HOW TO STOCK YOUR SURVIVAL KIT FOR A TREACHEROUS HIKE: CARING FOR OUR MOST COMPLEX PATIENTS

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OBJECTIVES

At the completion of this workshop the participant will be able to:

- Identify the most predominant symptoms associated with COPD, CHF and dementia
- Describe the trajectory of disease for COPD, CHF and dementia
- Create a plan of care to address the most predominant and distressing symptoms associated with COPD, CHF and depression
CAUSES OF DEATH IN THE U.S.

Heart disease-#1 cause of death in U.S.
Cancer-#2 cause of death
COPD-#3 cause of death
Alzheimer’s dementia-#6 cause of death
WHAT IF YOU COULD ONLY ASK ONE QUESTION?

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
COPD

Progressive
Airway obstruction
Not fully reversible reversible
Unpredictable course of illness=stress
Multisystem disease

While COPD is the 3rd leading cause of death, palliative care is not currently a part of the standard of care for those suffering from the disease. It is reserved largely for use at the end of life in hospice settings. People with lung cancer are more likely to receive palliative care than those people with COPD. Of the 6th leading causes of death in the U.S., it is the only one that has steadily risen over the last 30 years.

GOLD CLASSIFICATION OF SEVERITY

<table>
<thead>
<tr>
<th>Stage</th>
<th>Characteristics</th>
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</thead>
<tbody>
<tr>
<td>0: Atelectasis</td>
<td>Normal Spirometry</td>
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<tr>
<td></td>
<td>Chronic Symptoms (cough, sputum production)</td>
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<tr>
<td></td>
<td>GOLD-0 was introduced in the GOLD 2001 publication, but was no longer used in GOLD 2010</td>
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<tr>
<td>1: Mild COPD</td>
<td>FEV1/FVC &lt; 70%</td>
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<tr>
<td></td>
<td>FEV1 &lt; or equal to 60% predicted</td>
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<tr>
<td></td>
<td>With or without chronic symptoms (cough, sputum production)</td>
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<tr>
<td>2: Moderate COPD</td>
<td>FEV1/FVC &lt; 70%</td>
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<tr>
<td></td>
<td>FEV1 between 50 and 80% predicted</td>
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<tr>
<td></td>
<td>With or without chronic symptoms (cough, sputum production)</td>
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<tr>
<td>3: Severe COPD</td>
<td>FEV1/FVC &lt; 70%</td>
</tr>
<tr>
<td></td>
<td>FEV1 between 50 and 70% predicted</td>
</tr>
<tr>
<td></td>
<td>With or without chronic symptoms (cough, sputum production)</td>
</tr>
<tr>
<td>4: Very Severe COPD</td>
<td>FEV1/FVC &lt; 70%</td>
</tr>
<tr>
<td></td>
<td>FEV1 &lt; or equal to 50% predicted or FEV1 &lt; 50% predicted plus chronic respiratory failure</td>
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</tbody>
</table>
COPD CLASSIFICATION OF SEVERITY-BODE INDEX

BODE index serves as a guide to shortened survival

BMI (below 18)

airflow obstruction (FEV1 < 25%)

dyspnea and exercise capacity

Respiratory failure (PaCO2 > 50mmHg) and right heart failure

Helps assess clinical outcomes including exacerbation, hospitalization, mortality

• Significant as we are trying to anticipate changes

DISEASE TRAJECTORY

Compared with patients who have cancer, those with COPD spend increasing amounts of time in the hospital as their disease progresses.

In the last year of life as many as 94% of patients with chronic lung disease experience dyspnea.

Compared to patients with lung cancer, patients with COPD are more likely to die with poor control of dyspnea.

Final years characterized by progressive functional decline, poor QOL, and increase dependence on caregivers and healthcare system.

Hospitalized patients with COPD are more likely to receive technological interventions, often without establishing previous life support preferences.
DISEASE TRAJECTORY

Often die in ICU setting with greater symptom burden and less input from specialty palliative care.

Disease trajectory is highly unpredictable.

Providers have difficulty communicating that COPD is a life threatening illness which impedes access to quality EOL care.

Prognoses is quite inaccurate.

May be appropriate for hospice once patient experiences persistent troublesome symptoms that are refractory to treatment and severe limitation of activity.

