Alberta Hospice Palliative Care Community of Practice: **Pain and Anxiety Medications at End of Life from a Palliative Nurse Consultant Perspective**

Presenter:

Luisa Arevalo, RN

Facilitator:

Danica Hans, Education Lead, Covenant Health Palliative Institute

Host:

Manpreet Tatla, Program Assistant, Covenant Health Palliative Institute

Date:

May 29, 2025

Project ECHO® Palliative Care - Canada BY Pallium Canada

Covenant Health Palliative Institute

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a five-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

Stay connected: www.echopalliative.com

Project ECHO Palliative Care - Canada BY Pallium Canada

Covenant Health Palliative Institute

Disclosures

The Palliative Care Public Awareness project is funded by the Government of Alberta. The views expressed herein do not necessarily represent the views of the Government of Alberta.

Reminders

- This session is being recorded.
- Please do not disclose any personal health information during the session.
- Your microphones are muted. When we invite participation, please unmute yourself if you'd like to speak at that time.
- If you experience technical difficulties, please let us know in the chat.

Covenant Health
Palliative Institute

Pain and Anxiety Medications at End of Life from a Palliative Nurse Consultant Perspective

May 29th 2pm-3pm MST

Land Acknowledgement

Quality palliative care helps you honour your culture, spirituality, and traditions. At LivingMyCulture.ca, people from various cultures share their stories and wisdom about living with serious illness, end of life and grief to support others.

First Nations, Inuit, Metis perspective

Living My Culture

Member Introductions

Tell us a little about you:

- Your role
- Location of work
- Your favorite summer getaway location

Let's Reflect

Learning Objectives

After this session participants will:

1. Describe common causes and presentations of pain and anxiety, and opioid induced neurotoxicity
2. Identify pharmacologic strategies to effectively manage pain and anxiety
3. Demonstrate a compassionate, patient-centered approach to communication about symptom management with patients and families

Outline

Pain and anxiety review

Meet Darlene

- Management of pain and anxiety

How to assess and document

Reaching out for specialist

Involving the family

Pain Review

Palliative Care Corner

Covenant Health
Palliative Institute

Pain Assessment #1

Use consistent, systematic, and evidence-based tools to assess symptoms. In palliative care pain is a prevalent symptom that can negatively impact quality of life and is consistently a primary source of fear for end-of-life care.

Ask these questions for pain assessment

Fraser Health Symptom assessment acronym (OPQRSTUV Evaluation)

Onset	• When did it begin? • How long does it last? • How often does it occur?
Provoking/ Palliating	• What brings it on? • What makes it better or worse?
Quality	• What does it feel like? • Can you describe it?
Region/ Radiation	• Can you show me where it is? • Does it spread anywhere or move around?
Severity	• How intense is the symptom? (pain scales) • How bothered are you by this symptom? • Are there any symptoms that accompany this?
Treatment	• What medications/treatments are you currently using? How effective are they? • Do you have side effects from these medications/treatments • What have you used in the past?
Understanding/ Impact on you	• What do you believe is causing this symptom? • How is this symptom affecting you and/or your family?
Values	• What is your goal for this symptom? What is your comfort/acceptable level for this symptom? • Are there any views or feelings about this symptom that are important to you or your family?

Hagarty, A.M., Bush, S.H., Talarico, R., Lapenskie, J., Tanuseputro, P. (2020). *Severe pain at the end of life: a population-level observational study*. BMC Palliative Care, 19 (1). https://doi.org/10.1186/s12904-020-00569-2

For more information and to access this tool and other AHS approved tools visit https://www.albertahealthservices.ca/info/Page14546.aspx under Assessment Approaches or contact Palliative.Institute@CovenantHealth.ca

Pain Review

Interior Health

Pain Assessment in Advanced Dementia (PAINAD) Scale

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched, knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			TOTAL	

Scoring:

1–3	Mild pain	*Provide comfort measures (i.e., non-pharmacologic approaches such as repositioning or distraction or a mild analgesic such as acetaminophen)*
4–6	Moderate pain	
7–10	Moderate to Severe pain	*Pain that warrants stronger analgesia, such as an opioid, as well as comfort measures*

Warden, V., Hurley, A. & Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. JAMDA, 4(1), 9 -15.
Horgas, A., & Miller, L. (2008). Pain assessment in people with dementia. American Journal of Nursing, 108(7), 62-70.

