HOSPICE & PALLIATIVE NURSING CARE Review Course

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Disclaimer

Taking this course and/or studying the Core Curriculum DOES NOT GUARANTEE a passing score.

About the Exam

- Generally has 150 questions
- Computerized testing
- Offered via appointment at a local testing center 4 months out of the year
Things to Remember

- Know generic drug names
- Think of national standards vs. local custom
- Answer from a TEAM perspective

Study Hints

- Make flash cards for generic drug names
- Plan group or personal study to be multiple sessions, not one or two cram sessions
- Study Guide for the Generalist Hospice and Palliative Nurse (HPNA)

HOSPICE & PALLIATIVE NURSING CARE Review Course

The RN’s Role in Interdisciplinary Collaborative Practice in Hospice and Palliative Care
Hospice Philosophy

- Hospice affirms life
- Provides support and care for persons with incurable illness so they might live fully
- Recognizes dying as a normal process
- Neither hastens nor postpones death
- Care to assist patients/families to attain desired mental and spiritual preparation to die

Key Hospice Concepts

- Reimbursed through Medicare, Medicaid, private insurance and occasionally other local community programs
- Patient and family are unit of care
- Interdisciplinary Team approach
- Around-the-clock availability
- Utilization of volunteers
- Bereavement counseling

Palliative Care

- Palliative care is treatment that enhances comfort and improves quality of life.
  *No specific therapy is excluded from consideration.* (NHPCO, 1988)
The RN's Role in the Coordination of Care

- Incorporate each discipline's assessments into the plan of care
- Act as patient, family, and caregiver advocate
- Establish care goals based on the quality of life needs identified by the patient
- Review plan for continuity of care and update as needed

Supervision of the CHHA

- The Hospice RN will......
  - Provide an individualized patient care plan
  - Give written instruction for handling patient care problems
  - Encourage feedback from the CHHA
  - Provide supervision for the CHHA
  - Document on the appropriate form, supervision and teaching of care procedures
  - Provide on-going support and education

Supplies, Medications and DME

- The Hospice RN will......
  - Assess the medical need for equipment and supplies
  - Assess patient need and obtain orders for medications
  - Incorporate into the comprehensive plan
  - Follow agency/provider guidelines and reimbursement requirements
Facilitating a Change in the Level of Care

- Transfer is based on medical needs of patient
- Change in level of care requires
  - Discussion with the patient/family and the IDT/IDG
  - Changes in the plan of care
  - Attending physician’s order
  - Documentation in the patient’s record

Facilitating a Transfer to a Different Care Setting

- Discuss possibility with all involved
- Coordinate transfer to maintain continuity of care
- Transfer mechanisms
  - From one hospice care service to another
  - Discharge to pursue treatment not covered in current healthcare setting
  - Patient withdraws from all services

Collaboration with the Patient’s Primary Care Physician

- Oversee the medical aspects of plan of care
- Assure medical eligibility for healthcare services
- Provide information regarding medical conditions
- Develop initial plan of care
- Provide ongoing medical management and orders
Participation in the Development of the Plan of Care

- Developed within the IDT
- Begins prior to the admission
- Follows through to discharge and into bereavement care for the family

Participation in the Development of the Plan of Care

- Individualize the plan according to the expressed needs of the patient and family for achieving and or maintaining QoL as defined by them.
- Continually evaluate and update the plan to meet the on-going and changing patient and family needs.

Evaluate Progression of the Disease Process

- Discuss the trajectory of the disease with the MD and the IDT
- Assess effectiveness of interventions to promote comfort
- Document the patient’s condition and response to interventions
- Review the care being provided for appropriateness
- Include patient/family in evaluation process
- Discuss each team member’s role, keeping in mind patient/family goals
Encourage the Family to Participate in Discussions

- The patient and family are a unit of care
- The overall plan of care is developed in collaboration with the patient and family
- Participation in the decision making process allows the patient and family greater autonomy

The Advocacy Role

- The RN acts as a patient and family advocate with the other team members
- The RN educates patient/family
  - Benefits vs. burdens of treatments
  - Support for expressed preferences and needs of patient/family

The Advocacy Role

- The RN functions as resource for hospice/palliative care in different care settings
- The RN knows policies and procedures for advance directives, changes in levels of care, etc., and shares information with IDT
Balancing the Benefit - VS - The Burden

Benefit - VS - Burden

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Burden</th>
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<tbody>
<tr>
<td>Longer Life</td>
<td>Pain</td>
</tr>
<tr>
<td>Comfort</td>
<td>Suffering</td>
</tr>
<tr>
<td>Relationships</td>
<td>Isolation</td>
</tr>
<tr>
<td>Community</td>
<td>Tech. dependent</td>
</tr>
<tr>
<td>Communication</td>
<td>Isolation</td>
</tr>
<tr>
<td>Closure</td>
<td>Immobility</td>
</tr>
</tbody>
</table>

Utilize the Group Process

- **Coordination and continuity of care**
  - Utilize a comprehensive plan of care
  - Ensure that the plan is carried out by all responsible
- **Collaboration**
  - Open, forthright communication
  - Resolve conflict caused by blurring of roles
    - Natural byproduct of shared responsibility for patient/family
    - Both individual and whole team need support
Incorporate Standards Into Practice

- HPNA Standards of Hospice Nursing Practice and Standards of Professional Performance
- Accreditation Standards
  - JCAHO (Joint Commission Accreditation of Healthcare Organizations)
  - CHAP (Community Health Accreditation Program)
  - ACHC (Accreditation Commission for Home Care)
- ANA Standards of Clinical Nursing Practice
- State Nurse Practice Acts

Incorporate Standards Into Practice

- AHRQ clinical practice guidelines
  - “Management of Cancer Pain” (Agency for Healthcare research and Quality)
- WHO 3-step Analgesic Ladder
- National Hospice and Palliative Care Organization
  - Prognosis in non-cancer diagnoses
  - Standards of Practice for Hospice Programs
  - Guidelines for Nursing in Hospice Care
  - Symptom management algorithms for palliative care

