PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

CONTENTS OF THIS SUMMARY DOCUMENT

- **REFLECTION**

  Brief personal thoughts about this project, and how it might help shape decisions about the kind of care I aim to provide to patients in the future.

- **EXPERIENCES**

  A listing of the clinical and learning experiences related to palliative, hospice, and geriatric care in which I have participated in the completion of this project.

- **RESOURCES**

  A listing of relevant articles, books, and websites that I have collected over this period while learning more about palliative, hospice and geriatrics – my own little library of go to resources. I believe I will turn to these frequently as I move forward in my training, for both personal reference and while educating others.

- **APPROACH TO…**

  A series of (mostly) one-page handouts that I have prepared based on the highest-yield clinically applicable learning that I have gained over the course of this project. These are sort of like my own versions of the neat little cards that San Diego Hospice used to give out to trainees, expanded to incorporate more specific and complete info that I can use and teach from. My intention is to use these handouts as quick reference for myself as I approach patients and symptom management as a resident, and also in educating others (med students, fellow residents, etc.). Topics include: pain, constipation, nausea/vomiting, delirium, goals-of-care discussions, and the geriatric assessment. (I actually think a smart-phone app would be a really neat thing to explore for most of these approaches/algorithms…. future project?)

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

REFLECTION

Upon looking over the proposal I created at the outset of this project, I am struck at how positively sure I was at the time of its writing that my future career path would be composed solely of palliative and hospice work. Here and now, one year later – having been exposed to palliative and hospice care in a variety of settings via this project, also with MICU and geriatrics rotations behind me, and having had the benefit of lots of time for self reflection on the residency interview trail – I admit that my current thinking about future plans is much less certain.

My belief in the absolute value of compassionate, whole-person care for patients and their families – a palliative approach, if you will – has not wavered. But what I have discovered is that the idea of applying this approach to a wider range of patients – not only those nearing the end of life – is much more appealing to me than it was previously. What I envisioned for myself at this project's outset was a future of full-time work with hospice patients – in an inpatient care facility, in nursing facilities, on a hospital consult service of some sort, or some combination therein. What I see for myself now is more along the lines of being a provider who is very well skilled in palliative medicine, and who applies those skills, along with lots of other skills and knowledge, to the care of a broader pool of patients. Right now, I'm thinking about geriatrics as that broader pool, and am most curious about home care and how that actually works. However, I recognize that these notions are written only in the sand beneath my fledging feet.

Gladly, I am much more excited and open now than I was at the year's outset – about discovering my path and seeing where it leads. And for lots of reasons, this project included, I am now more able to appreciate that this journey through medical training is just that, a journey – and one that I am only just beginning.

Aside from these intangibles, this project has given me a great deal of exposure to clinically relevant information and resources. I hope to bring this information to bear in the care of my future patients – whether they are facing chronic or life-limiting illness, are coming in to clinic to see me for a routine check up, or are my responsibility for just a few hours, when I'm on night float or rotating through the ED. Additionally, this project has broadened my understanding of what whole-person care can actually mean – at different times, in different clinical contexts, to different providers, and, most importantly, to different patients. For me, it means doing my best to approach each patient as an individual, and to try to meet them where they're at – what does the patient want to get out of the medical encounter? And what role can I play in getting him/her the things that he/she wants and needs? The project has also opened my eyes to some of the complexities inherent in attempting to provide that care. And it has deepened my resolve to remain committed to the palliative approach as I go forward, regardless of the specifics of my future career path.

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

EXPERIENCES

• San Diego Hospice and the Institute for Palliative Care → September 2012, 20 clinical days
- Inpatient Care Center

• UCSD Moores Cancer Center → December 2012/January 2013, 10 clinical days
- Doris Howell Consult Service

• George Washington University (GWU) → October 2012
- VA inpatient palliative consult service (10 clinical days)
- GWU geriatric home visit service (10 clinical days)

• Rady Children's Hospital of San Diego → December 2012/January 2013, 5 clinical days
- Pediatric Advance Care Team rounds
- Fostering Excellence in Pediatric Palliative Care conference

• Online coursework → March 2013, 6 hours
- Geriatric Education Utilizing a Palliative Care Framework (GEPaC)
http://gepaconline.gwnursing.org/

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

RESOURCES

ARTICLES:

• Caregivers

- Rabow MW, Hauser JM, Adams J. Supporting family caregivers at the end of life: "they don't know what they don't know." JAMA. 2004;291(4):483-91.

