Nursing, Palliative Care & Death: A Natural Progression Of Life

Presented by
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Presenter, Veronica Gordon have no interest to disclose.
Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Identify the Benefits Palliative Care Consultations have on Improving End of Life Care

2. Identify the Quality of Life Model by addressing the Four Dimensions of Assessment and Care of patients to Improve End of Life Care

3. Recognize Indicators of Imminent Death and the Death Event

4. Describe How Palliative Nursing Impacts Quality End of Life Care
What is Palliative Care

* Palliative care is specialized care for individuals with serious or terminal illnesses.

* The main goal is to ease pain and discomfort from symptoms and stress of a serious illness.

* Palliative care aims to enhance quality of life
Palliative Care Team Members

* Palliative care is provided by a specially-trained team of doctors, nurses, social workers and other specialists who work together with a patient’s doctors to provide an extra layer of support.

* Massage therapists, pharmacists, nutritionists, chaplains and others may also be part of the team.

* The palliative care team works in partnership with the patient’s doctor to provide an extra layer of support for the patient and their family. The team provides expert symptom management, extra time for communication and help navigating the health system.

* Palliative patients identified hospitals as a safer place than home, offering relief to the

Get Palliative Care, 2016
Taylor, & Chadwick, 2015
Identifying Patient’s Need for Palliative Care

* Palliative care is needed if a patient suffers from symptoms due to a serious illness. This may include cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer’s, HIV/AIDS, ALS, MS, and more.

* Symptoms include pain, stress, depression, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and much more.

* Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.
Benefits of Palliative Care at the End of Life

- Expert Physical, Pain, and Symptom management
- Psychosocial/Emotional support
- Spiritual and Cultural support
- Discussion, Negotiation, Advance Life Planning, End of Life Goals
- Early education and execution of advanced directive allows patient preferences to be honored and decreases decision-making burdens on the family.
- Guidance in appropriate disposition (inpatient or community hospice)
- Holistic and supportive care regardless of palliation or curative intent

Bailey, Harman, Bruera, & Arnold, 2016
Finestone & Inderwies, 2008
McAteer, R., & Wellbery, C, 2013
Fast Facts: U.S. Statistical Data

* 2014 registered deaths: 2,626,418
* Patients received hospice service: 1.6 to 1.7 million
* Deaths while under hospice care: 1,200,000
* Leading causes of death:
  Non- Cancer: 63.4%
  Cancer: 36.6%
* Veterans deaths: One of every four Americans who die each year is a Veteran

Hospice Care in America, 2015
Shreve, 2016
Fast Facts
Hospice and Palliative Care
Department of Veterans Affairs
Annual Report-FY15

* 73% of all inpatient deaths received palliative care
* More inpatient deaths occurred in VA inpatient hospice units than inpatient ICU and Acute Care combined
* 84% of the families of the inpatient decedent, rated care in the last 30 days as “Excellent” or “Very Good”
* Earlier palliative care consultation continues, with now 41% occurring more than 30 days prior to death

Shreve, 2016
Workload Complexity - All inpatient and outpatient completed palliative care consults with an encounter.

**Level 1-2**
- 99251- 20 minute consult
- 99252- 40 minute consult

**Level 3-5**
- 99253- 55 minute consult
- 99254- 1 hour or longer consult
- 99255- 1 hour or longer consult
  OR admission to hospice or palliative care
Palliative Care Metric Report

VISN Definition and Terms

**Treating Specialty** - Inpatient Hospice Admission (TS96/1F)
1F - Patients with hospice admission to Acute Care Setting
TS96 - Patients with hospice admission to Community Living Center

**Inpatient Palliative Care Summary**

\[
\text{Inpatient deaths w/completed PCC within 12 mo. of death OR hospice adm.} = \frac{1}{\text{Inpatient deaths}}
\]

