

ADVANCING PALLIATIVE CARE EDUCATION IN SCHOOLS OF NURSING 2023 INNOVATIONS SERIES

ELNEC Undergraduate/New Graduate
Module 4– Symptom Management in Palliative Care
September 2023

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American Nurses Association Professional Issues Panel

**Call for Action:
Nurses Lead and Transform Palliative Care**

**Approved by ANA Board of Directors
March 13, 2017**

**Developed in Partnership With Organizational Affiliate
Hospice and Palliative Nurses Association**



Historical Context

ANA Professional Issues Panel & HPNA.
(2017). Call for action: Nurses lead &
transform palliative care.

<http://www.nursingworld.org/CallforAction-NursesLeadTransformPalliativeCare>

RECOMMENDATION #1

“Adopt the End of Life Nursing Education Consortium (ELNEC) curricula (Core, Geriatric, Critical Care, Pediatric, Advanced Practice Registered Nurse [APRN], and Online for Undergraduate Nursing Students) as the standard for primary palliative nursing education for pre-licensure, graduate, doctoral, and continuing education for practicing registered, vocational, and practical nurses and advanced practice registered nurses” (p. 3)

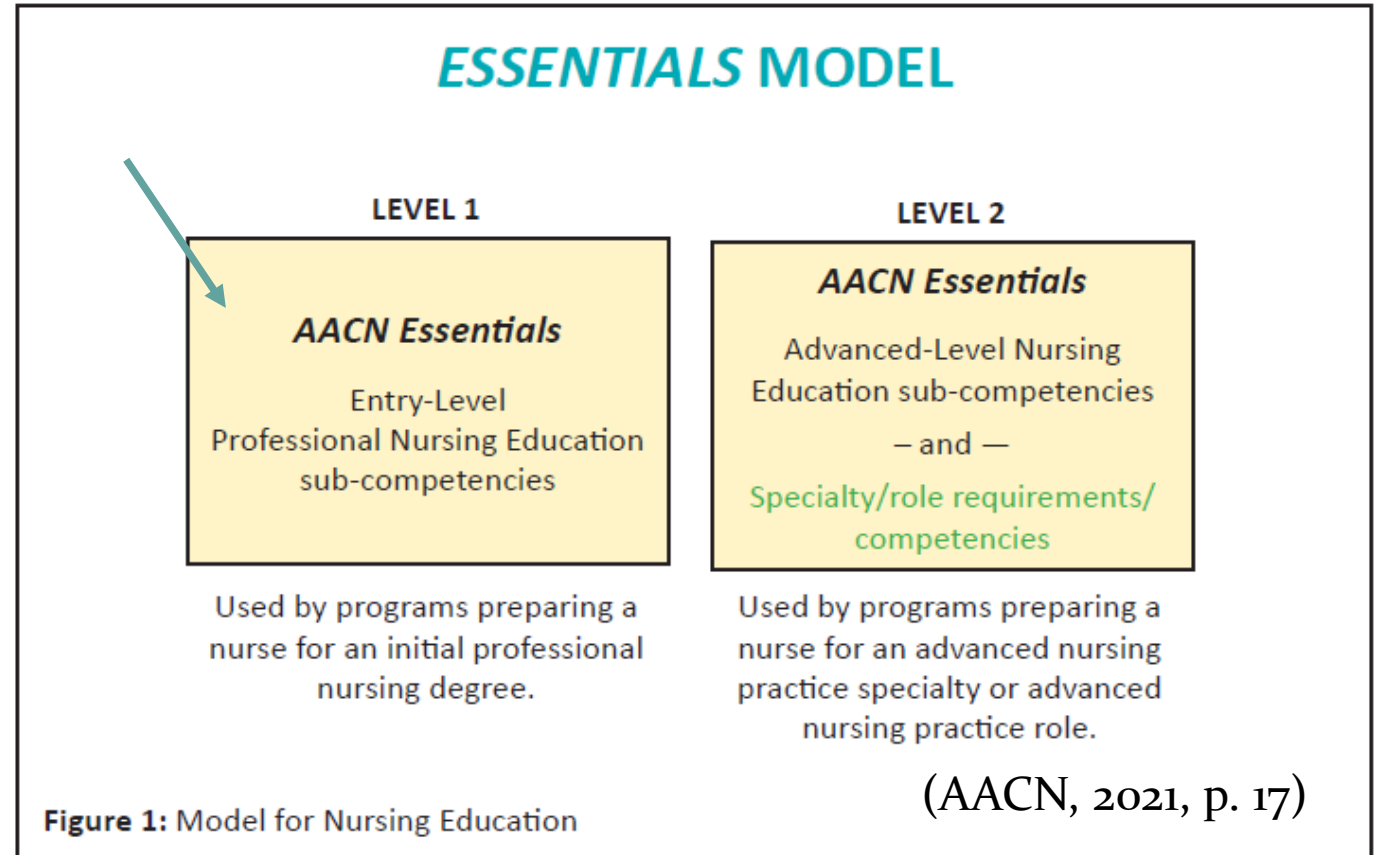
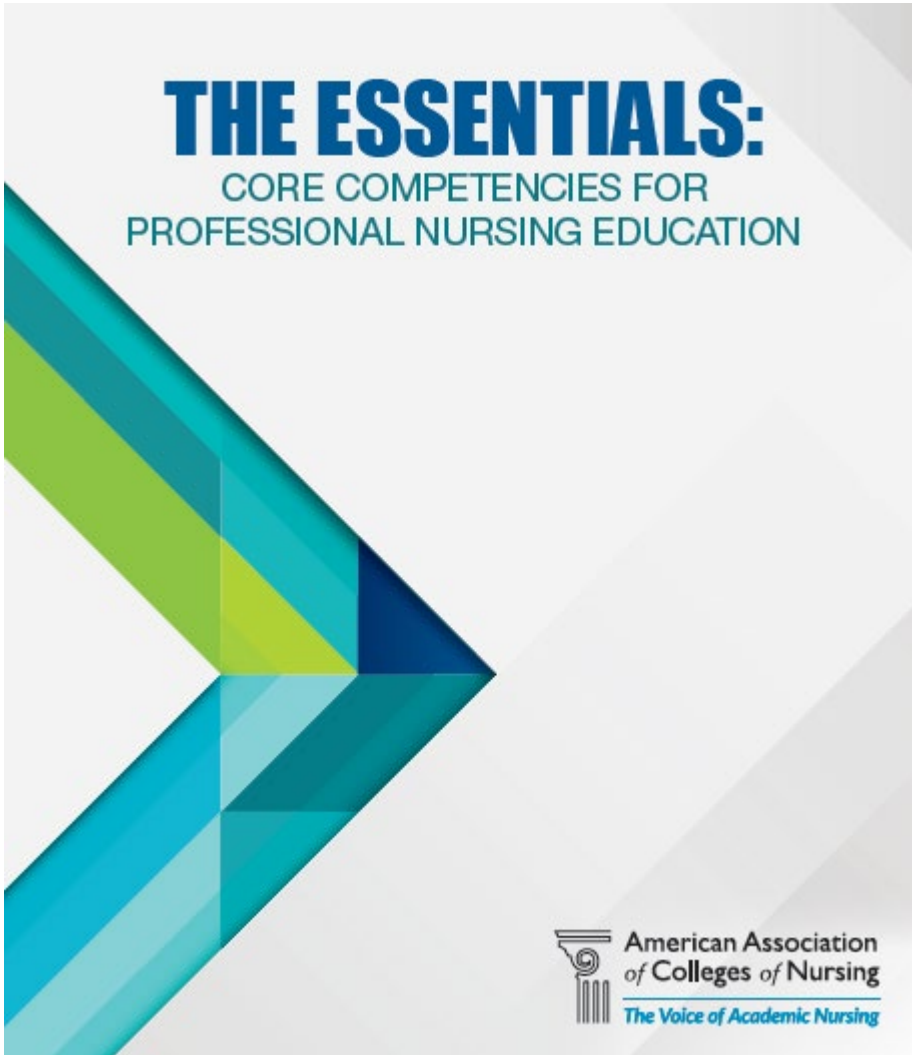
ELNEC HISTORY