Incorporate Legal Regulations into Practice

- CMS Medicare Conditions of Participation (Centers for Medicare and Medicaid Services)
- OSHA regulations
- Medicaid regulations where applicable
- CMS Long Term Care Regulations
Educate the Public

- Advance directives
  - Living Will
  - DPA for Health Care or Health Care Proxy
  - "Five Wishes" (Legally valid in 26 states & DC)
- Termination of treatment
- Do Not Resuscitate orders
- Patient Bill of Rights

Other Professional Issues

- Evaluate patient/family/caregiver educational materials
- Utilize research findings to improve care and quality of life
- Educate healthcare providers
- Contribute to professional development of peers as preceptor, mentor, educator

Strategize to Resolve Ethical Issues

- Nursing Imperative to Provide Palliative Care
  - Nurses have an ethical obligation to assess and respond to patient's pain, symptoms and suffering
  - Nurses must respond to patients in an ethical and legal manner
  - Interdisciplinary collaboration is essential
- Facilitating Ethical and Legal Practice
  - Nurses have an obligation to be knowledgeable about the ethical/legal dimensions of professional practice
  - Ethical dilemmas are inevitable
Ethical Principles

Ethical Dilemma
Choosing between equally unsatisfactory alternatives

Ethical Principles
Respect for persons: Inherent worth of every person
Autonomy: right to self-determination
Veracity: truth-telling
Privacy: Confidentiality of patient information
Beneficence: do good
Non-malfeasance: avoid harm
Justice: equal treatment

Ethical Decision-Making

- Identify and clarify the issue
- Identify the values interested parties use to address the issue
- Gather information
- Determine ethical principles/theories involved

Participate in Professional Self-Care

- Accept that stress naturally exists among those working with the dying
- Acknowledge we may not always recognize stress in ourselves
Participate in Professional Self-Care

- Recognize reasons for stress
  - Role conflict and overload
  - Daily facing reality of death
  - Too much giving, too little receiving
  - Repeated losses and feelings of failure
  - Inadequate rest and unhealthy diet

Maintain Professional Boundaries

- Establish boundaries and limits for self and others to minimize conflict
- Understand team member roles and stay within defined role
- Foster independence of patients, families and caregivers

Stress Management

- Clinical competency helps reduce stress
- Develop and maintain strong personal support systems
- Practice spiritual self-care
- Set reasonable and attainable goals
Stress Management

- Get adequate rest, regular physical exercise, proper diet
- Maintain sense of balance in interactions with patients/families
- Remain involved with IDT for mutual support and a feeling of belonging

HOSPICE & PALLIATIVE NURSING CARE - Review Course

Patterns Of Disease Progression

HIV/AIDS

**Definitions**

- AIDS is characterized by infections and cancers that are the consequence of extreme immunodeficiency caused by infection with HIV.
- AIDS is most advanced stage of HIV infection. HIV is a retrovirus that attaches to a cell and enters it.
HIV/AIDS Disease Progression

- **Primary or acute infection** - flu-like symptoms, seroconversion within 6-12 weeks
- **Clinical latency** - resolution of flu-like symptoms, asymptomatic state, clinically stable
- **Early symptomatic stage** - CD4 drops below 500 cells/mm³, often occurs after years of infection

HIV/AIDS Disease Progression

- **Late symptomatic stage** - CD4 drops below 200 cells/mm³, HIV viral load above 100,000/ml, opportunistic infections and AIDS related malignancies occur
- **Advanced HIV disease** - CD4 drops below 50 cells/mm³, immune system severely impaired

Issues in HIV Progression

- Disease and its progression unpredictable
  - More a “chronic” and less a “terminal” illness
  - Uncertainty of prognosis
- Treatable nature of opportunistic infections
  - Availability of new treatments
  - When/if to discontinue treatment
  - Death not from HIV/AIDS itself, but rather from complications caused by it
Issues in HIV Progression

- Potential care differences
  - Large network for consumer advocacy and education
  - Most patients young
  - Many patients with non-traditional lifestyles and values
- Hospice/Palliative care program issues
  - Financial concerns
  - Staff education needs
  - Lack of flexibility of hospice admission criteria
  - When does a change to hospice become appropriate?

Grief Issues in AIDS Bereavement

- Disenfranchised grief
- Stigma of HIV/AIDS leading to secrecy and isolation
  - Homophobia and heterosexism
  - Substance abuse
- Guilt of survivors
- Feelings, fears related to the illness itself
- Multiple and continuing losses

Symptom Management Issues Related To AIDS

- AIDS-related diarrhea
- Pain
- Opportunistic infections
  - Fungal
  - Bacterial
  - Protozoal
  - Viral
- Common cancers
  - Kaposi’s sarcoma
  - CNS lymphoma
  - Non-Hodgkin’s lymphoma
- Other conditions
  - HIV-associated dementia
  - Wasting syndrome
Neoplastic Conditions
Pathophysiology

- Mass of abnormal cells characterized by dysplasia and hyperplasia
- Unregulated growth
- Poor cell differentiation
- Cells able to invade other tissues
- Ability to evade immune system
- Ability to initiate growth at distant sites
- Cancer is second leading cause of death
  - >1.5 million new cases each year
  - Approximately 500,000 deaths yearly

Patterns of Progression

- Metastatic Process
  - Angiogenesis – generation of blood vessels around primary tumor. Increases chance for tumor cells to reach the bloodstream
  - Attachment or adhesion – tumor cells need to attach to other cells or cell matrix proteins