810310 Feb 13-19

Palliative Care Corner

Covenant Health
Palliative Institute

Pain Assessment #1

Use consistent, systematic, and evidence-based tools to assess symptoms. In palliative care pain is a prevalent symptom that can negatively impact quality of life and is consistently a primary source of fear for end-of-life care.

Ask these questions for pain assessment

Fraser Health Symptom assessment acronym (OPQRSTUV Evaluation)

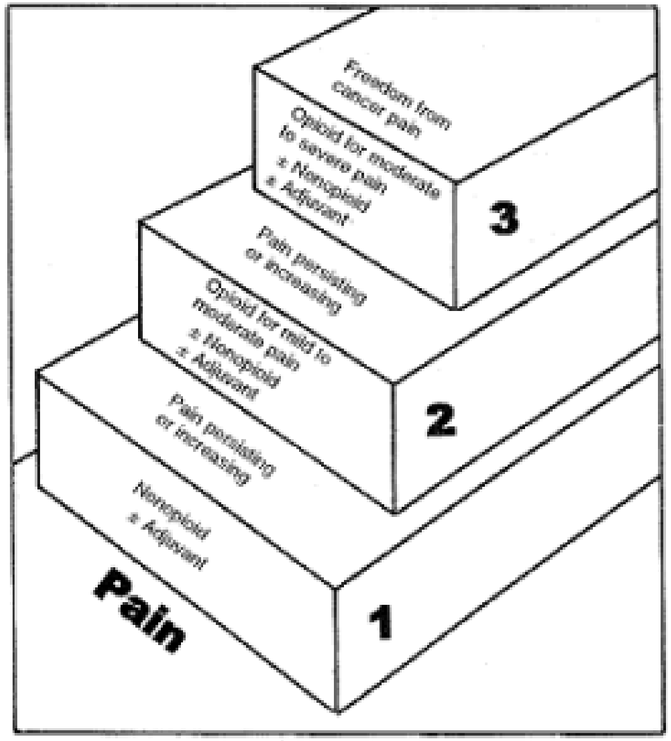
Onset	• When did it begin? • How long does it last? • How often does it occur?
Provoking/ Palliating	• What brings it on? • What makes it better or worse?
Quality	• What does it feel like? • Can you describe it?
Region/ Radiation	• Can you show me where it is? • Does it spread anywhere or move around?
Severity	• How intense is the symptom? (pain scales) • How bothered are you by this symptom? • Are there any symptoms that accompany this?
Treatment	• What medications/treatments are you currently using? How effective are they? • Do you have side effects from these medications/treatments • What have you used in the past?
Understanding/ Impact on you	• What do you believe is causing this symptom? • How is this symptom affecting you and/or your family?
Values	• What is your goal for this symptom? What is your comfort/acceptable level for this symptom? • Are there any views or feelings about this symptom that are important to you or your family?

Hagarty, A.M., Bush, S.H., Talarico, R., Lapenskie, J., Tanuseputro, P. (2020). *Severe pain at the end of life: a population-level observational study*. BMC Palliative Care, 19 (1). https://doi.org/10.1186/s12904-020-00569-2

For more information and to access this tool and other AHS approved tools visit https://www.albertahealthservices.ca/info/Page14546.aspx under Assessment Approaches or contact Palliative.Institute@CovenantHealth.ca

Pain Management and the WHO Analgesic Ladder

- Drug selection matching severity
- WHO Analgesic Ladder
  - By the ladder
  - By the clock
  - By the mouth
- Use of adjuvants
  - Pharmaceutical (antidepressants, gabapentin, corticosteroids, etc.)
  - Non-pharm (RT, nerve blocks, hot/cold, etc.)



Pain Management Considerations

- Bowel care
- Sedation
- Short versus long acting
- Respiratory depression

} Strong opioids

- Risk of gastric ulcers with NSAIDs and corticosteroids (prescribe PPI)

We gave the breakthrough, now what?

