Palliative Care Emergencies:

Do You Know What To Do?

Host: Amanda Tevelde

Presenters: Laura Bates

Lynda Meeks

Date: Thursday, October 24th, 2024

Project ECHO® Palliative Care - Canada BY Pallium Canada

NSMHPCN North Simcoe Muskoka Hospice Palliative Care Network

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

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Introductions

Host and Moderator

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Thank you for joining us today!

Please remember to complete the satisfaction survey following todays session.

Learning Objectives

By the end of the session, participants will be able to:

Describe the most common palliative emergencies.

Know how to prepare other healthcare workers and patient/family when there is a risk for a palliative emergency.

Use both pharmacological and non-pharmacological interventions to handle palliative emergencies.

Palliative Emergencies at the End of Life

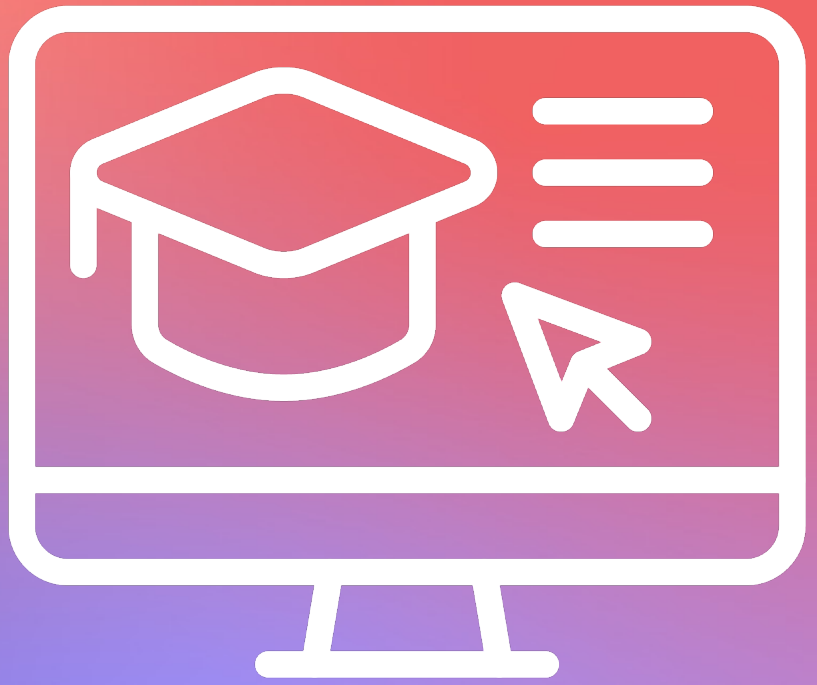
- Palliative emergencies at the end of life are different than other non-palliative emergencies.
- Where death from the emergency is a foreseeable outcome, emergencies will threaten “quality of life” in their remaining time on top of potentially affecting “quantity of life”.
- Timely management of symptoms is critical.

(Oxford Handbook)

When Do Emergencies Occur?

- Palliative emergencies can occur at any time during the illness journey but are more prominent in advance disease states.
- Important to recognize those patients with the potential for an event, the type of event and the possible interventions in case the event does occur.
- Often the health teaching occurs when the disease progresses or if the patient is starting to show some subtle signs (i.e. in the case of a bleed).

TYPES OF PALLIATIVE EMERGENCIES



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Types of Palliative Emergencies

- Airway obstruction
- Airway hemorrhage
- Massive GI (oral and/or rectal) bleed
- Massive bleed from other sources (i.e. wounds or fungating tumors)
- Intractable seizures
- Pulmonary embolism
- Neutropenic sepsis
- Pain crisis
- Spinal cord compression
- Superior Vena Cava syndrome
- Hypercalcemia
- Malignant bowel obstruction

Airway Obstruction Including Severe Dyspnea

Causes:

- Foreign object, food bolus
- Tumour invasion from primary or metastatic sources
- Emboli
- Infections or effusions
- Blood vessel occlusion/encasement
- Pre-existing conditions

Airway Obstruction & Severe Dyspnea Management

- **Non-pharmacological**:
  - Sit at 45◦
  - Open window or fan
  - Meditation/relaxation therapy
  - Humidified air
  - keep staff, family, and patient calm

  Always treat the underlying cause when possible!

