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SECTION 5: HOSPICE AND PALLIATIVE CARE

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KEY POINTS
1. Many different types of cardiac pacemakers are available. One way to categorize them is by the amount of energy they discharge to the heart:
   a. “Regular” pacemakers deliver low energy pulses. These pacemakers are not problematic for patients wishing to die peacefully.
   b. Automatic implantable cardioverter-defibrillators (AICDs) provide preprogrammed high-pulse energy (shock) when tachycardia or fibrillation occurs. AICDs can discharge successively, attempting to defibrillate/restart the heart when cardiac activity becomes irregular or ceases.
2. Terminally ill patients face the risk of repetitive AICD discharges during the dying process:
   a. The discharge may look and feel like “a kick” in the chest.
   b. Such discharges are usually not consistent with the goals of patients in hospice and palliative care. As the dying process progresses, the AICD is likely to be a source of pain for the patient and distress for the caregiver.
   c. Deactivation of an AICD does not constitute euthanasia and is not likely to hasten death.
3. All patients with AICDs should be identified on admission to hospice and palliative care programs. Device type, manufacturer and model should be documented.
4. The option of deactivating AICDs should be explained to the patient/caregiver as soon as possible upon admission. Patients’ values and goals should drive the decision-making process.
5. Document discussion with patient/caregiver regarding defibrillator deactivation.
6. Once the patient/caregiver has given consent to turn off the device, a written order by the primary care provider is required.
7. An AICD can be emergently and temporarily disabled by holding a magnet on the skin over the implanted AICD; this technique is temporary and should not be a substitute for deactivation.

EQUIPMENT
Primary care provider order to deactivate device
Contact numbers for the AICD manufacturer’s local representative

PROCEDURE
1. Establish that
   a. The patient has an AICD (not a "regular" pacemaker)
   b. The patient/caregiver has given consent to have the AICD deactivated.
   c. The primary care provider has given an order to deactivate the AICD.
2. Verify the location, model and serial number of the device.
3. Contact the manufacturer or vendor to request a home visit appointment for deactivation. If the patient is able, the deactivation can be scheduled at the primary care provider’s office.
4. Arrange a home visit from a nurse to be with the patient at the same time as deactivation, to provide support to family and document when the device is deactivated and by whom.

AFTER CARE
1. Document deactivation in patient record including:
   a. Confirmation of consent to deactivate and verification of primary care provider orders
   b. Patient response to procedure
   c. Caregiver response to procedure
   d. Instructions and support given to patient/caregiver
2. Notify primary care provider to confirm that AICD was deactivated.

REFERENCES
KEY POINTS
1. Good nutrition at the end-of-life is not the main focus of care, but it can provide pleasure and comfort to patients and caregivers.
   a. Food and fluids provide well-being, and prevent problems such as constipation and delirium from electrolyte imbalance.
   b. Adjust recommendations about providing food and fluids as patient’s condition declines.
   c. Goal is to provide food and fluids in a safe manner when the patient is hungry or thirsty.
2. When patients start losing their appetites, discuss with caregivers that this is a time the patient can eat anything they want whenever they want.
   a. Balanced and nutritious meals aren’t as important as calories and the enjoyment that food can give.
   b. Give favorite foods. What would tempt the patient?
   c. Best foods are ones the patient likes to eat, are easy to eat, and which are also high in calories, nutrients, and protein.
   d. Consider smoothies, ice cream shakes, creamy pasteurized eggnog, chocolate pudding with whipped cream, etc.
3. When providing food, fluids, or medications, ensure proper positioning for aspiration precautions:
   a. If able, the patient should be in a sitting position in a chair.
   b. If bedbound, elevate the head of the bed or place pillows behind patient, to approximate an upright position.
4. Starvation vs. Anorexia:
   a. There is a difference between starvation and not feeling hungry.
   b. Withholding food from a hungry person is starvation.
   c. When a person is approaching death, due to a disease, the person will not feel hungry.
   d. Offer food and fluids regularly throughout the day, when patient is awake and alert.
   e. Force feeding, when not hungry, can lead to choking and aspiration.
   f. Families want the patient to be nourished, but teach the family that loosing appetite is a normal process as the gastrointestinal tract has slowed down and the body can no longer process food.
5. Dehydration at End-of-Life:
   a. As a patient approaches death, becoming dehydrated decreases sensations of pain and discomfort. Though thirst for a healthy person is a distressing sensation, as body processes slow, the sensation of thirst wanes.
   b. Parental hydration at the end-of-life tends to increase feelings of discomfort, because the body is unable to process fluids. Fluids during this time tend to pool in places where they cause discomfort, and make it more difficult for the person to breathe.
   c. Decreased fluid intake eases discomfort because it decreases urine output, nausea/vomiting, edema, congestion in the lungs, and coughing.
   d. Dehydration at the end of life acts as a natural anesthesia in the body, easing suffering and promoting comfort.
   e. A dry mouth can be uncomfortable even if the patient doesn’t want to drink. A small amount of fluid or oral care may make the patient more comfortable even if not able to drink more than a couple of sips.
6. Non-Verbal Cues:
   a. When the patient is not able to communicate, offering food and fluids regularly allows the patient to eat or drink when the patient feels better to do so.
   b. If the patient responds to offers of food and fluids by opening his/her mouth and swallowing, continue to provide the nourishment. Patients who are not hungry or thirsty resist eating or drinking, closing lips tightly or turning the head away. The patient will feel more comfortable not eating and drinking.
   c. Pocketing food in the mouth is an indication that food/fluids are not indicated, but only increase the risk of aspiration.

