Palliative Care Concerns in the Older Adult

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Objectives

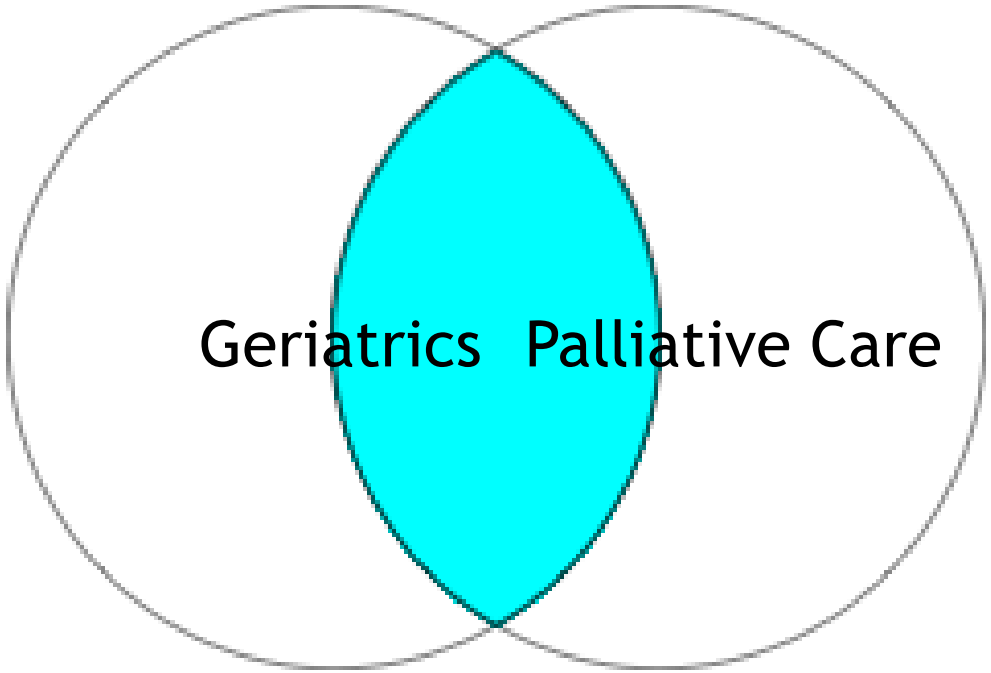
- Discuss common concerns of the older adult with cancer in palliative care.
- Identify, analyze and implement interventions for the treatment of common concerns of the older adult including: Functional status, anorexia, cachexia and delirium.
- Recognize and implement the Beers criteria for older adults to identify potentially inappropriate medications.
- Describe strategies to maintain and promote quality of life utilizing the dimensions of quality of life model.

What is palliative care?

