End of Life Care
Current Awareness Bulletin
November 2019

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Title: Volunteers in a biography project with palliative care patients – a feasibility study.

Citation: BMC Palliative Care; Oct 2019; vol. 18 (no. 1)
Author(s): Hesse, Michaela; Forstmeier, Simon; Cuhls, Henning; Radbruch, Lukas

Background: Increasing the quality of life with short interventions for vulnerable patients is one of the objectives of palliative care. Biographical approaches are used in a range of different interventions which may require considerable resources of staff time and energy. This study evaluated the feasibility of training hospice volunteers in biographical interviews of patients confronted with a life-limiting disease. For the purpose of this study, we evaluated resources such as time needed for training, coordination and supervision, outcome such as completion of the intervention in appropriate time and risks such as causing distress in patients or volunteers as major determinants of feasibility.

Methods: Nine volunteers from a hospice service attended an advanced training with an introduction to palliative care, biography work, interview techniques, transcribing and writing. Volunteers interviewed a patient and developed a written narrative from the interview. Volunteers completed a questionnaire before training and were interviewed at the end of the project. The interviews were audiotaped, transcribed, and evaluated using descriptive and qualitative content analysis.

Results: Patients provided positive feedback from the intervention. Volunteers felt that their involvement was personally rewarding and were moved by the courage and confidence of the patients. There were no systematic problems or negative experiences reported neither by volunteers nor by patients.

Conclusions: We found the use of volunteers for biography work with patients in palliative care feasible and effective in this study. Volunteers needed supervision and ongoing support in providing this intervention.

Title: Behind the doors of home hospice patients: A secondary qualitative analysis of hospice nurse communication with patients and families

Citation: Palliative & Supportive Care; Oct 2019; vol. 17 (no. 5); p. 579
Author(s): Debra Parker Oliver; Tappana, Jessica; Washington, Karla T; Rolbiecki, Abigail; Craig, Kevin; Demiris, George; Schafer, Collyn; Winjobi, Mumeenat; Clayton, Margaret F; Reblin, Maija; Ellington, Lee

Objective: Hospice nurses frequently encounter patients and families under tremendous emotional distress, yet the communication techniques they use in emotionally charged situations have rarely been investigated. In this study, researchers sought to examine hospice nurses’ use of validation communication techniques, which have been shown in prior research to be effective in supporting individuals experiencing emotional distress.

Method: Researchers performed a directed content analysis of audiorecordings of 65 hospice nurses’ home visits by identifying instances when nurses used validation communication techniques and rating the level of complexity of those techniques.

Result: All nurses used validation communication techniques at least once during their home visits. Use of lower level (i.e., more basic) techniques was more common than use of higher level (i.e., more complex) techniques.

Significance of Results: Although hospice nurses appear to use basic validation techniques naturally, benefit may be found in the use of higher level techniques, which have
been shown to result in improved clinical outcomes in other settings.

Title: Addressing cancer patient and caregiver role transitions during home hospice nursing care

Citation: Palliative & Supportive Care; Oct 2019; vol. 17 (no. 5); p. 523
Author(s): Hudson, Janella; Reblin, Maija; Clayton, Margaret F; Ellington, Lee

Objective: Many family caregivers and hospice patients experience role changes resulting from advancing illness and the need for increased caregiver responsibility. Successful navigation of conflicts that arise because of these role transitions has been linked to higher quality of patient care and improved caregiver bereavement adjustment. Nursing communication with patients and their caregivers plays an important role in facilitating these transitions. Our objective is to describe patient-caregiver-nurse communication during transitions at end of life.

Method: A secondary, qualitative analysis was conducted on transcripts. Using an iterative process of constant comparison, coders inductively categorized nurse, caregiver, and patient communication behavior into overarching themes. Participants were home hospice nurses and cancer patient/spouse caregiver dyads; participants were >45 years of age, English speaking, and cognitively able to participate. Research took place in the home during nurse visits.

Result: Nineteen unique home hospice visits were analyzed. Patient-caregiver conflict occurred in two major content themes (1) negotiating transitions in patient independence and (2) navigating caregiver/patient emotions (e.g., frustration, sadness). Nurse responses to transition conflict included problem-solving, mediating, or facilitating discussions about conflicts. Nurse responses to emotional conflict included validation and reassurance.

Significance of Results: Our findings provide insight into the topics and processes involved in patient and caregiver transitions in home hospice and the role hospice nursing communication plays in mediating potential conflict. Nurses are often asked to take on the role of mediator, often with little conflict resolution communication education; results can be used for nursing education.

Title: Use of Auditing and Feedback in an Outpatient Hospice Setting: Quality and Pharmacoeconomic Oversight

Citation: Journal of Pain and Symptom Management; Oct 2019; vol. 58 (no. 4); p. 690
Author(s): Kestenbaum, Matthew G, MD; Harrison, Krista, PhD; Masi, Domitilla, MS; Kuhl, Emily A, PhD; Muir, J Cameron, MD

Background: Clinicians play an important role in containing pharmaceutical spending at the patient level, as well as ensuring efficacy and quality outcomes, yet little research has examined how to achieve this goal.

Measures: Using auditing and feedback (A&F) as part of a Pharmacy and Therapeutics (P&T) Committee, we evaluated our community-based hospice program’s prescribing habits for opioids, antipsychotics, and antidepressants and calculated oral pharmaceutical prescription costs per-patient-day. Quality of care was reflected by patient pain scores in electronic medical records.
**Intervention:** Our P&T Committee adopted an A&F approach to monitor and assess provider prescribing habits and cost. An already-existing pain quality improvement program assessed care quality.

**Outcomes:** Pain relief either improved or was maintained while medication costs were reduced by over $1.00 per-patient-day from 2010 to 2011.

**Conclusions/Lessons:** Learned An active, hospice P&T Committee featuring A&F can significantly affect medication costs for a hospice program while maintaining or improving patient outcomes.

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**Title:** A Comparison of Rural and Urban Hospice Family Caregivers’ Cancer Pain Knowledge and Experience

**Citation:** Journal of Pain and Symptom Management; Oct 2019; vol. 58 (no. 4); p. 685

**Author(s):** Washington, Karla T, PhD; Oliver, Debra Parker, PhD; Smith, Jamie B, MA; Kruse, Robin L, PhD; Meghani, Salimah H, PhD; Demiris, George, PhD

**Context:** Family caregivers play a vital role in managing the pain of hospice patients with cancer; however, caregivers' knowledge of pain management principles and experiences as pain managers vary widely. Differences in cultural values and access to resources suggest that rural and urban hospice family caregivers may differ with regard to their pain knowledge and experience, but this has not been empirically investigated.

