Module 3: Symptom Management
Supplemental Teaching Materials/Training Session Activities Contents

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Module 3
Table 1: Symptoms Common in Serious Illness

GI Function	**Bowel Function**	**Mood**
Anorexia	Constipation	Depression
Nausea/vomiting	Diarrhea	Anxiety
Dysphagia	Loss of function or control	
Weight loss		
Unpleasant taste		
Ascites		
Bladder Function	**Cognition**	**Skin Integrity Issues**
Incontinence	Insomnia	Decubitus
Changes in function or control	Delirium/agitation/confusion	Mucositis
Bladder spasms	Memory changes	Candidiasis
		Pruritis
		Edema
		Ascites
		Hemorrhage/blood loss
		Herpes Zoster
		Lymphedema
Breathing	**Functional Ability**	**Other**
Dyspnea	Fatigue	Fever
Cough/congestion/rattles	Immobility	Diaphoresis
Hiccups	Pathological fractures/	
Altered breathing patterns	Spinal cord compression	
	Weakness	

Source:
Funded by the National Cancer Institute. B. R. Ferrell, Principal Investigator. (1998). HOPE: Home Care Outreach for Palliative Care Education Project. Reprinted with permission.

Module 3

Table 2: Self-Management Strategies / Activities for Nausea and Vomiting

Dietary Management:

- Eat smaller, more frequent meals
- Eat bland, cold or room-temperature food [Avoid spicy, fatty, high salty foods]
- Decrease food aromas and other strong odors around food
- Clear liquids
- Premedicate with antiemetics prior to meals
- Lie flat for 2 h after eating
- Use of ginger

Environmental Modifications:

- Have fresh air with a fan or open window
- Limit sounds, sights, and smells that precipitate nausea and vomiting
- Avoid the sight/smell of food when not hungry
- Avoid strong or unpleasant odors
- Wear loose-fitting clothes
- Oral care after each episode of emesis

Psychological Strategies

- Relaxation and meditation
- Deep breathing
- Guided imagery
- Acupuncture

Other Strategies:

- Apply a cool damp cloth to the forehead, neck, and wrists
- Exercise
- Taking medications as prescribed

References:

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Module 3
Table 3: Quick Reference Guide for Symptom Management

QUICK REFERENCE GUIDE FOR SYMPTOM MANAGEMENT	
SYMPTOM	**TREATMENT**
Fatigue	• 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	• 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 • Buspirone (Buspar®) 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]	• Assess frequency, volume, consistency and normal patterns of BMs • Diarrhea may be due to impaction; rectal exam indicated • Goal ≈ 3/week without straining, pain, tenesmus • Identify potential causative factors that can be addressed: opioids, anticholinergics, antihistamines, 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: — 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]
Constipation [Ongoing Prevention]	• All patients on opioids should have an order for a bowel regimen • Add stimulant and softener combination (e.g., senna/docusate) and titrate to effect (max 8 tabs/day) • Increase with upward titration of opioid dose • If persistent, consider adding bisacodyl 2-3 tabs PO QD or 1 rectal suppository QD; lactulose 30-60 mL PO QD; metoclopramide (Reglan®) 10-20 mg PO QID; magnesium hydroxide (Milk of Magnesia) 30 mL PO QD • When constipation is related to opioids or in debilitated patient, changing the diet or adding fiber supplements is rarely helpful • Educate patients/families; there is much stigma about discussing bowel function *Even when not eating, patients should have bowel movements every 1-2 days. Untreated constipation can lead to discomfort and increased pain, as well as agitation in the cognitively impaired patient.*

QUICK REFERENCE GUIDE FOR SYMPTOM MANAGEMENT	
SYMPTOM	**TREATMENT**
Diarrhea	• Evaluate for potential causes of diarrhea common in palliative care and correct/treat when feasible: medications (overuse of laxatives, antibiotics, magnesium, chemotherapy, immunotherapy), infection, diet, herbal products (e.g., milk thistle, cayenne, ginger) fecal impaction, malabsorption syndromes from surgery or tumor, radiotherapy that includes abdomen in treatment field, inflammatory bowel disease and other comorbid disorders • **Loperamide (Imodium®)** 2 mg PO –start with 4 mg, followed by 2 mg after each BM, not to exceed 8 capsules/24 hours • **Diphenoxylate/atropine (Lomotil®)** 1-2 tabs PO QID, maximum 8 per 24 hours • **Tincture of opium** – 0.6 mL PO q 4-6 hours prn • **Methylcellulose (e.g. Metamucil®)** or pectin can help provide bulk to liquid stools • **Octreotide (Sandostatin®)** 50 mcg SQ/IV q 8 hours, maximum 1500 mcg/day • **Cholestyramine** – 2-4 g PO/day before meals (especially for c. difficile diarrhea) • **Pancrelipase (Creon®, Pancreaze®)** 500 – 2500 lipase units/kg PO with meals
Dyspnea [Shortness of breath; Air hunger]	• Identify and treat reversible causes: airway obstruction (e.g., bronchodilators and/or corticosteroids), infection (e.g. antibiotics), CHF or fluid overload (e.g., diuretics), anxiety (e.g., anxiolytics) • Opioids are first line therapy; start with **morphine** 2.5-5 mg PO every hour (any opioid can be used) - titrate upward aggressively 25-50% if unrelieved • Liquids may be easier to swallow or can be placed sublingually [although absorbed enterally]: **morphine** liquid; **oxycodone** liquid • **Parenteral (IV or SQ) opioids -** can be used if patient unable to swallow • Add anxiolytics (benzodiazepines) only if anxiety is present [e.g., lorazepam every 4 hours as needed] or opioids fail to provide relief • Elevate head of bed [can use a fan for comfort]; pursed lip breathing • Consider oxygen only if patient is hypoxemic • Distraction, relaxation, mindfulness, create calm environment
Anorexia	• Educate and counsel patient/family regarding anorexia as a natural response to disease; interventions below only when loss of appetite bothersome to patient • Environmental alterations: small, frequent meals, moist foods or those with sauce/gravy take less energy to eat, assistance with meal preparation to improve energy for eating • **Dexamethasone (Decadron®)** 4 mg PO QD or prednisone 20 mg PO QD, especially when prognosis < 6 weeks • **Dronabinol (Marinol®)** 2-10 mg PO every 4 hours, use with caution in the older adult • **Mirtazapine (Remeron®)** 15 mg PO QHS to enhance sleep, also improves appetite
Nausea & Vomiting ***Not intended to prevent or treat chemo -induced N&V***	• Rule out potentially reversible causes: constipation, central nervous system disease, pain, altered electrolytes, ↑ICP, obstruction, antibiotics, chemotherapy, radiation therapy, opioids, digoxin **If N & V due to activation of chemoreceptor trigger zone (CTZ) (e.g., medication-induced):** ◆ **Prochlorperazine (Compazine®)** 10 mg PO q 6 hours or 25 mg PR q 8 hours ◆ **Haloperidol (Haldol®)** 0.5-4 mg PO or IV/SQ q 6 hours ◆ **Ondansetron (Zofran®)** 4-8 mg PO or IV q 8 hours (best when used for chemo or RT induced N/V; less effective when treating opioid induced N&V) ◆ **Olanzapine (Zyprexa®)** 2.5 – 10 mg PO QD - BID ◆ **Promethazine (Phenergan®)** 12.5 –25 mg IV q 6 hours or 25 mg PO or PR q 6 hours **If N & V due to gastric stasis causing early satiety, GI tract spasm:** ◆ **Metoclopramide (Reglan®)** 10-20 mg PO or IV TID AC & HS **[not with bowel obstruction]** ◆ **Hyoscyamine (Levsin®)** 0.125-0.25 mg PO/SL q 4 hours prn **If N & V due to vestibular effects (nausea exacerbated by movement):** ◆ **Scopolamine** transdermal patch 1.5 mg q 3 days (especially if underlying mechanism is vestibular - increased nausea or dizziness with ambulation) ◆ **Cyclizine (Meclizine®)** 25-50 mg PO every 8 hours; best for motion sickness or increased intracranial pressure **If mechanism of N & V is unclear, or unresponsive to other therapies:** ◆ **Dexamethasone (Decadron®)** 4-8 mg PO/IV daily ◆ **Dronabinol (Marinol®)** 2-10 mg PO every 4 hours ***Administer antiemetics around the clock (scheduled). If nausea is controlled, then try reducing after 2-3 days.***
Pain in the Final Hours of Life	• Observe for escalating pain and increase medications accordingly • May need to change route if swallowing is diminished; alternatives include transdermal, concentrated liquids taken orally in small volumes, parenteral • Abruptly discontinuing opioids or benzodiazepines may precipitate withdrawal syndrome -reduce dose 25% daily if no sign of pain in comatose patient; return to previous dose if any sign of return of pain