2000: Curriculum Developed

2001: 1st National ELNEC Course

Currently 10 ELNEC Curricula:

- ELNEC Core
- ELNEC Geriatric
- ELNEC Pediatric Palliative Care
- ELNEC Critical Care
- ELNEC APRN
- ELNEC International
- ELNEC Undergraduate/New Graduate (2017)
- ELNEC APRN Oncology
- ELNEC Communication (2018)
- ELNEC Graduate (2019)



American Association of Colleges of Nursing. (2021). *The Essentials: Core Competencies for Professional Nursing Education*. American Association of Colleges of Nursing.
<https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf>

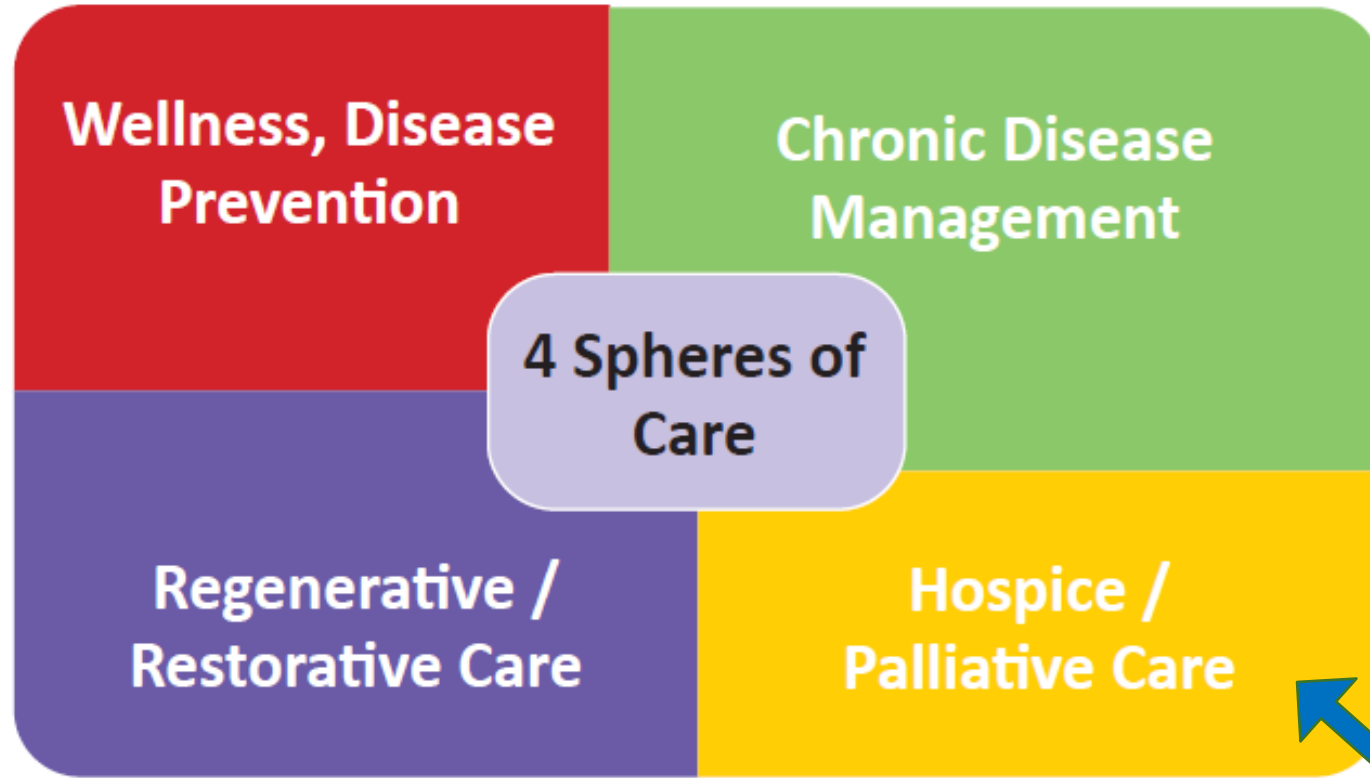
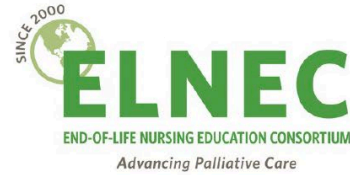