- **Pharmacological**:
  - Oxygen for hypoxia only
  - Opioids
  - Bronchodilators for bronchospasm
  - Dexamethasone
  - sedation (discuss early on especially if risk is known)

Massive Hemorrhage

- Life-threatening, condition deteriorates quickly
- Very distressing for the patient, their family and healthcare workers
- Rarity for massive bleeds from an artery that causes a patient to die (terminal hemorrhage)
- Most at risk include:
  - those with advanced cancer (caused by the tumour itself as the cancer spreads into a blood vessel or a vascular fungating wound) or whole body effects from cancer (i.e. impaired blood clotting)
  - liver disease
  - surgery or radiation therapy for head/neck cancers
  - some medications such as NSAIDS, steroids (Dexamethasone) and anticoagulants (Heparin)

Signs and Symptoms

- **Hemoptysis:** coughing up blood
- **Hematemesis:** vomiting up blood
- **Melena:** dark, tarry stools from blood in the GI tract
- **Hematuria:** blood in urine
- Increased amounts of blood from ulcers, tumours or wounds (i.e. increased bleeding with dressing changes)

If a massive bleed, only a few minutes until the patient loses consciousness and is not painful.

Airway Hemorrhage Management

- When a possibility, be aware of the patient's resuscitation status and goals of care and complete education
- Have black towels and disposable pads on hand just in case
- Stay calm and **do not leave** the patient if the massive bleed occurs, explain what is happening and reassure them
- Call for help from other staff
- Call 911 only if patient wants to be resuscitated
- Administer sedation if ordered (some hospitals and hospices have catastrophic event sedation orders)

Other Hemorrhage Management

Non-Pharmacological Management:

- Early identification of those at risk of developing a bleed and preparations done.
- If vomiting blood and conscious, sit upright with a bucket, if unresponsive or goes unresponsive, place in left lateral recumbent position to prevent aspirating blood.
- Use black towels to collect/cover blood on white sheets.
- Advise patient and family this is an emergency that was previously discussed and staff will manage symptoms to ensure patient's comfort.
- If from a wound; apply pressure with gauze (ABD pads) until bleeding stops and inform the most responsible physician or nurse practitioner if bleeding does not stop, utilize pressure dressings and change often.

Pharmacological Management of Hemorrhage

- Midazolam for sedation, dose dependent on degree of symptoms
- If death is not imminent, can try Haldol or Maxeran to assist with upper GI bleeding
- Lorazepam for anxiety
- Breakthrough opioids
- Hold all anticoagulants
- Seek further advice and orders from most responsible physician or nurse practitioner

Intractable Seizures

- Defined as seizures lasting more than 2 minutes
- 1% of pts with cancer
- Causes:
  - Brain tumour (primary or mets) with incidence of 20-50%
  - Existing epilepsy or other seizure disorders
  - Metabolic conditions
  - Medications

Seizure Prevention & Management

- Review resuscitation status and goals of care ahead of time.
- Investigate if the cause is reversible.
- If seizures are caused by a tumour, radiation therapy can be considered as an option.
- Steroids like Dexamethasone to reduce pain and confusion but may help prevent seizures; anti-epileptic medications.
- During a seizure, provide airway support and use Midazolam and/or Lorazepam and in some cases Phenobarbitone.
- Palliative sedation for terminal events.