Palliative Care Reporting, 2016
<table>
<thead>
<tr>
<th>MEDVAMC Palliative Care Data</th>
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<tbody>
<tr>
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<tr>
<td><strong>Completed Consults, Level 1-2</strong></td>
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<tr>
<td><strong>Completed Consults, Level 3-5</strong></td>
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<tr>
<td><strong>Total Consults, total</strong></td>
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<tr>
<td><strong>Average days between completed initial PCC and death</strong></td>
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<tr>
<td><strong>Level 3-5 consult within 12 mo. prior to death</strong></td>
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<tr>
<td><strong>Hospice admission - TS96 or 1F w/i 12 mo. prior to death</strong></td>
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<tr>
<td><strong>Level 3-5 consult w/i 12 mo. prior to death OR hospice admission</strong></td>
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<tr>
<td><strong>Inpatient deaths</strong></td>
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<tr>
<td><strong>% inpatient deaths with completed PCCT consult within 12 months prior to death OR hospice admission</strong></td>
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MEDVAMC Palliative Care Workload Complexity

FY17 data:
through March 26; 48% of year

Consults, Level 1-2
Consults, Level 3-5
Total Consults
Percent Level 3-5
Transitioning to Comfort Care

Houston VA FY17 data: through March 26; 48% of year

FY13: 121, 522, 249, 241, 121
FY14: 413, 415, 389, 361, 184
FY15: 54%, 64%, 67%, 66%, 66%
FY16: 29%, 54%, 64%, 67%, 66%
FY17 TD*: 0%, 50%, 60%, 70%, 80%
Hospice is not about GIVING UP!

It is about receiving specialized care at end of life

my story
Hospice is not a place, but a concept for healthcare delivery to those dealing with life-limiting illness.

Hospice focuses on creating a natural and comfortable end-of-life experience for those confronted with a terminal condition.

Through a range of palliative, medical, nursing, psychosocial, and spiritual care provided by an interdisciplinary team of experts, hospice seeks to manage symptoms and provide comfort when cure is no longer possible.
Impact of Transitioning to Comfort Care on Quality End-of-Life

- Improved pain and symptom management
- Improved quality of life and mood
- Prevent suffering and unnecessary hospitalization
- Prevent invasive and burdensome procedure and treatments
- Decreased hospitalization costs with improved utilization of supportive and health care resources
- Increased decision making and a sense of control
- Caregivers, family, and friends report greater satisfaction
- Improved end-of-life care and increase survival rate
- Communicate end-of-life wishes; reduce confusion about goals of care

Ahluwalia et al., 2014
Bailey, Harman, Bruera, Arnold, & Savarese, 2016
McAteer, R., & Wellbery, C. 2013
Temel et al., 2010
DEATH

"How do I tell him he is going to die?"

"When will he tell me I'm going to die?"
Quality of Life Model: Four Dimensions of Assessment and Care

* Physical Well-Being
  - Activities of daily living, Appetite, Strength, Pain, Fatigue, Nausea

* Psychological (Mental) Well-Being
  - Stress, Fear, Cognition, Depression, Anxiety, Relief

* Social Well-Being
  - Relationships, Finances, Sexual Function

* Spiritual Well-Being
  - Religion, Hope, Loss, Meaning
Death a Fearsome Subject

- Death Cafe’s goal: help people make the most of their lives, their “finite” lives, by giving them a chance to talk about death. It’s something family and friends often refuse to contemplate.


The Kansas City Star: May 23, 2014
DEATH, a Natural Process

* Two dynamics at work
  - Physical plane
  - Emotional-Spiritual-Mental plane

* Body
  - Final process of shutting down
  - Maintaining comfort enhancement measures

* Spirit
  - Final process of release from the body, its environment, and all attachments
  - Support and encourage this release and transition

Hospice, 2016
Indicators of Nearing Death and Clinical Death

- Decreased level of consciousness, Palliative Performance Scale ≤20%,
- Dysphagia of liquids appeared at high frequency and >3 days before death and had low specificity (<90%) and positive LR (<5) for impending death.
- Apnea periods,
- Cheyne-Stokes breathing,
- Death rattle
- Peripheral cyanosis,
- Pulselessness of radial artery
- Respiration with mandibular movement
- Decreased urine output occurred mostly in the last 3 days of life and at lower frequency. Five of these signs had high specificity (>95%) and positive LRs for death within 3 days, including pulselessness of radial artery (positive LR: 15.6; 95% confidence interval [CI]: 13.7–17.4), respiration with mandibular movement (positive LR: 10; 95% CI: 9.1–10.9), decreased urine output (positive LR: 15.2; 95% CI: 13.4–17.1), Cheyne-Stokes breathing (positive LR: 12.4; 95% CI: 10.8–13.9), and death rattle (positive LR: 9; 95% CI: 8.1–9.8).

