Palliative Care and End of Life Issues: A Pharmacist’s Perspective

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I do not have commercial or financial relationships to disclose relating to the content of this presentation.
Objectives

- Describe the roles and responsibilities of the pharmacist in palliative care

- Assess, recommend, and treat pain and common symptoms encountered in the palliative care setting

- Discuss advance directives commonly encountered in palliative care, and their effect on patient care

- Understand the concept of a "dignified death," and how the pharmacist can assist the patient and family in achieving optimal outcomes
Definition of Palliative Care

- WHO: “Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, other symptoms, psychological, social, and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families.”

- NHPCO: “Treatment that enhances comfort and improves the quality of an individual’s life during the last phase of life. No specific treatment is excluded....”

- “Hospice care” is palliative care provided to patients during the last months of life

World Health Organization. Definition of Palliative Care. Available at: http://www.who.int/cancer/palliative/definition/en/
National Hospice and Palliative Care Organization. What is Palliative Care. Available at: http://www.nhpco.org/about/palliative-care
Old Way of Thinking

New Way of Thinking

ASHP Statement on the Pharmacist’s Role in Hospice and Palliative Care

- Palliative care should be provided in conjunction with curative care at the time of diagnosis of a potentially terminal illness

- Palliative care alone may be indicated when attempts at a cure are judged to be futile

- Admissions to hospice and/or palliative care programs often come too late for optimal services to be provided
  - Length of stay
    - Mean: 50 days; Median: 25 days

The Pharmacist’s Responsibilities

- Assessing the appropriateness of medication orders and ensuring the timely provision of effective medications for symptom control.

- Counseling and educating the hospice team about medication therapy.

- Ensuring that patients and caregivers understand and follow the directions provided with medications.

The Pharmacist’s Responsibilities

- Providing efficient mechanisms for extemporaneous compounding of nonstandard dosage forms.
- Addressing financial concerns.
- Ensuring safe and legal disposal of all medications after death.
- Establishing and maintaining effective communication with regulatory and licensing agencies.

## Symptom Management

<table>
<thead>
<tr>
<th>Pain</th>
<th>Delirium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea and Vomiting</td>
<td>Oral Complications</td>
</tr>
<tr>
<td>Bowel Issues</td>
<td>Dyspnea</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Death rattle/terminal secretions</td>
</tr>
<tr>
<td>Depression</td>
<td>Insomnia</td>
</tr>
<tr>
<td></td>
<td>Anorexia/Cachexia</td>
</tr>
</tbody>
</table>

- Pain
- Nausea and Vomiting
  - CINV
  - Generalized N/V
- Bowel Issues
  - Constipation & Bowel Obstruction
  - Diarrhea
- Anxiety
- Depression
- Delirium
- Oral Complications
  - Xerostomia and mucositis
- Dyspnea
- Death rattle/terminal secretions
- Insomnia
- Anorexia/Cachexia
General Approach to Symptom Management at End-of-Life

- Search for cause of symptom
  - History, physical, laboratory (as appropriate)

- Treat underlying cause (if reasonable)

- Treat the symptom

- Re-evaluate frequently
Pharmacotherapy in Palliative Care

- Essential for many symptoms
- Non-symptom based drugs may be no longer appropriate or desired
- Data often limited
  - Pharmacokinetic/pharmacodynamic differences
  - Goals of treatment differ
- May need unusual routes of administration and/or dosage forms
Pain Management

“My arm hurts.”
“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage

It’s what the patient says it is!

Feeling Pretty Remarkable. Preventing Chronic Pain. Available at: http://www.feelingprettyremarkable.com/blog/preventing-chronic-pain
Pain Management

- **Types of pain**
  - Nociceptive
    - Transient in response to noxious stimulus
  - Inflammatory
    - Tissue damage occurs despite nociceptive defense
  - Neuropathic
    - Spontaneous pain and hypersensitivity to pain, associated with damage to or pathologic changes in the periphery or CNS
  - Functional
    - Pain sensitivity due to an abnormal processing or functioning of the CNS in response to normal stimuli
Pain Assessment

- P-Palliative, precipitating
- Q-Quality
- R-Radiating
- S-Severity
- T-Timing
- U-You
Pain Terms Defined

- **Addiction**
  - Continued repetition of a behavior despite adverse consequences

- **Physical Dependence**
  - Normal adaptive state that results in withdrawal symptoms if the drug is abruptly stopped or decreased

- **Tolerance**
  - Process by which the body continually adapts to the substance and requires increasingly larger amounts to achieve the original effects

- **Pseudo-addiction**
  - A drug-seeking behavior that simulates true addiction, which occurs in patients with pain who are receiving inadequate pain medication
General Approach to Treatment