Neutropenia and Neutropenic Sepsis

- Emergency situation and urgent medical care is required.
- Develops as a reaction to an infection, which can occur in patients with neutropenia which makes it harder for the body to fight infections.
- Patients at risk include those with severe neutropenia or long-term neutropenia, or those who have a fast decline in neutrophil count.
- Causes:
  - bone marrow disorders (i.e. aplastic anemia and myelodysplastic syndromes)
  - treatments that suppress the immune system (i.e. chemotherapy or immunotherapy, post-transplant anti-rejection medications)
  - those who received a stem cell transplant

Signs and Symptoms of Neutropenia

- Remember neutrophils are a type of white blood cell that works as part of the immune system to fight infections.
- Symptoms of concern: fever, fatigue, swollen lymph nodes, malaise, and other typical signs of local or systemic infection.
- Neutropenia with an infection can progress to neutropenic sepsis quickly, so any symptoms of an infection, no matter how vague, need to be investigated.

Pain Crisis

- Can be associated with the terminal diagnosis (cancer, heart disease, COPD, etc.)
- Can be a symptom of a palliative emergency like Spinal Cord Compression
- Can be related to side effects of surgery, radiation or chemotherapy
- Must determine the cause of increased pain – is it a change in condition or under-managed pain?

Pain Crisis Management

- Optimize opioid management, especially short-acting meds
- Use of adjuvant medications (i.e. Gabapentin, Ketamine, Methadone)
- Change the route of medications (i.e. PO to SC), change the medication (i.e. morphine to hydromorphone)
- Non-pharmacological interventions
- Use pain pump instead of s/c injections
- Intrathecal, epidural, nerve blocks procedures
- Palliative sedation as a last resort

Spinal Cord Compression

- MSCC: Metastatic or malignant spinal cord compression is an emergency with urgent medical attention required.
- Tumour damages or presses on nerves in the spinal cord, interrupting the messages travelling up/down the cord.
- Without treatment, symptoms include: weakness and paralysis in legs, decrease or loss of sensation, urinary and/or fecal incontinence and loss of sexual dysfunction.
- Signs and symptoms: back pain, narrow band of pain around chest and/or abdomen, pain spreading down the legs, spine tenderness, leg weakness with difficulty standing or walking, numbness and/or tingling in legs, urinary/fecal incontinence or retention.

Spinal Cord Compression Management

- If suspected call MD, palliative or oncological teams
- Lay the patient flat on their back with no movement until MD notified
- Administer pain relief
- Treatment dependent on the severity and goals of care:
  - Steroids
  - Surgery, radiation
  - OT, PT and social services

Superior Vena Cava Syndrome (SVCS)

- Can be related to external compression, thrombus formation inside or direct invasion of the Superior Vena Cava (SVG) by malignancy.
- Puts the patient at risk for seizures.
- Without treatment, deterioration occurs over days leading to death.
- If the condition is acute the ***symptoms*** are very distressing.
- General symptoms: breathlessness, visual changes, dizziness, headache, swelling (face, neck, arms)
- Signs of **acute distress** of SVCS: periorbital edema, dilated neck veins, dilated chest & arm veins, arm & hand edema, increased respiratory rate, stridor, cyanosis, papilledema

SVCS Management

- **Non-pharmacological management**: remove any restrictive clothing to upper body, place arms on pillows, elevate HOB, review treatment goals, encourage relaxation and provide support
- **Pharmacological management**: oxygen, symptom management (opioid and benzodiazepines for pain, dyspnea and anxiety management), call ASAP for advice and orders; other possible medications could be Lasix to reduce venous return, Dexamethasone to reduce size of tumour
- If a known possibility or condition deteriorates into a catastrophic event, utilize Midazolam 5-10mg S/C q10min PRN or follow your organization's catastrophic event policy and procedures or standing orders

Hypercalcemia

- Requires urgent medical attention
- High level of calcium in the blood which causes changes to the bones
- Most at risk: those with advanced cancer (10-30%), depending on type of cancer (breast, multiple myeloma, lung, kidney)
- Symptoms: weakness, fatigue, feeling generally unwell, high level of thirst and drinking lots, voiding lots, confusion, seizures, loss of appetite, N/V, bone pain, constipation, drowsiness and delirium

