

The Role of Speech-Language Pathology in Palliative Care

Laura Chahda

Speech-Language Pathologist (CPSP)

Associate Lecturer, La Trobe University, Bundoora

Palliative Care

“An approach that improves the quality of life of patients and their families, facing the problems associated with life-limiting illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other physical, psychological and spiritual issues”

(World Health Organisation (WHO), 2005)

- Palliative care in an **active care option** (Fins, 2006)

What is a palliative approach?

- End of Life care is done through generalist health professionals and is not limited to palliative care oncology “experts”

(A Healthier Future for all Australians, 2008)



What is a Speech-Language Pathologist?

Speech-Language Pathologists (SLPs) work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders in children and adults.

Scope of Practice:

1. Speech (e.g. articulation)
2. Voice
3. Fluency
4. Language (comprehension and expression)
5. Cognition (e.g. attention, memory, executive functioning)
6. Dysphagia (i.e. feeding and swallowing)

Why should SLPs be involved in palliative care?

The scope of practice for SLPs has increased for several reasons:

- Ageing population
- More chronic disease and untreated clinical symptoms
- Unmet family needs
- Poorly trained health professionals
- MORE communication and swallowing problems

Why should SLPs be involved in palliative care?

- 35-37% of palliative patients have an associated dysphagia (swallowing problem)

Two broad client categories for whom enteral nutrition (feeding tubes such as NGTs and PEGs) may be considered:

CATEGORY 1: Potentially reversible conditions where tube feeding may have distinct health benefits (e.g. CVA)

CATEGORY 2: Typically very elderly people where the prognosis is unclear

Why should SLPs be involved in palliative care?

- ▶ End of Life (EoL) decisions are often dependent on determining a person's cognitive-communication skills including their decision-making capacity
- ▶ SLPs may develop a functional communication system with the person with a life-limiting illness and their family to fully participate in the choices being made (Gooden, Jones, Mann, McDowell & Shugg, 2005)



SLP Goals in Palliative Care

- To provide consultation to patients, families and caregivers with regard to communication, cognition and swallowing function
- To develop strategies in the area of communication skills in order to support the patient's role in decision-making and communication with the family and the palliative care team
- To assist in optimising function related to dysphagia symptoms in order to improve comfort and patient satisfaction with regards to feeding
- To communicate with the palliative care team and provide input on the overall care of the patient

(Pollens, 2012)



Considerations for Dysphagia Management (Swallowing)

- The treatment will usually be modified as the person's condition changes
- The treatment plan will differentiate tolerance between solids and liquids but also the recommended amount for each consistency (with dietitian consultation)
- Goal of intervention will be education and comfort for the person with the life-limiting illness, the family and palliative care team
- The primary goal will **not** be necessarily to reduce the risk of aspiration but rather to ensure comfort and support the person/family wishes
- Documentation and agreement of oral/non-oral feeding decisions
- Consideration of potential compensatory techniques (i.e. positioning)
- Educate and inform the person, family and palliative care team on artificial nutrition and hydration

Artificial Nutrition and Hydration

- ❑ Feeding tubes will not change the outcome; it will likely marginally prolong the inevitable
- ❑ The discomfort of the feeding tube can lead to the person the tube out and result in negative consequences
- ❑ Artificial hydration can lead to fluid overload potentially resulting in peripheral oedema and pulmonary congestion

Potential complications:

- Pain with insertion and removal
- Oesophagitis / Oesophageal stricture
- Regurgitation / **aspiration**
- Death from procedure (PEG tube)
- Wound infection
- Self-extubation (esp. cognitive deficits)

Case Study (Dysphagia/Swallowing):

- ❖ 73 Year old gentleman, Andy* presents with moderate intellectual disability, terminal colorectal cancer, recurrent chest infections and nil dentition
 - ❖ Palliative trajectory according to medical team however prognosis likely 12-18 months
 - ❖ Limited verbal output – communicates primarily with gestures and facial expressions and yes/no responses
 - ❖ Carers explain that Andy is on a pureed diet and moderately thick fluids however ‘sneaks sandwiches’ from other residents plates and the kitchen when carers are not looking – he thoroughly enjoys bread and a beer on Fridays (happy hour). Andy is generally compliant however refuses to eat with residents on Friday afternoons and throws his beer when he receives it (thickened)
 - ❖ Andy is an avid Collingwood supporter
-
- Videofluoroscopy
 - Trial of bread and beer (unthickened)
 - Trial of compensatory strategies (chin tuck) – Collingwood inspired!
 - Confirmation of needs via carers and Rt (behaviour) – confirmation of reliable answers from Andy to determine needs/wants

Considerations for Communication & Cognitive Deficits

Common deficits seen with deterioration of health status / palliation:

- Motor speech disorders (dysarthria)
- Memory impairment
- Reduced judgement / problem solving skills
- Disorders of comprehension
- Impairment in word retrieval skills
- Impairment in breath support and ability to obtain sufficient breath support for speech

What would persons nearing EoL communicate about?