**Objectives:** We sought to determine if rural and urban hospice family caregivers differed in terms of their knowledge of cancer pain management principles and their experiences managing cancer pain.

**Methods:** Our study consisted of a secondary analysis of baseline, cross-sectional data from hospice family caregivers (N = 196) participating in an ongoing cluster randomized crossover pragmatic trial. We performed multivariable regression to model associations between caregivers' demographic characteristics and their scores on the Family Pain Questionnaire (FPQ), which included subscales measuring pain knowledge and experience.

**Results:** When controlling for other demographic variables, rural caregivers' scores on the FPQ knowledge subscale were worse (P = 0.01) than their urban counterparts. FPQ experience subscale scores and FPQ total scores were not statistically significantly different between the two groups.

**Conclusion:** Rural hospice family caregivers report greater pain knowledge deficits than urban hospice family caregivers, although the two groups report comparable pain management experiences. Additional research is needed to better explain observed differences.

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**Title:** Quality improvement in hospice settings: perceptions of leaders

**Citation:** International Journal of Health Care Quality Assurance; 2019; vol. 32 (no. 7); p. 1098-1112

**Author(s):** Singh, Jitendra; Sillerud, Brandi; Omar, Marah

**Purpose:** The purpose of this paper is to explore and examine attitudes and perceptions of leaders on application of quality improvement (QI) strategies in a palliative and hospice care organization.

**Design/Methodology/Approach:** This study employed qualitative research methodology where leaders working in a hospice and palliative care organization were invited to
participate in 45–60-min-long semi-structured interview. Interviews were recorded and transcribed verbatim. Qualitative content analysis was utilized to analyze the data collected during participant interviews.

**Findings:** Seven leaders participated in the interviews. Five themes were developed from data analysis: patient-centered care; continuous QI; leadership involvement and commitment; communication as a foundation for QI; and perceived barriers. Data analysis suggests that use of QI approach in palliative and hospice care enhances the quality of care provided for patients, and can help improve patient satisfaction.

**Practical Implications:** Because there is a paucity of research on implementation of QI strategies in hospice and palliative care settings, this research can have wide practical implications. This research can provide useful practical tips to leaders as they work on implementing QI projects in their organization.

**Originality/Value:** This manuscript can be of value to leaders, administrators and academicians who are interested in applying QI principles to healthcare processes especially in palliative and hospice care settings. Ability to work with others, solid communication and involvement of employees from all levels can help in streamlining current systems of care.

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**Title:** Informal Caregivers’ Perceptions of Needs From Hospice Providers: An Integrative Review.

**Citation:** American Journal of Hospice & Palliative Medicine; Dec 2019; vol. 36 (no. 12); p. 1114-1123

**Author(s):** Engbers, Ruth Anne

**Introduction:** In the United States, informal caregivers (ICs) provide care to over 70% of patients at the end of life. Approximately 500,000 ICs contribute to the end-of-life care for patients in the United Kingdom. Hospice care is expanding worldwide to meet the needs of these ICs. Because ICs play an instrumental role in the provision of hospice services, and their perspective of their needs of formal services requires further clarity, the purpose of this review is to synthesize research that elucidates perceptions of ICs regarding their experiences with hospice providers.

**Methods:** Twelve research studies regarding perceptions of informal hospice caregivers were obtained by searching CINAHL, PsycINFO, and MEDLINE databases.

**Results:** Four primary themes emerged that describe what ICs perceive as beneficial contributions of hospice providers in aiding their caregiving: providing easy access to desired care, building up the caregiver, forming a relationship, and utilizing culturally relevant interpersonal skills.

**Conclusion:** Particular attention must be paid to ensuring that the IC is acknowledged as an expert part of the team. Clearly explaining available services, creating better ways to ease the IC’s transition from caregiving to bereavement, and recruiting minority hospice providers are other important efforts that could improve the caregiving experience. The needs of ICs are complex, but by listening to their perspective, we can begin to clarify the best ways to aid them in their difficult job.

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**Title:** Patients’ Needs Regarding Anxiety Management in Palliative Cancer Care: A Qualitative Study in a Hospice Setting.

**Citation:** American Journal of Hospice & Palliative Medicine; Nov 2019; vol. 36 (no. 11); p. 947-954
Author(s): Zweers, Danielle; de Graeff, Alexander; Duijn, Jette; de Graaf, Everlien; Witteveen, Petronella O.; Teunissen, Saskia C. C. M.

Introduction: Anxiety is a common symptom in the palliative phase, and symptom management depends on the competencies of individual professionals. This study aims to get insight into the needs of anxious hospice patients with advanced cancer regarding support.

Method: Semi-structured interviews were performed in admitted hospice patients with cancer. Patients admitted from May 2017 till May 2018 were eligible whether or not they were anxious. Interviews were analyzed and coded within predefined topics.

Results: Fourteen patients were included: 10 females, median age 71, and median World Health Organization performance score 3. Most patients were highly educated. Thirteen patients were interviewed within 6 months before death. Information, open communication, sense of control, safety, adequate symptom management, and respect for patients' coping strategy were the 6 main expressed needs.

Conclusion: Assessing patients' needs regarding anxiety provided important angles where health-care professionals can make a difference in order to support anxious patients in their final stage of life to realize tailored palliative care. Future research should focus on the development of a systematic approach for health-care professionals to manage anxiety in daily care of terminal patients.

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Title: The Impact of Advance Care Planning on End-of-Life Care: Do the Type and Timing Make a Difference for Patients With Advanced Cancer Referred to Hospice?

Citation: The American journal of hospice & palliative care; Dec 2019; vol. 36 (no. 12); p. 1089-1095

Author(s): Prater, Laura C; Wickizer, Thomas; Bower, Julie K; Bose-Brill, Seuli

Purpose: This study aimed to determine the impact of advanced care planning (ACP) on potentially avoidable hospital admissions at the end of life (EOL) among a sample of hospice-referred patients with cancer, in order to present actionable considerations for the practicing clinician.

Methods: This study was designed as a retrospective cohort using electronic health record data that assessed likelihood of hospital admissions in the last 30 days of life for 1185 patients with a primary diagnosis of cancer, referred to hospice between January 1, 2014, and December 31, 2015, at a large academic medical center. Inverse probability treatment weighting based on calculated propensity scores balanced measured covariates between those with and without ACP at baseline. Odds ratios (ORs) were calculated from estimated potential outcome means for the impact of ACP on admissions in the last 30 days of life.

