ELNEC
END-OF-LIFE NURSING EDUCATION CONSORTIUM
Advancing Palliative Care

THE CHANGING NATURE OF PALLIATIVE NURSING IN ONCOLOGY

Where We've Been & A Path Forward

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Memorial Sloan Kettering Cancer Center

@BROSA_PHD

OBJECTIVES

- Reflect on how moral suffering has showed up in our practice environments
- Discuss relevant research on moral distress and implications for palliative care clinicians
- Identify tools to promote moral resilience and moral courage
- Use advocacy as a method for improved self-efficacy and palliative care integration


COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)
Last Updated at (M/D/YYYY
6/12/2021, 1:23 PM
Cases
175,397,648
Deaths
3,787,525
Vaccine Doses Administered
2,311,447,662
Cases and Deaths by Country/Region/Sovereignty
33,451,618 | 599,570 US
29,359,155 | 367,081 India
17,296,118 | 484,235 Brazil
5,795,719 | 110,509 France
5,325,435 | 48,668 Turkey
5,133,938 | 123,961 Russia
4,574,445 | 128,160 United Kingdom
4,243,482 | 126,976 Italy
4,093,090 | 84,628 Argentina
Admin0
NORTH AMERICA
EUROPE
AFRICA
SOUTH AMERICA
North Pacific Ocean
North Atlantic Ocean
South Pacific Ocean
South Atlantic Ocean
Esri, FAO, NOAA
Powered by Esri
Cumulative Cases
Daily Cases
2M
1.5M
1M
500k
0
Jul
2021
Daily Deaths
20k
10k
0
Jul
2021
Total Vaccine Doses
3B
2B
1B
0
Jul
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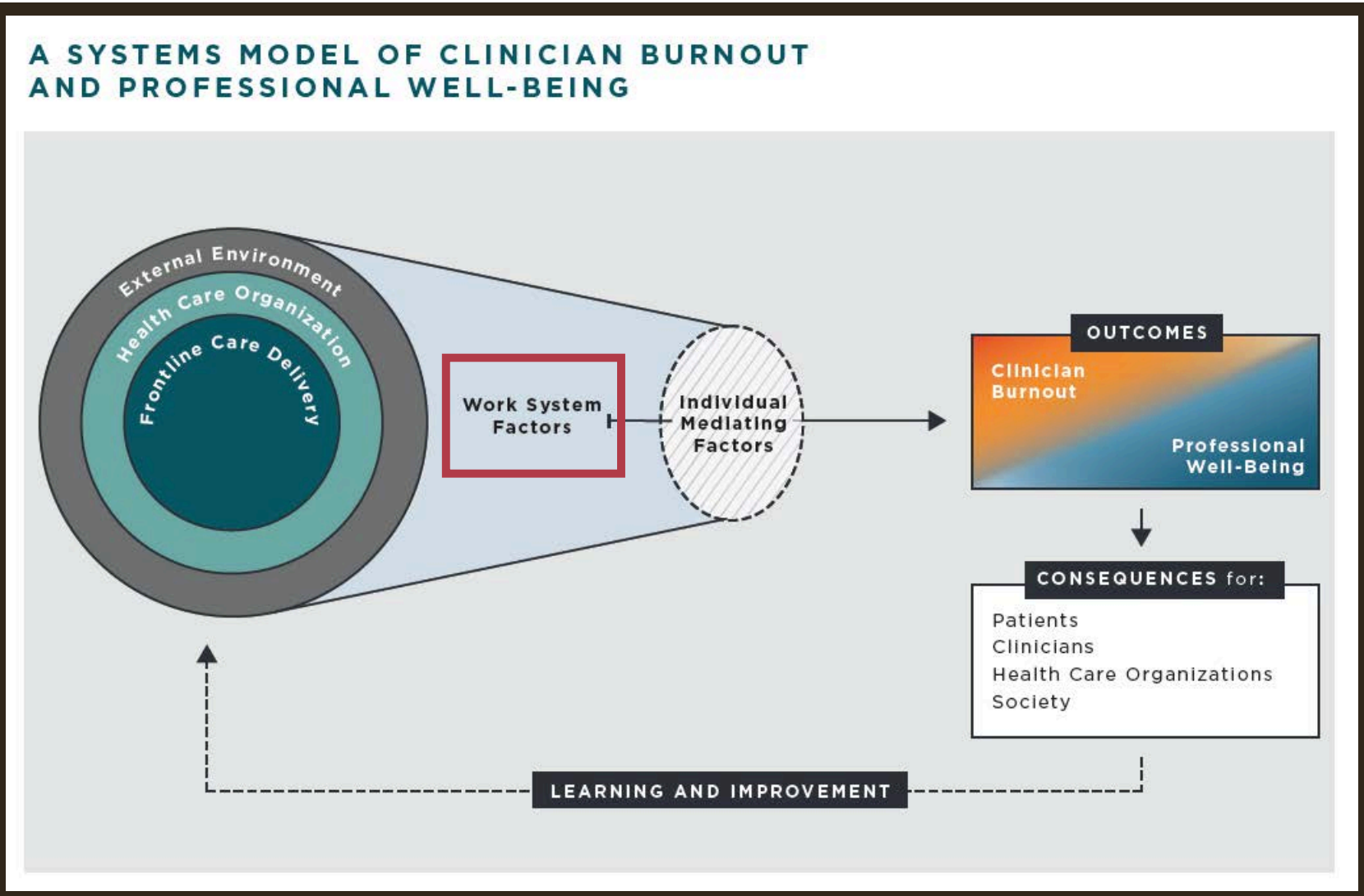

Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being
-The National Academies (2019)

How Reframing Distress can Support Your Workforce & Heal Your Organization
–Moral Injury of Healthcare (*fixmoralinjury.org*)

Palliative and Supportive Care

cambridge.org/pax

Original Article

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Navigating the terrain of moral distress: Experiences of pediatric end-of-life care and bereavement during COVID-19

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To define the ways the COVID-19 pandemic has impacted end of life care and approach to bereavement care in pediatric palliative care (PPC).

Background

Cumulative loss, isolation/disconnection, and uncertainty

Parental worry about seriously ill children

“Will I be able to be with my child?”

