Palliative Nursing Care for Patients with Chronic Obstructive Pulmonary Disease

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COPD.

Chronic Obstructive Pulmonary Disease is not curable and is characterised by airflow obstruction that is usually progressive and not fully reversible

(National Institute for Clinical Excellence 2010; World Health Organisation 2011).

COPD Grades

Stage	Symptoms	Pulmonary Function Tests based on Post-Bronchodilator FEV1 In patients with FEV1/FVC <0.70
Stage 1 Mild	Often minimal shortness of breath with or without cough and/or sputum. Individuals are usually unaware that lung Function is abnormal.	>80% of predicted values/ Performance.
Stage 11 Moderate	Often moderate or severe shortness of breath on exertion, with or without cough or sputum. This is typically the first stage at which patients seek medical attention due to chronic respiratory symptoms or an exacerbation of their disease.	50-80% of predicted values/ performance.
Stage 111 Severe	More severe shortness of breath, reduced exercise capacity, fatigue and repeated exacerbations which usually impact on patients' quality of life.	30-50% of predicted values/ performance.
Stage 1V Very Severe	Very appreciable impaired quality of life due to shortness of breath. Possible exacerbations may be life threatening. Respiratory failure may lead to right heart failure.	Less than 30% of predicted values/performance- or less than 50% with chronic respiratory failure.

(The GOLD Guidelines 2013)

Palliative Care and COPD.

The palliative care needs for people with COPD have been acknowledged in International Health Guidelines.

(The American Thoracic Society; The European Respiratory Society 2004).

Despite this only 65.4% of patients with COPD have access to specialised palliative care services as inpatients in acute hospitals in Ireland.

(Irish Thoracic Society, Health Service Executive & Irish College of General Practitioners, 2008).

LITERATURE REVIEW

- Nurses need to be able to aid patients to live with COPD as a chronic condition (Halding, Heggdal & Wahl 2010).
- However some nurses expressed difficulty in using the words ‘palliative care’ with patients McLoughlin (2012) & Bailey et al. (2004).
- An intensive end of life medical intervention approach was widely adopted for patients with COPD resulting in a lack of comfort, dignity, respect and peace for patients with COPD (Connor et al., 1995 and Goodridge et al. 2009).
- Nurses can have a limited knowledge of COPD as a condition (Yawn and Wollan 2008) but have the potential to lead patient education (Vrijhoef et al. 2007).
- A multidisciplinary team approach to providing palliative care is essential (McIlfatrick 2007 & O’Leary and Tiernan 2008).
- Dowell (2002) and Spence et al. (2009) felt nurses knowledge is influenced by nursing experience and ‘crisis-point’ care. Nurses need to question their own knowledge and be responsible for ensuring their practice is evidence-based.

METHODOLOGY

- A qualitative descriptive approach was adopted.
- Ethical approval was obtained.
- A purposive sample of nurses (n=10) in the acute setting was recruited.
- The semi-structured interview questions used were based on the literature review.
- Data were analysed according to the following predetermined categories:
  - -Nurses' attitudes to COPD.
  - -Nurses' attitudes to palliative care for patients with COPD.
  - -Nurses' attitudes to end of life care for patients with COPD.
  - -Nurses' knowledge of COPD.
  - -Nurses' knowledge of palliative care for patients with COPD.

Study Findings.

- In relation to nurses' attitudes, nurses recognised the value of palliative care needs of patients with COPD. Nurses supported individualised care in addressing palliative care with patients.

- Nurses due to clinical experience and previous education had a good understanding of COPD as a condition however they also valued on going specialised multidisciplinary team support.

- Findings from this research will aid the development of a care delivery system for patients with COPD receiving palliative care.

- These findings provide an evidence-based structure for future discussion regarding palliative care for patients with COPD.

Palliative and End of Life Care For Patient's with COPD.

