Pain and Symptom Management at Home: Managing Emergencies

Presenters:

Dr. Cornelius Woelk, Southern Health-Santé Sud
Melanie Spencley NP, Champlain

Host and Moderator: Jennifer Campagnolo, CHCA

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Project ECHO
Palliative Care - Canada
BY Pallium Canada

Canadian Home Care Association

Learning Objectives

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

Describe an emergency in the context of palliative care and the certainty of death

Identify treatment goals of palliative emergencies

Understand the role of advanced directives

Describe decision-making with the patient, family and care teams

Introductions

Presenters:

Dr. Cornelius Woelk, CCFP(PC), FCFP
Assistant Professor, Dept of Family Medicine, Univ of Manitoba
Medical Director of Palliative Care – Southern Health-Santé Sud
Medical Director, Boundary Trails Regional Cancer Program hub
Family Physician C.W. Wiebe Medical Centre

Melanie Spencley NP
Regional Palliative Consultation Team
Home and Community Care Support Services
Champlain

Palliative Care Emergencies

- Emergencies in palliative care occur, despite presence of life-limiting illness and anticipated death
- Emotions, physical location, lack of preparation and information contribute to sense of urgency and distress
- Shift focus from “what can be done?” to “what is appropriate for this patient in this particular situation?”

Common Emergencies in Palliative Care

- Catastrophic Hemorrhage
- Dyspnea and breathing difficulties
- Spinal cord compression
- Superior vena cava syndrome
- Hypercalcemia
- Seizures
- Pain crisis

Palliative Care Emergencies

Dr. Cornelius Woelk MD,CCFP(PC),FCFP

I have no conflicts of interest pertaining to this topic or this presentation.

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C. Woelk MD,CCFP(PC),FCFP

Oxymoron - definition

- *Two concepts that do not really go together, but are used together*
- *A phrase containing two contradictory terms*

