The Role of Speech-Language Pathology in Palliative Care

By : Dr Leila Ghasisin
Assistance professor of Isfahan Rehabilitation School

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 Organization (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”

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
- Un met 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

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

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

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)

گزارش موردی

- آقای ۷۳ ساله مبتلا به سرطان ناحیه گردن که با عفونت های مکرر ریه مواجه بود. بعد از چندین بار درمان ریه، پزشک نامبرده را به گفتار درمانی ارجاع داد
- اقدامات انجام شده:
- ارزیابی کامل بلع (ارزیابی بلع)
- ارزیابی بلع از طریق Videofluoroscopy
- پس از ارزیابی بلع مشخص شد که نامبرده در بلع حلقی دچار مشکل است و silent aspiration دارد.

Considerations for Communication & Cognitive Deficits

- **Common deficits seen with deterioration of health status / palliation:**
- Motor speech disorders (dysarthria)
- Memory impairment
- Reduced judgment / 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

- Goals should include
- 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

گزارش موردی

- خانم ۵۷ ساله ای به دلیل متاستاز سرطان ریه به مغز دچار گفتارفلجی شدید (Severe Dysartheria) است. علایم

- 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

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 maximize 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

Challenges facing SLPS

- Inconsistent approaches to palliative care across settings (e.g. aged care facilities)
- New approach to palliative rehabilitation
- Lack of organizational 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

Swallowing Difficulties in Palliative Care

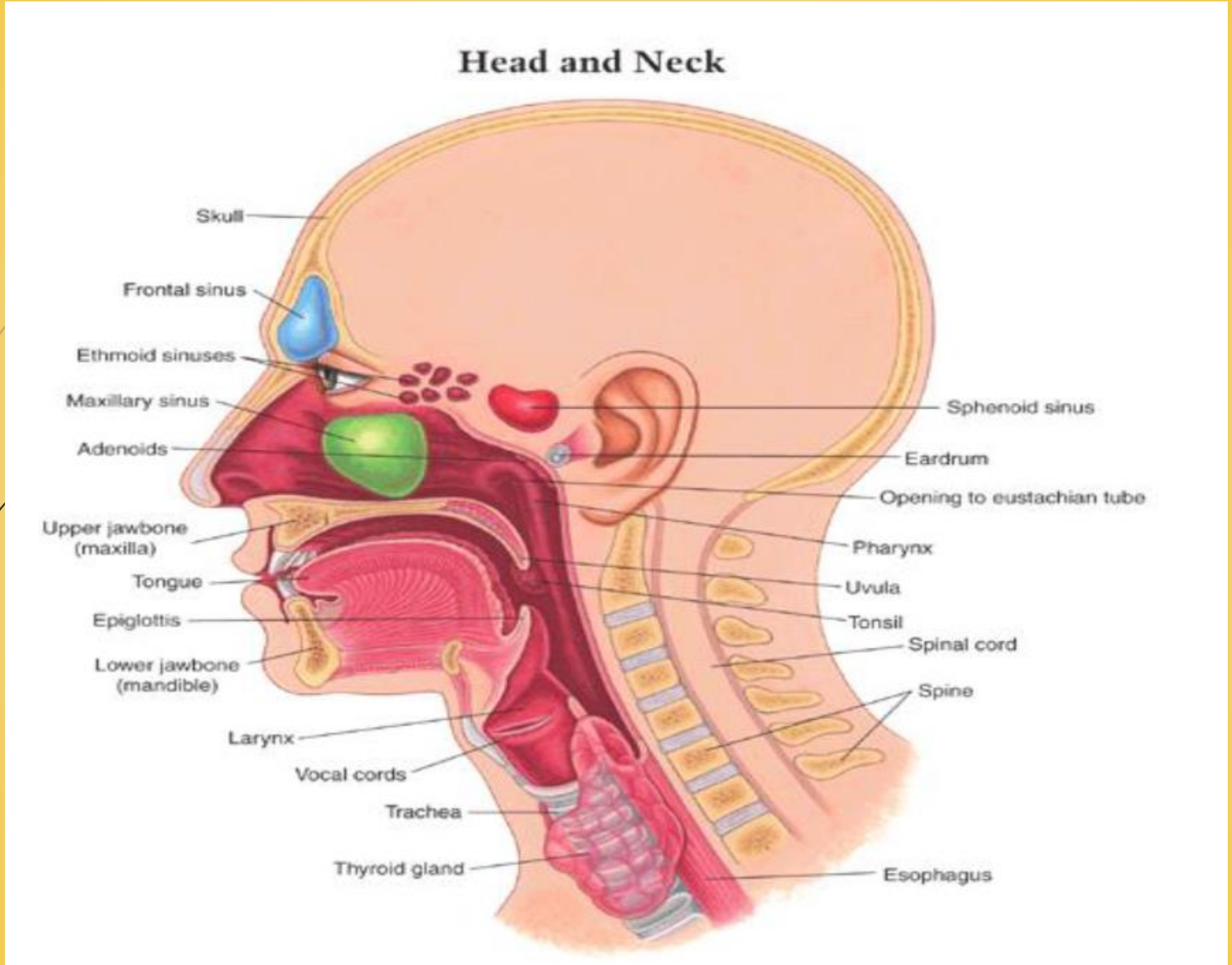
- What is Dysphagia
- Conditions that may cause dysphagia
- Normal swallowing
- Signs and consequences of dysphagia
- How dysphagia is managed