- **Effective treatment**
  - Evaluate cause, duration, intensity
  - Selection of an appropriate treatment modality

- **Two common approaches**
  - Based on pain severity
  - Based on mechanism responsible for the pain

- **Goal**
  - Reduce peripheral sensitization, subsequent central stimulation and amplification associated with windup, spread, and central sensitization
Pain Treatment Paradigm

- **Physical**
  - Heat, cold, ultrasound, TENS, massage, exercise

- **Behavioral**
  - Imagery
  - Distraction
  - Relaxation
  - Cognitive behavioral therapy

- **Pharmacotherapy**

- **Surgical**

- **Regional/Spinal Anesthesia**

Pharmacotherapy

- **Non-opioids**
  - APAP & NSAIDs

- **Opioids**
  - Mu Agonists
  - Partial Agonists
  - Tramadol?

- **Adjuvants**
  - Topical Agents
    - Lidocaine
    - NSAIDs
  - Antidepressants
    - TCAs
    - SNRIs
  - Anticonvulsants
    - Gabapentin, Pregabalin

---

Opioid
\( (\text{morphine, fentanyl, etc.}) \)
\( \pm \text{Non-opioid, } \pm \text{ adjuvant} \)

Moderate to severe pain

Opioid
\( (\text{Codeine, Tramadol, etc.}) \)
\( \pm \text{Non-opioid, } \pm \text{ adjuvant} \)

Mild to moderate pain

Non-opioid
\( (\text{Acetaminophen, aspirin, NSAID}) \)
\( \pm \text{adjuvant} \)

Mild pain

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# Choosing Analgesics

- Type of pain
- Efficacy of analgesics for indication
- Route(s) available
- Renal and hepatic function
- Safety (NSAID vs. Cox-2)
- Drug interactions
- Cost
- Patient and/or family preference
Opioid Analgesics

- Classified by receptor activity (stimulate opioid receptors \( \mu, \kappa, \delta \) in CNS), usual pain intensity treated, and duration of action

- Pure agonists
  - Three classes
  - Bind to \( \mu \) receptor and have no “ceiling”

- Partial Agonists
  - Butorphanol, pentazocine, nalbuphine
  - Partially stimulate \( \mu \)-receptor and antagonize the \( \kappa \)-receptor
    - Reduced analgesic efficacy with a ceiling-dose
    - Reduced side effects at the \( \mu \)-receptor
    - Psychometric side effects due to \( \kappa \)-receptor antagonism
    - Possible withdrawal in patients dependent on pure agonists
## Classes of Opioids

<table>
<thead>
<tr>
<th>Class I (Phenanthrenes)</th>
<th>Class II (Phenylpiperidines)</th>
<th>Class III (Phenylheptalamines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>Fentanyl</td>
<td>Methadone</td>
</tr>
<tr>
<td>Codeine</td>
<td>Meperidine</td>
<td>Propoxyphene (Disc)</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Semisynthetic**

<table>
<thead>
<tr>
<th>Hydrocodone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydromorphone</td>
</tr>
<tr>
<td>Oxycodone</td>
</tr>
<tr>
<td>Oxymorphone</td>
</tr>
</tbody>
</table>
The best opioid option for a patient with a true morphine allergy is:

- A) hydromorphone
- B) oxymorphone
- C) oxycodone
- D) fentanyl
Self-Assessment

The best opioid option for a patient with a true morphine allergy is?
- A) hydromorphone
- B) oxymorphone
- C) oxycodone
- D) fentanyl
Opioid Switch

Why switch?
- Lack of efficacy
- Development of intolerable side effects
- Change in patient status
  - Inability to use specific dosage formulations
  - Transition of care
- Other practical considerations
  - Availability of opioid, or dosage formulation
  - Cost or formulary issues
  - Patient, family preferences (morphobia)
## Equianalgesic Doses of Selected Opioids

### Equianalgesic Opioid Dosing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equianalgesic Doses (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Parenteral</td>
</tr>
<tr>
<td>Morphine</td>
<td>10</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>0.3</td>
</tr>
<tr>
<td>Codeine</td>
<td>100</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>NA</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
</tr>
<tr>
<td>Meperidine</td>
<td>100</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>10*</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>1</td>
</tr>
<tr>
<td>Tramadol</td>
<td>100*</td>
</tr>
</tbody>
</table>

*Not available in the US

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McPherson ML. Demystifying Opioid Conversion Calculations: A Guide For Effective Dosing. Amer Soc of Health-Systems Pharm, Bethesda, MD, 2010. Copyright ASHP, 2010. Used with permission. NOTE: Learner is STRONGLY encouraged to access original work to review all caveats and explanations pertaining to this chart.
Opioid Chart Issues

- Unidirectional vs. bidirectional?
  - A=B
  - But does B=A?

