Effective Ways of Educating Healthcare Professionals about Palliative Care

Presented by:
Nancy Joyner, RN, MS, APRN-CNS, ACHPN
Altru Health System, Grand Forks, ND

Objective 1
Demonstrate two methods to increase communication regarding the need and benefits of palliative care with those patients with a progressive, debilitating illness.

Objective 2
Identify two palliative care planning techniques for patients who have been identified in the early stages of a progressive debilitating disease.
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Objective 3
Discuss two methods to increase the completion, documentation and ongoing utilization of advance directives for patients with a progressive, debilitating illness.

Objective 4
Describe three tools used to assess and re-assess the patient's palliative care plan as conditions warrant, utilizing the eight domains of care.

1. Methods for Improving Communication
   ‣ ABCDE
   ‣ Dispelling Myths
   ‣ Initiate Discussions for Goals of Care
   ‣ Family Conferencing
   ‣ Addressing Needs of Palliative Care
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ABCDE tool for Communication

Advance preparation
Build a therapeutic environment/relationship
Communicate well
Deal with patient and family reactions
Encourage and validate emotions

(Vandekieft, 2001)

Dispel the Myths About Palliative Care

- Palliative Care Team takes away from the physician in charge.
- Palliative care teams try to convince patients to stop treatments
- When patients are referred to palliative care, patients think the doctor is giving up on them.
- Palliative care is only for actively/imminently dying patients
- Palliative care is doing nothing—“nothing more can be done”
- Palliative care starts when curative treatment stops.

Myths (continued)

- Physicians can suffer regulatory and legal consequences for prescribing opioids and sedation in doses sometimes needed for palliative and end-of-life care.
- Palliative sedation is considered euthanasia.
- Once artificially administered hydration and nutrition is started, it is illegal and/or immoral to discontinue it.
- Once dialysis is initiated, it is suicidal and/or immoral to discontinue it.
- A formal legal opinion or opinion from a court of law is required to withdraw treatment.
Initiate the Discussion

› Many providers feel they lack experience in discussing the issues that come with progressive, debilitating illnesses

› The more a provider prepares for discussions and practices, the more skilled the provider becomes

› Focused education improved skills at breaking bad news

2. Palliative Care Planning Techniques

› Identify the conditions that prompt palliative care planning

› Follow Palliative Care Algorithm by Institute for Clinical Systems Improvement (ICSI)

› Assess the palliative care needs

› Utilize Palliative Care Screening Tool

› Identify Palliative Care Performance Level

› Address the continuum of care

Conditions That Prompt Palliative Care Planning

› Cancer: metastatic/recurrent

› Advanced COPD

› Stroke with decreased function of 50 % or <

› End stage renal disease

› Advanced cardiac disease; CHF, CAD, Cardiomyopathy

› Other life limiting illness (Ex: ALS, MS, dementia)
Assessment of Palliative Care Needs

- Recognition of patient autonomy in choosing care
- Team approach
- The patient must have the capacity to understand the choices available
- The options available may change as the patient’s medical condition changes
- The process is ongoing. Inpatient and outpatient.

Palliative Care Screening Tool

- Not a candidate for curative therapy
- Has a life limiting illness and has chosen not to have life prolonging therapy
- Has unacceptable pain > 24 hours
- Has uncontrolled symptoms (i.e., nausea, vomiting)
- Has uncontrolled psychosocial or spiritual issues
- Has frequent visits to the ER (> 1 x month for same dx)
- Has more than one hospital admission for the same dx in last 30 days

Palliative Care Screening Tool (cont)

- Has prolonged LOS without evidence of progress
- Has prolonged LOS in ICU or transferred from ICU without evidence of progress
- Is in an ICU with documented poor or futile prognosis
- Family support needs or communication challenges
- Palliative Performance Level < 50%
- Co-morbid disease processes

Center to Advance Palliative Care (CAPC)
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**Continuum of Care Model**

- Therapy to modify disease
- Therapy to relieve suffering and/or improve quality of life
- Palliative Care
- Limiting-end-of-life care
- Life-sustaining care
- Life-sustaining treatment
- End-of-life care
- Treatment to extend life
- Treatment to prevent or relieve suffering

**POLST**

**Physician’s Orders for Life-Sustaining Treatments**

- A mechanism to communicate patient preferences for life-threatening treatment across treatment settings
- A physician/nurse practitioner order
- Can be completed by any provider but must be signed by MD, DO, NP or PA
- Complements, but does not replace, advance directives
- Voluntary use, but provides consistent recognized document

www.POLST.org

# 178 The National POLST Paradigm Initiative, 2nd Edition
http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_178.htm

**National POLST Paradigm Programs**

- Endorsed Programs
- Developing Programs
- No Program (Contacts)
FAST FACT AND CONCEPT #179: CPR Survival in the Hospital Setting

- Survival 20 minutes after CPR was 44% but only 17% of all CPR patients survived to discharge.

NEJM (2009)
- CPR will not significantly extend life, might prolong death and suffering.
- Sometimes best interest to forego CPR.

