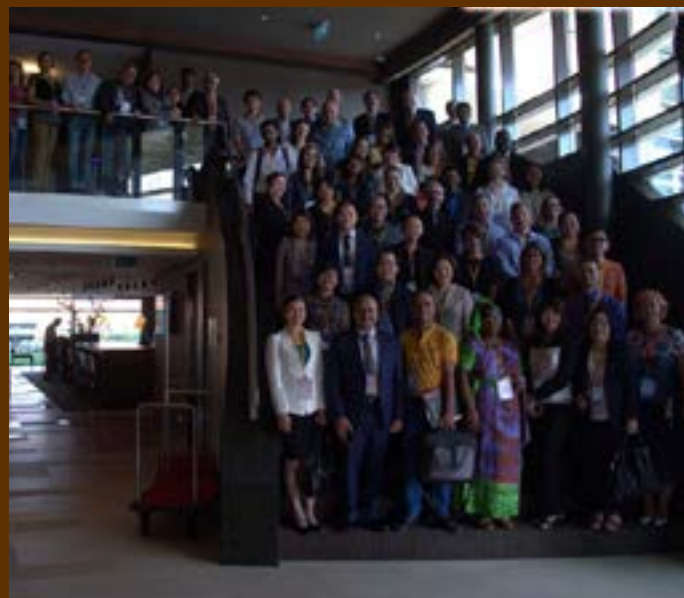


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RESILIENCE AND COPING: A STUDY WITH OLDER PALLIATIVE CARE PATIENTS

Mariana Ribeiro^o and **Moema Borges^o**^oUniversity of Brasília, Brazil**Objective:** To analyse the coping strategies that is used to handle aging and illness.**Method:** Exploratory and qualitative research, based on the phenomenology theoretical framework. We interviewed 11 older palliative care patients with advanced cancer in a hospital in Brazil (semi-structured interviews). Afterwards, those interviews were analysed through Alceste software.**Results:** The 11 participants had an average age of 68, 9 years and an average education of 4, 54 years. From the content analysis, we identified two axes. The first one covers the class resilient coping and the formation of personality, which refers to a resilient personality structure that has been forged throughout the life cycle. In this axis, we identified that the participants had many adverse situations throughout their lives scarce socioeconomic conditions, loss of their parents, and loss of their childhood. To manage these difficulties, we believe that the participants used coping strategies, which forged a resilient personality. The second axis is composed by the class illness and stressors. There we identified the situations that the participants experienced throughout their illness. The main stressors we highlight were: Bad news, and the difficulty in accessing treatment. In the management of the stressors arising from the illness process, the participants reported using resilient coping strategies as spiritual support and accommodation.**Conclusion:** The difficult events throughout the participants' life allowed the development of capacity to deal with adverse situations, to overcome pressures and obstacles, and to become able to react positively to them. Those are characteristics of a resilient personality. Faced with aging and illness, the participants used coping strategies capable of managing the stressors in a positive way.

Biography

Mariana Ribeiro is a Nurse. She is specialized in aging from the Federal University of São Paulo and a Master's candidate at the Postgraduate Nursing Program of the University of Brasília, Brazil.

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ANALYZING THE MOVIE “MY LIFE” UNDER THE PERSPECTIVE OF THE KÜBLER-ROSS

Mariana Ribeiro^a, Moema Borges^a, Tamires Ruana^a, Maria Emilia Bottini^a and Mariana Souza^a

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Objective: To analyze the five stages of death and dying through the narrative of the movie “My Life” (1993), directed by Bruce Joel Rubin.

Method: Exploratory and descriptive study grounded in qualitative approach. We regard the movie as a possible pedagogical byword of the death and dying process, under the outline of the verbal and non-verbal content of the narrative. We, therefore, identified, analyzed, and described its scenes, before classifying them into categories under the Kübler-Ross frame.

Results: After we select and discuss the scenes which illustrate the stages of denial, anger, bargaining, depression, and acceptance, we achieve the following conclusions: denial was shown just after receiving the bad news, when Bob, the main character, insisted on pursuing the cure of a disease without cure; anger was evident during the scene in which Bob entered the medical office without authorization and expressed his non-conformism with the diagnosis; bargaining was evidenced by the moment when the main character asked God to let him live long enough time to see his son’s birth; depression was illustrated when Bob entered a more introspective mood, under which his sleep was dysregulated and he solely remained watching television, the introspective state characterizes a preparatory grief with little need for words. It is a beneficial and necessary stage to overcome agony and anxiety, in order to die under the stages of acceptance and peace. Acceptance was evident when Bob claimed for his son not to feel bad about his departure and reported feeling grateful for the time he could spend with him. Those reactions demonstrate that Bob recognized and accepted his finitude.

