Fundamentals of palliative care

Pain and symptom management
WELCOME FROM HOSPICE NZ

Welcome to this training package – we do hope that you enjoy this learning experience and the information here is useful to you in your work.

We would like to take this opportunity to put this education package in context and give you some background to this overall education programme.

In 2009 the Ministry of Health and Hospice New Zealand considered the results of a national stock-take into palliative care service provision.

Nationally, there were two areas of need that required our focus;

- The need for nationally consistent education programmes that support primary palliative care providers.
- The need for revised palliative care standards and an ongoing implementation programme to ensure consistency in the quality of service regardless of locality.

It was agreed Hospice New Zealand was well placed to work on two specific projects to address these needs due to our previous experience and a recent commitment from member hospices throughout the country that these were also priorities for them.

The Minister of Health then allocated a portion of the funding that was available to address difficulties in accessing palliative care services to Hospice NZ for the two projects, this funding commenced on 1 January 2010.

The outcome of both projects will improve the quality and equity of palliative care services available to people and their families and whānau, regardless of the care setting.

This package is part of a 10 part learning series – each contributing to the overall Fundamentals of Palliative Care.

Warm regards,

Mary Schumacher
CEO, Hospice NZ
ABOUT HOSPICE NZ

Hospice NZ exists to support member hospices in their work caring for people who are dying. We are the national organisation whose primary goal is to give voice to the interests, view and concerns of our member hospices.

All hospice services throughout the country are members of Hospice NZ – 30 full members and 4 associate members.

Our purpose is to lead the hospice movement to ensure that every New Zealander has access to quality palliative care.

Our vision is that everyone with a life limiting condition and their families have access to the best possible care.

Our goals:
1. Community engagement – raise awareness and understanding of hospice care through community engagement
2. Leadership – provide national leadership, direction and support through collaboration with members and the wider sector
3. Advocacy – ensure equitable funding and delivery of hospice care
4. Workforce development – support a high performing hospice and palliative care workforce
5. Quality and standards – enhance the quality and standard of palliative care by supporting members to deliver good outcomes for patients, families and whānau.

Our organisational values are a cornerstone to our work;
• Professional
• Respectful
• Caring
• Collaborative
• Honour diversity

www.hospice.org.nz
ACKNOWLEDGEMENTS

Hospice New Zealand was assisted in developing this resource through collaboration with the hospice, primary health, hospital, aged residential care, health of older people and home based support sectors, ensuring the learning packages are ‘fit for purpose’. Both the governance and project teams represent this approach.

Hospice New Zealand wishes to acknowledge the expertise, experience and commitment of members of the Hospice New Zealand Education Governance Group and Education Working Group in developing this version of the Hospice New Zealand Fundamentals of Palliative Care education resource. We sincerely thank them and their trust boards for their contributions of knowledge and time.

The Education Governance Group, chaired by Mary Schumacher, CEO Hospice New Zealand, provided strategic advice on palliative care education and informed the planning of the education programme. The Education Governance Group members were:

Dr Michal Boyd – Senior Lecturer, Freemasons’ Department of Geriatric Medicine, University of Auckland and Gerontology Nurse Practitioner, Community Services for Older Adults, Waitemata District Health Board

Julie Haggie – CEO, Home and Community Health Association New Zealand

Dr Marion Taylor – General Practitioner, Wicksteed House Medical Centre Wanganui and Senior Medical Officer, Hospice Wanganui

Kate Gibb – Nursing Director for Older People, Population Health, Canterbury District Health Board

Dr Brian Ensor – Director of Palliative Care, Mary Potter Hospice and Clinical Advisor to the Hospice New Zealand Board of Trustees

The Education Working Group assisted Hospice New Zealand with developing the content of the education resource through clinical and technical advice, and expert content advice. The Working Group members were:

Rachel Hale – Nurse Practitioner for Older People, Matamata Medical Centre

Liz Angus – Community Team Leader, Access Homehealth Limited

Gayle Elliott – Clinical Nurse Specialist, Specialist Hospital Palliative Care Service, Southern District Health Board

