Comprehensive Wound Malodor Management: Win the RACE
Samala R, Davis M

Complex wounds that give off a foul odor are common in various patient care settings. Wound malodor has grave effects, both physical and psychological, and its management presents a serious challenge for caregivers. Multiple factors and processes involved in malodor production need to be considered in designing a comprehensive treatment plan described by the acronym RACE: removal of necrotic tissue, antibacterials, odor concealers, and education and support. Improving quality of life is the outcome of winning the RACE against malodor. Cleve Clin J Med 2015;82(8):535-543

Cannabinoids: Is There a Potential Treatment Role in Epilepsy?
Blair R, Deshpande L, De Lorenzo R

Cannabinoids have been used medicinally for centuries, and in the last decade, attention has focused on their broad therapeutic potential particularly in seizure management. While some cannabinoids have demonstrated anticonvulsant activity in experimental studies, their efficacy for managing clinical seizures has not been fully established. This commentary will touch on our understanding of the brain endocannabinoid system’s regulation of synaptic transmission in both physiological and pathophysiological conditions, and review the findings from both experimental and clinical studies on the effectiveness of cannabinoids to suppress epileptic seizures. At present, there is preliminary evidence that non-psychoactive cannabinoids may be useful as anticonvulsants, but additional clinical trials are needed to fully evaluate the efficacy and safety of these compounds for the treatment of epilepsy. Exp Opin Pharmacother 2015;16(13):1911-1914

Medications That Older Adults in Hospice Care in the United States Take, 2007
Dwyer L, Lau D, Shega J

Objectives: To describe medications that older adults in hospice with cancer, dementia, debility, heart disease, and lung disease take during the last week of life. Design: Retrospective cross-sectional study. Setting: Nationally representative sample of 695 U.S. hospices in the 2007 National Home and Hospice Care Survey. Participants: Individuals aged 65 and older with a primary diagnosis of cancer (49%), dementia (12%), debility (14%), heart disease (16%), or lung disease (10%) who received end-of-life care during their last week of life (N = 2,623). Measurements: Medication data were obtained from hospice staff, who were asked, “What are the names of all the medications and drugs the patient was taking 7 days prior to and on the day of his or her death while in hospice? Please include any standing, routine, or PRN medications.” Results: The unweighted survey response rate was 71%. The average number of medications taken was 10.2. The most common therapeutic classes were analgesics (98%); antiemetic and antivertigo medications (78%); anxiolytics, sedatives, and hypnotics (76%); anticonvulsants (71%); and laxatives (53%). Approximately one-quarter of the individuals took proton pump inhibitors, anticoagulants, and antidepressants, and fewer than 20% took antacids and antibiotics. A smaller percentage of individuals with dementia and debility than of those with cancer took opioid analgesics. Individuals with heart disease were more likely than individuals in the other clinical cohorts to take diuretics, and those with lung disease were more likely than those in the other clinical cohorts to take bronchodilators. A higher percentage of individuals with dementia and with debility than with cancer and lung disease took antidepressants. Conclusion: People continue to receive disease-focused therapies at the end of life rather than therapies exclusively for palliation of symptoms, suggesting that treatments may vary according to the person’s primary diagnosis. J Am Geriatr Soc 2015;63(11):2282-2289
Ethical and Legal Implications of Pacemaker Withdrawal Toward the End of Life
Gordon M, Grossman D

End-of-life decisions are never easy. With the proliferation of modern technological interventions, such as the permanent implanted pacemaker for a previously demonstrated serious bradycardia that can promote cardiovascular or respiratory function, the apparent ability to extend or defer the final outcome may become a barrier to a gentle and quality death. It is such a death devoid of modern technology that reverts the focus to comfort and care, the hallmarks of quality palliation, which should be considered as important goals of end-of-life care. Reynolds and associates stated the following in their 2005 article: Families and patients should never feel abandoned during this process and attention should be devoted to communicating that care is not being withdrawn. The family needs to be prepared for what the dying process may look like. Assure them that all energy is now being directed toward the comfort of the patient including sedation as required if signs of suffering are observed. Easing death, like easing birth, can be one of the most fulfilling contributions one can make to reduce the suffering and enrich the lives of patients and their families. Ann LTC 2015;23(10):35-39


Hospice Services for Complicated Grief and Depression: Results from a National Survey

Objectives: To describe the prevalence of screening for complicated grief (CG) and depression in hospice and access to bereavement therapy and to examine whether screening and access to therapy varied according to hospice organizational characteristics or staff training and involvement. Design: Cross-sectional national survey conducted from 2008 to 2009. Setting: United States. Participants: Hospices (N = 591). Measurements: Whether hospices screened for depression or CG at the time of death or provided access to bereavement therapy (individual or group). Organizational characteristics included region, chain status, ownership, and patient volume. Staffing-related variables included training length and meeting attendance requirements. Results: Fifty-five percent of hospices provided screening for CG and depression and access to bereavement therapy, 13% provided screening but not access to bereavement therapy, 24% provided access to bereavement therapy but not screening, and 8% neither screened nor provided access to bereavement therapy. Hospices with 100 patients per day or more were significantly more likely to provide screening and access to bereavement therapy. Conclusion: Hospices appear to have high capacity to provide screening for CG and depression and to deliver group and individual therapy, but data are needed on whether screeners are evidence based and whether therapy addresses CG or depression specifically. Future work could build upon existing infrastructure to ensure use of well-validated screeners and evidence-based therapies. J Am Geriatr Soc 2015;63(10):2173-2180
Symptoms and Fear in Heart Failure Patients Approaching End of Life

