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

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Disclosures

Presenter(s), Veronica Gordon, Lavonya McAlister, and Julius Penning have no interest to disclose.

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Learning Objectives

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

1. Describe palliative care, death, and how nurses impact it.

2. Identify a patient’s need for palliative care.

3. Discuss the nurses need to understanding pain and the four dimensions of assessment and care.
What is DEATH???

- The cessation of all vital functions of the body including the heartbeat, brain activity (including the brain stem), and 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
Clinical DEATH

- Cessation of all vital functions of the body
  - Heartbeat
  - Brain activity (including brain stem)
  - Breathing

- Organ Transplantation
  - Identifying moment of death may involve another life
  - It takes on supreme legal importance
  - Precisely defined due to the need for transplant of organs
Death a Scary Subject

- Death Cafe’s goal: to 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.

- Read more here: http://www.kansascity.com/news/local/article405967/Appreciating-life-at-Death-Cafe.html#storylink=cpy
Why is **DEATH** so Scary???

**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))
Why is **DEATH** so Scary???

- 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))
DEATH

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

"When will he tell me I'm going to die?"
Why is DEATH Not Accepted???

- Death has a thousand faces, but dying has a millions ways.
  * “A Million Ways To Die In The West”
- Death is ubiquitous and universal
- Death attitudes affect how we live
- We live in a death-denying culture

(Wong, P. (2002))
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)
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)
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. Never-the-less, social, psychological and existential support may also be offered to both patients and relatives.

- Palliative care aims to enhance quality of life (gain the strength to carry on with daily life) for patient’s and the family as much as possible when cure is no longer an option.
Patient’s need for palliative care

- Palliative care is needed if a patient suffers from pain, stress or other symptoms due to a serious illness. Serious illnesses may include cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer’s, HIV/AIDS, amyotrophic lateral sclerosis (ALS), multiple sclerosis and more.

- Symptoms due to a serious illness include depression, pain, 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.
Who is Part of the Palliative Care Team?

- 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 family and the possibility of feeling better. So we need our hospitals more than ever to be confident and competent in palliative care.

(Get Palliative Care, 2016)
(Taylor, & Chadwick, 2015)
Nurses Preparing for Palliative Caregiving

- Preparedness facilitates the transition experience, and related to this is knowledge about what to expect during a transition and what strategies may be helpful in managing it—something that could be supported by nursing interventions.

- Preparedness for caregiving is the perceived readiness.

(Janze & Henriksson, 2014)
Nurses Preparing for Palliative Caregiving (cont.)

- Readiness includes:
  - Providing physical care
  - 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)
Nursing Responsibility

- 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 patients 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.
Four Dimensions of Assessment and Care

- Physical Well-Being
  * Activities of daily living, Appetite, Strength, Pain, Fatigue, Nausea
- Psychological Well-Being
  * Stress, Fear, Cognition, Depression, Anxiety, Relief
- Social Well-Being
  * Relationships, Finances, Sexual Function
- Spiritual Well-Being
  * Religion, Hope, Loss, Meaning
Cultural Competence

“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)
Ethical Dilemmas

- Redirecting negative thoughts of the team
- Changing the “culture” of acute rehabilitation
- Team perceptions
  * Fears and anxieties
  * Biases
  * Need to teach “old dogs new tricks”
- Help the team replace anger and frustration with empathy and compassion
Nurses Revisiting the Mission

- The mission:
  - improve quality of life
  - providing high quality physical rehab
  - providing high quality cognitive rehab

- Shift of thinking for the whole team
  - feeling guilty
  - sensation of giving up
Honoring Patients’ Preferences for End-of-Life Care
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, S. S. (2016))
Fast Facts (cont.)
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, S. S. (2016))
Spinal Cord Injury Facts & Statistics

- 2015 estimates range from 240,000 to 337,000 people live with SCI in the USA
- 52% of spinal cord injured individuals are considered paraplegic and 47% quadriplegic