Trish Fleming – Manager, Learning and Development Team, Hospice West Auckland

Jenny Blyde – Team Leader, Counselling and Bereavement Service, Hospice Taranaki

Jan Waldock – Lead Clinical Nurse Educator, Arohanui Hospice

Chris Murphy – Community Liaison and Educator, Mary Potter Hospice

Dr Oleg Kiriaev – Geriatrician and Palliative Care Consultant, Totara Hospice South Auckland and Mental Health Service for Older People, Waitemata District Health Board
Sylvia Meijer – Nurse Practitioner and Team Leader, Health of Older Adults, Central Primary Health Organisation

Anne Hampton – Nurse Specialist/Manager, Te Amo Health, Motueka (also representing Te Kaunihera o Nga Neehi Maori – National Maori Nurses Organisation)

We thank Anne Morgan, Hospice New Zealand Practice Development Advisor, for her role as content coordinator and writer of the education resource.

Project funding from the Ministry of Health has been invaluable in assisting with the development of this programme. Hospice New Zealand gratefully acknowledges the partnership and support of the Ministry.
Pain and symptom management

Teaching time: 3 hours

LEARNING OUTCOMES

These sessions will assist staff to provide care for people with physical symptoms in the palliative phase of their care.

The sessions will be primarily focused at General Practitioners, registered and enrolled nurses but the non drug sections are directed at all members of the multidisciplinary team.

For non medical/nursing staff some of the pre reading may contain medical terminology you are unfamiliar with – note down anything that needs further explanation for clarification during the teaching session.

At the end of the session the participants will be able to;

Session A

1. Describe how pain and symptoms can be assessed using the model of total suffering
2. List the possible causes of physical pain
3. Describe the known barriers to accurate pain and symptom assessment and effective management
4. Outline assessment tools which may be used to assess symptoms, their benefits and limitations
5. Discuss the importance of impeccable and ongoing assessment in developing care plans

Session B

1. Discuss the management of nausea and vomiting
2. Explain the importance of good bowel care and the prevention of constipation
3. Describe how to assess and manage dyspnoea, fatigue, bowel obstruction, delirium
4. Explain the importance of providing the person, family and whanau with support and accurate information about symptoms and their management
5. Explain how to access specialist resources to assist with symptom management
PRE-SESSION READING AND REFLECTION

All care settings

Symptoms are multifactorial with physical presentation being only one consideration. Careful assessment, appropriate diagnosis of the symptom cause and a thorough knowledge of management options are imperative. There are a number of barriers to assessment including the high prevalence of dementia, disability and sensory impairment. It is important to recognise the differences between the person's perception of pain or other symptom and that of the relatives, health workers and medical staff. Only the person with the symptom can feel it. Failing to relieve physical symptoms and the associated distress is a major cause of loss of quality of life.

Pain is defined as an unpleasant sensory and/or emotional (suffering) experience. McCaffery's definition of pain is probably the most relevant: “pain is whatever the experiencing person says it is, existing whenever he says it does” (McCaffery, 1999).

Pain is associated with many health issues faced by people and can have a profound effect on functioning. They may suffer from arthritis, bone and joint disorders, back problems and many other chronic conditions such as heart and vascular disease, neuropathic pain, post-stroke pain and neuralgia.

Assessment of pain is vital for good management. The first principle of assessing pain is to ask the person about the presence of pain on a regular basis. Don’t trust that the person is not in pain because they 'look comfortable.' Always ask them and believe the person's assessment of their own pain.

Aged care settings

It is important for those working in the aged residential care sector to make the management of symptoms a priority area as it can cause a great deal of suffering for people. They experience a range of physical symptoms that require prompt attention, such as fatigue, pain, dyspnoea, constipation, delirium, anorexia and many people may also have dementia. Therefore, holistic care that focuses on regular, detailed assessment and review, establishing as far as possible the person’s priorities and goals for treatment is central to a palliative approach in residential care facilities (Australian Pain Society).

