Supportive & Palliative Care Consult Service
Study Visit at University Of Missouri Hospital

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Team Members

Deborah Hamilton RN, ADN

Carol Goodnick RN, BSN

Renee Knipfel, MSW

Our Supportive & Palliative Care Consult Service

- Inpatient consult service at University Hospital available 24/7

  On-Call staff listings available via UMHC Call Schedules Directory and Text Paging system
  - **Palliative care office call 884-7103 or page 397-0262**
- Palliative Care Outpatient Clinics Ellis & Green Meadows. Nurse: Mary Cunningham, RN, AOCN, APRN, CHPN
- Physicians, Manager, Office Support
- Inpatient Nurse Clinicians: Carol Goodnick BSN, Deborah Hamilton ADN
- Grief Counselor: Renee Knipfel MSW
- Chaplain: Mark Steffen
- Collaborate with hospital based RT, Nutrition, Rehab & other services
- Learning opportunities for medical students, residents, fellows, social work & nursing students.

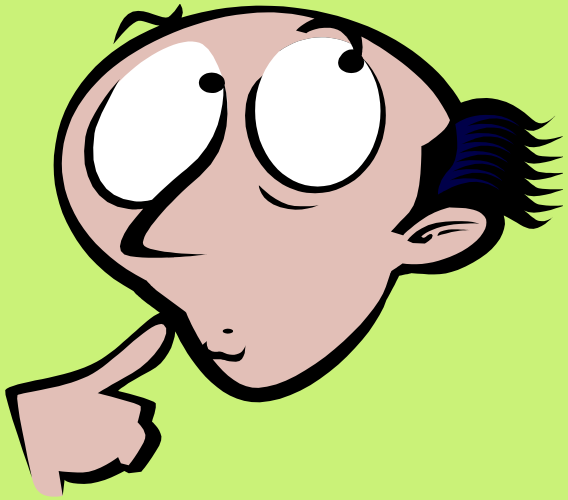
What is Supportive & Palliative Care?

- Patient & Family Centered Care.
- Improves Quality of Life by anticipating, preventing and relieving suffering.
- Addresses physical, emotional, social, intellectual, and spiritual needs.
- Respects patient choice/helps with decision making.
- Is appropriate regardless of the stage of disease or the need for other therapies.

