Supporting Palliative Care In Long-Term Care Facilities

Dr. Mike Harlos
Professor and Section Head, Palliative Medicine, University of Manitoba
Medical Director, WRHA Adult and Pediatric Palliative Care

Sarah Brown
Clinical Nurse Specialist, Canadian Virtual Hospice and the WRHA Palliative Care Program

Lori Embleton
Program Director, WRHA Palliative Care Program
Objectives

• To review common challenges in providing palliative and end-of-life care in Long Term Care settings

• To consider ways to meet the needs of palliative clients and their families, and to support staff in the provision of palliative care

• To review the existing resources and services of the WRHA Palliative Care Program, and how it can help in the provision of palliative and end-of-life care in Long Term Care settings
The presenters have no conflicts of interest to disclose
What Is Palliative Care?

• Surprisingly difficult to define

• In contrast to other areas of health care, it is not defined by:
  o body systems (e.g. cardiology, dermatology)
  o age (e.g. pediatrics, geriatrics)
  o care setting (critical care, emergency)
  o procedures done (anesthesiology, surgery)

• Any diagnosis, any age, any location
Palliative Care is an approach to care which focuses on comfort and quality of life for those affected by life-limiting/life-threatening illness.

Its goal is much more than comfort in dying; palliative care is about living, through meticulous attention to control of pain and other symptoms, supporting emotional, spiritual, and cultural needs, and maximizing functional status.
There are no “do-overs” in managing a death.
Final Common Pathway

**Progressive Illness**
- cancer,
- neurodegenerative illness
- organ failure (heart, kidney, lung, liver)

**Sudden Health Conditions**
- non-survivable brain injury (CVA, anoxia, trauma)
- sepsis
- inoperable surgical conditions (ischemic gut or limbs)

- bedridden
- weak, swallowing impaired, poor airway protection, can’t clear secretions; *pneumonia* – dyspnea, congestion
- *delirium* – agitation
Common Issues At End Of Life In Long Term Care Residents

- Functional decline – heavier care needs
- Compromised oral intake – feeding, fluids, medication administration
- Symptoms – particularly in the final hours/days there can be the rapid development of dyspnea, congestion, delirium
- Family concerns – oral intake, care expectations including tests, treatments, location
Role of the Health Care Team

- **Anticipate** changes
- **Communicate** with patient/family regarding potential issues:
  - What can we expect? What are the options?
  - Not eating/drinking; sleeping too much
  - How do we know they are comfortable?
  - Are medications making things worse?
  - Would things be different in hospital?
- **Prepare** a care plan for predictable issues, including:
  - Health Care Directive and/or Advance Care Plan
  - Plan for addressing loss of mobility, self-care, food/fluids
  - Medications by appropriate routes for potential symptoms
Challenges/Barriers

**Staff Challenges**
- staffing ratios
- increasing patient needs as death nears – may be rapid
- training/comfort with palliative meds
- difficult conversations with families

**MD Challenges**
- comfort with aggressive use of opioids for dyspnea, pain
- familiarity with current palliative approaches to variety of issues (e.g. alternate medication routes, complex pain, opioids in renal insufficiency, bowel obstruction)
- availability for contact by staff and family, timely responsiveness, on-site assessment 24/7
- time commitment for discussions with patient/family

**System/Administrative**
- availability of medications
- policy/procedure support
- overall resources to support comprehensive end-of-life care

**Patient/Family Issues**
- “treat the treatable” approach
- may have unrealistic expectations
- addressing goals of care
Clinical Considerations As Death Nears

1. Are there preexisting medical conditions needing attention in the final hours?
   - not typically necessary to continue ongoing medical management of underlying illnesses, with the possible exception of seizure disorder

2. What new symptoms might arise (typically dyspnea, congestion, agitated delirium), and related medication needs?
   - Uncommon for pain to arise as a new symptom in final hours
   - What are the available routes of medications administration?

