November 2024
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Palliative Care: NCCN Clinical Practice Guidelines for Palliative Care (2022)

About the Guideline

- The National Comprehensive Cancer Network (NCCN) published this guideline on March 8, 2022, as the first version in 2022. The guideline provides updates and changes to the previous version.
- The NCCN panel consisted of 30 physicians from cancer centers across the United States. Their specialties include medical oncology, hematology/hematology-oncology, internal medicine, pediatric oncology, palliative care and pain management, psychiatry and psychology, neurology and neuro-oncology, anesthesia, geriatric medicine, radiation oncology, supportive care, and patient advocacy.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in an acute care setting.

Palliative Care Definition

- Palliative care is an approach to patient- and family-centered care that focuses on optimal symptom management while incorporating psychosocial and spiritual care in the care plan based on the patient's and family's or caregivers' needs, values, beliefs, and culture.
- The goal of palliative care is to anticipate, prevent, and reduce suffering and allow the patient to have the best possible quality of life.
- Indications for palliative care include uncontrolled symptoms; distress related to a cancer diagnosis or cancer therapy; physical, psychiatric, or psychosocial conditions; family or caregiver concerns (or both) about the course of treatment and decision-making; a request for palliative care; the patient's poor performance status; and potentially life-limiting disease.
- The NCCN recommends an interdisciplinary team approach to palliative care that includes practitioners, nurses, specialists, and other palliative care team members.
- The care team should educate the patient and family about the role of palliative care as part of the comprehensive cancer care plan and should make the distinction—and note overlaps—between palliative and hospice care.

Assessment by the Oncology Team

- An oncology team assessment may be indicated to discuss the benefits and burdens of cancer therapy, financial toxicity, decision-making capacity, coping strategies, management of symptoms or psychosocial or spiritual distress, educational needs, functional status, or cultural factors affecting care. It may also be indicated to discuss personal goals for—and values and expectations of—treatment and care.
- The oncology team should screen the patient at every visit for any concern that may trigger a full palliative care assessment, including a request by the patient, the family, or both.
- Assessment by the primary oncology team can result in collaboration with and referral to an interprofessional team experienced in palliative care delivery.

Consultation with the Palliative Care Specialist

- Patients with just one of the following characteristics may benefit from consultation with a palliative care specialist:
    - Uncontrolled symptoms
    - Serious comorbid conditions
    - Life-limiting cancer diagnosis
    - Limited cancer treatment options
    - Poor prognostic awareness
    - Need to clarify the goals of care
    - Resistance to engaging in advance care planning
    - High risk for uncontrolled pain
    - High non-pain symptom burden
    - High level of psychological distress based on standardized screening
    - Frequent emergency department visits, hospital admissions, or both
    - Communication barriers
    - Request for a hastened death
    - Complex family issues

Benefits and Burdens of Anticancer Therapy

- The benefits and burdens of anticancer therapy vary with the patient's life expectancy and performance status.
- Patients with a good performance status often want to continue anticancer therapy to extend survival and improve symptom control.
- Palliative care plans should align with the patient's and family's goals and should include the management of the side effects of therapy and disease progression.
- The palliative care plans below are organized by anticipated life expectancy. At any time, the care plan can be altered to address the patient's and family's wishes and needs.
    - Life expectancy of years to months
        - Assess understanding of prognosis and the goals of care.
        - Prepare the patient for possible disease progression or recurrence.
        - Provide palliative care for symptom management, as needed.
        - Optimize psychosocial support for patient and family/caregivers.
        - Consider nonpharmacologic and/or integrative interventions.
    - Life expectancy of months to weeks
        - Confirm the patient's understanding of the disease state.
        - Redirect treatment based on prognosis and life expectancy.
        - Encourage advance care planning.
        - Offer supportive care related to the end of life.
        - Consider discontinuing cancer treatment that does not directly address the symptoms.
    - Life expectancy of weeks to days
        - Discontinue any treatment not related to patient comfort.
        - Intensify palliative care modalities in anticipation of death.
        - Refer the patient to hospice care.
        - Assist with the completion of legal documents, if appropriate.
        - If not already completed, encourage advance care planning.