QUICK REFERENCE GUIDE FOR SYMPTOM MANAGEMENT

SYMPTOM	TREATMENT
	• Myoclonus may occur; treat with clonazepam (Klonopin®) 0.5 mg PO TID, MAX 20 mg/day or lorazepam (Ativan®) 0.5-2.0 mg PO/IV q 4 hours if patient unable to swallow; may require midazolam (Versed®); IV/SQ; rotate opioids
Delirium & Agitation	• Identify and treat reversible causes: full bladder, fecal impaction, pain, dyspnea (hypoxemia, secretions, pulmonary edema), severe anxiety, nausea, pruritus, medications (e.g., corticosteroids, neuroleptics, anticholinergics), dehydration, infection • Reduce noise, orient gently, reduce nighttime interruptions to promote sleep/wake cycle • **Haloperidol (Haldol®)** 0.5-2 mg PO every 2-4 hours PRN or IV/SQ 50% of oral dose (may repeat q 1 hour PRN in severe delirium) • **Olanzapine (Zyprexa®)** 2.5 – 5 mg PO QHS; to start, increase to 10 mg after one week • **Risperidone (Risperdal®)** 1-2 mg PO q PM, increase by 0.5-1 mg q 2-7 days • **Quetiapine (Seroquel®)** 12.5 – 25 mg PO q 12-24 hours; to start, increase up to 50 mg BID • **Chlorpromazine (Thorazine®)** 12.5-25 mg PO/SQ q 4-12 hours, or 25 mg per rectum q 4-12 hours (IV can cause hypotension-avoid unless other agents ineffective and oral/rectal route unavailable) • **Buspirone** 5-20 mg PO TID
Excessive Secretions ["Death Rattle"]	• **Atropine** 0.4 mg SQ q 15 minutes PRN • **Scopolamine** transdermal patch 1.5 mg topical, start with 1 mg (about 4 hour onset), increase to 2 mg after 24 hrs. If insufficient, begin scopolamine 50 mcg/hr IV or SQ; double every hour to maximum of 200 mcg/hr • **Glycopyrrolate (Robinul®)** 1-2 mg PO or 0.1 mg –0.2 mg IV/SQ q 4 hours PRN or 0.4-1.2 mg/day continuous IV/SQ infusion (this agent does not cross the blood brain barrier – less likely to cause confusion) • **Hyoscyamine (Levsin®)** 0.125 – 0.25 mg PO q 4 hours (liquid can be placed sublingually) • Change patient's position • D/C IV and/or enteral fluids as they may increase discomfort (e.g., cough, pulmonary congestion, sensations of choking/drowning, vomiting, edema, pleural effusions, ascites) • If fluids not discontinued, IV or SQ rate ought not exceed 500 mL/24 hours • **Furosemide (Lasix®)** PRN to control over hydration. • Control thirst by moistening lips and mouth with substitute saliva (**Oral Balance Moisture Gel®** or **Salivart®,** at bedside apply as frequently as needed) ***Patients may be too weak to expectorate. This is not painful, but distressing to family. Suctioning is traumatic, can cause bleeding and is painful. Do not suction beyond the oral cavity***.

References (and for more details):

Ferrell, B., & Paice, J. (Eds). (2019). ***Oxford textbook of palliative nursing*****, 5th Edition. New York, NY: Oxford University Press.**

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For additional resources, refer to:
City of Hope Nursing Research and Education Resources www.cityofhope.org/NRE; and
ELNEC: End-of-Life Nursing Education Consortium www.aacnnursing.org/ELNEC

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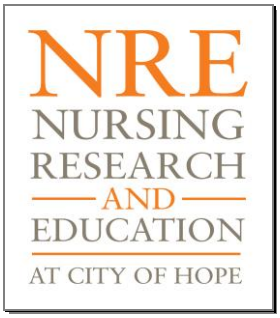

Module 3
Table 4: PTSD: Post-Traumatic Stress Disorder

- Many Americans experience terrifying and life-threatening ordeals that can precipitate PTSD. It is important that the healthcare team caring for a Veteran or non-Veteran with PTSD is aware of this diagnosis (Grassman, 2019). Causes include:
  - Various fears, including fear for their own life or another's (e.g., serious, life-threatening illness)
  - Witnessing horrific events during one's life (e.g., battle, rape, murder) (Grassman, 2019).
  - Feeling helpless in being able to respond to the horrific event(s) (Veterans Advisory Council, 2009).

- Scientists in the neuroscience field are looking at areas of the brain that can provide answers to the pathophysiology of PTSD.

NOTE: Some terminally ill patients may never have been diagnosed/treated for PTSD until they are seen by the palliative care team. Patients may have PTSD, but it is unknown to them upon admission.

- PTSD symptoms are important for nurses to assess (Grassman, 2019; Periyakoil, 2009). These symptoms include: reliving the trauma; avoiding reminders; and persistent hyperarousal.
  - Persistent re-experiencing of the trauma or "flashbacks" (e.g., war, natural disaster, automobile accident, etc.).
  - Persistent avoidance of the thoughts and feelings, places and people that are connected with the trauma. They may have feelings of detachment (e.g., unable to have loving feelings, etc.) and a sense of not seeing a future (e.g., not able to think of marriage, children, career, etc.).
  - Persistent hyperarousal (e.g., hypervigilance, difficulty going to sleep and staying asleep, outbursts, difficulty in concentrating, startle response that is over exaggerated)
  - Duration of symptoms is present for one month and can occur right after the trauma or later in life.
  - Functional impairment in social and/or occupational settings or other areas.