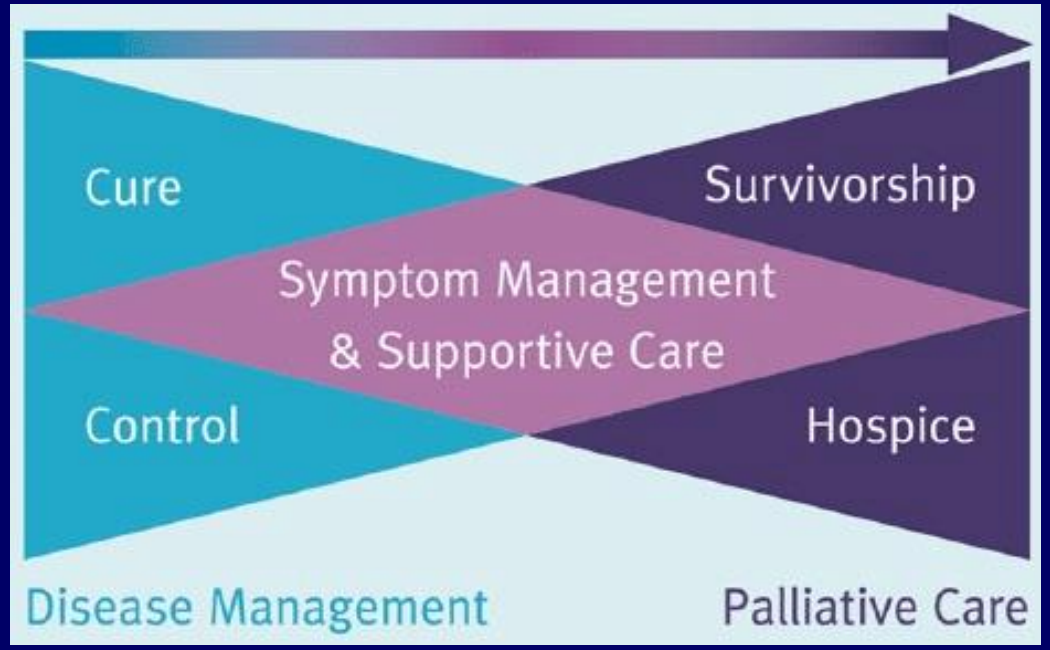
Fundamental Principles

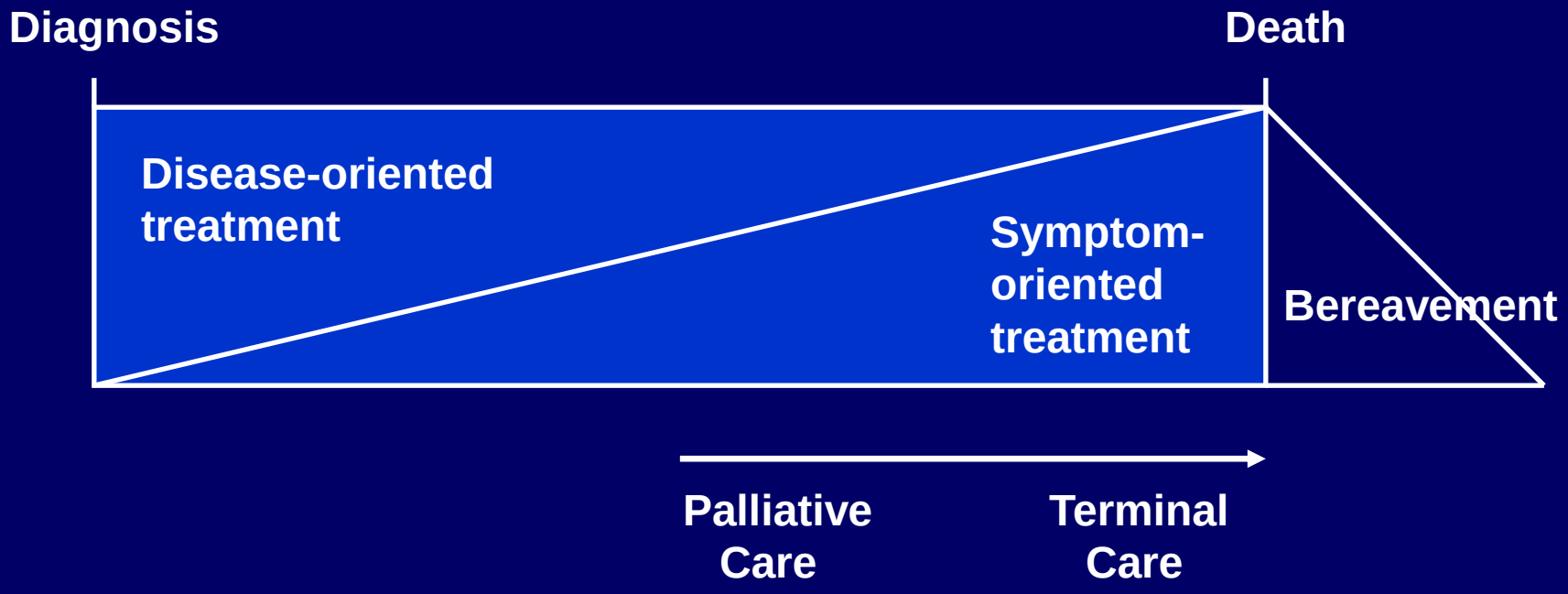
- primary or underlying rules on which something is based

1

Palliative Care is an Approach to Care – not only the very end of life

Urgencies and Emergencies happen anywhere along the way





Potential Emergencies in Palliative Care

- Pain Crisis
- Spinal Cord Compression
- Hypercalcemia
- Superior Vena Cava Syndrome
- Severe Hemorrhage
  - Respiratory or Gastrointestinal
- Respiratory Distress
- Seizures
- Delirium
- Others

Potential Goals in Treating Palliative Emergencies

- Improvement in function
- Decrease in symptoms
- Prolongation of life
- Improved quality of life
- Less complicated bereavement

2

The Patient (or Designate) is key in Decision Making

ABCD's of Advanced Cardiac Life Support (ACLS)

- Airway
- Breathing
- Circulation
- Differential Diagnosis

ABCD's of Dignity in Care

- Attitude
- Behaviour
- Compassion
- Dialogue

http://dignityincare.ca/en/the-abcds-of-dignity-in-care.html

Dialogue – Patient Dignity Question (PDQ)

What should I know about you

as a person

to give you the best care possible?

http://dignityincare.ca/en/the-abcds-of-dignity-in-care.html

3

Underlying Goals of Care Determine Actions

Orders		Actions
Palliative Care		Do not intervene
Do not resuscitate / DNR	≠	Ignore
Allow Natural Death / AND		Sedate
Advanced Care Plan / ACP-C		

Emergent *syndrome* management? **Sometimes**

Emergent *symptom* management? **Always**

4

In Palliative Care, the family becomes an essential component of care






5

Good Decisions require Good Strategy

How do we help others make difficult decisions?