Figure 2: Four Spheres of Care (AACN, 2021, p. 19)



Primary Palliative Care Competencies for Undergraduate and Graduate Nursing Students (*CARES/G-CARES*, 2nd ed)

Entry-level Professional Nursing

CARES (2016) = 17
competency statements

CARES (2nd ed., 2022) = 15
competency statements

**CARES COMPETENCY
STATEMENTS
2ND EDITION
2022**

CARES COMPETENCY STATEMENTS

#2: Consider the **complex and evolving socio-economic factors** that influence equitable palliative care delivery within health care systems.

#4: Demonstrate respect for diversity, equity, and inclusion as essential for the delivery of **culturally sensitive, quality palliative care**.

#6: Collaborate effectively within the interprofessional team to **coordinate the delivery of high-quality palliative care across healthcare settings**.

#7: Demonstrate respect for person-centered care by **aligning the plan of care with patient and family values, beliefs, preferences, and goals of care**.

CARES COMPETENCY STATEMENTS

#10: Utilize evidence-based tools to perform a **holistic health assessment** of pain and other symptoms, considering physical, psychological, social, and spiritual needs.

#11. **Synthesize assessment data to develop and implement plans of care** that address physical, psychological, social, and spiritual needs, utilizing holistic, evidence-based approaches.

12. **Conduct ongoing reassessment and evaluation** of patient outcomes, modifying the plan of care as needed to be consistent with goals of care.

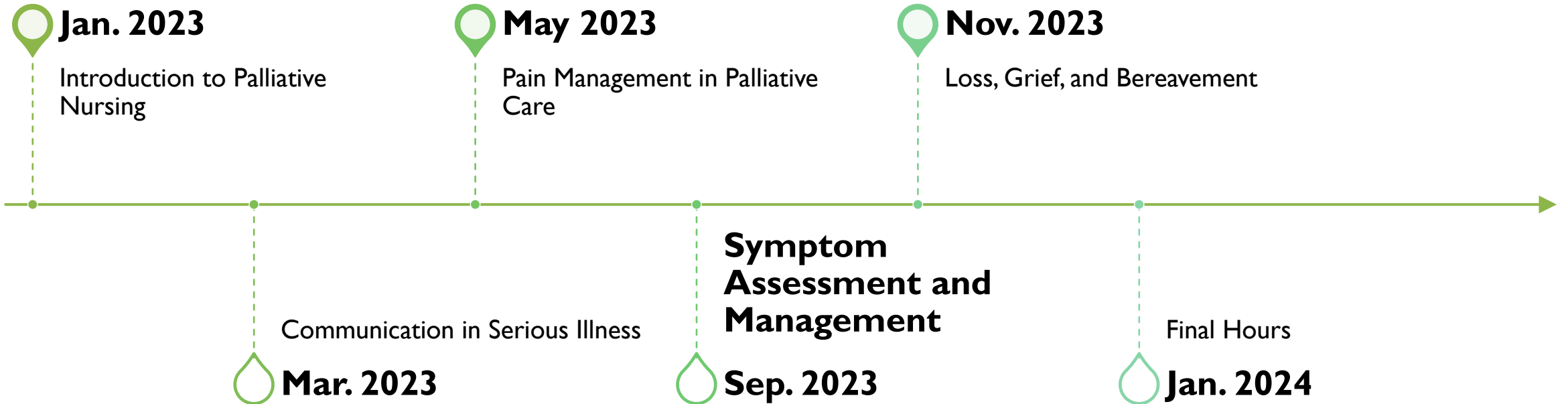
13. Provide culturally sensitive care that is **responsive to rapidly changing** physical, psychological, social, and spiritual needs **during the dying process and after death.**