Conclusion: We found out that the movie “My Life” elucidates the stages of death and dying. It can moreover be used as a pedagogical tool to stir up critical reflections on the theme.

Stages of Kübler-Ross in the movie “My Life”	
Denial	Bob insists on pursuing the cure of a disease without cure.
Anger	Bob enters the medical office without authorization and expresses his non-conformism with the diagnosis.
Bargaining	Bob asks for God to let him live long enough to see his son’s birth.
Depression	Bob enters a more introspective mood, in which his sleep is dysregulated and he could only remain watching television.
Acceptance	Bob claims for his son not to feel bad about his departure.

Figure 1. Describes scenes from the movie “My Life” that illustrates the five stages of death and dying of the Kübler-Ross Model.

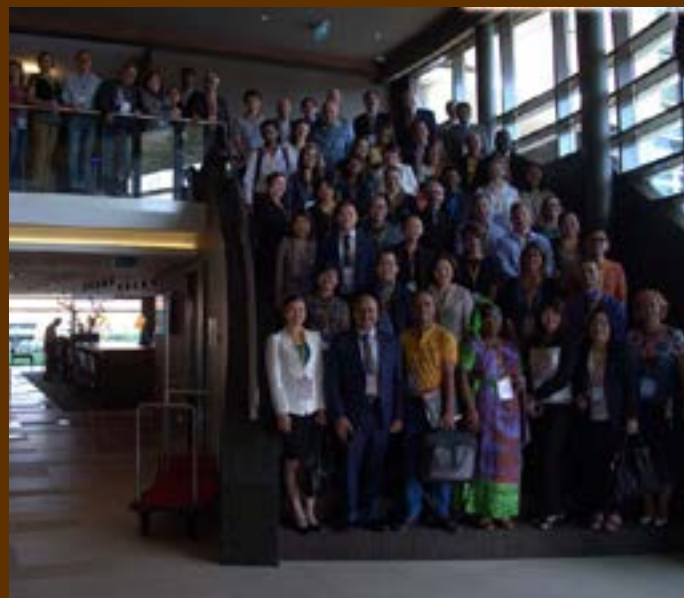
Biography

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CONSUMER DIRECTED CARE AND SPIRITUALITY | END OF LIFE FROM A DIFFERENT PERSPECTIVE

Peter Bewert*

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Session Description: Care planning in residential aged care is a regulatory requirement. Despite a compliance framework, the importance of individualism, one's story and spirituality is integral to holistic care provision for the older person, especially during end of life. The session will outline clinical assessment processes which achieve a holistic framework of care provision for terminal phase care grounded in the uniqueness of individuality and one's spiritual self. The session will outline how clinical assessment is completed from a lifestyle approach to ensure the most positive end of life experience during the terminal phase of palliation.

Findings: The Salvation Army Aged Care Plus has implemented a number of systemic changes in relation to care planning and assessment to ensure spirituality is a primary consideration as part of the person centred approach to care delivery. The uniqueness of individuality and the interface with culture, religious practice and spiritual expression are key considerations associated with end of life care planning (Advanced care planning). The Changes to care planning includes a focus on the importance of "story" and encapsulates individuality and the "inner spirit" of Older Australians. Comprehensive spiritual assessment and care planning is paramount to a person centred approach. During palliative and terminal phase care, spirituality is a significant consideration; it cannot be underestimated in its significance to the completion of an individual's story through dying and end of life.

Objectives: An understanding of clinical assessment processes from an individualised perspective which embraces persons lived experiences associated to end of life. Clinical assessment from a nursing and medical model perspective has a very prescriptive framework that often does not include adequate analysis of spirituality. When completed from a person centred philosophy which embraces an understanding of spirituality the assessment process can encompass a more meaningful context. This result in improved well-being and a quality of end of life experience for not only the individual, but their family and loved ones as well. An understanding of staff awareness and how to overcome bias when being confronted with spiritual planning and end of life is important. One's own story and spiritual awareness is critical to the success of assessing others and putting this into practice in a consumer directed approach to death and dying. Personal bias is present for all individuals; this is a consequence of our own individual stories. In order to ensure a comprehensive holistic spiritual assessment which underpins care planning processes, biases need to be made aware. Staff impacts are significant as spiritual assessments results in confrontation of our own spiritual awareness. An understanding of the multi-collaborative approach between clinicians and chaplains to achieve optimal outcomes for residents in their dying experience.