• Clinical Trajectory

- Lunney JR, Lynn J, Foley DJ, Lipson S, Guralnik JM. Patterns of functional decline at the end of life. JAMA. 2003;289(18):2387-92.

• End-of-Life Conversations

- Lamas D, Rosenbaum L. Freedom from the Tyranny of Choice – Teaching the End-of-Life Conversation. N Engl J Med. 2012;366(18):1655-7.
- Quill TE. Initiating end-of-life discussions with seriously ill patients: addressing "the elephant in the room." JAMA. 2000;284:2502-7.
- Quill TE, Holloway RG. Evidence, preferences, recommendations – finding the right balance in patient care. N Engl J Med. 2012;366(18):1653-5.
- von Gunten CF. Discussing do-not-resuscitate status. J Clin Oncol. 2003;21(9 Suppl):20s-25s.
- Weissman DE. Decision making at a time of crisis near the end of life. JAMA. 2004;292(14):1738-43.

• Landmark

- Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363(8):733-42.

• Medicare

- Medicare Benefit Policy Manual. Chapter 9: Coverage of Hospice Services Under Hospital Insurance. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf (Accessed on March 11, 2013)

• Palliative Care – cost, culture

- Albanese TH, Radwan SM, Mason H, Gayomali C, Dieter K. Assessing the financial impact of an inpatient acute palliative care unit in a tertiary care teaching hospital. J Palliat Med. 2013;16(3):289-94.
- Levy Associate Editor C. Isn't that just good medical care? J Palliat Med. 2013;16(3):218-9.

• Pediatrics

- Klick JC, Hauer J. Pediatric Palliative Care. Curr Probl Pediatr Adolesc Health Care. 2010;40(6):120-51.
- Wolfe J, Hammel JF, Edwards KE, Duncan J, Comeau M, Breyer J, Aldridge SA, Grier HE, Berde C, Dussel V, Weeks JC. Easing of suffering in children with cancer at the end of life: is care changing? J Clin Oncol. 2008;26(10):1717-23.

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

- Davies B, Sehring SA, Partridge JC, Cooper BA, Hughes A, Philip JC, Amidi-Nouri A, Kramer RF. Barriers to palliative care for children: perceptions of pediatric health care providers. Pediatrics. 2008;121(2):282-8.

• Symptom Management
- Wood GJ, Shega JW, Lynch B, Von Roenn JH. Management of intractable nausea and vomiting in patients at the end of life: "I was feeling nauseous all the time…nothing was working." JAMA. 2007;298(10):1196-1207.

• Wound Care
- Ayello EA, Cuddigan JE. Conquer chronic wounds with wound bed preparation. Nurse Pract. 2004;29(3):8-25; quiz 26-7.
- Lionelli GT, Lawrence WT. Wound dressings. Surg Clin North Am. 2003;83(3):617-38.

BOOKS:
• Bodtke S. 2012. Patty Wu's Palliative Medicine Pocket Companion. 2nd ed. San Diego: The Institute for Palliative Medicine at San Diego Hospice.
• Quill TE, Holloway RG, Stevens Shah M, Caprio TV, Olden AM, Porter Storey Jr, C. 2010. Primer of Palliative Care. 5th ed. Glenview: American Academy of Hospice and Palliative Medicine.

WEBSITES:
• Canadian Hospice Palliative Care Association (http://www.chpca.net/)
• Center to Advance Palliative Care (http://www.capc.org/)
• Education on Palliative and End-of-Life Care (http://www.epec.net/)
• Fast Facts (http://www.eperc.mcw.edu/EPERC/FastFactsandConcepts)
• GeriPal Blog (http://www.geripal.org/)
• Growth House: Guide to Death, Dying, Grief, Bereavement, and End-of-Life Resources (growthhouse.org)
• GWU Center for Aging, Health & Humanities (http://cahh.gwu.edu/)
• International Palliative Care Resource Center (http://www.ipcrc.net/)
• Pallimed Blog (http://www.pallimed.org/)
• Societal Education About Aging for Change – children's books with positive portrayals of elders (http://cahh.gwu.edu/sites/cahh.gwu.edu/files/downloads/SEAChange_booklist.pdf)
• Stanford Faculty Development Center End-of-Life Curriculum (http://www.growthhouse.org/stanford/modules.html)