PRIMARY PALLIATIVE NURSING CARE COMPETENCE ASSESSMENT TOOL (LIPPE & DAVIS, 2022) ©

ASSESSMENT	Using standardized tools, performs comprehensive assessment of:
	• Symptoms common in serious illness
	• Pain and its meaning
	• Social determinants of health and needs
	• Spiritual, religious, and existential status and needs
	• Psychological status, coping and needs
	• Caregiver knowledge, stressors, capacity, resources, and needs
PRIORITIZATION AND INTERVENTION	Prioritizes and implements holistic evidence-based (nonpharmacological and pharmacological) interventions to address:
	• Physical concerns and needs (pain and other symptoms)
	• Social concerns and needs
	• Spiritual, religious, and existential concerns and needs
	• Psychological needs and coping
	• Caregiver concerns and needs
	Advocates for resources to address complex concerns and needs across physical, psychological, spiritual, and social domains
EDUCATION	Educates patients and families regarding:
	• Specialty palliative care or hospice services when appropriate
	• Ongoing pain and symptom management
	• Signs and symptoms of imminent death
EVALUATION	Continuously reassesses outcomes and modifies plan when needed, in alignment with goals of care
CARE NEARING END OF LIFE	Assesses patient and family preferences for setting of care, treatment decisions, and wishes in preparation for death.
	Adjusts care to rapidly changing needs (physical, psychological, social, and spiritual) during the imminent death period.



ELNEC UNDERGRADUATE/NEW GRADUATE





ELNEC
Undergraduate/New Graduate 1122 Schools



ELNEC Graduate 388 Schools



LET'S TAKE A CLOSER LOOK

ELNEC Undergraduate and New Graduate Module 4: Symptom Management in Palliative Care

[START COURSE](#)

NEW LOOK FALL 2023



Q&A  **SESSION**

DIALOGUE WITH
PAT COYNE
AND
CONNIE DAHLIN



Breakout Room #1

Everyone – share how you are incorporating palliative care education and specifically symptom management principles. Remember we are all doing different things and at different places with this so if you don't know, that's okay too! How can we help each other to advance palliative care education?

Breakout Room #2

Review Infographic Supplemental materials – ELNEC Resource Page: How might you use this in what course?

<https://www.aacnnursing.org/elneec/resources>

NURSING MANAGEMENT OF DYSPNEA

Assessment of Dyspnea

- Assessment is based upon self report
 - Ask history "What is your 'usual' level of exertion?"
 - Intensity: rate using 0-10 scale (0=no distressness, 10=severe breathlessness)
 - Effect on function, activity and quality of life
 - Diagnose dyspnea by history and physical exam
 - Anxiety and depression are common in dyspnea
 - Diagnostic tests may be used to identify treatable causes (e.g., bronchospasm, pulmonary embolism, pleural effusion)
 - Pulse oximetry, blood gases may be normal despite presence of dyspnea
- Causes of dyspnea, especially in people with serious illness:
 - Acute/Chronic: Pneumonia, Sepsis, COPD, Heart Failure, Pulmonary Embolism, Anemia, Asthma, COVID-19, Advanced AIDS

Pharmacologic Palliative Management: Opioids

Opioids are the foundation for management of dyspnea for palliative care

- Start doses for opioid naïve patients:
 - Morphine IV 2mg every 2-4 hours prn
 - or 2-5 mg for longer acting adults
- Hydrocodone/ Acetaminophen 5/500 2-3
- Morphine 10 20
- Oxycodone 5/500 2-3
- Hydrocodone/N/A 2-4 mg every 4 hours prn
- Morphine 10 20
- Hydrocodone/N/A 2-4 mg every 1 hour prn
- Titrate upward by 25-50% if dyspnea unresolved
- Increase frequency if dose provides relief but is not sustained
- Every hour for oral administration
- Every 15 minutes for IV administration
- Initial doses for opioid tolerant patients:
 - Higher doses may be needed
 - Dose requirements table by calculated current 24 hour dose and administer 10-20%, increase gradually

Pharmacologic Management: Other Medications

- In **Caution** - Bronchodilators can relieve heart rate and a sense of anxiety or agitation although the drugs do not improve the flow, they treat only symptoms and use of any anxiety in present and opioids have been adequately treated
- Lorazepam is recommended due to its relatively short half-life and its availability in liquid form. Doseage: 0.5-1 mg PO/IV, q 4 hours.