Investigations & Treatment of Hypercalcemia

- Bloodwork (if part of goals of care): urea, lytes, eGFR, LFT & Calcium levels
- Treatment depends on timing and goals of care: IVF replacement and bisphosphonates (IV)
- Drinking oral fluids unless there is kidney issues or heart disease
- Increasing mobility if possible
- Discontinuation of calcium supplements

Malignant Bowel Obstruction

- Causes:
  - Intramural, Intraluminal, or Extraluminal
- Types:
  - Mechanical: caused by a physical blockage
  - Functional (paralytic or ileus): caused by a physiological dysfunction in motility
- Symptoms: nausea, vomiting, abdominal distension, abdominal pain (especially colicky), failure to pass feces or flatus
  - The location of the obstruction in the GI tract and whether it is acute/subacute and partial/complete will affect the timeline of onset of symptoms and when vomiting occurs
- If untreated, can lead to bowel ischemia and perforation

Malignant Bowel Obstruction Investigations and Treatment

- Bloodwork, plain film radiography, contrast studies, CT scan, complete history and physical examination
- Must determine: mechanical vs. functional, partial vs. incomplete, at what level is the obstruction, what are the causes, reversible or irreversible, and surgical candidate or medical management
- Medical management: NPO (or PO intake as tolerated), change routes of medications, stop laxatives/prokinetic medications if complete obstruction, symptom management for pain/nausea, add antisecretory agent (Octreotide), corticosteroids, anticholinergic agents, and consider hyoscine butylbromide for severe colic pain
- If earlier in illness trajectory or within goals of care, may consider NG tube, IV hydration, colonoscopic decompression, venting PEG tube

BEING PREPARED

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Who is at Risk for a Palliative Emergency?

- Anyone with advanced disease.
- Uncontrolled or poorly managed symptoms.
- Those already at risk for delirium.
- Experiencing side effects or adverse reactions to medications.
- Those who have had certain treatments (i.e. chemotherapy, surgery, radiation).

Being Prepared For a Palliative Emergency

- Understanding who is at risk and reassessing the risk level as their condition changes.
- Knowing the patient's resuscitation status and goals of care.
- Education to family and caregivers on the possible type of event, interventions for before and during the emergency and aftercare.
- Knowing whom to call if an emergency occurs.
- Being clear about what your role is during an emergency

Palliative Emergencies in the Home or Retirement Home

- Home care nurses and PSWs should be aware of the risk of predicting an emergency in addition to what to do in the event one happens.
- Health teaching to the patient and family on signs and symptoms to look out for, preparedness and what to do/who to call if it occurs.
- Informing the care team and MD if any signs are developing like bloody sputum, malignant wounds that are now bleeding, etc.
- SRK in the home with Midazolam in pre-filled syringes if the patient is showing signs of an approaching event.

Palliative Emergencies in the Hospital

- Education to all healthcare workers on the different types, symptoms and management options for those palliative/EOL patients who are at risk for a catastrophic event.
- Supplies and medications are ordered and on stand-by for easy and fast access.
- Health teaching to patient and family.
- Documenting resuscitation status and goals of care.
- Ensuring resuscitation status, goals of care, and risk level are communicated to all on the care team.

Palliative Emergencies in Hospice

- Education for all staff and their roles during an emergency.
- Health teaching to patient and family.
- Ensuring your hospice has standing orders for catastrophic events.
- Having an exsanguination kit prepared and in the room.
- Pre-filling midazolam syringes.
- Communicating risk level and goals of care to all on the care team.

Palliative Emergencies in LTC

- DNR status and Goals of Care conversations are had with the resident and family.
- Education for all staff.
- Emergency kits are available on each unit or one placed in the room of a high-risk resident.
- PRN order for Midazolam for those high-risk residents already showing signs of an event (i.e. bloody sputum or bleeding wounds).
- Communication shift to shift of signs and action plan.