Results: A verified do-not-resuscitate (DNR) order prior to the last 30 days of life was associated with reduced odds of admission compared to those without a DNR (OR = 0.30; P < .001). An ACP note in the problem list prior to the last 30 days of life was associated with reduced odds of admission compared to those without an ACP note (OR = 0.71, P = .042), and further reduced odds if done 6 months prior to death (OR = 0.35, P < .001).

Conclusions: This study shows that dedicated ACP documentation is associated with fewer admissions in the last 30 days of life for patients with advanced cancer referred to hospice. Improving ACP processes prior to hospice referral holds promise for reducing EOL admissions.

Title: Outcomes and Cost of Patients With Terminal Cancer Admitted to Acute Care in the Final 2 Weeks of Life: A Retrospective Chart Review.

Citation: The American journal of hospice & palliative care; Nov 2019; vol. 36 (no. 11); p. 1020-1025

Author(s): Kyeremanteng, Kwadwo; Ismail, Abid; Wan, Cynthia; Thavorn, Kednapa; D'Egidio, Gianni

Background: Patients with terminal conditions are often admitted to the emergency department (ED) for acute medical services, but studies have suggested that multiple ED admissions may negatively impact end-of-life (EOL) care. Research have shown that incorporating palliative care (PC) is integral to optimal EOL care, but it is an aspect of medical practice that is often neglected. The current study sought to provide an overview of health outcomes and hospital costs of patients with cancer admitted to The Ottawa Hospital and/or received acute medical services during their final 2 weeks of life. Cost comparisons and estimates were made between hospital and hospice expenditures.

Methods: We conducted a retrospective chart review of palliative patients who died at The Ottawa Hospital in 2012. A total of 130 patients who visited the ED within 2 weeks of death were included in the analyses.

Results: In this cohort of patients, 71% of admitted patients did not have advanced care directives and 85% experienced a metastasis, but only 18% had a PC medical doctor.
Patients were hospitalized, on average, for 7 days and hospitalization costs exceeded the estimated hospice cost by approximately 2.5 times (Can$1 041 170.00 at Can$8009.00/patient vs Can$401 570.00 at Can$3089.00/patient, respectively).

**Conclusion:** Our study highlighted the importance of PC integration in high-risk patients, such as those in oncology. Patients in our sample had minimal PC involvement, low advanced care directives, and accrued high costs. Based on our analyses, we concluded that these patients would have likely benefited more from hospice care rather than hospitalization.

**Title:** Elements of Palliative Care in the Last 6 Months of Life: Frequency, Predictors, and Timing.

**Citation:** Journal of general internal medicine; Oct 2019

**Author(s):** Ernecoff, Natalie C; Wessell, Kathryn L; Hanson, Laura C; Dusetzina, Stacie B; Shea, Christopher M; Weinberger, Morris; Bennett, Antonia V

**Importance:** Persons living with serious illness often need skilled symptom management, communication, and spiritual support. Palliative care addresses these needs and may be delivered by either specialists or clinicians trained in other fields. It is important to understand core elements of palliative care to best provide patient-centered care.

**Objective:** To describe frequency, predictors, and timing of core elements of palliative care during the last 6 months of life.

**Design:** Retrospective chart review.

**Setting:** Inpatient academic medical center.

**Participants:** Decedents with cancer, dementia, or chronic kidney disease (CKD) admitted during the 6 months preceding death.

**Exposures:** We identified receipt and timing of core elements of palliative care: pain and symptom management, goals of care, spiritual care; and specialty palliative care utilization; hospital encounters; demographics; and comorbid diagnoses. We ran Poisson regression models to assess whether diagnosis or hospital encounters were associated with core elements of palliative care.

**Results:** Among 402 decedents, the mean (SD) number of appropriately screened and treated symptoms was 2.9 (1.7)/10. Among 76.1% with documented goals of care, 58.0% had a primary goal of comfort; 55.0% had documented spiritual care. In multivariable models, compared with decedents with cancer, those with dementia or CKD were less likely to have pain and symptom management (respectively, 31% (incidence rate ratio [IRR], 0.69; 95% CI, 0.56-0.85) and 17% (IRR, 0.83; CI, 0.71-0.97)). There was a median of 3 days (IQR, 0-173) between transition to a goal of comfort and death, and a median of 12 days (IQR, 5-47) between hospice referral and death.

**Conclusions and relevance:** Although a high proportion of patients received elements of palliative care, transitions to a goal of comfort or hospice happened very near death. Palliative care delivery can be improved by systematizing existing mechanisms, including prompts for earlier goals-of-care discussion, symptom screening, and spiritual care, and by building collaboration between primary and specialty palliative care services.

**Title:** Palliative and Hospice Care in Correctional Facilities: Integrating a Family Nursing Approach to Address Relational Barriers.

**Citation:** Cancer nursing; Oct 2019
**Author(s):** Burles, Meridith; Holtslander, Lorraine; Peternelj-Taylor, Cindy

**Background:** The need for palliative and hospice care for persons with life-limiting conditions who are incarcerated is increasingly common in correctional facilities worldwide.

**Objective:** Through a family nursing lens, we critically analyze the unique challenges experienced by those requiring palliative care while incarcerated. Key concerns and implications for nursing are illustrated through the discussion of a representative case scenario.

**Methods:** The case scenario was developed based on the findings of a scoping review of academic and gray literature (such as policy documents and editorials) about palliative, hospice, and end-of-life care in corrections.

**Results:** The case scenario highlights multilevel barriers that were identified, including the individual, relational, institutional, and sociocultural contexts of palliative care in correctional facilities. Evidence is presented of how integration of a family nursing perspective can enhance specialized palliative and hospice care services in correctional settings.

**Conclusions:** By applying a family nursing approach, nurses practicing with correctional populations can ensure persons with life-limiting illnesses are not denied their right to appropriate end-of-life care by playing a key role in addressing barriers to palliative and hospice care access in corrections. Specific attention to relational issues and holistic care can contribute to enhanced palliative and hospice care, greater dignity in dying, and improved family and peer outcomes, which have benefits for individuals, families, communities, and society.

**Implications for practice:** Through the case scenario, we illustrate real issues emerging in correctional contexts and offer evidence of how family nursing relational principles can be applied to promote adequate palliative and hospice care.