Role of SLT

Assessment and management

Practical session and scenarios

Risk feeding in end of life care


Head and Neck
Skull
Frontal sinus
Ethmoid sinuses
Maxillary sinus
Adenoids
Upper jawbone (maxilla)
Tongue
Epiglottis
Lower jawbone (mandible)
Larynx
Vocal cords
Trachea
Thyroid gland
Sphenoid sinus
Eardrum
Opening to eustachian tube
Pharynx
Uvula
Tonsil
Spinal cord
Spine
Esophagus

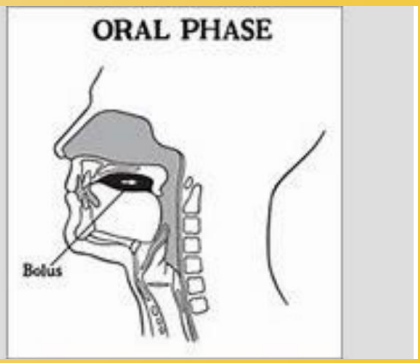
- Safe swallowing involves the efficient, timely and coordinated transport of food, fluid and saliva from the mouth through the throat to the stomach

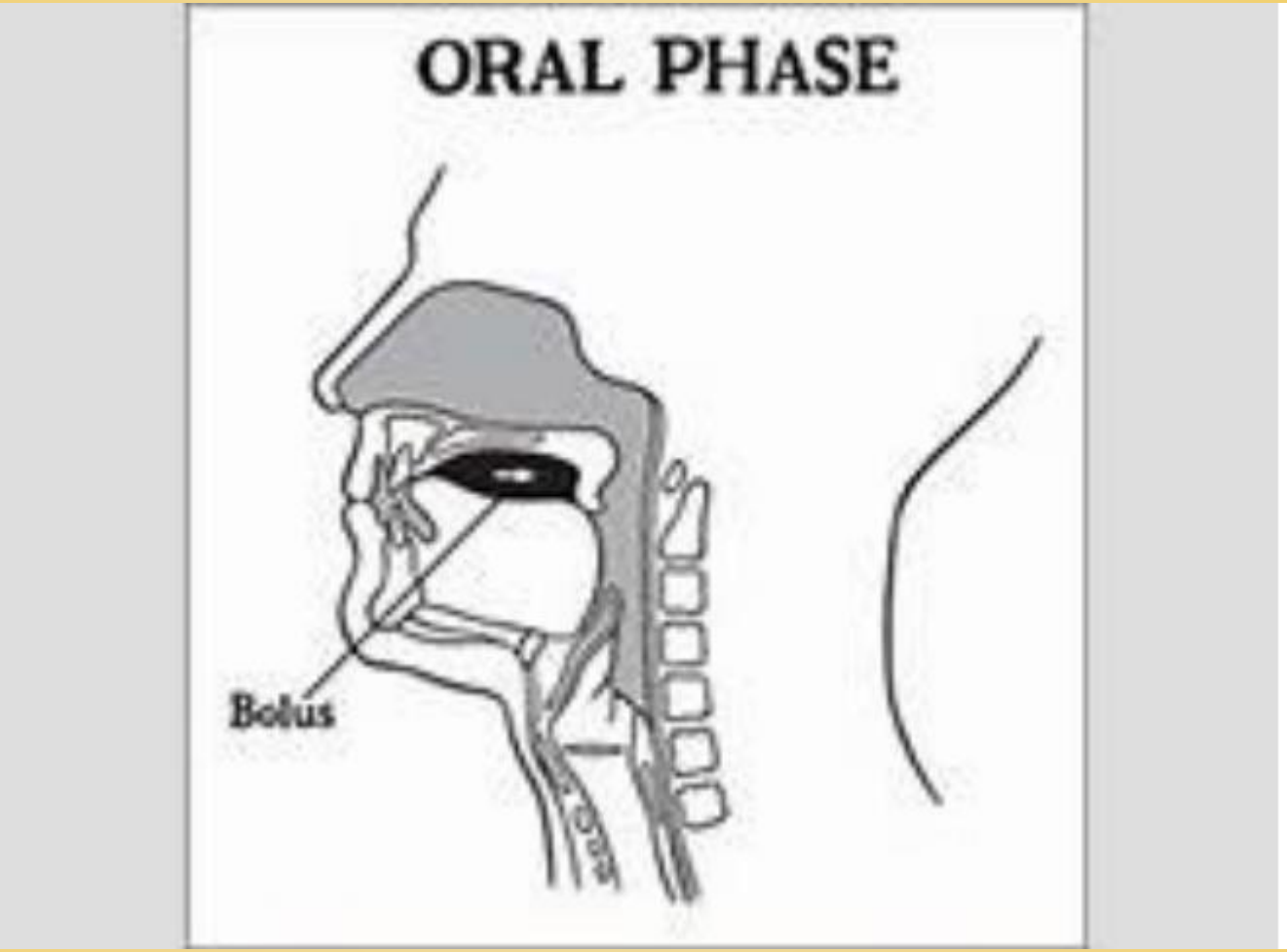
Conditions That Might Cause Dysphagia

Stroke	Tracheostomy
Dementia	Hypoxic brain damage
Head injury	Cardiac conditions
Progressive conditions – motor neuron disease, Huntington's chorea, Parkinson's disease, MS	Progressive Supranuclear Palsy
Neurological conditions: Myasthenia gravis, Guillain-Barre syndrome	Multiple Systems Atrophy
Head and neck surgery	Muscular Dystrophy