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO PAIN (PAGE 1 OF 2)

1. Assess the patient's pain.
- Known cause? – underlying illness, inciting event or trauma?
- Location – localizable? radiation?
- Quality/Modifiers – what adjectives describe the pain? what makes it better? worse?
- Time course – acute (days-weeks) vs chronic (weeks-months); constant, intermittent, breakthrough
- Intensity – 0 (no pain) to 10 (extremely severe pain); or MILD (1-3) / MODERATE (4-6) / SEVERE (7-10)
→ Goal: generally <4 because 4-10 interfere with function, sleep, concentration; negotiate with each patient
- Other factors – inquire about psychological, social, spiritual, financial concerns – can affect perception/tolerance
- Treatment – what has been tried? opioid naïve/tolerant? allergies?

To assess pain in cognitively impaired/uncommunicative patients, look for signs of discomfort:
labored breathing, moaning/groaning, calling out, crying, furrowed brow, grimace, looking scared, tense/rigid posture, clenched fists, pulled up knees, inconsolable by voice or touch
→ **Educate nursing and other caregivers about what to look for, include clear descriptors in PRN orders.**

2. Determine level and most likely type of pain (somatic, visceral, neuropathic, mixed) – target treatment.

World Health Organization 3-Step Ladder of PAIN → tells you where to start. Although used as a general approach to many different kinds of pain, was developed specifically as an approach to CANCER pain.

MILD (1-3)	**MODERATE** (4-6)	**SEVERE** (7-10)
+non-opioid: acetaminophen/paracetamol **+/- adjuvant**	**+opioid**: tramadol acetaminophen/codeine (Tylenol #3, Tylenol #4) acetaminophen/hydrocodone (Vicoden, Norco, Lortab) acetaminophen/oxycodone (Percocet) **+/- non-opioid** **+/- adjuvant**	**+opioid**: morphine hydromorphone oxycodone fentanyl **+/- non-opioid** **+/- adjuvant**

NOCICEPTIVE		**NEUROPATHIC**
Somatic /peripheral nociceptors/ -skin, soft tissue, muscle, bone -wounds, soft tissue tumors, sports injuries, arthritis, bone metastases	**Visceral** /thoracic, abdominal, pelvic nociceptors/ -heart, lung, GI tract, GU tract -fluid collections, ascites, bulky metastases, obstruction -opioids not as helpful	/PNS or CNS - myelin or nerves/ -nerves killed or damaged by compression, transection, infiltration, ischemia, metabolic injury, toxins/drugs
dull/sharp, aching, throbbing easy to localize	deep, pressure, crampy, colicky difficult to describe or localize	burning/cold, shooting, stabbing, tingling, shock-like, itching
NSAIDS -beware GI s/e, bleeding - ~~**renal impair**~~ -naproxen, ibuprofen, ketoralac (toradol)	**Anticholinergics** -beware in elderly; delirium, lethargy, constipation, urinary retention -scopolamine, hyosycamine, glycopyrrolate, oxybutynin	**Anticonvulsants** -gabapentin, pregabalin (renally dose!) -valproate, carbamazepine (follow levels, ~~**hepatic impair**~~)
Bisphosphonates -esp for bone pain/mets -beware ↑Cr -pamidronate, zolendronate	**Other** -steroids – dexamethasone -BDZs – lorazepam -prokinetics – metoclopramide -antisecretories – octreotide	**Antidepressants** -TCAs – amitriptyline > nortriptyline (beware elderly, hepatic impair; monitor levels) -SNRIs – venlafaxine (renal dosing, beware hepatic impair), duloxetine (renally dose, ~~**hepatic impair**~~)
Steroids -beware ↑glucose, thrush, sleep disturb, mood disturb -dexamethasone, prednisone		**Topicals** -transdermal lidocaine (few s/e, good for elderly) -capsaicin cream

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO PAIN (PAGE 2 OF 2)

3. What to know about opioids. Don't be scared!
- $t_{½}$ = ~4 hours
- steady state = $5t_{½}$
- ∴ opioid steady state = ~**20 hours** after starting routine dose or changing dose → **time to evaluate effectiveness!**
- C_{max} depends on route → IV = 10min / SQ = 30min / PO = 60min
- PO breakthrough = 10% of total daily dose

Morphine
- why not morphine? prior intolerance, renal failure, hepatic failure, patient preference
- liver (glucuronidation) → neuro-excitatory metabolites (M3G, M6G) → beware seizures, myoclonus
- 1mg IV/SC/IM = 3mg PO

Choosing an opioid
- Renal insufficiency → fentanyl best; hydromorphone and oxycodone with caution; do not use morphine
- Hepatic insufficiency → oxycodone, hydromorphone, fentanyl with caution; decrease or discontinue morphine
- Long-acting → morphine, oxycodone, fentanyl, methadone
- If a patient is SOB (COPD, CHF, lung cancer) and also in pain, won't an opioid interfere with already labored breathing? NO! Opioids treat SOB and pain – double whammie.