Pain in the elderly is a common and often underestimated problem. On the whole older people tend not to report pain, because they believe it is just part of being old. They also don’t wish to complain and give it a low priority compared to other medical issues (Drage & Schug, 2000). It is therefore imperative that elderly people are asked directly about pain and should not be denied analgesia on the basis that pain is a normal part of the aging process. The prevalence of pain increases with increased age. The prevalence of pain has been reported to be as much as 70 - 80% (Weiner et al. 1999).
The older person may present substantial barriers to accurate pain and symptom assessment and we will discuss those in the teaching sessions. Cognitive and communicative problems will also complicate assessment but there are a number of assessment tools which can help us with assessment.

**Assessment of Symptoms**

Think back to the Essence of Palliative Care package and to the model of total suffering. This should be applied to pain or any other symptom being experienced by a person and will require a team approach.

People with life limiting conditions may develop a number of symptom issues as their disease advances. An awareness of the impact of total suffering is crucial and as health professionals we need to anticipate and manage symptoms as they present.

**THE CONCEPT OF TOTAL SUFFERING**

Each person’s journey with a life limiting condition is unique. The concept of "total pain" or "total suffering" indicates that there are many factors which contribute to the experience of pain and other physical symptoms and each person must be treated with the knowledge that physical symptoms cannot be treated in isolation. Whatever symptom a person is experiencing it is important to look at it in the context of the above models which describe holistic assessment.

For example, if we look at pain as the presenting issue for a person as only a physical symptom then we negate the impact of all the other aspects of total suffering. We need to also look at the pain of leaving behind a spouse. The possible guilt of a previous lifestyle they have lived, cultural aspects of pain and the meaning of pain for a person and the impact it may have on their life; all these aspects will contribute to the lived experience of their pain.
The concept of total suffering can be explained as a ‘clockwork mechanism’ in which various aspects of suffering interact with others. Each aspect of the above model is interdependent and must be viewed as a whole - just as with a clock if one cog is affected the clock can no longer function effectively no matter how much we wind it. Contributing factors to symptoms may change with time so assessment needs to be done regularly and management of symptoms must be timely and medications regularly given on time.

All these aspects identified in the diagram must be considered when assessing symptoms in people with advanced disease in order to provide the best quality of care and to plan goals of care. The person and their needs are the centre of this concept and health professionals must actively engage in listening to their story in order to work with them in finding solutions. It requires a synergistic partnership, takes time and necessitates the building of a therapeutic relationship.

It is important to look at where the person is on this particular day at this particular time. It is their journey and their needs will be constantly changing and evolving over time. It is also important to realise that the choices that people make may not be the ones that we would make for ourselves. We must above all respect people and work with them collaboratively to develop shared goals and realistic aspirations.

Physical assessment of pain

- Accept the person’s description
- Assess pain carefully - history (onset, course, site, radiation, severity, quality, frequency, associated factors, etc.), examination, investigations
- Assess each pain
- Assess extent of disease
- Assess other factors which influence pain
- Reassess
- Examine the site/sites of pain having reviewed the extent of their disease impacting on these sites
- Palpate the areas for tenderness
- Observe for nonverbal cues such as grimacing, body posture, withdrawn behaviour, moaning, agitation or irritability
- Assess for fluid accumulation (e.g. ascites or pleural effusions), abnormal breath sounds (e.g. pneumonia or heart failure), bowel obstruction or neurological problems (e.g. spinal cord compression or neuropathic pain syndromes)
Pain and symptom management

Psychological assessment
• What pain experiences has this person had previously?
• How have they coped with pain previously?
• What are the implications of their diagnosis/prognosis?
• Guilt - do they feel they deserve pain?
• Fear?
• Vulnerability?

Spiritual assessment
• What are their beliefs?
• Are there conflicts in belief systems?
• Questions about strength of faith/loss of faith?
• Will they now be accepted?
• How is pain expressed?
• Culture affects how they understand health and illness and it also affects health professionals and their attitudes to their people

Social and intellectual assessment
• Altered roles and relationships they now face?
• Financial implications?
• Pain of leaving loved ones behind?
• How much do they wish to know?