Cancer esp. head & neck, lung, brain	
Cerebral palsy	
Respiratory issues e.g. COPD	

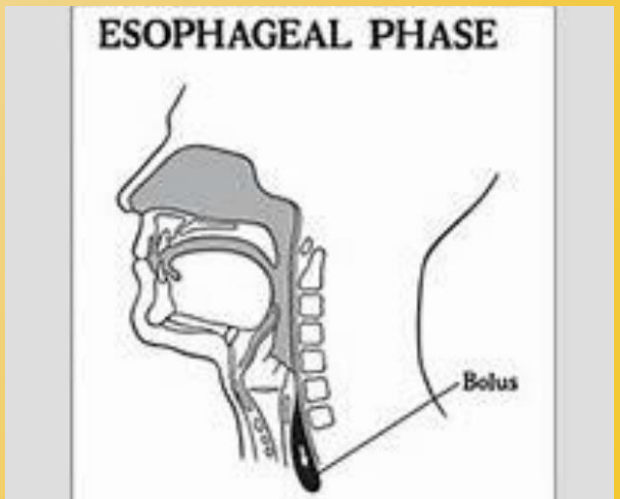
Normal Swallowing

Oral Preparatory Phase	Oral Phase
feel hungry, anticipate meal, smell/see food arrive- senses stimulated and saliva is produced	tongue moves food around mouth, to teeth-off again, squashing it against palate mixing it with saliva to form ball called a bolus
food placed in mouth, lips close breathing continues via nose	when we are ready to swallow tongue moves bolus towards back of the mouth
	When food moves posteriorly swallow triggered
Voluntary	Voluntary




ORAL PHASE
Bolus

Pharyngeal Phase
vocal folds close –hold breath
soft palate rises to close off the nose
epiglottis closes over the larynx
larynx lifts up and forward
the tongue retracts -airway is now protected by epiglottis vocal folds. Apnoeic period
back wall of pharynx pulls inwards to meet the tongue, creating pressure to push bolus downwards Involuntary