Educating Patient and Family

- Type of potential emergency based on diagnosis or signs and symptoms the person may be experiencing.
- Reminding them a palliative emergency is rare but it is better to be prepared for it.
- If a pt is at risk of bleeding, early preparedness like getting dark linens/towels gathered is essential.
- If an issue arises call their home care nurse, MD/NP, or help from other staff for support, not 911 (unless resuscitation or going to hospital is a part of the goals of care).
- Utilize ordered medications, making sure they understand why, when and how to use them (if at home or in a Retirement Home).

The Role of the PSW During a Palliative Emergency

- If the PSW is the first person to come upon a patient in distress, they are not to leave the patient but alert other staff via the call button or call out into the hallway.
- **Remain calm,** speak in a calm tone of voice, and reassure the patient they will not be left alone at any time.
- Depending on the emergency, the PSW can grab the exsanguination kit from the closet in the room and place black towels or the basin, etc.
- Continue to support the patient while the Nurse is giving medications.
- Call for extra support as needed from other staff.
- Assist with room and patient cleanup after the event.

The Role of the Nurse During a Palliative Emergency

- If the Nurse is the first person to come upon a patient in distress, they are not to leave the patient but alert other staff via a call button or call out into the hallway.
- Remain calm and stay with the patient until extra help arrives.
- Direct other care staff on what to do, do not leave the patient to retrieve medications unless necessary.
- Give appropriate s/c medications necessary for symptom management and utilize catastrophic event sedation orders if appropriate.
- Health teaching for patient and family (if present).
- Support all those involved in the event, and consider a clinical de-brief session.
- Documentation of event.

General Pharmacological Management of a Palliative Emergency

- Utilize a Standard Order For Catastrophic Event (i.e. Midazolam 5-10 mg S/C q10 min or your facility's appropriate orders) if catastrophic and sedation is required

- Other S/C medications for symptom management:
  - Opioids: as already ordered for pain and/or dyspnea
  - Scopolamine/Glycopyrrolate: secretions
  - Methotrimeprazine/Lorazepam: additional sedation, helpful with dyspnea and pain
  - Haloperidol/Metoclopramide: nausea & vomiting
  - Midazolam/Lorazepam: seizures

**** Call MD for advice and additional orders for ongoing symptom management****

General Non-Pharmacological Management of an Emergency

- Suction: oral secretions only
- Positioning: for airway or gastric secretions, lay the patient in the left lateral position (recovery position), can also be put in Trendelenburg to assist with drainage
- Wound care: if it is a hemorrhaging wound, have compress bandages (or thick piles of gauze) readily available and compress the wound until help arrives
- Emotional support: be calm and reassuring, explain what is happening, the interventions that will be used and answer questions

****The patient's comfort is the priority but support to the family is required as well****

What to Say During a Palliative Emergency

- Never leave the patient alone during a catastrophic event (use the staff call button or look into the hallway).
- Remain calm and speak in a calm and reassuring/comforting tone.
- “I’m here with you and I will not leave” and “Is there anything specific I can do for you right now?”
- Use of silence and physical touch as appropriate (tell the patient to pull away if they don’t want you to hold their hand).
- Explaining what is happening to the patient and family.
- Ask if they wish to use music, reduction of lights during this event, or have people close/give them more physical space.

Supporting the Family

- In some circumstances, the family is fully aware ahead of time of the risk of a catastrophic event and what it entails.
- Allow family to stay or leave during the event, reassure them their loved one will be well taken care of, and that the patient will receive sedation/symptom management medication until comfortable but may also die during the event.
- Explain what and why you are completing each intervention and answer their questions.
- Ensure the family is supported after the event no matter the outcome.
- If the palliative emergency results in death (often the case especially in airway obstruction, seizures and terminal bleeds), encourage the family to seek additional ongoing support.

After the Event

- Physical clean up of the body (bathing and re-dressing).
- Physical clean-up of the room and/or bed.
- Use appropriate waste bags for disposable items and laundry that will be discarded.
- Allow family to return to room if they wish to do so.
- Informing the family of grief and bereavement support available.
- Staff should ask for a debrief of the event, utilize their EAP, and/or seek support from their own support systems.