IMPORTANT: The above questions can be adapted to ANY symptom and impeccable assessment makes management much more effective and means the person’s needs will be met in the best possible way. This will assist in the delivery of holistic or person centred care.

General guidelines when assessing symptoms
(Modified from a CME Resource: Pain and Symptom Management in End of Life Care, 2002)
• Symptom assessment should be performed at regular intervals e.g. on admission, if there is a change in symptom, after medication administration and if there has been a change in the symptom management plan
• Know the person’s medication history and what the person has already tried, which medicines were effective and which were unhelpful
• Ask about non prescribed medications (over the counter medications, herbal products, homoeopathy, naturopathy, tonics etc.), complementary therapies (acupuncture, massage, reiki, reflexology etc.) being used and non drug methods that they may find helpful (massage, osteopathy, heat, cold, music, art, distractions they use)
• Discuss the meaning of their symptoms with them. What are their beliefs and knowledge about them, the reporting of symptoms and their fears about their disease?
• What are their spiritual and cultural beliefs around their symptoms e.g. is it viewed as a punishment or do they believe they must suffer? Is reporting of issues culturally acceptable?

Remember successful provision of symptom relief requires impeccable assessment and a thorough knowledge of the options for management of the symptoms both pharmacological and non-drug and a therapeutic relationship with the patient and family.

REFLECTION TO BRING TO THE TEACHING SESSION

Reflect on a person that you have cared with experiencing pain or other symptoms. Describe the symptoms they were experiencing and reflecting on what you have read about total suffering what may have been some of the factors that need to be considered when assessing this person’s symptoms.

How were their symptoms managed?

Was the care given effective?

Was there something else that you could do that may help?

Registered Nurses/GP’s only

Please complete the quiz on page 13 and bring to pain management teaching session.

All participants

Bring to the teaching session any questions/challenges you face around pain and symptom management.

POST-SESSION EXERCISE

1. Think about the case scenarios discussed in the teaching session and as a multidisciplinary care team create a care plan to meet their pain and symptom needs.
2. Think of your role within the care plan. What can you do to relieve the person’s suffering?
3. How will you support their family?
KEY REFERENCES


Pain and symptom management

1. Giving opioids on a regular schedule is preferred over a prn schedule for persistent pain  
True / False

2. A patient should experience pain or discomfort prior to giving the next dose of medication  
True / False

3. What is the preferred parenteral route of administration of opioids in cancer related pain?  
   Intravenous / Intramuscular / Subcutaneous
   Indicate reason(s) for your choice: _________________________________________________________

4. As opioids can cause respiratory depression, their use is contraindicated in patients with respiratory disease  
True / False

5. When a patient requests increasing amounts of analgesics to control pain, this usually indicates that the patient is psychologically dependent  
True / False

6. For effective treatment of cancer pain it is necessary to continuously assess the pain and the efficacy of the treatment  
True / False

7. What are the 3 main complications of opioids?  
   ___________________________________________________________  
   ___________________________________________________________  
   ___________________________________________________________

8. For constipation related to opiate use in palliative patients, lactulose is the preferred laxative  
   (Explain)  
True / False

9. Morphine elixir when charted regularly for analgesia should be given every _______ hours?  
   In patients with renal impairment how should the dosing regime be amended and why?  
   ___________________________________________________________  
   ___________________________________________________________

10. In patients with dementia it is best to seek alternatives to morphine as analgesia to avoid worsening confusion  
True / False

11. When a patient is on Morphine Sulphate SR 60mg bd what is the appropriate breakthrough dose?  
   ___________________________________________________________

12. It may be useful to give a placebo to a patient in pain to assess that the pain is genuine  
True / False

13. It is a patient’s right to expect total pain relief as a consequence of treatment  
True / False

14. Lack of pain expression shows the patient has no pain  
True / False
Pain and symptom management

Learning outcomes – Part A

1. Describe how pain and symptoms can be assessed using the model of total suffering
2. List the possible causes of physical pain
3. Describe the known barriers to accurate pain and symptom assessment and effective management
4. Outline assessment tools which may be used to assess symptoms, their benefits and limitations
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Models of care
Cultural considerations at the end of life

- What are the attitudes, values and beliefs you bring to your practice?
- What are your rituals around death and dying?
- What is the organisational culture?
- Discuss the important role of the family at this time

Adapted from Waitemata Palliative Care Education Programme 2011

Symptom control

- Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness.
- The approach focuses on the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual.