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**Title:** Cancer Pain Social Processes and Pain Management in Home Hospice Care.

**Citation:** Pain management nursing : official journal of the American Society of Pain Management Nurses; Oct 2019

**Author(s):** Ehrlich, Olga; Walker, Rachel K; Jacelon, Cynthia S

**Background:** The high incidence of pain associated with end-stage cancers indicates the need for a new approach to understanding how and why patients, caregivers, and clinicians make pain management choices.

**Aims:** To provide pilot data and preliminary categories for developing a middle-range nursing theory and framework through which to scrutinize and identify problematic processes involved in management of poorly controlled pain for home hospice patients, caregivers, and nurses, the "caring triad."

**Design:** A qualitative pilot study using constructivist grounded theory methodology to answer the question, "In the context of hospice, what are the social processes occurring for and between each member of the hospice caring triad and how can these processes be categorized?"

**Settings:** Home hospice care.

**Participants/subjects:** Hospice patients experiencing cancer pain, family caregivers, hospice nurses.

**Methods:** From a sample of triads including hospice patients, caregivers and nurses, data were collected at observational visits, individual interviews, and a focus group over the
course of each triad’s study involvement. We used recursive coding processes to interpret data.

Results: Three preliminary categories of social processes were identified: Pain Meaning, Working Toward Comfort, and Bridging Pain; and six subcategories: perceiving pain and discomfort, knowing what to do, planning activities, negotiating a pain plan, talking about pain, and being together in pain.

Conclusions: As illustrated in the caring triad cases presented, this study moved the management approach of pain from a dichotomous realm of nurse-patient, to the more naturalistic realm for home hospice of nurse-patient-caregiver. In analyzing social processes within and across triad members, we identified categories of impact to target assessment, intervention, and education to improve pain outcomes.

Title: Multi-dimensional approach to end-of-life care: The Welfare Model

Citation: Nursing Ethics; Nov 2019; vol. 26 (no. 7-8); p. 1955
Author(s): Sim Shin Wei; Soh Tze Ling Gwendoline Beatrice; Radha Krishna Lalit Kumar

Abstract: Appropriate and balanced decision-making is sentinel to goal setting and the provision of appropriate clinical care that are attuned to preserving the best interests of the patient. Current family-led decision-making in family-centric societies such as those in Singapore and other countries in East Asia are believed to compromise these objectives in favor of protecting familial interests. Redressing these skewed clinical practices employing autonomy-based patient-centric approaches however have been found wanting in their failure to contend with wider sociocultural considerations that impact care determinations. Evaluation of a number of alternative decision-making frameworks set out to address the shortcomings of prevailing atomistic and family-centric decision-making models within the confines of end-of-life care prove these alternative frameworks to be little better at protecting the best interests of vulnerable patients. As a result, we propose the Welfare Model that we believe is attentive to the relevant socio-culturally significant considerations of a particular case and better meets the needs of end-of-life care goals of preserving the welfare of patients. Employing a multi-professional team evaluation guided by regnant psychosocial, legal, and clinical standards and the prevailing practical and clinical realities of the particular patient’s setting the Welfare Model provides a clinically relevant, culturally sensitive, transparent, and evidence-based approach to care determinations.

Title: Advance care planning for older people: The influence of ethnicity, religiosity, spirituality and health literacy

Citation: Nursing Ethics; Nov 2019; vol. 26 (no. 7-8); p. 1946
Author(s): de Vries Kay; Banister, Elizabeth; Dening Karen Harrison; Ochieng Bertha

Abstract: In this discussion paper we consider the influence of ethnicity, religiosity, spirituality and health literacy on Advance Care Planning for older people. Older people from cultural and ethnic minorities have low access to palliative or end-of-life care and there is poor uptake of advance care planning by this group across a number of countries where advance care planning is promoted. For many, religiosity, spirituality and health literacy are significant factors that influence how they make end-of-life decisions. Health literacy issues have been identified as one of the main reasons for a communication gaps between physicians and their patients in discussing end-of-life care, where poor health literacy, particularly specific difficulty with written and oral communication often limits their
understanding of clinical terms such as diagnoses and prognoses. This then contributes to health inequalities given it impacts on their ability to use their moral agency to make appropriate decisions about end-of-life care and complete their Advance Care Plans. Currently, strategies to promote advance care planning seem to overlook engagement with religious communities. Consequently, policy makers, nurses, medical professions, social workers and even educators continue to shape advance care planning programmes within the context of a medical model. The ethical principle of justice is a useful approach to responding to inequities and to promote older peoples’ ability to enact moral agency in making such decisions.

**Title:** Deprescribing in end-of-life care.

**Citation:** British Journal of Community Nursing; Oct 2019; vol. 24 (no. 10); p. 474-477

**Author(s):** Gardner, Emma

**Abstract:** The aim of deprescribing in end-of-life care is to improve the patient's quality of life by reducing their drug burden. It is essential to engage the patients and enable them to make choices about medications by discussing their preferences and implement a pharmacy management plan. Withdrawing medications during the end stages of life is extremely complex because the period of care varies substantially. The aim of this article is to address polypharmacy within end-of-life care. It will review which medications should be stopped by examining the non-essential and essential drugs. The intention is to encourage an approach to care which provides an equal balance between treatment and patient expectation.

**Title:** What do relatives value most in end-of-life care for people with dementia?

**Citation:** International Journal of Palliative Nursing; Sep 2019; vol. 25 (no. 9); p. 432-442

**Author(s):** Bolt, Sascha; van der Steen, Jenny; Schols, Jos; Zwakhalen, Sandra; Meijers, Judith

**Background:** End-of-life care for older people with dementia is often sub-optimal. Understanding the experiences of the relatives involved in the care of the person with dementia may help to improve care practice.

**Aims:** To investigate relatives’ experiences with end-of-life care for people with dementia, comparing the nursing home and home setting.

**Methods:** In-depth interviews were conducted with 32 individuals who were bereaved of someone with dementia. Thematic analysis was performed to identify main themes from the data.

**Findings:** Experiences translated into four themes: acknowledging human dignity; being recognised as an important caregiver; (not) talking about death and dying and making decisions together. A lack of person-centered care was mainly evident in nursing homes. Relatives took on a more prominent role in the care of the older person with dementia when the relative was cared for in a home setting and this involvement in the care of the older person was something that the relatives valued. Surrogate decision-making induced similar challenges in both settings.

