Be Prepared: Palliative Care Emergencies in the Home Breathing

Presenters:

Dr. Christine Jones, Island Health BC
Katarina Bvoc Berta, Spectrum Health Care

Host and Moderator: Jennifer Campagnolo, CHCA

Date: April 28, 2022

Land Acknowledgement

We recognize with humility and gratitude that Canada is located in the traditional, historical and ceded and unceded Lands of First Nation, Inuit and Metis Peoples. On behalf of us all, we acknowledge and pay respect to the Indigenous peoples past, present and future who continue to work, educate and contribute to the strength of this country.

Learning Objectives

By the end of the session, participants will be able to:

Provide an overview of dyspnea (causes, clinical picture/symptoms and assessments) in the context of home-based palliative care

Identifying patient goals of care for someone receiving palliative home care supports and experiencing dyspnea

Explore and discuss approaches and interventions to manage dyspnea in the home

Introductions

Dr. Christine Jones
Palliative Care Physician
Island Health

Katarina Bvoc Berta R.N. CHPCN(C)
Palliative Care Nurse
Spectrum Health Care

Management of Breathlessness in Advanced Illness

Dr. Christine Jones

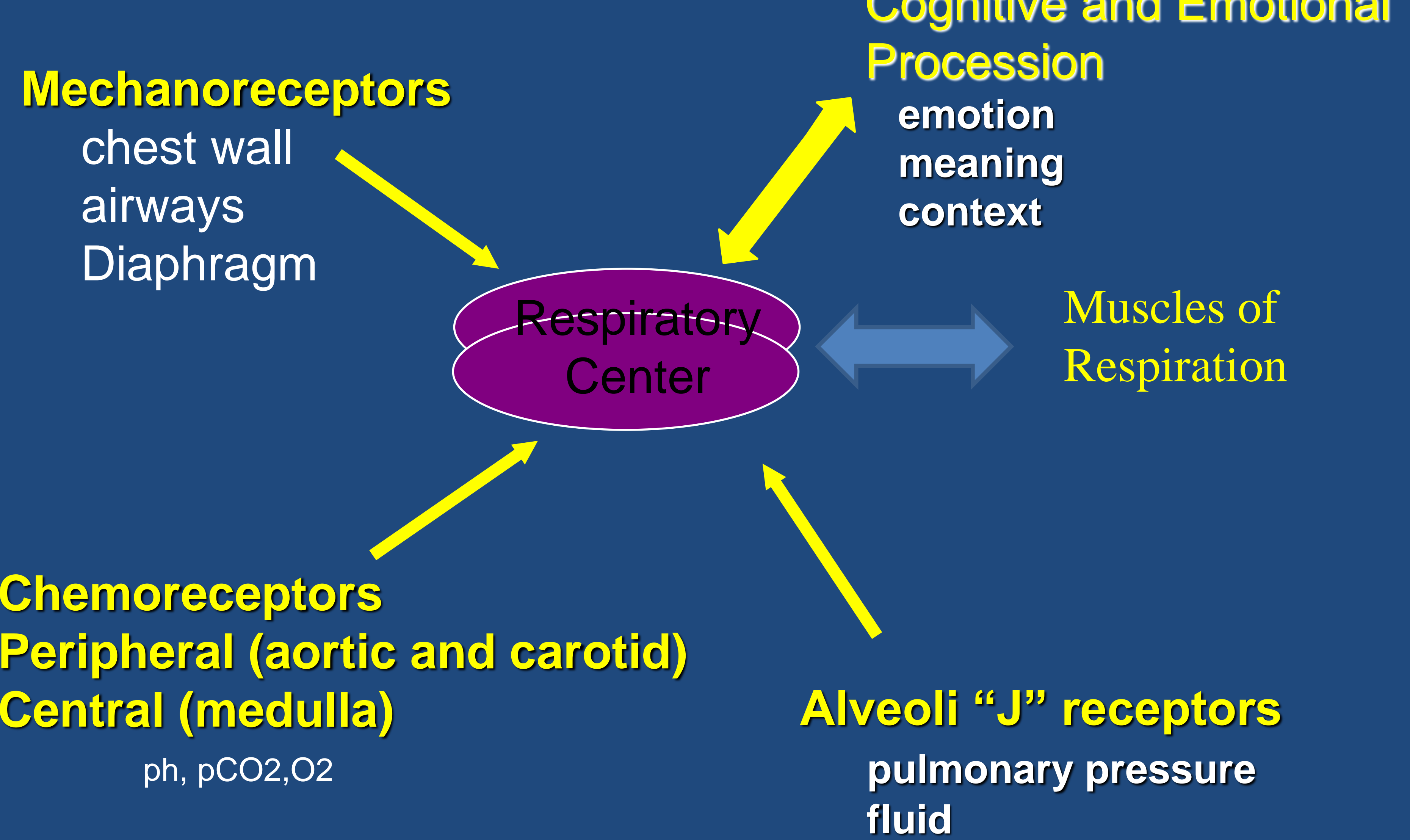
Questions

- Who is most likely to experience breathlessness?
- How to we assess for breathlessness?
- Is there an approach to breathlessness?
- How to we educate and prepare patients?
- What are some tips and tricks?