MANAGEMENT OF COPD
COPD is a multisystem disease
- Right sided heart failure (cor pulmonale)
- Peripheral muscle wasting
- Mood and cognitive changes

Stop smoking!
- Ongoing smoking leads to a more rapid decline in lung function over time which can worsen symptoms and survival

Immunization—offer influenza and pneumococcal vaccines
- A study conducted over 3 influenza seasons compared vaccinated to unvaccinated individuals. There was a 52% reduction in hospitalizations for both PNA and influenza and a 70% reduction in risk of death in those who were vaccinated.
- Similarly, a study for pneumococcal vaccine found reductions of 43% and 29% respectively and there seemed to be a synergistic effect when both vaccines were given together (Parmar, 2015)
MANAGEMENT

❖ Self-management
- Early recognition of exacerbation and prompt initiation of rescue oral steroids, inhaled SABAs and/or abx may reduce hospitalizations.

❖ Anxiety and Depression
- Disabling and distressing symptoms of COPD = social isolation, inability to take part in activities previously enjoyed = depression/anxiety
- COPD patient is 2.5 times more likely to suffer from depression, which worsens with severity of disease
- 51-75% of patients with ESCOPD experience anxiety; 37-71% experience depression
  * Offer psychological, psychosocial support before initiation of antidepressant therapy.

PHARMACOLOGICAL MANAGEMENT COPD
**INHALERS**

- Delivery method is as important as the drug being administered.
- Incorrect use = ineffective therapy
- Inspect technique regularly. One study showed that elderly patients who acquired proper technique initially demonstrated ineffective use at one month.
- In severe disease patients can't use inhalers. There is no clear evidence of benefit of nebulized over inhaled therapy. Should not be used as replacement for inhaled therapy when operation of inhaler is impaired. Patients may benefit from short trial period when caregiver able to assist.

**INHALERS**

SABAs (i.e. albuterol) and SAMAs (short-acting muscarinic antagonists) (i.e. ipratropium)
- Most commonly employed bronchodilators
- Use on a regular or as needed basis
- Can be effective on airway caliber for up to 4 hours
- Initial treatment for the relief of breathlessness and exercise limitation in COPD

LAMAs (long-acting muscarinic antagonist) (i.e. tiotropium)
- Increases health related QOL and improves FEV1
- Reduces exacerbation rates
- Use caution in patients with arrhythmia

LABA + corticosteroid (i.e. budesonide/formoterol)
- Shown to reduce rate of exacerbations, provide small increase in QOL
- Increase the risk of pneumonia from 3 to 4% annually compared to LABAs alone
OPIATES

Subjective sensation of breathlessness-dyspnea
- Derived from multiple physiological, psychological, social and environmental factors

Up to 98% of patients with advanced COPD experience breathlessness at rest or with minimal exertion.

Low dose morphine (<30mg/day) can be safely used for the treatment of dyspnea for those not in the terminal phase of the disease.

Exact mechanism by which opiates relieve breathlessness is not entirely understood.

OUR GOOD PAL, MORPHINE

- Administer IV or oral route
- Nebulized morphine is associated with fewer side effects but do not significantly reduce breathlessness intensity. It is not recommended.
- Several studies support the use of morphine for treatment of dyspnea.
- Side effects-nausea, vomiting, constipation and sedation
- Barrier to use-fear of respiratory depression
  - To date there have been no studies that have documented respiratory depression from low dose oral opioids used for dyspnea (Smallwood, 2015)
OUR GOOD PAL, MORPHINE

- Not all patient’s have a good response to morphine. Remains unclear who will potentially benefit.
- Higher baseline dyspnea and younger age seems to more strongly predict a favorable response to morphine, but functional status and cause of breathlessness don’t.
- Initiate at 5-10mg q3-4h prn.
- Counsel patient it may take time so see therapeutic effect.
- Escalate dose at weekly intervals to max of 30mg/day. If no relief in symptoms consider stopping morphine and trialing again later.
- Doses greater than 30mg/day may cause toxicity