EQUIPMENT
Mini Nutritional Assessment
Mouth Swabs

PROCEDURE
1. Perform a Mini-Nutritional Assessment.
2. Ask patient/caregiver about food/fluid concerns.
3. Ask patient to identify favorite foods.
4. Adjust recommendations to patient's appetite and caregiver's concerns.
5. Advise to try following suggestions to increase food intake:
   a. Eat small snacks 5 to 6 times instead of 3 meals.
   b. Put foods on small plates.
   c. Put fluids in small glasses and cups.
   d. Make fluids "nutritious" – milk, ice cream shakes, smoothies, soups made with cream or cheese, etc.
   e. Focus on favorite foods; make eating delicious even if not "nutritious." High calorie and high fat foods – foods previously avoided – are now appropriate.
   f. Buy "full fat" milk, yogurt and cheeses. Be liberal when cooking with oil.
   g. Try substituting milk for water in recipes.
   h. Try "sneaking in" some dry milk, protein powder, or canola oil into some foods.
6. When patient approaches death, to provide fluids:
   a. Position patient for aspiration precautions.
      Elevate head of bed to comfort level.
   b. Offer fluids from a cup, without a straw.
      1) If patient can hold the cup, encourage small sips.
      2) If unable to hold the cup, provide small sips from the cup.
   c. Try using a teaspoon to offer fluids.
   d. Give one small sip at a time. Wait for patient to swallow, before providing the next sip.
   e. Offer fluids every few hours while patient is awake. Continue to provide fluids until patient does not want to drink.
   f. Keep upright for at least 15 minutes, if tolerated, after drinking.
   g. If unable to swallow fluid, but is verbalizing thirst or dry mouth, try mouth swabs dipped in water, swiping the mouth to provide moisture.

7. To provide food to a patient close to death:
   a. Position patient for aspiration precautions.
      Elevate head of bed to comfort level.
   b. Offer food periodically throughout the day, if awake and alert. If patient is too sleepy, let the patient sleep.
   c. If unsure of patient’s ability to swallow, try providing a pureed consistency such as pudding, yogurt, ice cream, or applesauce.
      1) Provide about a quarter of a teaspoon of food with each bite.
      2) If patient takes a bite, allow the patient time to chew and swallow before providing another bite.
      3) If food is not swallowed, be sure it is removed from mouth before lying down. Use a mouth swab or a toothbrush to remove food from mouth if necessary.
   d. If tolerating pureed foods well, with no coughing, holding, pocketing, or choking on foods, try advancing the foods provided. Offer soft canned fruits, well cooked vegetables, scrambled egg, pasta, beans, or cottage cheese.
   e. Continue to advance food textures if the patient tolerates, and patient has the desire for other foods. If swallowing difficulties occur with the advance in food texture, downgrade to the previous texture.
   f. Continue to provide foods at a meal until patient does not want to eat anymore.
   e. Provide fluids separately from foods. Wait for the patient to swallow food before providing a drink. Having different textures together can lead to choking.
   f. Keep upright for at least 15 minutes, if tolerated, after eating.

8. If patient starts to cough when eating or drinking, instruct caregiver to:
   a. Sit patient as upright as possible.
   b. Encourage patient to continue to cough.
   c. Fluids are not helpful to clear the airway.
   d. If a patient is able to cough, it means the patient is able to breathe.
   e. Allow patient time to recover from coughing before attempting to provide food or fluids again.

9. Educate family to the dying process:
   a. If family wants the patient to eat, even if patient has no desire, ask gentle questions enabling the family to consider a different perspective:
      1) Can you think of a time when you felt too ill to eat or drink? Did it make you feel better or worse to eat then?
      2) If someone made you eat or drink, would you feel loved and comforted, or bothered and feel a loss of control?
   b. Discuss with the family about how everything in the patient's body is feeling very tired, needing to slow down:
      1) Teach that the body needs to work hard to process food and fluids.
      2) Explain that the body is not feeling hungry or thirsty because it is working so hard just to keep the heart beating and to keep breathing. The body needs to do this work, and will not process food. Food and fluids are a burden on the body at this time.
      3) More important than food/fluids is feeling loved and cared for by the family, which isn’t expressed with nourishment at this time.

AFTER CARE
1. Communicate with interdisciplinary team about patient and family's concerns, and advice given.
2. Document in patient's record:
   a. Patient’s response when offered food or fluids
   b. Amount of food and fluids patient presently taking
   c. Teaching provided to the caregivers
   d. Response of caregivers to guidance given

REFERENCES
PATIENT EDUCATION RESOURCE

KEY POINTS

1. A catastrophic bleed is a bleeding event which could lead to patient death in a short period of time.

2. Patients at risk for a catastrophic bleed include those with:
   a. Head and neck cancer involving the carotid arteries
   b. Thoracic tumors involving the main bronchus
   c. Significant erosion of the GI tract (due to tumor or varices).

3. A catastrophic bleed can be a highly frightening and traumatic event for patients and their families.
   a. The risk for catastrophic bleeding should be assessed for each patient.
   b. Options for reducing the risk should be considered and discussed in relation to patient goals. Radiation therapy, stents, cauternization or other procedures may be an option to reduce risk.
   c. Incidence of catastrophic bleeding is relatively rare.

4. If a catastrophic bleed should occur, family caregivers will most likely be alone with the patient. The need to prepare them for such an event must be balanced with the need for not unduly frightening them.

5. Literature for how to best manage a catastrophic bleed in the home is scarce. Considerations include:
   a. Plan to help patient cope. Having benzodiazepines available to be administered buccally or per rectum are suggested in the literature.
   b. Plan to help family cope and remain calm during event.
   c. Plan to discard large amount of blood in home environment and plan to disinfect contaminated areas.

6. Considerations for disposing of bloody items include:
   a. OSHA, local and state regulations governing disposal of biohazard materials and preparing body for funeral home personnel.
   b. In general, relatively large amounts of blood can be disposed of in municipal sewage systems.
   c. Bloody sheets and towels can usually be washed in home washing machines.
   d. The nurse needs to consider the needs of the family, sanitation workers, and the community in advising and helping families clean and disinfect from such an event.

EQUIPMENT

Gloves
Personal protective equipment
Dark colored towels and bed linens
2 Basins for emesis, larger than emesis basins (2 should be available for rotation, if needed)
2 rolls of absorbent paper towels

Large plastic trash bags
Disinfectant, bleach or EPA-registered solution

Blood Spill procedure

PROCEDURE

1. Discuss risk for catastrophic bleeding with interdisciplinary team, and consider appropriate options for patient and family caregivers.

