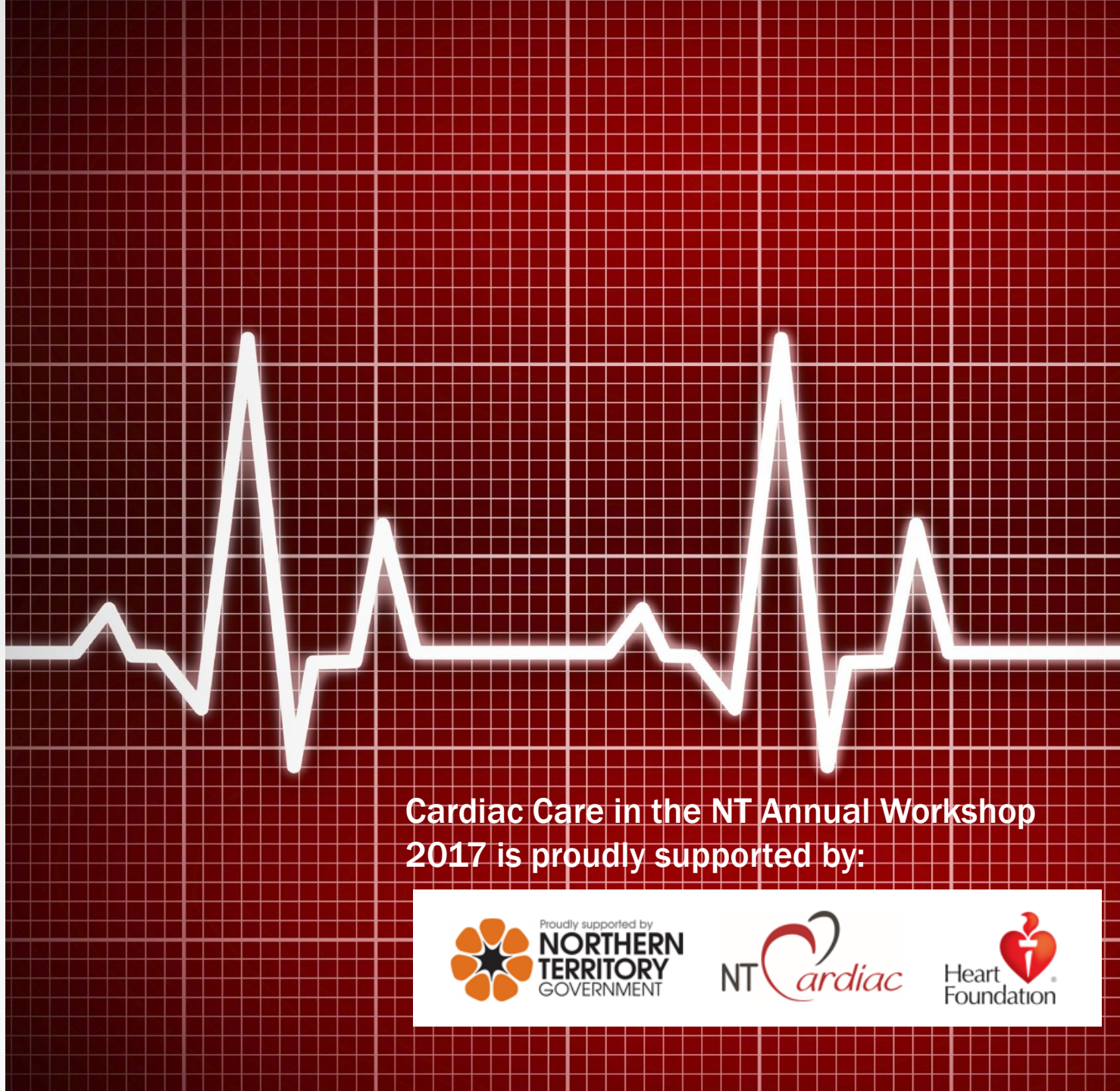
Precious Mapendere

Nurse Practitioner Palliative Care



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Definition of Palliative Care

Palliative care ;

- is an approach aimed at improving the quality of life of patients and their families facing problems with life threatening illnesses, through the prevention and relief of suffering, by means of early identification and impeccable assessment of pain, and other problems which are;
- **physical, social, spiritual** and **psychological**

(WHO definition)

Role of Palliative in Cardiac patients

The aim of palliative care involvement is to;

- Prevent and relieve suffering through a holistic approach to symptom management
- Promote best quality of life rather than quantity
- Neither hasten nor prolong life, but rather regard dying as a normal process
- Address the needs of patient s and their families (**physical, psychological, social, and spiritual**)
- Offer end-of-life-care (EOLC) support/advice to other health care professional and families
- Support the patient to die in their place of choice
- Follow up post death