Palliative Care V's End of Life Care

- The term palliative is derived from the Latin word 'pallium' (a cloak or cover).
- Therefore palliative care aims to prevent and relieve suffering and to support quality of life for patients and families (Meier 2010).
- The WHO (2012) also clarifies that palliative care aims to provide symptom relief and regards dying as a normal process however palliative care also neither hastens nor postpones death.
- A palliative care approach aims to reduce suffering by means of a holistic early identification, assessment and treatment of symptoms including physical, psychosocial and spiritual (WHO 2002).
- The WHO (2012) explicitly states palliative care is applicable early in the course of illness and can be used in conjunction with therapies to prolong life.

End of Life Care

- End of life care is the provision of supportive and palliative care in response to the assessed needs of patient and family during the last phase of life (National Council of Palliative Care, 2006).

- Common Symptoms are:
  - -Dyspnoea
  - -Cough
  - -Fever
  - -Haemoptysis
  - -Stridor
  - -Chest wall pain.

Breathlessness

- Is subjective and severity can only be judged by the patient.
- Individual causes may prompt specific treatments e.g:

-Physical Causes:

Pleural/pericardial effusion, SVC obstruction, Phrenic nerve palsy, chest wall pain, ascites, fatigue, primary or secondary tumor.

-Treatment related causes

-surgery (lobectomy, pneumonectomy), radiotherapy, chemotherapy, medication induced fluid retention or bronchospasm.

-Other conditions

-infection, heart failure, pneumothorax, PE, COPD disease grade.

(Watson, Lucas, Hoy, Back and Armstrong, 2011)

Management of Breathlessness.

- Pharmacological Management:

  -Anxiolytics
  -Antidepressants
  -opioids.
  -Mucolytics
  -Bronchodilators
  -Corticosteroids
  -O2 therapy

- Non-pharmacological Management:

  -reduce aspiration risk.
  -physiotherapy
  -occupational therapy
  -fan, open window, regular repositioning
  -management of constipation
  -nutritional support
  -psychological support
  -non-invasive mechanical ventilation
  -vaccinations.

(Watson, Lucas, Hoy, Back and Armstrong, 2011)

Cough.

- Prolonged coughing is exhausting and can be associated with breathlessness, haemoptysis, pain, incontinence, insonmia & social isolation.

- Reversible causes:

  -infection, airway obstruction, asthma, ace inhibitors, irritants, smoking, rhinitis/post nasal drip, GI reflux.

- Management:

  -Mucolytics.

  -Physiotherapy.

  -Cough suppressants.

  -Opioids

Pain.

- Common causes

  -chest wall or back pain due to muscle strain

  -pleuritic pain,

  -co-existing arthritis and osteoporosis secondary to corticosteroid use.

- WHO analgesic ladder.

- Opioids and respiratory depression considerations.

- Aspirin and NSAID’s considerations.

Nursing considerations during End Stage COPD

- Persistent dyspnoea despite maximal therapy
- Poor Mobility.
- Increased frequency of hospital admissions.
- Decreased improvements with repeated admissions.
- Expressions of fear, anxiety.
- Panic attacks.
- Concerns expressed about dying.

Staff Support Structures.

- Nationally support and education available through the Irish Hospice Foundation.

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Emotional Issues Nurses need to Address.

- “The last part of life may have an importance out of all proportion to its length” Dame Cicely Saunders.

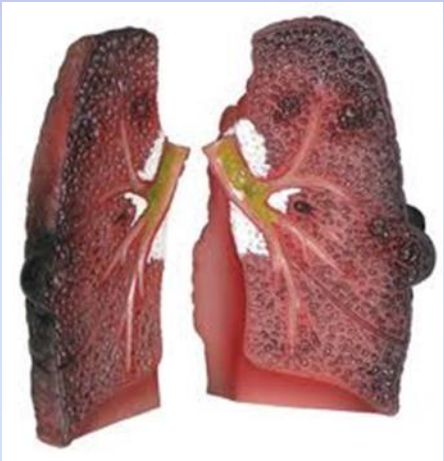
- There is a balance to be made between fully informing the patient about their disease and prognosis and completely overwhelming them with facts and figures or providing only minimal and inadequate information.

Conclusion

- This study period is timely for nursing, in the context of the national program entitled ‘Palliative Care for All’

  (Irish Hospice Foundation & Health Service Executive 2008).

ANY QUESTIONS?



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