- Risk factors for PTSD include:
  - History of child/sexual abuse
  - Chronic mental illnesses
  - Females
  - Ethnic minorities (e.g., Hispanics and African Americans)
  - War Veterans
    - These symptoms may begin within three months of the traumatic event, though may not begin until many years later (Periyakoil, 2009).
    - PTSD may surface initially at the end of life and it can be frightening at a time when the Veteran is already vulnerable. The palliative care team must work closely with the mental health professionals to identify the best plan of care for Veterans in their final days. All Veterans, especially those admitted for end-of-life care, should be screened for PTSD, just to obtain a baseline (Grassman, 2019).

- Veterans with PTSD or those suspected to have PTSD must be diagnosed and closely followed by a mental health professional. Frequent consults should be provided from the mental health professional to the palliative care team.
  - PTSD Checklist (PCL)—a 17-item self report measure. Respondents rate on a 1-5 scale (1 = not at all, 5 = extremely) how much they were "bothered by that problem in the past month." An example question includes, "In the past month have you had repeated disturbing memories, thoughts or images of a stressful military experience?" Examples of PTSD Screening Questions (Davidson, 2016). During your life, have you had an experience(s) that was/were so frightening, horrible, or upsetting that in the <u>past month</u> you:
    #1: Have had nightmares about/came to your mind when you did not want it to?
    #2: Tried hard to not think about it or attempted to avoid situations that would remind you of it?
    #3: Continuously were on guard, watchful, or easily startled?
    #4: Felt numb or detached from family, friends, others, activities, surroundings?
  - These questions can be used to screen for thoughts that may be intrusive, avoidance, hypervigilance, and numbness or detachment. If a patient has answered "YES" to two of the above 4 questions, then "it is considered positive." Some clinicians use these questions in both inpatient and outpatient palliative care settings and provide further clinical attention and investigation even if one answer out of the four is positive (Periyakoil, 2009).

<u>NOTE</u>: Remember that exposure to a traumatic event is required for a diagnosis of PTSD.

- Psychotherapy treatments can be used along with medications for the treatment of PTSD. These include evidence-based trauma-focused cognitive-behavioral treatments such as prolonged exposure therapy or cognitive processing therapy. Skill-building treatments such as anger management or stress management can also be used. A combined approach of medication and therapy has the added benefit of focusing on all aspects of PTSD with the goal of improving the quality of life.

- "Posttraumatic Stress Disorder (PTSD) has biological, psychological, and social components. Medications are used to address the biological basis for PTSD symptoms, resulting in improvement of psychological and social symptoms. Although not as effective as cognitive-behavioral therapy, pharmacotherapy usually helps the majority of patients achieve a clinically meaningful reduction in symptoms. Medication is also useful for treating the comorbid depression and other anxiety disorders that often accompany PTSD" (Department of VA Affairs: National Center for PTSD, 2017).

- Selective Serotonin Reuptake Inhibitors (SSRIs) are the cornerstone of pharmacotherapy and often the first-line used in treating PTSD. They primarily affect the neurotransmitter serotonin, which is important in mood, anxiety, stress modulation, appetite regulation, and sleep. SSRI's reduce symptoms associated with PTSD [i.e., reexperiencing the trauma, hyperarousal, avoidance, etc.] (Davidson, 2016).
  - There are currently only two FDA-approved medications for the treatment of PTSD: Sertraline (Zoloft®) and Paroxetine (Paxil®).
  - These medications may not be practical or feasible in the last few weeks of life due to long delay effects.

- Opioids: A recent study, supported by the US Navy Bureau of Medicine and Surgery under the Wounded, Ill, and Injured-Psychological Health-Traumatic Brain Injury Program, showed evidence that morphine, when used in trauma care, may protect soldiers against subsequently developing PTSD after a traumatic injury. By administering morphine as a first line to pain control and anxiety, the risk of developing PTSD may be reduced (Holbrook et al., 2010).

- Psychotherapy treatments can also be used along with medications for the treatment of PTSD. These include evidence-based trauma-focused cognitive-behavioral treatments such as prolonged exposure therapy or cognitive processing therapy. Skill-building treatments such as anger management or stress management can also be used. A combined approach of medication and therapy has the added benefit of focusing on all aspects of PTSD with the goal of improving the quality of life for the Veteran (US Department of Veterans Affairs: National Center for PTSD, 2017).

NOTE: Treatment for PTSD is difficult, challenging, and individualized. Below are some sites that are appropriate for your patients who are Veterans. Remember, 96% of Veterans die in a non-VA facility. Routinely assess whether your patients are Veterans.

- The Institute of Medicine (IOM) recommends that the VA and other government agencies promote and support research on early intervention in PTSD. Additional research is essential to review every treatment modality (IOM, 2007).
- Contact local *Vet Centers* to get help for Veterans struggling with PTSD. Hospice organizations are encouraged to partner with a Vet Center in their community to provide services to Veterans who have PTSD, especially if it is emerging for the first time or is complicating a Veteran's death. For more information, go to: https://www.vetcenter.va.gov and https://www.ptsd.va.gov [Accessed August 21, 2022].
- The VA/DoD Clinical Practice Guidelines, *Management of Post-Traumatic Stress Disorder and Acute Stress Reaction 2017* describes the critical decision points in managing PTSD and provides clear and comprehensive evidence based recommendations that incorporate current information and practices for practitioners throughout the DoD and VA Health Care systems. This guideline is intended to improve patient outcomes and local management of patients with one of these diagnoses. For more information, go to: https://www.ptsd.va.gov/professional/treat/txessentials/clinician_guide_meds.asp [Accessed August 21, 2022].

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Module 3 Table 5: WHV Screening Guide for Veterans

Screening Guide for Veterans

Welcome to the Screening Guide for Veterans. This guide is intended to support organizational development of screening and interventions for trauma-informed care (TIC) and to provide clear direction for what staff should do, not just what to avoid. Interventions should support meaningful, consistent relationships with the spirit of "Let's find solutions together" instead of "We, the 'staff' or 'the IDT', know best". Interventions should provide individualized information about how staff can help the individual meet an unmet need as well as continue to enhance needs that are being met.

An important premise is that this guide has been created with the expectation that the organization has begun the journey to adopt trauma-informed care including staff training. The intention is to support staff who are trained in a trauma-informed care approach and demonstrate that skillset. For staff that have not received TIC training or for whom TIC is not in their scope of practice, this guide can serve as a resource to find information and learn about training options. NHPCO's Trauma-Informed End-of-Life Care Work Group's Tools and Resources page and the We Honor Veterans Trauma-Informed Care for Veterans Resource page are excellent resources. This guide provides screening interventions and is not intended to serve as a diagnostic tool. To facilitate usability, cut and paste sections into your Electronic Medical Record.

Always remember when guiding conversations to include the family and/or care partner as part of the process. If you have not already done so, we encourage your trauma-informed care information gathering to include the Work Group's Q&A found here.