Please use the chat!

- In your practice, who is most likely to get breathless?

It's NOT just low oxygen!



Spiritual

- I just feel so useless and helpless . when you go to do something and you realise you can't do it and you mustn't do it . I feel mainly frustrated and disappointed. It's mainly the lack of the normal life I suppose and not being able to do, looking after myself properly and the housework and the cooking.

Social

- It has an awful effect on my life. Making love, I can't make love very often because I can't breathe.

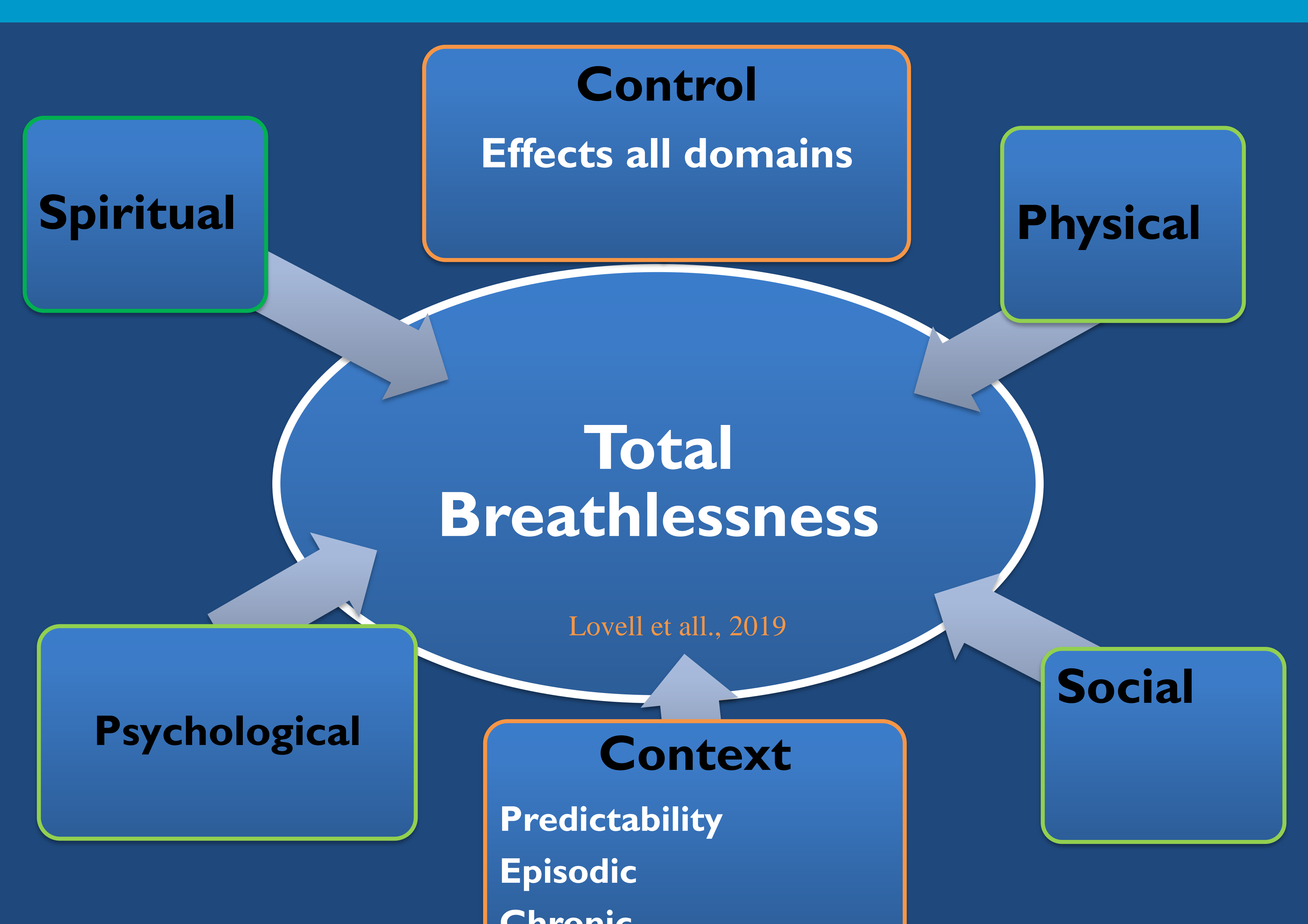
Total Breathlessness

Psychological

- It [shortness of breath] would just take my breath away and just like somebody would grab me and start choking. I couldn't breathe and then when it happened my daughter would take me to emergency.
- Patient with Heart Failure, Lowey 2012.