Limited accessibility of cultural rituals and celebrating a loved one’s life

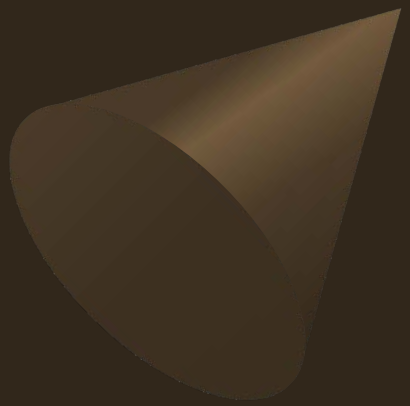
Limited ability of health teams to best support patients/families navigating death of a child

Dissonance between need for community and safety of self/others

Results

- N=207 PPC team members from 80 cities within 39 states and D.C.
  - 38 NE, 51 S, 58 MW, 34 W, 23 SW per Nat Geo criteria
  - MDs, RNs, SWs, child life specialists, and psychologists

Moral Distress Associated with Care Provided



- Open-ended questions gave opportunities to describe differing types of distress
- Example questions:
  - Can you tell us about an experience you have had related to COVID-19 that you feel with stay with you, always?
  - What is something you have learned since COVID-19 that will impact your palliative care practice going forward?
  - What is something you wish you'd learned prior to the pandemic that might have impacted how you approached palliative care during COVID-19?

Moral-Constraint Distress[a] One is feeling distressed because they are constrained from doing what they think is the ethically appropriate action *N* = 21	*I will never forget telling a mama that her child would die, while the child's dad looked helplessly on via facetime, because he had not been allowed on campus due to new Covid-19 restrictions. It was heartbreaking.*
	Caring for dying children right now is much more difficult and sad. … Trying to balance which patients to check on from home and which need to be seen in person has led to a great deal of conflict within the team. That conflict and difficulty will stay with me for a long time.
	Have a mother crying and very upset about her dying infant and not being able to hug her. It will stick with me. I hated it.
	I had a child abuse case, likely due to stress of COVID-19, that ended in redirection of care. It was a terrible case, and to top it off we couldn't get Mom the additional support she needed during EoL care for her daughter. Also had a re-direction of care where grandfather facetimed from the lobby to say goodbye because he was not allowed to come to the room.
	I've learned how important touch is…especially during difficult conversations and at the end of life.
Moral-Observer Distress Observing (potentially) traumatic events but institutional or public hea constraints make it impossible for a different action to be taken *N* = 18	*Some families have held drive by funerals for teenagers and stood in their yards while the teens drove by to send love. Heart breaking to imagine.*
	A young mother facing removal of LST (extubation) of her toddler with only one other family member able to visit with her and their priest performing a ritual from the hospital parking lot.
	The despair of families who knew their child was approaching the end of their life and not be able to be all together as a family until the child was actively dying.
	The trauma inflicted upon siblings that were not able to visit their sibling as they died.
	How awful awful awful it is when a family is not whole, when only one parent can be with a child, how staggering the suffering is for all family members.
Moral-Uncertainty Distress[a] One is feeling distressed because they are uncertain about whether they are doing the right thing *N* = 6	*I don't know if it's the larger grief and stress we are all facing, or the lack of my team members with me, or if people are making different choices than usual and deaths are clustering, or what the root of it is.*
	Decisions about furlough, salaries, hiring freezes will impact teams for years and are not easy ones to make. Even those, like myself who are experienced leaders find the uncertainty overwhelming at times.
	Big increase in personal anxiety — fear of going to people's homes, apartment buildings, etc. and worrying about bringing infection home to loved ones or other patients.

PERCEIVED SELF-EFFICACY OF PALLIATIVE CARE CLINICIANS

- How effective did you feel in meeting the psychosocial and spiritual needs of acute oncology inpatients using telehealth during the first COVID-19 surge?
- 11 clinicians across 6 disciplines (NP, PA, SW, PharmD, Chaplaincy, MD)
- One hour interviews
- Qualitative descriptive approach

“I don’t know what I was telling myself, I think I just told myself, ‘This is the normal. You just have to make it work. This is what we’re doing to keep everyone safe, and just figure out a way to make it work.’

You know, making multiple, multiple calls throughout the day to reassure myself that this is okay. Yeah. And you know, checking with the team. I got peer support from the team to say this was okay.

And that's how I kept going. But the cases still made you feel … uncomfortable.” -P2, NP

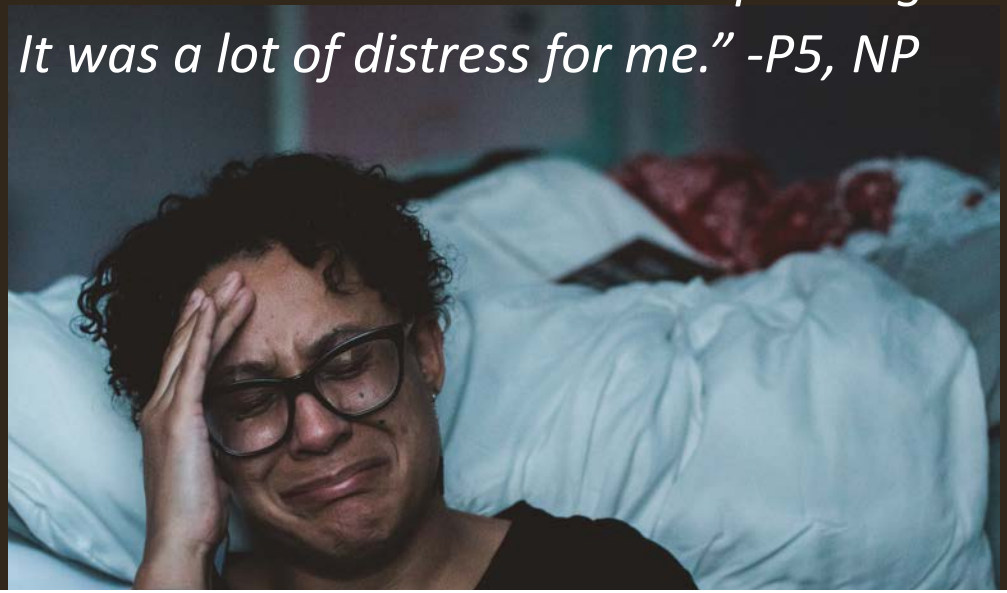
“But there are just those moments and those particularly difficult cases where just the frustration sticks.

You carry it with you and those are the patients that I remember. I'm sure I took care of a lot of happy patients that maybe weren't COVID positive or maybe they were but they were discharged.