- Based on single-dose conversion data or multiple-dose conversion data?

- Pharmacogenomics

- Influence of age?
Steps in Opioid Conversion

- Globally assess the patient and pain complaint
- Determine the total daily dose of the current opioid
- Decide which opioid to switch to (or formulation)
  - Consult an opioid conversion chart
- Individualize dose based on assessment info
- Patient follow-up and continued reassessment
Setting Up Conversions

- Calculate total daily dose (TDD) of current opioids
- Set up conversion ratio between old opioid (and route of administration) and new opioid (and route of administration as follows:

\[
\frac{"X" \text{mg TDD new opioid}}{\text{mg TDD current opioid}} = \frac{\text{equianalgesic factor new opioid}}{\text{equianalgesic factor current opioid}}
\]

Or

\[
\frac{"X" \text{mg TDD new opioid}}{\text{equianalgesic factor of new opioid}} = \frac{\text{mg TDD current opioid}}{\text{equianalgesic factor current opioid}}
\]
Conversion Calculations

- Cross multiply, solve for “x”

- Three choices:
  - Reduce calculated dose due to lack of complete cross-tolerance
  - Begin with calculated dose
  - (Rarely) increase calculated dose

- Decide how many times per day you’re going to dose the new opioid; divided by the appropriate dosing interval, and select a dosage that is available in that strength
Self-Assessment

- Convert Morphine 5mg IV every 4 hours + 0.5mg IV every 2 hours prn (used 6 doses in 24 hours) to oral oxycodone
Self-Assessment

- TDD = 33mg IV morphine

\[
\frac{33mg \text{ IV morphine}}{10mg \text{ IV morphine}} = \frac{"X"mg \text{ oxycodone}}{20mg \text{ oral oxycodone}}
\]

- X = 66mg oral oxycodone
- Reduce by 25-50% for cross tolerance
  - 66mg x 0.75 = 49.5mg daily; 66mg x 0.5 = 33mg daily
- Available as 5mg, 10mg, 15mg, 20mg, 30mg
- Dose: 5-10mg every 4 hours
Symptom Management
Opioid Induced Constipation

- Tolerance does not develop

- Prevention is key!
  - Stimulant laxative cornerstone of therapy
  - Stool softener offers no benefit

- Golden rule
  - “The hand that writes for the long acting opioid, is the hand that writes for the breakthrough opioid, is the hand that orders the laxative”
Nausea/Vomiting

**Chemoreceptor Trigger Zone (CTZ)**
- Dopamine, 5HT3, Neurokinin-1

**Gastrointestinal Tract (GI)**
- Dopamine, 5HT3

**Cerebral Cortex**
- Dopamine, 5HT3, Neurokinin-1

**Vestibular Nerve**
- Acetylcholine, Histamine

**Vomiting Center**
- Acetylcholine, Histamine, 5HT2

Nausea & Vomiting

11 M’s of Emesis

- Metastases (cerebral, liver)
- Meningeal irritation
- Movement
- Mentation (anxiety)
- Medications (opioids, chemo)
- Mucosal irritation
- Mechanical obstruction
- Motility
- Metabolic (hypercalcemia, hyponatremia, hepatic/renal failure)
- Microbes
- Myocardial

## Managing N/V

<table>
<thead>
<tr>
<th>Etiology</th>
<th>Pathophysiology</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningeal Irritation</td>
<td>Increased ICP</td>
<td>Steroids</td>
</tr>
<tr>
<td>Movement</td>
<td>Vestibular stimulation</td>
<td>Anticholinergics</td>
</tr>
<tr>
<td>Mentation (anxiety)</td>
<td>Cortical</td>
<td>Anxiolytics</td>
</tr>
<tr>
<td>Metastases</td>
<td>• Increased ICP</td>
<td>Steroids</td>
</tr>
<tr>
<td>• Cerebral</td>
<td>• Direct Chemoreceptor Trigger Zone (CTZ) effect</td>
<td>Mannitol</td>
</tr>
<tr>
<td>• Liver</td>
<td>• Toxin buildup</td>
<td>Anti-Dopaminergic Antihistamine</td>
</tr>
<tr>
<td>Motility</td>
<td>GI tract, CNS</td>
<td>Prokinetic agents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stimulant laxatives</td>
</tr>
</tbody>
</table>

