Taking the Long View: Incorporating Palliative Care Principles into the Care of the Older Adult with Hip Fracture

Kathleen Drago, MD, and Juliana M. Bernstein, MPAS, PA-C

Dr. Drago (drago@ohsu.edu) is an assistant professor in the Division of General Internal Medicine & Geriatrics at Oregon Health & Science University and codirector of OHSU’s Inpatient Geriatrics Program. Ms. Bernstein (bernstej@ohsu.edu) is an assistant professor in the Division of General Internal Medicine & Geriatrics at Oregon Health & Science University and codirector of OHSU’s Inpatient Geriatrics Program.

Ms. R is an 82-year-old woman with advanced dementia, seizure disorder, chronic dysphagia, and malnutrition with recent weight loss and sarcopenia. She is able to transfer independently from bed to wheelchair at baseline; she was admitted after an unattended fall at her memory care facility with a displaced femoral neck fracture. After discussion between the orthopedics team and her son, she underwent a successful left hemiarthroplasty. Post-operatively, she developed acute blood-loss anemia, hypotension, and delirium. Further discussion with her son revealed a steady course of decline over the last year; Mrs. R had had repeated hospitalizations for seizures, UTI with bacteremia and delirium, and falls. After each hospitalization and subsequent stay in rehab, she never seemed to reach her prior cognitive nor functional baseline. Now, she could only intermittently recognize her family, and her ability to speak had declined such that she was only able to state one short phrase at a time. After further reflection on Mrs. R’s life and her previously completed Advance Directive, Mrs. R’s family decided that she would not want to live the last years of her life bouncing hospital to skilled nursing facility and back again. They decided to enroll her with hospice and forego yet another stay in skilled rehab. She received two units of red blood cells, one liter of normal saline, and her pain was controlled with low doses of oral oxycodone and scheduled acetaminophen. She was discharged home to her memory care facility with a hospice intake appointment upon arrival.

Despite the surgical advances and improvements to care in the last 20 years, hip fracture remains a life-altering and potentially devastating event for more than 200,000 older adults every year.1 Mrs. R’s story feels familiar because it is common for a hip fracture to mark the final chapters of someone’s life. Femoral neck fracture is the flagship fragility fracture and it is just that—fragility—that comes to define the often prolonged, tumultuous recovery. Knowing this, a question arises: Are we doing enough to acknowledge and consider frailty from the day of the fracture? In 2014, Fred Ko and R. Sean Morrison coauthored an excellent editorial calling for integrating palliative care teams alongside the interprofessional team in the care of frail hip fracture patients, an approach designed to replace our current model of separating curative and palliative care.2 We agree that a holistic focus on symptom management coupled with discussion around goals and care coordination, provided concurrently with standard care, provides an excellent framework for patient-centered care.

When palliative care consultants are available in the hospital, we highly recommend involving them early. Here, we propose the following four strategies to improve the care of elderly patients with hip fracture by incorporating palliative care principles in the acute care hospital setting to be implemented as soon as frailty has been identified:

1. Inquire about the patient’s recent functional trajectory and goals for care upon admission.

Beyond an advance directive or POLST form, we should get a sense from every hip fracture patient and/or their caregivers about their functional status, living situation, burden of chronic disease, and priorities for the rest of their lives. Incorporating these questions into our standard work will stratify the frail from nonfrail, assist in our ability to prognosticate, and enable the task of providing advice and guidance to be more straightforward. We often start by asking about an advance directive and/or POLST followed by questions that promote reflection on previous experiences and identify priorities for the remaining years of the patient’s life.

2. Assess prognosis and provide clear, thoughtful information about the future.

Prognosis lends context to the clinical advice we offer patients. It is the difference between an arthroplasty or pinning, or no surgery at all. It is the difference between planning for a stay in post-acute rehab versus going home with hospice. In large part, the treatment plan for a hip fracture patient depends on our collective sense of prognosis; however, prognostication has generally been difficult for conditions other than cancer or heart failure. New tools such as UCSF’s ePrognosis (eprognosis.ucsf.edu) have simplified validated prognostic scales into a collection organized by clinical setting that is quick and easy.

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to use. Clinical judgment remains the cornerstone of prognostication but can be strengthened when coupled with an applicable and validated prognostic scale.

3. Strive for optimal pain control. Undertreated post-operative pain is significantly associated with the development of delirium (RR 5.4), delayed ambulation, longer lengths of stay, and long term mobility restrictions. Prior to ortho-geriatric co-managed care, a hip fracture patient with dementia was far less likely to have a standing analgesic order because his/her recall of pain is often limited to that point in time. Additionally, multifactorial, post-operative hypoactive delirium can present with somnolence which can be misinterpreted as an adverse effect of opiates, when in fact uncontrolled pain may be driving the hypoactive state. Orders for post-operative pain control commonly call for a range of opiate dosing as needed while adjunctive agents such as scheduled acetaminophen, heating pads, lidocaine patches and non-steroidal anti-inflammatory creams are under-utilized. Judicious attention to non-verbal pain indicators, consideration of scheduled opiate doses in patients with difficulty communicating pain, and liberal use of adjunctive agents can improve pain control in patients with impaired cognition.

We recommend Tylenol 1000 mg three times a day (assuming preserved liver function) and a low dose oral opioid like oxycodone or hydromorphone every 3-6 hours with close eye on usage in the first 24 hours post-operatively.

4. Reconsider the presumed pathway of hospital to SNF to long-term care. With increasing age, medical complexity, and advanced cognitive impairment, many older adults do not benefit from intensive physical and occupational therapy to the same degree as their younger, or more fit, counterparts. Furthermore, transitions to an unfamiliar setting with new providers increase the risk of both worsening disorientation and psychological discomfort. In addition, adverse drug events with transfer from hospital to long-term care are common including risks that agents can be inadvertently omitted, dose adjustments missed or held or prescriptions not restarted. Families often report not knowing that any other pathway exists, but demonstrate palpable relief when an alternative focus on comfort, rather than intensive rehabilitation, is proposed. Initiation of home health therapy or hospice in place of a short stay at skilled rehab may allow a frail but otherwise well-cared-for patient continue to live in a familiar setting with known caregivers.

In summary, hip fracture often heralds a downward trajectory in physical, cognitive, and emotional well-being in frail older adults. Thoughtful implementation of palliative care principles may assist clinicians in shifting focus away from an automated plan of standardized care toward a more patient-centered approach.

References