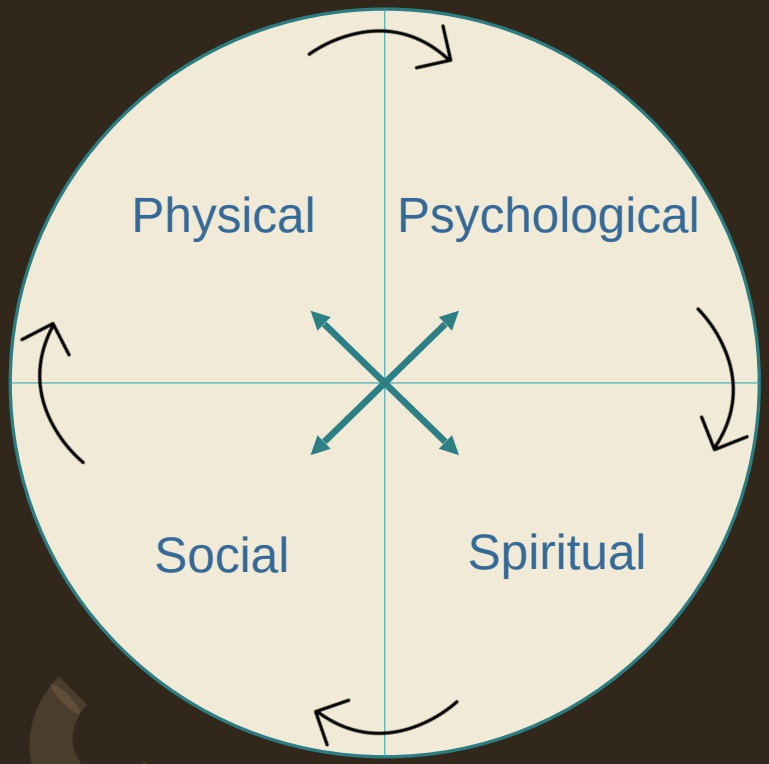
But of course, those are not the patients that I remember.”

-P3, MD

“One of the cases that haunts me is… this woman was COVID positive, her daughter was in the room. I called her daughter and… her daughter was really upset and crying and I was asking what's going on and she was like, ‘My mom isn't doing well, something's different.’ And I said, ‘Just take a deep breath, can you see if [your mom is] breathing?’ And her daughter paused and started freaking out because her mom wasn't breathing. Her mom had died. And so, it's like, being at home and being on the phone with somebody whose just lost a loved one and then telling that loved one, her daughter, to [ring] the call bell and have the nurse come in is so upsetting that I feel like I wasn't there to do my job. … It was a lot of distress for me.” -P5, NP



Our ‘Total Moral Pain’

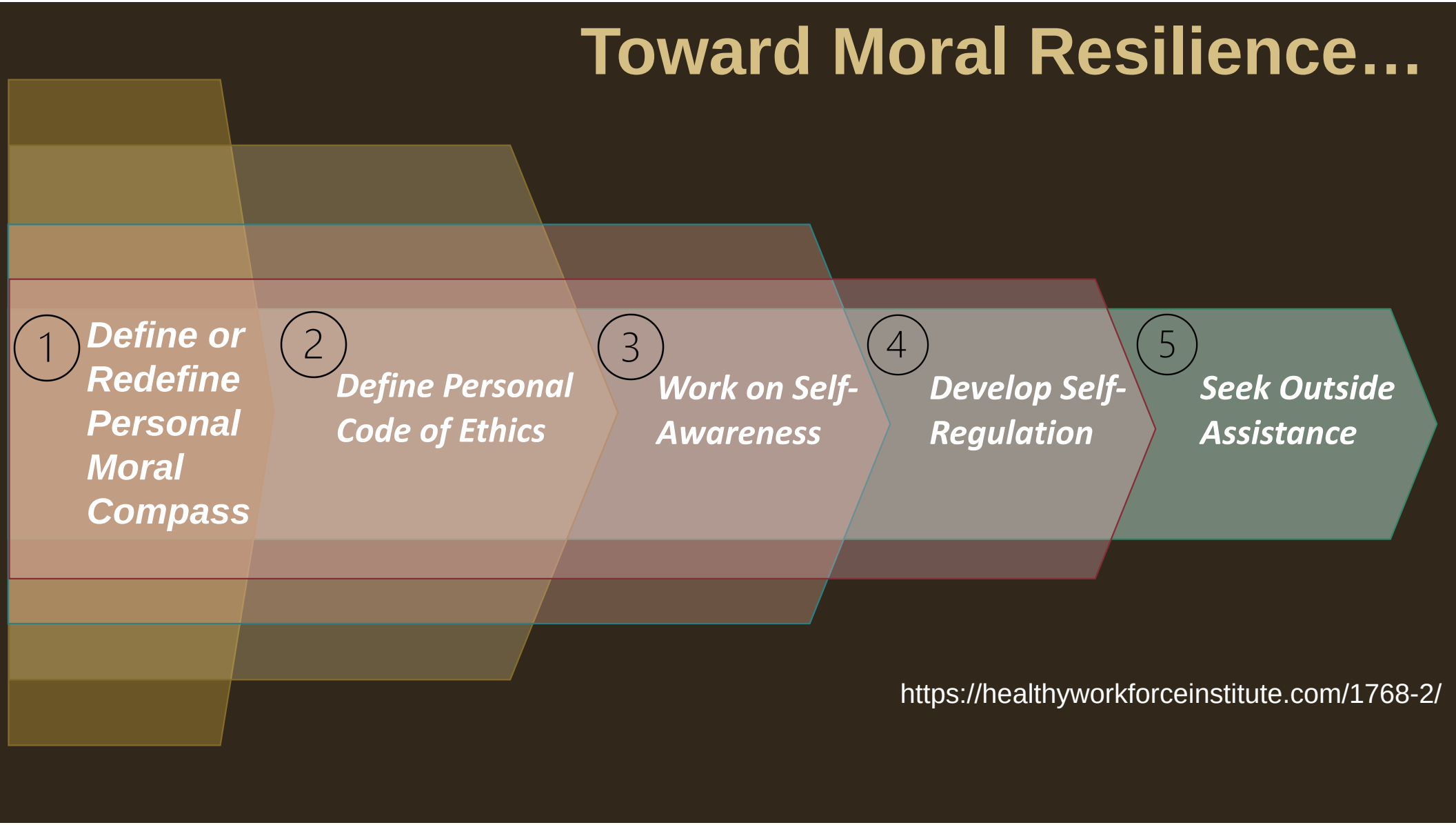


“We are trying to figure out how to [decipher the need for support] way before people get to the point where they are so distressed that it’s affecting them physically, emotionally, and spiritually.”