Before beginning, recognize that most

complex and sensitive discussions are a

PROCESS

not an event

What main factors are involved in making decisions?

- Urgency
- Importance
- Possible Alternatives
- Clarity of potential outcomes
- Inherent qualities in the decision maker

Working with excess adrenalin in the room

- Anxiety
- Fear
- Panic
- Fight

A Systematic Approach for Making Decisions

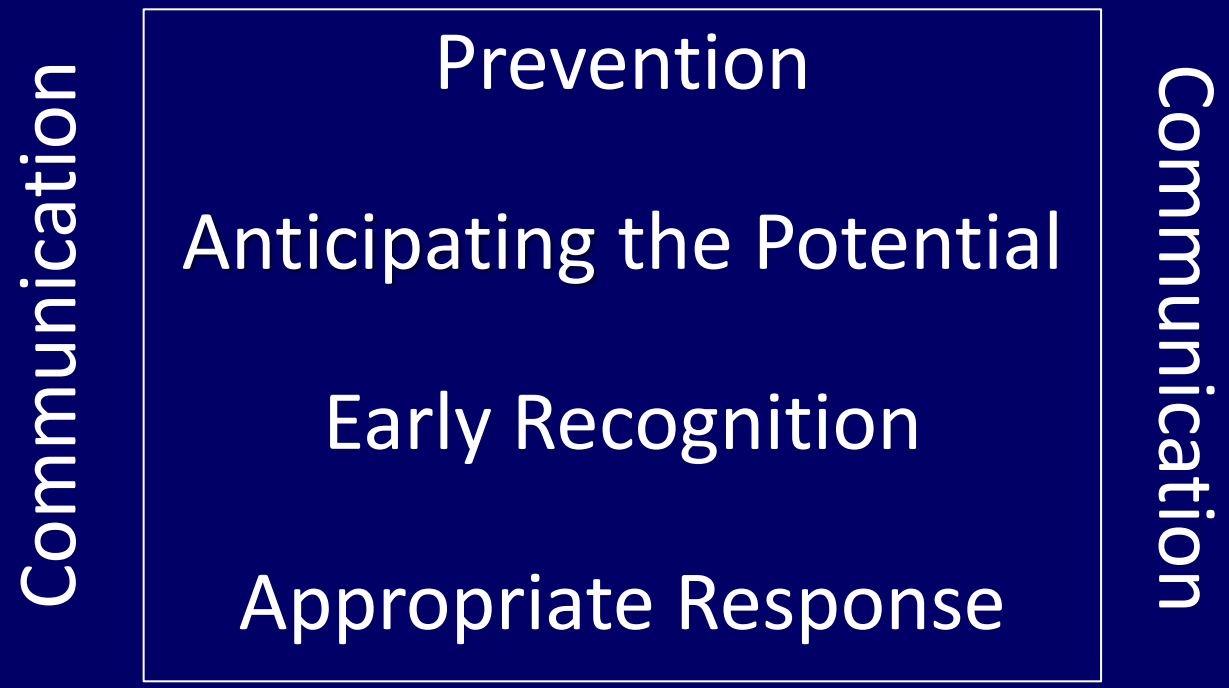
1. Create a constructive environment
2. Investigate the situation in detail
3. Generate good alternatives
4. Explore your options
5. Select the best solution
6. Evaluate your plan
7. Communicate your decision and take action

Difficult Decision-Making

- What do you understand about your illness and its prognosis?
- What are your fears about what is to come?
- What are your goals? What would you still like to do as time runs short?
- What are the trade-offs you are willing to make? How much suffering are you willing to undergo for the sake of the possibility of added time?