It may take up to 5 half lives to reach full effect

3 rules of 3s

Titration

- **Frequency** (q8 hr→ q 6 hr → q 4 hr)
- Start increasing **dose** (Looking at TDD or 25% every 24 hours)
- +/- Adjuvants

Why it's ordered q 1 hourly

Rule of 3's

- If > 3 PRN's in 24 hours consider scheduling
- If > 3 BT in 24 hours, consider titrating
- If > 3 BT in 8 hours with minimal effect, consider immediate reassessment

How To Document Your Assessment

Edmonton Symptom Assessment System Revised (ESAS-r)

Nursing Notes and Handover Notes

- Document what, when, why you gave, and effectiveness

Connect Care:

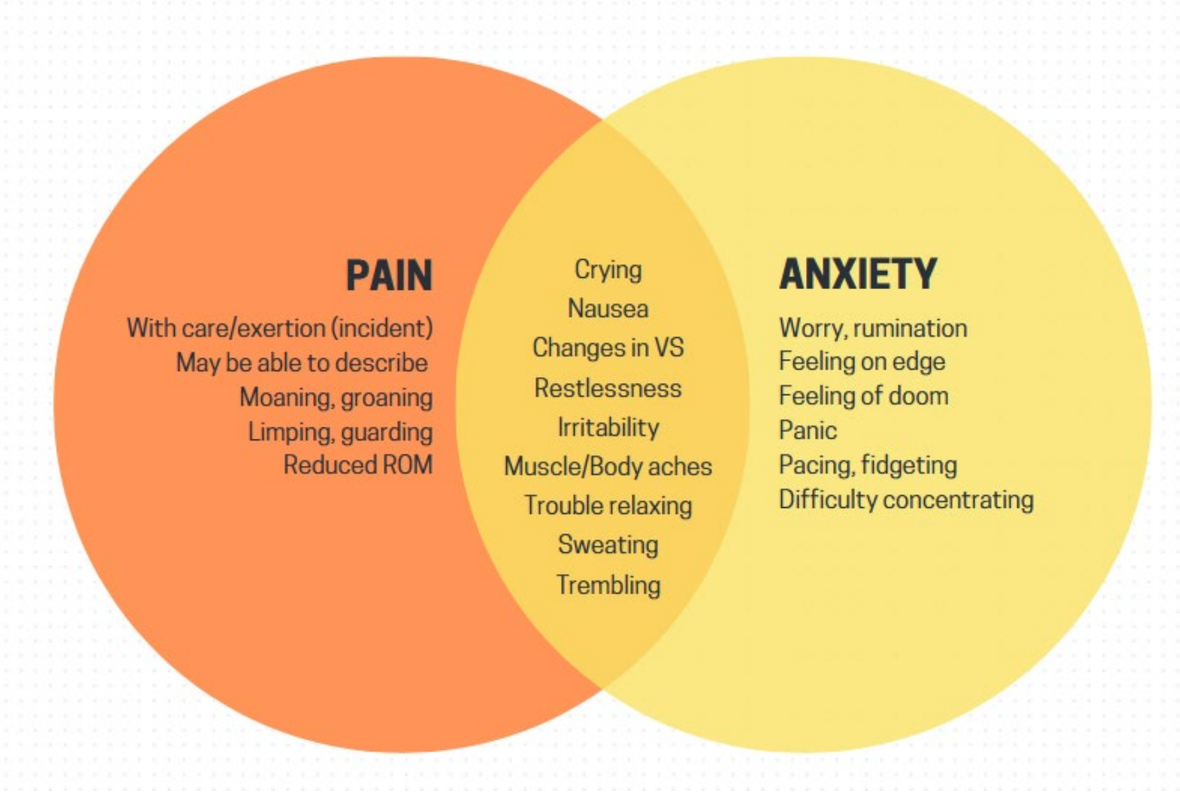
Basic Assessment Flowsheet

Vitals (Pain Assessment)

C2 Pathway Nursing Symptom/Care (*AHS/CH)

