JEOPARDY!
Palliative Care Pearls

by Meg Mullin, MD
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Palliative Care:

Palliative care, and the medical sub-specialty of palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.
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Who is on the Palliative Care team to provide psychosocial support?
Palliative Care is an interdisciplinary team consisting of Providers (MDs/NPs), RNs, SW, Chaplains. All team members are trained to provide support!
Who needs support from the palliative care team?
“Palliative care provides support for families, communities, and all staff. We occasionally support pts too!”
How does the palliative care provide support for staff?
Members of the PC team are available for debriefing after difficult events, provide grief care, and are always a confidential shoulder to lean on while you do this hard, important work.
Psychosocial - $400 Question

Why is grief different from sadness?
Grief is closer to an altered mental status than to an emotion. It behaves like other altered states such as delirium: comes and goes, causes irrational thoughts and behaviors, and is not in the control of the person experiencing it.
Is there a normal way to grieve?
Nope! Grievers tend to array along a spectrum from “instrumental” grievers (the list makers) to the “intuitive” grievers (the wailers)
How is symptom management different in Palliative Care?
The types of treatments offered vary with the goals of care for a patient and directly reflect that patients' quality of life.
Are opiates the only option for pain control?
Opiates can be very effective for somatic and bony pain. Gaba analogs (Gabapentin) and tricyclic antidepressants (Nortryptyline) can be used for neuropathic pain. And don’t forget about good old Tylenol and other analgesics. Lastly, there may be surgical or procedural treatments that can make a lasting difference.
Is Docusate a useful treatment of slow-transit constipation that’s a side effect of opiates?
Nope!

Docusate is a stool softener, and not real helpful when the bowel is still. Better to start with a mesenteric plexus stim (Senna) and an osmotic agent (Miralax).
What are the three most common conditions that lead to opiate ODs in the hospital?
Symptoms- $400 Answer

1. Morbid Obesity (BMI>30): hypoventilation leading to hypercarbic respiratory failure
2. Renal insufficiency/failure (GFR <40): impaired clearing of CNS active metabolites leads to respiratory depression
3. Older age (>65): aging brains react to altering medications must more strongly and put pts at high risk for delirium
What opiates are safe in renal failure and why?
Fentanyl and Methadone! Morphine and oxycodone have toxic metabolites. Dilaudid also has metabolites, but can be cleared by dialysis.
What is a POLST form?
Physician’s Orders for Life Sustaining Treatment (POLST) is a form patients can fill out to enforce their wishes if they are too sick to speak.

It has 3 sections:

1. CPR or allow a natural death
2. Transport to the hospital including intubation vs comfort oriented care
3. Preferences around use of antibiotics and artificial nutrition
Are advance directives (including POLST forms) legal documents?
Yes and No. POLST forms are orders for medics to follow. Advance directives (including POLST forms) are guides for families and providers to follow but not legally binding.
Who can make healthcare decisions on behalf of a patient that can’t talk to us?
Surrogate decision makers! The default is the legal next of kin. Or a patient can designate a Durable Power of Attorney (DPOA). If no one is available, a guardian ad litem can be legally appointed.
A 60 yo woman is brought to the ED with a stroke. She has no advance directive. She is married to brain injured man, has 6 children, and her mother is still alive and lives with her. Who makes decisions on her behalf?
In the absence of a guardian or DPOA, the legal next of kin in WA is:

1. Competent spouse
2. ALL 6 kids together (awesome. You might consider a PC consult. Just sayin...)
3. Parents
4. Siblings
5. Other relatives
What do you do with an unbefriended, non-decisional patient who is critically ill?
Treat!
The default ethical position is to preserve life if possible. And, to honor personhood, attempt to learn as much as possible by communicating with friends and community. Consider a guardian ad litem. And consider what medical treatments to offer based the likelihood that the patient will benefit. When in doubt, ask for an ethics consult.
Why do we consider goals of care?
We want to ensure that the medical care patients and families receive matches what they value. The only way to do this is to ASK. Two different people can reasonably make very different choices.
What’s a family meeting and how is this procedure used?
Family meetings are a communication tool to ensure all stakeholders are in agreement and questions get answered. It’s typically conducted by:

1. Assembling all parties in a quiet place
2. Introducing everyone
3. Obtaining an understanding of the situation
4. Answering questions
5. Reaching consensus on plan
6. Making recommendations and a plan
What if the goals of the care team are different than the patient or families?
The ethical principle of autonomy must be balanced against the principle of nonmaleficence (do no harm). As much as possible, we try to respect pt and family wishes but not to the point of offering care that won’t benefit them. Likewise, if we want something that is abhorrent to the pt and family, we are obligated to acquiesce.
A 75 yo man is in the ICU and has a devastating stroke. He has an advance directive that says he wouldn’t want to be “kept alive by machines”. His grieving son can’t bear to “pull the plug” and wants to continue care indefinitely. The physician says “whatever he wants”. What’s a bedside RN to do?
ASK questions!
Ask the son what his father would say if he was here? Ask what his experience of other deaths and illnesses has been like? Ask what he’s hoping for? Ask what he’s afraid of?
Frame this as a decision his father has already made.
Aaaand, get a palliative care consult (just sayin...)
What do you do if the goals of care for a patient are in direct opposition to what you believe is right?
Get Help!
This is a set-up for moral distress and burnout:

1. Talk to your colleagues and supervisor
2. Talk to your family and friends about your experience
3. Talk to your friendly palliative care team
4. Consider getting professional support if this is common in your work
What the heck is Hospice and how is it different from palliative care?
GOC - $100 Answer

Hospice is a federal benefit provided by Medicare/Medicaid for pts and families in the last 6 months of their life. It can be provided in any care setting and is aimed at maximizing quality of life, not longevity.

Palliative Care is a subspecialty of medicine for pts and families (and providers caring for them) facing serious illness. It’s aimed at determining what quality of life is for them, and designing medical treatments to meet those needs.
What are hospice services?
Hospice teams are interdisciplinary: MD, RN case managers, SW, Chaplains, Pharmacy, Bath aids etc, Chore workers and Volunteers.
How do you know who has 6 months left to live and qualifies for hospice benefits?
In the community, any provider who thinks “I wouldn’t be surprised if this guy was dead in 6 months” can refer them to hospice (after a discussion! please!). Then the Hospice medical director reviews the case to see if they “qualify” based on federally mandated criteria (i.e. metastatic cancer not pursuing palliative treatment). A hospice liaison or case manager then communicates and coordinates with family to see what they need and if hospice can help.
What if a patient goes home with hospice and then needs to come back to the hospital for symptom management?
No worries!

If symptoms can’t be managed in the care setting they are in (home, SNF etc) the hospice arranges for ED or admission for symptom management and they stay on hospice. This is called the General Inpatient Palliative (GIP) benefit.
What if the patient can’t be managed at home and needs hospital level care through the end of life?
Short answer- Yes!

Longer answer- if a patient doesn’t want to die in the hospital but needs more care, an inpatient hospice facility is a better answer. These beds are few and criteria is strict. So, bottomline- any dying pt deserves to have excellent care and hospice and the hospital work together to find the best fit.
An ICU patient on hospice
You are a bedside ICU RN and admit an 89 yo man from the ED with respiratory failure who comes from home on hospice, with a POLST that says DNR/DNI and comfort measures. His daughter freaked out when he started to die and wasn’t breathing well. She authorizes intubation in the ED. How can you help this family and honor this man’s wishes?
ASK QUESTIONS!

1. Is the daughter the DPOA or LNOK? Does she have other people to help?
2. What are the goals of care?
3. Are we keeping him comfortable while this gets sorted?
4. What is she hoping for? Afraid of? How can you support her?
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Final Jeopardy!

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