THE ROLE OF OXYGEN THERAPY

Appropriate for a non-smoking patient with O2 saturation at rest of <= 89% or PaO2 < 55mm Hg.
Appropriate for pt with pulmonary HTN secondary to COPD or cor pulmonale
Little evidence to support long-term benefit from short-term use secondary to exercise induced desaturation.
O2 limits function for some people and this should be considered.
Use during acute exacerbations should be carefully controlled for patients with baseline hypercarbia. High flow O2 can cause increase in PaCO2 by several mechanisms. During acute exacerbations O2 is best delivered by mask to better regulate concentration of delivered oxygen and prevent deleterious effects. Titrate to keeps sats around 89%
Supplemental O2 can improve exercise tolerance and dyspnea in patients with mild hypoxemia (even those who don't meet traditional criteria of <89%)
OTHER MODALITIES

Use of a fan
Pursed-lip breathing
Meditation
Relaxation
Behavioral techniques
Use of rolling walker (changes the posture)
Chest wall vibration
Pulmonary rehabilitation

The Dyspnea Ladder
Heart disease is the number one cause of death in the US (633,842 deaths in 2016)
*Death rate increased 28% from 1994-2004, attributed in part to increased survival following MI

More people in the U.S. die of heart disease than all cancers combined. In 2009, 40.1% of all US hospice patients died of cancer while only 11.5% died of heart disease.
CHF

Clinical syndrome that results from a structural or functional cardiac disorder that hinders the ability of the ventricle to fill with or eject blood.

Clinical manifestations include dyspnea, fatigue, exercise intolerance, volume overload

May or may not have reduced EF, peripheral edema or abnormal breath sounds.
NYHA CLASSIFICATION SYSTEM

I. Symptoms only with more than ordinary activity
II. Symptoms with ordinary activity
III. Symptoms with minimal activity
IV. Symptoms at rest

ACC/AHA STAGING SYSTEM

A. At high risk for developing HF but no structural heart disease or symptoms of HF
B. Structural heart disease but no signs of symptoms of HF (includes asymptomatic patients with low EF, valvular disease, LVH, or prior MI)
C. Structural heart disease with prior or current symptoms of HF
D. Refractory HF requiring specialized interventions such as heart transplant, chronic inotropes, or LVAD
BURDENS OF HEART FAILURE

Experience a similar symptom burden as patients with advanced cancer. Depression, decline in spiritual well-being, life disruption, social isolation, memory impairment, decrease in psychomotor speed and executive functioning, anorexia, cachexia, fatigue, dyspnea, mood changes, poor exercise capacity, pain, constipation, n/v

Up to 78% of patients dying from heart failure experience pain, 61% dyspnea, 59% low mood, 30% anxiety.

Patients dying of heart failure experience a functional decline sooner than patients dying of cancer.

DISEASE TRAJECTORY

Difficult to predict because of the advancements in management of heart failure.

* LVAD
* Cardiac transplantation
* ICD

Chronic illness marked by exacerbations and periods of recovery.

Many patients die of heart failure during an exacerbation but it is difficult to predict during which exacerbation however this is significantly improved by medical therapies and ICDs. In many cases, cardiac patients die within just a few days of being stable.
DISEASE TRAJECTORY

Following independent risk factors may contribute to a worse prognosis
• More severe NYHA classification
• Ischemic etiology
• Low EF
• Low systolic blood pressure
• Low serum sodium

Online calculator
http://depts.Washington.edu/shfm

DISEASE TRAJECTORY

Determining a 6-month or less prognosis is a challenge to accurately determine however a pattern of worsening functional status with little improvement, despite guideline directed medical therapy titration, is a key indicator of limited life expectancy that has consistently emerged in the research. Other poor signs include:
• Recurrent and/or recent HF hospital admissions
• Unintentional weight loss (pattern of decreasing dry weight) and cachexia
• ICD shocks of ventricular arrhythmias
• Presence of a 3rd heart sound (S3) in patient with reduced EF
• Recent with withdrawal of ACE or beta-blocker due to intolerance
BARRIERS TO ACCESSING PALLIATIVE CARE

Perception that symptom control is most effectively accomplished with guideline based cardiac therapies and delivery of this requires specialist cardiac training.

Many options available to treat advanced HF symptoms (i.e. medications, interventional procedures, surgeries, devices) and need for split second decision making in an emergency. Low mortality rate = quality cardiac care and intervention effectiveness.

Palliative care = hospice

Lack of access to hospice agencies who can provide guideline based care such as inotropic dependent patients, LVAD, those wishing to keep ICD active.

Unpredictability of disease trajectory.