-Cynda Rushton, PhD, RN, FAAN

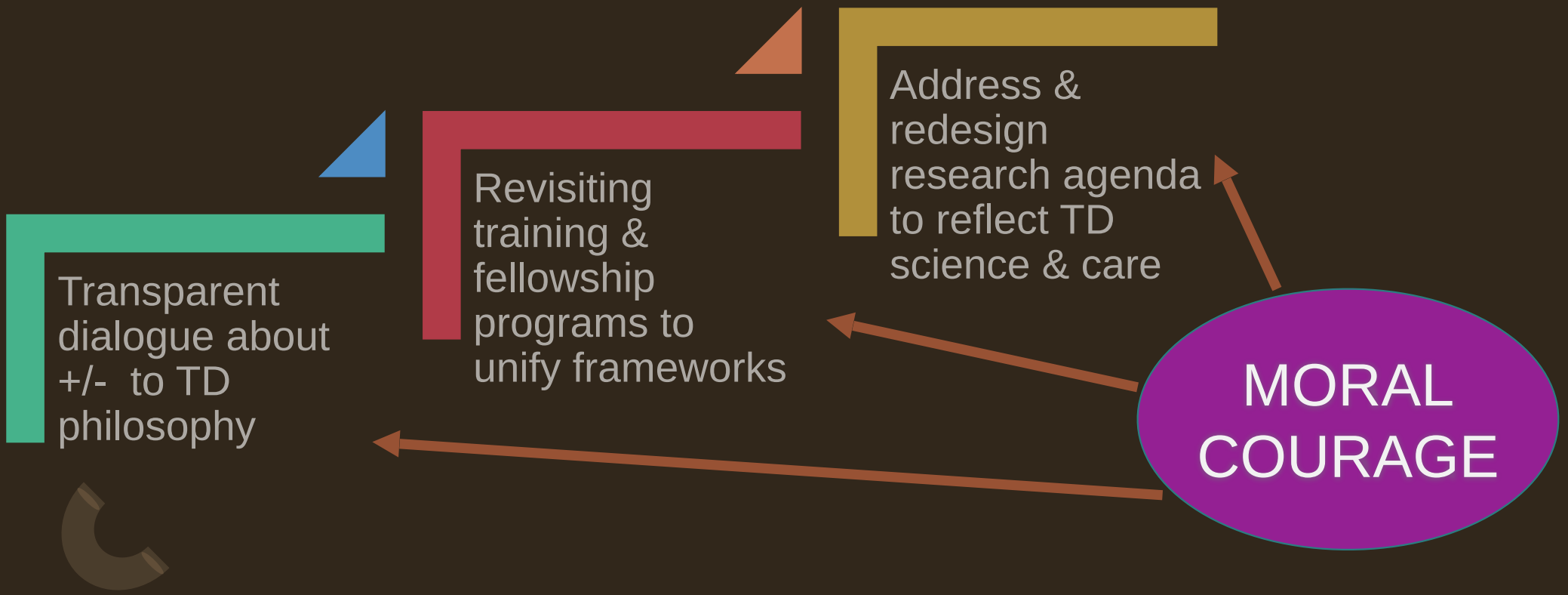
https://moraldistressproject.med.uky.edu

Toward Moral Resilience…



https://healthyworkforceinstitute.com/1768-2/

The Role of Enhanced Transdisciplinary (TD) Models



https://www.liebertpub.com/doi/full/10.1089/jpm.2020.0306

JAMA Forum

JAMA Health Forum™

"Every patient treated with a ventilator also needs palliative care. It is not an either-or clinical proposition, but rather a both-and moral imperative… Access to palliative care is a human right. Our inability to deliver it in the setting of COVID-19 and other serious illnesses is a human rights violation. Each of us is a stakeholder."

Integration of Palliative Care Into All Serious Illness Care as A Human Right

William E. Rosa, PhD, APRN[1]; Betty R. Ferrell, PhD, RN[2]; Diana J. Mason, PhD, RN[3]

Website

- ELNEC Home
- ELNEC Support For Nurses During COVID-19
- About ELNEC
  - ELNEC Curricula
  - ELNEC Team
  - ELNEC Faculty
  - FAQs
- ELNEC Courses
- Tools For Trainers
  - Find a Trainer
- Resources
- ELNEC Store

ELNEC Support for Nurses During COVID-19

Welcome | ELNEC Educational Materials | COVID-19 Resources | Schools of Nursing | Advocacy & Support | Publications | Team

End-of-Life Nursing Education Consortium (ELNEC) project is a national and international education initiative to improve palliative care. Learn more. The ELNEC COVID-19 section is supported by grant funding from the Cambia Health Foundation and Pfizer.

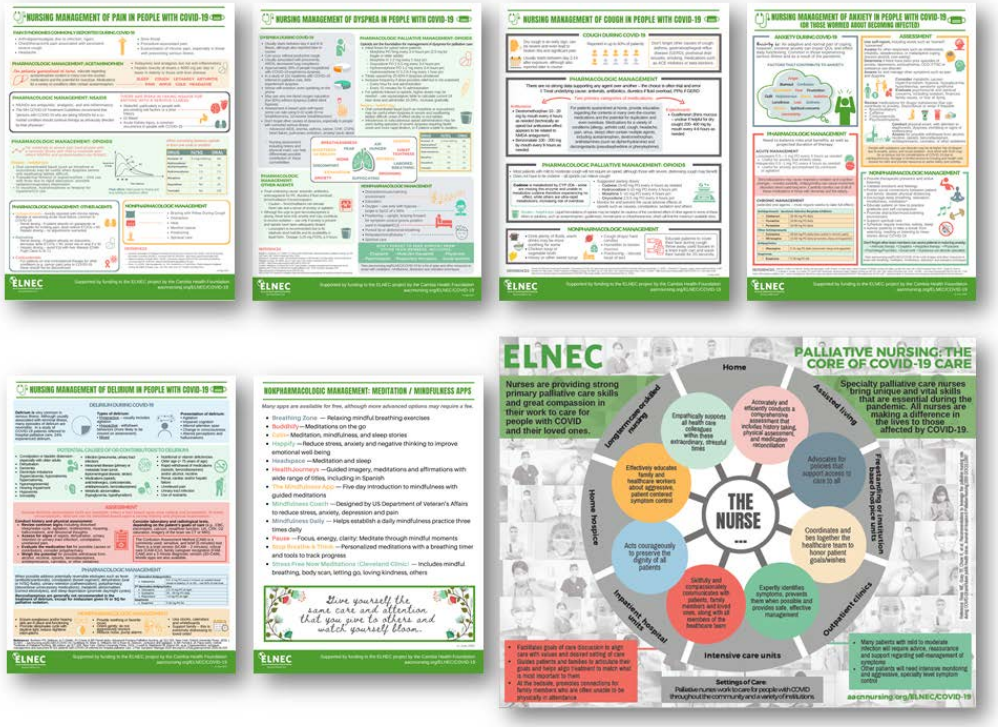
Visit the **ELNEC Materials** tab for free modules including slides, recorded presentations, infographics, video vignettes, and more. Visit the **Resources** tabs for materials, websites, and webinars from our palliative care colleagues.