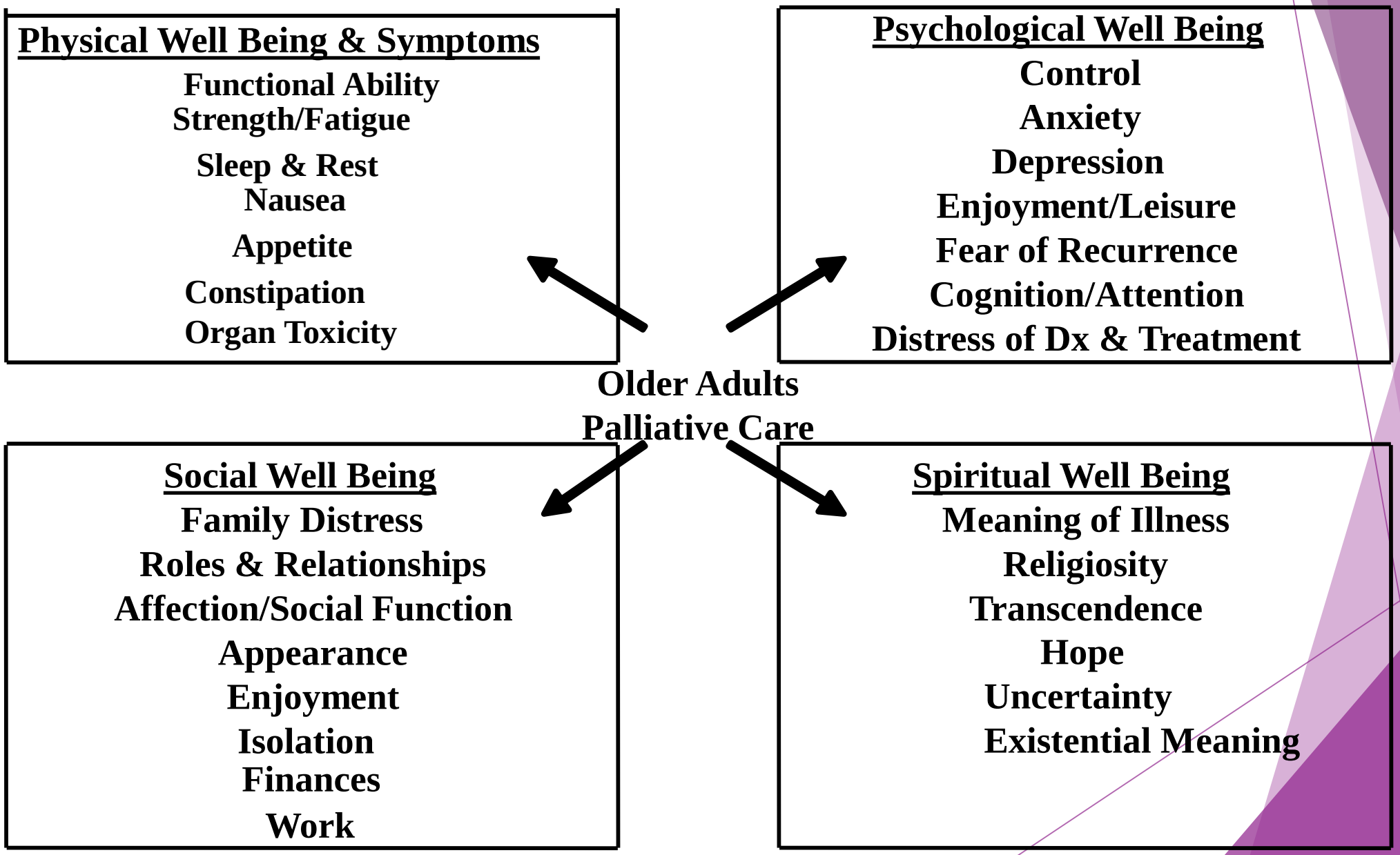
The National Consensus Project for Quality Palliative Care defines palliative care as follows:

"Beneficial at any stage of a serious illness, palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families and caregivers. Palliative care can be delivered in any care setting through the collaboration of many types of care providers. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family."

Geriatrics and Palliative Care



Dimensions of Quality of Life



Functional Status

- Activities of Daily Living (ADLs)
  - Bathing, dressing, transferring, toileting, grooming, feeding, mobility

- Instrumental Activities of Daily Living (IADLs)
  - Using a telephone, preparing meals, managing finances, taking medications, doing laundry, doing housework, shopping, managing transportation

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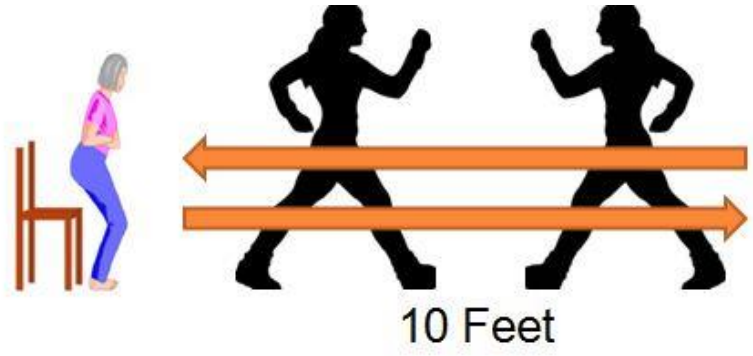
How to do a Timed Up and Go (TUG)