SIGNS OF LOW CARDIAC OUTPUT FAILURE

Signs of decreased cardiac output:
- Cool clammy skin
- Cyno:letic
- Decreased level of consciousness
- Dizziness
- Fatigue
- Anxiety
- Chest pain
- Shortness of breath
- Diaphoresis
LOW CARDIAC OUTPUT FAILURE - LEFT HEART FAILURE

RIGHT SIDED HEART FAILURE

RIGHT SIDED HEART FAILURE (Cor Pulmonale)

- Fatigue
- Peripheral Venous Pressure
- Ascites
- Enlarged Liver & Spleen
- Edema

- May be secondary to chronic pulmonary problems
- Distended Jugular Veins
- Anorexia & Complaints of GI Distress
- Weight Gain
- Dependent Edema
PHARMACOLOGIC MANAGEMENT

video
PHARMACOLOGIC THERAPIES

Mainstay of oral therapy-ACE inhibitors, beta blockers, diuretics.
African Americans benefit from addition of hydralazine and nitrates (stage III and IV)
Spironolactone (stage III and IV)
Should titrate up to maximum tolerated dosage.
Limitations-drop in BP, renal failure, electrolyte disturbances

Intravenous inotropes
Intravenous diuretics

It is unclear how helpful this in low cardiac output failure and attempting to implement these therapies in the home setting complicates the end of life and utilizes precious community nursing resources with little gain and perhaps increased mortality.
SYMPTOM MANAGEMENT

• Special considerations
  • Patients with heart failure often times have impaired clearance of medications and metabolites because of impaired renal and hepatic function.
  • Confusion and sedation from cerebral hypoperfusion

• Start low and titrate meds up slowly

PREDOMINANT SYMPTOM-DYSPNEA

Assess actual recent physical activity as those with DOE tend to avoid activity.
Orthopnea-(SOB when lying flat) hallmark sign of fluid overload-diurese
Paroxysmal nocturnal dyspnea-patient suddenly awakens in the night, feeling like they are suffocating, claustrophobic
Assess dry weight, JVD, hepatic congestion, ascites, edema, crackles. Absence of crackles and edema is not a sole indicator of fluid status. Consider BNP to determine cause of dyspnea.
Consider a new cardiac event-did the patient have an MI? Pulmonary edema?
PREDOMINANT SYMPTOM-DYSPEA

Management:
- Morphine and lorazepam to reduce sensation of air hunger
- Be mindful of potential poor clearance
- Should not be used in isolation for fluid volume overload

- Diuretics
  - Treats the underlying cause
  - Avoid in the patient who is actively dying—will not be effective because of poor perfusion

PREDOMINANT SYMPTOM-CARDIAC PAIN

When assessing for cardiac pain, use other descriptors such as discomfort, heaviness, pressure when inquiring.

Cardiac pain is a sign of poor perfusion and is aggravated by exertion, alleviated by rest.

Unless a treatment plan is already outlined, cardiac pain needs prompt assessment.

Women, people with diabetes and older adults are at increased risk for atypical cardiac symptoms or silent ischemia.
- Assess for shortness of breath, lightheadedness, GI upset or falls
- Dramatic presentation with these symptoms should prompt rapid evaluation for new cardiac event

Goal is complete relief and ongoing prevention with meds that promote coronary perfusion=improved QOL
PREDOMINANT SYMPTOM-CARDIAC PAIN

- Morphine
- Nitroglycerin
- Oxygen

PREDOMINANT SYMPTOM: NON-CARDIAC PAIN

Common in people with heart disease.

High rate of co-existing disease-arthritis, diabetic neuropathy, back problems, etc.

Avoid NSAIDS-higher risk of serious CV events such as stroke, MI and death.

NSAIDs block renal prostaglandin synthesis which can compromise renal function=fluid retention

NSAIDs and anticoagulant and antiplatelet meds don’t play well together.

When NSAID is required, naproxen may be the safest alternative at the lowest dose and for the shortest time possible.
ANXIETY, DEPRESSION AND FATIGUE

Nearly 50% of patients with advanced heart failure experience anxiety and depression.
- SSRI, SNRI, mirtazapine, bupropion
- Use caution with SNRI for patient with HTN, a-fib-can elevate BP and aggravate tachycardia
- Tricyclics can adversely affect the conduction system leading to changes in QT interval
- Short term, low dose benzodiazepines are helpful for anxiety. Can be used until SSRI reaches therapeutic effect.
- Quetiapine can be helpful for anxiety accompanied by insomnia

Fatigue is prominent for many patients. May be related to heart failure itself or to beta blocker therapy. Assess for other causes of fatigue (anemia, sleep-disordered breathing).

