HOT SPOT

The Newsletter of the Rapid Response Radiotherapy Program
of the Odette Cancer Centre

10 years

Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

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Editorial

By Edward Chow, MBBS

Spring has finally come! Welcome to our second quarterly issue in the year 2009. Our Ontario government is proposing to address the wait times in emergency departments. Ms. Karen Faith discusses the ethical considerations regarding wait times in a timely fashion. Mr. Stephen Jenkinson proposes the dying-centred care for the dying. He emphasizes the real competence of all health care professionals involved in palliative care should be in dying, not in what can be done to prevent, forestall, ameliorate, cloak or conceal dying. Dr. Carlo DeAngelis continues his part 2 in opioid dose equivalency—changes in opioid route or mode of administration. The article is of great practical importance and relevance. Dr. Amna Husain and her team introduce continuous quality improvement in a home palliative care program. Ultimately, this will translate into better patient outcomes and professional fulfillment. Dr. Ewa Szumacher has outlined the continuing medical education for us. The nursing team outlines the reasons, precautions and importance of the nursing escort of patients referred from other hospitals for palliative radiotherapy. The insert titled, “Individualizing a Cancer Pain Management Strategy: Beyond the Basics” is written by Drs. Carlo DeAngelis and Jeff Myers. We hope **Hot Spot** continues to be informative. Thank you for your continued support.

“Be patient”: Ethical considerations regarding wait times

By Karen Faith, BSW, MEd, MSc, RSW, Director Clinical Ethics Centre

My friend recently spent seven hours in an emergency department last week after injuring his hand. He learned from his nurse that two of those hours were spent needlessly waiting in his cubicle. The nurse mistakenly assumed the doctor had stitched his cut. My friend’s experience reflects what it is like to be a patient in our current health system. There is an expectation that patients need to “be patient”. Under our health care system, we have a right to “reasonable access to medically necessary hospital and physician services”. This does not necessarily mean immediate access to health care for non-urgent situations. My friend’s story is being shared to illuminate ethical questions about fairness and timely access to health care services in a publicly funded system where individual health needs must be balanced with the well-being and needs of our fellow citizens.

Currently the Ontario government is proposing a plan to address the wait times in our province’s emergency departments, as well as the number of patients who require alternative levels

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In this issue of HOT SPOT:

Dying-centred care for the dying

By Stephen Jenkinson, MTS, MSW, RSW

Most palliative care conferences tend to be strong on cheerleading. The normal mantra is: We are doing a pretty good job, and we can do it better. The bulk of the presentations proceed accordingly. Palliative care experts are invited to talk to palliative care practitioners about doing better palliative care. What is missing from most of these conferences is a sustained discussion designed to add some clarity and cohesive practice around what this job is. Most teaching in this field assumes we already have precision and legitimate consensus on this issue. As palliative care is practised and taught, it is not much of a question.

The historical roots of contemporary palliative care are found in the standardization of medical practice early in the twentieth century, in the radical innovations of the medical technology industries, in the church-based community service movements and, most recently, in the standardization and practice of psychology. The working assumption across the board is that the particular preoccupations and capacities of each of these fields are amenable to, appropriate for and imminently transferable skills in working with dying people. Going deeper still, the history of palliative care practice, training and innovation knows dying to be a subset of medicine, technology, religious conviction and psychology, and has made it so.

Each of these fields of endeavour developed independently of "the care of dying people and their families," and none of them are specific to that care. To a man with a hammer, the saying goes, everything looks like a nail. If your hammer, say, is medicine, then you turn dying into something medicine can adequately respond to: its nail is the body, and everyone concerned begins understanding dying principally as a medical event. If your hammer is psychology, then dying is a complex trauma, and the nail is the psyche, and the focus is on the intrapsychic mechanics of the patient. And so on.

What dying people have in common, the certain bond they all share, is not their need for medical technology, nor for religious affiliation, nor for psychology-driven counselling. These are all options. Dying people all have dying in common. They are all obliged to grapple with what dying asks of them, and with the almost certainly inadequate preparation available from their culture for the enormous human event that dying is. What dying people fundamentally require and deserve from the helping professions is a range of services that are seconded to the truths of dying. The current standards of practice reverse that arrangement. Dying people deserve dying-centred practice. The helping professions should consider outgrowing their specializations. Etymologically, the verb "to palliate" means to cloak or conceal. These specializations, in their devotion to their expertise, contribute, unfortunately, to the concealment of what dying is, means and must be from those who most need to understand and live it. The real competence of all those professions involved in palliative care should be in dying, not in what can be done to prevent, forestall, ameliorate, cloak or conceal dying.

