Palliative care in long-term conditions

2011 – 2012
Scottish Palliative Care Pharmacists’ Association
Aims & Objectives
• To explore symptoms, general management principles and appropriate palliative treatment of conditions at the end of life and related problems which are commonly presented in a community pharmacy or hospital in-patient setting.

Learning Outcomes
• Be aware of prognostic factors associated with conditions receiving palliative care
• Develop a knowledge of the typical physical symptoms associated with conditions requiring pall care management
• Describe the main pharmacological and non-pharmacological treatments for symptom management of the condition
• Increase staff awareness and sensitivity to potential social/psychological/spiritual support needs of patients or their carers and to know where to direct them for support
• Describe ways in which the clinical pharmacist (community or hospital) can impact on conditions including anticipatory prescribing and stopping medicines towards the end of life
What is Palliative Care?

Improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual.

WHO, 2004
LIVING and DYING WELL

Old concept

Treatment

Curative care

Palliative care

Death

Better concept

Treatment

Disease modifying or potentially curative

Supportive and palliative care

Bereavement care

Death

Time

Time
Raising Awareness

- 1% population die each year
- 55,000 deaths in Scotland
- Ageing population
- Increasing technologies
- Greater expectations
- Reducing resources
- Societal changes
Policy and Strategies etc - Palliative Care in Scotland
### Community pharmacy statistics 2010-11

<table>
<thead>
<tr>
<th>Service</th>
<th>Scotland</th>
<th>“Average” per pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescriptions dispensed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of prescription items</td>
<td>87.6m</td>
<td>71,046</td>
</tr>
<tr>
<td>No. of instalment fees</td>
<td>22.1m</td>
<td>17,941</td>
</tr>
<tr>
<td><strong>Minor ailments service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of items dispensed</td>
<td>1.7m</td>
<td>1379</td>
</tr>
<tr>
<td>Patients registered</td>
<td>790,509</td>
<td>641</td>
</tr>
<tr>
<td>Most prescribed item: paracetamol</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic medication service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient registration</td>
<td>75,000</td>
<td>61</td>
</tr>
<tr>
<td>ePharmaceutical Care Risk Assessments</td>
<td>30,000</td>
<td>24</td>
</tr>
<tr>
<td><strong>Public health service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cessation – 63% of primary care quit attempts</td>
<td>50,194</td>
<td>41</td>
</tr>
<tr>
<td>Supply of Levonelle via CPUS Rx</td>
<td>82,000</td>
<td>67</td>
</tr>
<tr>
<td>People with <strong>palliative care</strong> needs (estimate from Audit Scotland report)</td>
<td>41,670</td>
<td>34</td>
</tr>
</tbody>
</table>
Hospital Statistics

• Acute sector – output of Living & Dying Well Short Life Working Group 5

‘An Evolving Process: Snapshots of palliative and end of life care in acute care settings in hospitals’ is now available on NES website

• 58% of people die in hospital

• 30% of all acute bed days are used by patients in their last year of life

• 75% of people are admitted to hospital during their last year of life
Prognostication Tools

Prognostication Indicator Guidance PIG

Supportive and Palliative Care Indicators Tool – SPICT

Scott Murray (Lothian)
What conditions are we talking about?

1. The surprise question ‘Would you be surprised if this patient were to die in the next 6-12months’

2. Choice/ Need - The patient with advanced disease makes a choice for comfort care only, not ‘curative’ treatment, or is in special need of supportive / palliative care eg refusing renal transplant

3. Clinical indicators - Specific indicators of advanced disease for three main end of life patient groups - cancer, organ failure, elderly frail/ dementia
Trajectories

- **diagnosis** of a progressive or life-limiting illness

- the ‘surprise question’ (clinicians would not be surprised if the patient were to die within the next 6-12 months)

- **critical events** or significant deterioration during the disease trajectory indicating the need for a change in care and management

- significant changes in **patient or carer ability to ‘cope’** indicating the need for additional support

- onset of the end of life phase – ‘diagnosing dying’
Functional Status v Age
### Symptom prevalence at end of life

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Cancer</th>
<th>HF</th>
<th>RF</th>
<th>COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>75%</td>
<td>68%</td>
<td>49%</td>
<td>68%</td>
</tr>
<tr>
<td>Anorexia</td>
<td>75%</td>
<td>43%</td>
<td>48%</td>
<td>64%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>70 – 100%</td>
<td>70%</td>
<td>80%</td>
<td>68%</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>40%</td>
<td>61%</td>
<td>52%</td>
<td>94%</td>
</tr>
<tr>
<td>N &amp; V</td>
<td>45%</td>
<td>32%</td>
<td>39%</td>
<td>4%</td>
</tr>
<tr>
<td>CNS</td>
<td>45%</td>
<td>59%</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3.5 – 75%</td>
<td>30%</td>
<td>27%</td>
<td>53%</td>
</tr>
<tr>
<td>Constipation</td>
<td>80%</td>
<td>37%</td>
<td>28%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Poorly relieved suffering even in the final week of life

- Aesthenia and weakness ........... 85%
- Pain ........................................... 75%
- Constipation .......................... 75%
- Anorexia ................................. 75%
- Dyspnoea ................................. 45 - 60%
- Nausea and / or vomiting ........ 40%
- Confusion .................................. 40%
- Convulsions .............................. 10%

ack. D. Doyle
Symptom Management

• Local guidelines
  http://www.palliativecareggc.org.uk/

• National guidelines
  http://www.palliativecareguidelines.scot.nhs.uk/
Aesthenia, fatigue & anorexia
(anorexia-cachexia syndrome)