aacnnursing.org/ELNEC/COVID-19

Symptom Management - Infographics

Topics:

- Pain
- Dyspnea
- Cough
- Anxiety
- Delirium,
- Meditation/Mindfulness Apps
- Role of the Nurse



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NURSING MANAGEMENT OF PAIN IN PEOPLE WITH COVID-19

PAIN SYNDROMES COMMONLY REPORTED DURING COVID-19

- Arthralgias/myalgias due to infection, rigors
- Chest/thoracic/rib pain associated with persistent, severe cough
- Headache
- Sore throat
- Procedure-associated pain
- Exacerbation of chronic pain, especially in those with preexisting serious illness

PHARMACOLOGIC MANAGEMENT: ACETAMINOPHEN

For patients quarantined at home, educate regarding acetaminophen content in many over-the-counter medications and the potential for overdose. Medications for a variety of conditions often contain acetaminophen: SLEEP COUGH LETHARGY ARTHRITIS PAIN SINUS COLD HEADACHE

- Antipyretic and analgesic but not anti-inflammatory
- Hepatic toxicity at doses ≥ 4000 mg per day or lower in elderly or those with liver disease

PHARMACOLOGIC MANAGEMENT: NSAIDS

- NSAIDs are antipyretic, analgesic, and anti-inflammatory
- The NIH COVID-19 Treatment Guidelines recommend that "persons with COVID-19 who are taking NSAIDs for a co-morbid condition should continue therapy as previously directed by their physician."

THERE ARE RISKS IN TAKING NSAIDS FOR ANYONE WITH A SERIOUS ILLNESS:

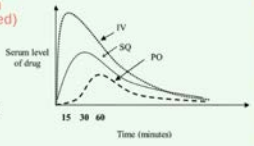
- Stoke/MI, particularly in people with pre-existing risk factors or a prior history
- GI Bleed
- Acute Kidney Injury, a common occurrence in people with COVID-19

PHARMACOLOGIC MANAGEMENT: OPIOIDS

For moderate to severe pain (and anyone with a seriously illness with mild to moderate pain where NSAIDs and acetaminophen use limited)

Routes – helpful tips:

- Oral concentrated liquid (such as morphine or oxycodone) may be useful when dyspnea severe and swallowing tablets difficult
- Transdermal fentanyl or buprenorphine – limit use with fever due to rapid absorption, possible sedation/respiratory depression
- IV morphine, hydromorphone or fentanyl for inpatient/ICU use



Peak effect: helps guide re-dosing and time activity to maximum effect

When converting between opioids or from one route to another:

DRUG	IV/SQ	ORAL
Fentanyl IV	0.1mg=100mcg	NA
Hydrocodone/ Acetaminophen	NA	30
Hydromorphone	1.5	7.5
Morphine	10	30
Oxycodone	NA	20
Tramadol	NA	120

PHARMACOLOGIC MANAGEMENT: OTHER AGENTS

- Gabapentinoids - toxicity reported with chronic kidney disease or worsening acute renal failure, common in COVID-19
  - Renal dosing - If patient already on gabapentin or pregablin for existing pain, dose reduce if CrClc < 60
  - Hepatic dosing – no adjustments warranted
- Duloxetine
  - Renal dosing - If patient already on duloxetine, decrease dose if CrClc < 90, avoid use or stop if ≤ 30
  - Hepatic dosing – avoid if pt with liver disease (Child-Pugh Class A, B, C)
- Corticosteroids
  - For patients on oral corticosteroid therapy for other conditions (e.g. cancer pain) prior to COVID-19, these should not be discontinued

NONPHARMACOLOGIC MANAGEMENT

- Bracing with Pillow During Cough
- Distraction
- Heat
- Menthol topical
- Positioning
- Spiritual care

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aacnnursing.org/ELNEC/COVID-19

NURSING MANAGEMENT OF DELIRIUM IN PEOPLE WITH COVID-19

DELIRIUM DURING COVID-19

Delirium is very common in serious illness. Although usually associated with terminal illness, many episodes of delirium are reversible. In a study of COVID-19 patients referred to hospital palliative care, 24% experienced delirium.

Types of delirium:

- Hyperactive – usually includes agitation
- Hypoactive - withdrawn behaviors (more likely to be missed on assessment)
- Mixed

Presentation of delirium:

- Agitation
- Impaired cognition
- Altered attention span
- Change in consciousness
- Altered perceptions and hallucinations

POTENTIAL CAUSES OF OR CONTRIBUTORS TO DELIRIUM:

- Constipation or bladder distension - especially with older adults
- Dehydration
- Dementia
- Electrolyte imbalance (hypercalcemia, hyponatremia, hypernatremia, hypomagnesemia)
- Hearing impairment
- Hypoxemia
- Immobility
- Infection (pneumonia, urinary tract infection)
- Intracranial disease (primary or metastatic brain tumor, leptomeningeal disease, stroke)
- Medications (opioids, anticholinergics, corticosteroids, antidepressants, benzodiazepines)
- Metabolic abnormalities (hypoglycemia, hypothyroidism)
- Nutritional or vitamin deficiencies
- Older age (> 75 years of age)
- Rapid withdrawal of medications (opioids, benzodiazepines) and/or alcohol, nicotine
- Renal, cardiac and/or hepatic failure
- Unrelieved pain
- Urinary tract infection
- Use of restraints

ASSESSMENT

Several delirium assessment tools are available; select a tool based upon your setting and population. In many circumstances, delirium can be identified based upon a strong history and physical examination.

Conduct history and physical assessment:

- **Review common signs** including disturbed sleep/wake cycle, agitation, restlessness, moaning, hallucinations, and delusional thoughts.
- **Assess for signs** of sepsis, dehydration, urinary retention or urinary tract infection, constipation, unrelieved pain.
- **Evaluate the medication list** for possible causes or contributors; consider polypharmacy
- **Weigh the potential** for possible withdrawal from alcohol, nicotine, opioids, benzodiazepines, antidepressants, cannabis, or other sedatives

Consider laboratory and radiological tests, depending on the patient's goals of care (e.g., CBC, electrolytes, calcium, renal/liver function, UA, CXR, O2 saturation, imagery of the brain via CT or MRI).

The Confusion Assessment Method (CAM) is a commonly used, sensitive, and brief (5 minutes) tool. There is a brief version (bCAM – 2 minutes), critical care (CAM-ICU), family caregiver recognition (FAM-CAM) and a 3 minute diagnostic version (3D-CAM). Mobile apps are also available.

