



The SLP & Palliative Care: Part I

Contributed by Caitlin Saxtein CCC-SLP, BCS-S, CBIS
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Introduction to Palliative Care

As the average life expectancy increases, the growth of the elderly population will have an impact on medical care. According to the U.S. Census Bureau, “by 2029, when all of the baby boomers will be 65 years and older, more than 20 percent of the total U.S. population will be over the age of 65” (Colby & Ortman, 2014, p.1). In addition, as the population ages and the prevalence of chronic illnesses continues to rise, medical care becomes more complex (Mahendra & Alonso, 2020). Patients battling chronic or terminal illness(es) will benefit from a comprehensive, interdisciplinary palliative care team approach to promote and improve their quality of life.

The purpose of this introductory-level resource series is to provide speech-language pathologists (SLPs) with the knowledge of foundational terms and the framework of palliative care. This resource will begin to prepare the reader to become an integral member of the interdisciplinary team, confidently perform evaluations and treatment, and to participate in providing education and support to patients and their caregivers.

Frequently Asked Questions

Is palliative care the same as Hospice or end-of-life care?

No, palliative care can be described as an umbrella term, encompassing communication, goals of care, pain and symptom management, advanced directives, decision making, and hospice care. Hospice care requires the patient to have a terminal diagnosis with a life expectancy of six months or less (U.S. Centers for Medicare & Medicaid Services, 2020).

Who is eligible for palliative care?

Any individual with a serious illness, regardless of life expectancy, age, or prognosis is eligible for palliative care (National Hospice and Palliative Care Organization, 2020a).

When should palliative care begin?

Palliative care can begin at the time of diagnosis of a serious illness (National Hospice and Palliative Care Organization, 2020a).



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Who is on the palliative care team?

The palliative care team may include (Mahendra & Alonso, 2020; National Hospice and Palliative Care Organization, 2020a):

- Physicians
- Nurse practitioner
- Nurses
- Social workers
- Chaplains
- Dietitians
- Pharmacists
- Occupational therapists
- Physical therapists
- Speech-language pathologists
- Trained volunteers

Key Terms

It is vital to have basic knowledge of foundational terms regarding palliative and hospice care to dispel misconceptions and provide accurate, informative education to the patient and their caregiver (Hanna & Joel, 2005).

Palliative care

Specialized medical care for patients with a serious or life-threatening illness. Palliative care aims to optimize quality of life for the patient and their caregiver by treating the whole person, including physical, intellectual, emotional, social, and spiritual needs; and may be provided alongside life prolonging treatments (National Hospice and Palliative Care Organization, 2020b).

Hospice

A philosophy of care for patients with a life-threatening illness when treatment is no longer curative. A patient is eligible for hospice care when a physician has certified a life expectancy of six months or less, assuming the disease process follows its expected course. If necessary, a patient may be recertified for hospice care post six months and/or discharged from hospice care if his/her condition improves (U.S. Centers for Medicare & Medicaid Services, 2020).

Advanced directives

A legal document that outlines preferences and planning for future medical treatment if one is unable to make his/her own medical decisions. It is suggested to create advanced directives when one is healthy and possesses the capacity to make decisions regarding life-sustaining treatments (National Institute on Aging, 2018).



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Living will

A type of advanced directive; a written document that outlines decisions of life-sustaining treatments that one may want to receive or avoid when unable to make his/her own medical decisions in situations of terminal illness, end of life or permanent unconsciousness (National Institute on Aging, 2018).

POLST

Physicians orders for life-sustaining treatment (POLST) is a form of medical orders that outlines decisions of life-sustaining treatments that one may want to receive or avoid when critically ill or nearing the end of life. A POLST is filled out by the patients provider (physician, nurse practitioner or physician assistant) after discussing the goals of care and medical treatment(s) with the patient and their caregiver. POLST forms vary in name and structure depending on which state one lives in, but are conceptually the same across all states (National POLST, 2020).

MOLST

Medical orders for life sustaining treatment (MOLST) is a form of medical orders that outlines decisions of life-sustaining treatments that one may want to receive or avoid when critically ill or nearing the end of life. A MOLST is filled out by the patients provider (physician, nurse practitioner or physician assistant) after discussing the goals of care and medical treatment(s) with the patient and their caregiver. MOLST forms are recognized in New York, Massachusetts, Ohio, Connecticut, Rhode Island and Maryland (Martin & McDonald, 2014; New York State Department of Health, 2020).

Health care proxy

Written authorization of a selected individual that will make healthcare decisions on behalf of the patient if he/she lacks decisional capacity. A healthcare proxy may be a family member, friend, attorney, or member of a spiritual or social community (National Institute on Aging, 2018).

Power of attorney

A power of attorney (POA) is written authorization of a selected individual authorized to represent or act on another's behalf, if he/she lacks decisional capacity in financial, business, private affairs, and legal matters (Singleton, 2019).



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Decision Making & Advanced Directives

According to the New York State Department of Health (2020), individuals may decide to receive or avoid life-sustaining treatments such as:

- Resuscitation Instructions
 - CPR order: Attempt cardio-pulmonary resuscitation
 - DNR order: Do not attempt resuscitation (allow natural death)
- Treatment Guidelines
 - Comfort measures only
 - Limited additional intervention
 - No limitations on medical interventions
- Intubation and Mechanical Ventilation/Do Not Intubate (DNI)
 - Do not intubate (DNI)
 - A trial period
 - Intubation and mechanical ventilation
 - Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate
 - Intubation and long-term mechanical ventilation, if needed
- Future Hospitalization/Transfer
 - Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled
 - Sent to the hospital, if necessary, based on orders
- Artificially Administered Fluids and Nutrition
 - No feeding tube
 - A trial period of feeding tube
 - Long-term feeding tube, if needed
 - No IV fluids
 - A trial period of IV fluids
- Antibiotics
 - Do not use antibiotics
 - Determine use or limitation of antibiotics when infection occurs
 - Use antibiotics
- Other Instructions (dialysis, transfusions, etc.)

Conclusion

The palliative care team may proactively encourage patients to complete advance directives and communicate their treatment preferences known to all loved ones and medical professionals. Facilitating shared decision-making based on the patient's wishes and values, free from coercion, is an essential component in determining a plan of care (Geppert et al., 2010). According to Slomka (2003), an important question to consider during this process is, "if the patient has a chance of survival, will the quality of life be acceptable to him or her?" (p.550). The palliative care team must consider the patients' emotional, cultural, spiritual, and religious views to maintain patient autonomy in the decision-making process.



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