2. Obtain information from funeral home director and local sanitation officials about proper preparation of body and proper disposal of bloody materials.

3. Discuss strategies for preparing for an event with patient/caregiver.
   a. Remind patient/caregiver that such a bleed is unlikely to occur, but in case...
   b. Keep supplies, if wished, at hand to prepare for event, such as:
      1) Gloves
      2) Dark fluid-resistant apron
      3) Several large dark towels
      4) Roll of paper towels
      5) Basins in case of bloody emesis
      6) Large plastic trash bags
   c. For mattress and bedding, suggest
      1) Cover mattress with plastic sheeting.
      2) Cover plastic sheeting with a thick absorbent mattress pad.
      3) Use dark-colored bed linens and covers.
   d. If severe bleeding begins, instruct caregiver to:
      1) Stay calm.
      2) Help the patient to stay calm. "...We knew this might happen... We are prepared."
      3) Call nurse.
      4) Use dark towels to stem blood; may apply pressure to area if it helps.
      5) Administer anti-anxiety medication if ordered.

4. On arrival at patient's home, adhere to Standard Precautions and use PPE as necessary.

5. Determine patient condition and pronounce death according to organization standards.

6. Assist with cleaning and disinfecting area of blood: See Blood Spill procedure.

AFTER CARE

1. After a catastrophic bleed caregivers will need emotional support. Assess for the emotional condition of witnesses.

2. Document in medical record:
   a. Patient condition on arrival
   b. Family reports of the event
   c. Plan for providing caregiver support
REFERENCES
KEY POINTS
1. Constipation is a distressing, subjective experience.
   a. Risk of constipation is high in patients at end of life.
   b. Even patients who have minimal intake experience constipation's symptoms since stool is produced by the sloughing of the surface of the GI tract. Stool is expected every 1-3 days even without measurable intake.
   c. Opioid medications are a primary cause of constipation in this patient population.
2. Preventing constipation, especially when patients are taking opioids, is the standard of care.
   a. Any patient started on an opioid should be started on a bowel program, unless there is a good reason not to start such a program.
   b. An opioid bowel program includes a stool softener and stimulant (e.g., docusate and senna). If not effective, doses should be increased or medications can be advanced. See Bowel Program procedure.
3. Hospice Information Set (HIS) question N0520 specifically asks that if a bowel program is in place, are N0500 or N0510 (scheduled or PRN opioids) part of the patient’s treatment plan.
   a. If a bowel program is not initiated, there should always be documentation explaining why a bowel program is not indicated.
   b. Ongoing monitoring of development of need and effectiveness of current bowel program is required.
4. The first step in treating constipation is to identify and resolve the cause, if possible. Causes include:
   a. Primary causes: Reduced fluid and fiber intake, decreased activity, advanced illness and slowed peristalsis
   b. Secondary causes: Structural, metabolic or neurologic disorders (e.g. tumors, hypercalcemia and spinal cord compression)
   c. Latrogenic causes: Pharmacological side effects (e.g., vinca alkaloids, anticholinergics, 5HT3 antagonists, tricyclic antidepressants, opioids)
5. If related to reduced fiber intake, see if dietary suggestions in High Fiber Diet procedure are helpful.
6. If medication review shows that patient is taking symptom management medications (e.g., anticholinergics, 5HT3 antagonists, tricyclic antidepressants, opioids):
   a. Consider consultation with primary care provider or pharmacist about other options that might not cause constipation.
   b. Institute a step-wise bowel regime, advancing doses and medications, as needed, to establish soft regular bowel movements.
7. Categories of medications for bowel regime include:
   a. Stool softeners: Retains fluid in stool to soften stool
   b. Bulk-forming agents: Absorb fluid in the intestine to make larger stool more likely to start peristalsis
   c. Stimulants: Cause intestines to contract and produce more stool
   d. Lubricants: Coat the surface of the stool to hold in fluid and ease passage through the rectum
   e. Opioid receptor antagonist: Methylnaltrexone (Restoril) selectively affects opioid receptors in GI track only to release medications and allow natural peristalsis. This is the only research-supported treatment for opioid-induced constipation at end of life.
   f. See Bowel Program procedure for additional information about options.

EQUIPMENT
Gloves
Stethoscope
Patient's medication list
Bowel Program procedure
High Fiber Diet procedure

PROCEDURE
1. Assess bowel function at each patient interaction.
   a. Determine day of last “normal” bowel movement.
   b. Ask patient/caregiver about subjective symptoms of constipation, including:
      1) Abdominal distension or feelings of bloating
      2) Change in amount/frequency/odor/difficulty of passing gas
      3) Changes in urge/frequency/amount/texture and effort required to pass stool
      4) Rectal pressure/fullness
      5) Increase in general malaise not otherwise explained
   c. Perform physical assessment:
      1) Inspect and palpate abdomen.
      2) Auscultate for bowel sounds.
      3) Perform digital rectal exam, if indicated, to assess for impaction.
   d. Assess medication list for increased use or changes in opioids and other constipating medications.
2. If signs or symptoms of constipation present:
   a. Advise to sit on toilet at the same time each day 30 minutes after a large meal or a cup of warm liquid, which stimulates the gastrocolic reflex.
   b. Increase fluid intake to 6-8 glasses of non-caffeine, non-alcohol fluids/day.
   c. Increase fiber intake with fruits, vegetables and whole grains. See High Fiber Diet for additional suggestions.
   d. Assess for and encourage opportunities for increasing activity during the day.
e. Consult with primary care provider and pharmacist about options for advancing bowel medication regime. See recommendations in Bowel Program procedure.