Common opioid side effects – nausea, sedation, pruritis, constipation
→ Tolerance to everything but constipation typically develops within a week or so of use
→ Severe side effects include respiratory depression, seizures, delirium – if trying opioids again, avoid whatever drug caused the severe side effect(s) and start with very low dose of new drug
→ ALWAYS start a bowel regimen with opioids! Docusate alone is not enough; need stimulant or osmotic laxative.

EQUIANALGESIC DOSING

PO/PR (mg)	analgesic	IV/SC/IM (mg)
150	**TRAMADOL**	–
150	**CODEINE**	50
15	**HYDROCODONE**	–
15	**MORPHINE**	5
10	**OXYCODONE**	–
3	**HYDROMORPHONE**	1
–	**FENTANYL**	0.050

rotating opioids = stopping one opioid and starting a new one, because the first had side effects or inadequate analgesia
incomplete cross tolerance = new opioid might have greater effect than estimated by equianalgesic dosing calculations; decide *what % of calculated dose of new med* to use based on <u>level of patient's pain control with first med</u>
<u>poor</u> = *100%* / <u>moderate</u> = *75%* / <u>excellent</u> = *50%*

Adapted from Patty Wu's Palliative Medicine Pocket Companion.

Concerns
- Tolerance – exposure to drug causes decreased effect, many patients require dose adjustments over time
- Physical dependence – physiologic withdrawal after abrupt cessation, rapid dose reduction, reversal agent
- Addiction – impaired control over use, craving, compulsive use, use in unprescribed ways, use in spite of harm
- Pseudoaddiction – iatrogenic, mimics addiction but behaviors are result of inadequate treatment of pain
- Overdose – somnolent/obtunded/unresponsive, ↓RR/TV, +/-pinpoint pupils → naloxone, observe x4h
- Withdrawal – early (8-12h) = diaphoresis, lacrimation, rhinorrhea, yawning
  mid (18-20h) = mydriasis, gooseflesh, tremors, restlessness/irritability, anxiety
  late (48-72h) = n/v, diarrhea, abdominal cramps, body aches, muscle spasms, insomnia, ↑HR/BP

- Bodtke S. 2012. Patty Wu's Palliative Medicine Pocket Companion. 2nd ed. San Diego: The Institute for Palliative Medicine at San Diego Hospice.
- Quill TE, Holloway RG, Stevens Shah M, Caprio TV, Olden AM, Porter Storey Jr, C. 2010. Primer of Palliative Care. 5th ed. Glenview: American Academy of Hospice and Palliative Medicine.

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO CONSTIPATION

1. Obtain history, including:
    - Youngish (<65yo) versus oldish (>65yo)? Is mobility intact or impaired?
    - Taking opioid analgesics? Other medications? Any radiation or chemo?
    - Adequate PO (food, fluids, fiber)?
    - At risk for obstruction (past abdominal surgery, abdominal/pelvic cancer)?
    - Other risk factors (thyroid disorder, IBS, hemorrhoids, abscess/fistula, trauma, anxiety/depression, impaired cognitive function)?
    - Stool specific Qs → frequency, consistency, hematochezia/melena, laxative use, continence, flatus

* Constipation clues:
- less than three bowel movements per week
- frequent straining, or stool is hard/dry, or stooling is painful
- abdomen feels distended, full, or bloated along with sensation of rectal fullness/pressure
- feeling of incomplete evacuation after stooling

* Medications that cause/worsen constipation: opioids; anticholinergics – diphenhydramine, scopolamine, oxybutynin, promethazine, tricyclic antidepressants; lithium; verapamil; iron