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"Be patient": Ethical considerations regarding wait times

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of care but must remain in hospital while appropriate, available space is located. Many Ontarians still don't have a primary care physician in their communities and are coming to hospital with serious undiagnosed illnesses. All of these facts help to explain why, in many instances, there are delays and longer-than-expected wait times.

I prefer to focus this discussion on the ethical considerations about caring for patients while we face these challenges and constraints. The following are four key ethical considerations:

Fairness

In times of increased demand for health care and scarce health resources, decisions like who gets admitted when there is one bed available should be informed by ethical principles that support procedural fairness. Without using appropriate criteria or an ethical framework, decisions will be difficult to explain and defend when challenged.

Transparency

Information regarding unavoidable delays and cancellations should be timely and delivered with respect and with sensitivity towards culture and language. This may require staff to take time away from other duties to find an interpreter, or to check in with a patient, express regret about the wait time or keep the patient posted about what is causing the delay.

Ethics of care

Despite the constraints faced in health care, we need to care about our patients. This may involve a simple act like getting an extra blanket for the patient who is waiting on a gurney for a diagnostic procedure. Such acts can define the patient's experience while in hospital.

Supporting an ethos or culture of caring brings me to the last point. While many patients who require non-urgent care are asked to "be patient", health care providers and support staff are exposed to work situations that are increasingly stressful. While efforts are undertaken to address the challenging wait times for non-urgent care, it is crucial for health care settings to examine how well they advocate for and model values of care and compassion not just for patients and their family members, but also for staff and health providers.

Opioid dose equivalency: Part 2—Changes in opioid route or mode of administration

By Carlo DeAngelis, PharmD

The dose of opioid may require adjustment when changing route of administration (e.g., oral to parenteral or vice versa) because of differences in the amount of opioid reaching the systemic circulation. However, for the purpose of equianalgesic dose calculations, the intravenous (IV) and subcutaneous (SC) routes of administration are considered to provide equivalent systemic exposure and, therefore, the dose of opioid required to give the same analgesic effect is the same (i.e., 10 mg of SC morphine is expected to give the same analgesic effect as 10 mg of IV morphine). The change from IV to SC dosing does, however, result in a change in onset of action. While an IV bolus has an onset of minutes, the SC route requires 10 or 15 minutes to take effect. From a patient perspective, this difference in onset has little impact on overall pain control in the majority of cases. We must not confuse rapidity of onset with better pain control, particularly when the principal goal of changing route or mode of administration is most often to facilitate and/or optimize drug delivery leading to better long term pain relief and reduced side effects. Similarly, a parenteral bolus dose provides the same pain relief as the same dose delivered as a parenteral continuous infusion and this applies to both IV and SC routes of administration. Therefore, 48 mg of morphine given IV or SC as a continuous infusion over 24 hours (i.e., 2 mg/hour) would be expected to provide the same pain relief as 8 mg of morphine given as an IV or SC bolus every four hours around the clock (i.e., 8 mg/dose x 6 doses = 48 mg). This same rule applies for the oral route when considering rapid versus sustained release formulations. The advantage of delivering the opioid as a continuous infusion or using a sustained release formulation would be a possible decrease in side effects such as sedation, nausea and/or vomiting, which are side effects typically associated with "peak" drug concentrations.

When converting a patient from parenteral (IV or SC) to the oral route of administration or vice versa, the dose of opioid must be adjusted. Morphine and hydromorphone are the two most commonly used opioids with both parenteral and oral formulations available. The conversion ratio from parenteral to oral for morphine is one to three and for hydromorphone is generally accepted as one to five (Gammaitoni, Fine, Alvarez, McPherson & Bergmark, 2003). The difference in conversion ratio being due, in part, to the fact that oral morphine administration produces greater amounts of active metabolite (morphine-6-glucuronide), which accumulates during chronic dosing of the medication. An example of how to use these parenteral-to-oral conversion ratios follows:

A patient with metastatic lung cancer admitted to hospital in pain crisis has been stabilized on a continuous infusion of hydromorphone 5 mg/hour and 1 mg breakthrough doses allowed every hour (the patient has used an average of four breakthrough doses per day over the last three days) is being planned for discharge home. Since the patient is still able to swallow medications, the physician would like to convert the patient's opioid regimen to the oral route. What would be the oral dosing regimen for hydromorphone in this patient?

