Principles of Palliative Care

Dr. Sarah Fakroodeen
Palliative Care

- Providing care
- Supporting the patient and family
- Dignity in death
Patient B

Referred from private oncologist. Presented at oncologist with a huge ulcerating lesion on his face and extending towards the mouth. The oncologist felt that the patient needed palliative care rather than oncology treatment. As such he preferred hospice care to hospital care.
- Admission: 01-02
- Diagnosis: Squamous cell Carcinoma of the cheek
- On admission: Patient is 65 years of age, Male
- History: Diagnosed with squamous cell carcinoma of the right cheek. Received radio-therapy with excellent results. Remained well and no further follow-up for the next 6 months
Social History:

Divorced with no contact with ex-wife. Two children, one daughter married and living out of town and one son unemployed (schizophrenia). Patient living alone and supplied food from Meals on Wheels.

On examination:

- Large ulcerating wound on the cheek with tumour obliterating part of the mouth.
- Right eye swollen and partially closed.
- Patient is also diabetic.
- History of tumour suddenly spreading.
Treatment:

- Morphine for pain control
- Oral hypo-glycaemics for diabetes
- Flagyl dressing for wounds
- Liquidised diet
- Social Worker for counselling
Progress:

- Patient made good progress and **discharge planning** was made.
- Social worker involved in engaging the estranged family to be more involved with the patient.
- Special arrangements for food to be liquidised as patient was too weak to prepare food for himself.
- Home nurses for daily dressing.
- Appointment made to see a surgeon for insertion of the peg-tube.
- Patient discharged after 2 weeks stay.
- Palliative care nurse visited once a week.
Re-admitted 2 months later

Patient’s condition deteriorated and he was no longer coping. The wound on the cheek oozing and eye infected. Blood sugar stable and patient in pain.

Treatment:

Morphine syrup administered through the peg tube

Hypo-glycaemias stopped
Patient remained drowsy and fed through the peg tube. Patient continued to get weaker. Social worker involved in counselling the patient, preparing him for terminal care and offering the family support. Patient died 10 days later without pain and discomfort and in the presence of family.
WHO Definition of Palliative Care

Palliative Care is an approach that improves the quality of life of patients and their families facing problems associated with life threatening illness, through the prevention and relief of suffering, the early identification and treatment of pain and other problems, physical, psychosocial and spiritual
Palliative Care

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated

- Will enhance the quality of life, and will also positively influence the course of illness
Continuum of Care

- Disease-oriented Care
- Palliative Care

- Diagnosis
- Death
Diagnosis

Disease-oriented care

Supportive and Palliative Care

Bereavement care

Death
Disease-oriented care

Supportive and Palliative care

Bereavement care

Orphan care

Individual Family Community Care

Primary health care and specialist care

Hospice care

Diagnosis

Death
Palliative medicine is the study and management of patients with active, progressive far advanced disease for whom the prognosis is limited and the focus of care is the quality of life.
Hospice Philosophy

- Today hospice signifies physical, emotional and spiritual well being of the terminally ill and their families that is holistic care.

- Hospice means skilled and empathetic care for sick and their families where ever they may be – at home, in hospital, in an actual hospice building.
Four Phases of a Disease

- Prevention of the disease (Education)
- Prevention of advanced disease (Screening)
- Prevention of death (Anti-cancer treatment)
- Prevention of suffering (Palliative Care)
National Policy Framework for Palliative Care

LIZ GWYTHRER
CEO HPCA
WHA Resolution 67.19

“Strengthening of palliative care as a component of comprehensive care throughout the life course”

South Africa one of the co-sponsors of the resolution (on the WHO executive board)

“Recognizing that palliative care, when indicated, is fundamental to improving the quality of life, well-being, comfort and human dignity for individuals,”

In May 2014
“Acknowledging that palliative care is an ethical responsibility of health systems, and that it is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured, and that end-of-life care for individuals is among the critical components of palliative care”
In May 2016, the Minister of Health, Dr Aaron Motsoaledi appointed a National Steering Committee for Palliative Care to create “a revolution in healthcare through palliative care”. One of the tasks of the steering committee is to provide a framework for teaching and learning of palliative care and to ensure service delivery. This should ultimately lead to the development of a specialty in palliative care.
# Members of Steering Committee

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<tr>
<th>Name</th>
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<tr>
<td>MEC Dhlomo</td>
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<td>Ms Janet Hunter; alt Prof Melvyn Freeman</td>
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<td>Dr Terence Carter</td>
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<td>Ms Sizo Mchunu</td>
<td>SANC</td>
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<td>Adv Phelelani Khumalo</td>
<td>HPCSA</td>
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<td>Prof Mavis Mulaudzi</td>
<td>UP &amp; FUNDISA</td>
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<td>Mr Ari Seirlis/alt Mrs Petra Burger</td>
<td>disability community</td>
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<td>Dr Vassie Naidoo</td>
<td>Pharmacy Council</td>
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<td>Dr Michelle Meiring</td>
<td>UCT/PATCHSA</td>
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<td>Dr Mpho Ratshikana-Moloko</td>
<td>Gauteng Centre for Excellence PC/Wits University</td>
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<td>Dr Liz Gwyther</td>
<td>HPCA/UCT</td>
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<td>Mrs Zodwa Sithole</td>
<td>HPCA</td>
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<td>Ms N GunnClark</td>
<td>HPCA providing secretariat</td>
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Purpose of Steering Committee

To provide expert guidance on the implementation, monitoring and evaluation of progress toward achieving resolution WHA 67.19.

7 task teams have been established to address the 9 WHA regulations

1. Policy Task Team for policy, guidelines, care pathways
2. Funding task team investment case has been presented to DoH
3. Support for Families & health care workers incl. spiritual care
4. Education and Training (in all health care disciplines, basic & intermediate levels and to motivate for specialty for nurses & doctors)
5. Drug availability task team (addresses 3 of the WHA recommendations & tasked to include nurse-prescribing of pain management medicines)
6. Vulnerable populations – children, older people, people with disabilities, the homeless, refugees, in TB & mental health care, in prisons
7. Ethics task team – additional TT to guide on the approach and considerations on End of Life decisions, including a statement on euthanasia and assisted suicide
Recognition of hospices

Throughout the document there is recognition of hospice contribution to PC in SA.

Purpose of the NPFSPC: “to guide the implementation of integrated supportive and palliative care services throughout SA’s health system”

“It also draws up on the strong national network of hospices & NGOs who have led the provision of care and support services to patients and their families for several decades and who have been instrumental in advancing education and training of health care providers.”
Thank You!