A Rehabilitative Approach to Palliative Care

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Palliative Care Physiotherapist
Therapy Services Manager
Increased Number of Deaths

Aging Population

Increased Disability

Increased Dependence on Carers

Increased Demand on Health Services

590,000/year in 2030 – increase 16.5% from 2012
Gomes and Higginson 2008

2030 people aged 65+ will account for 86.7% of all deaths, people aged 85+ will account for 43.5%
Gomes and Higginson 2008

Longevity compromised: people living with and dying from chronic diseases

Older people more likely to have complex problems and disabilities
(Better palliative Care for Older People. WHO Europe 2004)

Decrease proportion younger people, fewer family members available to provide care, families more dispersed. Likely to be elderly also.

Increased demand on Palliative Care Services
How can we meet the escalating need for Palliative Care provision in the future …

and maximise patient wellbeing?
Developing a Rehabilitative Approach to Palliative Care
‘All the work of the professional team .. is to enable the dying person to live until he dies, at his own maximal potential performing to the limit of his physical and mental capacity with control and independence whenever possible’

Dame Cicely Saunders
What is the aim of Rehabilitation in Palliative Care?

- Rehabilitation: “attempts to maximise patients’ ability to function, to promote their independence & to help them to adapt to their condition”

NICE Improving Supportive and Palliative Care for Adults with Cancer 2004
Palliative Care patients experience high levels of functional disability

- 500 cancer patients living with cancer for 1 year: 80% ambulation difficulties
  
  Ganz et al 1990

- Evaluation of 50 patients from a Cancer Rehabilitation Service. 100% had at least 1 problem affecting their function
  
  26%: 1 identifiable problem
  54%: 2 identifiable problems
  20%: 3 or more problems

  Brennan & Warfel, 1993

Montagnini et al 2003
Palliative Care patients experience high levels of inactivity

COPD patients had reduced spontaneous physical activity levels compared with healthy controls:
- 49% compared to the healthy controls
- 79% in those receiving long-term oxygen therapy

Sandland et al 2005
Most palliative patients express a desire to remain physically independent during their disease course

Yoshioka 1996, Morris et al 1986
Patient perspective

Threat of progressive debility and caretaker dependency among most distressing concerns for patients with advanced disease

- Fear of impending death often eclipsed by concern over functional decline and uncontrolled symptoms
  
  Breitbart 1998

- Loss of ability to do what one wants rated highly by both patients and carers among end of life concerns
  
  Axelsson 1998
• Prospect of functional decline may be distressing to point that it engenders a desire for hastened death or even assisted suicide
  
  Breitbart 1999

• Fear of becoming a burden to others among most frequently cited reasons for euthanasia requests

  Van der Maas et al 1996

• Incidence of psychological problems (anxiety/depression) greater when associated with an activity limitation

  Fialka-Moser et al 2003
Carer’s Perspective

Carers of patients with advanced disease face an escalating burden as patients approach the end of life

- Retrospective study of bereaved carers for COPD patients. 95% patients received help from family and friends in the last year of life. Tasks ranged from <5hrs (15%) to > 40 hours (42%)

Elkington 2004
In the face of advancing disease how can rehabilitation possibly make a difference?
In patients with advanced disease ‘pronounced infirmity and poor prognosis’ must be distinguished from functional improvement which is possible in most patients.

Cheville 2001

Rehabilitation focused on eliminating or reducing disability alongside maximising functional status, physical independence and quality of life is appropriate for patients with advanced disease and very limited life spans.

Montagnini et al 2003
What does a rehabilitative approach to palliative care look like in practice?
Rehabilitation as an approach to patient care

Involvement of the interdisciplinary team is central to the success of a rehabilitation approach

‘Rehabilitation should be acknowledged as an approach to treatment rather than a term to describe a few specific therapies’

Mason 2000

Fialka-Moser et al 2003
Case Study

Alf 77
Advanced Lung Cancer
History of severe COPD

Marion
Main carer
Rehabilitation Initiatives
## Functional Assessment

### Mobility

**How do you currently mobilise (move around)?**

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Assistance 1 person</th>
<th>Assistance 2 people</th>
<th>Equipment</th>
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<tbody>
<tr>
<td>Walking</td>
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<td>Inside (around house)</td>
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<td>Outside</td>
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<td>Stairs</td>
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**Transfers:**

- On and off Bed
- Bed → Chair/Commode/wheelchair
- In/out vehicle

**Bed Mobility:**

- Rolling onto side
- Moving up bed
- Repositioning self

**Do you have your walking aid with you?**

- Yes
- No

### Activities of Daily Living (ADL's)

**Personal ADL's:**

- Washing
- Bathing/Showering
- Dressing

**ADL's:**

- Feeding
- Cooking
Rehabilitation in Daily Care

• Enablement Training on Ward

• Joint nursing and physiotherapy assessment and care plans

• Promotion of independence with daily care

• Doctors contextualise symptom control in functional context
Rehab Groups
## Weekly Timetable