Palliative Care Interventions by Symptom

- Pain
    - Based on life expectancy, consider following the adult cancer pain guidelines for optimal pain management recommendations. (See Cancer pain: NCCN clinical practice guidelines for adult cancer pain [2022].)
    - When death is anticipated in weeks to days, educate the family about the dying process and the role of pain medication.
    - Consider palliative radiation for pain related to bone metastases.
- Dyspnea
    - Assess for dyspnea-related symptoms.
    - Educate the patient and family about the patient's condition and possible treatment options.
    - Treat any reversible underlying problems or comorbidities that contribute to dyspnea.
    - Manage dyspnea with interventions such as using oxygen, fans, cooler temperatures, relaxation therapy, opioids, benzodiazepines, and continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP).
    - When interventions are not effective, consider hospice care.
- Anorexia and cachexia
    - Assess the severity of anorexia and treat any reversible causes.
    - Consider a nutrition consultation and nutritional support, if appropriate.
    - Consider a swallowing evaluation.
    - Screen for conditions that interfere with oral intake such as the following:
        - Depression
        - Dysgeusia (taste disorder)
        - Mucositis (tissue swelling and irritation in the mouth)
        - Xerostomia (dry mouth)
        - Oral-pharyngeal candidiasis
        - Early satiety
        - Nausea and/or vomiting
        - Diarrhea
        - Constipation
        - Pain
        - Fatigue
    - Educate the patient and family about the patient's condition and possible treatment options.
    - Consider the goals of care.
    - If interventions are not effective, consider hospice care.
- Nausea and vomiting
    - Assess the severity of nausea and vomiting and their underlying causes such as:
        - Chemotherapy or radiation therapy
        - Constipation or fecal impaction
        - Gastric outlet obstruction
        - Bowel obstruction
        - Gastritis or gastroesophageal reflux disease
        - Opioid use
        - Hypercalcemia
        - Potentially reversible conditions.

  - Monitor for dehydration.
  - Educate the patient and family about the patient's condition and possible treatment options.
  - Consider medications that may relieve nausea and vomiting, including the following:
    - Dopamine antagonists
    - Corticosteroid
    - 5-HT3 antagonists
    - Antipsychotics
    - Anticholinergics
    - Antihistamines
    - Oral cannabinoids
    - Antidepressants
  - If needed, use alternative routes, such as the sublingual and rectal routes, for medication administration.
  - Consider palliative radiation for nausea and vomiting related to brain metastases.
- Constipation
  - Educate the patient on prevention measures such as:
    - Increased fluid and fiber intake
    - Exercise
    - Consider prophylactic medications, such as osmotic or stimulant laxatives.
  - Assess the severity of constipation.
  - Educate the patient and family about the patient's condition and possible treatment options.
  - If impaction occurs, administer glycerin suppositories with or without mineral oil retention enemas. Manual disimpaction may be indicated if the patient is not neutropenic.
  - If constipation persists, consider a peripherally acting mu-opioid receptor antagonist (PAMORA) for opioid-induced constipation.
- Diarrhea
  - Evaluate for the cause.
  - Assess the severity of diarrhea based on the number of stools per day. Use the diarrhea grading system to assess the severity.
  - Educate the patient and family about the patient's condition and possible treatment options.
  - Administer antidiarrheals according to the severity grade of diarrhea.
  - Delay chemotherapy, if the patient is still receiving treatment.
  - Test for and treat potential causes of diarrhea.
- Bowel obstruction
  - Determine interventions based on the anticipated life expectancy.
  - Evaluate the severity and cause of bowel obstruction.
  - Screen for and treat reversible causes.
  - Consider palliative procedural intervention, if appropriate.
  - Assess the goals of treatment and consider medical management if the patient's life expectancy is estimated at weeks to days.