PHARMACOLOGIC MANAGEMENT

When possible address potentially reversible etiologies such as fever (antibiotics/antivirals), constipation (bowel regimen), dehydration (oral or IV/SQ fluids), urinary retention (catheterization), polypharmacy (discontinue unnecessary medications), metabolic abnormalities (correct electrolytes), and sleep deprivation (promote day/night cycles).

Benzodiazepines are generally not recommended in the treatment of delirium, except for midazolam given IV or SQ for palliative sedation.

1st Generation Antipsychotics	
• Haloperidol	0.5 -2 mg PO every 2-4 hours as needed (lower doses in elderly); IV or SQ – use 50% of oral dose
2nd Generation Antipsychotics	
• Olanzapine	2.5-15 mg PO at night
• Quetiapine	25 – 50 mg PO daily
• Risperidone	1-2 mg PO at night
Azapirones	
• Buspirone	5-20 mg PO tid

NONPHARMACOLOGIC MANAGEMENT

- Ensure eyeglasses and/or hearing aids are in place and functioning
- Promote sleep/wake cycle with daytime light, reduce nighttime interruptions
- Provide soothing or favorite music
- Orient gently; do not aggressively reorient
- Reduce noise, pump alarms
- Use clocks, calendars and whiteboards
- Support family – this is extremely distressing to loved ones!

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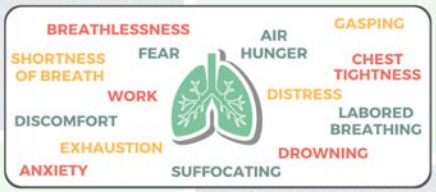
NURSING MANAGEMENT OF DYSPNEA IN PEOPLE WITH COVID-19

DYSPNEA DURING COVID-19

- Usually starts between day 4 and 8 of illness, although also reported later in course
- Can occur without productive cough
- Usually associated with pneumonia, ARDS, decreased lung compliance
- Approximately 30% of people hospitalized with COVID-19 experience dyspnea
- In a study of 101 inpatients with COVID-19 referred to palliative care, 66% experienced dyspnea
- Worse with exertion, even speaking on the phone
- May see very low blood oxygen saturation (low 80%) without dyspnea (called silent hypoxia)
- Assessment is based upon self-report; some can rate using 0-10 scale (0=no breathlessness, 10=severe breathlessness)
- Don't forget other causes of dyspnea, especially in people with comorbid serious illness:
  - Advanced AIDS, anemia, asthma, cancer, CHF, COPD, heart failure, pulmonary embolism, anxiety/ panic attack
  - Nursing assessment, including history and physical exam, can help differentiate possible contribution of these comorbidities



PHARMACOLOGIC PALLIATIVE MANAGEMENT: OPIOIDS

Opioids are the foundation for management of dyspnea for palliative care

- Initial doses for opioid naïve patients:
  - Morphine PO 5mg every 3-4 hours prn (2.5 mg for fragile or older adults)
  - Morphine IV 1-2 mg every 1 hour prn
  - Oxycodone PO 2.5-5 mg every 3-4 hours prn
  - Hydromorphone PO 1-2 mg every 3-4 hours prn
  - Hydromorphone IV 0.2-0.4 mg every 1 hour prn
- Titrate upward by 25-50% if dyspnea unrelieved
- Increase frequency if dose provides relief but is not sustained
  - Every hour for oral administration
  - Every 15 minutes for IV administration
- For patients tolerant to opioids, higher doses may be needed – use equianalgesic table to calculate current 24 hour dose and administer 10-20%; increase gradually

Routes – helpful tips:

- Oral concentrated liquid (such as morphine or oxycodone) may be useful when dyspnea is severe and swallowing tablets difficult; onset of effect similar to oral tablets
- Intravenous or subcutaneous opioid administration may be used during episodes of severe dyspnea requiring faster onset and more rapid titration, or if patient unable to swallow

DRUG	IV/SQ	ORAL
Fentanyl IV	0.1mg=100mcg	NA
Hydrocodone/ Acetaminophen	NA	30
Hydromorphone	1.5	7.5
Morphine	10	30
Oxycodone	NA	20
Tramadol	NA	120

PHARMACOLOGIC MANAGEMENT: OTHER AGENTS

- Treat underlying cause: antivirals, antibiotics, anticoagulants for PE, diuretics if fluid overload, bronchodilators if bronchospasm
  - Caution – bronchodilators can elevate heart rate and a sense of anxiety or agitation
- Although the urge to give benzodiazepines is strong, these treat only anxiety and may contribute to excess sedation – use only if anxiety is present and opioids have been adequately titrated
  - Lorazepam is recommended due to its relatively short half-life and its availability in liquid form. Dosage: 0.25 mg PO/SL q 4 hours.

NONPHARMACOLOGIC MANAGEMENT

- Distraction/music/calming environment
- Education
- Oxygen – use only with hypoxia – target is SpO2 of ≥ 90%
- Positioning – upright, bracing forward for symptom control (prone position used in hospital/ICU)
- Pursed lip or abdominal breathing
- Relaxation/mindfulness *
- Spiritual care

DON'T FORGET TO SEEK SUPPORT FROM OTHER TEAM MEMBERS, INCLUDING:

· Chaplains · Music/art therapists · Physicians
· Psychologists · Respiratory therapists · Social workers

*See aacnnursing.org/ELNEC/COVID-19 for a list of apps and other resources to assist with meditation, mindfulness, distraction and relaxation techniques

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NURSING MANAGEMENT OF ANXIETY IN PEOPLE WITH COVID-19 (OR THOSE WORRIED ABOUT BECOMING INFECTED)

ANXIETY DURING COVID-19

Anxiety is: An adaptive and normal part of coping; however, extreme anxiety can impair QOL and effect daily functioning. Common in those experiencing serious illness and as a result of the pandemic.

FACTORS THAT CONTRIBUTE TO ANXIETY:

PHARMACOLOGIC MANAGEMENT

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

ACUTE MANAGEMENT

Lorazepam 0.5 – 1 mg PO every 4 hours as needed
- Useful for anxiety that inhibits sleep

Haloperidol 0.5 -1 mg PO every 4 hours as needed
- Useful for anxiety accompanied by confusion or agitation

Benzodiazepines may cause respiratory sedation and cognitive changes – monitor carefully. Antipsychotics can cause movement disorders when used long term. Carefully monitor use of all of these medications in those with dementia and the elderly.