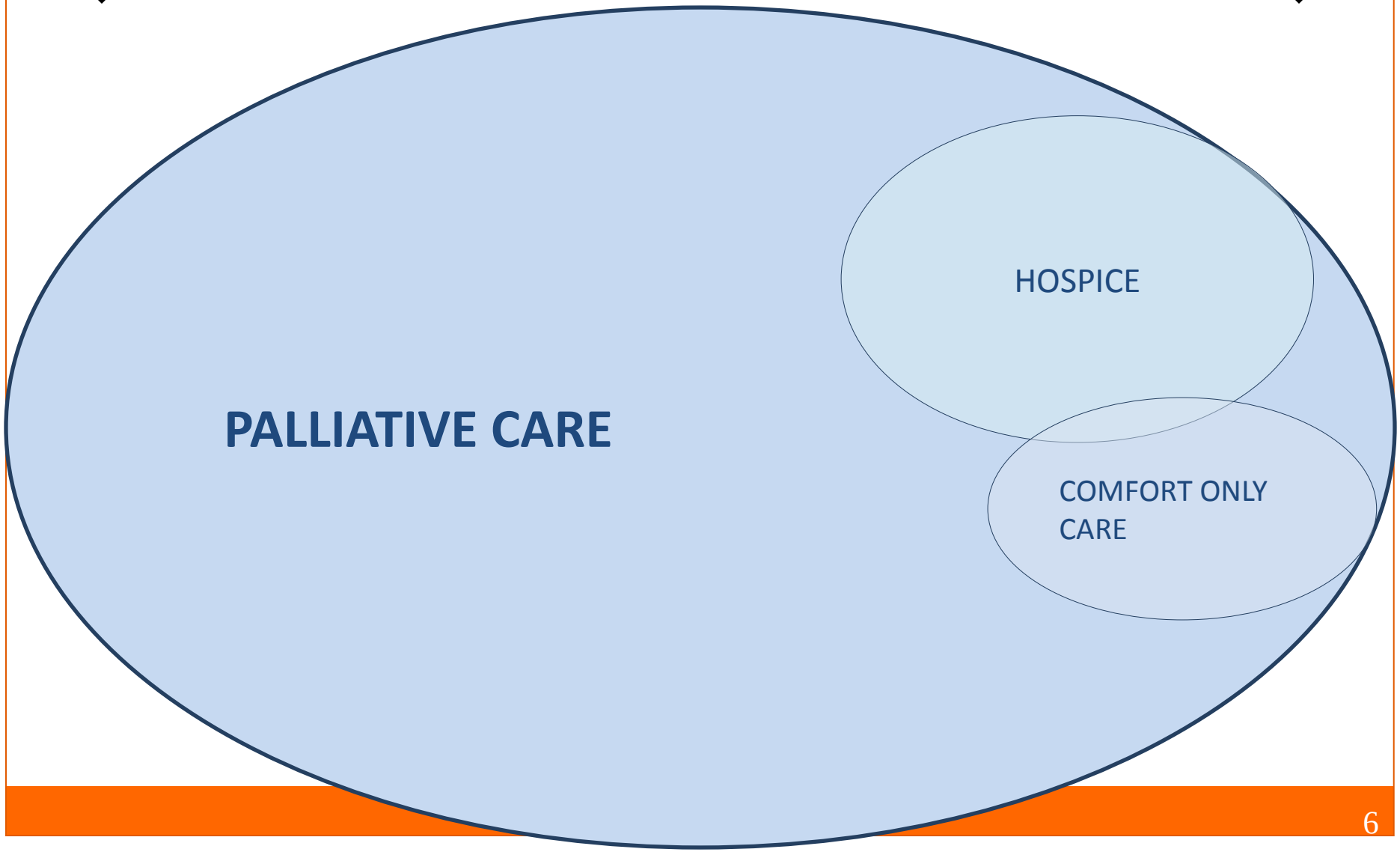
SPC Nurse's Role in Supporting Patient and Family