**Conclusion:** It is important that healthcare professionals inform and support relatives to help them make decision about end-of-life care and preferences. Nursing homes should learn to offer the same standard of person-centred care as a home care setting, and ensure that relatives are still involved in the care of the person with dementia.
Title: How to help researchers in palliative care improve responsiveness to migrants and other underrepresented populations: developing and testing a self-assessment instrument.

Citation: BMC Palliative Care; Oct 2019; vol. 18 (no. 1)
Author(s): Torensma, M.; Onwuteaka-Philipsen, B. D.; Strackee, K. L.; Oosterveld-Vlug, M. G.; de Voogd, X.; Willems, D. L.; Suurmond, J. L.

Background: European migrant populations are aging and will increasingly be in need of palliative and end of life care. However, migrant patients are often underrepresented in palliative care research populations. This poses a number of drawbacks, such as the inability to generalize findings or check the appropriateness of care innovations amongst migrant patients. The aim of this study was to develop a self-assessment instrument to help palliative care researchers assess and find ways to improve their projects' diversity responsiveness in light of the aging migrant population, and determine whether in addition to older migrants other groups should be included in the instrument's focus.

Methods: After developing a concept instrument based on the standards for equity in healthcare for migrants and other vulnerable groups, literature review and interviews with palliative care researchers, we conducted a Delphi study to establish the content of the self-assessment instrument and used think aloud methods in a study involving seven projects for usability testing of the self-assessment instrument.

Results: A Delphi panel of 22 experts responded to a questionnaire consisting of 3 items concerning the target group and 30 items on diversity responsiveness measures. Using an a priori set consensus rate of 75% to include items in the self-assessment instrument, experts reached consensus on 25 out of 30 items on diversity responsiveness measures. Findings furthermore indicate that underserved groups in palliative care other than migrant patients should be included in the instrument's focus. This was stressed by both the experts involved in the Delphi study and the researchers engaged in usability testing. Usability testing additionally provided insights into learnability, error-rate, satisfaction and applicability of the instrument, which were used to revise the self-assessment instrument.

Conclusions: The final self-assessment instrument includes a list of 23 diversity responsiveness measures to be taken at varying stages of a project, and targets all groups at risk of being underrepresented. This instrument can be used in palliative care research to assess diversity responsiveness of projects and instigate action for improvement.

Title: Association of Family Ratings of Quality of End-of-Life Care With Stopping Dialysis Treatment and Receipt of Hospice Services.

Citation: JAMA Network Open; Oct 2019; vol. 2 (no. 10)
Author(s): Richards, Claire A.; Hebert, Paul L.; Liu, Chuan-Fen; Ersek, Mary; Wachterman, Melissa W.; Taylor, Leslie L.; Reinke, Lynn F.; O'Hare, Ann M.

Abstract: This survey study examines the association of family-rated quality of end-of-life care with stopping dialysis treatment and receipt of hospice services among veterans with end-stage renal disease.

Key Points: Question: What is the association of family-rated quality of end-of life care with stopping maintenance dialysis treatments and receipt of hospice services before death?
Findings: In this survey study of family members of patients with end-stage renal disease who were undergoing maintenance dialysis, the adjusted predicted probability of family
rating the quality of end-of-life care as excellent was higher for patients who stopped dialysis before death than for patients who did not stop dialysis (54.9% vs 45.9%). Among patients who did not stop dialysis, receipt of hospice services was associated with a higher probability of the patient's family rating the quality of end-of-life care as excellent (60.5% vs 40.0%).

**Meaning:** Preparing patients for end-of-life decision-making and improving access to concurrent receipt of dialysis and hospice services may help to improve the quality of end-of-life care for patients undergoing dialysis for end-stage renal disease.

**Importance:** Approximately 1 in 4 patients receiving maintenance dialysis for end-stage renal disease eventually stop treatment before death. Little is known about the association of stopping dialysis and quality of end-of-life care.

**Objectives:** To evaluate the association of stopping dialysis before death with family-rated quality of end-of-life care and whether this association differed according to receipt of hospice services at the time of death.

**Design, Setting, and Participants:** This survey study included data from 3369 patients who were treated with maintenance dialysis at 111 Department of Veterans Affairs medical centers and died between October 1, 2009, to September 30, 2015. Data set construction and analyses were conducted from September 2017 to July 2019. Exposure: Cessation of dialysis treatment before death. Main Outcomes and Measures: Bereaved Family Survey ratings.

**Results:** Among 3369 patients included, the mean (SD) age at death was 70.6 (10.2) years, and 3320 (98.5%) were male. Overall, 937 patients (27.8%) stopped dialysis before death and 2432 patients (72.2%) continued dialysis treatment until death. Patients who stopped dialysis were more likely to have been receiving hospice services at the time of death than patients who continued dialysis (544 patients [58.1%] vs 430 patients [17.7%]). Overall, 1701 patients (50.5%) had a family member who responded to the Bereaved Family Survey. In adjusted analyses, families were more likely to rate overall quality of end-of-life care as excellent if the patient had stopped dialysis (54.9% vs 45.9%; risk difference, 9.0% [95% CI, 3.3%-14.8%]; P =.002) or continued to receive dialysis but also received hospice services (60.5% vs 40.0%; risk difference, 20.5% [95% CI, 12.2%-28.9%]; P <.001).

**Conclusions and Relevance:** This survey study found that families rated overall quality of end-of-life care higher for patients who stopped dialysis before death or continued dialysis but received concurrent hospice services. More work to prepare patients for end-of-life decision-making and to expand access to hospice services may help to improve the quality of end-of-life care for patients with end-stage renal disease.

**Title:** End-of-life care in intellectual disability: a retrospective cross-sectional study.

**Citation:** BMJ supportive & palliative care; Oct 2019

**Author(s):** Hunt, Katherine; Bernal, Jane; Worth, Rhian; Shearn, Julia; Jarvis, Paul; Jones, Edwin; Lowe, Kathy; Madden, Phil; Barr, Owen; Forrester-Jones, Rachel; Kroll, Thilo; McCarron, Mary; Read, Sue; Todd, Stuart

**Background:** Adults with intellectual disability (ID) experience inequality in access to healthcare that is considered to extend to end-of-life care. Their experiences of healthcare at the end of life and how these compare with the general population are unknown.

**Aim:** To describe the end-of-life care outcomes for adults with ID living in residential care in the UK using the VOICES-SF questionnaire and compare these with the general population.