** For urgent situations, the Veterans/Military Crisis Line at 800-273-8255 is available 24/7/365 and VA enrollment is not necessary to use this resource.*

Screen for Post-Traumatic Stress
Interventions
During all interactions, pay attention to comments that could indicate symptoms of post-traumatic stress and plan to follow up with interventions and/or referrals as appropriate once trust is established.
Identify potential signs or symptoms of post-traumatic stress (e.g., reports of intrusive thoughts, memories, or triggering events) and how they affect the individual in the present moment. Determine if follow up or special consideration from team members is indicated.
After sufficient trust is established, ask permission to discuss symptoms of traumatic stress and to identify contributing factors (including previous military assignments).
Inquire if the individual would like to speak with someone skilled in trauma work. If the answer is "yes," make a referral and notify the individual of the outcome. If "no" include the individual's choice and continue to observe for signs and symptoms of post-traumatic stress.
Refrain from attempts to minimize guilt or distress; avoid platitudes such as: "You were just following orders", "You were just doing what you were trained to do," etc. **See additional resources below for a list of Empathy Blocks and a three-step approach to addressing PTSD symptoms.*
Provide empathy to help identify feelings related to the situation (e.g., progression of illness, experience of physical symptoms, loss of control and independence) and unmet needs.
Invite conversation about the difficulty of feeling helpless, losing control and independence, facing changing routines, having less privacy, experiencing physical symptoms that may trigger traumatic stress (i.e., shortness of breath, diarrhea).
Offer to provide education on the correlation between post-traumatic stress and life and disease

hanges.
Utilize accepted approaches for stabilizing symptoms of traumatic stress (e.g., patient-specific ody-awareness and grounding techniques, mindfulness, visualization, EMDR, DBT, and others) n alignment with staff expertise and certification.
f the individual experiences distress or has a paradoxical reaction to anti-anxiety medications, creen for traumatic stress and post-traumatic stress syndrome (in addition to terminal estlessness). Identify and implement alternative interventions to increase wellbeing and comfort. Monitor effectiveness.
• Create an emotionally safe environment by reducing avoidable triggers and utilize accepted approaches for stabilizing symptoms of traumatic stress
• Shorten the length of traumatic stress response episodes by using symptom stabilizing strategies appropriate for traumatic stress (e.g., grounding, mindfulness, visualization). Where possible, teach these to patient and caregivers to foster a sense of independence and self-regulation.
• Other Patient Specific:
Interventions for Pain and Other Symptoms
• Assess for severity and frequency of pain or other symptoms.
• Use a comparative approach. For example, if you assess that patient seems more/less uncomfortable than the last visit, ask if pain or symptoms are greater or worse than the last time you were there.
• Consider under/over reporting of pain. Query caregivers who may know the history of the patient in self-reporting of pain or other symptoms.
• Monitor for unintended emotional side effects of medications; i.e., sedation which may trigger feelings of helplessness and lack of control.
• Immediate reduction of distress (pain, or other specific symptom) that supports optimal functioning.
• Other Patient Specific:
Moral Injury
Interventions:
• Traumatic stress is difficult on relationships - inquire if it has impacted patient's relationships. If so, ask if he/she is interested in speaking with someone about this and make appropriate referrals as needed.
• Spiritual interventions and chaplain support can be necessary when core values and beliefs have been violated, integrate other disciplines that could help address (e.g., art therapy, music therapy, spiritual care, pet therapy, Reiki, Vet-to-Vet volunteer supportive ceremonies, nature-centric interventions such as forest bathing). **See additional resources for the FICA Spiritual History Tool.*
• Listen without judgement and do not diminish the strength of their feelings regarding the issue.
• In collaboration with other team members, develop a plan to address symptoms of traumatic stress and document on the hospice plan of care. **See additional resources for the Seven C's of the Stress First Aid Model.*
• For further information regarding Soul Injury and forgiveness techniques, please go to https://www.wehonorveterans.org/soul-injury-and-opus-peace-tools-deborah-grassman
Goals
• Patient will identify and participate in interventions designed to mitigate his/her traumatic stress symptoms. Involve caregivers in interventions, particularly when cognitive capacity may be limited.
• Other Patient Specific:
Military Rituals
Interventions

• Identify any desired salutations (Sir, Ma'am, Acknowledge Rank) including other ways they may wish to identify that weren't acknowledged during their service (see NHPCO's LGBTQ+ resource guide on ways to treat, identify and honor patients respectfully) or preferences that these be avoided (some who have experienced moral injury do not wish to have their service recognized or honored).
• Identify desire for military funeral or flag draping (or other rituals).
• Acknowledge and recognize their era (e.g., a "Welcome Home" to Vietnam Veterans or presentation of Challenge Coin.
• Ask about their desire for a pinning ceremony. **Tools available on the WHV Honoring Veterans Resource page*
• Other Patient Specific:
Goals
• Military rituals will be honored as per patient request/desire.
• Other Patient Specific:

Additional resources

Defining trauma:

NHPCO has adopted the definition provided by the Substance Abuse and Mental Health Services Administration (www.samhsa.gov) as its depth and breadth is most relevant to the hospice and palliative care field.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

(Substance Abuse and Mental Health Services Administration; www.samhsa.gov)

Trauma-informed care is the adoption of principles and practices that promote a culture of safety, empowerment, and healing.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.integration.samhsa.gov/clinical-practice/trauma

Goals related to the 6 Principles of Trauma-Informed Care:

Safety (physical and psychological) – (personal, interpersonal, and environmental – page 70 of Blue Knot); be aware that telling someone they are safe can trigger fear and anxiety, e.g., for someone with a history of abuse

- How do you describe safety?
- What helps you feel safe?
- What can we do to help your space feel safe for you?
- What can staff do to help you feel safe?
- What helps you achieve a sense of calm? A sense of comfort?
- What's bothering you the most right now?
- What turns on the painful memory for you?
- When you think about that painful memory, what happens to your pain?
- Is the pain where the disease/injury is or where the stress is?

Trustworthiness and Transparency

- How can the resident be involved in decision-making? About their own care? About their environment?
- How does you describe trustworthiness? What qualities does that include?

Peer Support and Mutual Self-Help
(Peers may also be referred to as "trauma survivors" in some situations/settings)

- What would a meaningful sense of social support be for you?
- In what ways would you like to be engaged in life, care, facility life…?

- How can staff increase the resident's sense of social support?
- What are your stories of resilience?
- How can these stories be integrated into the current situation to help support healing, recovery, settling?

Collaboration and Mutuality

- How would you like to be involved in decision-making?
- What is important to you to make decisions about?
- How would staff know that you need more help?

Empowerment, Voice and Choice

- How can the resident be involved in decision-making? About their own care? About the environment?
- What information would be helpful for us to know about what happened to you?
- What helps take the 'edge' off?
- What do you feel you need?
- What are your strengths?
- What helps you express your feelings in a healthy way?
- What helps you find meaning in life?
- What supports you to feel good about yourself?
- What helps you feel hopeful?
- What sustains you during difficult times?
- How do you manage stress? Is this different from how you managed it before? If so, how?
- Does the resident have some healthy self-regulation skills? Positive connection with other people?
- What do you value? What beliefs are important?
- From your experience, what responses from others appear to work best for you when you feel overwhelmed by your emotions?
- What are some of the ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- Imagine for a moment that a group of people are standing behind you showing you support in some way. Who would be standing there? What would they be doing? (It doesn't matter how briefly or when they showed up in your life, or whether or not they are currently in your life or even alive.)
- Who are the people you enjoy being around? Who feels grounded to you?
- How do you gain support today?
- What does recovery look like to you?
- What makes a good day for you?
- What are the things you do each day or each week because you really prefer or choose, not because you must?
- What do you do well? What kinds of things did you previously do well?
- What has always given you confidence or made you proud?
- What is most important to you right now?
- What helps you feel good about yourself, self-worth, higher self-esteem?
- What are the verbal and non-verbal ways this person is trying to communicate?