Patterns of Progression

- Metastatic process
  - Invasion – tumor cells move across normal barriers imposed by extracellular matrix
  - Tumor cell proliferation - new colony of tumor cells stimulated to grow at secondary site
  - Patterns historically predicted by pattern of lymphatic and venous drainage in area around tumor
Common Sites of Metastases

- Most common sites of metastases
  - Lung
  - Bone
  - Liver
  - Lymph nodes

- Most likely to go to bone
  - Breast, lung, prostate

- Most likely to go to lung
  - ALL except bladder, brain, uterus

- Most likely to go to brain
  - Breast, lung, melanoma, kidney

Signs and Systems of Advanced Cancer

- Asthenia - debility, loss of strength, weakness
- Anorexia with weight loss and cachexia
- Pain
- Nausea
- Constipation/obstipation
- Sedation or confusion
- Dyspnea
- Edema/swelling
- Bleeding
- Infections

Cancer Treatment Modalities

- Surgery
  - Diagnostic, prophylactic, staging, curative, palliative, adjuvant or supportive, reconstructive or rehabilitative

- Radiation
  - Primary therapy, combined modality therapy, prophylactic, palliative therapy, oncologic emergencies
Cancer Treatment Modalities

- **Chemotherapy**
  - Cure, control, palliation

- **Supportive**
  - Blood component therapy, antimicrobial therapy, nutritional support, complementary therapies, unproven therapies

Side Effects of Chemotherapy

- **Short-term**
  - Nausea and vomiting
  - Diarrhea
  - Anorexia and stomatitis
  - Bone marrow suppression

- **Long-term**
  - Neurotoxicity
  - Nephrotoxicity
  - Cardiotoxicity
  - Hemorrhagic cystitis
  - Pulmonary fibrosis

Oncologic Emergencies and Complications

- Intervention considerations
  - Consider where patient is along disease trajectory
  - Clarify goals of treatment with patient and family
  - Help patient and family to arrive at attainable goals
  - Consider how likely it is that treatment will result in hoped-for outcomes
  - Consider benefit versus burden of treatment
Oncologic Emergencies

- **Central Nervous System**
  - Spinal cord compression
  - Intracerebral metastases

- **Metabolic/Endocrine**
  - SIADH
  - Hypercalcemia
  - Tumor lysis syndrome
  - Septic shock
  - Anaphylaxis

- **Cardiovascular/Hematologic**
  - Carotid artery rupture
  - Cardiac tamponade
  - Superior vena cava syndrome (SVCS)
  - Disseminated intravascular coagulation (DIC)

- **Gastrointestinal**
  - Bowel obstruction

Neurological Conditions
Patterns of Progression

- **Pathophysiology**
  - Injury - Cerebrovascular accident (CVA)
  - Trauma - Injury to skull, CNS Anoxia
  - Degenerative disease - Motor neuron diseases, Dementias

- **Indications of advanced disease**
  - Injury/trauma - permanent neurological deficits that predispose patient to complications
  - Dementia - complications related to immobility

Cardiac Conditions
Patterns of Progression

- **Pathophysiology**
  - Cardiomyopathy
  - Coronary artery disease (CAD)

- **Unique issues**
  - Perception by patient/family that there is always something more that can be done
  - “Ups and downs” of disease give hope that patient will “recover” again
  - Good symptom management can prolong patient's life
Cardiac Conditions
Indications of Advanced Disease

- **Left-sided CHF**
  - Anxiety, restlessness
  - Dyspnea
  - Orthopnea
  - Cough, hemoptysis
  - Tachycardia, palpitations
  - Basilar rales, bronchial wheezes
  - Fatigue, exercise intolerance
  - Cyanosis or pallor

- **Right-sided CHF**
  - Anorexia, nausea
  - Weight gain
  - Nocturia, oliguria
  - Dependent peripheral edema
  - Weakness

Pulmonary Conditions
Patterns of Progression

Pathophysiology
- Obstructive pulmonary disease
  - Type A COPD (Emphysema)
    - Patient typically thin, muscle wasting
    - No central cyanosis
    - Use of accessory muscles for breathing
    - "Barrel chest" appearance
  - Type B COPD (Chronic bronchitis)
    - Patient typically overweight
    - Central cyanosis present
    - Minimal use of accessory muscles
    - Adventitious breath sounds, typically wheezes

- Restrictive pulmonary disease
  - Pectus excavatum
  - Myasthenia gravis
  - Space occupying lesions

Indications of advanced disease
- Cor pulmonale
- Respiratory failure
Renal Conditions
Patterns of Progression

- Pathophysiology - Renal Failure
  - Most common reason for hospice referral - discontinuing dialysis
  - Patient/family often think death will occur in just a few days
- Indications of advanced disease
  - Fluid and electrolyte imbalances
  - Anemia
  - Uremia

GI and Hepatic
Patterns of Progression

- Pathophysiology
  - Gastrointestinal cancers or metastases
  - Hepatic failure - hepatocellular injury and cirrhosis
- Indications of advanced disease
  - Esophageal varices
  - Ascites
  - Hepatic encephalopathy
  - Jaundice
  - Pruritus
  - Anorexia, nausea

General Debility
Patterns of Progression

- Pathophysiology
  - Progressive multiple organ failure
  - Severe functional deficits in ADLs
  - Progressive physical deterioration
  - Low Karnofsky performance scores
- Indications of advanced disease
  - Terminal phase consistent with organ failure
  - Complications of immobility
Pain Management

Definition of Pain

- An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (APS, 1999)

  *American Pain Society*

Definition of Pain

- “Pain is whatever the person says it is…”

  *(Margo McCaffery)*
Undertreatment of Pain

- 70-90% of patients with advance disease experience pain
- 50% hospitalized patient's experience pain
- 80% of long term care experience pain
  - Only 40-50% are given analgesics

Cost of Poor Pain Management

- $100 billion per year
- Chronic pain is most expensive health problem
- 40 million physician visits per year for pain
- 25% of all work days lost are due to pain
- Improving pain management costs less than cost of inadequate relief