Symptom control

- People with advancing illness can experience many symptoms before they die
- Our challenge is to identify the problem, think of a possible cause and manage the symptoms in the best possible way in order to provide comfort and relief of suffering
- The person, family and whānau must always be at the centre of the assessment and management plan
Pain and symptom management

Pain

- Early recognition of symptoms is paramount
- Pain is often unrecognized and under treated particularly in the elderly and those with cognitive and communicative difficulties
- Pain is often overwhelming and slow recovery and decreases mobility leading to new problems
- Cognitive and communicative difficulties make assessment difficult
- Attitudes towards expectation of symptoms

Pain

- Pain is what the person says hurts; it is what the person describes and not what or where others say it is
- Good management of pain will aid the management of future pain
- Palliation of other symptoms will improve pain control
- Total suffering must be considered - failure to address psychological distress and social/cultural issues is a common cause of unrelieved pain

“We cannot know when another is experiencing pain, unless they tell us. Self-report is the only valid measure of pain.”

(Mesquita, 2002)

Physical assessment

- Accept the person’s description
- Assess pain carefully – history (onset, course, site, radiation, severity, quality, frequency, associated factors, etc.), examination, investigations
- Assess each pain
- Assess extent of disease
- Assess other factors which influence pain
- Reassess regularly
Physical assessment continued

Ensure a physical assessment is done

- Examine the sites of pain;
- Palpate the areas for tenderness
- Observe for nonverbal cues such as grimacing, body posture, withdrawn behaviour, moaning, agitation or irritability
- Assess for fluid accumulation (e.g. ascites), abnormal breath sounds (e.g. pneumonia or heart failure), bowel obstruction or neurological problems (e.g. spinal cord compression)

Psychological assessment

- What pain experiences has this person had previously?
- How have they managed pain in the past?
- When is the pain most troubling then?
- Guilt – does severe pain?
- Fear

Cultural and spiritual assessment

- What are their beliefs?
- Conflict in belief systems?
- Questions about strength of faith?
- Will they row be accepted?
- How will they express their pain?
- Culture affects how they understand health and illness and it also affects health professionals and their attitudes
- Gentle truth – telling
Pain and symptom management

Social and Intellectual Assessment

- Alteration of roles and relationships
- Pain of leaving loved ones behind
- How much do they wish to know?
- Financial issues

Impeccable Assessment

- What is the person saying?
- Assessment tools are not always helpful – good questioning is more accurate
- Consider barriers:
  - Cognitive and communicative deficits
  - Social diversity
  - Persons attitude to planned treatment
  - Health professionals better

Assessment Tools

- Pain scales – limited use
- Face scale – limitations
- Good questioning is more accurate (physical assessment questions)
- Needs to be multidimensional – not linear
- Body charts are a useful self reporting tool
- Documentation of assessment is imperative
Pain and symptom management

The Abbey Pain Scale

Possible causes of pain in palliative care

- Low back disorders
- Degenerative joint disease
- Rheumatoid arthritis
- Gout
- Pressure and skin ulcers
- Chronic leg cramps
- NYD
- Amputations
- Mood disorders
- Post-stroke pain syndromes
- Neuropathic pain – diabetic neuropathy, trigeminal neuralgia
- Headaches
- Dental problems
- Angina
- Constipation
- Immobility
- Improper positioning

Management of pain

Aim of treatment is prompt relief of the pain and prevention of its recurrence;
- thorough assessment (and reassessment)
- good communication
- reassurance about pain relief
- discourage acceptance of pain
- be consistent, not variable
- use the interdisciplinary team
Principles of analgesic use

By mouth if at all possible:
- By the clock – give regularly;
- Individual treatment
- Supplementation
- Prevention of side effects
- Adjuncts
- Subcutaneous if oral route no longer possible