Physical

- .The worst thing I think is the stairs, going up and down the stairs. Ordinary household chores I find difficult. Very restrictive, because of your breathing. And now of late . even simple things like having a shower and getting dressed.


Control
Effects all domains
Spiritual
Physical
Total Breathlessness
Lovell et all., 2019
Psychological
Social
Context
Predictability
Episodic
Chronic

Assessment:

- Tip #1: We may see increased Work of Breathing, but the patient may feel fine
- Tip #2: We may NOT see increased Work of Breathing, but the patient feels VERY breathless.
- Tip #3: The patient may be breathless even if oxygen saturations are NORMAL
- Tip #4: ASK often about breathlessness.

Assessment-Use your Assessment Tools!!

- OPQRSTUV Tool
- Numeric Rating Scales
- Visual Analogue Scales

- Know what your patient UNDERSTANDS, what are the GOALS for the breathlessness as well as for their overall care.

Assessment-if the patient is not verbal: Observed respiratory distress scale

Variable	0 Points	1 Point	2 Points	Sub-Total
Heart rate per min (beats/min = bpm)	less than 90 bpm	90–109 bpm	greater than or equal to 110 bpm	
Respiratory rate per minute (auscultated) (breaths/min)	less than 19 breaths	19–30 breaths	greater than 30 breaths	
Restlessness: non-purposeful movements	No	Yes - Occasional, slight movements	Yes - Frequent movements	
Paradoxical breathing pattern: abdomen moves in on inspiration	No		Yes	
Accessory muscle use: rise in clavicle during inspiration	No	Yes - Slight rise	Yes - Pronounced rise	
Grunting at end-expiration: guttural sounds	No		Yes	
Nasal flaring: involuntary movement of nares	No		Yes	
Look of fear: ☐ Eyes wide open ☐ Facial muscles tense ☐ Brow furrowed ☐ Mouth open ☐ Teeth together	No		Yes	
			Total	

Instructions for Use

- Count respiratory and heart rates for one full minute;
- Grunting may be audible with or without auscultation;
- An RDOS score of less than 3 indicates respiratory comfort[2];
- An RDOS score greater than or equal to 3 signifies respiratory distress and need for palliation[2,3];
- Higher RDOS scores signify a worsening condition[2,3].

Symptom Management Approach

Optimal Management of underlying disease

Reverse what is Reversible

Palliate:

Baseline breathlessness

Episodic breathlessness

Educate and Support

Prepare for Acute Episodes

Palliate: Oxygen therapy

- If hypoxic, probably helpful
- Add opioids and other adjuvants for best control
- If not hypoxic, likely not beneficial

Interventions for Alleviating Cancer-Related Dyspnea: A Systematic Review. J Clin Oncology 26 (14) May 10, 2008

Palliate: Use of a fan

https://www.youtube.com/watch?v=y5tBC5R8DYs

Palliate: Non-pharmacologic interventions

Information for patients and families

island health

Your health care team will work with you to identify the causes of your shortness of breath and recommend treatment(s) specific for your palliative condition. Even with these treatments your shortness of breath may persist. It is normal to feel anxious. This handout outlines tips to help you breathe comfortably.

Breathe out with movement – to rise from a chair or bed, bend over or step up a stair.

Rest before and after activity, including eating.

Use a handheld or table fan to move air across your face.

Set time aside daily for relaxation. Disconnect and use techniques such as visualization, listening to gentle music or nature sounds, or rhythmic breathing.

Move slowly and in shorter amounts. Slight breathlessness is easier to recover from.

Breathe cool air in your nose and warm air slowly out your mouth.

Are there medications that could help?

Yes, medicine such as morphine or other opioids, used appropriately, can help decrease shortness of breath. As well as taking your regular prescribed doses, take your prescribed breakthrough dose before activities that trigger your shortness of breath, like dressing or bathing, to ease the sense of shortness of breath.

Do you need oxygen?