WITHDRAWING LIFE PROLONGING CARE

Consider when a patient reaches a point in his or her illness when therapies no longer provide benefit or when death is imminent.

Ideally this has been discussed prior to initiation of therapy however this often does not occur.

Assess the patient’s goals.

If goal is comfort at the end of life, explain to patient and family that if ICD were to remain on, death might be traumatic. Additionally, fire of the device in advanced disease is not likely to be successful.

Contact device company to deactivate. Can also place magnet over device but this may not always work depending on the device.
WITHDRAWING LIFE PROLONGING CARE

Death following deactivation of LVAD is often immediate, generally within 20 minutes.
Decision making can be quite stressful.
Usually takes place in the hospital.
Acute pulmonary edema and circulatory collapse can occur following discontinuation of the device.
Management of symptoms at the time the device is withdrawn should be similar to care given to patients at the time of terminal ventilator wean.
Cited reasons for discontinuation of therapy-declining functional ability, declining cognition, worsening or new comorbidities.

HOSPICE ENROLLMENT

Difficult to predict 6-month prognosis.
Consider for NYHA class III or IV because of high 1-year mortality rate.
May be appropriate when QOL becomes more important to patient than aggressively pursuing disease-altering therapies such as LVAD or transplant.
May also be appropriate when patient expresses a desire to forgo frequent hospital admissions.
That being said, even when on hospice, these patients may benefit from chest xray, continued involvement of cardiologist, or IV diuretics for treatment of acute exacerbations.
Dementia

6th leading cause of death in the U.S.

2010-5 million people with AD

2030-8 million people projected to have AD

Direct and indirect cost of AD and other dementias amounts to more than $172 billion annually and does not include contributions from unpaid caregivers which is estimated to be $83 billion worth of services. $6.5 billion annually in lost productivity due to caregivers of those with dementia.

Healthcare costs rise substantially as the severity of disease increases.
DEMENTIA

A progressive irreversible clinical syndrome characterized by widespread impairment of mental function which may include memory loss, language impairment, disorientation, personality change, difficulties with ADLs, self neglect and psychiatric syndromes.

There is significant impact on caregivers as well. For every patient, there is at least one caregiver who will face complex and challenging problems as the disease progresses: incontinence, wandering, aggressive behavior, delusions, reduced mobility, feeding problems.

Prolonged and progressive disease course occurring over years. Since it typically affects older people, they usually have some decreased baseline function.

People with dementia (and their carers) have been shown to have palliative care needs equal to those of cancer patients.

DISEASE TRAJECTORY

Dementia types include Alzheimers, vascular, lewy body and frontotemporal-follow a similar disease course

Average life expectancy is 4-7 years after diagnosis. Age appears to influence this. Dx received in 60s: 6-7 year avg life expectancy. Dx received at age 90: 1.9 year avg life expectancy.

More rare dementias, Huntington’s disease, Cretuzfeld-Jakob disease-follow a much more rapid course of decline-months to a few years

During recovery from acute illness, patients with dementia usually establish a new lower level of cognitive and physical functioning. In advanced stages, any downturn-PNA, UTI, eating issues-can become a terminal event.

Hospitalization for PNA or hip fx: 6-month mortality rate 50%
<table>
<thead>
<tr>
<th>Type of dementia</th>
<th>Distinguishing feature</th>
<th>Important considerations</th>
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</thead>
<tbody>
<tr>
<td>Alzheimer’s dementia</td>
<td>Slow onset</td>
<td>Increased prevalence with aging</td>
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<tr>
<td>Vascular dementia</td>
<td>Usually associated with</td>
<td>Closely associated with cardiovascular disease</td>
</tr>
<tr>
<td></td>
<td>neurological deficits</td>
<td></td>
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<tr>
<td>Frontotemporal dementia</td>
<td>Changes in personality</td>
<td>Common cause of dementia in younger patients</td>
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<tr>
<td></td>
<td>typically marked by disinhibition</td>
<td></td>
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<tr>
<td>Lewy body dementia</td>
<td>Features overlap with</td>
<td>Haloperidol and chlorpromazine to be avoided</td>
</tr>
<tr>
<td></td>
<td>Parkinson’s disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hallucinations are common</td>
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**FAST SCALE**

Patient is hospice eligible once FAST score of 7C is reached: bed-bound uttering few words, and requiring assistance with ambulation and present with disease complications (e.g., asp PNA, upper UTI, sepsis, decubiti)
TREATMENT

Dementia treatment is focused on decreasing the rate of cognitive and functional decline and decreasing challenging behavior.