- Have patient sit in a straight backed chair
- Explain procedure to patient

  Say “Ready, set, go”
- Measures the time it takes a patient to stand up from the chair, walk a distance of 10 feet, turn, walk back to the chair, and sit down
- Patient may use assistive device if necessary
- Nurse may walk with unstable patient

https://www.cdc.gov/steadi/pdf/TUG_Test-print.pdf

Mobility in the Older Adult

- The older adult can begin to lose muscle mass after 2 days of bed rest resulting in sarcopenia. Muscle mass can decrease up to 5% day.

Pashikanti & Von Ah, 2012

- On average, hospitalized patients spend 83% of their day in bed; 73% of able patients do not walk daily.

Drolet et al., 2013

Functional Decline

- Functional decline is a poor clinical outcome and occurs in 20-40% of all older adults during hospitalization.

Messecar, D.C., 2012

Functional Status and the Older Adult

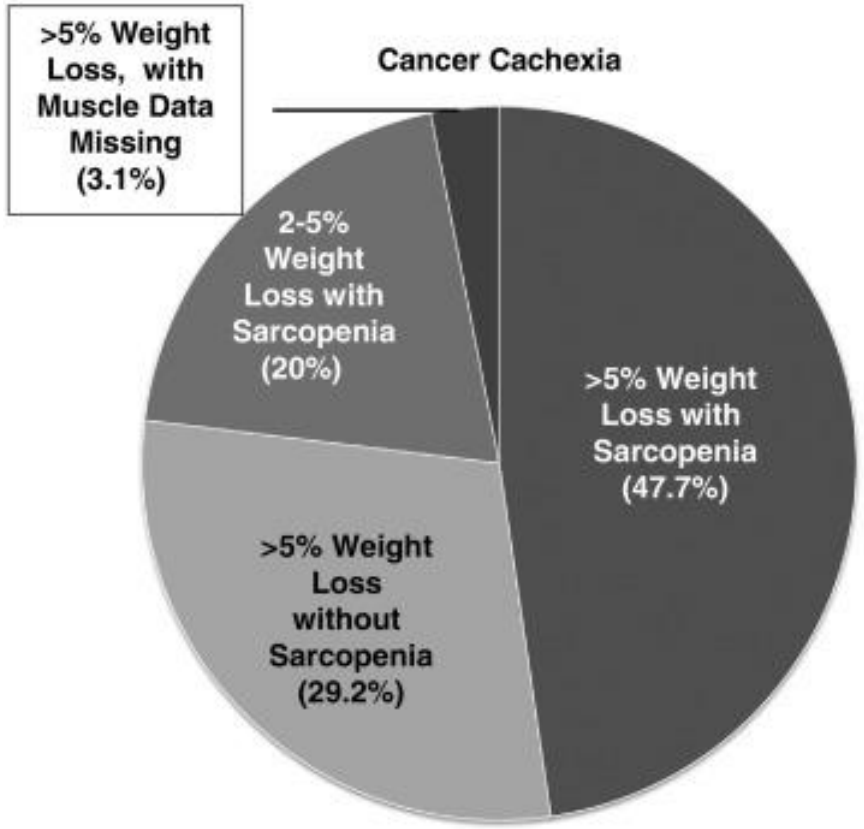
- Functional impairment = ↑comorbidities; ↓life span; ↑dependency and institutionalization; ↓QoL
- Predict decline and intervene
- Hospitalization ↑ functional decline

Geriatric Assessment	Assessment Tool	Results	Interventions
Function	TUG, IADL, ADL Falls in the last 6 months Baseline and repeated	TUG≥13 seconds or IADL/ADL dysfunction Any falls	Exercise Home safety evaluation PT/OT Vitamin D

Anorexia and Cachexia in the Older Adult

- Anorexia
  - Appetite loss
- Cachexia
  - Unintentional weight loss (Low BMI) correlated with:
    - Reduced muscle mass (sarcopenia) and adipose tissue
- Cancer Cachexia
  - Not fully understood
  - Associated with a poor prognosis
  - Signals progression of malignancy

Korc-Grodzicki & Tew, 2017



Journal of Geriatric Oncology. Dunne et al., 2019

Fig. 1 Mean age was 79.9 years (66-95)

Characterizing cancer cachexia: In those with cancer cachexia, the pie chart demonstrates what percentage of patients fit certain criteria for diagnosis relative to weight loss and sarcopenia.