AVOIDABLE EMERGENCY VISITS BY HOME HOSPICE PATIENTS: IS THERE A SOLUTION?

Cindy Porter*

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Although research has shown the majority of terminally ill people would prefer to die at home, many who are utilizing home-based hospice end up in the emergency room during their final weeks of life. This integrative review evaluates published studies identifying the causative factors and impact of emergency room visits among home-based hospice patients and their family/caregivers in the last few weeks of life from January 2005 to current. A search of the electronic databases EBSCO Host was utilized as well as the U.S National Library of Medicine/Pub Med, Google Scholar, and the Cumulative Index of National and Allied Health Literature (CINAHL) using key words: Nurse Practitioner, palliative care, hospice, end of life care, and emergency. Data was evaluated using a constant comparative approach as well as thematic content analysis to identify key issues. Thirteen studies from the United States were included as well as ten studies from other countries. From these studies, several factors are addressed including: primary reasons for accessing emergency services, the impact on perceived quality of life and caregiver bereavement outcomes, and prevention and guidance aimed towards reducing hospital admissions. The impact of potentially avoidable end-of-life hospital visits by the terminally ill has been shown to adversely affect quality of life and bereavement outcomes. A comprehensive and coordinated specialist palliative care approach may help minimize the number of patients presenting to the emergency department unnecessarily, thereby helping to maintain them in the setting of their choice for the provision of end-of-life care.

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HONOURING THY SELF: DISENFRANCHISED GRIEF AND THE PROFESSIONAL CAREGIVER

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Much has been written that highlights that fact that the profession of nursing is stressful and taxing both physically and emotionally on nurses. Most recently, the field of end of life (EOL) and palliative care has been acknowledged as a stressful occupation and that burnout, attrition, and a nurse's personal involvement is unique to this particular field of health care (Huggard & Nichols 2001; Lobb et al, 2010; Rollings, 2008). Caring for the nursing staff working within the field of EOL and palliative care has not kept pace with the advances in self-care that is acknowledge for other health care professionals. According to Gerow et al, 2010, the impact of death on a family and its members has been well documented throughout the literature including the grief response and process, yet the grieving process and self-care of registered nurses during and following the death of a patient has not been researched extensively as a result.

The purpose of this presentation is to demonstrate identify gaps that exist in EOL and palliative nursing for registered nurses in terms of self-care. Secondly, evidence will be presented in support of models that exist for registered nurses and policy makers to implement self-care within their organizations and into the EOL or palliative care setting. Implications of the lack of consideration of self-care in the profession will be discussed throughout the paper. Additionally, the concept of disenfranchised grief will be deliberated in terms of how this phenomenon has an additional negative affect and its consequences for health care professionals.

SUBJECTIVE QUALITY OF LIFE/SYMPTOM MEASUREMENT OVER TWO DECADES

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The Schedule for the Evaluation of Individual Quality of Life (SEIQoL) is a phenomenological approach to the measurement of quality of life (QoL), in which the terms- of-reference are determined by the individual. Little is known about the impact of symptoms on patients' quality of life. The degree to which the symptoms are actually bothersome to the patient is a missing area in symptom assessments. Waldron et al, demonstrated that symptom 'bother' is a separate entity from both symptom frequency and intensity. Quality of life is a dynamic construct. Over the course of time, areas of life meaningful to the patient to shift through a process of adaptation. There appears to a process of psychological adaptation that enables patients cope and maintain good quality of life, even in the face of adversity. This is a concept known as 'intra subject construct dynamism' or 'response shift'. Using an outcome measure as a clinical tool, especially in the area of quality of life (QoL) is uncommon. We hypothesized that individual QoL information may help improve patient's QoL outcome over time when shared with the multidisciplinary team.

Results: Results of seven Higher Theses are explored to reflect on all above views with both published and presented, Nationally and Internationally papers reviewed.