Cultural, Historical and Gender Issues

- Has the resident shared a history of stereotypes/discrimination/racism?
- Shared trauma (e.g., family legacy of slavery, a family member that was killed in a concentration camp)?
- Do you identify with traditional cultural values/connections? Cultural rituals?
- What can we do in this moment to help you feel safe? Take into account body language, distance, volume and tone of voice and eye contact.
- Can you help me understand how you express [e.g., sadness, joy]?
- What perceptions of health are important to you?

- What is important to you for healing?
- What are your beliefs about illness? About dying? About death? About suffering?
- What is your understanding of why things have happened the way they have?
- How are gender roles understood (rules about social distance, touch, eye contact, and how to approach a married/unmarried person)?
- If you don't understand, ask. If you make a mistake, acknowledge it, and ask for their help to learn.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf ; Courtesy of Paige Hector, LMSW

Delayed Reaction to Trauma Worksheet:

Box 3.9 **DELAYED REACTION TO TRAUMA**

Signs & Symptoms of Posttraumatic Stress

Possible Delayed Emotional Reactions YES/ NO source_____

Irritability; Aggression; Negative affect; Distress at trauma reminderes; Fear of trauma happening again; Negative thoughts about self; Detachment; Feelings of vulnerability; Mood swings; Grief reactions.

Possible Delayed Physical Reactions YES/ NO source_____

Nightmares; sleep disturbance; Hypervigilance/Heightened startle; Persistent fatigue; Changes in appetite or digestion or cortisol levels; Lowered immune function/more colds and infections; Focus on aches and pains

Possible Delayed Cognitive Reactions YES/ NO source_____

Intrusive memories; Flashbacks; Exaggerated self-blame or blame of others about the event(s); Difficulty concentrating; Belief that avoidance or other behaviors will protect them from trauma; Avoidance of trauma-related feelings or memories or preoccupation with the event; Panic & phobia-like behavior in response to trauma triggers; Inability to remember key features of the trauma

Possible Delayed Behavioral Reactions YES/ NO source_____

Avoidance of event reminders ; Decreased interest in activities; Risky or destructive behavior; Isolation/withdrawal; Disrupted social relationships; History of abuse of alcohol or drugs

Possible Delayed Existential Reactions YES/ NO source_____

Questioning ("why me"), disillusionment, cynicism; Loss of purpose or faith; Hopelessness; Also potential adaptive responses such as re-establishing priorities, redefiniting meaning and importance of life, reviewing life assumptions to accommodate trauma.

Adapted from HHS (2014). *TIP-57*, pp. 61-62.

Figure: Ganzel, B., Kusmal, N., Cheatham, C., Hector, P. & Clarke, D. (accepted). Trauma-informed long-term care. In R. Perley (ed.), Managing the Long-Term Care Facility: Practical approaches to providing quality care (2nd Edition, Chapter 3). John Wiley and Sons.

FICA Spiritual History Tool is to be used as a guide to aid and open discussion to spiritual issues, not a checklist.

F - Faith and Belief

- "Do you consider yourself spiritual or religious?" or "Is spirituality something important to you" or "Do you have spiritual beliefs that help you cope with stress/ difficult times?" "What gives your life meaning?"

I - Importance

- "What importance does your spirituality have in our life? Has your spirituality influenced how you take care of yourself, your health? Does your spirituality influence you in your healthcare decision making? (e.g. advance directives, treatment, etc.)

C - Community

- "Are you part of a spiritual community? Communities such as churches, temples, and mosques, or a group of like-minded friends, family, or yoga can serve as strong support systems for some people." "Is this community of support to you and how? Is there a group of people you really love or who are important to you?"

A - Address in Care

- "How would you like me to address these issues in your healthcare?"

Citation: Puchalski, C., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. Journal of palliative medicine, 3(1) 129-137.

EMDR Training and Certification: Eye Movement Desensitization and Reprocessing (EMDR) therapy is an extensively researched, effective psychotherapy method proven to help people recover from trauma and other distressing life experiences, including PTSD, anxiety, depression, and panic disorders.
EMDR Therapy is a recognized effective treatment for post-traumatic stress disorder (PTSD) and it has been endorsed as an effective therapy by many organizations including the Department of Veterans Affairs, the World Health Organization, and the American Psychiatric Association. Further information on training available and the certification process can be found on the EMDR International Association website.
PTSD: For further guidance refer to *Caring for Veterans with Posttraumatic Stress Disorder at the End of Life: Tips for Recognizing Trauma-Related Symptoms* on the WHV TIC Resource Page. If further help is needed refer to VA PTSD Consultation Program for Providers which includes experienced senior psychologists, psychiatrists, pharmacists, and other health professionals who treat Veterans with PTSD and are available to consult on everything from specific case instances to general questions. Call (866) 948-7880 or consider a telemental health visit by a VA Psychologist if the Veteran is enrolled.
VA offers telehealth services across the U.S. — including via VA Video Connect app. **Veterans will need to be enrolled** to receive VA telehealth services which can be initiated online at the link below or by calling **877-222-VETS (8387)**. https://www.va.gov/healthbenefits/online/. Telemental Health Hubs connect mental health specialists with Veterans at sites who require same-day or urgent access to mental health services. www.telehealth.va.gov.

Empathy Blocks include things like advising, interrogating, educating, judging, correcting, labeling, reassuring, etc. Examples include:

Advising: You really need to…
Interrogating: How did this happen?
Story Telling: This reminds me of…
Educating: Eating a healthy diet will help.
Sympathizing: I feel so badly for you.
Diagnosing: It sounds like you're depressed.
Judging: What a mess this is.
Correcting: No, that's not what happened.
One-upping: If you think that's bad, wait until you hear this.
Reassuring: Everything is going to be just fine.
Denial of Feelings: Don't be sad.
Minimizing: This isn't that bad.
Blaming: This is your fault.
Criticizing: If you took better care of yourself, this would not have happened
Labeling: Because you are an Asian woman…
Analyzing: He treats me like that because he has no boundaries
Consoling: Don't worry you will be ok.
Shutting Down: Don't think about it. Be happy.
Explaining: The reason why I'm telling you this is so you will be more compliant with treatment.
Courtesy of Paige Hector, LMSW and Melanie Sears, RN, MBA, PhD

Stepwise Approach to address PTSD Symptoms:

A useful approach to address PTSD in Hospice Care is the Stepwise Psychosocial Staged Model for Treating PTSD at the End of Life – A Patient Centered Approach. There are three stages to this model and treatment only moves on to the next stage if symptoms are not resolved and the Veteran would like additional treatment.
Stage I: Palliate immediate discomfort and provide social supports
Stage II: Enhance coping skills
Stage III: Treat specific trauma issues

Stage 1 Example: *A hospice nurse went to complete the initial intake with a Veteran referred for home hospice. Upon arriving his wife shared with the nurse that he has battled chronic PTSD since returning from Vietnam and has difficulty trusting other people.*
Stage 1 Approach: Stage one of the model aims to palliate immediate discomfort, provide social support and psychoeducation. Stage one targets what can be done in terms of the environment, relational, and related interventions that facilitate comfort. For example, in terms of environment the hospice team would want to help facilitate a relaxed environment that could be done with thoughtful scheduling of providers, not having an influx of providers in a short period of time. Engaging in relational techniques such as "ask" instead of "tell," explaining purpose of visit and procedures, and remaining accountable would all help to build trust. Incorporating interventions into the care plan that provide psychoeducation and avoid triggering of symptoms are other ways to address care needs.

