Palliative care

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Objectives

1. Introduction to service at CMH
2. Goals and approach to care
3. Symptom management
4. Syringe driver – when, how and practicalities of administration

Palliative care at CMH

A multidisciplinary, consultative, specialist service

Provides & facilitates integrated, holistic and both patient-centred and family-focused care

Provides education, support & advice to staff

Available 7.30am - 4pm, Monday - Friday

Consultants, one registrar, clinical nurse specialists

After hours: a palliative care SMO via switchboard

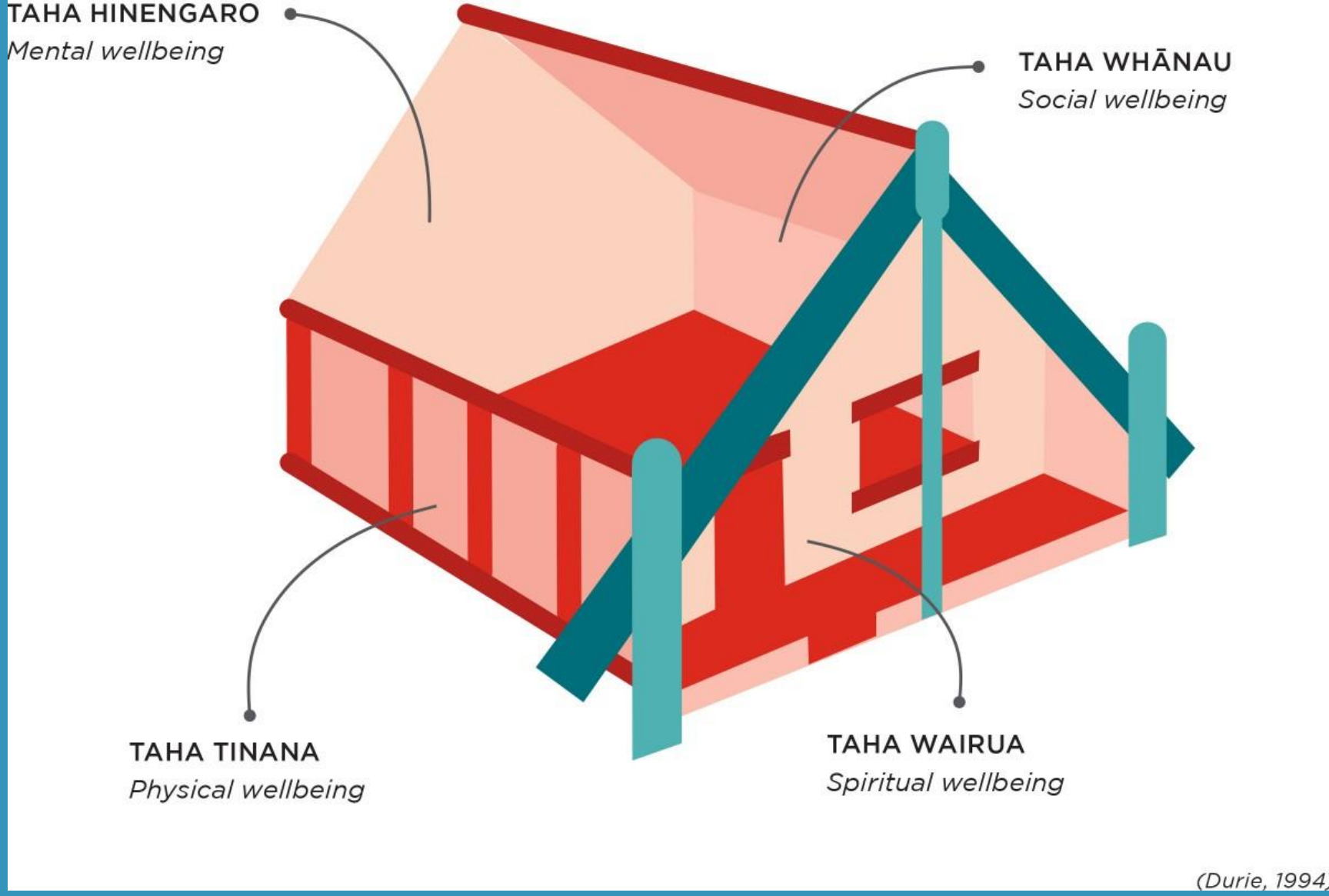
What is palliative care?