Not always. Your health care team will assess the oxygen levels in your blood; if the levels are low, they will prescribe oxygen for you. Even though you feel short of breath, your lungs may still be taking in enough oxygen. In this case, moving air across your face with a handheld or table fan is often helpful.

No patient should ever
wish for death
because of his/her
care team's reluctance
to use
adequate amounts
of
opioids ~

M. Downing

Baseline Breathlessness (or with minimal activity)

- Regular opioids, round the clock
- Breakthrough q1 h as needed
- Call MD if > 3 BTD required

Episodic breathlessness (exertion)

- Consider ultra short acting opioids (fentanyl or sufentanyl)
- Subling, buccal, intranasal

Breathlessness with Anxiety

- Add in anxiolytic:
- Ativan, Midazolam (intermittent or continuous)
- Mirtazapine***-new area of research
- Methotrimiprazine (Nozinan)

Acute breathlessness-ANTICIPATE

- Patients with past exacerbations resulting in hospital admissions
- Patients at risk for obstructed airways
- Advanced COPD/CHF
- Herald Bleeds
- At risk for Pulmonary Embolism
- Recurrent mucous plugging
- High anxiety states with advanced disease
- Risk for episodic breathlessness moving to respiratory PANIC

Acute breathlessness-Prepare

- Anticipate these episodes may occur and can cause significant suffering
- KNOW THE GOALS OF CARE
- Written instructions patient specific plan
  - Medications
  - Non-pharmacologic techniques
  - Numbers to call in a crisis (alternatives to EHS?)
- Ensure medications are ordered, prepared and accessible

Crisis Order Example

- For severe breathlessness may give:
- 1 mg hydromorphone subcut/IN q15 minutes
- AND
- 2.5 mg midazolam subcut/IN q15 minutes

AND

- Call crisis line
- Non-pharmacologic treatments: positioning, fan, calm presence, say a prayer, start music….. (a patient centred response)

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Palliate:

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Episodic breathlessness

Educate and Support

Prepare for Acute Episodes

Be Prepared:
Palliative Emergencies in the Home
Breathing

ECHO Hub Online Event

Thursday, April 28 2022

12:00 PM to 1:00 PM ET

April 28, 2022

Presentation Information

Katarina Bvoc Berta R.N. CHPCN(C)

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How far can you run before you are out of breath?

- Imagine you feel that way just by consuming breakfast.
- A simple morning shower means episodes of clinical hypoxia so severe, that the chest muscles are on fire with stabbing pain while fighting periods of brain fog and loss of consciousness.
- **And you still need to dress...**

Clinical Profile

- Meet Mrs. L.A. – 79 yrs old female
- Diagnosed in 2012 with interstitial lung disease.
- Sjogren's Syndrome
- Adequately treated latent tuberculosis,
- Cataracts
- Chronic dysphagia,
- Cold agglutinin disease
- Lupus
- Past TIA, temporal arteritis and rheumatoid arthritis, recurrent UTI

Clinical Profile

- She was referred to a home visiting palliative team after particularly difficult hospital admission, for acute respiratory failure, mucous plug, and bronchospasm.

Social Determinants

- Lives at home with her husband
- Relationship is frequently tested by conflict
- Two very supportive adult sons who live in town
- A grandchild that "loves spending time with granny"
- Indigenous origin
- Family members who also suffer from autoimmune illnesses

Setting goals of care

- Her father endured a similar diagnosis, but in the end, died of a stroke without the ability to speak
- She is very fearful of losing decision-making capacity and independence toward the end of her life
- She frequently deliberates and adjusts her advanced care plan
- Always clear on a Do Not Resuscitate decision
- Plans for the end of life shifted over time from palliative sedation at home, to MAiD, to palliative sedation in a hospital setting
- "I want to spare my family from having to change my diaper, but until that time I want to live my life at home, because, truly, I hate the hospital!"

Assessment/Care

First Assessment

- Mrs. L.A. was taking medications for hypertension, prednisone, pantoprazole, inhaled salbutamol, and ipratropium
- 60% functional status at admission on a Palliative Performance Scale
- Continuous oxygen therapy of 6 L/min, this sufficient while at rest. Increased flow rate necessary when rising from a chair, or walking down a hallway to the bathroom, usually 9L/min
- Even with this therapy she frequently found herself severely short of breath (SPO2 as low as 55% after a shower)

First Assessment Continues

- Mrs LA values her independence above all and continued to carry out usual ADL's while experiencing episodes of:
  - gasping for breath
  - pain in the chest and upper back
  - anxiety and panic attacks
  - dizziness and brain fog, headaches
  - loss of consciousness

Additional Information

- Her husband also becomes very anxious when she gets short of breath and he is not able to help her
- These episodes are exacerbated by respiratory infections, recurrent UTI, and lupus flare-ups.
- Occasionally symptoms are even accompanied by episodes of delirium, short-term memory loss, and disorientation

How can we intervene?