Atul Gawande

Managing Palliative Emergencies



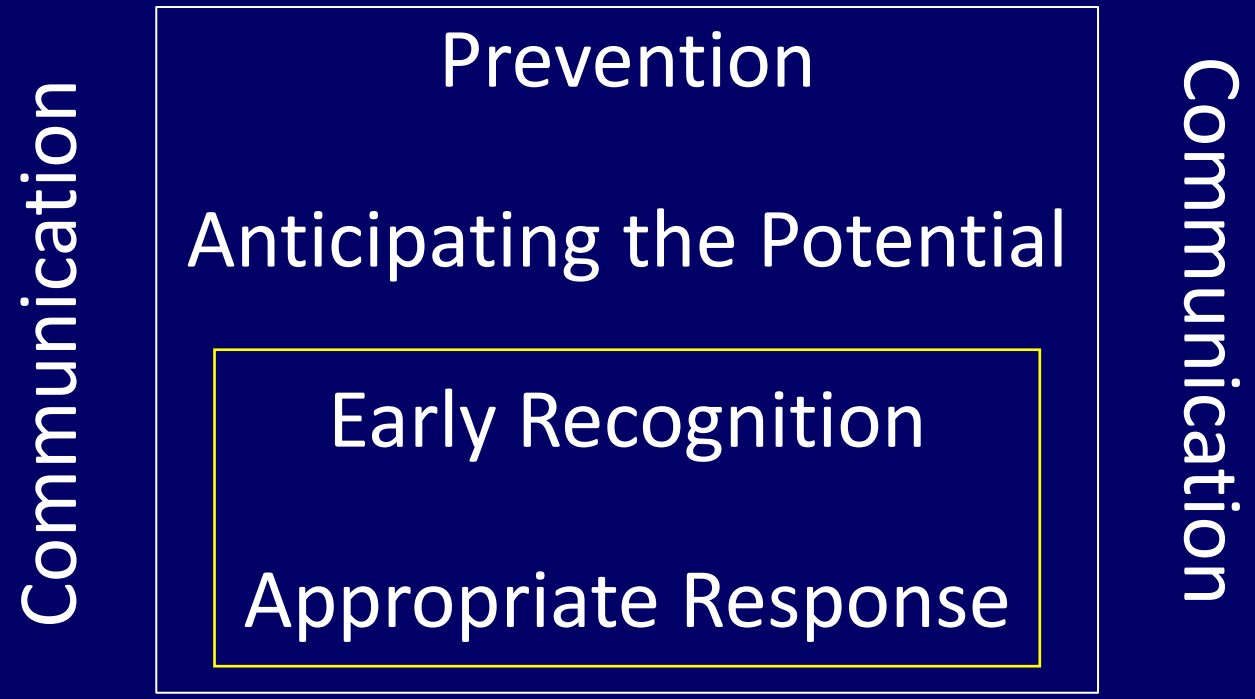
"An ounce of prevention is worth a pound of cure."

(Benjamin Franklin)

Anticipation

- Be aware of potential emergencies
- Be aware of patient wishes in case of emergency
- Be aware of family member wishes in case of emergency

Managing Palliative Emergencies



Is this an emergency?

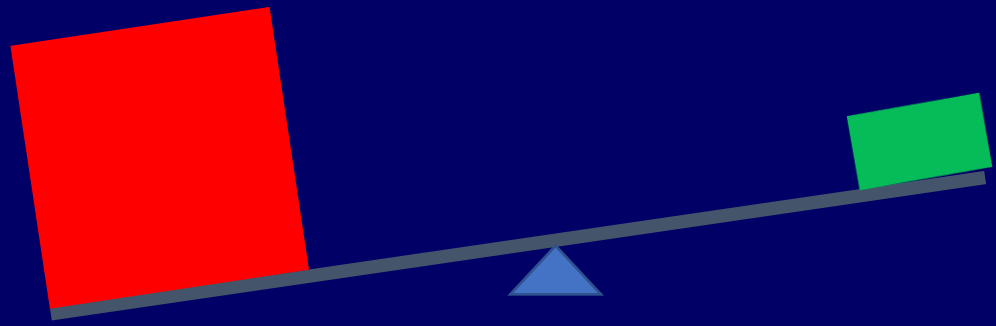
Who defines it as an emergency?

Examine the entire picture!

Is this a reversible event?

Is this a terminal event?

Is reversing this event reasonable?



Emergent **syndrome** management or
Emergent **symptom** management

APPROACHING PALLIATIVE CARE EMERGENCIES AT HOME

STABLE

Main Goal: *PREPARATION*

- Assessing Understanding
- Hopes and Fears
- Trade-offs
- Planning for Future (including others' futures)
- Advanced Care Planning (broadly)
- Anticipating Potential Emergent Problems (and potential solutions)
- Meeting the Family (determining their understanding and hopes and goals and fears)
- Work on Anticipated Grief
- Documentation (everyone involved needs to knows where things are at)

DECLINING

Main Goal: *RAPID ASSESSMENT*

- Availability of urgent access to health care providers must be clear
- Rapid Assessment (by phone / in person)
  - May be required ongoing over days
- Documentation
  - Symptoms
  - Symptom scores
  - Performance status
  - Momentum of decline
- Reporting of findings (to family; to team)
- What are client's wishes?
- Is the system capable of achieving them?
- Is family supportive and able to help?