**Design:** Nationwide population-based postbereavement survey.
Participants: 38 ID care providers took part in the study. The supported over 13,000 people with ID. Over the 18-month period of data collection, 222 deaths were reported. The survey was completed, by care staff, for 157 (70.7%) of those deaths.

Results: Decedents had complex health, functional and behavioural needs. Death was unanticipated in a high proportion of cases. Quality of care provided across care settings was generally well rated. However, hospital care and care provided at the time of was less well rated, particularly in comparison with the general population. Respondents reported low levels of involvement in care and awareness of approaching death among adults with ID, and lower than in the general population.

Conclusions: Access to end-of-life care for adults with ID may be constrained by a failure to identify approaching the end of life. The high proportion of unexpected deaths in this population warrants further study. There is a need to increase and support the involvement of adults with ID to be active partners in planning care at the end of their lives.

Title: End-of-life care and place of death in adults with serious mental illness: A systematic review and narrative synthesis.

Citation: Palliative medicine; Oct 2019; p. 269216319867847
Author(s): Wilson, Rebecca; Hepgul, Nilay; Higginson, Irene J; Gao, Wei

Background: People with serious mental illness have greater mortality risk than the general population. They experience health care inequalities throughout life; it is not clear if this persists to end of life.

Aim: Assess the empirical evidence describing end-of-life care and place of death for people with serious mental illness.

Design: A systematic review of original, peer-reviewed research, following Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Data were analysed using a narrative synthesis approach.

Data Sources: Five online databases (Embase, PsycArticles, PsyCINFO, Medline, PubMed) and additional sources were searched (without time restriction) for primary research reporting health care utilisation in the last year of life or place of death in adults with serious mental illness.

Results: After full-text screening, 23 studies were included. We found studies reporting hospital admissions, emergency department care, palliative care, and general practitioner (GP) visits at end of life. We found conflicting evidence for the association between serious mental illness and end-of-life care, although different patient groups, settings and measures were used across studies. People with serious mental illness were more likely to die in care homes than the general population. There were no patterns for other places of death.

Conclusions: The evidence was sparse and heterogeneous, demonstrating variability in patterns and reporting of health care use and with little consensus on where people with serious mental illness are likely to die. Given that people with serious mental illness have increased mortality risk, this gap in the knowledge around end-of-life care outcomes is concerning; this area of research needs further development.

Title: Evaluation of the quality of the communication and emotional support during the donation procedure: The use of the donor family questionnaire (DFQ)

Citation: Journal of Critical Care; Oct 2019; vol. 53; p. 198
Author(s): Poppe, Carine; Akum, Sandra; Crombez, Geert; Rogiers, Xavier; Hoste, Eric
Purpose: A multi-centric study in Intensive Care units (ICU) and Emergency departments (ED) was designed to evaluate whether the provided communication and emotional support to the family in the context of organ donation met the international recommendations of the European Donor Hospital Education Program (EDHEP).

Materials and Methods: Using a participatory approach and focus groups, a questionnaire was constructed: Donor Family questionnaire (DFQ). The questionnaire was distributed to 203 families. The data were analysed on item level.

Results: Sixty-four families participated, and 89% considered the communication as tactful. Only 24.1% had a separate conversation about passing and donation, which is the recommendation. 88.5% reported they could count on emotional support in the first phase on the ICU/ED. This dropped during the parting phase and the aftercare. The physician is perceived as the most active caregiver in the emotional support during the entire procedure.

Conclusions: The DFQ is a useful instrument to evaluate the donor procedure. The physician is important in the first phases of the donor procedure for the medical explanation. Other disciplines could be more involved in the following phases to assure enough emotional support, but this issue requires further exploration.

Title: Radical actions to address UK organ shortage, enacting Iran’s paid donation programme: A discussion paper

Citation: Nursing Ethics; Nov 2019; vol. 26 (no. 7-8); p. 1936

Author(s): Timmins, Rebecca; Sque Magi

Abstract: Globally there is a shortage of organs available for transplant resulting in thousands of lives lost as a result. Recently in the United Kingdom 457 people died as a result of organ shortage in just 1 year.1 NHS Blood and Transplant suggest national debates to test public attitudes to radical actions to increase organ donation should be considered in addressing organ shortage. The selling of organs for transplant in the United Kingdom is prohibited under the Human Tissue Act 2004. This discussion paper considers five ethical objections raised in the United Kingdom to paid donation and discusses how these objections are addressed within the only legal and regulated paid living unrelated renal donation programme in the world in Iran, where its kidney transplant list was eliminated within 2 years of its commencement. This article discusses whether paid living unrelated donation in Iran increases riskier donations and reduced altruistic donation as opponents of paid donation claim. The paper debates whether objections to paid donation based upon commodification arguments only oppose enabling financial ends, even if these ends enable beneficent acts. Discussions in relation to whether valid consent can be given by the donor will take place and will also debate the objection that donors will be coerced and exploited by a paid model. This article suggests that exploitation of the paid donor within the Iranian model exists within the legally permitted framework. However, paid living kidney donation should be discussed further and other models of paid donation considered in the United Kingdom as a radical means of increasing donation.

Title: Team type, team maturity and team effectiveness in specialist palliative home care: an exploratory questionnaire study.

Citation: Journal of Interprofessional Care; Sep 2019; vol. 33 (no. 5); p. 504-511

Author(s): Klarare, Anna; Hansson, Johan; Fossum, Bjöörn; Fürst, Carl Johan; Lundh Hagelin, Carina
Abstract: To meet complex needs in persons and families within specialist palliative care, care team members are expected to work together in performing a comprehensive assessment of patient needs. Team type (how integrated team members work) and team maturity (group development) have been identified as components in team effectiveness and productivity. The aim of the study reported in this paper was to identify team types in specialist palliative care in Sweden, and to explore associations between team type, team maturity and team effectiveness in home care teams. A national web-based survey of team types, based on Thylefors questionnaire, and a survey of healthcare professionals using the Group Development Questionnaire (GDQ-SE3) to assess team developmental phase, effectiveness and productivity were used in an exploratory cross-sectional design. The participants were: Specialist palliative care teams in Sweden registered in the Palliative Care Directory (n = 77), and members of 11 specialist palliative home care teams. Teams comprised physicians, registered nurses, social workers, physiotherapists and/or occupational therapists, full- or part-time. Our national web survey results showed that the 77 investigated teams had existed from 7 to 21 years, were foremost of medium size and functioned as inter- or transprofessional teams. Results from the 61 HCPs, representing 11 teams, indicated that more mature teams tended to work in an integrated manner, rather than in parallel. The effectiveness ratio varied from 52% to 86% in teams. Recommendations arising from our findings include the need for clarification of team goals and professional roles together with prioritizing the development of desirable psychosocial traits and team processes in clinical settings.