2. Perform physical exam, including:
    - abdomen → bowel sounds (listen 2min in each quadrant)? distention? ascites? mass? pain?
    - rectal → hemorrhoids? abscess? impaction? occult blood?
3. Patients at risk should be counseled regarding:
    - **Fluids** (any beverage): 8cups/day for women; 12cups/day for men
    - **Dietary fiber**: 25-30grams/day with adequate fluid intake (~1.5L/day), insoluble fiber (whole grains, vegetables, wheat bran) absorbs water → softens stools → waste moves quickly → soft, regular BMs
      But BEWARE! hi fiber or the use of bulking agents (eg, psyllium - Metamucil) are not appropriate for end-of-life patients or others with diminished fluid intake; without adequate fluid, *cause* impaction
    - **Toileting**: gastrocolic reflex is strongest in the AM, recommend 5-15min toileting after breakfast, upright on commode/toilet if possible
    - **Physical activity**: poor mobility may contribute to constipation, encourage exercise as tolerated

TREATMENT

SOFTENER TO EASE PASSAGE	**STIMULANT** TO INCREASE MOTILITY*	**OSMOTIC** TO INCREASE WATER CONTENT	**OTHER**
docusate -detergent laxative -200mg QD → BID or TID -max 600mg daily	**senna** -active metabolite irritates smooth muscle of intestine -1tab QD → 4tab BID -with docusate = senna-s **bisacodyl** -directly irritates smooth muscle of intestine -5mg PO QD → 15mg BID -10mg PR QD PRN -suppository can cramp *first evacuate existing stool with an enema!	**sorbitol OR lactulose** (10g/15mL) -non-absorbable sugars -15-60mL PO BID-TID -sickeningly sweet **polyethylene glycol** (MiraLAX) -17g/6oz fluid -well-tolerated **milk of magnesia** -15-30mL QD PRN ~~-**renal impair**~~	**PROKINETIC** **metoclopramide** -5-10mg Q6h **erythromycin** -150mg q6h→250mg q6h **ENEMA** -warm tap water is best -saline/sodium phosphate risks dehydration -mineral oil risks aspiration pneumonitis **REFRACTORY OPIOID-INDUCED** **methylnaltrexone** -peripheral μ-opioid-®-antagonist -does not reverse analgesia -BM within 30min

→ A bowel regimen should ALWAYS accompany a prescription for opioid analgesics! Eg, senna +/- docusate OR osmotic agent.

- Hallenbeck J. Constipation. Fast Facts and Concepts #15. Milwaukee, WI: End of Life/Palliative Education Resource Center; August 2005. Available at: http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_015.htm. Accessed March 21, 2013.
- Quill TE, Holloway RG, Stevens Shah M, Caprio TV, Olden AM, Porter Storey Jr, C. 2010. Primer of Palliative Care. 5th ed. Glenview: American Academy of Hospice and Palliative Medicine.
- National Guideline Clearinghouse (NGC). Guideline summary: Guidelines for constipation. In: National Guideline Clearinghouse (NGC) Website. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ). Available at: http://www.guideline.gov. Accessed March 21, 2013.

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO NAUSEA/VOMITING

1. Determine whether the patient's condition is stable or unstable, and whether emergent intervention is warranted (electrolytes, fluids, blood, surgery).
    - What are the vitals?
    - Is the patient having any pain?
    - Has there been hematemesis?
    - Recent labs or imaging?
    - Physical exam findings? (oral mucosa, abdomen, rectum, neuro)
2. Collect the history.
    - Who is this patient and what is their medical story? What are the goals of care?
    - Is the nausea/vomiting associated with meals, head movement, something else?
    - Are there concurrent bowel changes?
    - Any neurologic changes?
    - Medications?
3. Determine the most likely cause of the nausea/vomiting.
    - Which neurotransmitters are most likely involved?
    - Select treatment based on this approach. Start with one medication, titrate up. If adding additional agent(s), select from a different class.