Pain Management Barriers

- Patient/family
- Healthcare Provider
- Institutional
Impact of Poorly Controlled Pain

- Physical
- Psychosocial
- Emotional
- Financial
- Spiritual

Pain Assessment Principles

- Accept patient's complaint of pain
- History of pain
- Assessment for non-verbal patients
- Patient centered goals

Pain Assessment Principles

- Nonverbal signs of pain
- Psychological impact of pain
- Diagnostic workup
- Assess effectiveness and side effects of pain medication
Types of Pain

- Acute
  - Usually sudden onset but may be progressive
  - Self limiting
- Chronic
  - >6 months
  - May be more difficult to “pinpoint”

Classification of Pain

Nociceptive Pain

- The normal processing of stimuli that damages normal tissues or has the potential to do so if prolonged.
  - Somatic
  - Visceral

Somatic Pain

- Bone, Joints, Muscle, Skin
- Connective tissue
- Throbbing, dull
- Well localized
Visceral Pain

- Visceral organs
- Squeezing, cramping, pressure, deep
- Tumor involvement of organ capsule
  - Aching & well localized
- Obstruction of hollow viscus
  - Intermittent cramping & poorly localized

Classification of Pain

Neuropathic

Abnormal processing of sensory input by central or peripheral nervous system

- Mechanisms not as well understood
- Burning, shooting, tingling, numbness, radiating, electrical
- Responds to adjuvant analgesics

Neuropathic Pain

- Centrally Generated Pain
  - Pain is experienced below the spinal cord lesion
  - Divided into Deafferentation and Sympathetically pain
  1. Deafferentation pain
    - Caused by injury to either central or peripheral nervous system
  2. Sympathetically maintained pain
    - Associated with dysregulation of the autonomic nervous system
Neuropathic Pain

- Peripherally Generated Pain
  - Painful polyneuropathies
    - Pain is experienced along the route of the involved nerves
      - Diabetic neuropathy
      - Guillain-Barre syndrome
  - Painful mononeuropathies
    - Associated with known peripheral nerve injury
    - Felt along the route of the injured nerve
      - Nerve route compression
      - Nerve entrapment

WHO Ladder

- Orally whenever possible
- “By the clock” dosing
- Ladder
- Based on assessment of the individual’s pain experience

WHO Ladder

- Step 1 (Mild pain)
- Step 2 (Moderate pain)
- Step 3 (Severe pain)
Opioids

- CNS action - bind to opioid receptor site in brain and spinal cord
- mu, kappa, and delta receptor sites
- Pain relief occurs when opioids bind to 1 or more receptors as an agonist
- Agonists and agonist - antagonists

Pure Agonist Opioids

- Expect physical dependence
- Withdrawal will occur when abruptly stopped or naloxone (Narcan®) is given
- Prevent withdrawal by reducing by 25%
- Tolerance to side effects other than constipation
- Tolerance to analgesia is rare

Mixed Agonist-antagonists

- Indications
- Examples
  1. Buprenorphine (Buprenex®)
  2. Butorphanol (Stadol®)
  3. Nalbuphine (Nubain®)
  4. Pentazocine (Talwin®)
Choice of Opioid Drug

- One pure agonist with one route
- If one not relieving pain with titration, may need to switch med
- Switch opioids for
  - Potential accumulation of metabolites
  - Unmanageable side effects

Choice of Opioid Drug

- All pure agonist have same side effects
- Side effects may be reported as allergies
- Rapid onset formulation for breakthrough

Opioids

- Morphine
- Codeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Meperidine
- Methadone
- Oxycodone
- Propoxyphene
  (Ace-Darvocet / ASA-Darvon)
  Metabolite: Norpropoxphene
Opioid Dosing

- Multiple routes available for pure agonists
- If current dose safe but ineffective, increase by 25% to 50% until pain relief occurs or unmanageable side effects present
- No ceiling effect for pure agonists
- All opioids have side effects that eventually limit dose escalation

Opioid Routes

- Oral/Sublingual
- Intramuscular
- Subcutaneous
- Intravenous
- Transdermal
- Rectal
- Stomal
- Intraspinal
- Patient Controlled Analgesia

Opioid Side Effects

- Constipation
- Nausea and Vomiting
- Sedation
- Pruritus
- Mental status change
- Respiratory depression
Opioid Teaching Points

- Effects of unrelieved pain
- Administration
- Side effects
- Fear of addiction
- Written information

Equianalgesia

- Doses of various opioids analgesics that provide approximately the same pain relief
- Charts
- Most use morphine 10 mg and every 4 hour dosing as basis

Sample Equianalgesic Chart

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose (mg)</th>
<th>Dose (mg)</th>
<th>Duration (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (IR)</td>
<td>10</td>
<td>30</td>
<td>3-4</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
<td>7.5</td>
<td>3-4</td>
</tr>
<tr>
<td>Oxycodone (long acting)</td>
<td>----</td>
<td>20</td>
<td>8-12</td>
</tr>
</tbody>
</table>
Titration of opioids

- Adjusting the amount of dose of an opioid
- Make increases at the onset or peak effect
- Provide smallest dose that provides greatest relief with fewest side effects
- Titrate in increments of 25% to 100%

Methods of Titration

- Add total of scheduled doses and immediate-release over 24 hr period
- Increase by 50% if initial dose not effective
- Provide breakthrough dosing

Breakthrough Dosing

- Referred to as rescue or breakthrough dosing
- Assessing for breakthrough - no tool developed
  - rely on patient’s report of pain
Rescue/Breakthrough Dosing

- Types
  - Incident (predictable)
  - Spontaneous (without warning)
  - End-of-dose failure (increase dose or shorten interval between doses)

Adjust when the ATC dose increases
- Provide every 1-2 hrs
- May be taken with ATC dose
- Increase ATC dose if received more than 3 rescue doses in a 24 period