- Pain / discomfort
- Emotions
- Symptoms
- Family/home
- Physical care needs / positioning
- End of life considerations / advance care directives

Considerations for Communication & Cognitive Deficits

Goals should include:

- ❑ Identifying the most practical mode of communication for the current time and anticipate the most reasonable mode of communication for the future
- ❑ Communication will be facilitated if the family and care givers understand the types of deficits exhibited, their cause and compensatory strategies
- ❑ Treatment should focus on helping the family and care givers understand that the desire of the patient to communicate will be limited and will rapidly be centred on comfort
- ❑ The family and care givers will need to understand that they will need to be the topic generators
- ❑ Help family and care givers understand non-verbal cues in order to anticipate communication

Case Study (Communication):

- ❖ 56 year old woman, Amy* presents with Motor Neurone Disease (MND. Diagnosis approximately 7 years ago. Recent deterioration, prognosis unclear
- ❖ Speech has been moderately affected (mixed dysarthria); 50-70% intelligibility
 - Uncoordinated breath support (shallow clavicular breathing)
 - Hyponasality
 - Imprecise consonant, articulation, distorted vowels
 - Monopitch, monoloudness, slow rate of speech
- ❖ Receptive and expressive language skills – WNL
 - Discussion of short and long term goals
 - Important discussions of progression of MND; advance care directive; highlighting goals as identified by Amy (pain, loved ones, spiritual input)
 - Traditional speech therapy techniques to maximise current verbal output and maintain for as long as possible
 - Discussion of future plan; augmentative and alternative communication (AAC); communication board, voice banking (directives, loved ones), hi-tech/low-tech devices
 - Education / planning with family and palliative care team re: supportive communication strategies (i.e. forced responses, control of environmental factors etc.)

Challenges facing SLPS

- ❑ Limited appreciation of SLP role in palliative care teams
- ❑ Little academic knowledge of palliative care – minimal to no explicit curriculum in Speech Pathology courses
- ❑ Limited exposure to palliative care as a student or in previous clinical practice so new graduates may not appreciate their role
- ❑ Lack of clinical supervision / support / mentoring around palliative care
- ❑ Inconsistent approaches to palliative care across settings (e.g. aged care facilities)
- ❑ New approach to **palliative rehabilitation**
- ❑ Lack of organisational policy / procedure around palliative care to guide clinical practice (Speech Pathology Australia Code of Ethics, 2010) – **No clinical guidelines**
- ❑ Regular conflict with staff, patients and/or families about rights, responsibilities and duty of care around palliative care
- ❑ Increased likelihood of emotional burden and professional burnout in staff



Current Progress

OBJECTIVE 1: *Identify the current nature of SLPs roles in adult palliative care settings.*

1. What are the current roles and expectations of SLPs working in palliative care settings?
2. What are SLPs experiences, perceptions and expectations of working with people who are palliative?

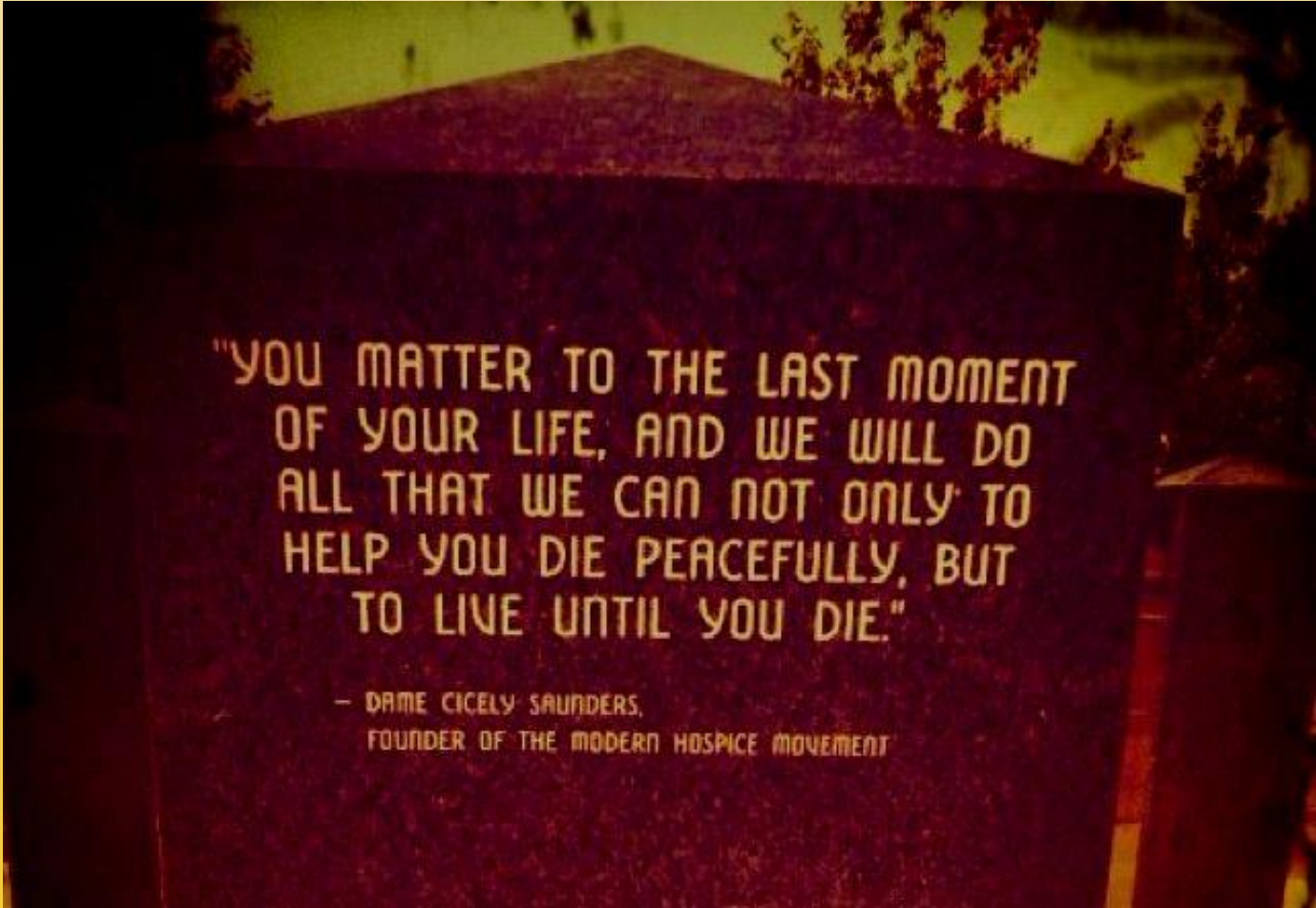
OBJECTIVE 2: *Collaborative development and evaluation of assessment/therapy strategies for palliative patients*