EXTRA-ABDOMINAL			INTRA-ABDOMINAL
Cerebral Cortex - sensory - anxiety - CNS irritation - pain	**Chemoreceptor Trigger Zone** (floor of fourth ventricle) - drugs - electrolytes (↓Na, ↑Ca) - metabolic disturbance (↑urea) - bacterial toxins	**Vestibular Apparatus** - motion sickness - labyrinth/middle ear disorder	**Gastrointestinal Tract** - GI mucosal injury - mechanical stretch - constipation
complex	- serotonin (5HT) - dopamine (D2) - neurokinin (NK1)	- acetylcholine (Ach) - histamine (H1)	- serotonin (5HT) - mechano® - chemo®
Input → Vomiting Center → Ach, H1, 5HT → nausea/vomiting ☹ (midbrain)			
BDZ	**Anti-5HT**	**Anti-Ach**	**Anti-5HT**
- lorazepam	- ondansetron	- diphenhydramine - scopalamine	- ondansetron
STEROIDS	**Anti-D2**	**Anti-H1**	**Soothe GI**
- dexamethasone	- haloperidol - metaclopramide - prochlorperazine (compazine) - promethazine (phenergan)	- diphenhydramine - meclizine - hydroxyzine	- octreotide - laxatives
OTHER			
- THC - pain medication			

- Bodtke S. 2012. Patty Wu's Palliative Medicine Pocket Companion. 2nd ed. San Diego: The Institute for Palliative Medicine at San Diego Hospice.
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- Wood GJ, Shega JW, Lynch B, Von Roenn JH. Management of intractable nausea and vomiting in patients at the end of life: "I was feeling nauseous all the time…nothing was working." JAMA. 2007;298(10):1196-1207.

PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO DELIRIUM

"Change in mental status."
→ history (incl collateral), physical (incl rectal), and medication review (incl recent dosage changes)

Delirium = acute onset (hours-days), fluctuating, usually worse at night
- impaired attention – cannot spell "world" backwards, cannot count back from 100 by 7s
- cognitive changes – disorganized thinking, impaired memory or language skills, disorientation
- impaired consciousness – vigilant OR lethargic/stuporous/unarousable
- perceptual disturbances – hallucinations, delusions
- psychomotor changes – hyperactive vs. hypoactive

→ There is a medical cause for delirium! May or may not be reversible.

What to think about:
- Medications – esp opioids, BDZs, antidepressants, anticholinergics, antihistamines, antisecretories, steroids
- Fluid or metabolic imbalance – assess volume status, electrolytes, ↑calcium
- Infection – UTI, pneumonia, sepsis, decubitus ulcers
- Waste accumulation – urinary retention, constipation
- Hypoxia
- Uncontrolled pain
- Cancer – mets (leptomeningeal, parenchymal), paraneoplastic syndromes, radiation-induced encephalopathy
- Progressive organ failure – especially hepatic, renal, cardiac, brain (dementia, primary tumor, mets)
- Active dying

TREATMENT

<table>
<tr><th colspan="2">Reversible</th><th>Non-Reversible</th></tr>
<tr><td>Haloperidol
-1-2mg PO/IV/SC Q1H PRN
-gero start at 0.25-0.50mg</td><td rowspan="2">- natural lighting
- frequent orientation
- sensory assists – glasses, hearing aides
- routine – consistent caregivers, sleep hygeine
- activity – ROM, up to chair, exercise
- familiar belongings, pictures
- companionship – family, pet therapy, 1:1
- calm environment</td><td>Lorazepam
-1-2mg PO/buccal Q1H PRN
-consider Q30min PRN for IV/SC</td></tr>
<tr><td>Chlorpromazine
-25-50mg PO/PR/IV Q1H PRN
-beware hypotension</td><td>Other – Midazolam, Phenobarbital, Propofol
Stronger meds – loading dose then round-the-clock or gtt. Consult for use of these in general patient populations.</td></tr>
</table>

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*Palliative Sedation – progressively higher levels of sedation for the relief of intractable and distressing physical symptoms at the end of a patient's life. For example, agitated terminal delirium, unrelenting pain.
- aim to achieve **least** level of sedation that adequately relieves patient's symptoms
- unconsciousness may occur, but is not an inevitable or intended outcome
- only appropriate for patients who are DNR/DNI, consent must be obtained (patient or proxy)
- document clinical decision, involve entire healthcare team, consult Palliative/Hospice providers
- typical medications used – lorazepam, midazolam, phenobarbitol, propofofol

- Bodtke S. 2012. Patty Wu's Palliative Medicine Pocket Companion. 2nd ed. San Diego: The Institute for Palliative Medicine at San Diego Hospice.
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PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO THE GOALS-OF-CARE DISCUSSION

Family meetings, with or without the patient present, are the "procedure" of palliative/hospice physicians.