- Prevalence: COPD > HF > cancer > RF > CF, RA, Alzheimers, HIV/AIDS
- **NOT** reversible with nutrition
- Inflammatory cells produce cytokines -> increase metabolic rate and muscle and fat breakdown
- Energy conservation techniques
  - keep energy for what is important to the patient, adds value and meaning
- Signpost to resources for assistance
- Pressure relieving techniques
- Increased concentration for unfinished business such as wills
  - may see methylphenidate prescribed
Pain

- Pain assessment tools
- WHO analgesic ladder

Opioids
- Scottish Patient Safety Programme and National Patient Safety Agency target strong opioids
- Titration: increments of 30 to 50%
- Breakthrough doses: $\frac{1}{10}$th to $\frac{1}{6}$th, may require titration
- Incident pain
- End of dose effects
- Toxicity

Unrecognised pain in dementia
Constipation

• Causes
  – drugs (opioids, anticholinergics)
  – lack of mobility
  – lack of fluid intake
  – lack of food intake
  – disease

• Prevention better than cure
• Stimulant /softener combination
• Place of methylnaltrexone?
Dyspnoea (breathlessness)

- Assessment
- Non-drug measures – air flow, space, open window
- Reversible
- Irreversible
- Anxiety – distraction, relaxation, benzodiazepine
- Role of oxygen – unproven, psychological dependence, barrier between patient and family, burden of supplies and equipment, isolating
- Diuretics (furosemide) in heart failure to relieve fluid overload
- Opioids
Nausea and Vomiting

- Symptom assessment - triggers
- Receptor activation – CTZ (drugs, toxins, biochemistry), vomiting centre (vestibular stimulus, central stimulus), mechano and chemoreceptors in gut
- Appropriate route of administration
- Avoid cyclizine in heart failure?
- Avoid anti-dopaminergics in Parkinson’s disease
- Non-drug – CBT, acupressure/acupuncture
Anxiety/ agitation & Delirium

• Assessment – check hydration, drugs (steroids, opioid toxicity), pain, urine retention (anticholinergics), unresolved issues
• Anxiety – non-drug measures relaxation & CBT, benzodiazepines
• Delirium – hypo and hyperactive
• Remember environment to orientate and avoid excess stimulus; relaxation; antipsychotics
**Highland Palliative Care Pathway - Overview**

**Point of Patient Journey**

- **Diagnosis** of progressive incurable disease process
- **Regular Review**
- **Recognition** of life-threatening nature of illness (Prognosis may be a matter of months a year)
- **Assessment** Multi-dimensional (e.g. PDI)
- **Living with the Illness**
- **Time is short** (may be weeks)
- **Final days**
- **Afterwards**

**Acknowledgement of life-threatening nature of illness - communication with patient and professional health care team**

- **Global Assessment completed, Care Plan formulated, Key Worker nominated and individual placed on Palliative Care Register**

- **Regular assessments made and recorded, regular Primary Care Team discussions recorded, Anticipatory / Crises care recorded and reviewed**

- **Anticipatory Care Plan including prescriptions, JIC box and equipment, DNACPR form completed (after discussion with patient, if appropriate)**

- **Liverpool Care Pathway completed. Bereavement risk assessments performed and recorded**

- **Key personnel to provide support during bereavement are identified with the family and recorded**
Anticipatory care planning

- GP Palliative Care registers
- ePCS
- DNA CPR
- Living Wills & Advance directives
- Powers of attorney – financial and welfare
- Capacity
Anticipatory Care Planning
- Pharmacy issues

What is likely pattern of the disease/ complications/ issues for e.g. MND, HF, dementia, Parkinson’s?

and therefore:

• What do you need to think about in terms of prescribing/ medicines?
  – concordance....
  – changing routes
  – drug formulations
  – equivalences – where do you get information?
  – off label prescribing
  – ‘specials’ – accessibility/continuity of supply
  – stopping medicines....
  – place of care supply issues/communications across care settings
Concordance

• Choice
• Tablet or medicines burden
• Knowing what the drug is for and how to use e.g. short/long acting opioids
• Appropriate route as symptoms change e.g. can no longer swallow
• Continuity of supplies – community network
• Aids – medication charts, non-click lok tops etc
Stopping medicines

1. Does the drug have a valid and current Formulary indication. Take particular regard of **drugs that are tolerated poorly in frail patients**

2. Is the drug expected to give day to day **symptomatic** benefit? Or is important in preventing **rapid symptomatic deterioration**

3. Is the drug **replacing a vital hormone**?

4. Is the drug in a form the patient can take, supplied in the **most appropriate way** and the **least burdensome dosing strategy**

5. Is the drug contraindicated or one of the **High Risk Drugs Group**?

6. For secondary prevention is life expectancy long enough to benefit?
Anticipatory prescribing ("Just in case")

- Opioid – pain, breathlessness
- Levomepromazine – nausea, vomiting, delirium
- Midazolam – anxiety & agitation, anticonvulsant
- Lorazepam (for sublingual use)
- Hyoscine butylbromide (Buscopan®) – colic, secretions
- Diluent
Information sources and resources

- www.highlandhospice.org.uk/getdoc/e338b416-27f9-4f71-822d-338a48f8731d/Highland-Palliative-Care-Pathway-Final.aspx
- www.palliativecareguidelines.scot.nhs.uk
- www.palliativecareggc.org.uk/
- www.palliativedrugs.com
- www.sign.ac.uk
- www.pallcare.info
- www.nes.scot.nhs.uk/pharmacy
- www.macmillan.org.uk