CRASHING

Main Goal: *COMFORT*

- Comfort trumps everything
- Availability of urgent access to health care providers must be clear
- Rapid Assessment (by phone / in person)
- Client's wishes should have been determined, as should family's ability to support them
- Use of back-up medications
- Consider ambulance call if regional EMS willing / able to help in palliative care
- Call EMS as emergency if comfort cannot be achieved at home or if family unwilling / unable to continue

C. Woelk MD

To cure sometimes,
To relieve often,
To comfort always.

Edward Livingston Trudeau (1848-1915)

Case Study: Mrs. A

Managing palliative emergencies in the community

Melanie Spencley| November 25, 2021

Ontario

Disclosures

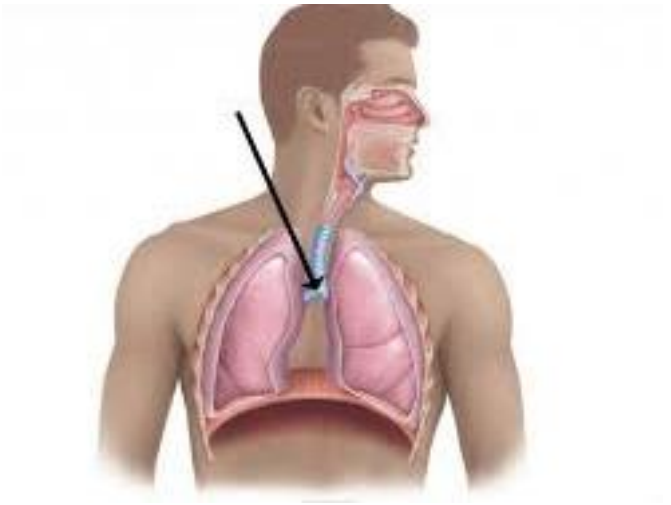
- No financial partnerships/disclosures
- Demographic/health data of case study has been changed in an effort to maintain anonymity
- Pictures are not case-specific and used without permission.

Case Study

- Mrs. A:
  - 68 years old
  - Lives with spouse in rural community
  - Son nearby but limited contact related to COVID
  - Extended family/friends
  - “Retired”

