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

Physical Well Being & Symptoms
- Functional Ability
- Strength/Fatigue
- Sleep & Rest
- Nausea
- Appetite
- Constipation
- Organ Toxicity

Psychological Well Being
- Control
- Anxiety
- Depression
- Enjoyment/Leisure
- Fear of Recurrence
- Cognition/Attention
- Distress of Dx & Treatment

Older Adults

Social Well Being
- Family Distress
- Roles & Relationships
- Affection/Social Function
- Appearance
- Enjoyment
- Isolation
- Finances
- Work

Palliative Care

Spiritual Well Being
- Meaning of Illness
- Religiosity
- Transcendence
- Hope
- Uncertainty
- Existential Meaning
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

[www.consultgeri.org](http://www.consultgeri.org)
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

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

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

www.nccn.org
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.

[www.consultgeri.org](http://www.consultgeri.org)
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
www.consultgeri.com
www.nccn.org
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
www.consultgeri.org
www.nccn.org
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
www.consultgeri.org
www.nccn.org
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 hospitalized 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.

[geriatricscareonline.org](http://geriatricscareonline.org)
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.

geriatricscareonline.org
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.

geriatricscareonline.org
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.

[geriatricscareonline.org]
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