Stage 2 Example: *As the hospice care team worked with the Veteran, he began having significant difficulty with increased anxiety upon wakening early in the morning and finding himself alone. He had previously completed trauma treatment. The LCSW was able to review the coping skills he had previously learned during treatment and found helpful. He successfully incorporated relaxation and breathing exercises into his routine. His family was alerted to increase frequency checks to provide additional reassurance and comfort if they found him awake.*
Stage 2 Approach: Interventions to Enhance Coping Skills

- Relaxation and breathing re-training
- Sleep apps
- Thought-stopping skills
- Mindfulness-based/acceptance skills
- Problem-solving interventions
- Communication/social-skills training
- Psychoeducation regarding coping skills for PTSD symptoms with patient and family

Stage 3 Example: *As his health declines, his symptoms appear to be worsening. He would like to engage in psychotherapy and at this point in his disease progression he is able to participate in individual sessions but would prefer telehealth.*
While many symptoms are successfully managed using techniques from the first two stages, if the Veteran desires further intervention, this is the point in the model that a hospice agency would refer to another provider trained in evidence based treatments for PTSD if they do not have one on staff.
Stage 3 Approach: Referral to Treat Specific Trauma Concerns

- Apply traditional recommended exposure-based methods if appropriate given prognosis and energy level.
- Telehealth options
- Modified EMDR – "On-the-spot"
- "Life-review-based" exposure approach
- Spiritually oriented psychotherapy
- Complementary and Alternative approaches

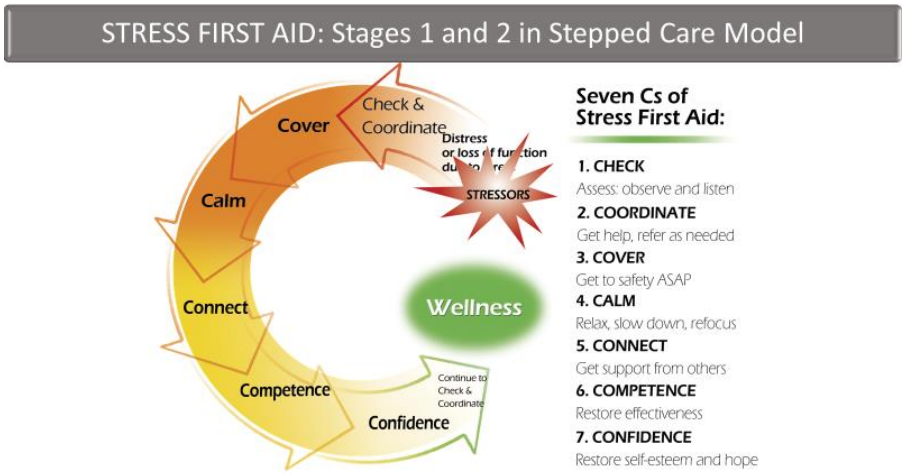
Sorocco and Bratkovich (2018); Feldman.B., Sorocco, Bratkovich (2014); Based on Hyer & Woods (1998)

The Stress First Aid Model:

Stress first aid is a model that was developed in military settings to help service members have better self-care and provide peer support to each other. It has applicability in hospice and palliative care settings

with Veterans because the actions of stress for state are simple and very much tailored towards military culture.
Stress First Aid is based on research literature that says that people tend to do better when they feel safe, are able to calm themselves, feel connected to others, feel like they can get through what they're having to deal with, or have a sense of hope.
Stress First Aid maps onto these five elements, and adds two more, check and coordinate because it is a long-term model that starts with assessing ourselves and others (check) and may require coordinating with others in order to access other resources and support progress or recovery:

- Check should be continuous, and it involves observing, paying attention, and checking in on people on a regular basis.
- Coordinate should also be continuous, and it involves always being aware of additional resources that you may need to refer to, if your SFA actions aren't sufficient to make a difference in alleviating stress reactions.
- Cover maps onto helping a person feel safer.
- Calm involves calming the person down or staying calm through an extended difficult experience.
- Connect involves helping a person feel a greater sense of connection to others, which may be peers, mentors, or family members. This is important because when people are stressed or responding to moral injury or PTSD, they often isolate themselves from others, and remove the possibility of social support, which of been shown to be very helpful in recovery from many types of stress.
- Competence involves helping a person feel more capable in a number of different ways, including feeling more capable to handle their own stress reactions, or feeling better able to function and recover from stressful situations.
- The last element is Confidence, which maps onto helping people have more hope or Confidence in themselves, life, or their spiritual beliefs or values. It may involve helping reduce their sense of guilt or shame, or philosophical questions that arise as a result of the stressors in their life.
- This diagram makes it seem like these actions are sequential, but in actuality, Check and Coordinate are continuous, and the others are only used as needed.
- The goal of SFA is to move people towards wellness.



Trauma Reactions and Symptoms:

Immediate Emotional Reactions

- Numbness and detachment
- Anxiety or severe fear
- Guilt (including survivor guilt)
- Exhilaration as a result of surviving
- Anger
- Sadness
- Helplessness
- Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself)
- Disorientation
- Feeling out of control
- Denial
- Constriction of feelings
- Feeling overwhelmed

Delayed Emotional Reactions

- Irritability and/or hostility
- Depression
- Mood swings, instability
- Anxiety (e.g., phobia, generalized anxiety)
- Fear of trauma recurrence
- Grief reactions
- Shame
- Feelings of fragility and/or vulnerability
- Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)

Immediate Physical Reactions

- Nausea and/or gastrointestinal distress
- Sweating or shivering
- Faintness
- Muscle tremors or uncontrollable shaking
- Elevated heartbeat, respiration, and blood pressure
- Extreme fatigue or exhaustion
- Greater startle responses
- Depersonalization

Delayed Physical Reactions

- Sleep disturbances, nightmares
- Somatization (e.g., increased focus on and
- worry about body aches and pains)
- Appetite and digestive changes
- Lowered resistance to colds and infection
- Persistent fatigue
- Elevated cortisol levels
- Hyperarousal
- Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease

Immediate Cognitive Reactions

- Difficulty concentrating
- Rumination or racing thoughts (e.g., replaying the traumatic event over and over again)
- Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes)
- Memory problems (e.g., not being able to recall important aspects of the trauma)
- Strong identification with victims

Delayed Cognitive Reactions

- Intrusive memories or flashbacks
- Reactivation of previous traumatic events
- Self-blame
- Preoccupation with event
- Difficulty making decisions
- Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma
- Belief that feelings or memories are dangerous
- Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day)
- Suicidal thinking

Immediate Behavioral Reactions

- Startled reaction
- Restlessness
- Sleep and appetite disturbances
- Difficulty expressing oneself
- Argumentative behavior
- Increased use of alcohol, drugs, and tobacco
- Withdrawal and apathy
- Avoidant behaviors

Delayed Behavioral Reactions

- Avoidance of event reminders
- Social relationship disturbances
- Decreased activity level
- Engagement in high-risk behaviors
- Increased use of alcohol and drugs
- Withdrawal

Immediate Existential Reactions

- Intense use of prayer
- Restoration of faith in the goodness of others (e.g., receiving help from others)
- Loss of self-efficacy
- Despair about humanity, particularly if the event was intentional
- Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)

Delayed Existential Reactions

- Questioning (e.g., "Why me?")
- Increased cynicism, disillusionment
- Increased self-confidence (e.g., "If I can survive this, I can survive anything")
- Loss of purpose
- Renewed faith
- Hopelessness
- Reestablishing priorities
- Redefining meaning and importance of life
- Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, &
Grant, 2011.

