

Haematology & Palliative Care

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Other members of the team



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The aim of my presentation

**To create an awareness rather than a
consensus of the role of Palliative
Care in Haematology**

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Exciting times in palliative care

- Increasing public awareness around death and dying.
- New pharmacology.
- Research is ongoing.
- Establishing its self in national health policy.
- Ethos of palliative care for all.
- Moving up stream from care of the dying.

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What is Palliative Care about?

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What's in a definition

“Palliative Care provides relief from pain and other distressing symptoms, affirms life and regards dying as a normal process, and intends neither to hasten nor prolong death”

(World Health Organisation 2009)

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What is Palliative Care about?

Palliative care relieves suffering and improves the quality of life of the living and the dying.

(Stjernsward and Gomez Batise 2009)

At least 100 million people world wide would have improved quality of life if today's great knowledge of palliative medicine could be applied so as to reach all those in need of palliative care

(Stjernsward and Gomez Batise 2009)

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What is Palliative Care about?

Good medical care must support , and not obstruct,
living fully until death

(Ferrell and Coyle 2002)

Where we cannot alter the course of an illness, we
must at least (when the patient wishes) foretell the
course sensitively and, together with the patient and
family, plan care for better or for worse.

(Murray 2009)

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What is Palliative Care nursing about?

- The active total care of patients with a life threatening illness.
- Built on
 - Relationships
 - Patient and family
 - Expert knowledge and skills.
 - Physical
 - Psychological
 - Spiritual.



(Ferrell and Coyle 2010)

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What is palliative Care Nursing about?

Other key concepts

- Knowing the patient
- Teamwork
- Dignity
- Comfort
- Empathy
- Support
- Hope
- Suffering
- Quality of life

(Payne *et al.* 2004)

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Can Haematology Nursing
and
Palliative Care Nursing
work together?

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Important principles in Haematology Nursing?

Important principles in Palliative Care Nursing!

- Relief of pain and other distressing symptoms ?
- Offers a support system to patients to live as actively as possible?
- Integrates psychological and spiritual aspects of care?
- Enhances quality of life
- Uses a team approach to meet the needs of the patient and family?
- All happen in conjunction with other therapies?

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Are the odds stacked
Palliative Care in the
Haematology setting?

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The culture in Acute General Hospitals

- “Getting people better” V care of the dying.
- Dying not recognised as a legitimate diagnosis.
 - “Sometimes nobody calls it”
 - Healthcare professionals receive little training in this area.
- “do everything that can be done” a safe option
- Lack of clear policies... support staff in making
- Diverse dying-related situations.
- No specific training for some staff.
(Hospital friendly Hospice Programme 2007)

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Issues specific to haematology nursing

- High tech and invasive nature of treatments offered.
- Significant sequelae from treatments. Quality V Quantity.
- The speed of change to a terminal event.
- Frequent blood testing and blood products.
- Varied diagnostic groups with different prognosis and disease patterns.
- (Mc Grath and Holewa 2006)

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Issues specific to haematology nursing

- Treatments can go on over many years.
- Close patient relationships.
- Clinical optimism based on a myriad of treatment options.
- Patients occasionally show positive signs of recovery when close to death.
- In some cases no clear distinction between the curative and palliative phase.

(Mc Grath and Holewa 2006)

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Effects on Haematology Nurses