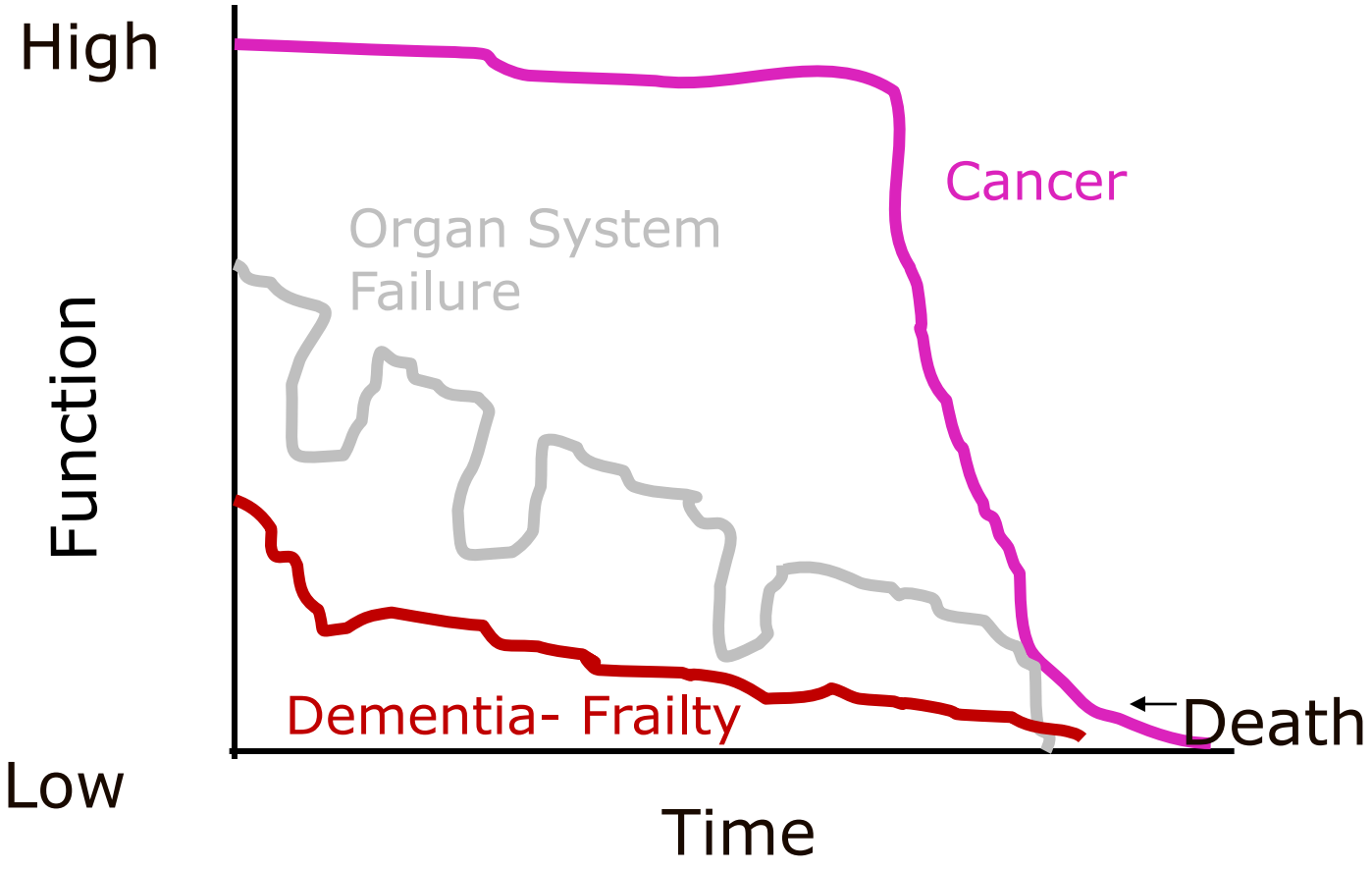
- Assist in setting goals
- Guidance in making complex treatment choices
- Coordination with healthcare providers
  - Primary Team
  - Other Consulting Teams
  - Social Workers, Case Managers, Nurses
- Being attentive to spiritual and emotional needs
- Assistance in discharge planning

Confused about Comfort/Palliative/Hospice care



Relationships between Palliative, Hospice, and Comfort Only Care:





Trajectories of Function and Well-Being over Time in Eventually Fatal Chronic Illnesses

Supportive & Palliative Care Consult Triggers

- Multi-system organ failure, complex care requirements, or critical incident.
- Extended ICU stay greater than or equal to 7 days.
- Disagreement about or unclear goals of care amongst the patient, family, and care givers.
- Unacceptable pain or symptoms for longer than 24 hours.
- New diagnoses of life limiting illness.
- The ICU oversight committee also suggests honoring nurse-recommended consults.

Palliative vs. Hospice vs. Comfort Care

Palliative Care	Hospice Care	Comfort Care
• Anyone with a serious illness, regardless of life expectancy, can receive palliative care. • Palliative care and curative care can be administered at the same time • Occurs ➢ Hospital via Inpatient services at UMHC ➢ Outpatient Clinic via Outpatient services at Ellis and Green Meadows • Hospital and/or Clinic based multidisciplinary palliative **consult** team of doctors, nurses, social workers, and chaplains	• Someone with an illness with a life expectancy measured in months not years • Includes treatments and medicines aimed at relieving symptoms only • Where ever patient resides ➢ in home ➢ assisted living ➢ nursing home • Hospice organization based multidisciplinary team of doctors, nurses, social workers, & chaplains.	• Anyone in the terminal phase of incurable illness who has refused life-sustaining treatment • Includes treatments and medicines aimed at relieving symptoms only • Occurs ➢ In hospital setting • Hospital based Multidisciplinary team of doctors, nurses, social workers, and chaplains