1. What therapy strategies do SLPs perceive as essential in palliative care settings?
2. How do SLPs feel supported in palliative care settings?
3. What training/knowledge is expected of SLPs entering palliative settings?

OBJECTIVE 3: *Develop a set of recommendations for understanding and enhancing the SLP role in palliative care settings to contribute to future Clinical Practice Guidelines in palliative care*

1. What areas do SLPs believe they are unsupported in managing people who are palliative?
2. How can SLPs be guided to provide evidence-based communication and swallowing management for people who are palliative?

Thank You



"YOU MATTER TO THE LAST MOMENT
OF YOUR LIFE, AND WE WILL DO
ALL THAT WE CAN NOT ONLY TO
HELP YOU DIE PEACEFULLY, BUT
TO LIVE UNTIL YOU DIE."

— DAME CICELY SAUNDERS,
FOUNDER OF THE MODERN HOSPICE MOVEMENT

References

- Altilio, T., & Otis-Green, S. (2011). Oxford textbook of palliative social work. *Oxford textbook of palliative social work* (pp. xxxiii, 812). New York, NY: Oxford University Press; US.
- Chahda, L., Mathisen, B. & Carey, L. (submitted 2016) The role of speech-language pathologists in adult palliative care. *International Journal of Speech-Language Pathology* (IJSLP)
- Dunn, H. (2009) *Hard choices for loving people: CPR, artificial feeding, comfort care, and the patient with a life-threatening illness* (5th ed.). Lansdowne, VA: A&A Publishers, Inc.
- Frost, M. (2001). The role of physical, occupational, and speech therapy in hospice: Patient empowerment. *American Journal of Hospice & Palliative Medicine*, 18(6), 397-402.
- Gooden, J-F., Jones, C., Mann, A., McDowall, M. & Shugg, J. (2005). Care and communication: The role of the speech pathologist in palliative care. Melbourne: La Trobe University. Retrieved 26th June, 2006 from <http://www.latrobe.edu.au/careandcommunication>.
- Jackson, P., Robbins, M., & Frankel, S. (1996). Communication impediments in a group of hospice patients. *Palliative Medicine*, 9, 1-26.
- Lambert, H. (2012). The allied health care professional's role in assisting medical decision making at the end of life. *Topics in Language Disorders*, 32(2), 119-136. doi: <http://dx.doi.org/10.1097/TLD.0b013e318254d321>
- Mathisen, B., Yates, P & Crofts, P. (2011). A Palliative Care Curriculum for Speech-Language Pathology Students. *International Journal of Language & Communication Disorders*, 46, 3: 273-285.
- McNamara, E. P. & Kennedy, N. P. (2001) Tube feeding patients with advanced dementia: An ethical dilemma. *Proceedings of the Nutrition Society*, 60(1), 179-785
- Pollens, R. (2012) Integrating speech-language pathology services in palliative end-of-life care. *Topics in Language Disorders*, 32 (2), 137-148.
- World Health Organization (WHO) (April 13, 2005). WHO definition of palliative care. Retrieved 1st February, 2008 from <http://www.who.int/cancer/palliative/definition/en/>