CHRONIC MANAGEMENT

(selected oral agents – most require weeks to take full effect):

Antidepressants - Serotonin Selective Reuptake Inhibitors	
• Citalopram	20-40 mg PO daily
• Fluoxetine	10-80 mg PO daily
• Paroxetine	10-60 mg PO daily
Other Antidepressants	
• Duloxetine	30-60 mg PO daily (also useful in chronic pain)
• Mirtazapine	15-60 mg PO daily (promotes sleep and appetite)
Antipsychotics	
• Olanzapine	5-15 mg PO daily (promotes sleep and appetite)
Azapirones	
• Buspirone	5-20 mg PO tid

ASSESSMENT

Use self-report, including words such as "worried", "concerned".
Assess for other responses such as restlessness, irritability, sleeplessness, or maladaptive coping (excess alcohol, over-eating)
Determine if there have been prior episodes of anxiety, depression, schizophrenia, OCD, PTSD or substance use disorder
Assess for and manage other symptoms such as pain and dyspnea

Consider metabolic causes: Hyperthyroidism, hypoxia, hypoglycemia, hyperthermia, serotonin syndrome
Evaluate psychosocial and spiritual concerns, including isolation, finances, family issues, or fear of dying

Review medications for drugs/ substances that can contribute to anxiety. Discontinue or wean if feasible:
- Bronchodilators
- Caffeine
- Corticosteroids
- Psychostimulants

Conduct physical exam, with attention to diaphoresis, dyspnea, trembling or signs of restlessness
Assess for possible withdrawal from alcohol, nicotine, opioids, benzodiazepines, antidepressants, cannabis, or other sedatives

People with substance use disorder may be at higher risk of relapse due to anxiety, stress, and social isolation. And some with SUD may be at serious risk for complications of COVID-19 due to cardiopulmonary damage or limited access to housing and health care. Assess for risks and provide resources to assist safety and sobriety.

NONPHARMACOLOGIC MANAGEMENT

- Provide therapeutic presence and active listening
- Validate emotions and feelings
- Foster social connections between patient and family, despite physical distancing
- Encourage deep breathing, relaxation, mindfulness, meditation*
- Educate patient on how to practice gratitude and self-compassion
- Promote distraction/music/calming environment
- Support spiritual care
- Schedule regular exercise, eating, sleep
- Advise patients to take a break from watching, reading or listening to news stories about COVID-19

Don't forget other team members can assist patients in reducing anxiety:
• Art/music therapy • Chaplains • Integrative therapy • Physicians
• Psychology/Psychiatry • Social work • Substance use disorder specialists

*See aacnnursing.org/ELNEC/COVID-19 for a list of apps and other resources to assist with breathing, meditation, mindfulness, distraction and relaxation techniques

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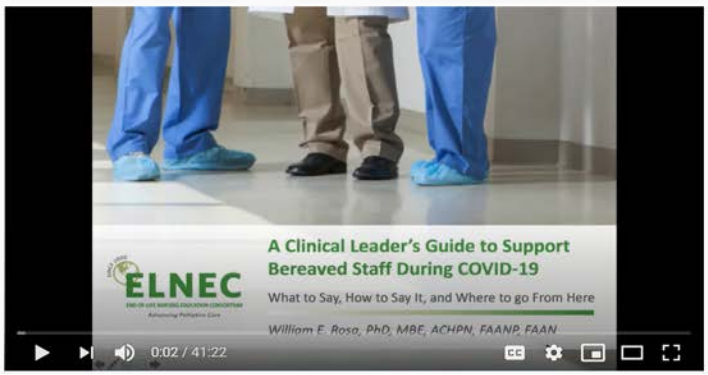
ELNEC
END-OF-LIFE NURSING EDUCATION CONSORTIUM
Advancing Palliative Care

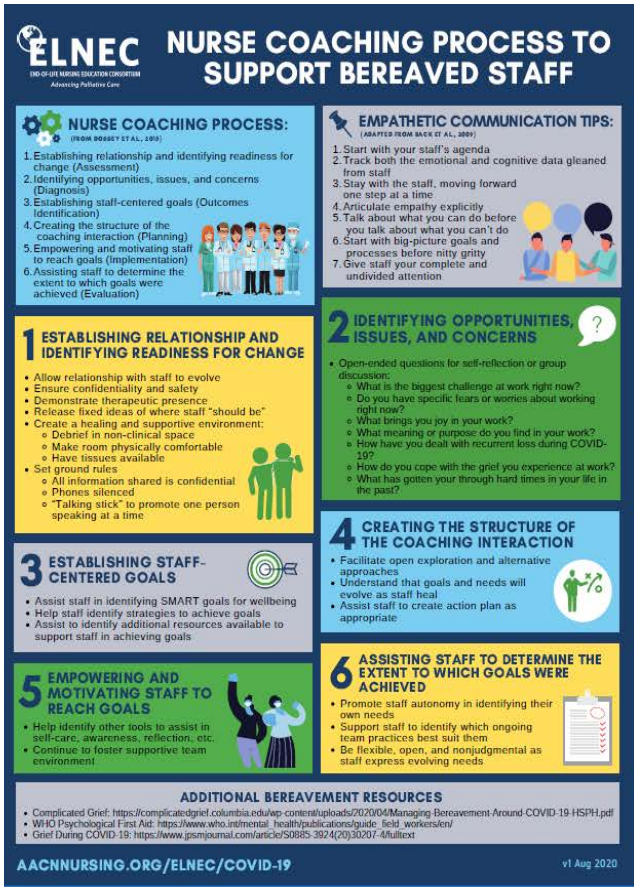
Supported by funding to the ELNEC project by the Cambia Health Foundation
aacnnursing.org/ELNEC/COVID-19
v1 June 2020

ELNEC Materials – Loss, Grief, and Bereavement

Loss, Grief, and Bereavement

- **ELNEC Loss, Grief & Bereavement in a Pandemic Module**
  - Materials developed and presented by Polly Mazanec PhD, ACNP-C, AOCN, ACHPN, FPCN, FAAN
  - Supplemental Materials
  - Recorded Presentation
  - Slides (PDF)
- **Complicated Grief and Loss: Uncharted Territory With COVID-19**
  - Recorded Webinar and Blog
- **Supporting Bereaved Staff**
  - Developed by Billy Rosa, PhD, MBE, ACHPN, FAANP, FAAN
  - Nurse Coaching Process to Support Bereaved Staff - Infographic
  - A Clinical Leader's Guide to Support Bereaved Staff During COVID-19
    - Slides (PDF)
    - Recorded Presentation