Case Study #1

- 76 y/o man with past medical history myelodysplastic syndrome with evolvement to full chronic myelogenous leukemia not responsive to chemo, progressive neuromuscular disease > 4 years, dependent in all ADL's, presented to the ER and transferred to MNICU for chronic hypercapnic/hypoxic respiratory failure.

Would this patient qualify for:

- A. Palliative Care Inpatient Consult
- B. Hospice
- C. Comfort Care
- D. All of the above

ANSWER

- All of the above

Case Study #2

- 56 y/o man with a past medical history of depression and bipolar disorder presented to the ER with Right hand cellulitis after getting into an argument and punching a tree with his bare fists.

Over hospital course cellulitis progressed to

- necrotizing fasciitis
- amputation of entire right arm
- septic shock
- intubation
- ARDS
- Patient deteriorated, became unresponsive

- A. Comfort Care
- B. Palliative Care Consult
- C. Hospice
- D. All of the above
- E. None of the above

Answer

- Comfort Care

WHERE DO YOU RATE YOUR PAIN?

INTERVENTION FOR THE MANAGEMENT OF:

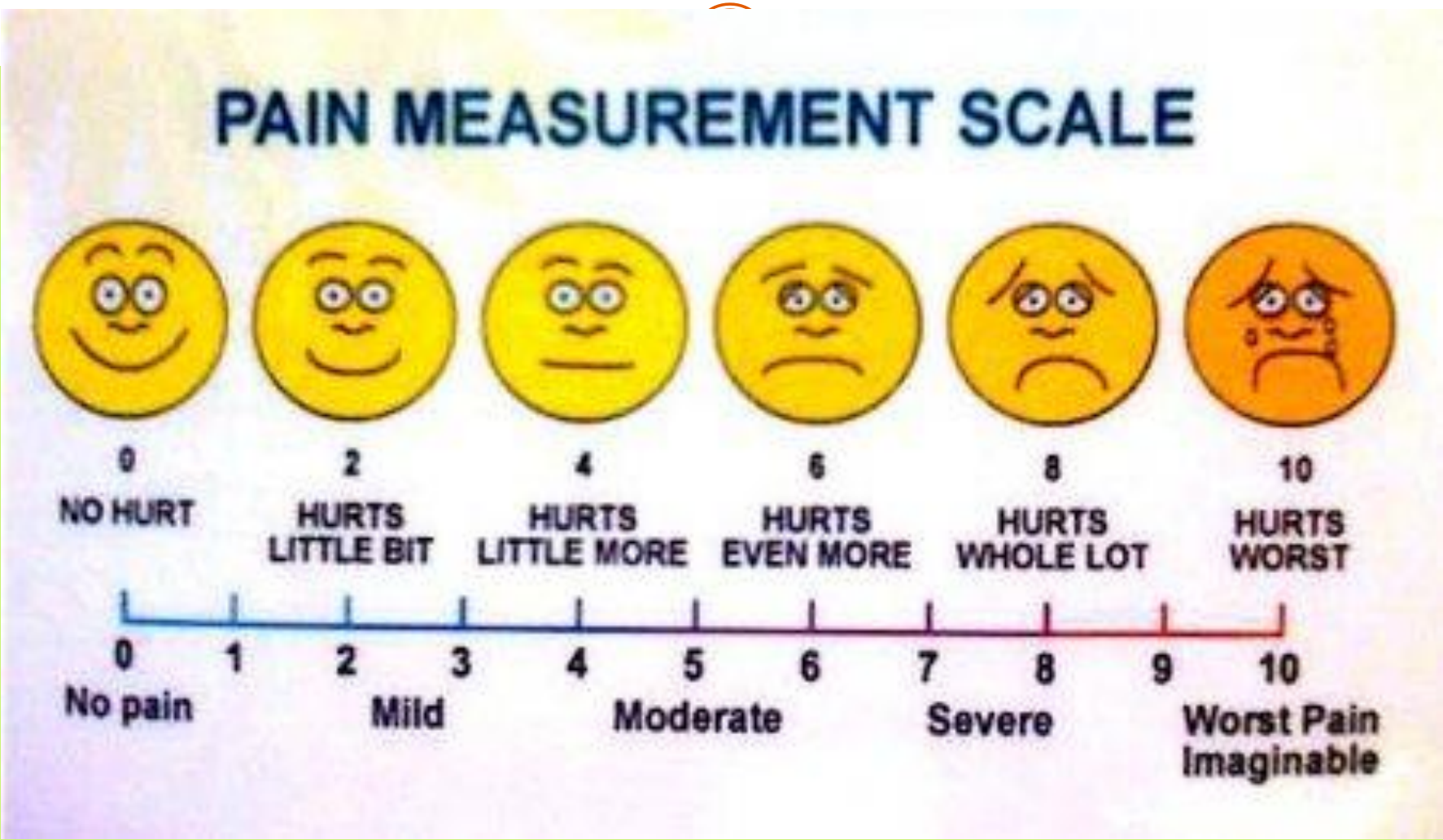
PAIN, DYSPNEA, DEHYDRATION, AND DELIRIUM

A DEFINITION OF PAIN

- “ Whatever the experiencing person says it is, existing whenever he says it does” ~ Margo McCaffrey 1968

- A patient’s verbal self report is the most reliable indicator of pain intensity

ASSESSING FOR PAIN



PAIN

- Increase B/P
- Increase heart rate
- Wrinkles in forehead
- Restlessness
- Assessing pain is consider the fifth vital sign and should be evaluated as part of every nursing assessment.

- Opioids

  - are often the medication of choice for end-of-life pain. They are safe and effective for the treatment of patients with moderate to severe pain, and they have side effects that can be managed effectively