3. Anticipated concerns of family
Symptom Prevalence In Final Days

- Dyspnea: 80% +
- Congestion: reported as high as 92%
- Delirium: 80% +

When these issues arise at end-of-life, things haven’t “gone wrong” … they have gone as they are inclined to.
### Management of Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Drug</th>
<th>Non-Oral Route(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Dyspnea</strong></td>
<td>opioid</td>
<td>• sublingual (SL) – small volumes of high concentration; same dose as oral&lt;br&gt;• subcutaneous – supportable in most settings; same dose as IV = ½ po dose&lt;br&gt;• IV – limited to hospital settings&lt;br&gt;• intranasal – fentanyl – lipid soluble opioid; use same dose as IV to start&lt;br&gt;• Note: Transdermal not quickly titratable</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>opioid</td>
<td>see above</td>
</tr>
<tr>
<td><strong>Secretions</strong></td>
<td>scopolamine</td>
<td>• subcutaneous&lt;br&gt;• transdermal (patches; compounded gel)</td>
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<td></td>
<td>glycopyrrolate</td>
<td>• subcutaneous</td>
</tr>
<tr>
<td><strong>Agitated Delirium</strong></td>
<td>neuroleptic (methotrimeprazine; haloperidol)</td>
<td>• SL – use same dose for all routes&lt;br&gt;• subcutaneous (most settings); IV (hospital)</td>
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<tr>
<td></td>
<td>lorazepam</td>
<td>• SL – generally use with neuroleptic</td>
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Common Concerns About Aggressive Use of Opioids at End-Of-Life

• How do you know that the aggressive use of opioids doesn't actually bring about or speed up the patient's death?

• “I gave the last dose of morphine and he died a few minutes later… did the medication cause the death?”
1. **Literature**: the literature supports that opioids administered in doses proportionate to the degree of distress do not hasten death and may in fact delay death

2. **Clinical context**: breathing patterns usually seen in progression towards dying (clusters with apnea, irreg. pattern) vs. opioid effects (progressive slowing, regular breathing; pinpoint pupils)

3. **Medication history**: usually “the last dose” is the same as those given throughout recent hours/days, and was well tolerated
PAIN

• Resident describes pain or exhibits pain behaviour (grimacing, localizing, restless, agitated)
• ?? Any reversible causes: positioning, urinary retention, fecal impaction??
Pathway A
Pain Management In The Final Days Of Life

Resident unable to describe pain; exhibits pain behaviour: grimacing; localizing; restless; agitated

Assess for potentially reversible causes, such as positioning, urinary retention, fecal impaction

Resident already on opioids?

Yes

Consider one or more of:
- If resident is just on "as-needed" (prn) opioids, add scheduled q4h short-acting opioids
- If resident is receiving long-acting oral opioids, switch to equivalent dose of scheduled short-acting opioids
- Increase frequency of scheduled short-acting opioids to maximum of q4h
- Increase opioid dose by a factor of 20-100%, depending on the clinical context
- Change route to subcut if unable to swallow*
- Consider opioid induced neurotoxicity**

No

Consider:
(Start with the lower dose with frail patients)
Morphine 2.5 - 5 mg po/subling q4h scheduled plus q1h prn
OR
Morphine 1.25 - 2.5 mg subcut q4h scheduled plus q1h prn
OR
Hydromorphone 0.5 - 1.0 mg po/subling q4h scheduled plus q1h prn
OR
Hydromorphone 0.25 - 0.5 mg subcut q4h scheduled plus q1h prn

Review pain medication q24h:

If pain control not achieved, such as using > 3 breakthrough doses in past 24h
Continue present analgesics

Pain control adequate, using < 3 breakthrough doses in 24h
Continue present analgesics

Patient sedated, comfortable, not using breakthrough doses
Consider reducing scheduled dose by 20 - 50%
Resident on opioids already?

**YES**
- On PRN only: add scheduled q4h short-acting opioids
- If on LA oral opioids, switch to equivalent dose scheduled short-acting opioids.
- Increase frequency of scheduled short-acting opioids – Max q4h
- Increase opioid dose by a factor of 20-100% depending on clinical context

**NO**
- Morphine 2.5-5mg PO/SL q4h & q1h PRN or
- Morphine 1.25mg-2.5mg subcut q4h & q1h PRN or
- Hydromorphone 0.5mg-1mg PO/SL q4h & q1h PRN or
- Hydromorphone 0.25-0.5mg subcut q4h & q1h PRN

* In renal insufficiency, consider hydromorphone rather than morphine in the short term.
Pain