Calculating Rescue Dose- po/pr

- Add up the total 24 hr ATC dosage
- Calculate 10%-15% of the 24 hr total
- Rescue dose is given PRN Q 2 hrs
Calculating Rescue Dose - po/pr

ATC Long Acting Morphine po 90 mg q 12 hrs  
= 180 mg q 24 hrs  
10% - 15% = 18 mg - 27 mg q 2 hrs

Calculating Rescue Dose SQ/IV

SQ/Parenteral opioid infusions  
- 50% - 100% of the hourly rate  
- Peak effect generally in 15 minutes  
- Boluses can generally be safely given q 15 minutes

Sample  
ALC Morphine Sulfate 10 mg q 1 hour via SQ line  
Rescue dosage will be 5 mg q 15 minutes via PCA pump

Adjuvants

- Medications that have analgesic effects on certain types of pain  
- Chronic neuropathic pain  
- Additional therapy to opioids  
- Distinct primary therapy
Adjuvants

- Choice of Drug
- Depends on type of pain, patient age, and other medical condition
- Individual response
- Sequential trials (if one adjuvant in a drug group is ineffective, try another one)

Non-opioids

- Relief for mild/moderate pain
- Combined with opioid analgesics for both additive analgesic effects or opioid dose sparing effects

Non-opioids

- Acetaminophen
  - Mechanism (peaks in 2hrs)
  - Dosing
  - Routes
  - Side effects
  - Considerations
    - 4000mg/3000mg/2000mg Q 24 hrs
Non-opioids

- NSAIDs
  - Characteristics
  - Drug choices
  - Dosing
  - Routes of Administration
  - Side Effects

Teaching Points for Non-opioids

- Risk for GI bleeding with NSAIDs
- Need to stop NSAID before surgery?
- Use
- Stopping medications
- Reporting side effects

Tricyclic Antidepressants

- Mechanism of action: unknown
- Analgesia usually occurs within 1 week
- May be effective for both lancinating and continuous neuropathic pain
Tricyclic Antidepressants

- Multipurpose analgesic
- Not indicated for acute onset pain
- In palliative care, strongest indication in neuropathic pain not responding to opioids

Choice of Drug

- Amitriptyline (Elavil®)
- Imipramine (Tofranil®)
- Doxepin (Sinequan®)
- Clomipramine (Anafranil®)
- Desipramine (Norpramine®)
- Nortriptyline (Aventyl®, Pamelor®)

Dosing

- Start low: elderly 10 mg; younger 25 mg
- Increase by same amount as starting dose
- Evaluate and increase every 3 to 5 days
Tricyclic Antidepressants

- Side Effects
  - Orthostatic hypotension
  - Sedation and mental clouding
  - Anticholinergic effects: Dry mouth, blurred vision, constipation
  - Cardiotoxicity: Falls and weakness
    Cardiac pt’s, Renal pt’s most at risk

SSRI’s

- (Selective Serotonin Reuptake Inhibitors)
  - Duloxetine (Cymbalta®)
  - Venlafaxine (Effexor®)
  - Paroxetine (Paxil®)
  - Fluoxetine (Prozac®)

Anticonvulsants

- First line drugs for chronic lancinating neuropathic pain
- Variability among drugs is great
- Analgesia similar mechanism that inhibit seizure activity
- Lessens conduction of pain signals along damaged peripheral nerves
Anticonvulsants

- Gabapentin (Neurontin®)
- Carbamazepine (Tegretol®)
- Phenytoin (Dilantin®)
- Clonazepam (Klonopin®)
- Valproic acid (Depakene®)
- Baclofen (Lioresal®)

Other Adjuvants

Corticosteroids

- Considered multipurpose adjuvant analgesic
- Mechanism of action as analgesia is unknown

Corticosteroids - Drug of choice

- Dexamethasone (Decadron®)
- Prednisone and methylprednisolone

Corticosteroids - Adverse Effects

- Short Term Therapy
- Long Term Therapy
Other Adjuvants

Local anesthetic agents
- Local action with minimal systemic side effects
- Limited information on long term safety and effectiveness

Medications
- Mexiletine (Mexilil®)
- Tocainide (Tonocard®)
- Lidocaine®

Other Adjuvants

Local anesthetic agents: Adverse Effects
Central Nervous System (CNS)
- Lower concentrations
  - Dizziness, perioral numbness (mouth), tremor
- Higher concentrations
  - Cardiac conduction disturbances, myocardial depression

Other Adjuvants

Psychostimulants
- Multipurpose for acute or chronic pain
- Useful in nociceptive or neuropathic pain
- Often can treat somnolence associated with opiate use
  - Caffeine (PO)
  - Dextroamphetamine: (Dexedrine®) (PO)
  - Methylphenidate: (Ritalin®) (PO)
Other Adjuvants

- Teaching Points
  - May take days to weeks for pain relief
  - Reassessment and titration may be necessary
  - Review adverse effects
  - Provide educational materials

Addiction

- “A pattern of compulsive drug use characterized by a continued craving for an opioid for effects other than pain relief”
  (APS, 1999)

Pseudoaddiction

- The patient who seeks additional medications appropriately or inappropriately secondary to significant undertreatment of the pain syndrome.
  - Behaviors cease when the pain is treated.
Tolerance

- A form of neuroadaptation

- When an opioid is chronically administered, there may be a need for increasing the doses or making them more frequent in order to achieve therapeutic effects.

Physical Dependence

- A physiological state in which abrupt cessation of the opioid results in withdrawal syndrome.