- Sleep-wake disturbances
    - Evaluate the cause of the sleep-wake disturbance, such as apnea, sudden involuntary movement, daytime drowsiness, and co-sleeper observations.
    - Assess and treat contributing factors such as the following:
        - Pain
        - Depression
        - Nausea
        - Anxiety
        - Delirium
    - If the patient's life expectancy is months to weeks, consider such medications as the following:
        - Antipsychotics
        - Sedative-hypnotics
        - Antidepressants
        - Benzodiazepines
        - Melatonin-receptor agonists.
- Delirium
    - Educate the patient and family about treatment options.
    - Screen for underlying causes of delirium.
    - Maximize the use of nonpharmacologic interventions, including optimizing the sleep-wake cycle and addressing any sensory impairments.
    - Reduce delirium-causing medications, if possible.
    - Administer haloperidol.
    - For refractory delirium, consider palliative sedation.
- Malignant wounds
    - Assess wound(s) and educate the patient and family on the risks and benefits of treatment options.
    - Perform wound care in alignment with treatment goals.
    - Provide symptom relief while considering odor, infection, exudate, bleeding, pain, pruritus, and body image.

Support and Resources

- Options for resources are based on life expectancy and include the following:
    - Teaching coping skills.
    - Caregiver availability.
    - Ensuring adequate transportation to and from appointments.
    - Assessing for financial support.
    - Providing culturally acceptable care.
    - Educating the patient and family about coping skills and available support groups, counseling, therapy options, and respite care options.
    - Consider respite care for families and caregivers when appropriate.
    - Assessing the need for referral to hospice care.

Preparation for Transition to Hospice Care

- Assess the patient's and family's awareness and understanding of the expected course of disease.

- Provide clear and consistent communication about the prognosis.
- Facilitate advance care planning.
- Assess the patient's decision-making capacity and the need for a surrogate decision-maker.
- Determine the need for palliative care or hospice care.
- Explain that the goals of preparation are intended to reduce patient and family distress, increase the sense of control, decrease the caregiver burden, and optimize the quality of end-of-life care.
- Provide information, support, and referrals for psychosocial and spiritual needs.

Advance Care Planning

- Expect to initiate advance care planning as soon as possible after learning the patient's life expectancy prognosis.
- Inquire about the establishment of a living will and the designation of power of attorney or a patient surrogate. If these documents have not been completed, encourage the patient to complete the process.
- Refer the patient to social services for assistance.
- Assess the patient's and family's decision-making capacity.
- Document the patient's values and preferences for care.
- Provide emotional support.
- Initiate discussion regarding values, care preferences, and goals.
- Encourage the patient to discuss their wishes with the family or caregiver.
- Initiate discussions about palliative care and hospice care.
- Follow the appropriate state guidelines for advance care planning documents.

Request for Hastened Death/Medical Aid in Dying

- When a patient or family requests a hastened death, the initial response is to intensify palliative care to manage symptoms. The following additional responses apply:
    - Inquire about the reason for the request. Evaluate and discuss the request in detail with the patient. Determine the “why now.”
    - Reassess symptom management.
    - Reassess the patient's psychosocial status, fears, values, beliefs, and relationships with friends and family.
    - Explain the legal implications of the request and inform the patient that medical aid in dying is legal in seven states however, euthanasia is not legal in any state in the United States.
    - Educate the patient and family that the withdrawal of any treatment is not a request for a hastened death.

Care of the Imminently Dying

- *Imminently dying* is defined as the expectation of death within hours. A patient in this state is too unstable for transport.
- Consider using an order set that includes physical and psychosocial interventions.
- Intensify comfort measures.
- Deactivate an implanted defibrillator if present.
- Discontinue all unnecessary tests and medications. Support the family when treatments and medications are stopped.

- Switch medication administration routes from oral to a route that is possible, such as the rectal or subcutaneous route.
- Treat dyspnea, delirium, pain, and terminal secretions.
- Consult social services, spiritual care providers, or both, as needed.
- Ensure that do-not-resuscitate orders are present in the medical record.
- Be prepared to discuss organ donation and autopsy requests.

Palliative Sedation

- Palliative sedation is intended to lower awareness toward unconsciousness for patients with severe and refractory symptoms.
- Patients with refractory symptoms that cannot be adequately managed without affecting consciousness may be considered for palliative sedation.
- Refer to individual facility and institutional protocols for guidance.
- Continue pain and symptom management, adjusting it as needed.
- Provide ongoing psychosocial and spiritual support for the family.

Reference

National Comprehensive Cancer Network. (2022). *NCCN clinical practice guidelines in oncology: Palliative care* (Version 1.2022).