Total daily hydromorphone dose:

Dose from parenteral continuous infusion: 5 mg/hour x 24 hours = 120 mg

Dose from parenteral breakthrough use: 1 mg x 4 doses/24 hours = 4 mg

Total daily parenteral hydromorphone dose = 124 mg

Using the above mentioned 1 to 2 parenteral to oral potency ratio, the equivalent oral dose of hydromorphone would be: 124 mg x 2 = 248 mg

The oral dosing regimen could be calculated as follows:

Background opioid:

For ease of administration and to reduce the number of pills required, the sustained release formulation of hydromorphone was chosen to meet the "background" opioid requirements. To reduce the number of capsules the patient has to take at any given time, it was decided to administer the sustained release formulation three times daily (i.e., every eight hours). The dose of hydromorphone each administration would therefore be:

248 mg/24 hours ÷ 3 dose/24 hours = 82.7 mg/dose

Hydromorphone sustained release formulation is available in 3 mg, 6 mg, 12 mg, 18 mg, 24 mg and 30 mg capsule strengths. Starting with the highest strength capsule (30 mg); the number of capsules that could divide evenly into 248 would be eight. Keeping in mind our desire for every eight hour dosing and for convenience, six of the eight required 30 mg capsules could be prescribed as follows: 2 x 30 mg = 60 mg every eight hours = 180 mg/24 hours. There remains 248 mg - 180 mg = 68 mg to be given. Using the 24 mg strength, the number of 24 mg capsules required would be 3 (68 ÷ 24 = 2.8). Thus using a combination of the 30 mg and 24 mg strengths available, the patient would be discharged on 84 mg every 8 hours (2 x 30 mg capsules plus 1 x 24 mg capsule each dose every eight hours).

Breakthrough opioid:

Being conservative and using 10% of the total daily dose, the breakthrough dose for our patient would be:

248 mg/24 hours x 0.1 = 24.8 mg in divided doses

Hydromorphone regular release formulation is available in 1 mg, 2 mg, 4 mg and 8 mg tablet strengths. Thus, the patient could be instructed to take a breakthrough dose of 24 mg (3 x 8 mg tablets) every four hours as needed for breakthrough pain. If an every-two-hour dosing strategy is desired for breakthrough dosing, the patient could be prescribed 12 mg (3 x 4 mg tablets) to be taken every two hours as needed.

Reference

Gammaitoni, A.R., Fine, P., Alvarez, N., McPherson, M.L. & Bergmark, S. (2003). Clinical application of opioid equianalgesic data. **Clinical Journal of Pain, 19**, 286–297.

Integrating continuous quality improvement in a home palliative care program

By Ceilidh Eaton Russell, BA, CLSt Dip, CCLS, Christopher Obwanga, BSc,
Natalie Parry, MHSc, and Amna Husain, MD, CCFP, MPH

Continuous quality improvement (CQI) methods are recognized to translate into better patient outcomes and professional fulfilment. Although most CQI projects are not considered research, some CQI projects may be generalizable beyond an organization. More often, CQI is a way to translate learning from many sources, including organizational learning to the day-to-day functioning of an organization and to the care of patients and families. In this way, CQI embodies a process for effective knowledge translation that is customized to a specific setting. Despite evidence of improved outcomes for patients and providers alike, the implementation of CQI methods is infrequent and delegated to quality assurance staff at many health care organizations.

The Temmy Latner Centre for Palliative Care provides home palliative care serving Toronto, East York and parts of North York. The program includes the Max and Beatrice Wolfe Centre for Children's Grief and Palliative Care (MBWCC). The Latner Centre has embarked on a plan to integrate CQI across all areas at the centre: clinical, administration, counselling, education and research processes. Our objective is to incorporate CQI principles and procedures in all our activities to develop a culture of self-examination and relentless improvement at the centre. To this end, we have begun to educate ourselves in CQI methods, with invited speakers, group discussions and professional development of our staff. We have established a CQI working group with a flexible, rotating membership that will involve most staff of our centre over a period of time.