• Review pain medication q24h
• If pain control not achieved, (3+ BTs in 24h) then increase opioid dose (see ‘yes’ column)
• If resident sedated, comfortable, not using BT doses: consider decrease scheduled dose by 20-50%.
• Route may need to be changed if resident unable to swallow
Case Study

• Mrs. Imin Pane is 83 years old and has a history of CHF, severe dementia, lung cancer with bone mets.
• Her medications include:
  – Tylenol extra strength ii tabs TID PRN
  – Omeprazole 20mg OD
  – Lasix 40 mg OD
  – Ativan 1mg at HS prn
• Over the last 4 months, her appetite has decreased and she has lost 15 lbs. She is now having trouble swallowing even small spoonfuls of pureed food. She sleeps for most of the day and can no longer tolerate going to the dining room for meals.
Case Study

• Mrs. Pane seems to be becoming more restless. She is grimacing when you reposition her in bed.
• You think that Mrs. Pane’s restlessness may be due to feelings of pain. You reposition her and she is still restless. She does not have any urinary retention or fecal impaction.
Case Study

• You phone the doctor and get an order for hydromorphone 0.5mg-1mg PO/SL q4h and q1h PRN as she has some renal insufficiency.

• You give her the hydromorphone 0.5mg PO which is effective for her pain.
AGITATED DELIRIUM

- Acute onset of global cognitive impairment r/t general medical condition with:
  - Fluctuating consciousness
  - Disorientation
  - Disrupted sleep-wake cycle
  - Reduced attention
  - Perceptual disturbances
  - Disorganized thinking
  - Paranoid ideation
Pathway B
Management of Agitated Delirium In The Final Days Of Life

Delirium Present:
Acute onset of global cognitive impairment presumed related to a general medical condition, with: disturbance of consciousness (often fluctuating); disorientation; disrupted sleep-wake cycle; reduced attention; perceptual disturbances (hallucinations, illusions - misinterpretation of sensory stimuli); disorganized thinking; paranoid ideation

If clinically appropriate and consistent with goals of care, assess for and treat potentially reversible causes, such as infections, adverse medication effects, metabolic abnormalities, hypoxia, pain, urinary retention, fecal impaction

Is the resident agitated, aggressive, restless?

No (hypoactive delirium)
- Sedation not indicated
- Provide general comfort measures as needed
- Support family

Yes (hyperactive delirium)

Consider:
- haloperidol (Haldol®) 0.5 - 1 mg po/SL/subcut q6-8h regularly plus q1h prn
- higher doses may be needed in severe agitation

Reassess at least q24h... more often if indicated

Management effective
Continue present management

Management ineffective

Consider:
- discontinue haloperidol
- change to a more sedating neuroleptic such as methotrimeprazine (Nozinan®) 5 mg po/SL/subcut q6-8h plus q1h prn.
- Higher doses of methotrimeprazine (up to 25 mg) may be needed in severe agitation
Agitated Delirium

- If clinically appropriate & consistent with goals of care - assess & treat potentially reversible causes such as:
  - Infections
  - Adverse medication effects
  - Urinary retention
  - Hypoxia
  - Etc.
Is the resident agitated, restless, aggressive??

**NO**
- Sedation not indicated
- Provide general comfort measures
- Support family

**YES**
- Haloperidol (Haldol®)
  0.5mg-1mg PO/SL/subcut q6-8h & q1h PRN
- Higher doses may be needed in severe agitation
Agitated Delirium

• If management is ineffective with haloperidol:
  – Discontinue haloperidol
  – Switch to more sedating neuroleptic – methotrimeprazine (Nozinan®) 5mg PO/SL/subcut q6-8h & q1h PRN
  – Severe agitation- higher dose (up to 25mg)
Case Study

- Mrs. Imin Pane’s condition continues to deteriorate. Now she responds only by opening her eyes and groaning when she is repositioned, otherwise she sleeps all the time. She can’t swallow her PO medications.
- The doctor has switched her hydromorphone to 0.25mg-0.5mg subcut q4h & q1h PRN and d/c’d her PO meds.
- Her restlessness is worse. She is flailing in bed and ripping off her gown. Her breathing is becoming more irregular and you notice some mottling in her knees. You have given her 2 BTs of hydromorphone but she continues to be restless.
Case Study