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NURSE COACHING PROCESS TO SUPPORT BEREAVED STAFF

① ② ③ ④ ⑤ ⑥

1 ESTABLISHIN

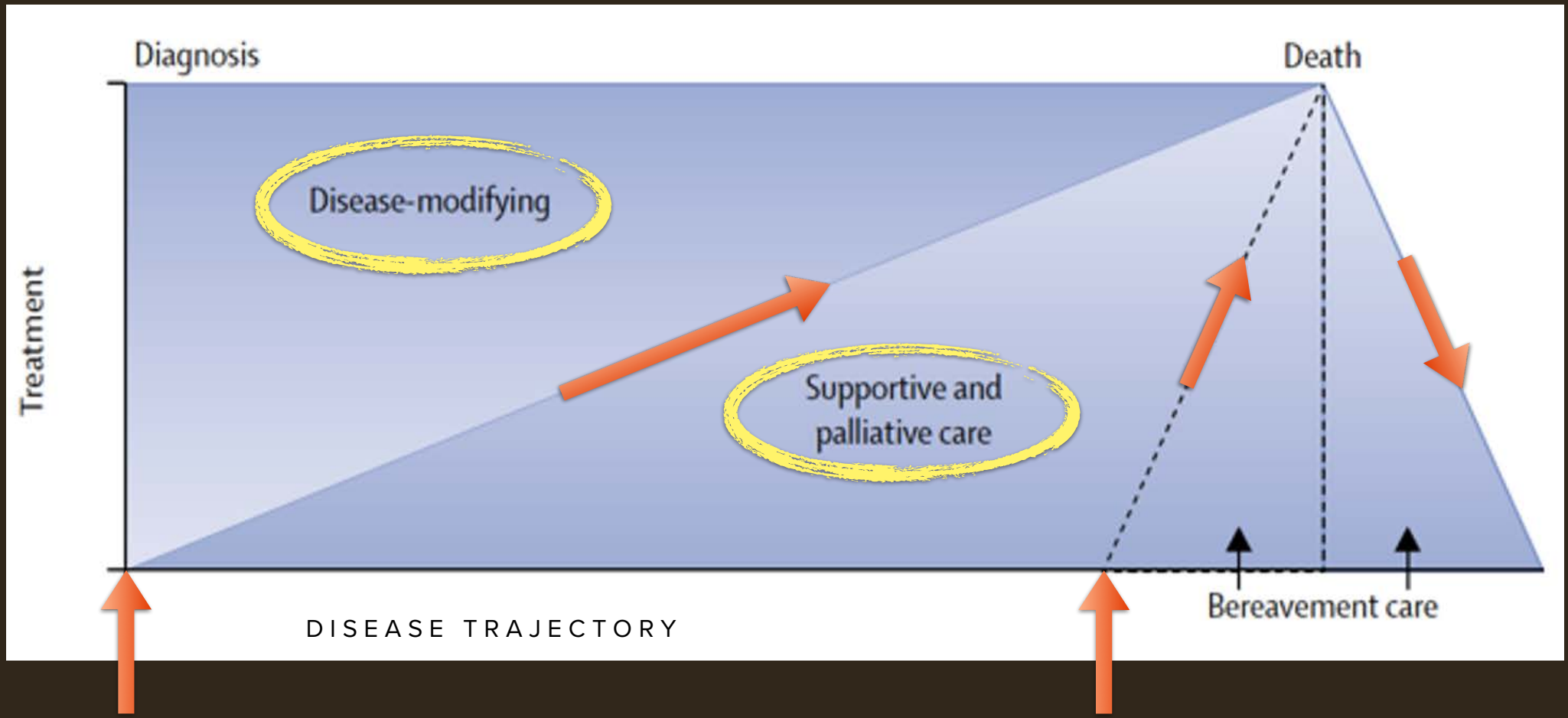
2 ESTABLISHING STAFF-

EMPATHETIC COMMUNICATION TIPS (ADAPTED FROM BACK ET AL., 2009):

1. Start with your staff's agenda
2. Track both the emotional and cognitive data gleaned from staff
3. Stay with the staff, moving forward one step at a time
4. Articulate empathy explicitly
5. Talk about what you can do before you talk about what you can't do
6. Start with big-picture goals and processes before nitty gritty
7. Give staff your complete and undivided attention

- S
  - What brings you joy in your work?
  - What meaning or purpose do you find in your work?
  - How have you dealt with recurrent loss during COVI 19?
  - How do you cope with the grief you experience at work?
  - What has gotten you through hard times in your life in the past?

team practices best suit them
- Be flexible, open, and nonjudgmental as staff express evolving needs



Knaul et al. (2018)

Palliative Care in the COVID-19 Pandemic

Briefing Note

Palliative Care for LGBT+ People in the Time of COVID-19

Authors

Harding R (Cicely Saunders Institute, King's College London, UK), Ciruzzi MS (Hospital de Pediatria Samic Prof. Dr Juan P. Garrahan, Argentina), Downing J (ICPCN, UK/Uganda), Hunt J (Independent Social Worker, Zimbabwe), Morris C (WHPCA, UK), Rosa W (University of Pennsylvania, USA)

Palliative Care in the COVID-19 Pandemic

Briefing Note

Palliative Care for those Experiencing Homelessness in the Time of COVID-19

Authors

Skinner E (Ottawa Inner City Health, Canada), Colclough A (St Luke's Cheshire Hospice, UK), Downing J (ICPCN, UK/Uganda), Harding R (Cicely Saunders Institute, UK), Luyirika E (APCA, Uganda), Palat G (MNJ Institute of Oncology and Regional Cancer Centre, Hyderabad, India), Rosa W (University of Pennsylvania, USA).

World Health Organization

EXECUTIVE BOARD
148th session
Agenda item 19.3

EB148/CONF./8
20 January 2021

The highest attainable standard of health for persons with disabilities

Draft resolution proposed by Argentina, Australia, Botswana, Brazil, Canada, Chile, Costa Rica, Ecuador, Israel, Mexico, Norway, Peru, United Kingdom of Great Britain and Northern Ireland, Uruguay and the Member States of the European Union

(PP23) Underscoring that the health needs of persons with disabilities need to be met across the life course, through comprehensive preventive, promotive, curative, rehabilitative services and palliative care and including psychosocial support;

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Palliative Care Specialists Series

Featured Editors: Christopher A. Jones and Arif H. Kamal

Top Ten Tips Palliative Clinicians Should Know About Evidence-Based Advocacy

William E. Rosa, PhD, MBE, ACHPN, FAANP, FAAN,[1,2,*] Katherine I. Pettus, PhD,[2] Liliana De Lima, MHA,[2] Allison Silvers, MBA,[3] Stacie Sinclair, MPP,[3] and Lukas Radbruch, MD[2,4]

"In any dark time, there is a tendency to veer toward fainting over how much is wrong or unmended in the world. Do not focus on that...

We are needed, that is all we can know...

One of the most calming and powerful actions you can take to intervene in a stormy world is to stand up and show your soul.

Soul on deck shines like gold in dark times...

When a great ship is in harbor and moored, it is safe, there can be no doubt.

But that is not what great ships are built for."

-Clarissa Pinkola Estés, PhD