    - Morphine, Fentanyl, Dilaudid

- INDIVDUALS WHO ARE TAKING OPIOIDS SHOULD ALWAYS FOLLOW A <u>BOWEL REGIMEN</u>!

COMMON FEARS

- Long term use of opioids can lead to drug addiction
- *(The incidence of addiction when opioids are taken for pain relief is rare < 1% (www.ampainsoc.org)*

- That I may give that “fatal last dose.”

DYSPNEA

- Dyspnea (like pain) is a subjective experience in which a patient feels short of breath.
- Dyspnea frequently causes a stress response that increases ones level of fear and anxiety.
- Patients who are on mechanical ventilators often experience resp. discomfort despite the significant reduction in the work of breathing.
- Modes of vent and flow rate can influence dyspnea.
- Patients should be assessed regularly for dyspnea.

PHARMACOLOGICAL MANAGEMENT

- Opioids are the drugs of choice in treating acute and chronic dyspnea.
- Morphine
- Fentanyl
- Methadone (rarely used here)
- Oxycodone
- Can be administered PO, Sub q, IV
- Morphine will usually provide relief for most patients

NON PHARMACOLOGICAL

- Fan
- Oxygen

DEHYDRATION

- There is no real treatment for dehydration at end of life. Comfort measures could include:
  - Keeping mouth moist with swabs
  - Lotions to soothe dry skin

DELIRIUM

- Delirium is a decline in awareness or ability to focus that occurs rather quickly (days to hours). It usually includes impaired memory, problem solving ability, or perception

CAUSES OF DELIRIUM

- Causes may be multi-factorial. One mnemonic to help identify the etiologies is:
- D: Drugs, depression and dehydration
- E: Endocrine, environment changes and electrolytes
- L: Loss of mobility and liver disease
- I: Infection and ischemia (hypoxia)
- R: Reduced senses and renal failure
- I: Impaction (fecal)
- U: Urinary retention
- M: MI, malignancies and metabolic disorders