Signs of Oropharyngeal Dysphagia

Pre-Oral Phase	Oral Phase	Pharyngeal Phase
Unable to self feed	Poor lip seal	Loss of control of bolus
Unable to make appropriate choices	Poor tongue movements , leading to: -loss of bolus - Reduced bolus formation - Poor chewing -Pocketing of food -Long oral phase	Inadequate clearing of bolus from pharynx
Unable to recognise food and drink	Sensory changes – taste, temperature	Residue collecting in the valleculae/ pyriform fossae
Drowsy	Food/drink coming down nose	Incomplete opening of the crico-pharyngeus
		Penetration and/ or aspiration of solids/ fluids into the larynx

Aspiration

- Aspiration refers to entry of material below the level of the vocal cords”

Anything going the “wrong way”

This includes:

Food

Fluid

Medication

Secretions

Silent Aspiration

- Occurs when the respiratory mechanism does not respond in any way to the aspiration event
- No cough, no throat clearing, vocal quality is clear
- Some research estimates 40% of patients who silently aspirate are missed on bedside assessment

Signs and Consequences of Dysphagia

- Coughing/choking
- Chest infections/ pneumonia
- Dehydration
- Reluctance to eat & drink due to discomfort
- Poor nutrition/weight loss- impact on success of treatment
- Re-planning of treatment
- Decreased quality of life- long term
- Loss of personal dignity
- Psychological effect
- Social withdrawal (isolation)
- Requirement to have alternative feeding, potentially for life

Swallow Management

- Exercises
- Head posture
- Swallow techniques
- Modified diet
- Adapted cutlery
- Alternative feeding

Tips for feeding people well

- Make sure they are awake and alert!
- Ensure mouth is clean before feeding
- Enable independent feeding where able
- Feed one person at a time
- Sit them as upright as possible, preferably in a chair
- Create calm, relaxed environment - turn off television/radio
- Use recommended textures
- No lidded beakers (unless individually assessed)
- Avoid straws
- Use appropriate utensils

Oral vs non-oral feeding

- Some patients are able to have modified diet and fluids safely (eg – level 6 soft and bitesized diet and level 1 thickened fluids)
- Some patients do not have a safe swallow across consistencies

Feeding in palliative care

- Enhance quality of life
- Provide support to enhance safe feeding techniques
- Educate family and caregivers

Communication in palliative care

- The client's ability to communicate is key to providing quality palliative end-of-life care.
- A speech–language pathologist (SLP) can facilitate the patient's ability to communicate concerns or preferences in order .

(1) improve the health care team's ability to manage symptoms and engage in end-of-life discussions

(2) (2) support the patient and family's ability to maintain social connectivity

AAC Systems

- Several factors that had a major impact on the development of AAC devices:
- In 1975, mandating that all handicapped children between 5 to 21 years of age be provided with a free public education.
- The development of microcomputer technology was the second factor that impacted the AAC field.

AAC Systems

- ***Low technology***
- ***High technology***

- **تکنولوژی سطح پایین :** وسایلی مانند تخته های وایت برد یا کاغذ و مداد نیز مفید هستند زیرا باعث گسترش و اصلاح پیام ها به طور مستقیم در یک تعامل مداوم ، و به سرعت موثر هستند.

- این نمایشگرهای دستنویس (مداد و کاغذ) می توانند به شرکای ارتباطی کمک کنند تا واژگان خاص را برای مکالمه مداوم، در اختیار داشته باشند.

- ***تکنولوژی پیشرفته (High technology):*** شامل میکرو کامپیوترهایی است که امکان ذخیره و بازیابی اطلاعات پیام را فراهم می کند.
- در۱۰ سال گذشته تکنیک های الکترونیکی و کامپیوتری به طرز چشمگیری تغییر کرده است. بازار مصرف عمومی باعث افزایش ظرفیت حافظه، سرعت پردازش و عمر باتری شده است در حالی که وزن ، اندازه رایانه ها و الکترونیک کاهش یافته است.
- از آنجا که دوربین های دیجیتال ، نرم افزارهای ویرایش فیلم دیجیتال ، اسکنرها و چاپ رنگی در بخشهای بیشتری از جمعیت عمومی استفاده گسترده تری دارند ، این فناوری ها برای حمایت از ارتباط یکپارچه می شوند.
- عکس های دیجیتالی به عنوان ابزاری برای نمایش اشیاء، مردم و سایر موارد کاربرد دارند و می توان به سرعت به سیستم AACافزود.

References

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.

.

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.

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.

.

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/