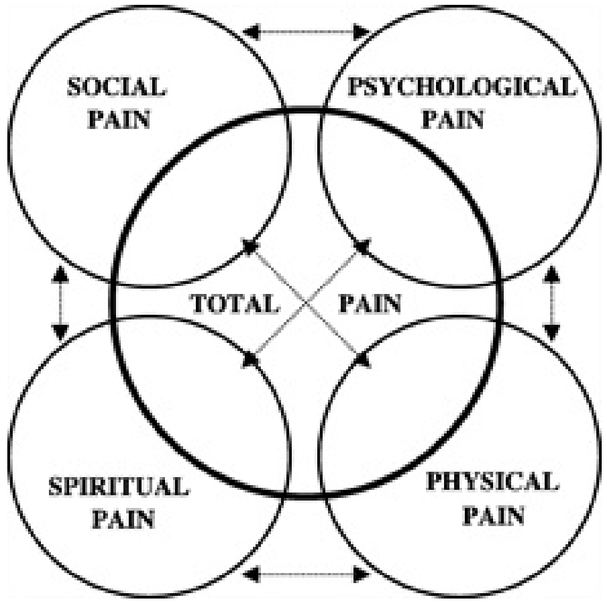
Pain vs Anxiety

Cannot be easily separated, as it is the patient's experience



Total Pain

Pain to be understood as a multifaceted experience encompassing physical, emotional, social, and spiritual aspects, rather than solely physical symptoms.



Delirium vs Distress

Confusion and/or delirium could be an expected change at end of life

Can be hyperactive, hypoactive*, or a mix of both

They may or may not be in distress

Hyperactive	Hypoactive
Anxious, restless, or agitated	Sad, withdrawn, and drowsy

Meet Darlene

82 yo woman from ALC with history of breast cancer, diagnosed 6 years ago, on background of multiple co-morbidities. Despite surgery, chemotherapy, and radiation, her disease progressed with metastases to bone and liver.

Over the past month has had increasing fatigue, weight loss, and escalating bone pain unrelieved by oral opioids. PPS 40%.

She has had two hospital admission for pain crises and hypercalcemia. She has changed her GCD to C1 and returned to ALC. She does not want to return to hospital if her condition worsens.

Darlene Case Example Cont'd

Darlene has been having increasing pain "all over".

No other symptom concerns.

You give a breakthrough and review her chart to assess what is ordered for pain management.

An hour later, Darlene tells you the pain medication only helped for a short time (?end of dose failure)

Darlene Case Example Cont'd

Hydromorphone 1 mg PO every 6 hours ATC with 0.5 mg PO q1 hr PRN for pain/dyspnea

- Has had 6 BT hydromorphone in 48 hours

Expect increase in frequency

Increase hydromorphone to 1 mg PO every 4 hours ATC with 0.5 mg PO q1 hr PRN for pain/dyspnea

- Several days later, reassessed and found to have used 4-6 BT/day

Expect an increase in scheduled dose (based on TDD, or 25%)

Darlene Case Example Cont'd

Next time you assess Darlene, she tells you she is having vivid dreams, and you observe some myoclonus.

Simple things that did not hurt her before, she is sensitive to (the sheets on her skin, the pillow behind her back).

Opioid-induced Neurotoxicity (OIN)

Myoclonus, Vivid dreams

(may precede onset of opioid-induced neurotoxicity)

Hallucinations

Hyperalgesia (heightened sensitivity to the existing pain)

Allodynia (a normally non-noxious stimuli resulting in a painful sensation)

Seizures

What To Expect In A Rotation

Fluids (via clysis)

Dose reduction- if the pain was controlled on previous dose

If pain not controlled, then conversion

- Expect a 20-25% reduction due to incomplete cross-tolerance

Gap in pain control, utilize breakthroughs

Darlene Case Example Cont'd

Her hydromorphone has been rotated to morphine, and her pain control is mostly well-controlled.

But now Darlene seems to be in a hypoactive delirium. She spends most of her time sleeping, and when she is awake, she is restless.

The team rules out polypharmacy and infection, but her calcium is elevated again.

MRHP discusses this with the family. They know that IV pamidronate may or may not be effective at this stage (already had 2 doses in hospital), nor do they want more pokes (IV medication).

They opt to focus on symptom management, which is in line with her GCD.

Darlene Case Example Cont'd

When she's awake, she is restless and not having meaningful interactions with her family.

Nurses have ruled out constipation and dyspnea as reasons for the restlessness

Started on haloperidol 0.5 mg SC every 8 hours ATC

- Used 2-3 BT haldol/day and nurses report minimal effect

Escalating Anxiolytics/Antipsychotics

Rule out other causes (bowel care, polypharmacy, infection)

E.g., haloperidol to methotrimeprazine (use the 3 rules of 3)

- Consider palliative diagnosis (Parkinson's, risk for seizures)
- Risk for EPS, QTc prolongation

Could also see olanzapine, loxapine, lorazepam, midazolam

Expect to see 1st, 2nd, 3rd line medications

Darlene Case Example Cont'd

D/C haloperidol. Methotrimeprazine 12.5 mg SC every 6 hours

- Used 2-3 BT/day and nurses report partial effect

Increased methotrimeprazine to 12.5 mg SC every 4 hours and then added Lorazepam 1 mg SC every hour as needed for agitation, restlessness if methotrimeprazine ineffective

Darlene Case Summary

Maximized her hydromorphone (frequency, and then dosing) until she became toxic, and then rotated to morphine

Pain is managed but developed a hypoactive delirium the team thinks is related to hypercalcemia

Escalated her antipsychotics to help settle.