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS PublicationNo. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Module 3
Table 6: WHV & NHPCO Trauma Informed Care Resource Sheet

Trauma Informed Care: Resource Sheet

1) **"Conversation starters":**
   a. "As people live with serious illness, they sometimes experience reminders of prior scary or upsetting events. Has this happened to you?"
   b. "Have you felt guilty or bothered about events that previously happened in your life?"

2) **Recognizing PTSD (post-traumatic stress disorder):** Providers begin to recognize PTSD symptoms in two Veterans – Helen who is emotionally distant, and Les who has cognitive impairment.
   https://www.youtube.com/watch?v=fPMBtOZ6vUA&list=PL3AQ_JVoBEyyJX0UhUmQG8q4B5nex3cl8&index=1
   Teaching guide: Recognizing PTSD Teaching Guide.pdf

3) **Responding to Trauma Disclosures:** A hospice provider listens empathically as Helen discloses a traumatic memory.
   https://www.youtube.com/watch?v=VXBA9epUqqE&list=PL3AQ_JVoBEyyJX0UhUmQG8q4B5nex3cl8&index=3
   Teaching guide: Responding Teaching Guide.pdf

4) **Addressing trauma related issues**, these are VA developed video training sessions (60 minutes) to include Q&A sessions afterwards (30 minutes):

   - Moral Injury in Vietnam Veterans
   - Suicide Prevention in Vietnam Veterans
   - Posttraumatic Stress Disorder in Vietnam Veterans

   The same training sessions as above with CEUs but no Q&A sessions:
   - https://www.train.org/vha/welcome

5) **Selected Resources from VA and the *We Honor Veterans* program:**
   a. VA Crisis Line- Free, confidential support for Veterans in crisis and their families and friends. **Call 1-800-273-8255 and Press 1.**
   b. ***We Honor Veterans*** link to numerous resources on Trauma Informed Care https://www.wehonorveterans.org/trauma-informed-care/

c. **VA PTSD Consultation Program**- available to healthcare providers caring for Veterans (enrolled or not). Note, this program shares guidance and resources but does not participate directly in care.
www.ptsd.va.gov/consult

d. **VA Telemental Health**- Veterans need to be enrolled prior to accessing services
www.telehealth.va.gov

e. **VA link on all things related to PTSD**:
https://www.ptsd.va.gov/

6) Selected VA developed brochures on PTSD at end of life:

a.


Recognizing Symptoms Caring fo


Caregiver Challenges Caring f


Caregiver Responses Caring fc


Ways to Respond Caring for Veterans

7) **Cognitive Impairment and PTSD:** A hospice provider uses grounding techniques to help Les during a flashback.
https://www.youtube.com/watch?v=Tc_lSzjuVvo&list=PL3AQ_JVoBEyyJX0UhUmQG8q4B5nex3cl8&index=5

Teaching guide:


Cognitive Impairment and PTS

Module 3
Figure 1: Imagery Exercise

Get into a comfortable position (lying or sitting; arms should be at the patient's side or relaxed in the lap if sitting; legs should be uncrossed). Let your jaw drop to relax your facial muscles. I'd like you to begin by taking some deep, slow, cleansing breaths. Breathe in … Breathe out … Breathe in … Breath out … I'd like you to think about your hands. Feel your hands becoming warm, heavy, and relaxed as you breathe in slowly and deeply and exhale slowly. Breathe in … Breathe out … In … Out … Feel the warmth and relaxation flow from your hands into the muscles of your forearms and upper arms; feel those muscles become warm, heavy, and relaxed as you breathe in slowly and deeply. Breathe in … Breathe out … In … Out … Your hands and arms feel warm, heavy, and relaxed.

Now feel the warmth and relaxation flow from your arms into the muscles of your shoulders, neck, and head; feel these muscles become warm, heavy, and relaxed as you breathe in slowly and deeply and exhale slowly. Breathe in … Breathe out … Breathe in warmth and relaxation; breathe out tension and pain; the muscles of your head, neck, and shoulders feel warm, heavy, and relaxed. Feel the warmth and relaxation flow from the muscles of your arms, shoulders, head and neck into the muscles of your upper back and chest. Feel these muscles become warm, heavy, relaxed, as you breathe in slowly and deeply and exhale slowly. Breathe in … Breathe out.... The muscles of your chest and upper back feel warm, heavy, and relaxed.

Now feel the warmth and relaxation flow from your chest and upper back into the muscles of your abdomen and lower back. Feel these muscles become warm, heavy, and relaxed as you breathe in slowly and deeply and exhale slowly. Breathe in … Breathe out … The muscles of your abdomen feel warm, heavy, and relaxed.

Now feel the warmth and relaxation flow into the muscles of your pelvis and buttocks. Feel these muscles become warm, heavy, and relaxed as you breathe in slowly and deeply and exhale slowly. Breathe in … Breathe out … The muscles of your pelvis and buttocks feel warm, heavy, and relaxed. Now feel the warmth and relaxation flow into the muscles of your legs and feet. Feel these muscles become warm, heavy, and relaxed as you breathe in slowly and deeply and exhale slowly. Breathe in … Breathe out … The muscles of your legs and feet feel warm, heavy, and relaxed.

I'd like you to be aware, now, that your whole body is totally relaxed. You feel warm, relaxed, and comfortable. Continue breathing in and out, slowly and deeply. And, while you are feeling relaxed, I'd like you to imagine that your eyelids are a movie screen. See yourself in that special place, the place where you usually feel relaxed and comfortable. It may be indoors or outdoors; you may be alone or with others. Use all of your senses to enter this place of peace, comfort, and relaxation. Be aware of what you see. Be aware of what you feel - are you warm or cool? Be aware of the aromas, the smells associated with this special place. Think about what you hear - hear those sounds now. You are in your special place, feeling comfortable … relaxed … Spend some time there, enjoying this time away... (allow 1 or more minutes to elapse, then continue).

At the count of three, take a deep breath, let it out slowly, and open your eyes. When you open your eyes, you will feel alert, relaxed, and comfortable. (This last instruction can be modified for

subsequent coaching sessions or for an individualized cassette by offering the patient the option of remaining relaxed with eyes closed but advising the patient that your coaching will end).

