





Partnering for Quality

Care

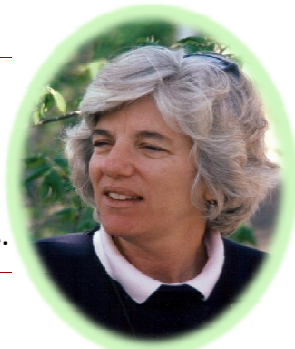
**MODULE 8: PALLIATIVE AND END OF LIFE
CARE OF PATIENT WITH CKD**

Partnering for Quality



Chronic Kidney Disease: What Every Nurse Caring for the CKD Patient Should Know!


These modules are dedicated to the memory of **Sally Burrows-Hudson, MSN, RN, CNN** – a past-president of the American Nephrology Nurses' Association (ANNA) and a fierce proponent of continuing education for *all* nurses.



CKD: What Every Nurse Should Know

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Chronic Kidney Disease: What Every Nurse Caring for the CKD Patient Should Know!


1. Introduction to Chronic Kidney Disease: An Overview of Causes, Staging, and Treatment
2. Chronic Kidney Disease - Stages 1 through 3
3. Chronic Kidney Disease - Stages 4 and 5: Overview of Therapy Options
4. Kidney Replacement Therapy – Transplantation
5. Kidney Replacement Therapy – Self-Care Dialysis
6. Kidney Replacement Therapy – Assisted Dialysis
7. Chronic Kidney Disease in the Pediatric Population
8. **Palliative and End of Life Care of the Patient with CKD**

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Objectives

The learner will be able to:

1. Define palliative care.
2. Discuss approaches to guide collaborative dialogue about treatment options which includes the 4th option of NO kidney replacement therapy.
3. Discuss the importance of including palliative care and advance directives in all patients' plan of care.
4. Describe co-management of individuals receiving palliative or hospice care.

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What Do Patients with Serious Illnesses Want?

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Singer et al. *JAMA* 1999;281(2):163-168.

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Person-Centered Care



Hain & Sandy, 2013;
McCance et al., 2012

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Potential Palliative Care IDT Members

- Patient/Family
- Nurse
- Advanced practice nurse
- Physician
 - Nephrologist
 - Primary care provider
 - Palliative care provider
- Pastoral Care Counselor
- Social Worker
- Therapists (i.e. physical therapist, pharmacy, music, touch)
- Bereavement counselor

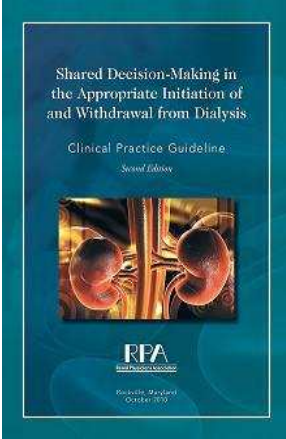
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Guidelines from Renal Physician's Association

<https://www.renalmid.org/catalogue-item.aspx?id=682>



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Shared Decision-Making

- Shared decision-making includes estimation and communication of prognosis to patients and family
- Prognosis should go beyond survival and include outcomes that matter most to patients and families
- One tool used for consideration of hospice care is:
 - Palliative Performance Scale (PPS)

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Palliative Performance Scale (Anderson, 1996; Lau, 2006; Lau, 2009)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity <i>with</i> Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

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Frailty in Adults with CKD

- Frailty is emerging as major predictor of mortality and morbidity
 - Disability
 - Falls
 - Hospitalization
- Assessing for frailty
 - Physical and cognitive status
- Potential treatment of frailty

Bohm, et al. 2015
Lam et al., 2015
Musso, et al., 2015

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The Surprise Question


“Would you be surprised if this patient died in the next year?”