Conclusion: Subjective QoL can be measured in Advanced Cancer patients and incorporation of Symptoms, Symptom Bother/ Symptom interference with QoL and Response Shift as well as 'Using the Outcome as a Clinical tool' can really help this very vulnerable patient group.

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THE EFFECTIVENESS OF FOUR-FACTOR PSYCHOTHERAPY IN THE DECREASE OF CORTISOL LEVEL

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Many Patients with cancer are disturbed about the possibility of recurrence, death, body image and other psychological problems. These stresses can increase cortisol level and lead to suppression of immune – system strength. The important role of cortisol level in regulating immune- system has well documented. The aim of this research was to assess the effectiveness of four-factor psychotherapy in decreasing the level of cortisol in women with breast cancer. The sample comprised 25 women diagnosed with breast cancer who were selected using voluntary sampling and were randomly assigned to the experimental and control groups. Groups were assessed in terms of serum levels of cortisol before and after the intervention. The experimental group underwent 12 sessions of four-factor psychotherapy whereas the control group received no intervention. The result of co-variance analysis indicated that the four-factor psychotherapy is effective in decreasing the cortisol's level of women with breast cancer. It can be concluded that the four-factor psychotherapy by reducing cortisol levels and also decreasing physical and mental exhaustion contribute significantly to the recovery of patients.

THE CHAMPLAIN SYMPTOM MANAGEMENT KIT: ENHANCING EOL CARE BY PROVIDING TIMELY ACCESS TO MEDICATIONS AND SUPPLIES IN THE HOME

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Adequate pain and symptom management is an essential component of palliative and end-of-life care and has a direct impact on patient and caregiver experience. In September 2014, the Champlain CCAC, in collaboration with regional pharmacies, service provider organizations, the Regional Palliative Consultation Team and community palliative care physicians, introduced a Champlain Wide Pain and Symptom Management Kit (SMK). The SMK is a standard package of medications and related medical supplies placed in the home of a patient who is approaching the end-of-life for the purpose of relieving unanticipated or rapidly escalating symptoms in a timely manner.

The overall purpose of the Kit is to facilitate pain and symptom management at the end of life by providing timely access to medications and supplies, therefore optimizing patients' chances of remaining at home until death; enhancing informal caregiver support in the home; and enabling nurses to manage symptoms without needing immediate access to a physician, which is often difficult.

One year after implementation, a robust evaluation was completed. The results demonstrate a positive impact of the Kit on patients, caregivers, and provider experience, including reduction of caregiver anxiety and increased self-efficacy. The results also demonstrate a positive impact on a number of outcome measures, such as reduced emergency department visits and hospital admissions, and increased patient deaths in their preferred location.

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OPPONENTS AND PROPONENTS VIEWS REGARDING PALLIATIVE SEDATION AT END OF LIFE

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Palliative sedation is sedating a patient to the point of unconsciousness to relieve one or more symptoms, when all other possible measurements have failure. Palliative sedation is charged with controversy since developed. The purpose of this position statement paper is to support and discussing opponents and proponents' views comprehensively around palliative sedation in terminally ill patients. The most important dispute was if palliative sedation hastens death or not, if it can be used as physician-assisted suicide, if it legalized euthanasia and (or) if it violate patient's autonomy. The current authors are supporting palliative sedation with advanced incurable patients in order to alleviate patients suffering, palliative sedation offer to terminally ill patients' comfortable experience at end of life and allow them to die in peace. Palliative sedation should be encouraged to get health care facilities and legal support.

IMPACT OF AGE AND FINANCIAL STATUS OF PATIENTS OR CAREGIVERS ON PERCEPTIONS OF HOSPICE CARE AND THE CHOICE OF HOSPICE V. HOSPITAL CARE AT TERMINAL DIAGNOSIS

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Hospice is designed to provide quality end-of-life medical care for patients and support for their families. Most insurance, including Medicaid, provides hospice benefits. Why then do so few people enter hospice? I hypothesized that the perception of hospice care as a last resort drives the decision to choose hospital care at terminal diagnosis. However, the data shows that although a large number of respondents across age and income groups did not regard hospice care as a last resort, when asked to make a hypothetical decision between hospice and hospital care, they primarily chose hospital care except when life expectancy was less than 3 months. Subjects aged 30 and under showed higher preference for hospital care even when given life expectancy of less than 3 months. Respondents were more likely to choose hospital over hospice care when making the decision for a family member than for themselves. Given 6 months or more to live with a terminal disease, respondents generally chose hospital care, perhaps in anticipation of a curative option which may not be available for diseases such as end-stage Alzheimer's. Thus my hypothesis that the perception of hospice as a last resort drives choice of hospital care at terminal diagnosis was not proven. Multiple factors affect decision making when life expectancy is 3 months or less. Age and income do impact the choice; however end-of-life care decisions are clearly more complex and require careful guidance and support.