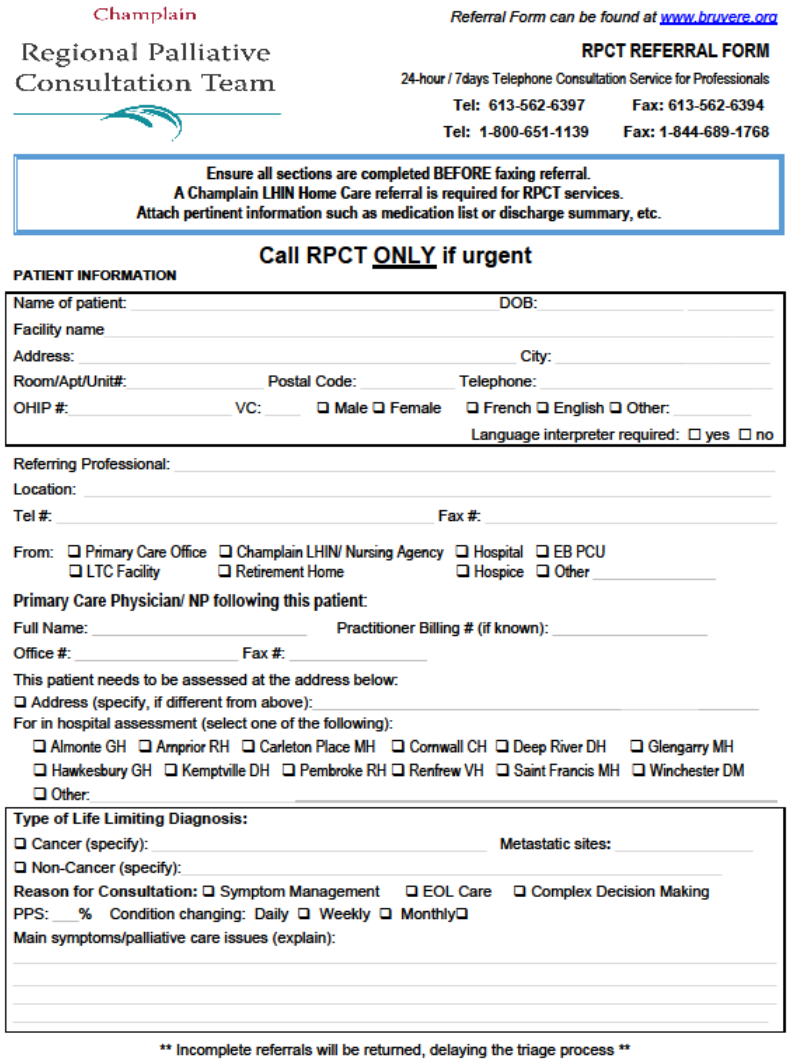
Case Study

- Diagnosed with SCC trachea in 2018
- Stent placed for airway management
- Chemo/Rads
- Relative stability with immunotherapy until recently



Case Study—Referral

- Referral from Medical Oncologist:
  - Pain
  - Dyspnea
  - EOL planning



Champlain
Regional Palliative Consultation Team

Referral Form can be found at www.bruyere.org

RPCT REFERRAL FORM

24-hour / 7days Telephone Consultation Service for Professionals

Tel: 613-562-6397 Fax: 613-562-6394

Tel: 1-800-651-1139 Fax: 1-844-689-1768

Ensure all sections are completed BEFORE faxing referral.
A Champlain LHIN Home Care referral is required for RPCT services.
Attach pertinent information such as medication list or discharge summary, etc.

Call RPCT ONLY if urgent

PATIENT INFORMATION

Name of patient: DOB:

Facility name

Address: City:

Room/Apt/Unit#: Postal Code: Telephone:

OHIP #: VC: ❑ Male ❑ Female ❑ French ❑ English ❑ Other:

Language interpreter required: ☐ yes ☐ no

Referring Professional:

Location:

Tel #: Fax #:

From: ❑ Primary Care Office ❑ Champlain LHIN/ Nursing Agency ❑ Hospital ❑ EB PCU
❑ LTC Facility ❑ Retirement Home ❑ Hospice ❑ Other

Primary Care Physician/ NP following this patient:

Full Name: Practitioner Billing # (if known):

Office #: Fax #:

This patient needs to be assessed at the address below:

❑ Address (specify, if different from above):

For in hospital assessment (select one of the following):

❑ Almonte GH ❑ Arnprior RH ❑ Carleton Place MH ❑ Cornwall CH ❑ Deep River DH ❑ Glengarry MH
❑ Hawkesbury GH ❑ Kemptville DH ❑ Pembroke RH ❑ Renfrew VH ❑ Saint Francis MH ❑ Winchester DM
❑ Other:

Type of Life Limiting Diagnosis:

❑ Cancer (specify): Metastatic sites:

❑ Non-Cancer (specify):

Reason for Consultation: ❑ Symptom Management ❑ EOL Care ❑ Complex Decision Making

PPS: ___% Condition changing: Daily ❑ Weekly ❑ Monthly❑

Main symptoms/palliative care issues (explain):

** Incomplete referrals will be returned, delaying the triage process **

Case Study—First visit (August)

- PPS 50%
- Pain: acute sternal, responsive to morphine
- Dyspnea: exertional, cough present--secretions/sputum, occasional hemoptysis (reduced since radiation)

Case Study—First visit (August)