As a first project, we examined the intake process of referrals to the Children's Centre. We began by consulting the people involved in the intake process and staff representing different areas of the centre who provided their perspective on the process. We mapped out the existing process, designed a data collection sheet and measured its performance. The old process had no consistent method for triaging, or a consistent strategy for providing information and resources to families and, therefore, did not always meet the needs of children and their families in a timely way. As the referrals to the centre grew, so did the wait-list. In designing a new way of responding to referrals, we streamlined inefficient steps in the intake process. We designed a new intake procedure that involved the counsellors rotating intake responsibilities on a weekly basis and contacting the family within seven to 10 days of referral. The information, resources, referrals and support provided during the intake phone call were standardized. The phone call was also an opportunity to assess the family's situation, the complexity and urgency of issues and the family's capacity to support the children involved. Ongoing measurement with the data collection sheet, which captures details of the steps in the intake process from referral to visit, allows us to measure the effectiveness of the intervention.

Data suggest that the intake phone call is itself an effective intervention for many families whose needs were met by the information, education and support provided during the intake call. Next steps in this iterative CQI project are to determine: (1) time from intake to being seen if the child or family are triaged to wait-list versus those who are fast-tracked; (2) the number of Children's Centre interventions/services related to children or families who are fast-tracked versus those wait-listed; (3) the number of interventions/services related to the child's relationship to the dying person; (4) the number of interventions/services related to a child with a palliative diagnosis versus a child receiving care for grief. Gathering these data will allow resource planning and further refinement of the intake process and will translate into more timely and appropriate care for children and their families.

To facilitate and encourage as many staff as possible to use the lens of CQI to examine the activities in which they are involved, we have created a template to guide the design of a CQI project and record the unfolding of a CQI process. To translate the learning across the organization and to build on the experience of the Children's Centre, we will examine the intake process as it relates to physician palliative care services using CQI methodology. Additional CQI work is being done in evaluating the effectiveness of an EMR implementation and standardizing the process of data entry.

Nursing escort for patients attending Rapid Response Radiotherapy Program (RRRP)

By Lynn Faltl, RN, BHA(c), RRRP and Pager Office Nursing Staff

The Odette Cancer Centre at Sunnybrook is an ambulatory care centre that provides consultation and treatment for 800 to 1,200 patients a day. Due to these volumes, we are unable to provide one-on-one nursing care or supervision. In an effort to continue building collaborative relationships with your facility and to ensure patients who are sent to the Odette Cancer Centre will receive safe and quality care, we have identified necessary transfer requirements.

In our experience at the Odette Cancer Centre, many patients have been accompanied by a health care provider. On occasion, however, patients have not been accompanied. This has had the potential to compromise care. A family member may accompany a patient at any time, but is not a substitute for a health care provider when a patient requires care. The health care provider should be familiar with the patient, especially if the patient requires supportive care, supervision, has an IV, oxygen, indwelling catheter, requires suctioning, injections or is incontinent. We request that all medications the patient is to receive for the day including analgesics are sent as ambulance pick-up may be delayed. Any special supplies should also be provided, as we do not always have the correct items in stock.

Communication is essential to quality patient care. The patient should also arrive with a “Patient Transfer Form”, an updated copy of their Medication Administration Record (MAR) for the day, their chart and all medical imaging films/discs.

A checklist is attached to facilitate your preparation for sending patients to the Odette Cancer Centre.

We thank you for your cooperation in coming alongside us to provide excellent and safe care to our patients. If you have any questions please feel free to contact one of the nursing supervisions at (416) 480-5000 at extensions 1937 or 1498.

Check list for ambulance transfer to Odette Cancer Centre (OCC)

Please send this completed checklist with the patient to their appointment at the OCC.

Patient Name ____________________

Sending facility ____________________

Floor and Nursing Station Phone Number ____________________

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☐ COMPLETED TRANSFER RECORD

☐ PATIENT CHART
If not possible to send complete chart, please include copy of resuscitation orders in addition to other relevant information.

☐ UPDATED MAR SHEET

☐ MEDICATION TO LAST UNTIL 2200 HRS.

☐ I/V SOLUTIONS (if specially mixed)

☐ EQUIPMENT (analgesic pump, I/V pump, etc.)