Source:

Spross, J. A., & Burke, M. W. (1995). Nonpharmacological management of cancer pain. In: D.B. McGuire, C. H. Yarbro and B. R. Ferrell. (Eds.), *Cancer pain management*, 2nd edition (p. 181). Sudbury, MA: Jones and Bartlett Publishers. Reprinted with permission.

Module 3:
Figure 2: Memorial Symptom Assessment Scale (MSAS)

MEMORIAL SYMPTOM ASSESSMENT SCALE														
Name									Date					
Section 1														
Instructions: We have listed 24 symptoms below. Read each one carefully. If you have had the symptom during this past week, let us know how OFTEN you had it, how SEVERE it was usually and how much it DISTRESSED or BOTHERED you by circling the appropriate number. If you DID NOT HAVE the symptom, make an "X" in the box marked "DID NOT HAVE."														
DURING THE PAST WEEK Did you have any of the following symptoms?	DID NOT HAVE	IF YES How OFTEN did you have it?				IF YES How SEVERE was it usually				IF YES How much did it DISTRESS or BOTHER you?				
		Rarely	Occasionally	Frequently	Almost Constantly	Slight	Moderate	Severe	Very Severe	Not at all	A Little Bit	Somewhat	Quite a Bit	Very Much
Difficulty concentrating		1	2	3	4	1	2	3	4	0	1	2	3	4
Pain		1	2	3	4	1	2	3	4	0	1	2	3	4
Lack of energy		1	2	3	4	1	2	3	4	0	1	2	3	4
Cough		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling nervous		1	2	3	4	1	2	3	4	0	1	2	3	4
Dry mouth		1	2	3	4	1	2	3	4	0	1	2	3	4
Nausea		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling drowsy		1	2	3	4	1	2	3	4	0	1	2	3	4
Numbness/tingling in hands/feet		1	2	3	4	1	2	3	4	0	1	2	3	4
Difficulty sleeping		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling bloated		1	2	3	4	1	2	3	4	0	1	2	3	4
Problems with urination		1	2	3	4	1	2	3	4	0	1	2	3	4
Vomiting		1	2	3	4	1	2	3	4	0	1	2	3	4
Shortness of breath		1	2	3	4	1	2	3	4	0	1	2	3	4
Diarrhea		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling sad		1	2	3	4	1	2	3	4	0	1	2	3	4
Sweats		1	2	3	4	1	2	3	4	0	1	2	3	4
Worrying		1	2	3	4	1	2	3	4	0	1	2	3	4
Problems with sexual interest or activity		1	2	3	4	1	2	3	4	0	1	2	3	4
Itching		1	2	3	4	1	2	3	4	0	1	2	3	4
Lack of appetite		1	2	3	4	1	2	3	4	0	1	2	3	4
Dizziness		1	2	3	4	1	2	3	4	0	1	2	3	4
Difficulty swallowing		1	2	3	4	1	2	3	4	0	1	2	3	4
Feeling irritable		1	2	3	4	1	2	3	4	0	1	2	3	4

Module 3:
Figure 2: Memorial Symptom Assessment Scale (MSAS) [cont.]

Section 2										
INSTRUCTIONS: We have listed 8 symptoms below. Read each one carefully. If you have had the symptom during this past week, let us know how SEVERE it was usually and how much it DISTRESSED or BOTHERED you by circling the appropriate number. If you DID NOT HAVE the symptom, make an "X" in the box marked "DID NOT HAVE."										
DURING THE PAST WEEK, Did you have any of the following symptoms?	DID NOT HAVE	IF YES How SEVERE was it usually?				IF YES How much did it DISTRESS or BOTHER you?				
		Slight	Moderate	Severe	Very Severe	Not at all	A little bit	Somewhat	Quite a bit	Very much
Mouth sores		1	2	3	4	0	1	2	3	4
Change in the way food tastes		1	2	3	4	0	1	2	3	4
Weight loss		1	2	3	4	0	1	2	3	4
Hair loss		1	2	3	4	0	1	2	3	4
Constipation		1	2	3	4	0	1	2	3	4
Swelling of arms or legs		1	2	3	4	0	1	2	3	4
"I don't look like myself"		1	2	3	4	0	1	2	3	4
Changes in skin		1	2	3	4	0	1	2	3	4
IF YOU HAD ANY OTHER SYMPTOMS DURING THE PAST WEEK, PLEASE LIST BELOW AND INDICATE HOW MUCH THE SYMPTOM HAS DISTRESSED OR BOTHERED YOU.										
Other:						0	1	2	3	4
Other:						0	1	2	3	4
Other:						0	1	2	3	4

Source: National Palliative Care Resource Site (www.npcrc.org) and accessed August 21, 2022 from http://www.npcrc.org/files/news/memorial_symptom_assessment_scale.pdf

Module 3
Figure 3: Nursing Management of Dyspnea

Please view and downloaded from: https://www.aacnnursing.org/ELNEC/COVID-19

Module 3
Figure 4: Nursing Management of Anxiety

NURSING MANAGEMENT OF ANXIETY

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. A multidimensional subjective and objective experience:

◦ Physical ◦ Affective ◦ Behavioral ◦ Cognitive ◦ Spiritual ◦ Existential

ASSESSMENT

- Listen carefully: Patients may use words such as "worried", "concerned", "on edge", or "tightly wound" rather than anxious.
- Determine if there is a history of anxiety, depression, PTSD or substance use disorder
- Assess for and manage other symptoms such as pain and dyspnea
- Consider metabolic causes: hyperthyroidism, hypoxia, hypoglycemia, hyperthermia, hypocalcemia, serotonin syndrome
- Evaluate psychosocial and spiritual concerns, including isolation, finances, family concerns, existential distress, 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, tachcardia, physical symptoms such as pacing, trembling or signs of restlessness
- Assess for possible withdrawal from alcohol, nicotine, caffeine, 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. Assess for risks and provide resources to assist safety and sobriety.

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	Dose Ranges (start low and gradually increase)
• Citalopram	10-40 mg daily
• Fluoxetine	10-80 mg daily
• Paroxetine	10-60 mg daily
Other Antidepressants	
• Duloxetine	20-60 mg daily (also useful in chronic pain)
• Mirtazapine	15-60 mg daily (promotes sleep and appetite)
Antipsychotics	
• Olanzapine	5-15 mg daily (promotes sleep and appetite, reduces nausea)
Azapirones	
• Buspirone	5-20 mg tid

NONPHARMACOLOGIC MANAGEMENT

- Listening
- Validate emotions and feelings
- Normalize reactions
- Foster connections
- Deep breathing, relaxation, mindfulness, meditation*
- Distraction/music/calming environment
- Spiritual care
- Help patient create a schedule for regular exercise, eating, sleep

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

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

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• Fast Facts #186 Anxiety in palliative care – causes and diagnosis. https://www.mypcnow.org/wp-content/uploads/2019/02/FF-186-anxiety-eval.[illegible]

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Module 3
Figure 5: Mindfulness Apps

NONPHARMACOLOGIC MANAGEMENT FOR STRESS: 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
- **HealthJourneys** – 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 compassion does not include yourself, it is incomplete.' – Jack Kornfield

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

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