AFTER CARE

1. Instruct/reinforce/monitor patient identified treatment plan.
2. Document in medical record:
   a. Bowel movement pattern
   b. Consistency of stools (use a continuum scale: hard, pebble-like to watery)
   c. Instructions given to patient/caregiver
   d. Effectiveness of/adherence to recommended suggestions
3. Communicate with primary care provider about:
   a. Level of patient’s constipation
   b. Need for medication changes

REFERENCES


PATIENT EDUCATION RESOURCES

Hospice and Palliative Nurses Association.


(Both are available in Spanish and Chinese, and include a bowel record form.) Both retrieved from http://www.hpna.org/DisplayPage.aspx?Title=Patient/Family%20Teaching%20sheets

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KEY POINTS

1. Delirium is a state of sudden and often severe confusion. It develops over a short period of time usually hours to days.

2. Causes of delirium are numerous, but major ones seen in hospice/palliative care patients include:
   a. Metabolic changes (dehydration, hypoxia, hypo/hyperglycemia)
   b. Medication side effects (opioids, opioid metabolites, sedatives, benzodiazepines, anticholinergics)
   c. Renal and liver dysfunction
   d. Infection (UTI, pneumonia)
   e. Discomfort (impaction, bladder, distention, dyspnea, pain, nausea)
   f. Alcohol, drug or benzodiazepine withdrawal
   g. Disease progression (e.g. brain metastasis)

3. Terminal delirium occurs in over 70% of patients during the last hours to days of life.
   a. Unlike other causes for delirium, which can be reversed, terminal delirium is associated with underlying physical responses that occur during the last days or hours.
   b. It can present as:
      1) Hyperactive symptoms (agitation, hallucinations, restlessness)
      2) Hypoactive symptoms (withdrawn and quiet)
   c. Hallucinations that are not unpleasant may not need to be treated.

4. Delirium and dementia are frequently confused, but are different disorders with different characteristics:

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5. Medications that may be helpful include:
   a. Haloperidol
   b. Options also include risperidone, chlorpromazine (especially if sedation is indicated) and lorazepam.

PROCEDURE

1. Perform a complete physical assessment to identify potentially reversible causes, such as:
   a. Infection: Check for fever, urine changes, respiratory changes.
   b. Dehydration and electrolyte imbalance: Check skin turgor, oral mucosa, urine color and amount.
   c. Fecal impaction: Check for last bowel movement of change in bowel patterns. Perform digital exam.
   d. Dyspnea/SOB: Check for use of accessory muscles and breathing pattern and rate. Auscultate for breathing sounds; use of accessory muscles and breathing pattern.

2. Involve primary care provider and other members of the interdisciplinary team for their recommendations and assistance symptoms.

3. Review patient’s medications with primary care provider or pharmacist for medication modifications that might be indicated:
   a. Benzodiazepines can worsen symptoms of agitation, hallucinations and confusion.
   b. Opioids can cause hallucinations.
   c. Anticholinergics can cause hallucinations.

4. Teach and encourage family and caregivers to use interventions that may lessen symptoms:
   a. Offer easy to eat and digest foods and fluids.
   b. Assist patient to use glasses and hearing aids.
   c. Provide a calm, soothing environment with familiar objects, pictures, music and pets.
   d. Anticipate needs such as thirst, hunger, toileting, pain and feeling cold.
   e. Use "calming" communication techniques, such as:
      1) Speak slowly in short sentences.
      2) Change from "asking" to "gently directing."
      3) Avoid rushing or hurrying the patient.

5. Provide education and support to family and caregivers as these behaviors can be very distressing to them.

AFTER CARE

1. Evaluate effectiveness of interventions.
2. Provide ongoing support to family and caregivers.
3. Document in the patient’s record:
   a. Patient symptoms
   b. Data from physical assessment
   c. Non-pharmacologic interventions initiated/employed, and their effectiveness
   d. Communication with primary care provider and orders obtained
   e. Family/caregiver support provided
   f. Family/caregiver education and teaching and response to same
   g. Communication with other members of the IDT

REFERENCES


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PATIENT EDUCATION RESOURCE

KEY POINTS
1. Dyspnea is the feeling of not getting enough air:
   a. Subjective feeling as perceived by the patient
   b. Does not always correspond with objective measures of oxygenation, i.e. pulse oximetry and other respiratory measures are normal
   c. Terrifying feeling for patient; disturbing for family members
   d. Studies report it is experienced by 20% to 80% of terminally ill patients.
2. Dyspnea in terminally ill patients can have many causes:
   a. Sometimes the etiology can be determined and resolved.
   b. Evaluate for oxygen equipment problem, fluid overload, bronchial constriction/plug, and other conditions which can be treated.
      1) Bronchodilators or corticosteroids may help if patient has respiratory disease.
      2) Diuretic may be helpful if patient has fluid overload.
3. If etiology cannot be determined or resolved:
   a. Pharmacologic treatment:
      1) Opioids are very effective at reducing dyspnea; drug of choice.
      2) If dyspnea is accompanied by anxiety or is unrelieved by an opioid, a benzodiazepine may be helpful.
   b. Non-pharmacologic treatments:
      1) Positioning so lungs can fully expand
      2) Moving air (fan, open window)
      3) Breathing or relaxation exercises
4. If patient cannot verbalize symptoms use the Respiratory Distress Observation Scale to determine severity of patient's distress.
5. Institute non-pharmacologic interventions:
   a. Position patient so lungs can expand:
      1) Elevate head of bed.
      2) Sit patient on edge of bed/chair in front of a table, arms on table, and feet flat on floor (tripod position).
   b. Encourage effective breathing using instructions in Breathing and Coughing Techniques procedure.
      1) Demonstrate pursed lip breathing.
      2) Encourage diaphragmatic breathing.
   c. Increase air movement in the room:
      1) Open a window.
      2) Turn on a fan.
      3) Turn fan so it blows directly on patient's face.
   d. Use scripts in Breathing and Relaxation procedure to help patient relax.
6. Consult with primary care provider about cardiopulmonary assessment and pharmacologic interventions:
   a. Recommendations for opioids:
      1) Opioid-naïve patients: 5 - 10 mg of oral morphine immediate release (MSIR) every hour as needed.
      2) Opioid-tolerant patients: Increase current MSIR dose by 25% to 50%.
   b. Recommendations for oxygen:
      1) A trial may be indicated: start at 2 - 4 L/min; there is no benefit in increasing beyond 4 - 6 L/min.
      2) Usually not indicated if patient is actively dying; face mask usually not tolerated.
   c. Anxiolytics (benzodiazepines) reduce the anxiety associated with dyspnea.
7. Provide patient/caregiver education about:
   a. Positioning and moving air
   b. Pursed lip and diaphragmatic breathing
   c. Relaxation exercises and techniques
   d. Energy conservation
   e. If medication ordered, instruct in safe use
   f. If oxygen ordered, instruct in safe use

