National Association of Orthopaedic Nurses

Advancing the Art and Science of Orthopaedic Care

NAON Position Statement:
Palliative Care for Patients with Musculoskeletal Conditions

Issue

Chronic musculoskeletal conditions can at times lead to a significant decrease in quality of life. With a goal of achieving and maintaining comfort while preserving function to support the best possible quality of life, palliative care has a role in the provision of care for patients with chronic, debilitating musculoskeletal conditions and/or a limited life expectancy.

NAON's Position

The National Association of Orthopaedic Nurses (NAON) promotes palliative care with a goal of optimal functioning and the relief of suffering for patients with chronic, debilitating musculoskeletal conditions and/or a limited life expectancy. Recognizing the role of the nurse in supporting the best possible quality of life for patients and their families it is important that consideration of palliative care planning begin early in the patient's course of a progressive, debilitating condition.

Background/Rationale

Clinical Practice Guidelines for Quality Palliative Care (developed by the National Consensus Project for Quality Palliative Care, 2009) help address the growing population of patients with advanced illness. Palliative care is an approach to care and addresses the following eight domains: 1) Structure and processes of care; 2) Physical aspects of care; 3) Psychosocial and psychiatric aspects of care; 4) Social aspects of care; 5) Spiritual, religious, and existential aspects of care; 6) Cultural aspects of care; 7) Care of the imminently dying patient; and 8) Ethical and legal aspects of care (National Consensus Project for Quality Palliative Care, 2009).

Typically, palliative care is provided by an interdisciplinary team, including medicine, nursing, social work, chaplaincy, counseling, nutrition, and rehabilitation specialties. They provide for assessment and treatment of pain and other symptoms; help with patient-centered communications and decision-making; and, coordination of care across the continuum of care settings (Institute of Clinical Systems Improvement, 2009; National Consensus Project for Quality Palliative Care, 2009). Ideally, palliative care planning should begin early so that the patient and family get the most benefit from the services available (Lorenz, 2008). Palliative care may be provided at the same time as other interventions that treat the underlying disease process, but the intensity of palliative care services provided increases as the patient's condition declines.

Palliative care should be considered for patients with chronic, debilitating conditions including, but not limited to, individuals who have sustained significant musculoskeletal trauma. This may be during the initial hospitalization after the trauma if end of life is likely or later in the rehabilitative period if the injuries sustained have caused progressive chronic pain and functional limitations. Another high-risk group that may benefit from palliative care is older adults with a hip fracture. Twenty to thirty percent of adults with a hip fracture die within 12 months of their fracture (Abrahamsen et al., 2009; Vestergarrd et al., 2007). Many more experience significant functional loss after a hip fracture with a decreased quality of life and inability to return to their pre-fracture level of function (Abrahamsen et al., 2009; Boonen et al., 2004). Consideration of palliative care while rehabilitating from a hip fracture may improve the quality of life for many older adults. Arthritis and other rheumatic conditions are the most common cause of disability in the United States (MMWR, 2009). The functional limitations, chronic pain, and decreased quality of life incurred by many with arthritis make this a high-risk group that may also benefit from palliative care especially in their older years. Lastly, palliative care may be indicated for patients with metastasic bone disease who may undergo orthopaedic procedures to alleviate pain or impairment caused by the metastasis. In an effort to optimize function, to minimize discomfort, and ultimately improve the quality of life, palliative care should be considered for all patients with chronic, debilitating musculoskeletal conditions and/or a limited life expectancy.

References

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Boonen, S., Autier, P., Barette, M., Vanderschueren, D., Lips, P., & Haentjens, P. (2007). Functional outcome and quality of life following hip fracture in elderly women: a prospective controlled study. *Osteoporosis International, 15*(2), 937-941.

Lorenz K, Lynn J, Sydney D, Wilinson A, Mularski R, Morton S, Hughes R, et al. Evidence for improving palliative care at the end of life: a systematic review. *Ann Intern Med.* 2008; 143(2):147-159.

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Vestergaard. P., Rejnmark, L., & Mosekilde, L. (2007). Increased mortality in patients with a hip fracture— effect of pre-morbid conditions and post-fracture complications. *Osteoporos Int. 18*(12),1583-1593.

Links for additional resources/information

EPERC End of Life/Palliative Education Resource Center and the Medical College of Wisconsin: Fast Facts and Concepts
http://www.mcw.edu/EPERC/FastFactsIndex

Institute for Clinical Systems Improvement – Health Care Guidelines: Palliative Care (3rd edition 11/2009)
http://www.icsi.org/palliative_care/palliative_care_11918.html

National Consensus Project for Quality Palliative Care (2009). *Clinical Practice Guidelines for Quality Palliative Care, Second Edition*. http://www.nationalconsensusproject.org/guideline.pdf

National Hospice and Palliative Care Organization. (2009). *NHPCO facts and figures: hospice care in America*
http://www.nhpco.org/files/public/Statistics_Research/NHPCO_facts_and_figures.pdf