1. Pre-meeting → all procedures require preparation, GOC discussions included!
   - Gather information – review the medical chart, talk with other members of the care team.
   - Logistics – talk with the patient about who should/should not be there; choose an appropriate location
   - Pre-meeting – meet briefly with other clinicians to clarify intentions and anticipate problems
   - Keep an open mind – don't go into meeting with a firm agenda; the point is to clarify and be responsive to the needs and wants of the patient/family

2. Meeting
   - What does the patient/family know? Want to know?
   - Share medical information and respond empathically as patient/family receive information.
   - Identify and resolve conflicts → acceptance vs non-acceptance.
   - Set goals → "Now that we have discussed your condition and the reality that time may be short, I want to find out what is most important to you. What do you need to accomplish? Who do you need to see in case time is shorter than we hope? What else is important to you?"
   - Make plans → with goals established, review current treatments/potential interventions and decide which align with goals and which do not; be prepared to make clear recommendations to patient/family
   - Summarize agreed-upon next steps, invite questions, close.

*GOOD: an approach to difficult conversations
G → Goals. What are the 'big picture' goals of this patient/family? What values guide the patient/family?
O → Options. Share relevant options with patient/family. Are they considering others? Discuss benefits/burdens.
O → Opinion. Offer your opinion, based on your understanding of patient/family goals and values.
D → Document. Tell the story.

*Prognosis: days to weeks, weeks to months, months to years

*What to expect at the end of life:
- weakness/fatigue – most bedbound
- decreased food/fluid intake – not hungry or thirsty
- decreased ability to swallow/cough; noisy breathing, gurgling and 'death rattle' can occur
- decreased circulation, arms/legs cool, pale, mottled; decreased urine output
- decreased consciousness, sleeping more, may be confused or quiet when awake
- agitation, delirium
- incontinence
- slow, shallow breathing
- inability to close eyes
- near-death awareness – some patients articulate a sense that death is approaching

- Hallenbeck JL. Palliative Care Perspectives. New York: Oxford University Press, Inc. Available online at: http://www.growthhouse.org/stanford/. Accessed April 1, 2013.
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PALLIATIVE AND HOSPICE CARE IN THE CLINICAL SETTING

APPROACH TO THE GERIATRIC ASSESSMENT*

→ Older people continue to grow and develop in new ways. There are many normal variations at all stages of life!

Multi-dimensional assessment – what is the patient's current quality of life? What's important to the patient and family? What does the patient and family want and need? How can you help?
Three magic questions to start the conversation:
1. Tell me about yourself (loved one).
2. What makes you (him/her) happy these days?
3. What worries you (him/her) these days?

Physical.
- Functional ability – how far can you walk? exercise tolerance? strength?
- Is there anything you can't do that you wish you could – because of medical problems?
- Do you have pain? SOB? fatigue? constipation?
- How is your sleep? How much time do you spend in bed?
- How is your appetite? Any nausea?
- Any falls/injuries/close calls?

Psychological.
- What has been stressful? How did you react? What do you do to cope?
- If you have pain, is it distressing?
- Any depression? anxiety? fears?
- How is your memory?
- How is your concentration? Are you able to complete the tasks you want complete?

Activities of Daily Living.
- feeding, toileting, dressing/choosing clothes, grooming, continence, bathing, walking, transferring
- finances, transportation, shopping, preparing meals, telephone use, medications, laundry, housekeeping

Social.
- Tell me about your living situation. Tell me about a typical day.
- What roles/responsibilities do you have?
- Who are the important people in your life right now?
- Does anyone act as a caregiver in some way?
- Are you happy with your appearance? Are there things about the way you look that you wish you could change?
- Are you able to express affection to those you care about? Are you sexually active?

Spiritual.
- Do you find your activities worthwhile? What is your purpose?
- Are you involved in the community?
- Are you involved in religious practices/activities?
- Do you feel you have things you'd like to pass on to younger generations? What ways have you found to do that?

Future.
- Have you made plans for yourself – long-term insurance? advance care planning? Code status? POLST?
- Do you have family or friend that is involved in your health care? can act as a proxy?
- What are your thoughts about death? What happens when people die?

→ Partner with patient/family to make a plan of care.
→ Re-evaluate that plan anytime there is a change in health status (new diagnosis, decline), change in treatment setting, change in treatment options, or a change of preferences related to goals of care.

*Adapted from the teachings of Dr. Elizabeth Cobb, MD at George Washington University and content from the Geriatric Education Utilizing a Palliaitve Care Framework online curriculum @ gepaconline.gwnursing.org