• Her family just wants her to be comfortable and they do not want her to have any further tests or treatments.
• Her doctor orders haloperidol 0.5mg-1mg subcut q6-8h & q1h PRN.
• She settles after 3 doses.
Noisy Secretions

• Noisy secretions present AND distressing to resident and/or family
• 1st: Try repositioning. “Best side”
• Oral suction? Only if visible oral or posterior pharyngeal secretions.
• No deep suctioning.
Pathway C
Management of Noisy Secretions In The Final Days Of Life

Noisy secretions present, and distressing to resident and/or family

Consider impact of positioning (resident may have a "best side" to lie on where secretions seem less troublesome)

Oral suctioning should be used only for visible oral or posterior pharyngeal secretions; no deep suctioning

Is the resident alert?

Yes

**Glycopyrrolate:**
(non-sedating, not likely to cause delirium)
- 0.2 - 0.4 mg subcut q8h pm
- If secretions persist, consider using a scheduled dose of glycopyrrolate 0.2 - 0.4 mg q8h plus q1h pm

No

**Scopolamine:**
(very sedating, likely to cause delirium in the awake patient)
- 0.3 - 0.6 mg subcut/intranasal* q4h prn
- If secretions persist, consider using a scheduled dose of scopolamine 0.3 - 0.6 mg subcut/intranasal* q4h plus q1h prn

**Review secretions management q shift:**

Management Ineffective

- Maximize doses and schedule of antisecretory medications
- If receiving glycopyrrolate, consider switching to scopolamine (although there is limited evidence supporting this)
- Reevaluate positioning of patient
- If the patient is unresponsive (as is commonly the case in refractory terminal secretions), help family understand that there is unlikely to be any distress experienced by the noise
- Consider a Palliative Care consultation 237-2400

Management effective

- Continue present treatment
- If receiving scheduled doses of glycopyrrolate or scopolamine, consider switching to prn only
Is Resident Alert?

**YES**
- Glycopyrrolate 0.2mg-0.4mg subcut q2h PRN
- If secretions persist: glycopyrrolate 0.2mg-0.4mg subcut q6h & q1h PRN
  * Non-sedating, not likely to cause delirium

**NO**
- Scopolamine 0.3mg-0.6mg subcut/intranasal q1h PRN
- If secretions persist: Scopolamine 0.3mg-0.6mg subcut/intranasal q4h & q1h PRN
  * Very sedating; likely to cause delirium in awake resident
Case Study

• Mrs. Pane is now unresponsive and sounds like she is getting congested.
• The doctor orders scopolamine 0.3mg-0.6mg subcut q1h PRN.
• You give her 5 doses and she still sounds congested.
Case Study

- The doctor orders scopolamine 0.3mg -0.6mg subcut q4h & q1h PRN.

- You give her the regular dose scopolamine, reposition her again, and explain to the family that there is unlikely to be any distress experienced by her mother.

- After a few more regular doses, Mrs. Pane sounds somewhat better and the family feel that she is comfortable. She dies a few hours later.
Dyspnea

Resident describes air hunger/breathlessness
Or
Resident unable to describe dyspnea but exhibits evidence of respiratory distress:
• Increased work of breathing
• Increased respiratory rate
• Using accessory muscles
• Agitated, restless, fearfulness
Pathway E
Dyspnea Management In The Final Days Of Life

Resident unable to describe dyspnea; exhibits evidence of respiratory distress: increased work of breathing (increased resp. rate, using accessory muscles) and one or more of: restlessness, agitation, fearfulness

Resident describes air hunger/breathlessness

If clinically appropriate and consistent with goals of care, assess for and treat potentially reversible causes, such as pneumonia, CHF exacerbation

Non-pharmacologic measures: position sitting upright; cool air (fan)

Consider oxygen for the alert resident, particularly if hypoxic

Resident already on opioids?