Cancer Cachexia in the Older Adult

- Cancer cachexia:
  - Unintentional weight loss
  - Sarcopenia
- Results in:
  - Functional Decline
  - Lower survival
  - Not fully understood
  - More research is needed

Dunne et al., 2019

Anorexia and Cachexia Assessment

- Nausea/vomiting
- Constipation
- Dysgeusia
- Xerostomia
- Mucositis
- Oral-pharyngeal candidiasis
- Early satiety
- Dyspnea
- Fatigue
- Pain
- Eating disorders/body image
- Hypo/Hyperthyroidism
- Hypogonadism
- Metabolic abnormalities (increased calcium)
- Depression

Korc-Grodzicki & Tew, 2017
www.nccn.org

Anorexia and Cachexia Interventions

- Medication review
- Mobility
- Fatigue management/energy conservation
- Social/economic factors
- Nutrition consult
- Enteral/parenteral feedings (as applicable)
  - Risks include fluid overload, infection and accelerated death

www.nccn.org

Anorexia and Cachexia Interventions

- Anorexia and Cachexia due to malignancy
  - No treatment has been proven to extend life
  - Education of patient and family

Korc-Grodzicki & Tew, 2017

Anorexia and Cachexia Treatment

- Nonpharmacological Therapies
  - Favorite foods
  - Increase the number of small meals
  - No restrictions
- Pharmacologic Therapy
  - Limited Benefits
    - Increased appetite however not an extension of life

Korc-Grodzicki & Tew, 2017

Anorexia and Cachexia Medications

- Progestins: Megestrol Acetate
  - Consider Side Effects
    - Risk of thromboembolism
    - Edema
- Corticosteroids: Dexamethasone or Prednisone
  - Review risk vs benefit
  - High toxicity
  - Not recommended with a months to years life expectancy
- Synthetic Cannabinoids
  - Dronabinol
    - Treatment has not been proven to improve cancer
    - Not recommended routinely

Korc-Grodzicki & Tew, 2017

Anorexia and Cachexia Treatment

- Provide education for the patient/family/caregiver
  - Risk vs benefit of treatment options
- Consider patient goals and preferences
- Reassessment of Treatment

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Delirium in the Older Adult

- Older adults have an increased risk of delirium during hospitalization and is attributed to increased mortality, increased costs, cognitive and functional decline.

- The recognition of patients at risk for delirium, standardized protocols to reduce delirium and consultations to geriatric teams can reduce delirium.

- A comprehensive evaluation of older adults to recognize risk factors and routine screening for delirium is a key component of prevention.

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Delirium in the Older Adult

- It is estimated that 89% of hospitalized and community-dwelling older adults have delirium superimposed upon dementia.

Fick, Hodo, Lawrence, & Inouye, 2007

- Symptoms of delirium may often lead nursing staff to restrict the activities of older adults to prevent falls.

Wykle & Gueldner, 2011

Delirium in the Older Adult

- DSM-5 Criterion of delirium as a neurocognitive disorder:
  - A. Attention and awareness disturbance
  - B. Acute onset (hours to days) and typically changes over the course of the day
  - C. Cognitive changes and/or disturbances in perception
  - D. The alterations in Criteria A and C cannot be explained by a pre-existing, established or evolving disorder
  - E. Substantial decline from a preceding level of functioning with evidence that alteration is caused by a medical condition, substance or variety of causes.