☐ X-RAYS

☐ SPECIAL SUPPLIES

☐ SPECIAL ORDERS – e.g., diet

☐ EQUIPMENT FAILURE BACK-UP PLAN

☐ Metro Ambulance

or

☐ Private Ambulance

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Name of Ambulance Service ____________________

Phone Number of Ambulance Service ____________________

Continuing Medical Education 2009–2010

By Ewa Szumacher, MD, MEd, FRCP(C)

Continuing Medical Education (CME) can update health care professionals on the latest advances for modifications to their clinical practice. At the request of the CME organizers, Hot Spot lists the national and international CME activities in palliative medicine that are of interest to our readers. Please kindly forward details of the CME activities to: **Ewa.Szumacher@sunnybrook.ca**

- April 15–18, 2009—Association for Death Education and Counselling—31st Annual Conference, Hyatt Regency Dallas, Dallas, Texas; Phone: (847) 509-0403; E-mail: **info@adec.org**; **http://www.adec.org**
- April 24, 2009—Palliative Care Conference—Strengthening Supportive Care when Death is Near: Familial, Institutional, Cultural and Spiritual Care at the End of Life, Crowne Plaza Hotel; Toronto, Ontario; **http://www.careconferences.com/conferences.html**
- April 27–June 24, 2009—Certificate in Essential Palliative Care, Esher, Birmingham; Belfast, UK; Contact: Mrs. Catherine Hazell; E-mail: **catherinehazell@pah.org.uk** **www.pah.org.uk/education**
- April 30–May 2, 2009—Nova Scotia Hospice Palliative Care Association Conference 2009: Peace Talks—Facilitating the Palliative Care Journey, Annapolis Basin Conference Centre in Cornwallis Park; Annapolis Valley, NS; Tel.: (401) 863-9627; **http://www.nshpca.ca/**
- May 3, 2009—2009 Hike for Hospice Palliative Care, Canada; Contact: Linda Truglia, Canadian Hospice Palliative Care Association; Tel: 1-800-668-2785; E-mail: **ltruglia@scohs.on.ca**
- May 3–9, 2009—2009 National Hospice Palliative Care Week, Canada; **http://www.chpca.net/events/nhpc_week.htm**
- May 5–12, 2009 & November 10–17, 2009—The Program in Palliative Care Education & Practice (PCEP), Royal Sonesta Hotel, Boston; Tel.: (617) 582-7859; E-mail: **pallcare@partners.org**
- May 7–9, 2009—American Pain Society 28th Annual Scientific Meeting, San Diego Convention Center, San Diego, CA; **http://www.ampainsoc.org/meeting/**
- May 7–10 2009—11th Congress of the European Association for Palliative Care, Vienna, Austria; **http://www.eapcnet.org/Vienna2009/**
- May 29–June 2 2009—2009 ASCO Annual Meeting, Orlando, Florida; **http://www.asco.org/ASCO/Meetings/ASCO+Annual+Meeting**
- May 11–15 2009—3rd Annual National Interprofessional Institute in Palliative Care, McMaster University, Hamilton, Ontario; **http://fhs.mcmaster.ca/palliativecare/summerinstitute2.html**
- June 25–27 2009—Supportive Care in Cancer, MASCC/ISOO 2009 International Symposium, Rome, Italy; **http://www.mascc.org/content/8.html**
- September 24–27, 2009—International Conference on Cultural Connections for Quality Care at the End of Life, Perth, Western Australia; **http://www.conlog.com.au/palliativecare2009/**
- September 30–October 3, 2009—23rd CARO Annual Scientific Meeting, Quebec City, Quebec; **http://www.caro-acro.ca/Meetings___Education.htm**
- October 8–11, 2009—American Academy of Pain Management—20th Annual Clinical Meeting, Sheraton Phoenix Downtown Hotel, Phoenix, AZ; **http://www.aapainmanage.org/conference/Conference.php**
- October 18–21, 2009—2009 Canadian Hospice Palliative Care Conference, Winnipeg, Manitoba; **http://www.chpca.net/events/calendar_of_events.htm#oct09**
- November 1–5, 2009—51st Annual ASTRO Meeting, McCormick Place, Chicago, Illinois; **http://www.astro.org/Meetings/AnnualMeetings/index.asp**
- February 11–14, 2010—IXVII International Conference of Palliative Care of IAPC, Trichirappalli, Tamilnadu, India; Contact: Dr. T. Mohanasundaram; E-mail: **drmohs.trichy@hotmail.com**

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