Non-medical Interventions

- **Family members each assumed an increasingly involved caregiving role.**
- **PSW support was initiated daily, to assist with ADL's and ensure safety checks.**
- **OT assessment conducted and shower chair, grab bars, commode chair at the bedside, a rollator, and positionable hospital bed were installed, as well as a stairlift*.**
- **Nursing** visits initiated daily when required, decreased to 2w at times of optimal coping.
- Palliative visiting **physician/NP** team involved to manage medical needs on 24/7 on-call bases.
- **Counselling** was initiated*, to deal with the multitude of psycho-social and emotional stressors.
- **Home care lab** arranged for specimen collection as needed.
- All of it is coordinated by the **case manager**.
- **Portable fan** recommended in principle rooms.
- **Community pharmacy** involved in optimizing medications and home delivery.

Medical Interventions

- Initially, Mrs LA started using *Lorazepam to manage episodes of severe SOB* and anxiety, prescribed by her family physician in the past. This she found helpful and started using it with increased frequency.
- *Opiates are first-line therapy* in the treatment of severe SOB, so Mrs. LA started hydromorphone 0.2 mg, q1h, prn. The transition was challenging due to *biases regarding opiates.*
- *Antibiotics* were ordered as appropriate:
  - Septra and phosphomycin depending on C&S results, about 7 times over a 2 yr period
  - Amoxi-Clav for respiratory infections, 10 times in recent 2 yrs
- With exacerbation of respiratory symptoms, *prednisone* is used on a sliding scale between 10-50mg.
- Mrs. LA developed thrush, *nystatin* oral rinse is frequently needed.
- Senokot, Lactulose, Restoralax, and Bisacodyl suppositories are utilized for *bowel management* and constipation.
- Metoclopramide for *nausea* associated with *decreased motility.*

Currently…

- Hydromorphone 1 mg used 4-6x/day. Preloaded each day to make self administration practical.
- Lorazepam is still used as second line thx for anxiety attacks or when hydromorphone isn't effective enough to decrease symptoms.
- Mrs LA currently continues to live at home with an overall decreased palliative performance scale of 40%.
- Over the course of the past two years, the client was hospitalized only twice, due to *reversible delirium.
- CADD PCA pump was initiated, however unsuccessfully, as client did not find this intervention practical.
- Symptom management kit* on standby in the home.

Evaluating Care

- Mrs LA learned strategies can effectively prevent or intervene in the events of critical SOB.
- Continues to spend quality time with her two children and grandchild, and able to leave the home for short trips outside with aid of electric w/c.
- Took up several sedentary hobbies and rekindled connections with her extended family.
- She considered LTC several times, but ultimately chose to live at home.
- Deliberates her advanced care plan with decreased frequency.

Questions & Discussion

Next Learning Session:

Be Prepared: Palliative Emergencies in the Home

Balance (Hypercalcemia)

June 2022

Presenters:

- Dr. Jennifer Shapiro
- Dr. Aamir Haq

Details and registration
www.cdnhomecare.ca/palliative-care-echo-hub

CHCA ECHO Hub Community

www.echo.cdnhomecare.ca

- Palliative Emergencies at Home Microlearning

- Recordings
- Presentations
- Evidence-Based Resources

Join the CHCA ECHO Hub Community

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As a CHCA Palliative Care ECHO Hub member I agree to:

- Participate in the ECHO learning sessions, join the discussion, and give feedback
- Share my expertise and issues to help shape the content of the CHCA Palliative Care ECHO Hub
- Participate in program evaluation to help us better understand our impact and how we can support teams across the country

Register:

First Name:* Last Name:*

I agree to the statement of participation, to becoming part of the CHCA ECHO Hub community and receiving regular notifications from the CHCA. By completing the registration for the CHCA Palliative Care ECHO Hub, you consent to the collection, use and disclosure of your personal information for the purposes of program planning, evaluation and research. *

Username:*

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Palliative Care Emergencies in the Home: An Approach to Guide Home Care

March 26, 2022 / in / by Team CHCA

0% COMPLETE 0/11 Steps

Course Content

Expand All

Course Introduction

Recognizing Palliative Care Emergencies
1 Topic
Expand

Types of Palliative Care Emergencies
1 Topic
Expand

Involving Patients and their Caregivers
1 Topic
Expand

Considerations for Palliative Care Emergencies in the Home
3 Topics
Expand

Canadian Home Care Association