American Psychiatric Association, 2013

Delirium Assessment Tools

- Confusion Assessment Method (CAM)
- Confusion Assessment Method for the ICU (CAM-ICU)
- Delirium Rating Scale – Revised
- Delirium Observation Screening Scale
- Bedside Confusion Scale

Kennedy-Malone, Martin-Plank, & Duffy, 2019
www.consultgeri.org

Confusion Assessment Method (CAM)

- 1. Acute onset and fluctuating course
- 2. Inattention
- 3. Disorganized thinking
- 4. Altered level of consciousness

- Diagnosis requires presence of features 1 AND 2 plus either 3 OR 4

Delirium Assessment

- Etiology
  - Metabolic
  - Infection
  - Cardiac
  - Neurological
  - Pulmonary
  - Sensory impairment
  - Medications and toxins

Kennedy-Malone, Martin-Plank, & Duffy, 2019

Delirium Assessment Common to the Older Adult

- Cognitive baseline
- Environment
- Polypharmacy
- Dehydration
- Pain
- Immobility
- Sensory loss
- Hypoxia
- Nosocomial infections
- Bowel Obstruction/ obstipation
- Bladder outlet obstruction
- Brain metastases

Wykle & Gueldner, 2011
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Delirium Interventions in the Older Adult

- Therapeutic Environment
  - Reorient patient
    - Calendar, clocks, caregiver identification, daily routine
  - Environment
    - Noise reduction, adequate light, decrease stimuli, reduce tasks to one at a time
  - Sleep hygiene
    - Regular sleep wake cycles, limit naps, be active during the day, sleep in a dark, cool, quiet and relaxing room, noise reduction, bundle interventions

Kennedy-Malone, Martin-Plank, & Duffy, 2019
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Delirium Interventions in the Older Adult

- Encourage mobility
- Comfort Maintenance
  - Hearing aids, glasses, personal possessions
- Address Patient Needs
  - Adequate fluid intake, elimination needs
- Clear communication
- Provide education for patient, family and caregivers
- Avoid chemical or physical restraints
- Last resort for agitation is psychotropic medications

Kennedy-Malone, Martin-Plank, & Duffy, 2019

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Delirium Treatment in the Older Adult

- Review the current treatment plan
- Discontinue unnecessary medications and consider hepatic/renal function
- Provide adequate pain management
- Consider rotation of opioids if appropriate
- Review antipsychotic agents and provide appropriate upward dose titration
- Consider that under or over treatment of pain may exacerbate delirium
- Evaluate and discontinue foley catheters, tubes, lines, etc.
- Fecal impaction or distended bladder evaluation as potential causes of delirium

www.nccn.org

Delirium Treatment in the Older Adult

- Comprehensive assessment
- Treat the underlying cause
- Prevent complications
- Review medications
- Review pertinent labs
- Ensure safety/behavioral considerations:
  - environment, behavior and pharmacologic therapies
- Support patient, family and caregivers

Kennedy-Malone, Martin-Plank, & Duffy, 2019

Delirium Model

- Hospitalized Elder Life Program (HELP)
  - Model for prevention
  - Multicomponent strategy
  - Independence is promoted for hospitalize older adults

Kennedy-Malone, Martin-Plank, & Duffy, 2019

Polypharmacy and the Older Adult

- The Beers Criteria and Older Adults
  - Review the risks and benefits of medications.
  - Use clinical judgement when applying the criteria to individualize the management of each patient.
  - Utilize non-pharmacological measures when appropriate.

American Geriatrics Society 2019 Beers Criteria

American Geriatrics Society Beers Criteria

- A list of medications that are potentially inappropriate medications for older adults.
- The AGS Beers Criteria was created to assist, not challenge clinical decisions.
- It is intended to be utilized with clinical judgement.

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How to use the Beers Criteria

- Medications on the list should be considered possibly inappropriate however not definitely inappropriate.
- Medications on the list may be possibly inappropriate in certain situations. Know the intent of the criteria for appropriate interpretation.
- There is a rationale statement for each criterion on the list. Utilize the criteria as a guide to make decisions.
- Consider non-pharmacological alternatives.