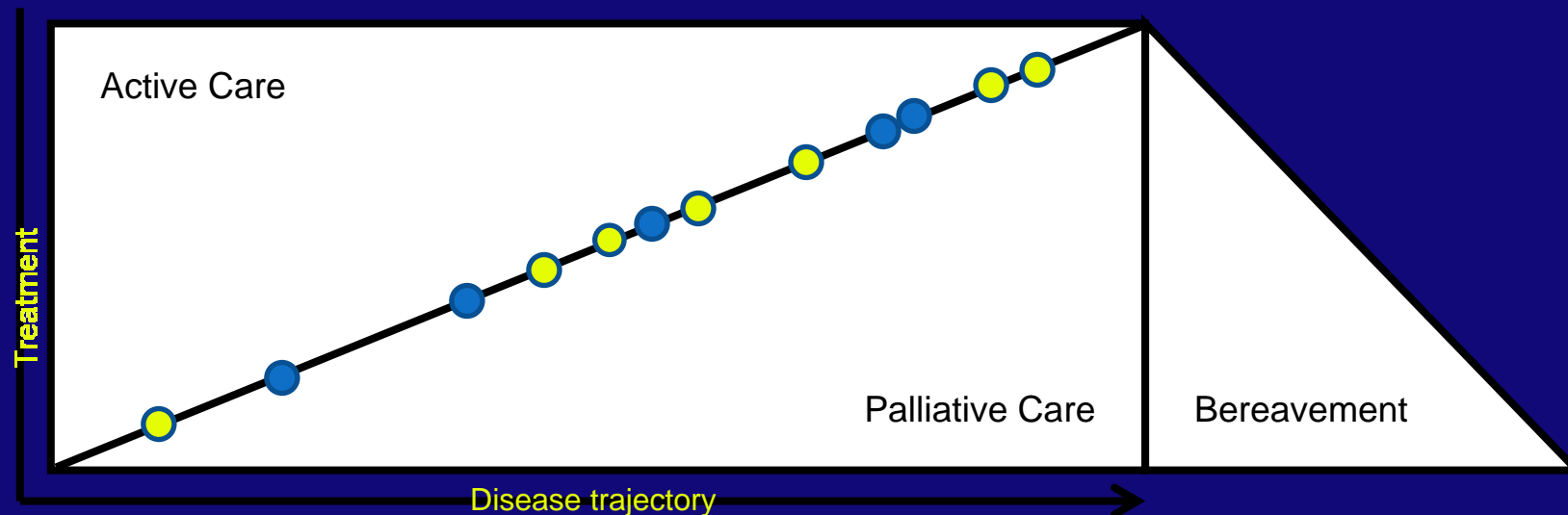
- Stress
- Powerlessness

(Mc Grath and Holewa 2006)

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Transition towards Palliative Care

Combination of the Lynn and Adamson (2003) model and Monteverde model (2009)



● Dramatic events

● Un-dramatic events

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As nurses we must ensure that.....

un-dramatic aspects of a patients illness are heard
as they are key also when priorities have to be
set in the course of an illness

We live *at* the same time, but we also
live *in* different in different times.



(Monteverde 2009)



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So what then are the
professional barriers to
involving Palliative Care ?

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Professional barriers to partnerships in Specialist Palliative care

- Non referral would maintain hope
- Patients would refuse referral anyway!
- Communication difficulties
 - Problems working with colleagues
 - Difficulties transmitting relevant practical knowledge
 - Lack of consensus about care coordination responsibilities
 - Lack of standardised documentation

(Walshe *et al.* 2006)

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Is there a future for haematology
and palliative care?

Most definitely

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Integrating Haematology and Palliative Care:

A 10 point strategy (Mc Grath and Holewa 1996)

1. Issues about death and dying are addressed.
2. Leadership at unit level developing a culture.
3. Organisational issues.
4. Positive experiences.
5. Patient centred continuum of care from diagnosis to bereavement.
6. Provision of honest information and respect for patient choice.
7. Complexity of hope is understood
8. Understanding and use of specialist palliative care:
9. Appropriate and timely integration of palliative care
10. Specific issues regarding patients with haematological malignancies are addressed.

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Another Model

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Another model ... At St. James's Hospital, Dublin

- Senior nurse with
 - Haematology experience
 - Specialist palliative care H.Dip and experience
 - ½ time Haematology, ½ time Palliative Care.
- Results
 - Greater co-operation and communication with haematology team.
 - Greater understanding of each other. "What each other is about"
 - More haematology referrals.

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An account of shared care for a patient undergoing BMT for CML (Mander 1997)

- Bill, 52 year old, married man
- CML in blast crisis.
- HLA matching revealed no sibling donor.
- Poor response to first line therapy.
- Decision maker in the family... very keen to proceed to transplant
- Nurses on Transplant Team pushed for the Palliative Care Team to be involved in initial transplant discussions with Bill

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An account of shared care for a patient
undergoing BMT for CML (Mander 1997)

- Palliative Care Consultant attended meeting.
- Not ready to die but accepting of palliative care maintaining a profile in his overall care.
- Transplant course was short and complicated
 - Drug toxicity
 - Bleeding
 - Respiratory complications
- Palliative Care Team informed

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An account of shared care for a patient
undergoing BMT for CML (Mander 1997)

- 100% o₂
- Decided against ventilation
- Wanted to say his good bye while still conscious.

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An account of shared care for a patient
undergoing BMT for CML (Mander 1997)

The benefits

- No indecision regarding timing of referral to Palliative Care.
- Relationships with Bill and his family were not formed in a time of crisis.
- Readily available advice regarding symptom control.
- Offered formalized bereavement afterwards.

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**Thank you.
Questions?**