Foundations of Palliative Care Series

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This course was developed in collaboration with the UBC Learning Circle to support palliative care within the First Nations communities.
“Homework” Exercises

How was this for you?
Each builds on the previous
3. Ongoing Support
   continued...
Nausea

A common symptom in all of end of life diseases

Depending on Goals of Care, may need to determine the cause, also need to exclude oral thrush and constipation

Multiple causes of nausea

Each cause act through different neurotransmitters so may need different anti-emetics
Nausea - Causes

Nausea can be broken into five groups

- Gut causes
- Chemical causes (this includes medications and electrolytes)
- Raised intracranial pressure
- Motion induced nausea
- Anxiety
Nausea – Assessment

Is the nausea worse with food intake?
Do they have headaches?
Is the nausea worse with movement?
Are they constipated? When was their last bowel movement?
Do they have thrush?
Have they been started on any medications that can cause nausea?
Nausea – Treatment

Depending on the type of nausea, different anti-emetics are used:

- Nausea from the gut responds to maxeran or Zofran
- Nausea from a new drugs or electrolyte problems respond to haldol
- Nausea from raised intracranial pressure (brain mets) may respond to steroids
- Motion induced nausea responds to gravol
- Complex nausea respond to nozinan
Dyspnea - Causes

Pulmonary causes ie. pneumonia, pleural effusion, lymphangitic carcinomatosis

Cardiac causes ie. anemia, CHF

Other ie. anxiety, ascites, pain
Dyspnea - Assessment

Very common and can be linked to anxiety in a positive feedback loop

Need to determine:

- Does the client have pre-existing lung disease?
- Is the client bothered by the breathing and when did the dyspnea start?
- Is the dyspnea associated with a productive cough?
- Is dyspnea present at rest or mostly with exertion?
- What the client has used in the past to help with dyspnea?
Dyspnea does not always mean a client requires oxygen.
Dyspnea - Treatment

Many clients with dyspnea do not need oxygen (to qualify, O2 sats need to be <88%)

Non-pharmacological measures for dyspnea:

- Open windows, turn on fan
- Change in positioning (ie. sitting up)
- Complementary therapies (massage, music, healing touch, etc)
- Keep a calm environment
Dyspnea - Treatment

Frontline medication for dyspnea is to start an opioid at a low dose.

- Similar to pain for opioid naive clients, opioids should be started on a prn basis
- Once tolerance and effectiveness is known, opioids can be changed to around the clock dosing
Constipation - Causes

Palliative clients are high risk for constipation because:

- They are not eating a lot
- They are drinking less fluid
- They are mobilizing less
- Medications used in palliative care cause constipation
How often did you have a bowel movement before you got sick?

How often are your bowels moving now?

Are you passing gas?

What medications and other treatments are you currently using for constipation?

Does client have bowel sounds present?

Does client have stool in the rectum?
Most commonly, sennosides are started. This medication increases peristalsis in the gut.

If ineffective, titrate up the dose or change/add an osmotic ie. lactulose

If stool is in the rectum, suppositories, microlax, or enemas may be needed.
Constipation - Complications

If not treated constipation may lead to:

- Confusion
- Nausea
- Pain
- Urinary retention

 ..........And may add to cachexia
Delirium is common in advanced disease

Sometimes, this can be an indicator that a person is actively dying

The person’s goals of care will decide if investigations for an underlying cause are needed

If the client wants reversible causes treated, assess for infections, electrolyte imbalances and brain mets
Delirium: Causes

Drugs

Ethyl alcohol

Low oxygen level

Infection

Raised intracranial pressure

Impaction

Urinary retention

Metabolic disturbances

Source: Dr. Jacqueline Fraser, Providence Healthcare
Delirium – Assessment

When did the confusion start?

What are the associated features along with the delirium? i.e. pain, fever, constipation, dyspnea, dysuria
Many medications are available.