Survivors
- 51% returned home
- 47% discharged to another hospital, a rehabilitation facility, or a nursing home
- 2% discharged to hospice care.
- 25% decline in overall function
- 6.7% of cancer patients survived CPR to discharge
- 14% of dialysis patients survived to discharge

“CPR for hospitalized patients is associated:
- Overall poor outcomes
- Roughly 15%, or 1 in 6 patients, who undergo CPR in the hospital may survive to discharge
- Usually associated with advanced chronic illness
- Specific co-morbidities will reduce the chance of survival
- Surviving patients are at risk complications including permanent neurological and functional impairment.”

# 179 CPR Survival in the Hospital Setting
FAST FACTS AND CONCEPTS #179
3. Healthcare Directive Discussion

- What are they?
- Why do we have them?
- Who are they for?
- When should they be done?
- Where should they be done?

What are Healthcare Directives?

- Written advance directs are legal in every state, but laws and forms vary state to state
- Health Care Power of Attorney – appoints someone to make medical decisions if the patient cannot make them
- Health Care Directive – written document with the patient’s wishes if unable to communicate at the end of life

Defining Living Will

A Living Will (also known as a Health Care Directive) specifies whether patients want artificial life support if they become permanently unconscious or are otherwise dying and unable to speak for themselves.

It is often accompanied by a specific type of Power of Attorney for Healthcare (POAHC) or healthcare proxy or agent. These are legal instruments that are usually witnessed or notarized.
**Why Healthcare Directives?**

- Advances in medical technology—be kept alive by artificial means.
- May be a temporary measure
- May be undesirable—only prolong the process of dying
- May be an acceptable quality of life.
- Patient have the personal right to decide—instigate, continue or terminate
- As long as a patient is mentally competent
- When a patient has lost the capacity to communicate, however, the situation is different.

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**Healthcare Directives (cont)**

**Q**: Who are they for?
**A**: Anyone over the age of 18

**Q**: When should they be done?
**A**: Avoid doing in times of crisis or in the hospital. Annual review is recommended. National Healthcare Decisions Day—April 16.

**Q**: Where should they be done?
**A**: Can be done anywhere, often done in the attorney's office at the time of completing the legal will.

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**Healthcare Directive Checklist for Patients and Families**

**GATHER INFORMATION FOR DECISION-MAKING.** Physicians and Healthcare professionals are a good place to start for understanding options on health care treatment at the end of life. In addition, many organizations have information that may be useful.

**DISCUSS YOUR END-OF-LIFE DECISIONS WITH KEY PEOPLE.** Talk about decisions with family, physician and others who are close. Some questions to consider for discussion:
- What is important to you when you are dying?
- Are there specific medical treatments you especially want or do not want?
- When you are dying, do you want to be in a nursing home, hospital or at home?
- What are the options in Palliative Care and/or Hospice Care?

**PREPARE YOUR ADVANCE CARE DIRECTIVE FORM.** Under state law, you have a legal right to express your health care wishes and to have them considered in situations when you are unable to make these decisions yourself.
DESIGNATE PERSON TO CARRY OUT WISHES. Select who should handle your health care choices and discuss the matter with them. You could name a spouse, relative or other agent.

INFORM KEY PEOPLE OF PREFERENCES. Notify your doctor, family and close friends about your end-of-life preferences. Keep a copy of your signed and completed advance health care directive safe and accessible. This will help ensure that your wishes will be known at the critical time and carried out. Give a copy of your form to:
- The person you appoint as your agent and any alternate designated agents
- Your physician
- Your health care providers
- The health care institution that is providing your care
- Family members
- Other responsible person who is likely to be called if there is a medical emergency

Barriers to Healthcare Directives
- Physicians do not feel the discussion is appropriate in an outpatient setting
- Many people think a financial power of attorney covers them
- Many people think advance directive means do not treat
- People fear advance directive means they lose control of their own care
- Only old people need advance directives

Health Care Guideline Algorithm
Institute for Clinical Systems Improvement (ICSI)
www.icsi.org
Palliative Care Algorithm
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Eight Domains of Palliative Care

- Structure and Processes
- Physical Aspects
- Psychological and Psychiatric Aspects
- Social Aspects
- Spiritual, Religious and Existential Aspects
- Cultural Aspects
- Care of the Imminently Dying Patient
- Ethical and Legal Aspects

National Consensus Project for Quality Palliative Care (NCP)

Useful Patient Education Tools

- “Hard Choices for Loving People” by Hank Dunn
- “What Everyone Should Know About Life Sustaining Treatment” (Channing Bete Co.)
- “Gone from My Sight” by Barbara Karnes

Websites:
- Caring Connections - free, in-depth resources and information on advance directives, including state-by-state forms and much more. doyourproxy.org is a website that makes advance directives easy and accessible.
- Initiative for Pediatric Palliative Care
- Getpalliativecare.org - A general website for overall patient information about palliative care

Conclusion

It is our responsibility as the Healthcare Team to educate:
- Patients
- Families
- Other staff / co-workers

The focus should be on:
- Comfort
- Communication
- Choices
- Control
References


References (cont.)


Related Website Resources

American Hospital Association–Put It in Writing
Aging With Dignity–Five Wishes
Investigations at the End of Life
CAPCconnections online
Center to Advance Palliative Care (CAPC) Resources
www.getpalliativecare.org
National Palliative Care Resource Center (NPCRC)