Choosing the right medication

- Individualised treatment
- What is the person currently taking?
- Best medication with least side effects
- Try one new medication at a time and assess effectiveness
- Regular charting for symptoms rather than just PRN
- Anticipate and treat drug side effects
- Rationise medications taken to avoid unnecessary polypharmacy

Non-drug options:

- Massage
- Music therapy
- Art therapy
- Heat packs
- TENS
- Relaxation and visualisation
- Humour and distraction
- Be resourceful
Pain and symptom management

Key to success

- Comprehensive assessment of pain
- Identification of type of pain
- Combination of pharmacologic and non-pharmacological treatment
- Adoption of medications to co-morbidities
- Start with medications having the best efficacy:adverse effects ratio
- ‘Start low, go slow’
- Be attentive to drug–drug interactions
- Re-evaluate frequently

Learning outcomes – Part B

1. Discuss the management of nausea and vomiting
2. Explain the importance of good bowel care and the prevention of constipation
3. Describe how to assess and manage dyspnoea, fatigue, bowel obstruction, delirium
4. Explain the importance of providing the person, family and whānau with support and accurate information about symptoms and their management
5. Explain how to access specialist resources to assist with symptom management

Other symptom issues

- Impeccable assessment – same principles apply as for pain assessment
- Correct the cause of the symptom if at all possible and if appropriate to do so
- Unrespected symptoms lead to poor quality of life, possible confusion and decreased function
- Listen to what the person is telling you
- Use model of total suffering for assessment of each troublesome symptom
What is nausea?

- Nausea is a subjective feeling of an unpleasant wave-like sensation experienced in the back of the throat and/or epigastrium that may or may not result in vomiting.
- Nausea, vomiting and retching are common and distressing.
- 50-60% of people with advanced disease suffer from one or more of these and it affects their quality of life.

Assessment of vomiting

- Need to take a detailed history of when they feel sick or vomit and a clinical examination to determine cause — may also need blood tests and X-rays.
- It is important to:
  - distinguish between vomiting, expectoration and regurgitation;
  - note the colour of the vomit;
  - separately evaluate nausea and vomiting;
  - review the medicines they are taking;
  - examine their mouth, abdomen — look for thrush, check bowel sounds to exclude a bowel obstruction;
  - the time of onset may provide clues as may associated symptoms.
- Re-evaluate at regular intervals.

Reversible causes of vomiting

- Hypercalcaemia — Rehydration and bisphosphonates
- Infection — Antibiotics
- Raised ICP — Dexamethasone
- Gastric irritation — Stop NSAIDs/give omeprazole
- Constipation — Laxatives and rectal measures
- Anxiety — Anxiolytics
## Pain and symptom management

<table>
<thead>
<tr>
<th>Causes</th>
<th>Characteristics</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting</td>
<td>Exacerbated by movement</td>
<td>Use cyproheptadine or scopolamine patch.</td>
</tr>
<tr>
<td>Obstructive</td>
<td>Constipation</td>
<td>Medical advice + recting with sedatives and laxatives.</td>
</tr>
<tr>
<td>Mucous</td>
<td>Upper GI obstruction – usually due to distal gut obstruction.</td>
<td>Medical advice + recting with sedatives and laxatives.</td>
</tr>
<tr>
<td>Injury</td>
<td>Intracranial pressure raised</td>
<td>Medical advice + sedatives and analgesics.</td>
</tr>
<tr>
<td>Faeces</td>
<td>Metabolic acidosis and vomiting</td>
<td>Medical advice + recting with sedatives and laxatives.</td>
</tr>
</tbody>
</table>

### General principles

**Diet**
- Avoid exposure to any foods that precipitate nausea
- Give small snacks and not big meals
- Perhaps the family can provide preferred foods
- Food presentation
- Nutritional supplements
- Avoid air conditioned circumstances

### Pharmacological principles

- Nausea can be treated with oral drugs
  - But alternative routes are needed for people with severe nausea
- Persistent nausea may decrease gastric emptying with resultant decrease in drug absorption
  - Use subcutaneous or rectal route
- Chart antiemetic’s regularity
- Combinations are often required—check interactions
Common issues to consider