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SYSTEMATIC ASSESSMENT AND PATIENTS' DRUG PRESCRIPTION FOLLOW-UP IN LONG-TERM CARE

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To optimize residents' drug prescription in long term care, we conducted a retrospective analysis of all patients' prescriptions admitted to the department between January 1 and June 30 2013. This analysis was to respond, for each drug, to the presence of an indication of prescription, the appropriateness of the dose and the duration of prescription and to the indication to continue the prescription beyond the date of evaluation. This analysis was performed independently by two geriatricians, based on the data contained in the medical records of the patients considered. The justified character of a prescription was defined from the drug authorizations market data (AMM), the French list of drugs potentially inappropriate in the elderly, indications based on evidence and certain clinical ethic principles of geriatric medicine. For the 50 drug orders analysed, this approach allowed an average reduction of three lines of drug prescription per resident. Non-appropriate requirements (indication) rate was 41% of prescriptions; inappropriate times were 16% of prescriptions and non-adapted doses was 23%. Forty three percent of drug treatments had not been continued. This systematic evaluation of drug orders on admission is now sustainable in long-term care. This leads to correct drug prescriptions and fights against poly medication and the avoidable supply in the elderly.

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END OF LIFE CARE EXPERIENCE AT THE PAEDIATRIC ONCOLOGY UNIT AT THE UGANDA CANCER INSTITUTE: WHAT ROLE CAN ONCOLOGY NURSES PLAY?

Isaac Mulyowa*

*Uganda Cancer Institute, Uganda

Background: The majority of childhood cancers are curable; but this is not yet true for low resource countries. In Uganda, cancer care is only at the Uganda Cancer Institute. The institute receives averagely 4,300 patients annually with approximately 8% being a proportion of children. The mortality rate is about 70% annually that is every three in five children diagnosed with cancer will not survive past one year after cancer diagnosis. Here, we reviewed the factors contributing to poor outcomes and potential solutions.

Objectives: The objective of this study is to determine the role of oncology nurses at the end of life care of children diagnosed with cancer.

Findings: Majority of the children were present with advanced diseases at cancer diagnosis. The chemotherapy is prescribed for palliative intent more frequently and high rates of complications are observed. Family involvement in decisions regarding the role of palliative chemotherapy at end of life is undocumented. The concept of quality of life for cancer patients with advanced cancer is not well perceived among care takers and some clinicians at UCI. Nurses play an integral role, identifying symptoms, providing care coordination, and assuring clear communication.

Conclusions: Educational initiatives for patients, families and health-care providers are essential. The oncology nurses play a key role in the multidisciplinary team approach to paediatric patients at end of life care.

EMERGENCY MEDICAL SYSTEM AND NURSING HOME PATIENTS: IS THERE A WAY TO BETTER USE EXISTING RESOURCES TO IMPROVE THE QUALITY OF CARE?

Fabrice Dami*

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Background: Our population is aging. There is a growing number of nursing home (NH) residents who benefit from ambulance transport to the emergency department (ED), which are not known to be 'seniors friendly' and are often on surge capacity. Simultaneously, we face a reduced availability of general practitioners (GP) to visit these patients prior their transport to the ED.

Hypothesis: Many NH patients are transported by ambulance to the ED without having benefitted from a medical evaluation on site. Palliative and end of life care could sometimes be provided on site rather than having the patient transported.

Setting: The State of Vaud (Switzerland) dispatch centre sends ambulances and, when a life-threatening situation is suspected, a prehospital emergency physician (PEP).

Results: We previously published a case series where PEPs have been able to provide palliative and end of life care on site, according to the patient and relative's will, and we with the support of the NH.

Discussion: EMS systems that dispose of PEPs should use this resource not only for life-threatening emergencies but also to provide palliative and end of life care, when all parties (patient, relatives, NH) agree with this strategy, therefore avoiding unnecessary transport to crowded ED.