AFTER CARE
1. Communicate with primary care provider if:
a. Assessment finding indicates a treatable condition (e.g. edema)
b. Medications indicated to control dyspnea.
c. Current interventions not effective.

2. Instruct patient/caregiver in:
   a. Strategies to reduce dyspnea
   b. Medication and oxygen safety, if ordered

3. Document in the patient’s record:
   a. Patient’s description of dyspnea
   b. Physical assessment data
   c. Patient/caregiver education provided
   d. Non-pharmacologic interventions and pharmacologic interventions used and effectiveness
   e. Communication with primary care provider and orders

4. Re-evaluate patient after medication/oxygen therapy initiated for effectiveness.

REFERENCES


PATIENT EDUCATION RESOURCE

CLINICIAN EDUCATION RESOURCES
VNAA Blueprint for Excellence. (2014). *Dyspnea Screening and Management*  
*Dyspnea Tools and Clinical Interventions*

KEY POINTS
1. Knowing the probable etiology of nausea and vomiting (N&V) helps with its effective treatment. Assessment of N&V should include its frequency, triggering or associated events, and identifying anything that relieves the nausea.
2. Etiologies, their symptoms, their incidence and suggested drug therapies include:
   a. Gastroparesis (impaired gastric emptying)
      1) Symptoms: Intermittent nausea; early satiety and fullness or bloating after meals; relieved by vomiting a small amount; emesis contains undigested food
      2) Incidence: 35%–45% of all N&V cases
      3) Suggested therapy: Metoclopramide before meals. Encourage small more frequent meals.
   b. Chemoreceptor trigger zone activation (CTZ)
      1) Symptoms: Persistent nausea, aggravated by the sight and smell of food, unrelieved by vomiting
      2) Incidence: 30%–40% of N&V cases
      3) Suggested therapy: Phenothiazine, haloperidol, cannabinoids (have shown anti-emetic properties with chemo induced nausea)
   c. Severe constipation or bowel obstruction with vagal nerve stimulation
      1) Symptoms: Intermittent nausea, abdominal cramps, altered bowel habits; relieved by vomiting, large volumes of emesis; emesis may be bilious or feculent
      2) Incidence: 10%–30% of N&V cases
      3) Suggested therapy: Bowel regime, decompression of bowel, steroids, octreotide (for obstruction), hyocine (for cramping)
   d. Intracranial pressure from brain tumors
      1) Symptoms: Early morning N&V, headache
      2) Suggested therapy: Steroids
   e. Vestibular disorder
      1) Symptoms: Nausea aggravated by movement
      2) Suggested therapy: Meclizine
   f. Anxiety
      1) Symptoms: N&V associated with anxiety
      2) Suggested therapy: Anxiolytics; supportive interventions
   g. Gastric hyperacidity
      1) Symptoms: Emesis of acidic fluid despite empty stomach
      2) Suggested therapy: H2 receptor antagonist
   h. Hyperkalemia
      1) Symptoms: Nausea, thirst, confusion, lethargy, somulence; associated with cancers of breast, lung and myeloma
      2) Suggested therapy: Fluids, bisphosphonates; may be a terminal event if left untreated
   i. Anxiety
      1) Symptoms: N&V associated with anxiety
      2) Suggested therapy: Anxiolytics; supportive interventions
   j. Gastric hyperacidity
      1) Symptoms: Emesis of acidic fluid despite empty stomach
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      1) Symptoms: Nausea, thirst, confusion, lethargy, somulence; associated with cancers of breast, lung and myeloma
      2) Suggested therapy: Fluids, bisphosphonates; may be a terminal event if left untreated

EQUIPMENT
Assessment equipment
Emesis basin.
Mouth swabs
Gentle mouthwash
Foods agreeable to patient.

PROCEDURE
1. Adhere to standard precautions. Perform hand hygiene.
2. Perform comprehensive assessment, especially gastrointestinal assessment. Consider following assessment strategies:
   a. Ask patient and caregiver about nausea:
      1) When did it start? Was it associated with any changes in medications?
      2) Is it intermittent or constant? Do you notice any pattern about when it occurs or worsens?
      3) Does anything make it feel better? Vomiting? Eating certain foods?
      4) Does anything seem to make it worse? Certain smells? Eating or drinking something?
      5) Are you noticing any other symptoms? Headaches? Cramps? Pain?
      6) Can you recall what you had to eat and drink over the past 24 hours?
      7) How is it affecting you? Ability to eat? Activities? Sleep?
   b. Ask about vomiting episodes.
      1) How frequently is vomiting occurring?
      2) How much are you vomiting at a time?
      3) Can you describe the emesis? Is it digested food? Undigested food? Yellow fluid? Other description?
   c. Ask about bowel movements.
      1) When did you last have a normal bowel movement? Have you had any problems with stool leaking?
      2) Have you had any changes to your bowel movement pattern? Consistency of stools?
   d. Perform physical assessment, including:
      1) Obtain vital signs, note tremors.
      2) Inspect mouth. Note oral mucosa for wetness.
      4) Perform digital rectal exam.
3. Consult with primary care provider about assessment data, and to obtain orders for medications to manage symptoms.
4. If medications ordered, instruct about medication, dose, frequency, administration and side effects to report.
5. Provide teaching about non-pharmacological interventions that may be helpful.
   a. Identify and avoid N&V triggers.
b. Eat smaller meals more frequently.
c. Avoid spicy foods that may irritate the stomach.
d. Avoid temperature extremes of foods and beverages.
e. Try salty foods such as crackers and broth.
f. Try "flat" carbonated beverages.
g. Minimize high-acid foods.
h. Minimize odors that may trigger nausea.
i. Assure frequent oral hygiene.
j. Try alternative therapies such as massage, guided imagery, or progressive muscle relaxation.