The purpose of this study was to consider how fear and symptom experience are perceived in patients with heart failure at the end of life. Background: Heart failure is a burdensome condition and mortality rates are high globally. There is substantive literature describing suffering and unmet needs but description of the experience of fear and the relationship with symptom burden is limited. Design: A convergent mixed methods design was used. Methods: Data from the McGill Quality of Life Questionnaire (n = 55) were compared to data from in-depth interviews (n = 5). Results: Patients denied fear when asked directly, but frequently referred to moments of being afraid when they were experiencing symptoms. In addition, patients reported few troublesome symptoms on the survey, but mentioned many more symptoms during interviews. Conclusions: These data not only identify the relationship between psychological issues and symptom experience but also elucidate the benefit of a mixed method approach in describing such experiences from the perspective of the patient. Future research should examine relationships between and among symptom experience, fear and other psychological constructs across the illness trajectory. Relevance to Clinical Practice: Conversations about the interaction of symptom burden and fear can lead to both a more robust assessment of symptoms and lead to patient centred interventions. J Clin Nurs 2015;24(21-22):3215-322

The Developmental Transition from Living With to Dying From Cancer: Hospice Decision Making.
Waldrop D, Meeker M, Kutner J

Despite increasing utilization of hospice care, older adults with cancer enroll in hospice for shorter periods of time than those with other life-limiting illnesses. How older adults with cancer and their family members consider hospice is unknown. The purpose of this study was to compare decision making in late-stage cancer in people who enrolled in hospice with those who declined. Concepts from the Carroll and Johnson (1990) decision-making framework guided the development of a hospice decision-making model. The study design was exploratory-descriptive, cross-sectional, and used a two-group comparison. Qualitative and quantitative data were collected in the same interview. Open-ended questions were used to explore the illness trajectory and decision-making process. The interrelationships between functional ability, quality of life, and social support with hospice decision making were assessed using the Katz, QLQ-30, and Lubben Social Network Scales. Study participants included 42 older adults with cancer who had been offered hospice enrollment (24 non-hospice and 18 hospice) and 38 caregivers (15 non-hospice and 23 hospice); N = 80. The decisional model illustrates that the recognition of advanced cancer and information and communication needs were experienced similarly by both groups. There was interaction between the decisional stages: formulation of awareness and generation of alternatives that informed the evaluation of hospice but these stages were different in the hospice and non-hospice groups. The hospice enrollment decision represents a critical developmental juncture, which is accompanied by a transformed identity and substantive cognitive shift. Increased attention to the psychosocial and emotional issues that accompany this transition are important for quality end-of-life care. J Psychosoc Oncol 2015;33(5):576-598
Factors Predicting Bereaved Caregiver Perception of Quality of Care in the Final Week of Life: Implications for Health Care Providers

Higgins P, Garrido M, Prigerson H

BACKGROUND: Cancer caregivers are key stakeholders in the final weeks of life and in bereavement. Research has highlighted end-of-life (EOL) factors important to caregivers, as well as factors contributing to caregiver mental health and bereavement outcomes. There has been limited data on factors predicting caregiver perceptions of quality of EOL care. OBJECTIVE: This study's purpose was to identify modifiable predictors of caregivers' Caregiver Evaluation of Quality of End of Life Care (CEQUEL) scores, with the broader aim of informing clinical interventions to improve caregiver impressions of care and subsequent bereavement adjustment. METHODS: Study data came from Coping with Cancer I (CwC1). CwC1 investigators interviewed advanced cancer patients and caregivers prior to the patient's death (Wave 1) and reinterviewed caregivers following the death (Wave 2) (N=275 dyads). The authors identified potential Wave 1 predictors of CEQUEL scores and performed a series of linear regression analyses to identify a parsimonious predictive model using corrected Akaike's Information Criterion (AICc) values. RESULTS: In adjusted analyses, caregivers rated quality of care as poorer when patients died in a hospital (B=-1.40, SE=0.40, p=0.001) (B, unstandardized regression coefficient; SE, standard error) or had less than one week of inpatient hospice care (B=-1.98, SE=-0.70, p=0.006). Whole-person physician care and caregiver religiosity were associated with perceived higher quality of care in unadjusted, but not adjusted, analyses. CONCLUSIONS: Findings suggest that place of death and hospice length of stay best predict bereaved caregiver evaluations of quality of EOL care. These findings equip health care providers with modifiable targets to improve caregivers' experience of EOL care and subsequent bereavement. *J Palliat Med* 2015;18(10):849-857