Special Populations

- Geriatric
- Cognitively impaired
- Dying
- Pediatric
Geriatric

- Under report pain
- Most under treated population for pain
- Common types of pain
- Analgesic Therapy issues
- Drug selection

Cognitively Impaired

- High risk for under treatment
- Assessment issues
- Communication and collaboration with family or caregiver

Dying

- Pain assessment continues to be a priority at end-of-life
- Opioid doses are based on assessment and response
- Dosing needs may decrease at EOL due to decreased renal function
- Family may not understand that patient can still be in pain even with decreased LOC
Pediatric

- Children may manifest their pain differently than adults
- Parents need to be brought into the plan.... “goals of care”
- Children need to be brought into the plan.... “goals of care”
  (age appropriate)

Non-pharmacological Pain Mgt

- Use concurrently with medications
  - Methods
    - Physical interventions
    - Hot and Cold
    - Massage
    - Positioning
    - Exercise

Non-pharmacological Pain Mgt

- Complementary Therapies
  - Therapeutic touch
  - Music therapy
  - Aromatherapy
Ethical Considerations

Related to Pain Management
- Patient Rights
- Advocacy
- Placebos
- Principle of Double Effect

Principle of Double Effect

Four conditions must be present for the Principle of Double Effect to justify claims that an act that causes evil consequences is not always morally prohibited.

1. The action itself must be good or at least morally indifferent
2. The individual must sincerely intend only the good effect and not the evil
3. The evil effect cannot be the means to the good effect
4. There must be a favorable balance between good & evil effects of the action
APS 12 Principles of Pain Mgt

1. Individualize dose, route and schedule
2. Around the clock dosing
3. Selection of opioids
4. Adequate dosing for infants/children
5. Follow patients closely
6. Use equianalgesic dosing

7. Recognize and treat side effects
8. Be aware of hazards of Demerol® (normeperidine) and mixed agonist-antagonists
9. Watch for development of tolerance
10. Be aware of physical dependence
11. Do not label a patient addicted
12. Be aware of psychological state

HOSPICE & PALLIATIVE NURSING CARE Review Course

SYMPTOM MANAGEMENT
Introduction

- Many physical and psychological symptoms common at the end of life
- Ongoing assessment and evaluation of interventions is needed
  - Requires interdisciplinary teamwork
  - Reimbursement concerns
  - Limit diagnostic tests
- Research is needed

Optimizing Care

- Etiology
- Interdisciplinary/Multidimensional Assessment
  - Initial
  - Ongoing
- Prioritize/Goal-Driven Care
- Etiology-based Management Plan
  - Pharmacologic
  - Non-Pharmacologic
- Documentation

Key Nursing Roles

- Patient advocacy
- Assessment - Nursing Process
- Pharmacologic treatment
- Non-Pharmacologic treatment
- Patient/Family Teaching
Symptoms and Suffering

- Symptoms create suffering and distress
- Psychosocial intervention is a key to complement pharmacologic strategies

Alteration in Skin and Mucous Membranes

- Definition
  - Disruption in integrity of skin or oral mucous membrane
- Possible etiologies
  - Skin integrity
  - Altered oral mucous membranes
  - Pruritis
- Assessment
- Nursing Diagnoses
- Planning/Intervention
- Patient/Family Education

Altered Mental Status

- Confusion/Delirium/Agitation
  - Definitions
  - Possible Etiologies/Diagnoses
  - Planning/Intervention
  - Patient/Family Education
- Terminal Restlessness
  - Definitions
  - Possible Etiologies/Diagnoses
  - Planning/Intervention
  - Patient/Family Education
Anorexia and Cachexia

- Definitions
  - Anorexia: Loss of appetite or inability to take in nutrients
  - Cachexia: Weight loss and wasting due to inadequate intake of nutrients
- Possible Etiology/Diagnoses
- Planning/Interventions
- Patient/Family Education

Ascites

- Definition
  - The accumulation of excessive fluid in the peritoneal cavity
- Possible Etiologies/Diagnoses
- Planning/Intervention
- Patient/Family Education

Aphasia

- Definition
  - Absence or impairment of ability to communicate through speech, writing or signs
- Types
  - Sensory
  - Motor
  - Global
- Possible Etiologies/Diagnoses
- Planning/Intervention
- Patient/Family Education
### Bladder Spasms
- **Definition**
  - Intermittent, painful contractions of the detrusor muscle, leading to suprapubic pain and urgency
- **Possible Etiologies/Diagnoses**
- **Planning/Intervention**
- **Patient/Family Education**

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### Bowel Incontinence
- **Definition**
  - The inability to control bowel movements
- **Possible Etiologies/Diagnoses**
- **Planning/Intervention**
- **Patient/Family Education**

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### Bowel Obstruction
- **Definition**
  - Occlusion of the lumen of the intestine, delaying or preventing the normal passage of feces
- **Complete Obstruction vs. Partial Obstruction**
- **Possible Etiologies/Diagnoses**
- **Planning/Intervention**
- **Patient/Family Education**
**Constipation**
- **Definition**
  - Difficulty in passing stools or an incomplete or infrequent passage of hard stools
- **Possible Etiologies/Diagnoses**
- **Planning/Intervention**
- **Patient/Family Education**

**Diarrhea**
- **Definition**
  - The frequent passage of loose, unformed, liquid stool
- **Possible Etiologies/Diagnoses**
- **Planning/Intervention**
  - Etiology will determine appropriate treatment
- **Patient/Family Education**

**Dysphagia/Odynophagia**
- **Dysphasia**
  - A subjective awareness of difficulty in swallowing
    - Obstructive
    - Motor
- **Odynophagia**
  - A report of painful swallowing
    - Inflammatory process
    - Dry mucous membranes
    - Corrosive esophagitis
- **Planning/Intervention**
- **Patient/Family Education**
Dyspnea/Cough

**Definitions**
- **Dyspnea**: subjective sensation of shortness of breath
- **Cough**: a natural defense of the body to prevent entry of foreign material into the respiratory tract