AFTER CARE
1. Evaluate effectiveness of therapy at managing N&V.
2. Collaborate with primary care provider and interdisciplinary team.
3. Instruct the patient/caregiver to notify the nurse if symptoms do not resolve or worsen.
4. Document in patient's record:
   a. Assessment data
   b. Interventions
   c. Response to interventions.
   d. Teaching provided and to whom provided
   e. Communication with primary care provider
   f. Communication with other disciplines related to emotional or spiritual support

REFERENCES

PATIENT EDUCATION RESOURCE
KEY POINTS
1. Palliative wound care focuses on wound symptoms rather than wound healing. Palliative wound care may be appropriate when:
   a. Wounds cannot heal because elements for healing are unobtainable at end of life (e.g., malignant wound continues to proliferate, high-protein nutrient-rich diet not tolerated).
   b. Quality-of-life goals run counter to wound-healing goals (e.g., frequent turning causes pain, off-loading limits activities).
   c. Patient's goals are to control the wound's symptoms rather than healing the wound.

2. Symptoms of wounds patients find most distressing include:
   a. Odor
   b. Hard-to-manage exudate
   c. Wound pain and pain on dressing change
   d. Bleeding
   e. Itching

3. Principles of palliative wound care include:
   a. Wound symptom management:
      1) Control odor, exudate, pain and discomfort.
      2) Minimize infection and bleeding.
      3) Keep the wound "clean."
      4) Reduce frequency of dressing changes.
   b. Promotion of well-being:
      1) Encourage autonomy and decisions consistent with values and goals.
      2) Eliminate embarrassment and social isolation.
      3) Enable function and participation in activities.

4. Odor and exudate are usually caused by high levels of bacteria in the wound bed.
   a. Odor and exudate leave patients feeling uncomfortable, unclean, self-conscious and reluctant to interact in social situations with family or friends.
   b. Malignant tumors – which erode the skin – are frequently associated with odor and exudate.
   c. Necrotic or infected wounds may cause odors.
   d. Thorough cleansing of wounds helps reduce bacterial load.

5. Odor management options are limited by a lack of evidence. The following are included as options for discussion with the care team; none have high level evidence to support efficacy.
   a. ¼ strength Dakin's solution for irrigation
   b. Systemic antibiotics
   c. Topical antibiotics/antifungals
   d. Metronidazole applied topically to wound bed or dissolved in normal saline for wound irrigation
   e. Silver-based, cadexomer iodine-based or charcoal dressings
   f. Aromatherapy oils applied to the wound bed, such as lemon grass, lavender and tea tree oil
   g. Dryer sheets tucked into the patients clothing
   h. Room air fresheners including charcoal, kitty litter or other commercial products.

6. Exudate management options:
   a. Hydrogels for light to moderate drainage
   b. Alginites for moderate to heavy drainage, or for light to moderate bleeding
   c. Hydrofibers for moderate to heavy drainage

7. Pain and discomfort frequently occur with wound care.
   a. Removal of dried-out dressings can cause pain.
   b. Gauze dressings are most likely to dry and cause pain at removal.
   c. Use of non-adherent dressings, such as petrolatum gauze, contact layers or silicone, can promote comfort.

8. To maintain functional capacity:
   a. Creatively use dressings that will enable patient independence in wound management, such as stockinette, and tube bandaging.
   b. Refer to physical therapy and occupational therapy for ambulation and participation in activities.

9. Consider consulting with CWOCN (certified wound ostomy continence nurse). These wounds are difficult to manage and require advanced knowledge or wound treatment options.

EQUIPMENT
Gloves
Dressing supplies per care plan
Procedures from Skin & Wound Care
   Wound Assessment
   Cleansing & Irrigation
   Dressing Application
   Wound Packing

PROCEDURE
1. Discuss the wound with patient and caregivers.
   a. Assess location, cause, history, and current and past management plans.
   b. Ask about patient's/caregiver's current experience with the wound:
      1) What about the wound bothers you?
      2) What about the wound has the most negative impact on your day-to-day well-being?
      3) On a scale of 1 to 10, with 10 indicating a very negative effect, which of the following wound symptoms bothers you most?
         a) Odor of the wound
         b) Drainage from the wound
         c) Bleeding from wound
         d) Pain on dressing changes
         e) Wound pain, even when dressings not being changed
         f) Itching of or around wound
         g) Effect of wound on my interactions with others

3. Based on the patient's and caregiver's responses to questions about goals and present status of wound, develop short and long-term goals for the wound, such as:
   a. First goal is to eliminate odor and exudate. Long term goal is healing.
   b. First goal it to eliminate itching. Long term goal is to need dressing changes no more than once a week.

4. Develop a plan to meet primary and secondary goals for the wound.
   a. Consult with interdisciplinary team (IDT).
   b. Consider referrals to:
      1) CWOCN
      2) PT and OT
   c. Obtain wound care orders from primary care provider, including orders for:
      1) Cleansing and irrigation
      2) Specialized dressings
      3) Evaluation and recommendations from CWOCN
   d. Always address pain and ensure interventions for pain management are employed, such as pre-medicate prior to scheduled dressing changes with short-acting break-through medications.

5. Perform and instruct on wound care as per orders. See procedures:
   a. **Cleansing & Irrigation**
   b. **Dressing Application**
   c. **Wound Packing**

**AFTER CARE**

1. Evaluate the effectiveness of the **Wound Plan of Care** to meeting the patient's goals.

2. Collaborate with IDT about plan's effectiveness and potential ways to enhance plan.

3. Reevaluate patient goals regularly as they may change frequently based on current symptoms.

4. Educate patient and caregivers about how to perform wound care and how to reinforce dressing if needed between nurse visits.