Autonomic, Behavioral, and Subjective Pain Responses in Alzheimer's Disease

Beach P, Huck J, Miranda M, Bozoki A

Objective: To compare autonomic, behavioral, and subjective pain responses of patients with Alzheimer's disease (AD) to those of healthy seniors (HS). As few studies have examined patients with severe Alzheimer's disease (sAD), we emphasized inclusion of these patients together with mild/moderate Alzheimer's disease (mAD) patients to characterize pain responses potentially affected by disease severity. Design: A controlled cross-sectional study involving repeated measures behavioral pain testing. Setting: An outpatient clinical setting and local nursing facilities. Subjects: Community dwelling HS controls (N = 33) and individuals with chart-confirmed diagnoses of AD (N = 38, Diagnostic and Statistical Manual-IV criteria). Methods: HS and AD groups were compared in their responses to repeated applications of five pressure intensities (1–5 kg) on the distal forearm. Autonomic responses (heart rate [HR]), pain behaviors (vocal, facial, and bodily as scored by the Pain Assessment in Advanced Dementia [PAINAD] scale), and subjective pain ratings (Faces Pain Scale-Revised) were measured. Results: HR responses to pressure stimuli were differentially affected based on AD severity: sAD patients had generally decreased HR reactivity compared with other groups (P < 0.01). In contrast, pain behaviors were increased in AD regardless of severity (P < 0.001), compared with HS, for all but the lowest pressure intensity. Increased behaviors occurred in all measured domains of the PAINAD (P < 0.005). While sAD were unreliable subjective reporters, mAD patients (N = 17) rated low level pressures as more painful than HS (P < 0.01). Conclusion: These findings provide behavioral and subjective-report evidence of increased acute pain sensitivity in AD, which should be taken into consideration with respect to pain management across the spectrum of AD severity. *Pain Med* 2015;16(10):1930-1942
Geographic Variation of Hospice Use Patterns at the End of Life

Little is known about state-level variation in patterns of hospice use, an important indicator of quality of care at the end of life. Findings may identify states where targeted efforts for improving end-of-life care may be warranted. OBJECTIVE: Our aim was to characterize the state-level variation in patterns of hospice use among decedents and to examine state, county, and individual factors associated with these patterns. METHODS: We conducted a retrospective analysis of Medicare fee-for-service decedents. The primary outcome measures were state-level hospice use during the last 6 months of life and the state's proportion of hospice users with very short hospice enrollment (≤7 days), very long hospice enrollment (≥180 days), and hospice disenrollment prior to death. RESULTS: In 2011, the percentage of decedents who used hospice in the last 6 months of life nationally was 47.1%, and varied across states from 20.3% in Alaska to 60.8% in Utah. Hospice utilization patterns also varied by state, with the percentage of hospice users with very short hospice enrollment ranging from 23.0% in the District of Columbia to 39.9% in Connecticut. The percentage of very long hospice use varied from 5.7% in Connecticut to 15.9% in Delaware. The percentage of hospice disenrollment ranged from 6.2% in Hawaii to 19.0% in the District of Columbia. Nationally, state-level hospice use among decedents was positively correlated with the percentage of potentially concerning patterns (including very short hospice enrollment, very long hospice enrollment, and hospice disenrollment) among hospice users (the Pearson correlation coefficient=0.52, p value<0.001). Oregon was the only state in the highest quartile of hospice use and the lowest quartiles of both very short and very long hospice enrollment. CONCLUSIONS: The percentage of decedents who use hospice may mask important state-level variation in these patterns, including the timing of hospice enrollment, a potentially important component of the quality of end-of-life care. J Palliat Med 2015;18(9):771-781

Specific Physician Orders Improve Pain Detection and Pain Reports in Nursing Home Residents: Preliminary Data

Despite evidence that many nursing home residents’ pain is poorly managed, reasons for this poor management remain unanswered. The aim of this study was to determine if specific order sets related to pain assessment would improve pain management in nursing home (NH) residents. Outcomes included observed nurse pain assessment queries and resident reports of pain. The pretest/post-test study was performed in a 240-bed for-profit nursing home in the mid-southern region of the United States and participants were 43 nursing home residents capable of self-consent. Medical chart abstraction was performed during a 2-week (14-day) period before the implementation of specific order sets for pain assessment (intervention) and a 2-week (14-day) period after the intervention. Trained research assistants observed medication administration passes and performed participant interviews after each medication pass. One month after intervention implementation, 1 additional day of observations was conducted to determine data reliability. Nurses were observed to ask residents about pain more frequently, and nurses continued to ask about pain at higher rates 1 month after the intervention was discontinued. The proportion of residents who reported pain also significantly increased in response to increased nurse queries (e.g., “Do you have any pain right now?”), which underscores the importance of nurses directly asking residents about pain. Notably 70% of this long-stay NH population only told the nurses about their pain symptoms when asked directly. Findings uncover that using specific pain order sets seems to improve the detection of pain, which should be a routine part of nursing assessment. Pain Manag Nurs 2015;16(5):770-780