Post-Event Debriefing

- Discuss with the supervisor/manager if you need a one-to-one debrief.
- Request a clinical debrief including those involved with the event as well as other staff to use as a learning opportunity.
- Debriefing involves discussing key points of the event, what went well and what didn't, what can be improved on for next time, further education, and a discussion of the emotional/mental results on staff present for the emergency.

CASE STUDY

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Case Study #1

- 39 y/o female with a terminal diagnosis of liver cirrhosis and esophageal varices along with a large gastric ulcer that bleeding
- Unable to cauterize bleeding varices (previous banding done)
- Currently in ICU with intermittent bloody emesis, abdominal pain and constant nausea
- Hbg 56 after 2 transfusions of PRBCs and 6 units of FFP
- No change in condition, DNR now has been obtained
- Current treatment: 02 @ 3L/min via NP, continuous Pantoloc infusion via IV, 2-4 PRBCs daily and FFP based on bloodwork, N/S via IV @ 200cc/hr to maintain BP

Case Study #1

- Is a hemorrhagic bleed the only palliative emergency she is at risk for?
- Besides the DNR order, what else should be discussed with the patient and family/SDM?
- What information does the patient and family need to know in case of a catastrophic event?
- Is there any orders the nurses will need to adequately manage these potential emergencies?

Case Study #2

- 79 y/o male with a history of lung cancer with tumour progression in his trachea
- At a residential hospice for EOL care due to distressing dyspnea and pain
- Current treatment: palliative sedation (for the dyspnea) with a continuous Midazolam S/C infusion of 3mg/hr with bolus of 1mg q20min PRN for breakthrough dyspnea or pain and Hydromorphone 2-3mg S/C q4hrs routinely with 2mg S/C q2hr PRN for breakthrough dyspnea or pain
    - **Sedation to RASS of -4 to -5 was obtained as ordered with this treatment**
- The w ife was at bedside quietly reading when suddenly at 0200 the patient awoke in severe respiratory distress, gasping with a frightened/anxious look in his eyes, causing her to panic and yell for help

Case Study #2

- This patient already has a Midazolam pump in place for palliative sedation, what do you do now to alleviate this distress?
- How do you calm the patient and his wife at the same time when minimal staff is present in hospice? (RN and PSW only on nights)
- What should be done after the patient dies?

Case Study #3

- 82 -year- old male with a history of cancer of the larynx who has an existing trach opening with no ventilator support required
- At home for EOL care, daily nursing visits
- The patient self-suctions with a yankauer in his tracheostomy opening to help expel thick mucous from the orifice, no reported issues with bleeding until Tuesday, he says there have been a few streaks of red blood in the mucous.
- Health teaching was done by the RN on Tuesday for a rare but high risk of a bleed from his airway, the patient is understanding of this risk and made aware of the course of action should he experience this, plan of what family are to do is started.
- 2 days later (Thursday), the patient was completing the self-suction per his usual routine and suddenly experienced copious frank red bleeding in front of his son and grandchild while the nurse wa s in the home
- The patient and son panic.

Case Study #3

- What are all of the possible catastrophic event(s) is this man at risk for and what are the possible causes?
- What is the nurse's responsibility?
- What should be done in regard to the son and young grandchild?
- What if it had been the PSW in the home at this time?
- What if the family had been alone at this time?
- What are the goals of care or intent of interventions in this scenario?

References/Resources

- Oxford Handbook of Palliative Care, 3rd edition; Oxford University Press
- Marie Curie: Recognizing emergencies in Palliative Care from https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/recognizing-emergencies/
- Pallium Canada: The Pallium Palliative Pocketbook, 2nd edition, 4th printing, 2020
- University of Alberta, Alberta Health Services, Emergencies in Palliative Care by Dr. Ingrid de Kock

Questions?

We hope you enjoyed todays session. Please remember to complete the satisfaction survey.