- Haldol
- Resperidone
- Nozinan
- Olanzapine

Some of these medications help clear confusion; others may sedate the person. Most do a combination of both.
Fatigue

Asthenia is the term for advanced disease related fatigue

In most cases is thought to be caused by rise in the body’s cytokines

Virtually universal with advanced diseases

An indicator that the disease is advancing

Some reversible causes exist
Coping with Fatigue

- Identify sources of beauty/nurture and incorporate into surroundings
- Identify simple rituals that anchor client in routine and meaning
- Explore prioritizing activities (energy conservation)
Cachexia

Like asthenia, is due to a rise in cytokines associated with advancing disease

People have reduced appetites and decreased need for food

Even if people do eat, the ability of their body to use the food is reduced

Food becomes about pleasure

Before concluding the cachexia is due to cytokines, exclude nausea and constipation
Not all diseases progress in the same pattern.
Cancer Trajectory
Organ System Failure Trajectory (ie. CHF, COPD)
Frailty and Dementia Trajectory
On-going assessment helps us to know what support may be helpful in addressing client’s needs concerning:

- Sense of completion
- Meaning in one’s life
Transitioning to end of life.....

What’s happening?
Goals of care

Options for care

Sense of loss

Greater caregiver needs

Personal helplessness

Final arrangements
4. Actively Dying
In preparing for a person's death it is important to anticipate their future needs.
PPS 20%

PO intake is reduced – may only be on sips – trouble swallowing. Medications shift to SC route.

Normalizing the dying process with family/caregivers.

It is at this stage that support shifts more towards the family than the client. Give families suggestions/options about how to care for their loved one.

This is a good time to find out who wants to be present when the client dies. Families often ask “how long?”.
Common symptoms at end of life

- Restlessness
- Dyspnea
- Pain
- Respiratory Congestion
Restlessness

Clients often become delirious before they die.

This restlessness is quite difficult to settle and can be quite distressing for families: suggest use of familiar objects, music, prayer (if applicable).

Ensure that when a client is coming to the end of their life, medication is ordered for restlessness.
If the client is not on a regular opioid, obtains orders for a prn dose.

Hydromorphone is preferred to morphine.

Clients will likely need a switch from oral to s/c route.
Respiratory Congestion

In some ways like snoring - more bothersome for those listening!!!!

Most times, the gurgling is not causing discomfort

Treatment is mostly for the family so they are not left with the memory of the sound.

If the sound does not bother them and the client is comfortable, treatment might not be needed.
Observe the client, do they appear comfortable?
• Communication is more difficult – likely unresponsive.

• Offer suggestions and options that might allow the family to still “care” for their loved one.

• Spiritually, care expressions can reflect patient/family sense of meaning/beliefs and comforts.

• Questions of suffering, world view perspectives may be challenged
Death – absence of breathing, heart rate.

It is not uncommon for families/caregivers/loved ones, not present at time of death, may want to know:

• circumstances surrounding death ie. peaceful

• that the right thing at the right time was done

Some families may experience a sense of relief and/or terrible sense of finality/emptiness
Post-mortem care

Offer family privacy

Ask family if they would like you to help wash, dress, and position their loved one

Ask if family would like to carry out any special rituals
After death........

Never underestimate the therapeutic effect of your presence.

Our presence accompanies their grief and uncertainty, thereby, reducing feelings of isolation and fear.

Expressions of sympathy and affirmation of family care can be supportive and comforting.
5. Grief and Bereavement
Types of Grief

**Normal:** The experience of the pain of loss while adjusting to a changed world

**Anticipatory:** A complex process of grieving, coping and planning in response to losses experienced in the past, present and future.

**Complicated and/or Prolonged:** Unresolved grief that interferes with daily functioning because emotions are regularly felt to be overwhelming
Energy Management Model in Grief

Source: *A Path Through Loss* by Nancy Reeves
Bereavement visits...more than picking up supplies

Honour the relationship you had with client and family

Opportunity for clinical assessment

Acknowledges a transition/change in a relationship
Assessment

Risk Factors: Relationship, Mental illness, Coping Skills, Spiritual distress, Context of the loss, Safety of vulnerable people

1. Beliefs that hurt rather than comfort – guilt expressions heard in: “I could have/should have” statements

2. Crisis of Faith – loss may challenge the foundation of beliefs about the universe and about God

3. Emotional Re-location of the deceased – remembering/honouring the deceased AND resuming one’s own life
The search for meaning and comfort is often not exclusively expressed in religious language but through the interpretation of a life story. This task ultimately asks:

“What does this death mean in my life?”
Forging Relationships
Ongoing Support
Actively Dying
Grief & Bereavement

Values & Beliefs
Stay with me.

Care for me.

Listen to me.

Dame Ciceley Saunders
The End