Holley, 2007; Moss et al., 2008

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Advance Directives (AD)

- Advance care planning is a **process** among patients, families, and healthcare providers
- Prevalence of AD in patients with CKD is about 30%
- Patients generally not aware of their poor prognosis
- Members of the interdisciplinary team are frequently unaware of their patients' wishes

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Late Symptoms of Uremia (Noland, 2015, pp. 377-378)

- Dry scaly skin and pruritus
- Frequent headaches
- Heat or cold intolerance
- Metallic taste
- Poor healing
- Dyspnea
- Easy bruising or bleeding
- Grayish-bronze color skin
- Anorexia
- Nausea and vomiting
- Weight loss (weight gain most likely due to fluid retention)
- Fainting or seizures
- Peripheral neuropathy
- Decreased concentration and memory
- Mood disturbance (e.g. depression)


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Slide 14

DH2 I am fine with taking this out
Debra Hain, 8/1/2016

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Symptom Management

- Nausea and vomiting
 - Haloperidol (1.5 to 5 mg daily by mouth or subcutaneous)and prochlorperazine (Compazine) two agents that block chemoreceptor trigger zone (CTZ) (Noland, 2015)
- Malnutrition
 - Important to monitor and implement strategies to reduce risk and early intervention

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Symptom Management

- Pain
 - Most frequently reported symptom
 - Treatment
 - Non-pharmacological
 - Pharmacological
 - Consider methadone or fentanyl
 - Demerol is contraindicated
 - Morphine is not appropriate for EOL
 - » Can accumulate and person may have myoclonus

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When to Refer to Palliative Care (and perhaps Hospice)

- Symptom management challenges
- Standard medical care is increasingly viewed as futile or not desired
- Progressing debility leads to decreased quality of life
- Patient's declining health is creating difficulties if the patient is on dialysis
- Assistance desired in advance care planning and decision making process

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Decision-making Capacity


The capacity of the patient to:

- Understand his/her medical condition
- Appreciate the consequences (benefits/burdens) of treatment options
- Judge relationship between the treatment options and personal values, preferences, and goals
- Reason and deliberate about options
- Communicate decision in a meaningful manner

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When to Refer to Hospice?


- Patient with ESRD who declines starting dialysis and has a prognosis <6 months can initiate hospice
- Any patient on dialysis who decides to withdraw from treatment

CMS guidelines for Hospice Care, 2010

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Dual Diagnosis Hospice Benefit for ESRD

- If the patient's terminal condition is not related to ESRD, the patient may receive covered services under both ESRD benefit and the hospice benefit. A patient does not need to stop dialysis treatments to receive care under the hospice benefit
- Occasionally, an ESRD patient, on dialysis, is imminently dying and a hospice may choose to accept the patient on dialysis

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Medicare **Guidelines** for Referral with Terminal Diagnosis of ESRD

- Serum creatinine 8mg/dL or greater (6mg/dL or greater in patients with diabetes) *or*
- Creatinine clearance is less than 10mL/min/1.73 m² (less than 15mL/min individuals with diabetes) *or*
- Symptoms of progressive uremia present (confusion, pruritus, oliguria, hyperkalemia, etc.)
- Other co-morbid conditions that may be attributing to a terminal decline

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Withdrawal from Dialysis

- Most common factors associated with withdrawal: age, nursing home residence, medical complications, DM, CV disease, dementia, depression, pain, and failure to thrive
- Factors apparent in dialysis facility
 - very limited prognosis, poor quality of life, symptoms resistant to treatment, progressive non-renal disease, technically difficult dialysis, lack of willingness to continue dialysis


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Slide 21

DH4 this if there is a referral so ned an order
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Symptoms Related to Withdrawal from Dialysis

Most patients and families can expect a comfortable death within 8 – 10 days (Germain et al. Semin Dial. 20:195-9. 2007)

	<u>symptom. preval. (%)</u>	<u>last 24h with PC</u>
Pain	55	22
Confusion	70	34
Dyspnea	48	28
Nausea	36	6
Twitching	27	9
Pruritus	24	6

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Resource



Coalition for Supportive Care
of Kidney Patients

<http://www.kidneysupportivecare.org/Home.aspx>

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