Non-reactive pupils
- Decreased response to visual stimuli
- Decreased response to verbal stimuli
- Inability to close eyelids
- Drooping of the nasolabial fold (which makes the face appear more relaxed)
Clinical Death

Clinical **DEATH**—The cessation of all vital functions of the body including the cessation of all vital functions of the body
- Heartbeat
- Brain activity (including brain stem)
- Breathing

The irreversible cessation of all vital functions especially as indicated by permanent stoppage of the heart, respiration, and the brain activity: The End of Life
How Palliative Nursing Impacts Quality End of Life

Avoid delay the introduction of a palliative approach
Nurses Preparing for Palliative Caregiving

Special Training

Special Equipment

Physical Distress

Social Distress

Psychosocial/Emotional Distress

Spiritual Distress

Existing long-term relationship

Preparedness

Readiness

Providing physical care

Interventions

Rehabilitation

Limited Disability

Values and Hope
Nursing Responsibility

* Health professionals often delay the introduction of a palliative approach by waiting for a clearly terminal event. By doing so, the dying patient may have a poor quality of life, suffering unnecessarily from preventable symptoms (Wilson, Avalos, & Dowling, 2016).

* It is important that providers and caregivers review the four dimensions in order to provide proper care and support.

* Assess all dynamics in relation to the closure of the patient's life.

* Poor management of these four dimensions may hasten death by increasing stress, pain, anxiety, and diminishing spiritual meaningfulness.

* Enlist help of interdisciplinary services such as chaplain, social worker, psychologist, pain management specialist, and etc.

* Make accommodations.
Nurses Preparing for Palliative Caregiving

Readiness includes:

❖ Being knowledgeable
   - Learning through actively seeking updated information, trial and error, earlier experience and guidance by others.
   - Be able to provide knowledge to the family on preparedness to include expectations on emotional and physical wellbeing.

❖ Giving emotional support
   - Knowing not only what to do, but also feeling ready to manage the demands of the caregiver role.
   - Providing support to family caregivers is an important aspect of both palliative care and nursing.

❖ Dealing with the stress of the role

Åhsberg & Carlsson, 2014
Janze & Henriksson, 2014
“Nurses who lack understanding of a dying patient’s cultural and spiritual needs at this difficult time can make that person’s death an even more traumatic experience for his or her family members”.

Minoritynurse.com, 2016
Self-Determination

Patient Self-Determination Act (1991)

* Right to facilitate own health care decisions
* Right to accept or refuse medical care
* Right to make their own advanced healthcare directive
  - Living Will
  - Power of Attorney

Cipolletta & Oprandi, 2014
Thanatophobia: Fear of Death

* Religious Issues
  - Beliefs may be wrong
  - Straight and Narrow path, deviations??
* Fear of the Unknown
  - Cannot be unequivocally proven
* Fear of Loss of Control
  - Utterly outside anyone’s control

Fritscher, L. 2014
The Fear of Death

* Concerns about Relatives
  ❖ Who will care for them, finances, what will happen

* Fear of Death in Children
  ❖ Don’t fully understand time, some people leave and come back again
  ❖ Healthy part of normal development, lack defense mechanisms

* Fear of Pain, Illness or Loss of Dignity
  ❖ Do not actually fear death itself

Fritscher, L. (2014)
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QUESTIONS

Honoring Veteran’s and Patients’ Preferences for End-of-Life Care
Honoring Veterans’ Preferences for End-of-Life Care