Nonpharmacologic Management

- Low calm respiratory rate and low with interactions
- Distraction/visual/ calming environment
- Education about dyspnea, causes and management
- Upright - open with head tilted back
- Positioning - upright, leaning forward for symptom control (prone position used in hospital/ICU)
- Fans for or abdominal breathing
- Relaxation techniques
- Spitball care
- Social support

Don't forget to seek support from other team members including:

- Chaplain/Religious providers
- Pharmacist/Pharmacists
- Respiratory therapists
- Physiotherapists
- Psychologists
- Social workers

References

1. Bazzani, L. (2019). *Journal of Palliative Care*, 35(1), 1-10. doi:10.1177/0898010118791111

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QUICK REFERENCE GUIDE FOR SYMPTOM MANAGEMENT

SYMPTOM	TREATMENT
Fatigue	<ul style="list-style-type: none"> The most prevalent of symptoms reported in advanced disease Rule out possible causative factors and evaluate which might be treatable given goals of care: anemia, iron deficiency, electrolyte imbalances, hypothyroidism, hypoxia, nutrition deficiencies, medications, anxiety/depression, sleep abnormalities Exercise, physical therapy, occupational therapy Assistive devices, caregiving support (hygiene, cleaning, meals) Stimulants such as methylphenidate (Ritalin®) 2.5-5 mg PO QD or BID to start, then titrate prn Dexamethasone (Decadron®) 2-8 mg PO QD, do not give in the evening Mirtazapine (Remeron®) 15 mg PO QHS to enhance sleep, also improves appetite and mood
Insomnia/ Sleep Disorders	<ul style="list-style-type: none"> Evaluate sleep patterns current and prior to diagnosis Suggest sleep hygiene measures: reduce caffeine in afternoon/evening, do not watch TV/computer/cellphone/tablets in bed, limit alcohol intake, cool room, warm bath before bed Relaxation therapy such as mindfulness exercises, meditation, guided imagery For some, pharmacologic therapies ineffective if used daily Zolpidem (Ambien®) 5-10 mg PO QHS; lower doses for women; safety concerns – sleep walking/eating Mirtazapine (Remeron®) 15 mg PO QHS to enhance sleep, also improves appetite and mood Bupropion (Wellbutrin®) 5-20 mg PO TID Trazodone (Desyrel®) 25-50 mg PO QHS Avoid antihistamines (diphenhydramine) for sleeping aid, especially in elderly or frail
Constipation [Acute]	<ul style="list-style-type: none"> Assess frequency, volume, consistency and normal patterns of BMs Diarrhea may be due to impaction; rectal exam indicated Goal ~ 3x/week without straining, pain, tenesmus Identify potential causative factors that can be addressed: opioids, anticholinergics, antidiarrhetics, phenothiazines, tricyclic antidepressants, diuretics, iron, chemotherapy, ondansetron, antacids, dehydration, inactivity, hypercalcemia, hypokalemia, partial bowel obstruction, spinal cord compression, autonomic neuropathy, depression, anorexia, hypothyroidism Encourage varied diet First evacuate bowel – magnesium hydroxide (Milk of Magnesia) 30 mL PO QD, magnesium citrate 150-300 mL per day, bisacodyl 2-3 tabs PO QD or 10 mg suppository or Fleet's Enema® (nothing per rectum if patient thrombocytopenic [$< 50,000$ platelets] or neutropenic [ANC $< 500-1000$]) – limit Fleet's and other sodium phosphate agents in renal dysfunction; if these are ineffective, give: <ul style="list-style-type: none"> Methylnaltrexone (Relistor®) SQ [for opioid induced constipation only] – dosing is weight based; contraindicated in obstruction Naloxegol (Movantik®) 12.5 or 25 mg PO Q AM [for opioid induced constipation only] Naldemedine (Symproic®) 0.2 mg PO QD [for opioid induced constipation for patients with chronic noncancer pain]

MEDITATION & MINDFULNESS APPS FOR NURSES AND PATIENTS

Being a patient or a nurse can be stressful. Being a patient means having to navigate a complex health system, insurance, treatments, and life. Being a nurse means understanding health conditions, implementing treatments, advocating for patients, giving one's all, along with navigating life. Research demonstrates that meditation and mindfulness are effective, inexpensive, and easy to implement strategies to alleviate stress. To support meditation and mindfulness, there are many apps available on smart devices and computers. Many are free, although more advanced options may require a fee.