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Myths of the Beers Criteria

- The AGS Beers Criteria is intended as a list of drugs that is always inappropriate in the older adult.

- Any use of medications on the AGS Beers Criteria list is problematic.

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Benefits of the Beers Criteria

- Recognize medications that should possibly be avoided in older adults.
- Allows considerations of why the drug is being taken.
- Provides a guide to be utilized for the older adult.

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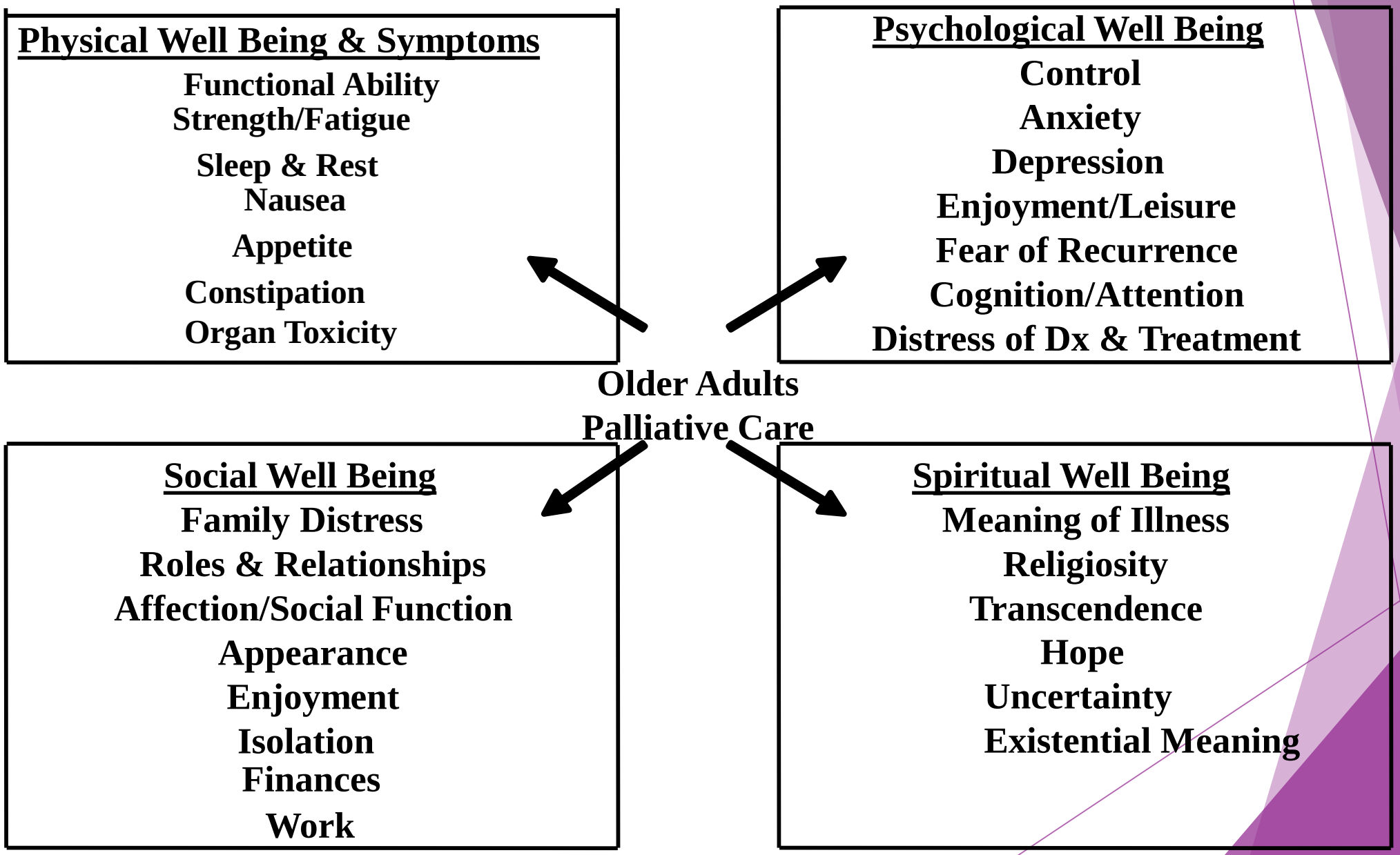
Dimensions of Quality of Life