Goldstein NE, Morrison RS. Use of Medications to Prevent and Treat Nausea and Vomiting Unrelated to Chemotherapy. In: Evidence Based Practice of Palliative Medicine. 2013: 143.
# Managing N/V

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<tr>
<th>Etiology</th>
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</thead>
<tbody>
<tr>
<td>Metabolic</td>
<td>CTZ</td>
<td>Anti-dopaminergic Antihistamines Rehydration Steroids</td>
</tr>
<tr>
<td>• Hepatic/renal failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hypercalcemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanical Obstruction</td>
<td>Constipation, tumor, fibrotic stricture</td>
<td>• Treat constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reversible: surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Irreversible: Manage fluids; decrease oral intake; octreotide</td>
</tr>
<tr>
<td>Medications</td>
<td>CTZ Vestibular effect GI tract</td>
<td>Anti-dopaminergic Antihistamines Anticholinergics Prokinetic agents Anti-5HT3 Steroids</td>
</tr>
<tr>
<td>• Opioids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chemotherapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Goldstein NE, Morrison RS. Use of Medications to Prevent and Treat Nausea and Vomiting Unrelated to Chemotherapy. In: Evidence Based Practice of Palliative Medicine. 2013: 143.
Managing N/V

- **Mirtazepine**
  - Antagonizes 5HT3 receptor
  - Refractory symptoms

- **Olanzapine**
  - Efficacy demonstrated in small case reports

- **Cannabanoids**
  - Efficacious for those with cancer and AIDS
  - Delirium and sedation, especially in older adults

- **Lorazepam, diphenhydramine, haloperidol, metoclopramide (ABHR) suppositories/gels**
  - No evidence to support efficacy
Dyspnea

- Commonly seen in patients with heart failure and pulmonary issues

- Potential causes
  - Muscle wasting
  - Acid/base disturbance
  - Anxiety
  - Obstruction
Treatment of Dyspnea

- **Non-pharmacologic**
  - Minimize need for exertion
  - Reposition upright
  - Avoid strong odors
  - Use fans or open windows
  - Adjust temperature/humidity

- **Pharmacologic**
  - Opioids
  - Benzodiazepines
  - Bronchodilators
  - Oxygen?
• True or False?
  ○ Opioids do not improve dyspnea through inhibition of the respiratory drive; rather, opioids improve dyspnea without causing significant deterioration in respiratory function.
Self-Assessment

- **True** or False?
  - Opioids do not improve dyspnea through inhibition of the respiratory drive; rather, opioids improve dyspnea without causing significant deterioration in respiratory function.
Advance Directives
# Advance Directives

## Document Description

**Substantive Directives**
- Living will
- Five wishes
- Personal wishes statement

Allows a patient to specify wishes for future care
May include a section to designate a proxy decision maker

**Process Directives**
- Health care power of attorney
- Heath care proxy
- Durable power of attorney for health care

Designates a surrogate decision-maker
Does not specify wishes for care

**Physician Orders for Life Sustaining Treatment**

Physician orders regarding CPR, antibiotics and artificial nutrition/hydration
Travels with a patient and is legally valid as an order in transit

**Code status**

Specifies whether to perform CPR in event of decompensation

---

Goldstein NE, Morrison RS. Effective Advance Care Plans and How they Differ From Advance Directives. In: Evidence Based Practice of Palliative Medicine. 2013: 259.
POST

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

West Virginia Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

A
Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitation (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in B, C, and D.

B
Check One Box Only

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry.

Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care unit.

☐ Full Interventions Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care unit.

Other Orders:

Last Name/First/Middle Initial
Address
City/State/Zip
Date of Birth (mm/dd/yyyy)
Last 4 SSN
Gender M F

### MEDICALLY ADMINISTERED FLUIDS AND NUTRITION

- [ ] No IV fluids (provide other measures to assure comfort)
- [ ] IV fluids for a trial period of no longer than
- [ ] IV fluids long term if indicated

**Other Orders:**

**Discussed with:**
- [ ] Patient/Resident
- [ ] Health care surrogate
- [ ] MPOA representative
- [ ] Spouse
- [ ] Court-appointed guardian
- [ ] Parent of Minor
- [ ] Other: __________________________ (Specify)

**Authorization**

**INITIAL BOX** if you agree with the following statement: If I lose decision making capacity and my condition significantly deteriorates, I give permission to my MPOA representative/surrogate to make decisions and to complete a new form with my physician in accordance with my expressed wishes for such a condition or, if these wishes are unknown or not reasonably ascertainable, my best interests.