- Breathing Zone** – Relaxing mindful breathing exercises
- Buddhify** – Meditations on the go
- Calm** – Meditation, mindfulness, and sleep stories
- Happify** – Reduce stress, anxiety and negative thinking to improve emotional well-being

Give yourself the same care and attention that you give to others.

- HeadSpace** – Meditation and sleep
- Headsurfer** – Guided imagery, meditations and affirmations with wide range of titles, including in Spanish
- The Mindfulness App** – Five day introduction to mindfulness with guided meditations
- Mindfulness Coach** – Designed by US Department of Veteran's Affairs to reduce stress, anxiety, depression and pain

If your expression does not include yourself, it is incomplete. – Jack Kerouac

- Mindfulness Daily** – Helps establish a daily mindfulness practice three times daily
- Pause** – Focus, energy, clarity. Meditation through mindful moments
- Stop Breathe & Think** – Personalized meditations with a tracking timer and tools to track progress
- Stress Free Now Meditations (Cleveland Clinic)** – Includes mindful breathing, body scan, letting go, loving kindness, and others

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NURSING MANAGEMENT OF ANXIETY

ANXIETY IS...

an adaptive and normal part of coping; however, extreme anxiety can impair O2, and affect daily functioning. Common in those experiencing serious illness. A multifactorial subjective and objective experience

ASSESSMENT

- Physical
- Behavioral
- Cognitive
- Spiritual
- Existential

Listen carefully. Patients may use words such as "worried," "concerned," "on edge," or "tightly wound"

Determine if there is a history of anxiety, depression, PTSD or substance use disorder

Assess for and change other symptoms such as pain and fatigue

Consider metabolic causes: hyperthyroidism, hypoxia, hypovolemia, hyperthermia, hypocalcemia, potassium imbalance

Identify psychosocial and spiritual concerns, including isolation, finances, family concerns, existential distress, or fear of death

Remind patients that you are available to help them with their anxiety

Non-pharmacologic interventions that can contribute to anxiety:

- Depression
- Substance use
- Chronic pain
- Delirium
- Medication side effects
- Psychosocial stressors
- Isolation
- Uncertainty
- Loss of control
- Loss of autonomy
- Loss of dignity
- Loss of hope
- Loss of meaning
- Loss of purpose
- Loss of identity
- Loss of self
- Loss of family
- Loss of friends
- Loss of community
- Loss of culture
- Loss of religion
- Loss of spirituality
- Loss of faith
- Loss of hope
- Loss of meaning
- Loss of purpose
- Loss of identity
- Loss of self
- Loss of family
- Loss of friends
- Loss of community
- Loss of culture
- Loss of religion
- Loss of spirituality
- Loss of faith

PHARMACOLOGIC MANAGEMENT

Need to balance risks and benefits, as well as projected duration of therapy.

ACUTE MANAGEMENT

- Lorazepam 1-2 mg PO every 4-6 hours as needed
- Useful for anxiety that inhibits sleep
- Haloperidol 1-2 mg PO every 4-6 hours as needed
- Useful for anxiety accompanied by confusion or agitation

CHRONIC MANAGEMENT (period oral agents – most require weeks to take full effect):

- Mirtazapine 15-30 mg PO QD
- Hydrocodone/ Acetaminophen 5/500 2-3
- Morphine 10 20
- Oxycodone 5/500 2-3
- Hydrocodone/N/A 2-4 mg every 4 hours prn
- Morphine 10 20
- Hydrocodone/N/A 2-4 mg every 1 hour prn
- Mirtazapine 15-30 mg PO QD
- Hydrocodone/ Acetaminophen 5/500 2-3
- Morphine 10 20
- Oxycodone 5/500 2-3
- Hydrocodone/N/A 2-4 mg every 4 hours prn
- Morphine 10 20
- Hydrocodone/N/A 2-4 mg every 1 hour prn

