanical ventilation in a conscious patient,[21] or changing the dressing on a pressure sore). Treating the symptoms associated with such procedures only after they occur is likely to lead to unnecessary discomfort until the appropriate medication takes effect.

Encourage oral assisted eating for pleasure but respectfully inform patients and families that the administration of intravenous fluids and nutrition through a feeding tube has no benefit in terms of comfort or survival at this phase of illness.

Inform the patient and family about any proposed major changes in the management of the patient's condition.

Consider home care, rather than care in the hospital, for the patient if appropriate. Most dying patients are more physically comfortable at home, and family members have generally been found to be most satisfied with the experience of relatives who die at home with hospice care.[22]

Resources



THANK YOU! kayers@humboldtipa.com