Yes

Consider one or more of:
- If resident is just on "as-needed" (prn) opioids, add scheduled q4h short-acting opioids
- If resident is receiving long-acting oral opioids, switch to equivalent dose of scheduled short-acting opioids
- Increase frequency of scheduled short-acting opioids to maximum of q6h
- Increase opioid dose by a factor of 20-100%, depending on the clinical context
- Change route to subcut if unable to swallow (consider 50% dose reduction for subcut)
- Call the Palliative Care team (237-2400) if dyspnea is persistent or severe

No

Consider:
(Start with the lower dose with frail patients)

Morphine 2.5 - 5 mg po/subling q4h scheduled plus q1h prn
OR
Morphine 1.25 - 2.5 mg subcut q4h scheduled plus q1h prn
OR
Hydromorphone 0.5 - 1.0 mg po/subling q4h scheduled plus q1h prn
OR
Hydromorphone 0.25 - 0.5 mg subcut q4h scheduled plus q1h prn

If strong anxiety component, consider adding methotrimeprazine (Nozimir®) 2.5 - 5 mg po/subcut q2h prn

Review dyspnea treatment q24h:

If dyspnea control not achieved, such as using >= 3 breakthrough doses in past 24h

Dyspnea control adequate, using < 3 breakthrough doses in 24h

Patient sedated, comfortable, not using breakthrough doses, resp. rate not elevated

Continue present approach
Consider reducing scheduled dose by 20 - 50%

Dyspnea

• Assess for & treat* potentially reversible causes:
  – Pneumonia
  – CHF exacerbation

* If clinically appropriate & consistent with goals of care
Dyspnea

- Position sitting upright
- Cool air (fan or open window)
- Oxygen for alert resident (& hypoxic)
- Pace or minimize activity
- Light bed covers, loose clothing
- Good mouth care
- Quiet music, calm presence, distraction
Resident on opioids already?

YES
- On PRN only: add scheduled q4h short-acting opioids
- If on LA oral opioids, switch to equivalent dose scheduled short-acting opioids.
- Increase frequency of scheduled short-acting opioids – Max q4h
- Increase opioid dose by a factor of 20-100% depending on clinical context

NO
- Morphine 2.5-5mg PO/SL q4h & q1h PRN or
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- Hydromorphone 0.25-0.5mg subcut q4h & q1h PRN
  * In renal insufficiency, consider hydromorphone rather than morphine in the short term.
Dyspnea

• If strong **anxiety** component: consider methotrimeprazine (Nozinan®) 2.5mg-5mg PO/subcut q2h PRN

• If dyspnea control not achieved, (3+BTs in 24h) then increase opioid dose (see ‘yes’ column)

• If resident sedated, comfortable, not using BT doses, resp rate not elevated: consider decrease scheduled dose by 20-50%.

• Route changed if resident unable to swallow
Winnipeg Palliative Care Services: Post-Regionalization

- Seven Oaks Hospital
- HSC
- Children’s Hospital
- Concordia Hospital
- Grace Hospice
  - 12 beds
- Grace Hospital
- Victoria Hospital
- SBGH
  - 15 beds
- RHC
  - 30 beds
- Jocelyn House
  - 4 beds
- Long Term Care/PCH

- Inpatient attending & consulting
- Home & facility consultative support
- Completely new component
Diagnosis of Life-Limiting Illness

Transitioning to Palliative

Palliative Consult Service

Community Palliative Nursing

- Case Coordinator
- Admission Eligibility
- Medication Coverage

- aggressive, often toxic treatment focused on cure or life-prolonging disease modification

- comfort-focused
- prognosis “6 mo. or less”
- some treatment limitations (DNAR, no TPN, no chemoTx with high adverse effects

• some treatment limitations (DNAR, no TPN, no chemoTx with high adverse effects
Community Teams:
- Community Nurses
- CNS
- MD
- Coordinator
- Psychosocial
Support for residents in LTC

• LTC staff provide quality palliative and end of life care
  – Palliative care program available to support the team in providing this care:
    • Symptom management
    • Psycho-social support
    • Clarifying goals of care
    • Assistance with transitions between care settings
Palliative Care as a philosophy of care

Formal Program

Increase capacity through education, advocacy, partnerships.

Resources

Formal Program
Resources:

• Canadian Virtual Hospice
• www.virtualhospice.ca
  - National website dedicated to providing information and support for people dealing with life-threatening illness and loss
    ▪ Written information for patients, families and health care providers
    ▪ Ask a Professional
QUESTIONS

AND

DISCUSSION