5. Document in the patient's medical record:
   a. Goals the patient and caregiver verbalized
   b. Wound assessment data
   c. **Plan of Care** and its effectiveness at meeting goals
   d. Teaching provided with patient/caregiver
   e. Communication with IDT

**REFERENCES**


**CLINICIAN EDUCATION RESOURCE**

KEY POINTS
1. This procedure focuses on the use of opioids in managing the escalating pain management needs of the terminal cancer patient.
2. Several abbreviations are used in the procedure:
   a. ATC: Around the clock
   b. IR: Immediate release
   c. ER: Extended release
3. The initial step in starting a patient on opioid therapy is a comprehensive pain assessment, which analyzes the pain from several perspectives; physical, psychosocial and spiritual pain dimensions of pain should be explored.
4. A key question that is too often forgotten is determining the patient’s goal for pain control:
   a. Goals are affected by personal beliefs and value systems. What is “right” for me is not necessarily what is best for this patient.
   b. Perceptions about pain and suffering are seen through a cultural and experiential lens. Each person has a unique set of “glasses.”
   c. What is this patient’s goal for pain control?
5. Other procedures in this manual set a foundation for managing escalating cancer pain. Review the procedures in the Pain Management sections
   a. Assessment: Screening and Comprehensive Assessment
   b. Management of Elderly Patients
   c. Management with Medications
6. When initiating opioids:
   a. Individualize the route, dosage and schedule when initiating an opioid.
   b. Use around-the-clock (ATC) dosing for persistent, unacceptable pain.
   c. Establish optimal dose by titrating immediate-release (IR) opioids based on patient assessment. This may take 48 hours or longer. The usual starting dose is 5 to 10 mg of IR morphine sulfate or its equivalent.
   d. Use caution when initiating opioids in the elderly. An initial starting dose of 2.5 mg may be indicated in the very old.
   e. During this initial dosing period, the healthcare provider, based on the clinical situation, may choose to prescribe the IR opioid in one of the following ways:
      1) Morphine sulfate IR 5 mg every 4 hours ATC with 5 - 10 mg every 1 hour PRN pain
      2) Morphine sulfate IR 5 - 10 mg every 1 hour PRN pain
   f. Once the pain-relieving dose has been established using IR opioids, consider converting the opioid to an extended-release (ER) formulation.
   g. When converting to an ER opioid, always add an IR opioid to manage breakthrough pain (BTP). This should be approximately 10% - 20% of the total 24-hour opioid total, given every 1 hour PRN BTP.
7. Titrating Opioids for Escalating Pain:
   a. For patients using a significant amount of IR opioid for breakthrough pain, consider increasing the ER opioid (e.g., morphine sulfate, oxycodone).
   b. Upward titration should occur only after steady state has been achieved:
      1) Morphine, oxycodone every 24 hours
      2) Fentanyl every 48 to 72 hours
      3) Methadone every 5 to 7 days
   c. Remember to assess for all types of pain, e.g. bone and nerve. A nonopioid or adjuvant may be helpful and actually reduce the amount of opioid needed.
8. Principles and Calculation of Upward Titration of Opioids:
   a. Calculate both ER and IR opioids taken in the past 24 hours.
   b. For mild to moderate pain, increase the total 24 hour opioid dose by 25% - 50%.
   c. For moderate to severe pain, in the absence of significant side effects, increase the total 24 hour opioid dose by 50% - 100%.
   d. Administer the new 24-hour opioid (OxyContin and MS Contin) dose every 12 hours.
   e. Recalculate the new breakthrough dose of IR opioid: 10%-20% if the new 24-hour total opioid dose.
9. Considerations for Opioid Rotation:
   a. The current opioid is ineffective managing the pain.
   b. Patient is on a combination opioid/nonopioid, and the dose required to manage pain exceeds the ceiling dose of the nonopioid.
   c. The patient develops unacceptable side effects from the opioid.
   d. A change in the patient’s condition occurs:
      1) Patient can no longer swallow.
      2) Transdermal absorption may be compromised.
      3) Administration of high doses of opioids is no longer practical via oral, rectal, or transdermal route.
   e. Other considerations may arise:
      1) Opioids are too costly for patient/caregiver
      2) There is an inability to obtain opioid prescriptions from local pharmacies
      3) Patient and/or caregiver have major fears regarding the use of opioids.

EQUIPMENT

Brief Pain Inventory
McGill Pain Questionnaires – Short Form
Management of Elderly Patients
Management with Medications
Pain Management Guidelines/Equianalgesic Chart

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PROCEDURE


2. Perform a comprehensive pain assessment.
   a. Consider using the Brief Pain Inventory or the McGill Pain Questionnaire – Short Form.
   b. Determine the source of escalating pain. Is it the same or a different pain source?

3. Determine if present medication plan addresses pain descriptors for source of pain.
   a. Are new adjuvant medications indicated?
   b. Should the current opioid dose be raised? Should a new opioid be considered?

4. If considering to recommend a different opioid, calculate the total daily opioid dose:
   a. Add all doses of ER and IR opioids taken in past 24 hours.
   b. If the patient is on multiple opioids, use an equianalgesic reference guide to calculate morphine sulfate equivalent doses.
   c. To calculate a total daily morphine sulfate equivalent dose, add all ER and IR doses of opioids taken in the previous 24 hours.