References

- 2019 AGS Beers Criteria Pocketcard®. American Geriatrics Society, 2019. (Accessed June 28, 2019, 2019, at geriatricscareonline.org.)
- American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.), Arlington, VA: Author.
- Drolet, A., DeJuilio, P., Harkless, S., Henricks, S., Kamin, E., Leddy, E. A., . . . Williams, S. (2013). Move to Improve: The Feasibility of Using an Early Mobility Protocol to Increase Ambulation in the Intensive and Intermediate Care Settings. *Physical Therapy, 93*(2), 197-207.
- Dunne RF, Roussel B, Culakova E, et al. Characterizing cancer cachexia in the geriatric oncology population. Journal of Geriatric Oncology 2019;10:415-9.
- Fick, Donna M., Hodo, Denise M., Lawrence, Frank, & Inouye, Sharon K. (2007). Recognizing delirium superimposed on dementia: assessing nurses' knowledge using case vignettes. *Journal of gerontological nursing, 33*(2), 40-49.
- Inouye, S. M. et al. (2015). Postoperative delirium in older adults: Best practice statement from the American Geriatrics Society. *Journal of the American College of Surgeons, 220*(2), 136–148.e1.
- Katz Indez of Independence in Activities of Daily Living (ADL). The Hartford Institute for Geriatric Nursing, 2019. (Accessed June 24, 2019 2019, at https://consultgeri.org/try-this/general-assessment/issue-2.pdf.)
- Kennedy-Malone, Laurie, Martin-Plank, Lori, & Duffy, Evelyn Groenke. (2019). Palliative Care and End-Of-Life Care. In M. J. Griffith & C. C. Hansen (Eds.), *Advanced Practice Nursing in the Care of Older Adults, 2nd Edition* (pp. 486). Philadelphia, PA: F. A. Davis Company.

References

- Korc-Grodzicki, Beatriz, & Tew, William P. (2017). Cognitive Syndromes and Delirium *Handbook of Geriatric Oncology* (pp. 81-85). New York, NY Springer Publishing Company.
- Messecar, D.C. (2012). Family Caregiving. In M. Boltz, E. Capezuti, T. Fulmer, D. Zwicker (Eds.), *Evidenced-based practice geriatric nursing protocols for best practice*. (p. 324-362). New York (NY): Springer Publishing Company.
- National Comprehensive Cancer Network (NCCN). (2019) Palliative Care Version 2. 2019-June 26, 2019 www.nccn.org
- National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition, 2018. (Accessed June 24, 2019, at https://www.nationalcoalitionhpc.org/ncp.)
- Pashikanti, L., & Von Ah, D. (2012). Impact of early mobilization protocol on the medical-surgical inpatient population: an integrated review of literature. *Clinical Nurse Specialist, 23*(2), 89-94. doi: doi: 10.1097/NUR.0b013e31824590e6.
- The Lawton Instrumental Activities of Daily Living (IADL) Scale. From The Hartford Institute for Geriatric Nursing, New York University Rory Meyers College of Nursing, 2019. (Accessed June 24, 2019, 2019, at https://consultgeri.org/try-this/general-assessment/issue-23.pdf.)
- Timed Up & Go (TUG). Centers for Disease Control and Prevention National Center for Injury Prevention and Control 2017. (Accessed June 24, 2019, 2019, at https://www.cdc.gov/steadi/pdf/TUG_Test-print.pdf.)
- Wykle, May L., & Gueldner, Sarah H. (2011). Preventing Functional Decline in Hospitalized Older Adults- An Exemplar for Nusing Education *Aging Well Gerontological Education for Nurses and Other Health Professionals* (pp. 238-240). Sudbury, MA: Jones & Bartlett Learning.