Title: Routine parental request of organ donation in end-of-life care of children in the United Kingdom: Unresolved medical, legal, cultural and religious challenges.

Citation: The Medico-legal journal; Oct 2019 ; p. 25817219875307
Author(s): Rady, Mohamed Y

Abstract: The opt-out system (or presumed consent) for end-of-life organ donation is being widely adopted in the United Kingdom. Since presumed consent for organ donation applies only to adults, commentators have recommended the implementation of routine parental request and integration of organ donation in the end-of-life care of children to increase the donor pool and the supply of transplantable organs. The empirical data for this recommendation originated from a survey of parents of deceased children with severe congenital and acquired brain injuries. The demographics of the surveyed parents were not representative of the diverse ethnic and religious affiliations of British society. Here, it is argued that there are unresolved medical, legal, cultural and religious challenges to the routine integration of end-of-life organ donation that can result in harmful consequences for children and parents. To address these challenges: (1) paediatric practice guidelines should be updated to incorporate new advances in the diagnosis and the treatment of severe brain injuries to eliminate potential clinical errors from premature treatment discontinuation and/or incorrect diagnosis of brain(stem) death and (2) a broad societal debate on the legal, cultural and religious consequences of routine integration of end-of-life organ donation in children.

Title: 'If I donate my organs it's a gift, if you take them it's theft': a qualitative study of planned donor decisions under opt-out legislation.

Citation: BMC public health; Nov 2019; vol. 19 (no. 1); p. 1463
Author(s): Miller, Jordan; Currie, Sinéad; O'Carroll, Ronan E
**Background:** There is a worldwide shortage of donor organs for transplantation. To overcome this, several countries have introduced an opt-out donor consent system. This system, soon planned for Scotland and England means individuals are automatically deemed to consent for organ donation unless they register an opt-out decision. This study was designed to explore the reasons underpinning donor choices for people who plan to actively opt-in to the register, take no action and be on the register via deemed consent, opt-out, and those who are unsure of their decision.

**Methods:** This study reports the analysis of free-text responses obtained from a large survey of intentions towards opt-out legislation in Scotland, England and Northern Ireland (n = 1202). Of the n = 1202 participants who completed the questionnaire, n = 923 provided a free text response explaining their views. Thematic analysis was used to explore the reasons why participants plan to: opt-in (n = 646), follow deemed consent (n = 205), opt-out (n = 32) and those who were not sure (n = 40).

**Results:** A key theme for people planning to opt-in is that it ensures one’s donor choice is explicitly clear and unequivocal. Some regarded deemed consent as unclear and open to ambiguity, thus actively opting-in was viewed as a way of protecting against family uncertainty and interference. For the deemed consent group, a key theme is that it represents a simple effortless choice. This is important from both a pragmatic time-saving point of view and because it protects ambivalent participants from making a challenging emotive choice about organ donation. Key themes for those planning to opt-out relate to fears around medical mistrust and bodily integrity. Notably, both participants who plan to opt-out and opt-in perceived presumed consent as “authoritarian” and a method of increasing Government control of organs. In response, registering an active decision protected their freedom of choice.

**Conclusions:** The findings highlight the importance of registering deliberate active consent for people who choose opt-in, due to concerns over possible family refusal under deemed consent. These findings could inform the development of communication campaigns that encourage family communication before the implementation of opt-out legislation.

**Title:** The Implementation of a Multidisciplinary Approach for Potential Organ Donors in the Emergency Department.

**Citation:** Transplantation; Nov 2019; vol. 103 (no. 11); p. 2359-2365

**Author(s):** Witjes, Marloes; Kotsopoulos, Angela M M; Otterspoor, Luuk; Herold, Ingeborg HF; Simons, Koen S; Wootitzev, Karen; Eijkenboom, Jos J A; van der Hoeven, Johannes G; Jansen, Nichon E; Farid Abdo, Wilson

**Background:** The aim of this study was to evaluate the implementation process of a multidisciplinary approach for potential organ donors in the emergency department (ED) in order to incorporate organ donation into their end-of-life care plans.

**Methods:** A new multidisciplinary approach was implemented in 6 hospitals in The Netherlands between January 2016 and January 2018. The approach was introduced during staff meetings in the ED, intensive care unit (ICU), and neurology department. When patients with a devastating brain injury had a futile prognosis in the ED, without contraindications for organ donation, an ICU admission was considered. Every ICU admission to incorporate organ donation into end-of-life care was systematically evaluated with the involved physicians using a standardized questionnaire.

**Results:** In total, 55 potential organ donors were admitted to the ICU to incorporate organ donation into end-of-life care. Twenty-seven families consented to donation and 20 successful organ donations were performed. Twenty-nine percent of the total pool of organ donors in these hospitals were admitted to the ICU for organ donation.
Conclusions: Patients with a devastating brain injury and futile medical prognosis in the ED are an important proportion of the total number of donors. The implementation of a multidisciplinary approach is feasible and could lead to better identification of potential donors in the ED.

Title: Teaching Palliative Care to Health Professional Students: A Systematic Review and Meta-Analysis of Randomized Controlled Trials.

Citation: The American journal of hospice & palliative care; Nov 2019; vol. 36 (no. 11); p. 1026-1041
Author(s): Donne, Jack; Odrowaz, Thomas; Pike, Sarah; Youl, Bonnie; Lo, Kristin

Background: End-of-life care is challenging on health professionals’ mental and emotional state. Palliative care education can support health professional students’ transition, helping them to cope with the challenges of working in this complex setting. Students feel that they need more preparation in this area.

Purpose: To collate the relevant information regarding how to teach health professional students about palliative care.

Method: The full holdings of Medline, PsycINFO, EBM Reviews, Cinahl Plus, ERIC, and EMBASE via Elsevier were searched until April 7, 2019. Inclusion criteria were randomized controlled trials of group interventions that aimed to increase health professional students’ knowledge, skills, or attitudes in palliative care. Studies were appraised using the PEDro scale. Data were synthesized using meta-analysis.