NONPHARMACOLOGIC MANAGEMENT

- Listening
- Normalizing reactions
- Cost containment
- Deep breathing, relaxation, mindfulness, meditation
- Distraction/visual/ calming environment
- Upright - open with head tilted back
- Positioning - upright, leaning forward for symptom control (prone position used in hospital/ICU)
- Fans for or abdominal breathing
- Relaxation techniques
- Spitball care
- Social support

Don't forget after time assessment can assist patients in reducing anxiety:

- Chaplain/Religious providers
- Pharmacist/Pharmacists
- Respiratory therapists
- Physiotherapists
- Psychologists
- Social workers

REFERENCES

1. Bazzani, L. (2019). *Journal of Palliative Care*, 35(1), 1-10. doi:10.1177/0898010118791111

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NURSING MANAGEMENT OF PEOPLE WITH LONG HAUL COVID

More than half of adults diagnosed with COVID experience at least one or more symptom of Post-acute Sequelae of COVID (PASC/COVID-19) – also called "post-COVID" or "long haul COVID". Even six months after infection, these symptoms can occur in people who were infected and had mild symptoms or were completely asymptomatic. These ongoing symptoms significantly affect quality of life.

PHYSICAL WELL-BEING & SYMPTOMS

- Dyspnea
- Cough
- Fatigue
- Post-exertional malaise
- Muscle weakness
- Myalgias & arthralgias
- Headaches
- Sinus and taste changes
- Diarrhea
- Neuropathy

PSYCHOLOGICAL WELL-BEING

- Difficulty concentrating
- Cognitive changes
- Depression
- Generalized anxiety disorder
- Other mood alterations
- PTSD
- Sleep disorders

SOCIAL WELL-BEING

- Financial burden
- Loss of employment/income
- Medical costs
- Access to healthcare and rehabilitation
- Caregiver burden
- Loss of usual roles and relationships

SPIRITUAL WELL-BEING

- Uncertainty about future and loss of hope
- Why me?
- Stigma around infection

NURSING INTERVENTIONS

- Conduct a complete nursing assessment - Consider pre-existing and new comorbidities
- Actively listen with compassion
- Believe the patient's report of symptoms and normalize that these are common. Taking time to resolve
- Address symptoms, health risks and benefits of pharmacologic management. Discuss pharmacologic strategies with attention to access, insurance coverage and cost
- Refer to palliative care and COVID clinics if available
- Engage team members when specialty clinics not available: physical therapy, occupational therapy, speech therapy, physical medicine & rehabilitation medicine, social work, psychology (including neuropsychology or neuropsychiatry), nutrition, complementary, integrative therapies
- Consider patients with support groups such as Survivor Corps (www.survivorcorps.com/) or Long Haul Alliance (<http://longhaulalliance.org/>)
- Address health disparities – long haul COVID appears to be more common in women; COVID disproportionately affects people of color

Therapies specific to treat long haul COVID conditions have not yet been established

- Exercise
- Behavioral interventions include:
 - Gratitude
 - Self-compassion
 - Healthy eating
 - Rest
 - Healthy management

REFERENCES

1. CDC. Evaluating and caring for patients with post-COVID conditions. <https://www.cdc.gov/media/releases/2023/s0914-post-covid.html>

2. Patel, R. et al. Quality of life in long haulers. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9111111/>

3. Gell, D., et al. Short-term and long-term rates of post-acute sequelae of SARS-CoV-2 infection: A systematic review. *JAMA Network Open*, 2023; 6(7): e2328368

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RESOURCES

- American Association of Colleges of Nursing. (2021). *The Essentials: Core Competencies for Professional Nursing Education*. American Association of Colleges of Nursing. <https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf>
- AACN/ELNEC Faculty Corner: <https://www.aacnnursing.org/elneec/elneec-school-of-nursing-faculty-corner>
- Lippe, M. & **Davis, A.** (2023). Development of a primary palliative care competence model and assessment tool: A mixed methods study. *Nursing Education Perspectives*, 44(2),76-81.

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<https://www.aacnnursing.org/elnece/elnece-school-of-nursing-faculty-corner>