<table>
<thead>
<tr>
<th>Time</th>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
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<td>1030</td>
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<td>Day Centre</td>
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<td>2.00</td>
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<td>Counselling</td>
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**Physical**
- Improve mobility and function
- Maximise Independence in ADL's
- Reduce fatigue
- Decrease secondary complications (pressure sores, chest infections, joint contractures)

**Psychological**
- Improve confidence/ motivation
- Improve self rated health
- Decrease feelings of dependency
- Reduce/prevent depression
- Maintain dignity

**Social**
- Maintenance of role
- Decreased burden on carers and family
- Reduced social isolation

**Spiritual**
- Promotes realistic hope
- Reduces helplessness - promotes empowerment
- Supports adaptation to and acceptance of loss
- Maintains self worth

**Improved Quality of Life**
What is the evidence to support Rehabilitation in Palliative Care?
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<tbody>
<tr>
<td>231 palliative cancer patients (121 Exercise, 110 usual care)</td>
<td>301 terminal cancer patients</td>
<td>110 Elderly patients with cancer asthenia (mean age 75.3)</td>
<td>72 palliative cancer patients</td>
<td>18 palliative patients (mixed diagnoses)</td>
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<td>Outpatient Hospital (Norway)</td>
<td>Inpatient Hospice (Japan)</td>
<td>Inpatient Hospital (USA)</td>
<td>Inpatient Hospital (USA)</td>
<td>Inpt Hospital palliative care unit (USA)</td>
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<td>RCT Phase II Trial</td>
<td>Retrospective r/v</td>
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<td>Retrospective r/v</td>
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<tr>
<td>Exercise Programme (8/52 – 2x 60min/wk)</td>
<td>Physical Therapy Programme</td>
<td>Multidisciplinary Rehabilitation Programme</td>
<td>Multidisciplinary Rehabilitation input</td>
<td>Physical Therapy Programme</td>
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<tr>
<td>Improved functional status Range physical outcomes. Large statistical &amp; clinical effect (6 min walk test p=0.08)</td>
<td>80% patients exp functional improvement</td>
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<td>56% patients exp functional improvement within 2/52</td>
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<td>Mean 27% improvement BMI (clinically significant change function)</td>
<td>24% improvement FIM (significant reduction in caregiver time: 30min/day)</td>
<td>31% improvement in function FIM (p=0.01) Metastatic disease made no difference to outcomes</td>
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<td>(ADL scores – no objective measure used)</td>
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<td>COPD</td>
<td>Heart Failure</td>
<td>Multiple Sclerosis</td>
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<td>22 RCT's  890 COPD patients</td>
<td>19 RCT's  3647 participants with Heart Failure</td>
<td>7 RCT's  747 patients with MS</td>
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<td>9 RCT's  432 COPD patients</td>
<td>Range of disease severity</td>
<td>Range of severity</td>
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<td>Range of settings</td>
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<td>Cochrane systematic reviews +</td>
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<td>meta-analysis</td>
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<td>Pulmonary Rehabilitation</td>
<td>Range of rehab programmes</td>
<td>Range of rehab programmes</td>
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<td>Relieves dyspnoea and fatigue</td>
<td>Non-significant trend towards decreased mortality</td>
<td>No change to impairment but improved patient experience and Quality of life</td>
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<tr>
<td>Improves patients’ physical and emotional function and control over the disease</td>
<td>Improved exercise capacity</td>
<td>Increase levels of activity and participation</td>
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<td>Decreases hospital admissions</td>
<td>Significant reduction in hospital admissions</td>
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<td>All outcomes moderately large and statistically significant</td>
<td>Significant improvement in Quality of Life</td>
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<tr>
<td>Improvements regardless of disease severity</td>
<td>Independent of degree of heart failure</td>
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Increased Number of Deaths
Aging Population
Increased Disability
Increased Dependence on Carers
Increased Demand on Health Services

Rehabilitation

Minimise disability
Maximise Independence & dignity
Reduce dependency burden on Carers
Promote wellness/ self-management
Reduce need for Health Services
Reduce pressure Palliative Care
Support Preferred Place of Care
Reduce Cost to health care Services and community
In the context of such weighty and compelling issues, the potential contributions of rehabilitation may seem trivial or inappropriate…

Cheville 2001
Rehabilitation offers a proactive approach to palliative care which has wide reaching impacts at the level of the patient, carer, organisation, community and society.
There is great opportunity to be more Rehabilitative in our approach to Palliative Care…