Results: The results favored the intervention and were statistically significant for knowledge and attitudes but not for skills. A 2-hour seminar accompanied by readings seems sufficient to improve both knowledge and attitudes. Quality assessment scores ranged from 1/10 to 7/10 (mean 5, standard deviation 1.73). When studies at high risk of bias were excluded, then only knowledge improved significantly. Key areas where rigor was lacking were in concealing the randomization, omitting intention-to-treat analysis and not blinding of participants, therapists, or assessors.

Conclusions: Palliative care education is effective in improving health professional students’ knowledge and attitudes toward palliative care. More research is required into skill development. This review highlights the need for more high-quality trials in both the short and long-term to determine the most effective mode of palliative care education.

Title: How Is End-of-Life Care With and Without Dementia Associated With Informal Caregivers’ Outcomes?

Citation: The American journal of hospice & palliative care; Nov 2019; vol. 36 (no. 11); p. 1008-1015
Author(s): Boogaard, Jannie A; van der Steen, Jenny T; de Boer, Alice H; van Groenou, Marjolein I Broese

Background: Palliative care for older people with life-limiting diseases often involves informal caregivers, but the palliative care literature seldom focuses on the negative and positive aspects of informal caregiving.

Objective: To assess the association of proximity to end of life (EOL) and dementia caregiving with informal caregivers’ burden of care and positive experiences and explain differences in outcomes.
Design: Data on 1267 informal caregivers of community-dwelling older people were selected from a nationally representative cross-sectional survey and analyzed using analysis of variance and multivariable regression analyses.

Measurements: The Self-Perceived Pressure from Informal Care Scale and the Positive Experiences Scale were administered to assess caregiver burden and positive experiences with providing care.

Results: Dementia care, both at EOL and not at EOL, was associated with the most caregiver burden relative to regular care. Dementia care not at EOL was associated with the fewest positive experiences, and EOL care not in dementia with the most positive experiences. Only the differences in burden of care could be explained by variables related to stressors based on Pearlin stress-coping model.

Conclusions: Informal caregivers of people with dementia are at risk not only of high caregiver burden but also of missing out on positive experiences associated with caregiving at EOL. Future research should examine how dementia-related factors reduce positive caregiving experiences, in order to make palliative care a positive reality for those providing informal care to community-dwelling persons with dementia.

Title: Initiating End-of-Life Care at the Emergency Department: An Observational Study.

Citation: The American journal of hospice & palliative care; Nov 2019; vol. 36 (no. 11); p. 941-946

Author(s): Chor, Wei Ping Daniel; Wong, Sarah Yun Ping; Ikbal, Muhammad Fadhli Bin Mohamad; Kuan, Win Sen; Chua, Mui Teng; Pal, Rakhee Yash

Objective: Terminally ill patients at their end-of-life (EOL) phase attending the emergency department (ED) may have complex and specialized care needs frequently overlooked by ED physicians. To tailor to the needs of this unique group, the ED in a tertiary hospital implemented an EOL pathway since 2014. The objective of our study is to describe the epidemiological characteristics, symptom burden and management of patients using a protocolized management care bundle.

Methods: We conducted an observational study on the database of EOL patients over a 28-month period. Patients aged 21 years and above, who attended the ED and were managed according to these guidelines, were included. Clinical data were extracted from the hospital's electronic medical records system.

Results: Two hundred five patients were managed under the EOL pathway, with a slight male predominance (106/205, 51.7%) and a median age of 78 (interquartile range 69-87) years. The majority were chronically frail (42.0%) or diagnosed with cancer or other terminal illnesses (32.7%). The 3 most commonly experienced symptoms were drowsiness (66.3%), dyspnea (61.5%), and fever (29.7%). Through the protocolized management care bundle, 74.1% of patients with dyspnea and/or pain received opiates while 59.5% with copious secretions received hyoscine butylbromide for symptomatic relief.

Conclusion: The institution of a protocolized care bundle is feasible and provides ED physicians with a guide in managing EOL patients. Though still suboptimal, considerable advances in EOL care at the ED have been achieved and may be further improved through continual education and enhancements in the care bundle.
Title: Dexmedetomidine as an Option for Opioid Refractory Pain in the Hospice Setting.

Citation: Journal of palliative medicine; Nov 2019; vol. 22 (no. 11); p. 1478-1481

Author(s): Mupamombe, Charles T; Luczkiewicz, Debra; Kerr, Christopher

Background: Opioid refractory pain is a common problem in pain management. Dexmedetomidine is suggested to have opioid-sparing effects, with well-described use in surgical and intensive care unit settings. Some authors advocate its benefit in reducing delirium. Its effects are thought to be exhibited through agonism of pre- and postsynaptic α2-receptors in the central nervous system. It is more selective on α2-receptors than clonidine, accounting for its relatively lower incidence of hypotension. Its use in sedation is favored because it does not depress the respiratory system. The main side effects reported include bradycardia.

Case Description: Twenty-eight-year-old woman with triple negative left breast cancer and a locally destructive tumor was admitted to hospice after exhausting her disease-directed therapy options. Her chief complaint was a throbbing, burning pain to the left chest wall, lower back, and bilateral lower extremities, rated 8/10 on a 10-point verbal scale. Multiple pharmacologic agents for pain, including patient-controlled analgesia infusions with adjuvant methadone and steroids, had failed to provide consistent pain management. Symptoms were difficult to control in the home setting, and she required multiple admissions to our inpatient hospice unit for pain management. She also developed episodes of delirium shortly after hospice admission. We attributed her symptoms to rapid disease progression. After failed pain control with opioids, ketamine, and lidocaine, we trialed a dexmedetomidine infusion. While on the infusion, her pain rating decreased to 0/10 and she had no delirium. Pain recurred soon after cessation of the infusion, initially rated 6/10.

Conclusion: Dexmedetomidine is safe for opioid refractory pain in the hospice inpatient setting. However, its effects may not be sustained. There is potential for use in end-of-life care, with added benefit for possible control of delirium.

Sources Used:

The following databases are searched on a regular basis in the development of this bulletin: British Nursing Index, Cinahl, Medline along with a number of other sources

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The results of your literature search are based on the request that you made, and consist of a list of references, some with abstracts. Royal United Hospital Bath Healthcare Library will endeavour to use the best, most appropriate and most recent sources available to it, but accepts no liability for the information retrieved, which is subject to the content and accuracy of databases, and the limitations of the search process. The library assumes no liability for the interpretation or application of these results, which are not intended to provide advice or recommendations on patient care.