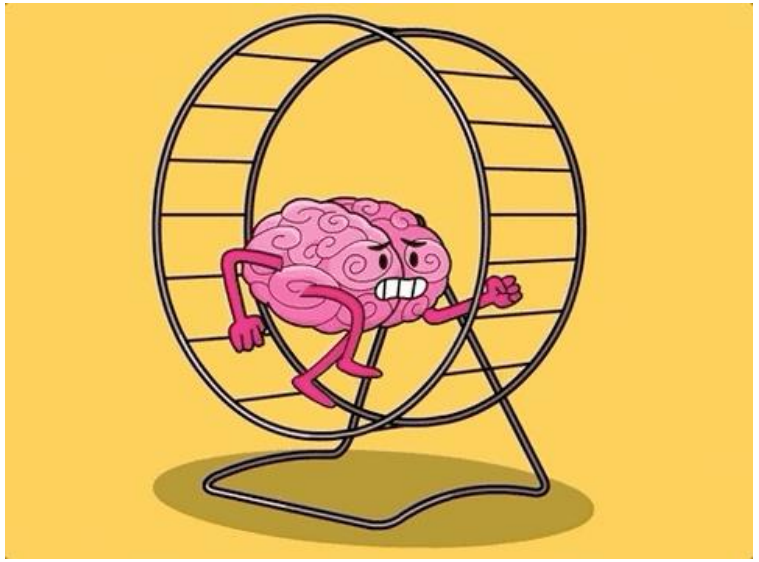
- Goals of Care (client's)
  - Pain control, gather family, make it to Christmas
- Examining Values
  - "If your condition were to decline, what would be the most important thing to you if time was short"
    - Family, being at home, privacy

Case Study—First visit (August)

- Plan:
  - regular morphine dosing for pain and dyspnea control
  - Tranexamic acid
  - DNR-C
  - Introduce Symptom Response Kit
  - Follow-Up in short term to re-assess interventions (via telephone); Home visit planned 2-4 weeks.

Case Study—Care planning

- Anticipation of the possible:
  - Airway obstruction
  - Metabolic complications
  - Bleeding



Case Study—Care planning

- Airway Obstruction
  - Currently Stable; prepared for decline
- Metabolic Complications
  - Currently stable; prepare for decline
- Bleeding
  - Stable → Declining
  - Intervention focused on decreasing symptom, improvement of QoL, prolongation of life

Case Study—Care planning

- Considerations:
  - Availability and ability of caregiver (spouse)
  - Availability of home care professional staff (amidst nursing shortage and during pandemic) to respond to changes in condition
  - Availability of medications/supplies/equipment that may be required to manage possible emergencies
  - Are alternatives acceptable to patient (hospice, PCU, hospital)

Case Study—Follow-up visit (Sept)

- PPS 50%
- Overall improvement in symptoms
- Scans show further progression on immunotherapy
- Discontinue immunotherapy, and focus on palliative approach to care

Case Study—Follow-up visit (Sept)

- “how important is it for you to know about what may happen as your cancer progresses?”
  - Opportunity for teaching around the “expected” end-of-life trajectory
  - Ordering of SRK
  - Checking-in—values “what’s important for you right now?”

Case Study—Follow-up visit (Oct)

- PPS 40%
- Good control of pain/dyspnea now with

  CADD

- Hemoptysis has returned—intermittent, minimally distressing
- No role for rads/IR, and client content with this!

Case Study—Follow-up visit (Oct)

- “we have talked a lot about how things may change in the time ahead and I think we have a really good plan in place, I do worry because of the location of your cancer that you may have a higher risk of bleeding…I wonder if that is something we could also set up a plan for”
- Explore possible options with best information available
- Checking-in: “what’s important for you right now”

Case Study--Preparation

- SRK in place with appropriate orders
- “bleed kit” in place under bed (dark towels, pre-drawn meds, printed instruction + phone numbers)
- Telephone plan-1st call, 2nd call, and post-event support
- Teaching complete with partner, reviewed on an ongoing basis
- Check-ins: client, family, home care nurses

Case Study--Communication

- Chart in the Home
- Dictated consultation note (GP, Visit Nursing, CITH)
- Availability of consultant for frequent check-ins
- Joint visits with nursing staff when possible
- Tick lists, phone list for client and spouse

Case Study—Event (November)

- Telephone call from visit nurse
- Client deceased in home
- Experienced catastrophic upper-airway bleed
- Kit used—1 dose midazolam administered by partner, call to VN (primary)
- 2 VN attended to home—EDITH, post-mortem care, family support

Case Study—Follow-up

- Initial call to Mrs. A's partner
- Follow up with VN team
- In-person visit

Case Study—Goals met

- Time with family
- Did not delay important events (Christmas gathering held in November)
- Stayed in own home (particularly important during Covid-19 pandemic)
- Maintained privacy
- Empowered spouse

Case Study--Summary

- Emergent situations in palliative care have the potential to alter trajectory
- Goals of care may be fluid based on client values, resources
- Exploring, explaining, and planning are all a part of caring
- Benefits of care do not stop with patient death

Thank you for joining,

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