**Possible Etiologies/Diagnoses**
- Planning/Intervention
- Patient/Family Education

Edema

**Definition**
- Presence of excessive fluid in the intercellular tissues especially in the subcutaneous tissues

**Possible Etiologies/Diagnoses**
- Planning/Intervention
- Patient/Family Education

Extrapyramidal Symptoms (EPS)

**Definition**
- Involuntary movements, hyperkinetic (akathisia) or hypokinetic (dystonia); tardive dyskinesia is a late effect, which may not respond to reversal therapies

**Possible Etiologies/Diagnoses**
- Planning/Intervention
- Patient/Family Education
Hematologic Symptoms

- Definitions
  - Hemorrhage: excessive bleeding
  - Clotting: systemic response to disease or medication that initiates coagulation cascade causing clotting
  - Cytopenia: reduction in bone marrow blood cell components, which can precipitate a systemic response
- Possible etiologies/diagnoses
- Planning/Intervention
- Patient/family Education

Hiccoughs

- Definition
  - An involuntary contraction of the diaphragm, followed by rapid closure of the glottis
- Possible Etiologies/Diagnoses
- Planning/Intervention
  - Non-pharmacologic interventions
  - Pharmacologic interventions
- Patient/Family Education

Impaired Mobility, Fatigue, Lethargy, Weakness

- Definitions
- Potential Etiologies/Diagnoses
  - Disease Process
  - Medications or therapy
  - Nutritional deficiencies
  - Infectious processes
  - Emotional and/or environmental factors
- Planning/Intervention
- Patient/family Education
Increased Intracranial Pressure

- **Definition**
  - Increase in the pressure within the cranial cavity due to increased volume of fluid or mass
- **Possible Etiologies/Diagnoses**
  - ICP leads to development of many neurological symptoms
- **Planning/Intervention**
- **Patient/Family Education**

Myoclonus

- **Definition**
  - Twitching or brief spasm of a muscle or muscle group
- **Possible Etiologies/Diagnoses**
- **Planning/Intervention**
- **Patient/Family Education**

Nausea and Vomiting

- **Definitions**
  - Nausea: a subjectively perceived stomach discomfort, ranging from stomach awareness to the conscious recognition of the need to vomit
  - Vomiting: the expelling of stomach contents through the mouth
- **Possible etiologies/diagnoses**
- **Planning/Intervention**
  - Modify diet
  - Correct reversible causes
  - Medication regimen
- **Patient/family Education**
Paresthesia and Neuropathy

- Definitions
  - Paresthesia: a sensation of numbness, prickling or tingling; heightened sensitivity
  - Neuropathy: any disease of the nerves; may include sensory loss, muscle weakness and atrophy and decreased deep tendon reflexes
- Possible etiologies/diagnoses
- Planning/Intervention
- Patient/family Education

Seizures

- Definitions: usually intermittent tonic, clonic movements; convulsions caused by a large number of neurons discharging abnormally
  - Primary: generalized, involving large parts of the brain
  - Focal: partial, involving specific regions of the brain
- Possible etiologies/diagnoses
- Planning/Intervention
- Patient/family Education

Urinary Incontinence and Retention

- Definition
  - Inability to control urination
    - Urge incontinence
    - Stress incontinence
    - Overflow incontinence
    - Functional incontinence
- Possible Etiologies/Diagnoses
- Planning/Intervention
- Patient/Family Education
HOSPICE & PALLIATIVE NURSING CARE
Review Course

Care of the Patient and Family

Introduction

- Hospice/Palliative Care provides
- Definitions
  - Family as a system
  - Caregiver

Caregiver Support

- Access appropriate resources
  - Agency resources
  - Patient/family resources
  - Community resources
  - Public information sources
  - Referral for counseling by IDT member or community resource
Family Assessment

- Shared responsibility
- Involves communication of all types
- Takes into account
  - Coping styles, strengths, skills
  - Needs related to symptoms & disease process
  - Emotional function of all members

Emotional and Cognitive Issues

- Anger and hostility
- Anxiety
- Denial
- Depression
- Despair/loss of meaning
- Fear and worry
- Guilt

Interventions

- Shared responsibility
- Individualized
- Treatment modalities
  - Counseling
  - Family meetings
Spiritual Issues

- Spiritual needs
  - Spirituality - vs - Religion
- Common concerns
- Assessment and Interventions
  - Loss of hope or meaning
  - Spiritual distress and unresolved spiritual issues

Cultural Issues

- Assessment
- Avoid Stereotyping
- Take into account assimilation and generational differences
- Know areas of healthcare especially impacted by cultural/religious beliefs

Patient/Family Education and Advocacy

- Definitions
  - Education: knowledge or skill obtained or developed by a learning process
  - Advocacy: the act of pleading or arguing in favor of something
  - Family: those individuals identified by the patient as their primary support system regardless of blood or legal ties
  - Family Caregivers: unpaid persons who provide or arrange for essential assistance to a relative or friend who is ill.
Caregiver Education
Steps to Effective Teaching

- State objective of learning experience
- Determine needs of the learner
- Devise a plan - utilize principles of adult learning
- Provide time for learner to clarify content
- Schedule practice time
- Schedule time to evaluate learner's new skills - monitor ability to provide care

Identify Barriers to Learning

- Personal factors
- Environmental challenges
- Familial/cultural barriers
- Language and communication challenges
- Emotional issues

Patient/Family Advocacy

- Monitor need for change in level of care
  - Identify barriers to communication
  - Inform patient/family of treatment options
  - Encourage and support patient/family in decision-making process
- Make referrals for IDT consults
- Participate in advance care planning
- Monitor care for signs of abuse/neglect
Resource Management
- Inform patient/family about how to access services
- Modify plan of care to accommodate psychosocial factors
- Assess and respond to environmental and safety factors
  - Risk management procedures
  - Monitor Schedule II drugs