5. Prepare to consult with the physician/primary care provider about switching to another opioid:
   a. Ask the patient about previous experiences with opioids before selecting the new opioid.
   b. Consider the best route of administration, ability to swallow, potential drug interactions, renal and liver function, cost, drug availability, and the patient and caregiver fears and concerns.
   c. To individualize the new opioid dose to meet the patient’s need, consider the following options:
      1) Due to incomplete cross-tolerance, decrease the new opioid by one-third to one-half the recommended equianalgesic conversion dose. This may be helpful if opioid rotation is caused by unacceptable side effects, even though pain is adequately managed with the opioid.
      2) If the patient’s moderate to severe pain is interfering significantly with his or her quality of life, consider increasing the daily dose of the new opioid by 50% - 100% based on patient assessment.
   d. Consider breakthrough dosing:
      1) Always use an IR opioid for breakthrough pain.
      2) Breakthrough medication should be 10% - 20% of daily opioid dose and should be available every hour.
      3) Considerations should also include competency of the patient or caregiver responsible for administering the breakthrough doses.

6. Consult with physician/primary care provider and provide your recommendations and calculations:
   a. Obtain new long-acting (ER) medication orders.
   b. Obtain new break-through pain (IR) medication orders.

7. Implement new medication plan.

AFTER CARE

1. Monitor the patient carefully after conversion:
   a. Doses of primary opioid may be titrated upward if the patient continues to require several daily doses of breakthrough medication.
   b. Doses may need to be titrated downward if patient experiences unacceptable side effects such as significant sedation.

2. Document in the patient’s record:
   a. Patient’s level of pain over the past 24 hours, at best and at worst
   b. Total dose of ER medication and IR medication over 24 hours
   c. Patients reports of pain and wishes for pain control
   d. Teaching provided to the patient/caregiver about how to administer new medication/dose safely, precautions to take, and symptoms to report
   e. All communication with and orders from the primary care provider

REFERENCES


KEY POINTS

1. Studies show that during end of life care, when referring to pain management, patients, families and professional caregivers are concerned with “total pain” management as described by Dame Cicely Saunders.
   a. Pain is a multidimensional experience, influenced by cultural backgrounds and life experiences, affecting values and beliefs about the meaning of pain and how it should be managed.
   b. The pain experience includes four domains:
      1) Physical
      2) Psychological
      3) Social
      4) Spiritual

2. "Total pain" should be assessed and managed. Tools that assess the distress and suffering that occur within all the domains are available.
   a. To assess physical pain, see the Pain Management section of this manual, especially the Pain Assessment: Screening and Comprehensive Assessment.
   b. To assess other components of total pain, consider using:
      1) Memorial Symptom Assessment Scale evaluates other physically distressing symptoms, not identified as "pain."
      2) Symptom Distress Scale identifies presence and severity of physical distress.
      3) Edmonton Symptom Assessment Scale identifies presence and severity of physical and psychological symptoms.
      4) Needs at the End of Life Screening Tool (NEST) assesses psychosocial issues that contribute to total pain.
      5) The FICA Spiritual Assessment Tool helps in identifying spiritual elements of pain and support.
      6) The Distress Thermometer prompts assessment of more physical symptoms than other scales, and includes other sources of distress – family relationships, emotional, spiritual, financial issues, etc.
      7) Critical Interventions for RN Assessment, Spiritual Assessment and Psychosocial assessment

3. Multiple procedures and guidelines are available to assist in the management of pain. Consider the following:
   a. Pain Management section of this manual includes pain management strategies and equianalgesic charts.
   b. Symptom Management procedures in Hospice and Palliative Care section of this manual include multiple interventions to relieve pain, anorexia, constipation, delirium, dyspnea, and nausea and vomiting.

   c. Common Distressful Symptoms: Tools and Interventions include interventions for anxiety, diarrhea, death rattle, depression and fatigue.
   d. Breathing and Relaxation Exercises procedure
   e. Guided Imagery and Visualization Exercises procedure
   f. Beliefs and Spirituality: Critical Interventions

EQUIPMENT

Assessment tools as appropriate
Management resources, as appropriate

PROCEDURE


2. Screen for other physical sources of suffering using tools such as:
   a. Memorial Symptom Assessment Scale
   b. Symptom Distress Scale
   c. Edmonton Symptom Assessment Scale

3. Screen for psychosocial and spiritual sources of suffering using tools such as:
   a. Needs at the End of Life Screening Tool
   b. FICA Spiritual Assessment Tool
   c. Distress Thermometer

4. Delve deeper in the comprehensive assessment and management of any symptoms of suffering using:
   a. Pain Management procedures
   b. Symptom Management procedures
   c. Common Distressful Symptoms: Tools and Interventions

5. Discuss assessment findings with the interdisciplinary team (IDT) and include interventions and ongoing evaluation on the Plan of Care for:
   a. Nursing to address physical sources of suffering
   b. Social worker to address psychosocial sources of suffering
   c. Chaplain to address spiritual sources of suffering

6. Consider use of complementary therapies:
   a. Breathing and Relaxation Exercises
   b. Guided Imagery and Visualization Exercises
   c. Prayer, meditation and spiritual practices
   d. Yoga and stretching exercises
   e. Massage of back, hands or feet
   f. Therapeutic and healing touch
   g. Affirmations
   h. Expression of emotions through art (e.g., painting, crafting)
   i. Life review/reminiscing
   j. Journaling or letter writing
   k. Music therapy
   l. Pet therapy
   m. Aroma therapy
   n. Humor and laughter therapy
AFTER CARE

1. Reassess patient’s plan 24 hours after the initiation of a new pharmacological or non-pharmacological interventions.

2. Communicate with physician/primary care provider and obtain orders when Plan of Care needs to changed or advanced.

3. Continue to support and encourage patient to explore strategies for attaining optimal well-being.

4. Instruct and teach patient/caregiver about options for addressing all types of suffering and distress, including using the IDT.

5. Document in patient record:
   a. Assessment findings and tools used
   b. Interventions used to address symptoms of distress and suffering.
   c. All teaching provided to patient/caregiver
   d. All communications and care coordination efforts with physician/primary care provider and IDT members.

REFERENCES


PATIENT EDUCATION RESOURCES


- Complementary Therapies
- Managing Anxiety
- Managing Depression
- Psychological Distress
- Respecting Cultural Beliefs
- Social Distress
- Spiritual Distress