- PRN drugs for nausea
  - Ondansetron not useful in palliative care
- Laxatives often omitted
  - Medical should not be used as first line
- Polypharmacy at EOL
- Subcutaneous medications

Constipation

Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Type 2</th>
<th>Type 3</th>
<th>Type 4</th>
<th>Type 5</th>
<th>Type 6</th>
<th>Type 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumps of hard stool</td>
<td>Lumps of soft but unformed stool</td>
<td>Lumps of semi-formed stool</td>
<td>Lumps of formed stool</td>
<td>Lumps of formed stool with visible straining</td>
<td>Smooth stool</td>
<td>Shapeless mass passing through a Rubin's sound</td>
</tr>
</tbody>
</table>

Treatment

- Most important is prevention
- Appropriate food and fluids
- Keep daily record of bowel motions or provide person with self-reporting diary
- Education of risk of constipation to person, family, and whanaun
- Intervention
  - See guidelines
Pain and symptom management

Non drug treatments

- Bowel Mixture
  - 1 cup of stewed apples
  - 1 cup of stewed prunes
  - 1/2 cup of cooking bran
  - Mix all together – take 2 lbs/day
- Encourage regular activity within the person’s abilities
- Encouraging good bowel habits
- Toilet facilities – ensure privacy
- Gentle abdominal massage

Dyspnoea

- Dyspnoea is the unpleasant awareness of breathing.
- It is subjective, usually frightening, and can be present even if the breathing appears normal
- Most distressing symptom experienced by people with life limiting illness
- There are many potential underlying causes – treat where possible
- Supportive therapy is important

Treating dyspnoea pharmacologically

- Oxygen: may be useful, however it is controversial – take care of people who retain CO₂
- Nebulisers
- Opioids: main therapy
  - decrease perception of breathlessness
  - decrease respiratory drive
  - decrease oxygen consumption
- Benzodiazepines
  - midazolam nasal spray
- Steroids – can help bronchodilation
Supportive therapy

- A calm environment
- Position
- Limit activity to reduce exertion
- A cool draft (fan, open window, air conditioner, humidifier)
- Breathing exercises (physiotherapy referral)
- Relaxation / lifestyle modification (OT referral)
- Complementary therapy (massage, acupuncture, self-hypnosis, music therapy etc)
- Educate patient, family and whānau about dyspnoea
- Evaluate and manage anxiety
- Not being left alone

Retained airway secretions

Also known as “death rattle”
- Explanation to family
- Regular position changes
- Administer anticholinergics
  - scopolamine patch – need to apply early to be effective
  - Buscopan (hyoscine butylbromide) tabs or subcut
  - Atropine (tends to be excitatory and should be avoided)
- Section – rarely indicated

DELIRIUM, AGITATION, RESTLESSNESS

Assess for underlying cause

D: Drug, e.g. opioids, sedatives, anticholinergics, psychotropics
- Delirium
- Drug, alcohol or nicotine withdrawal

E: Electrolyte or pH disturbances
- Hypokalaemia
- Metabolic acidosis

L: Liver failure

I: Infection

R: Renal failure

I: Infection of wound

U: Urinary tract or other infection

M: Metastases to the brain

Pain and symptom management

Management:

- Assess cause(s) and treat where possible
- Create environment
- Family present
- Drug therapy
  - Haloperidol
  - Benzodiazepine (lorazepam, midazolam)
  - Nuzenan

Specialist and local resources:

- NZ Palliative Care Handbook (2012)
- Your Local DHB resources such as:
- NZ Palliative Care Nursing – has monthly palliative care drug information provided by the Palliative Care Medicines Working Group
  - [http://www.palliativedrugs.com](http://www.palliativedrugs.com)

Conclusion

- You can make a difference
- Excellent communication is paramount – listen to understand, rather than listening to reply
- What is happening for the person at this particular time
- Their needs will change over time
- Think ahead of time – plan and prevent
- Use specialist resources