Grief and Loss
- Key concepts - definitions
- Four tasks of grief
  - Accept the reality of the loss
  - Experience the pain of grief
  - Adjust to the physical absence of the deceased
  - Withdraw emotional energy from grieving and reinvest it in other ways
- Abnormal, complicated or pathological grief

Children’s Grief
- Consider developmental stages as context for explanations and approaches
- Children’s grief responses
  - Infant (birth – 2 years)
  - Preschooler (3 – 5 years)
  - Grade school child (6 – 10 years)
  - Pre-adolescent and adolescent (10 – 18 years)
  - Young adult (19 years and over)
- Needs of grieving children
Indicators of Imminent Dying

The Nurse, Dying and Death
- Nurses are frequently exposed to death
- Interpersonal competence
- Being present and bearing witness
- Interdisciplinary care - Goals of Care during the last days

Dying as a Physical, Psychosocial and Spiritual Event
- Patient preferences
  - Keep comfortable
  - Maintain sense of dignity
- Nurses advocate for choices
- Family as unit of care
- Interdisciplinary care important as death nears
**Patient and Family Preparation**

- Nurse advocates for choices
- Open, Honest Communication
  - Convey caring, sensitivity, compassion
  - Provide information in simple terms
  - Patient awareness of dying
  - Maintain presence
- Family Education about Time of Death
  - Education as empowerment
  - Strategies for overwhelmed families
  - Signs, symptoms of dying

**The Imminently Dying Patient**

- Determining prognosis
  - Signs/symptoms only a guideline
- Dying process
  - Fear of the dying process
  - Fear of abandonment
  - Fear of the unknown
  - Patient awareness near death

**Terminal Symptoms**

- Changes in Mentation
  - Decreased LOC
  - Nearing death transition
  - Restlessness/agitation
- Circulatory Changes
  - Edema
  - Mottling, cyanosis, cool extremities
Terminal Symptoms

- Altered Elimination
  - Urinary incontinence/retention
  - Bowel changes
- Altered breathing patterns
  - Cheyne-Stokes, periodic apnea
  - Dyspnea
  - Respiratory congestion/ "death rattle"

Terminal Care

- Hydration and Nutrition
  - Discuss early in disease process
  - Goals directed at patient comfort
  - Prevent or correct related problems
- Alteration in comfort: Pain
  - Possible causes
  - Management options
- Anxiety, Agitation, Delirium

Psychosocial/Spiritual Issues

- Patient in control as able
- Maintain patient dignity
- Address patient fears
- Communication/support
  - Often non-verbal
  - Saying goodbye
The Death Vigil – Family Support

- Family presence – Common fears
  - being alone with patient
  - painful death
  - time of death
  - giving “last dose”

The Death Vigil – Family Support

- Nursing Interventions
  - Collaboration with physician/team
  - Reassurance and education
  - Role model comforting
  - Physical comforting
  - Spiritual care; honor culture

Death

- Signs and symptoms of death
- Visit at the time of death
  - Communicating the death
  - Death pronouncement
  - Care of body after death
  - Assistance with calls, notifications
  - Destroying medications
  - Assisting with arrangements
  - Initiating bereavement support
Economic Issues in Hospice and Palliative Care

- Treatment costs and spending rising
  - Costs of high technology
  - ↑ consumer demand for expensive, high tech care
  - Growth of elderly population
    - Survive longer
    - More chronic illness
- Insurance system
  - Rewards high tech interventions
  - No reimbursement for low tech interventions

Payment for End-of-Life Care
- Medicare - most common source of payment
- Hospice accounts for 1% of all Medicare spending
  - Hospice Benefit covers only the terminal illness
- Last year of life usually the most costly
Medicare Hospice Benefit Eligibility

- Patient has Medicare Part A
- Both referring and hospice physician certify terminal illness with 6 months prognosis - if disease runs usual course
- Patient signs “election” form for Hospice Benefit
- Care must be provided by Medicare-approved hospice program

Informed Consent

- Palliative nature of the services
- Service settings
- Services provided and those not covered
- Bereavement services
- Patient/family financial responsibility
- Discharge criteria

Hospice Benefit Levels of Care

- Routine home care
- Continuous home care
- Inpatient respite care - no more than 5 consecutive days
- General inpatient care - not to exceed 20% of total aggregate days (“80/20” rule)
“Core Services”
- Provided by the hospice agency; may not be subcontracted:
  - Nursing services (RN/LVN) - including continuous care staff when indicated
  - Social work services
  - Counseling services
    - Spiritual
    - Dietary
    - Bereavement

Other Services
Direct or Subcontract
- Physician - Considered part of core services when it comes to participation in care plan development/update
- Therapies - PT, OT, Speech, etc.
- Home Health Aide & Homemaker services
- Medical supplies, appliances, medications

Medicare Hospice Benefit
Volunteer Services
- Required under Medicare/Medicaid
  - Volunteer service hours must account for 5% of all direct patient care hours
    - May be direct patient care
    - May be indirect administrative
  - Volunteer professionals (RN, MSW, etc.) held to same requirements as employees
Benefit Periods

- Two 90-day periods; then unlimited 60-day periods
- Not necessarily continuous
- Dropping election loses any remaining days in that particular period
- May change hospice programs once each benefit period
- Patient “certified” at start of each period

Discontinuation of Hospice Care

- Patient/family initiated actions
  - Transfer to another hospice
  - Revoke the hospice benefit and withdraw from program
- Hospice initiated actions
  - Discharge
  - Non-recertification

The Hospice Benefit Does Not Cover

- Curative treatment for terminal illness
- Care provided by another hospice that was not arranged by the patient's hospice
- Care from another provider which duplicates care required to be provided by the hospice program
Conclusion

- Quality end of life care addresses Quality of Life concerns
- Increased Nursing knowledge is essential
- “Being with” – the importance of presence
- Importance of interdisciplinary approach to care