TOOLS TO ASSESS FOR DELIRIUM

- the Confusion Assessment Method for the ICU (CAM-ICU)
- ://www.icudelirium.org

DELIRIUM TREATMENT

- Mild to moderate
  - Interpersonal or environmental manipulation
    - Quiet reassurance in soft voices.
    - Frequent orienting cues (clocks, lights on/off at proper times).
    - Family member presence.
    - Minimizing noise levels and night disruption.
- Severe
  - Pharmacologic treatment:
  - Haldol 1-2mg PO/IV/SC
  - Ativan 0.5-1mg PO/SL/IV

SIGNS AND SYMPTOMS OF IMMINENT DEATH

PREPARATION FOR DYING SHOULD OCCUR FROM THE BEGINNING OF PALLIATIVE CARE INVOLVEMENT. WHEN A MEMBER OF THE TEAM RECOGNIZES THAT A PATIENT IS ACTIVELY DYING, THIS SHOULD BE COMMUNICATED TO THE FAMILY IN A CALM, REASSURING WAY.

- Increased restlessness due to lack of oxygen in blood.
- Breathing pattern changes:
  - Becomes slower
  - Irregular
  - Apnea periods lengthen and are more frequent

- Congestion becomes audible in back of throat
- Eyes may be open or slightly open with glassy look, not focusing. Often tears are noted.
- The hands and feet become cooler and purplish. Mottling can be seen on arms, legs, back and buttocks
- Usually the person is unresponsive to the environment and people around them.

PATIENT AND FAMILY COUNSELING

Palliative Care Social Worker Role

- Needs are determined based on Social Work Biopsychosocial Assessment

- Medical
- Family
- Financial/Employment
- Coping (Emotionally)

- Educate and assist with the completion of Durable Power of Attorney/Healthcare Directive Paperwork
- Network with community agencies
- Communicate with primary care team social workers
- Provide in services to social work staff, as well as assist in the education of Supportive/Palliative Care services to other professions
- Aid in discharge planning

Counseling Methods

- Supportive Counseling
- Grief Counseling
- Bereavement Follow Up Calls
- Goal planning (desires, dreams, etc)
- Life Review
- Crisis Intervention
- Family Systems Approach

Counseling Strategies

- Four things to ask the patient and family:
  - What is your understanding of your prognosis?
  - What are your fears?
  - What are your goals?
  - What trade-offs would you be willing to make?

Grief & Bereavement

- After a patient expires there is follow up with family members for up to a year by phone and mail.

- Bereavements calls are made at:
- 2 weeks
- 1 month
- 3 months
- 6 months
- 12 months
- 13 months
- Provide one on one counseling as needed

- Bereavement mailings are done:

- Initially
- 3 months
- 6 months
- 12 months

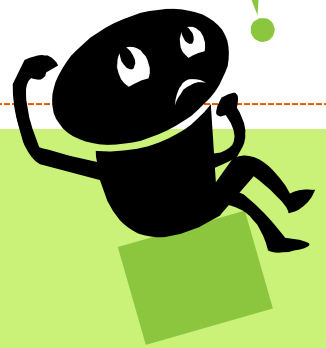
Factors that affect patient & family perceptions of end of life:

- Past experiences with illness and death
- Socioeconomic factors and resources
- Cultural and spiritual values and belief system
- Stage of life (e.g. younger, older)
- Knowledge base
- Family dynamics – guilt, anger, distance

Ethical Considerations

- Withdrawal of artificial feedings
- Family Dynamics vs. Caregiver (DPOA) status
- DNAR paperwork vs. comfort care and court decisions
- Physician has no ethical obligation to provide futile treatment
- Respect for patient/family belief/religious views
- Personal feelings vs. Profession

Questions ??



Your Thoughts?