Along with her scheduled analgesic, her symptoms were well managed.

When to reach out for a specialist:

Zone specific (palliative nurse navigators, RAAPID Pall On-call)

Indications/Triggers:

- Symptoms are difficult to manage
- Maximized breakthrough usage
- Comfortability of the team/MRHP
- Patient or family request

Drug administration considerations

Methotrimeprazine (Nozinan)	Dilute 1:1 with saline, and flush clysis site
Phenobarbital	Very thick and slow to absorb, push slowly
Lorazepam SC (Ativan)	Very thick, use bigger gauge needle. Flush clysis site with NS
Loxapine SC (Loxapac)	Dilute 1:1 with sterile water
Olanzapine	Follow package instructions, usually reconstitute with sterile water. Flush clysis site. Note stability after constitution

* Dedicate a site for each medication ** clysis port volume is about ~0.3 mL

Involving the Family

- Patient-family centered care
- Assessment and findings
- How to ask for PRN’s, however set the expectation
- Involve them in care (e.g., mouth care)
- Explain expected changes at EOL
- If they are resting comfortably…

Discussion

- What end of life symptoms do you often notice?
- How do you describe them to patients and families?
- What symptoms are hardest to manage?

- What is working well?

- What could be improved?

References

Pain Assessment australia palliative care pain assessment - Google Search

Pain Topics – Pain – Canadian Virtual Hospice

WHO Pain Ladder World Health Organization (WHO) Analgesic Ladder.indd

Rule of 3's 2-BCPC-Clinical-Best-Practices-colour-Pain.pdf

99 Common Questions (And More) About Hospice Palliative Care: A Nurses Handbook, 4rd ed.

Dementia Pain scale 810310-pain-assessment-advance-dementia-scale.pdf

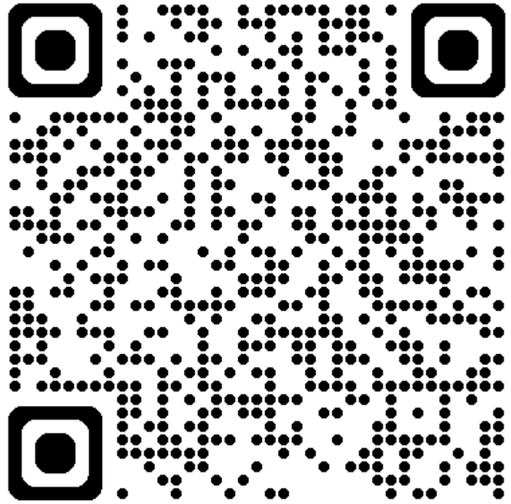
Assessing anxiety Day # 63: Mental Status Exam in Anxiety

Total Pain Journal of Hospice & Palliative Nursing

Delirium Delirium in palliative care | Information for professionals | Marie Curie

Thank you

Evaluation



[Alberta Hospice Palliative Care Community of Practice: Orientation and Continuing Education]

Project ECHO Palliative Care - Canada BY Pallium Canada

Covenant Health Palliative Institute

Upcoming Session

Palliative Sedation: A Nursing job aid

Date: September 25th 2025
Presenter: Sheila Killoran

This session will explore the steps and the implications of palliative sedation from a practical perspective.

Stay Connected

- Visit Compassionate Alberta (covenanthealth.ca) to access all our tools and resources.
- Please subscribe to our newsletter: Palliative Institute | Compassionate Alberta newsletter
- Contact us at: Palliative.Institute@covenanthealth.ca

@CHPalliative Covenant Health Palliative Institute Palliative Institute

Project ECHO Palliative Care - Canada BY Pallium Canada

Covenant Health Palliative Institute

Thank You!

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

Project ECHO Palliative Care - Canada BY Pallium Canada

Covenant Health Palliative Institute