'An approach that improves the quality of life of patients and their families facing the problems associated with a 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.'

Goals of care

- Providing relief from distressing symptoms
- Enhancing the patient's quality of life
- Neither hasten nor postpone death
- Affirmation of life and the regard that dying is a normal process
- Empower the patient to make decisions around their health and the course of their illness
- Providing support to the patient's family during the illness and bereavement
- Encompassing both the psychological and spiritual aspects
- Can be provided alongside additional therapies that can prolong life

Te Whare Tapa Whā



(Durie, 1994)

Symptom management principles

- Assess and address non-physical as well as physical issues
- Difficult to control symptoms may require different approaches
- Aim for the highest possible quality of life
- Review risk vs benefit
- Explain issues and medications to patient and whanau
- Reassess continuously

Symptoms at end of life

MANAGEMENT OF PAIN

MANAGEMENT OF AGITATION, DELIRIUM AND RESTLESSNESS

MANAGEMENT OF NAUSEA

MANAGEMENT OF EXCESS RESPIRATORY TRACT SECRETIONS

MANAGEMENT OF DYSPNOEA/ BREATHLESSNESS

Pain

MEDICATIONS COMMONLY USED:

- Morphine
- Oxycodone
- Fentanyl
- Methadone
- Dexamethasone

CONSIDERATIONS:

- Renal function
- Opioid Naïve patients
- Previous dose prior to admission
- Conversions
- PRN use

Agitation, delirium and restlessness

MEDICATIONS COMMONLY USED:

- Haloperidol
- Midazolam
- Clonazepam
- Levomepromazine

CONSIDERATIONS:

- Haloperidol – first line – less sedating
- Haloperidol – avoid in Parkinsons (blockade of dopamine receptors and risk of EPSE
- Midazolam – sedating – check with pall care

Nausea and Vomiting

MEDICATIONS COMMONLY USED:

- Cyclizine
- Metoclopramide
- Haloperidol
- Levomepromazine

CONSIDERATIONS:

- If oral ineffective can change to subcut
- Prokinetic effect required e.g. metoclopramide
- Cyclizine – irritating subcut and incompatible with many medications

Dyspnoea & breathlessness

MEDICATIONS COMMONLY USED:

- Morphine
- Midazolam nasal spray
- Fentanyl nasal spray

CONSIDERATIONS:

- Oxycodone can be used if patient already on this and renal impairment
- Midazolam used for anxiety related breathlessness
- Non pharmacological measures such as fans or positioning near window are useful

Excess or retained respiratory tract secretions

MEDICATIONS COMMONLY USED:

- Hyoscine butylbromide
- Octreotide

CONSIDERATIONS:

- More distressing to family than patient
- Repositioning patient usually enough
- Hyoscine butylbromide crosses BBB to lesser extent than hyoscine hydrobromide

De-prescribing in palliative care

Stopping inappropriate medications safely and effectively

Review regular medications regularly

Include patient and whaanau in conversations

- Reduces shock of hearing that medications have been stopped
- Patients often have strong feelings about medications
- Team discuss goals of care

Syringe Drivers

- Persistent nausea or vomiting
- Intestinal obstruction
- Comatose
- Swallowing difficulties
- Poor absorption orally

Syringe Drivers

PROS

- Improved comfort due to reduced need for repeat PRN use
- Can control multiple symptoms with different combinations
- More steady drug concentrations
- Patient can maintain independence and mobility
- ONCE daily replacement

CONS

- Associated with end of life
- Training required for patient and family
- Risk of infection at site
- Steady state 3-4 hours may need extra PRNs before

Syringe driver tips

We use BD 20ml syringes filled to 18ml

- If > 18ml: use 30ml syringe with max volume 23.5ml

Check diluent and medication combinations

- Incompatibility: precipitation, colour change, haziness

Usually max of 3 medicines in drivers (exceptions)

PRNs: restricted to max 1.5-2mL into subcutaneous area

Irritating medications to be aware of: cyclizine, levomepromazine, methadone