Referral Criteria to specialist palliative care

- ***Surprise question;***
- Would the clinician be surprised if the patient was to die with 12 months or less???
- if **NO, PLS Refer** (*sometimes difficult to predict Cardiac conditions as death may happen suddenly in the case of heart attack)*
- Frequent admissions to hospital within the past 12 months
- Frequent decompensation of chronic cardiac failure
- Progressive/rapid decline in functional status impacting on quality of life

Cardiac Disease Trajectory

Across the course of the illness, most cardiac patients go through 3 phases which are;

1) Stable phase

- Still going through routine and regular checks by cardiologists
- Acute mx, usually presenting to ED occasionally with symptoms of concern
- Improves with treatment to base line condition

Cardiac Failure Phases cont

2) Deteriorating Phase

- Declining functional status
- Requiring support systems to remain function at home (equipment, OT assessment)
- Frequent presentations to ED with moderate to severe symptoms
- Patient ‘s condition continues to decline with each presentation to ED

NOTE

- ***Time to think about Palliative care Referral***
- ***Discussions about advanced personal panning***

Cardiac Failure Phases cont

3) Terminal Phase

- Rapid deterioration functionally (completely bed bound, worsening symptoms)
- Death is imminent
- Short days to weeks.

Advanced Personal Plan (APP)

- Discussions with family, NOK regarding patient's condition
- Establish goals and ceiling of care (comfort measures only)
- Admission to hospice vs presenting to ED
- Resuscitation status (**Do Not Attempt Resuscitation**)
- No ICU intervention
- Substitute decision maker (Social work input)
- Discussions around place of death (Pastoral care/Chaplain)

Palliative Care Principles of Symptom mx for Cardiac Patients

1) Management of symptoms is based on Holistic approach
2) Optimising tolerated cardiac medication
3) Management of reversible conditions
4) Palliating any remaining symptoms

Common Cardiac Symptoms

1) Physical

Dyspnoea

- Most prevalent symptom
- Patients to maintain optimal cardiac failure medications to control dyspnoea
- Oxygen therapy
- Use of opioids mainly Morphine syrup/Ordine orally PRN (S/C if orals not tolerated or pt very dyspnoeic)
- Ms Contin slow release starting with 5 mg nocte or BD
- Benzodiazepines for anxiety, lorazepam mostly common, starting with ½ - 1 mg PRN

Symptoms cont

- ***Fatigue***
- On-going issue till death
- Rest, enough sleep, food intake

Pain

- Patients with cardiac diseases also experience pain due to other multiple commobidities associated with the disease
- Regular panadol,
- opioids (long and short acting) e,g. morphine, fentanyl patches, Oxycontin, Endone

Symptoms cont

- ***Other general symptoms include but not limited to :***
- ***Constipation*** (bowel regiments on daily basis, coloxyl and senna, movicol, shaws cocktail)
- ***Weight loss-*** *(on going)*
- ***Loss of appetite*** (meals as tolerated, supplement drinks e.g. sustagen
- ***Nausea/vomiting*** *(*anti-emetics e.g. maxolone, haloperidol)
- ***Insomnia*** (addressing worries plus symptoms, temazepam/lorezapam)

Symptoms cont

2) Psychological

- ***Anxiety/agitation***
- fear of impending death, Lorazepam, Haloperidol, Midazolam in small doses
- Fear of suffering due to worsening symptoms (dyspnoea/pain)
- Multidisciplinary approach helps to alleviate symptoms (S/W input - addressing pt' fears, practical issues, wills, financial issues)
- Depression (Pastoral Care input- fears/worries)
- Antidepressants e.g. mirtazipine nocte.

Symptoms cont

3) Spiritual

- Existential distress due to unfinished business, fear of unknown, fear of impending death
- Pastoral Care input

4) Social

- Worries about remaining family, how they will cope post death
- Financial issues, remaining kids/spouse, education
- S/W input (wills, centre link, accessing super, notifying school, referral to psychologist, GP for mental health plan)

Management of EOLC Symptoms

1) Pain, Dyspnoea

- Morphine 2,5 mg -5 mg hourly S/C PRN, and increase accordingly
- Start with 2.5 mg in opioid naïve patients
- Consider use of fentanyl in patients with renal impairment (Morphine can still be used but with caution)

2) Terminal Agitation/ Restlessness

- Haloperidol – 0.5 -1mg hourly S/C PRN as 1st line,
- Midazolam- 2.5 - 5mg hourly S/C PNR

3) Chest Secretions/ Death Rattle

- Glycopyrolate or Hyoscine- 200-400 mcg S/C hourly PRN
- Can be repeated 15 minutely if need be
- Repositioning

4) Delirium

- Haloperidol – 1 st line 0,5- 1 mg S/C hourly PRN
- Midazolam 2.5 -5 mg hourly S/C PRN

NB: All these meds can be combined in a syringe driver pump for better control of symptoms

QUESTIONS????

PRESENTATION AT THE CARDIAC CARE IN THE NT ANNUAL WORKSHOP

DARWIN, JUNE 2017

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