**Registry Opt-In**

**INITIAL BOX** if you agree to have your POST form, do not resuscitate card, living will and medical power of attorney form (if completed) submitted to the WV e-Directive Registry and released to treating health care providers. REGISTRY FAX - 304-293-7442

---

**Signature of Patient/Resident, Parent of Minor, or Guardian/MPOA Representative/Surrogate (Mandatory)**

**Date:**

**Signature of Physician:**

**Physician Name (Print Full Name):**

**Physician Phone Number:**

**Physician Signature (Mandatory):**

**Date and Time:**

---

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

<table>
<thead>
<tr>
<th>Preference</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Resident (Parent for Minor Child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advance Directive (Living Will or MPOA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ and Tissue Document of Gift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Court-appointed Guardian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Care Surrogate Selection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MPOA/Surrogate/Court-appointed Guardian/Parent of Minor Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

Person Preparing Form

<table>
<thead>
<tr>
<th>Signature of Person Preparing Form</th>
<th>Preparer Name (Print)</th>
<th>Date Prepared</th>
</tr>
</thead>
</table>

Review of this POST Form

Date of Review | Reviewer | Physician Signature | Location of Review | Outcome of Review
---|---|---|---|---

○ No Change
IBM VOICE: new form completed
FORM VOICE: new form completed

○ No Change
IBM VOICE: new form completed
FORM VOICE: new form completed

○ No Change
IBM VOICE: new form completed
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IBM VOICE: new form completed
FORM VOICE: new form completed

○ No Change
IBM VOICE: new form completed
FORM VOICE: new form completed

Review of POST Form

This form should be reviewed if there is a substantial change in patient/resident health status or patient/resident treatment preferences. According to state law, the form must be reviewed if the patient/resident is transferred from one health care setting to another. If this form is to be voided, write the word “VOID” in large letters on the front of the form. After voiding the form, a new form may be completed. If no new form is completed, note that full treatment and resuscitation may be provided. FAX voided form and newly completed form to the Registry. Additional forms can be obtained by calling 377-293-8086 or ordered online from the WV Center for End-of-Life Care website at www.wvendoflife.org/Request-Information.

Instructions for Submission to the WV e-Directive Registry (If Opt-in Box is initiated)

FAX a copy of BOTH sides of the POST form to the e-Directive Registry at 304-293-7442. Copy form on your copy machine and adjust the tightness/darkness to contrast depending on your machine so that the form is readable prior to FAXing to the Registry. If you have questions about submission of this POST form or other advance directive documents to the Registry, call 377-293-8086. If you are using POST forms that were printed prior to 2010 and wish to submit them to the Registry, please complete a Sign-Up Form that contains the additional demographic information needed to identify the patient/resident in the Registry. The Sign-Up Form can be downloaded at www.wvendoflife.org/e-Directive-Registry.

FORM SHALL ACCOMPANY PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Self-Assessment

Which of the following is false regarding most Physician Orders for Life Sustaining Treatment (POLST) forms?

- They contain orders regarding CPR
- They contain orders regarding artificial nutrition/hydration
- They contain orders regarding antibiotics
- They contain orders regarding care of delirium
Which of the following is false regarding most Physician Orders for Life Sustaining Treatment (POLST) forms?

- They contain orders regarding CPR
- They contain orders regarding artificial nutrition/hydration
- They contain orders regarding antibiotics
- **They contain orders regarding care of delirium**
Honoring Patient Wishes and the “Dignified Death”

- Step 1: Prepare for the conversation
- Steps 2 and 3: Determine what the patient knows and wants to know
- Step 4: Deliver any new information
- Step 5: Notice and respond to emotions
- Step 6: Determine goals of care and treatment priorities
- Step 7: Agree on a plan

Goldstein NE, Morrison RS. Effective Advance Care Planning. In: Evidence Based Practice of Palliative Medicine. 2013: 264.
5 Things to Say Before Death

- I love you
- Please forgive me
- I forgive you
- Thank you
- Good-bye

Boyock I. The Four Things That Matter Most: A Book About Living. 2004
Good-Bye For Now

- In my Father's house are many mansions: if it were not so, I would have told you. I go to prepare a place for you. And if I go and prepare a place for you, I will come again, and receive you unto myself; that where I am, there ye may be also. *John 14: 2-3 (KJV)*

- And God shall wipe away all tears from their eyes; and there shall be no more death, neither sorrow, nor crying, neither shall there be any more pain: for the former things are passed away. *Rev 21:4 (KJV)*
AND FINALLY, I WOULD LIKE TO BE BURIED WITH AN ELEPHANT BONE... JUST TO CONFUSE FUTURE ARCHAEOLOGISTS.
Palliative Care and End of Life Issues: A pharmacist’s perspective

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