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<tr>
<th>Age at Time of Injury (Paraplegic)</th>
<th>Life Expectancy After Injury</th>
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<tr>
<td>20</td>
<td>46 years</td>
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<td>40</td>
<td>28 years</td>
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<td>60</td>
<td>13 years</td>
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Spinal Cord Injury Facts & Statistics

- 85% of SCI patients who survive first 24hrs are alive at 10 years post injury
- 89% are discharged to a private home
  * 4.3% are discharged to a nursing home or LTCF
- Most common cause of death is respiratory
- SCI patients dying of unrelated causes: septicemia, cancer, cardiovascular, etc.
- Spinal Cord Injury patients receiving Hospice care increasing.
- Longevity of life increasing with improved & increasing technology

(Spinal Cord Injury Model Systems, 2015)
(NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION, 2015)
Palliative Role and Spinal Cord Injury

Interventions

Special Training

Physical Distress

Social Distress

Psychosocial/Emotional Distress

Spiritual Distress

Limited Disability

Rehabilitation

Special Equipment

Values and Hope

Existing long-term relationship
Palliative Care Metric Report
VISN Definitions and Terms

- **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 Reporting, 2016)
Palliative Care Metric Report
VISN Definition and Terms (cont)

- 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

  Inpatient deaths: completed PCC within 12 mo. of death OR hospice admit

  Inpatient deaths

(Palliative Care Reporting, 2016)
Workload Complexity

*Includes 38 outpatient consults for FY16*  
(Palliative Care Reporting, 2016)
Transitioning to Comfort Care

(Palliative Care Reporting, 2016)
<table>
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<tr>
<th>Metric</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16 FYTD</th>
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<td>Completed consults, Level 1-2</td>
<td>66</td>
<td>67</td>
<td>94</td>
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<tr>
<td>Completed consults, Level 3-5</td>
<td>497</td>
<td>420</td>
<td>599</td>
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<td>Completed consults, total</td>
<td>563</td>
<td>487</td>
<td>693</td>
<td>617</td>
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<td>Average days between completed initial PCC and death</td>
<td>40.8</td>
<td>53.2</td>
<td>52.1</td>
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<td>Patients with level 3-5 consult within 12 mo. prior to death</td>
<td>274</td>
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<td>Patients with hospice admission - TS96 or 1F</td>
<td>121</td>
<td>223</td>
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<tr>
<td>Patients with level 3-5 consult OR hospice admission</td>
<td>279</td>
<td>280</td>
<td>281</td>
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<tr>
<td>Inpatient Deaths</td>
<td>413</td>
<td>415</td>
<td>389</td>
<td>238</td>
</tr>
<tr>
<td><strong>Percent</strong> inpatient deaths with completed PCCT consult documented within 12 months prior to death <strong>OR</strong> hospice admission</td>
<td>67.6%</td>
<td>67.5%</td>
<td>72.2%</td>
<td>74.0%</td>
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Benefits Palliative Care Consults have on End of Life Care

- Expert Physical, Pain, and Symptom management
- Psychosocial/Emotional support
- Spiritual and Cultural support
- Discussions, Negotiation, and Advance Life Planning and End of Life Goals
- Early Education and execution of advanced directive, allows patients EOL preferences to be honored and decrease 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)
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

(Ahlulwalia et al., 2014)
(Bailey, Harman, Bruera, Arnold, & Savarese, 2016)
(McAteer, R., & Wellbery, C. 2013)
(Temel et al., 2010)
Dignified Transfer
A Final Salute

Dignified Transfer of the Veteran to the morgue is a final tribute and honor for the deceased Veteran

PROCEDURE:
- Union (field of blue STARS) should rest at the HEAD and over the LEFT SHOULDER of the deceased Veteran’s body.
- Exiting the Veteran’s room, the FEET exit FIRST.
- Entering the morgue, the Veteran’s HEAD enters FIRST.
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QUESTIONS
References:


References:


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