Good medical care of coexisting conditions is necessary for optimal management.

Cholinesterase inhibitors: rivastigmine, galantamine—indicated for MILD to MODERATE dementia; donepezil—only one indicated for MODERATE to SEVERE dementia

NMDA receptor antagonists—memantine—indicated for MODERATE to SEVERE dementia

Data is poor that any targeted medication is of significant benefit in end stage dementia.

CHOLINESTERASE INHIBITORS

Associated with reduction in cognitive and functional decline.

- One study showed that the median time to clinically evident functional decline was 208 days for placebo group versus 357 days for the donepezil group. The probability of no clinically evident functional decline at 48 weeks was 51% for the donepezil group versus 35% for the placebo group.

- Neuropsychiatric symptoms may also improve with cholinesterase inhibitor therapy.

- Have been shown to be slightly more effective in Lewy body dementia than in Alzheimers.

- Side effects: GI upset, particularly diarrhea (results in decreased intake and fluid/electrolyte imbalance)
NMDA RECEPTOR AGONISTS

One medication in this class: Memantine

Indicated for moderate to severe Alzheimer’s disease. Limited evidence to support its use in other forms of dementia.

Once at moderate stage of disease, has been shown to have a synergistic effect in slowing the disease when given with cholinesterase inhibitors, though this is small at best.

Limited side effects.

OTHER MEDICATION CONSIDERATIONS

Drugs of questionable benefit should be discontinued in advanced dementia unless they align with the goals of care.

- Statins and cholinesterase inhibitors not clinically beneficial
- Benzodiazepines and anticholinergics should be avoided in the elderly as they can precipitate delirium
- Haldol should be avoided in patients with Lewy body dementia.

For the patient with advanced dementia who may not be able to reliably report pain, consider scheduling pain medication.
NON-PHARMACOLOGIC THERAPIES

Sensory stimulation approaches
- Light therapy, aroma therapy, massage/touch therapy

Pet therapy
- Shown to decrease agitation and disruptive behaviors and improve social and verbal interaction

Behavioral management techniques
- Habit training, progressive muscle relaxation, CBT

Exercise therapy
- Increases sleep time; some slight reduction in agitation

CARE AT HOME

Complete advanced care planning discussion as early as possible to ensure patient participation in the discussion (consider if TPOPP is appropriate)

Assess vital signs and utilize appropriate pain assessment scale.

Approach patient calmly and explain actions to patient when performing physical exam to prevent agitation.

Utilize a functional assessment tool such as the Palliative Performance Scale at each visit. Assess other individual elements such as sleep patterns, skin integrity (provides clues about nutrition and mobility)

Reconcile medications
CARE AT HOME

High caregiver burden with high risk for burnout.

- Emotional/financial support screening
- Spiritual needs screening
- Home safety evaluation
- Caregiver screening—monitor for burnout!
  - Offer support groups
  - Written resources: “The 36 hour day.”
  - Offer respite

Provide education to caregivers about what to anticipate as disease progresses

CARE AT HOME

Monitor for issues regarding nutrition and hydration. Studies suggest no survival advantage with placement of PEG tube. PEG tube is of no benefit in prevention aspiration in patients with dementia and can lead to increased use of chemical and physical restraints.

- Use FAST scale to determine hospice eligibility. 7C or greater with complications (consistent weight loss, decubitus ulcer, pneumonia, etc.)

- Studies have shown that patients dying of dementia receive suboptimal EOL care that includes poor symptom control and overly aggressive treatments. They are more likely to undergo extensive diagnostic workups, aggressive treatment of coexisting medical conditions, transfers to acute care settings and CPR.

- Fewer than 10% of patients with advanced dementia die with the benefit of hospice services.
QUESTIONS...

REFERENCES


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REFERENCES


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